

TEXAS SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES



INTERIM REPORT TO THE 88TH LEGISLATURE

December 2022



THE SENATE OF TEXAS
COMMITTEE ON HEALTH AND HUMAN SERVICES

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December 14, 2022

The Honorable Dan Patrick
Lieutenant Governor of Texas
P.O. Box 12068
Austin, TX 78711

Dear Governor Patrick,

The Senate Committee on Health and Human Services submits this report in response to the interim charges you assigned to this committee. Please note that the interim charge you assigned to the committee related to the Department of Family and Protective Services is addressed in the report by the Senate Special Committee on Child Protective Services.

Respectfully submitted,

Handwritten signature of Lois Kolkhorst in black ink.

Senator Lois Kolkhorst, Chair

Handwritten signature of Charles Perry in black ink.

Senator Charles Perry, Vice-Chair

Handwritten signature of César Blanco in black ink.

Senator César Blanco

Handwritten signature of Dawn Buckingham in black ink.

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Senator Borris Miles

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Senator Kel Seliger



The Senate of Texas

César J. Blanco
Texas Senator
District 29

November 30, 2022

Dear Chairwoman Kolkhorst,

First, Thank you for your staunch advocacy and commitment to the health and well-being of all Texans through your leadership as our Committee Chair.

I'd also like to thank the committee staff for their work developing this report recapping the testimony delivered during the interim, and putting forth recommendations that will help bolster the healthcare workforce and improve public health data and pandemic response. I appreciate the opportunity to provide feedback on the interim committee report.

Although I mostly agree with the report and recommendations put forth, I believe that the prohibition of future mask mandates is of concern given the data that supports their use as an effective community measure to limit the spread of COVID-19 and other infectious diseases. Evaluations of the general state policies issued during COVID mandating face coverings showed a strong relationship with the reductions in county-level COVID-19 growth rates.¹ Although the mask mandates were not a perfect prevention strategy, they provided an extra layer of protection for all Texans, particularly our populations at most significant risk of severe illness, those that are immunocompromised and senior citizens. I respectfully request that the committee consider striking this recommendation from the report, as conflicting evidence substantiates their use as a community-based measure, and further evaluate their effectiveness in specific settings to put forth guidelines for their appropriateness. Additionally, I would like to express my concern about the establishment of an independent regulatory entity to develop and distribute disease treatments.

I appreciate your consideration of my suggestions and look forward to continuing to work with my Senate colleagues to develop effective policies for the betterment of all Texans' health.

Respectfully,

A handwritten signature in black ink, appearing to read "Cesar J. Blanco".

Cesar J. Blanco
District 29
Texas State Senator

¹ Wong, Angus K.; Balzer, Laura B.. State-Level Masking Mandates and COVID-19 Outcomes in the United States: A Demonstration of the Causal Roadmap. *Epidemiology*: March 2022 - Volume 33 - Issue 2 - p 228-236 doi: 10.1097/EDE.0000000000001453

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INTERIM CHARGE I: PUBLIC HEALTH DATA

Interim Charge Language: *Review the processes for public health data collection and coordination by local and state entities as well as regional trauma centers. Identify any continuing barriers to the real-time dissemination of data concerning health care facility capacity—including data that can expedite timely care—and mortality rates, as well as other information that can assist in public policy decisions.*

Introduction

Public health data is used by health officials, providers, private entities, research institutions and state, local, and federal governments to make decisions related to the health and safety of Texans. During the COVID-19 public health emergency, data about cases, hospitalizations, tests, and fatalities were crucial to make decisions related to business and school closures, prevention measures, testing, messaging, and resource allocation. The accuracy, timeliness, and completeness of public health data are essential to informing such decision-making and restoring the public trust in public health policies.

The Texas Department of State Health Services (DSHS) launched the public-facing state COVID-19 dashboard on March 24, 2020. Data elements reported on this site include regional hospital capacity, county-level counts, and trends of tests, cases, hospitalizations, and fatalities. Case and fatality demographic data are revised weekly, while case counts and hospitalization incidents are updated daily. The dashboard serves as a primary source of COVID-19 data for the state. Many local public health jurisdictions also publish local COVID-related data. Prior to the COVID-19 pandemic, DSHS published finalized infectious disease data six months after the calendar year, following rigorous quality checks.

The National Electronic Disease Surveillance System (NEDSS) is the basis for disease surveillance in Texas. The pandemic pushed NEDSS to its full capacity, resulting in the need for information technology (IT) improvements. However, due to the sheer volume of information generated during the pandemic, some providers, health facilities, and local governments lacked the necessary IT systems to report data in a timely manner, resulting in delays and backlogs. Among the number of data points required to be collected were: hospital bed capacity, diagnostic laboratory data, disease reporting, case information, immunization registry, and coding of COVID-19 deaths.¹ A lack of uniformity between state and federal reporting prompted legislators to seek statutory changes on how data is handled in a public health disaster. Senate Bill 969 sought to better ensure the accessibility and integrity of critical data by requiring DSHS to develop a standardized data collection and reporting method for use by various health facilities and laboratories during a declared public health disaster. In addition, the bill also gave authority to seek civil penalties for facilities that fail to report.²

Public Health Data and Implementation of Senate Bill 969

State law requires medical providers, laboratories, and other entities to report "notifiable conditions" such as COVID-19 to the local health authority.³ As such, COVID-19 data elements are sourced from health care providers, laboratories, hospitals, medical certifiers, and any entity conducting testing. During the early stages of the pandemic, outdated data systems operated with little flexibility and short-term durations.⁴ During typical events/disasters, data collection is vetted over time to ensure accuracy. As the pandemic required daily reporting, the need for IT improvements and a coordinated reporting system across the health care system became apparent. NEDSS had been the primary system of COVID-19 data collection. The volume of data reporting led to slow data extraction, with extractions taking up to 72 hours, delaying COVID-19 trends.⁵ Frequent system downtimes and inconsistent use by Local Health Departments (LHDs) forced LHDs to find alternative methods to report, such as submitting paper copies and incompatible data sets.⁶

Owing to federal and state funding, DSHS upgraded its data processing systems and increased its ability to collect larger volumes of information.⁷ NEDSS is now able to process approximately 400,000 lab reports per day compared to a pre-pandemic output of 2,000 per day.⁸ Federal funding improved the system with the addition of more permanent and temporary staff, the ability to onboard more users, enhanced training procedures, and improved help desk resources to assist users with the onboarding process.⁹

Epidemiological Modeling

Epidemiological modeling is a mathematical tool used to forecast according to a set of assumptions and statistics used to determine the efficacy of certain interventions. The Imperial College COVID-19 model was widely used in the early months of the pandemic to guide nations on how to mitigate the spread of the virus.¹⁰ Models like the Imperial model predicted a significantly higher number of deaths than what occurred.

As certain nations followed the erroneous Imperial model during the early phases of the pandemic, UT Southwestern Medical Center and other academic institutions applied their own data models to inform local authorities on relevant data trends related to the virus.¹¹ The UT Southwestern model's primary role is to follow hospitalization trends to better serve capacity data.

Data reported to DSHS suggest the SARS-CoV-2 "Omicron" wave and its subsequent variants have resulted in fewer hospitalizations due to multiple factors, including less severe symptoms, increased vaccination rates, and natural immunity.¹² Improvements in treatment and better protocol measures have led to shorter hospital stays and thus have reduced hospitalization rates in many regions.¹³ The UT Southwestern forecast model was used in the Dallas-Fort Worth region. The model's data did not differentiate between vaccinated/boosted versus unvaccinated hospitalizations. It did not determine whether a hospitalized individual received early treatment before admittance.¹⁴

The model does suggest COVID-19 is nearing the endemic phase, but additional data related to the next variant will provide a better long-term outlook on the presence of COVID-19.¹⁵ The recent

announcement by the U.S. Centers for Disease Control recommending annual booster shots for COVID-19 further suggests that Texas has entered the endemic stage, and variants of SARS-CoV-2 should be treated much like seasonal influenza.

Hospitalization and Hospital Capacity Data

On March 24, Governor Greg Abbott issued Executive Order GA-10, requiring hospitals to submit daily reports of hospital bed capacity to DSHS.¹⁶ Many subsequent decisions made by the Office of the Governor were based on this hospital data.

Hospitalization data, including capacity data, are reported daily on a regional level through the 22 Trauma Services Areas (TSAs) and have been publicly reported by DSHS since April of 2020.¹⁷ DSHS partners with Regional Advisory Councils (RACs) through the Hospital Preparedness Program (HPP) to gather data on bed and ICU capacity and availability of therapeutics, staffing, personal protective equipment (PPE), and ventilators, as well as patient information. RACs use two electronic systems, EMResources and WebEOC, to collect and provide the information to DSHS.¹⁸ At the start of the pandemic, some RACs were better positioned to be able to collect more comprehensive information than others, such as demographic data on hospitalized patients. Hospitals reported through TeleTracking until they were required to shift to EMResources.

Figure 1: State Agency and Hospital data collection tree

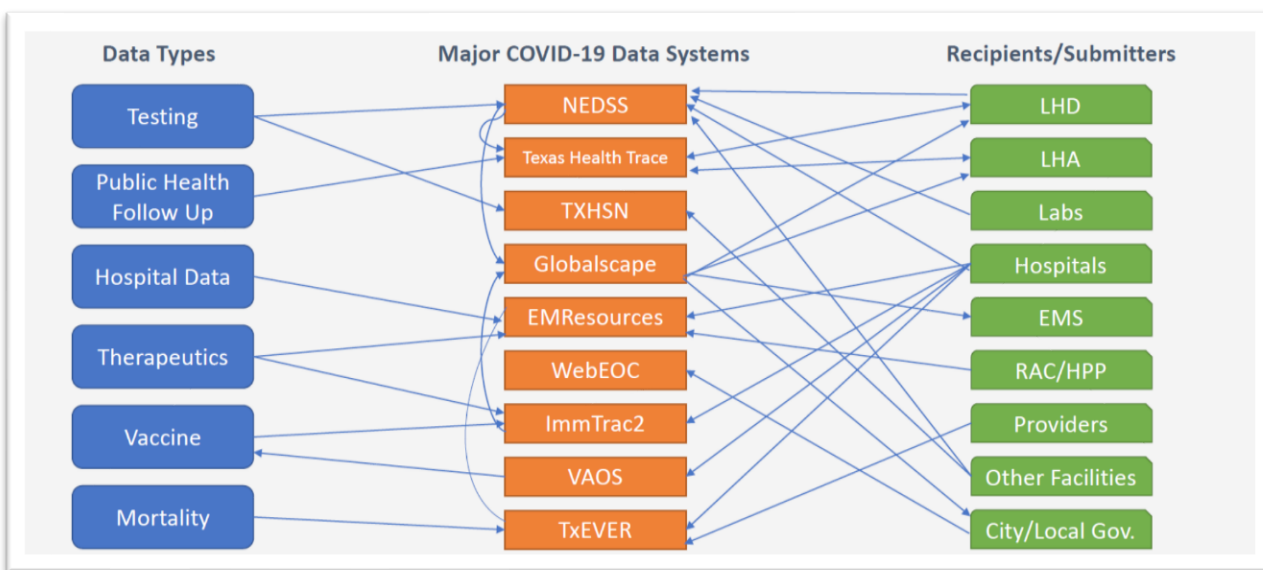


Figure 1 represents the COVID data relationships between hospitals and other public health partners. Texas currently does not have a comprehensive data collection system for all public health entities to review real-time information for any health-related situation and there is no unified reporting system for hospital bed capacity, a vital commodity during a public health disaster.¹⁹

Throughout the pandemic, state and federal authorities imposed inconsistent data collection requests from hospitals and other health care facilities. Since August 2020, facilities have been responsible for reporting over 60 aggregated data points including COVID-19 suspect and lab-confirmed inpatient patients, admissions, COVID-19 patients on ventilators, availability and use of durable medical equipment, ER visits, ICU bed capacity, available and used therapeutics, and COVID-19 fatalities.²⁰ At one point, facilities were required to report 120 different elements daily. For rural communities, like Lynn County Hospital in West Texas, hospital staff had to update more than 20 separate places in health records to keep pace with COVID outbreaks. Meanwhile, the hospital's human resource officer²¹ collected data related to vaccination rates which were then sent to the state.

The original purpose of hospital capacity data collection was to provide awareness of a hospital's ability to maintain care, but there was a desire to expand into tracking individual outcomes and real-time patient status.²² Public data of the causation of hospitalization has been mired by the inability or unwillingness to delineate between those individuals hospitalized directly due to SARS-CoV-2 variants versus those previously admitted individuals who merely tested positive while in the hospital as a consequence of mass testing requirements.

At the federal level, those who failed to report risked Medicaid reimbursement status and a loss of their funding.²³ Moreover, according to DSHS, the Centers for Medicare and Medicaid Services will consider making COVID-19 hospital reporting permanent,²⁴ although current regulations do not require the same reporting for other seasonal outbreaks such as influenza.²⁵

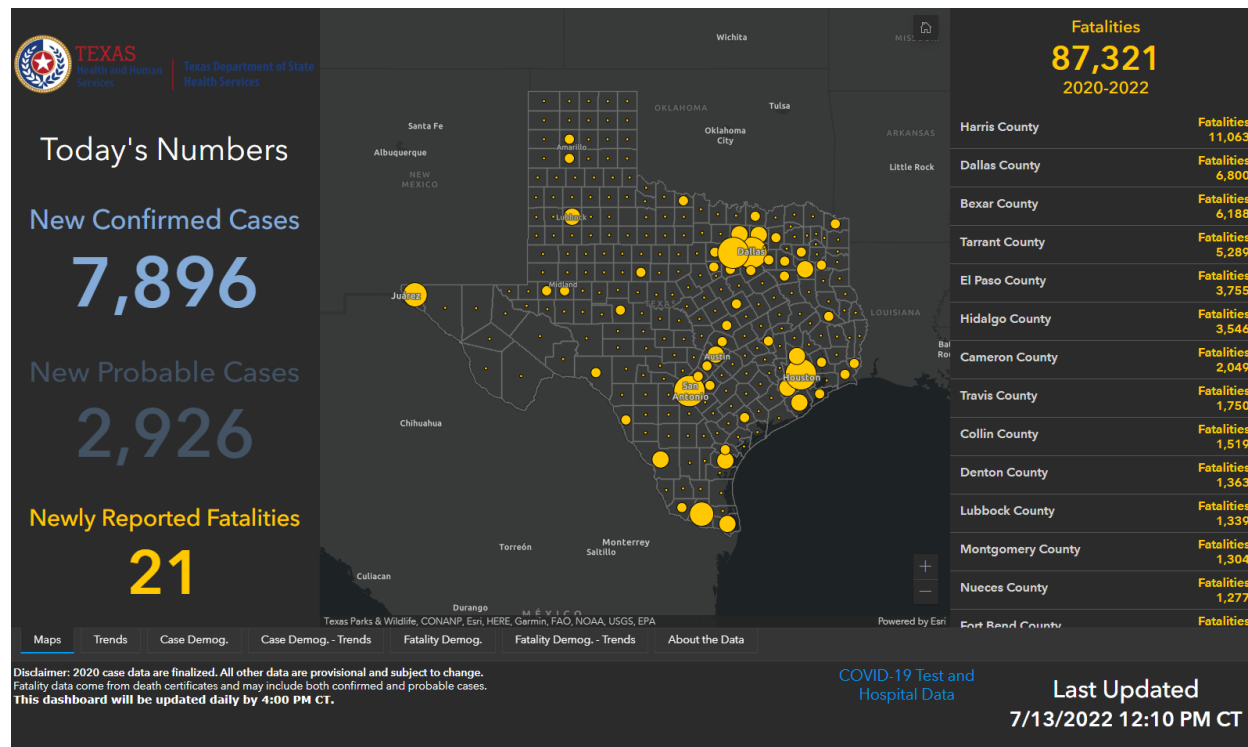
A best practice that emerged in hospital capacity data was progress made in coordinating patient transfers through the use of the Pulsara system. DSHS implemented Pulsara to aid facilities through matching available beds and transfers. Pulsara offered an opportunity to streamline the transfer process and to further refine reporting standards to ensure certain data, such as the number of individuals hospitalized that were vaccinated, are tracked.²⁶ The annual cost to operate the system is \$2.4 million and is currently funded by federal COVID-19 dollars.²⁷

Fatality Data

During the early phases of the pandemic, mortality reporting relied heavily on local jurisdictional reporting and case investigations, resulting in delayed reporting, inaccurate information, and limited data on the deceased demographics.²⁸ To fill the void in fatality data, DSHS began consolidating information from Texas death certificates and created a standardized approach toward determining residence and/or location of death.²⁹ Confusion occurred early during the pandemic as to the 'cause of death' versus 'contributing factors' in a death. Death certificates operate via a sequential model, with the first section referencing the immediate and underlying cause of death. The second portion is for contributing factors, such as hypertension, COVID, etc. Federal criteria and Texas criteria as it relates to reporting are different. Texas considers a COVID-19 death to be a definite underlying cause, whereas federal reporting is less strict.³⁰

This loose federal standard has led to some fatalities—such as those caused by a gunshot wound or vehicular accident—to be labeled 'covid deaths' because the victim tested positive for COVID-19 at the time of death.

Figure 2: Department of State Health Services COVID-19 Dashboard



COVID-19 data for the years 2020-2021, shows that 5,820 Texans over the age of 18 perished with only the virus as they cause of death.³¹ During the same period, 70,781 adults died with one or more comorbidities (2022 data is incomplete).³² Of those under the age of 18, 87 have died during the same period with eight dying of COVID-19 only.³³ Data reflecting deaths according to comorbidities is not currently listed in the DSHS COVID-19 dashboard nor the DSHS COVID-19 accessible dashboard data.³⁴

Vaccine Tracking Data

According to the Texas Health and Safety Code, immunization and other vaccine-related administration data is required to be reported to the Texas Immunization Registry (ImmTrac).³⁵ Immunization information is uploaded to ImmTrac depending on whether the individual consents. However, throughout the state's disaster declaration for the pandemic, providers have been required to include all COVID-19 vaccinations into the system per state statute and federal determinations.³⁶ ImmTrac holds more than 164 million records, making improvement to the system vital to maintaining the integrity of ImmTrac.³⁷ Federal funding has assisted in making improvements to ImmTrac such as streamlining the interface for providers and increasing system capacity and speed.³⁸

Therapeutic tracking proved just as difficult as the state did not have a system with this capability.³⁹ The closest system in place was the Electronic Vaccine Inventory (EVI) for handling vaccine management, but therapeutics were originally recorded via Excel.⁴⁰ It was not until August of 2021 that a system designed to track therapeutics was implemented in the form of the Vaccine Allocation and Ordering System (VAOS).⁴¹

According to DSHS, anyone can report to the Vaccine Adverse Events Reporting System (VAERS), including patients, parents, and guardians.⁴² Although DSHS does track vaccine administration, it is *not required* to track adverse events, nor does it require providers to input those data into the national VAERS system operated at the CDC⁴³ or make the public aware of VAERS. The CDC and FDA monitor the VAERS system to determine if there are any correlations between adverse events and the administration of a vaccine.⁴⁴

Local Health Authorities and Data Sharing

Texas's public health system is managed through a decentralized structure, whereby local municipalities determine both the level of funding invested in public health efforts, as well as what services their local health departments (LHDs) provide. Sixty-four LHDs operate within the state. In areas where no LHD exists (194 counties), DSHS Public Health Regions (PHRs) are responsible for providing public health services. Throughout much of the pandemic, these entities held great sway over the decisions made by locally elected officials, including override existing laws.

To provide more regional coordination, 22 Regional Advisory Councils (RACs) across Texas were created in the 1989 Omnibus Rural Healthcare Rescue Act.⁴⁵ Originally formed to manage regional trauma system plans, the mission of RACs has evolved to include additional systems of care including cardiac, stroke, maternal, and neonatal systems.⁴⁶ Yet despite additional regional coordination, COVID-19 presented a difficult situation for RACs and LHDs in data collection, communication, and supply chain.

Data sharing remained difficult due to inconsistent data systems across the state. Data resided in multiple locations and were reported in silo-databases.⁴⁷ Through the use of federal funds, DSHS has developed the State Health Analytics and Reporting Platform (SHARP) enabling a quicker and more accessible data systems for sharing across platforms.⁴⁸

Rural counties experienced unique hardships more urbanized regions of the state avoided such as vaccine access.⁴⁹ Others received proper testing equipment to process samples but failed to have reagents delivered for more than six months, resulting in an expensive unused machine.⁵⁰ Expenses proved difficult to chart due to the required measures of distinguishing between what can and cannot be allocated for COVID-19.⁵¹ Rural hospitals did not have adequate staffing levels to respond to a large-scale public health disaster. Thus, front office personnel were required to take on additional responsibilities to ensure frontline workers were able to focus on patient care. If an emergency were to occur in the surrounding area, the average response time was 20 minutes.⁵² If additional personnel were needed in the hospitals, or maintenance was required on the ambulance, it would essentially place 9-1-1 operations offline for however long the situation required.⁵³

Conclusion

Over two years have passed since Governor Abbott made a disaster declaration for the state of Texas related to the pandemic. Today, that declaration remains in place. Accurate and timely data has been at the forefront of the need for public health entities and state agencies. Coordination among state and local authorities is paramount to ensuring a well-established and -executed emergency response. Delays in implementation, the supply chain, and an inconsistent organizational structure impeded the response to COVID-19 across the state.

The inability to follow real-time bed capacity data hindered hospitals and RACs from identifying needed space for patients during the pandemic. What appears to be a consensus among state agencies and local health authorities is a call for a statewide transfer system for everyone to participate in. Access to accurate, timely, and actionable data is essential to patient outcomes. Early in the pandemic, less reliable information was used to justify controversial policies that infringed on existing constitutional rights and laws, such as lockdowns.

Systems like the RAC Data Collaborative should be expanded to include other data sets such as maternal and neonatal information.⁵⁴ Supplying adequate staffing to Regional Medical Operation Centers (RMOCs) continuously (not only during disasters) will vastly improve patient outcomes across the board.

Recommendations

- **Streamline communication efforts among public health agencies through a well-defined hierarchical structure;**
- **Ensure collected data points are well defined and accurately reflect what is happening in hospitals;**
- **Assess the need for a statewide transfer and bed capacity system that would allow for seamless review and processing, avoiding costly delays among hospitals;**
- **Ensure future public health emergencies differentiate rural and urban population areas in terms of public health decision-making; and**
- **Require health-related data associated with public health emergencies to be submitted to a single designated agency dedicated to providing data-driven efforts to the state with quality recommendations on public health matters.**
- **Require Texas Department of State Health Services to promote public knowledge and awareness of data reporting related to adverse vaccine events (VAERS); and**
- **Require DSHS to maintain its own publicly available "adverse events" tracking system related to vaccines and early treatments for COVID-19.**

¹ "Data Collection and Reporting Best Practices." Health and Human Services Commission. September 1, 2022.

² Senate Bill 969, 87R, 2021.

³ Chapter 97, Title 25, Texas Administrative Code.

⁴ Texas Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, June 27, 2022.

⁵ "Data Collection and Reporting Best Practices." Health and Human Services Commission. September 1, 2022.

⁶ Ibid.

⁷ Texas Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, June 27, 2022.

⁸ "Data Collection and Reporting Best Practices." Health and Human Services Commission. September 1, 2022.

⁹ Ibid.

¹⁰ "COVID-19: Imperial researchers model likely impact of public health measures" Imperial College London. March 17, 2020.

¹¹ Dr. Mujeed Basit, UT Southwestern Medical Center, *Testimony before the Senate Committee on Health and Human Services*, June 27, 2022.

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Exec. Order GA-10, March 24, 2020.

¹⁷ "Data Collection and Reporting Best Practices." Health and Human Services Commission. September 1, 2022.

¹⁸ "COVID-19: Texas Hospital Reporting Requirements." Texas Department of State Health Services. July 23, 2020.

¹⁹ Texas Department of Emergency Management, *Testimony before the Senate Committee on Health and Human Services*, June 27, 2022.

²⁰ "Data Collection and Reporting Best Practices." Health and Human Services Commission. September 1, 2022.

²¹ Melanie Richburg, CEO Lynn County Hospital District, *Testimony before the Senate Committee on Health and Human Services*, June 27, 2022.

²² "Data Collection and Reporting Best Practices." Health and Human Services Commission. September 1, 2022.

²³ Texas Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, December 7, 2020.

²⁴ Texas Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, June 27, 2022.

²⁵ Ibid.

²⁶ "Data Collection and Reporting Best Practices." Health and Human Services Commission. September 1, 2022.

²⁷ Ibid.

²⁸ Texas Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, June 27, 2022.

²⁹ Ibid.

³⁰ Ibid.

³¹ Department of State Health Services, Texas Death Certificate Data, July 5, 2022.

³² Ibid.

³³ Ibid.

³⁴ Department of State Health Services, Texas COVID-19 Data, July 14, 2022.

³⁵ Texas Health and Safety Code, Section 161.00705.

³⁶ "Data Collection and Reporting Best Practices." Health and Human Services Commission. September 1, 2022.

³⁷ Ibid.

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Ibid.

⁴¹ Ibid.

⁴² Department of Health and Human Services, Reporting Adverse Events (VAERS), September 23, 2020.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Wanda Helgesen, Border RAC (Regional Advisory Council) and Texas EMS, Trauma & Acute Care Foundation (TETAF), *Testimony before the Senate Committee on Health and Human Services*, June 27, 2022

⁴⁶ Ibid.

⁴⁷ "Data Collection and Reporting Best Practices." Health and Human Services Commission. September 1, 2022.

⁴⁸ Ibid.

⁴⁹ Melanie Richburg, CEO Lynn County Hospital District, *Testimony before the Senate Committee on Health and Human Services*, June 27, 2022.

⁵⁰ Ibid.

⁵¹ Ibid.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Wanda Helgesen, Border RAC (Regional Advisory Council) and Texas EMS, Trauma & Acute Care Foundation (TETAF), *Testimony before the Senate Committee on Health and Human Services*, June 27, 2022.

INTERIM CHARGE III: HEALTH CARE WORKFORCE SHORTAGE

Interim Topic Language: *Study the impact of the global pandemic on the health care workforce in acute and long-term care. Identify health care staffing challenges and examine how staffing services and payment models changed the economics of the health care workforce. Identify and recommend ways to increase the health care workforce pipeline.*

Introduction

Just days before the August 23rd hearing of the Texas Senate Committee on Health and Human Services, the Centers for Disease Control and Prevention (CDC) effectively allowed the nation to go back to normal by removing suggested spacing limits and isolation following infection, although mask mandates are still in effect at many facilities. But the impacts of these policies continue to linger, especially within the Texas health care system.¹

Many of these COVID-19 policies contributed to the decline in health care workers. Since February 2020, the health care sector in our nation has lost nearly 500,000 workers, according to estimates from the Bureau of Labor Statistics. As more people move to Texas, the state must be forward-thinking toward policies that will support balanced growth in the health care workforce, while not creating unintended consequences. The goal of the hearing was to look forward and learn from the past, but also to focus on the issues and the future of the labor market for health care in Texas.

State of the Health Care Workforce

The Texas Department of State Health Services (DSHS) regularly develops projections identifying workforce needs in the state's health care industry. According to DSHS data, all but one major medical profession (nurse practitioner) will experience a supply shortfall before 2032.² In the area of family medicine, the Rio Grande Valley will have an unmet need of 42.1%, while the Gulf Coast region will witness a shortfall of 832 FTEs by 2032.³ Additional Graduate Medical Education (GME) and residency slots are vital to limiting the projected supply shortfall. However, the data presented by DSHS does not include COVID-19 figures, both general and mandate related, creating a gap in determining the real numbers.⁴

The state's overall health care workforce numbers have reached the highest employed by the industry on record, placing job growth at pre-COVID levels.⁵ Wages are on the rise, showing a 10% increase over pre-COVID figures.⁶ During COVID, the workforce lost 1.5 million jobs between March and April of 2020.⁷ Despite growth in the health services industry, long-term trends continue to reflect an 18% shortfall in health care professionals around the state.⁸ The current gap reflects an estimated 700,000 to 800,000 in open positions compared to 200,000 to 300,000 pre-COVID.⁹

Meanwhile, Texas government intervened in the health care marketplace to provide "surge staffing" to hospitals and nursing homes to offset the shortfall during the pandemic. At this writing, taxpayers spent an estimated \$6,891,846,169.98 on medical surge staffing in hospitals and in long-term care facilities.¹⁰ The final result of injecting nearly \$7 billion into contract staffing labor rates has yet to be determined.

Figure 1: Department of State Health Services Medical Staff Surge Data

MEDICAL STAFF SURGE	Start Date	End Date	Peak Approved Staff	Total (Peak) Staff*	Estimated Cost
Surge 1	7/24/2020	1/10/2021	12,034	4,337	\$1,922,085,286.79
Surge 2	1/11/2021	5/17/2021	15,765	13,737	\$2,467,966,372.39
Surge 3 (Delta)	8/11/2021	12/29/2021	8,055	7,851	\$1,639,669,111.43
Surge 4 (Omicron)	12/30/2021	4/1/2021	5,470	4,941	\$862,125,409.37
				Total	\$6,891,846,179.98

While the surge in staffing was funded under a 100% FEMA reimbursement rate, COVID-19 relief funds, the American Rescue Plan Act, and other funding sources provided the cash flow to serve as a bridge for the reimbursement.¹¹

Texas Managed Long-Term and Specialty Care

Texas provides direct care in its state hospitals and state supported living centers to eligible populations. As such, the Health and Human Services Commission (HHSC) directly hires and manages a health care workforce that serves vulnerable individuals suffering from mental illness or intellectual and developmental disabilities.

State supported living centers are facing workforce shortages, but it expands into other professions such as custodians, social workers, and cooks.¹² As of the hearing, only Abilene offered clinical opportunities, but they are beginning to reduce their hours.¹³ Similar shortages are occurring in state hospitals as well. HHSC reported that Austin State Hospital currently has bed capacity of 263, but only 170 of those beds are operational due to staff shortages.¹⁴ Due to the shortages, state hospitals have a backlog in civil and criminal commitments with an estimated 700 beds offline.¹⁵ A major challenge for staffing for state hospitals has been the inability to compete with compensation offered by the private sector. The pandemic accelerated the retirements of the longest-tenured employees due to the need to work remotely from home.¹⁶

Other long-term care and specialty care facilities are experiencing higher personnel shortages as a result of COVID-19. The Centers for Medicare and Medicaid Services (CMS) rescinded a waiver allowing temporary nurse aides to work more than four months before meeting all certification requirements. A typical certification process takes 100 hours of training, an exam, and a background check. The training hours could be expedited by counting work experience, but the process takes time, and the exam requires more locations for the paper and in-person portion.¹⁷

State Programs to Assist Workforce Growth

Currently, Texas has various programs directed as workforce development, including the Skills Development program, which offers employer-based training grants, and the Jobs and Education for Texans (JET) Grant Program, which offers funding to high schools and higher education institutions for career and technical education.¹⁸ Once each quarter, the JET Advisory Board convenes to review applications for grant funding and recommend that year's recipients. Participation in the JET program is capped by the funding, which is currently \$15 million with additional federal dollars at \$50 million.¹⁹ The Texas Workforce Commission's (TWC) Adult Education Integrated Education and Training (IET) programs also provide training opportunities in health care professions. For Program Year 2021 (July 2021-June 2022), seven providers trained 1,540 students. More than half of those attained a credential, and more than 73% entered employment.²⁰

Utilizing federal Workforce Innovation and Opportunity Act funding, eligible training providers across Texas offer 1,172 training programs for health care practitioners, technical, and support occupations. Finally, In July TWC began accepting applications for a new opportunity for training in health care professions. The \$15 million Statewide Healthcare Apprenticeship Initiative will increase the number of career pathway opportunities for students who wish to pursue registered nursing certifications and other health care fields in Texas.

A significant barrier to entering the health care workforce has been the cost of receiving the necessary education and licensure requirements to practice in the field. The Texas Higher Education Coordinating Board has implemented multiple loan repayment programs—the Nursing Faculty Loan Repayment Program, the Physician Education Loan Repayment Program, and the Mental Health Professionals Loan Repayment Program—all designed to increase teachers and practitioners in various health fields. These programs have proven to be popular and are annually oversubscribed resulting in a long waiting list.²¹

Despite these investments, the supply of health care workers continues to fall short of demand. Witnesses testified to the fact there has been a chronic shortage of health care professionals in Texas for many years, but the pandemic exacerbated it.²²

Barriers to growing the health care workforce have been a common occurrence over the years and are not simply the result of COVID-19. Figures from TWC show improvement in various sectors of the workforce, including Health Care and Social Assistance industries with an addition of 47,100 positions between July 2019 to July 2022.²³ Recovery efforts seem to have been completed except for Nursing and Residential Care Facilities which are continuing to recover from COVID-19.²⁴

Vaccine mandates issued by hospitals and other health care facilities, as well as by CMS, may be one factor in the departure of some nursing staff and physicians from the industry. While medical and religious exemptions were offered, refusal of vaccination without an approved exemption resulted in an involuntary resignation.²⁵ One such example that occurred in 2021 was the resignation of over 150 employees within the Houston Methodist system due to the COVID-19 vaccination requirement.²⁶ For pregnant female employees, additional exemptions were offered to those currently carrying a child. The exemption was not extended to those seeking to become pregnant.²⁷ While there is no specific data on the number of individuals who were forced to leave health care jobs due to vaccine mandates, TWC offered follow-up data on vaccine mandate complaints following questions from Senate Health and Human Services Committee members. Commission Chair Bryan Daniel reported the agency collected reports on employer vaccine mandates through phone and email contacts and via employee applications for unemployment benefits.²⁸ TWC received 4,553 reports of employer vaccine mandates, and following Executive Order GA-40, the necessary direction was given that led to the submission of 92 potential violation referrals to 34 jurisdictions.²⁹ No additional follow-up was done by TWC, nor is there any current information on unreported vaccine mandates within the agency.³⁰

TWC received 4,400 complaints related to employer vaccine mandates.³¹ The precise number of nurses or other health care workers who have left the field is uncertain as few data sources tracked the issue. Nurses, for example, may have chosen retirement, resigned, or sought another medical facility without a mandate.³²

Licensing Requirements and Waivers for Licensure

Nursing Licensure

The nursing industry has experienced exhaustion, burnout, and reports of workplace violence during the COVID pandemic. Despite the challenges, COVID presented the opportunity for Texas to partake in the nurse licensure compact which proved invaluable during the pandemic. Licensing in Texas has grown with Advanced Practice Registered Nurses (APRNs) seeing a 12% increase, and Registered Nurses (RNs) increasing by 3.5%, but the Licensed Vocational Nurses (LVNs) have declined since 2021.³³ The Texas Board of Nursing was not immune to the effects of COVID-19 as staff shortages brought on by the required 5% reduction in budget limited the board's ability to efficiently process licenses and complaints.³⁴ The average time for complaint completion is 88 days but decreasing.³⁵ License processing before COVID-19 had a timeline of 10 days with a peak of 20 days during the pandemic. Currently, the time has been reduced to 15 days but remains high.³⁶

To speed up the process of licensing, waivers were created, including school of nursing acceptance for 50% of clinical experiences as simulation.³⁷ Licensing requirements maintain a standard of practice except for the necessary clinical hours which are determined by the individual nursing schools.³⁸ Witnesses reported that clinical hours have become a barrier for health professionals as there are fewer sites for nursing schools to partner with. Long-term care facilities can be a potential option for the additional clinical site, but there is difficulty increasing the interest in these facilities. There are not many professionals who wish to work in LTCs.³⁹

Opening additional facilities for

completing clinical hours would prove beneficial for rural areas as available sites are limited compared to urban areas. The consortium model has provided additional clinical space in areas like the Panhandle, but they are not available in all areas.⁴⁰

Physician Licensure

Similar to the nursing shortage, physicians were in high demand during the pandemic while continuing to experience a projected shortfall by 2032. The TMB exercised the use of emergency rules to fast-track temporary licensing of out-of-state TMB license types to assist.⁴¹ More than 5,300 temporary licenses were issued with an estimated 2,575 associated with a telemedicine company, representing 70% of the emergency licenses issued.⁴² Despite the emergency authorization and COVID waivers, the TMB reported there has been no increase in complaints between emergency and regular licenses.⁴³ With the increase in telemedicine activity, determining whether patients are speaking with actual physicians has become an area of potential intervention.⁴⁴

The State of the Health Care Workforce in Higher Education

Texas boasts 219 nursing schools providing the state and surrounding region with a well-educated and experienced workforce. Those testifying on nursing education before the committee included representatives from the Texas A&M School of Nursing, Blinn College, and the Texas Tech University Health Sciences Center. The current landscape for these schools, while dissimilar in some ways, is experiencing the same hardships in preparing their students. The Texas Center for Nursing Workforce Studies (TCNWS) reports that over 15,000 qualified applicants for Bachelor of Science in Nursing (BSN) and Associate of Science degrees in nursing programs were not admitted in 2020-2021.⁴⁵ According to testimony presented by Dr. Cindy Weston of Texas A&M, there is no way to determine how many applicants in the TCNWS report are duplicates due to students applying to multiple programs.⁴⁶

For qualified students who are accepted and can secure a spot in a nursing cohort, finding placements to perform clinical studies in a health care facility remains a major barrier. Consortia are one avenue some universities use, but they are not located throughout the state.⁴⁷ Some clinical sites are limited by operational hours. Others may have limits as to the types of students who can complete the clinical work. For example, State Supported Living Centers may offer clinical experience to satisfy licensure requirements, but only for LVNs.⁴⁸

Some academic institutions have created alternative ways to efficiently achieve clinical training placements. Texas Tech University reported that it developed private partnerships and now has over 3,000 clinical affiliations, with approximately 84% based in Texas.⁴⁹ For example, Texas Tech specifically recruited Certified Nurses Aides (CNAs) into their nursing program by allowing them to earn credit hours towards their BSN degree during their day jobs in hospitals or long-term care facilities.⁵⁰

Shortage of nursing faculty is another barrier to the workforce. Licensing rules require minimum ratios of faculty to students in clinical environments. Academic institutions have lost qualified

nursing faculty to higher salaries in hospitals or other health-related institutions. To remain competitive, these institutions are hiring more part-time faculty to fill the gap to meet teaching ratios.⁵¹

A second barrier has been clinical sites and the corresponding hours required for students to complete their programs. Limited hours and available space have forced some students to travel long distances and operate after hours and on weekends.⁵² Further exacerbating the problem, some witnesses reported to the committee that "for-profit" academic institutions may be seeking exclusive arrangements for clinical sites, or for clinical tools, including cadavers, making it difficult for public colleges to acquire additional capacity.⁵³

Witnesses stressed the importance of continuing to fund popular loan repayment programs, as well as the Nurse Shortage Reduction Fund, which rewards academic institutions for producing more nursing graduates.

Stakeholder Experiences

COVID-19 placed an excessive strain on hospital resources and capacity. Burnout and fatigue have become major problems, increasing the previous shortages already plaguing the industry, and increasing the demand for contract labor.⁵⁴ Hospital staffing accounts for roughly 60% of total expenses for hospitals.⁵⁵ Labor costs per patient have increased 19.5% through November 2021 from pre-pandemic levels.⁵⁶ It is estimated that costs for traveling health care staff have doubled between 2020 and 2021.⁵⁷ According to the testimony of Steven Hines of Dallas-based ADASTAFF, the premium rates travel staffing agencies charge to hospitals are between 150% and 200% of standard hourly rates for travel nurses compared to what hospitals pay staff.⁵⁸

During the various "surges" of SARS-CoV-2 variants, Texas authorized the use of federal funding to support hospitals with staffing needs. The influx of that funding increased demand for nurses and other health care professionals from various staffing agencies and may have inadvertently contributed to higher rates.⁵⁹ Staffing rates are falling according to Steven Hines, however, internal costs for nurses and other staff are being reported at 40% higher than pre-COVID costs.⁶⁰

Retention of health care workers is another challenge, especially for rural facilities. Barriers to recruiting, combined with industry burnout, turnover, and sickness, increased financial and operational pressures on vulnerable hospitals.⁶¹ To alleviate the workforce shortfalls, many facilities relied on recruiting measures, including "sign-on" bonuses for accepting jobs. Hospitals increased use of these measures from 16% in 2020 to 58% in 2021.⁶²

Additionally, health professionals have become conditioned to receiving higher "crisis-type" rates for their services, while facilities have relied on state and federal funding to hire adequate staff. While staffing agency rates are declining, the industry is experiencing a difficult effort to return to equilibrium. According to testimony, staffing agency rates and the market it has created will likely never return to pre-pandemic levels.⁶³

Moreover, the migration of LVNs, CNAs, and medical assistants from nursing facilities to acute care facilities due to financial shortfalls has exacerbated staffing issues in long-term care.⁶⁴ By

2020, 70-90% of long-term care facilities cited an inability to hire enough CNAs.⁶⁵ 94% of facilities carry unfilled LVN positions with 70% having limited admissions within the previous 120 days before the report due to staff shortages.⁶⁶ Since January of 2022, 82% have used staffing agencies to fill direct-care positions with 78% using more agency staff hours compared to the previous year.⁶⁷

Conclusion

The pandemic touched every corner of society, and Texas was not immune. Those workers on the front lines of protecting the health of Texans were greatly affected, both mentally and physically. Before COVID-19, the health care industry had been experiencing a staff shortage across the board. The aftermath of the virus has exacerbated the previous staff shortfall, but the industry in Texas does not fully understand how extensive the shortfall has become. Facilities fought staffing shortages through the use of staffing agencies, increasing the overall budgets of many hospitals. Nursing homes and other long-term care facilities lost staff to better paying positions in acute care. Institutions of higher education were not immune to the nursing shortage as nurse faculty have become scarce. These market disruptions continue today.

It is important to note the causes which led to the current workforce shortage but seeking solutions rather than focusing on failures will carry Texas into the future. Testimony presented before the Senate Health and Human Services Committee provided invaluable information for the committee to review. It is the Committee's hope the report and recommendations guide the Legislature toward policy decisions designed with the prosperity and independence of Texans as a key motivator.

Recommendations

- **Reexamine funding for the Nursing Shortage programs and determine whether an increase would reduce the educational bottleneck;**
- **Extend the statutory expiration date for the Nursing Innovation Grant Program (NIGP) from 2023 to 2027;**
- **Consider ways to direct health care professionals to medically underserved regions of the state;**
- **Consider alternatives for medical school graduates who cannot place in Texas-based residency slots;**
- **Fund additional Graduate Medical Education slots to keep more Texas medical graduates in-state;**
- **Evaluate the feasibility of allowing for mental health-related degrees to be approved across multiple mental health care fields as it pertains to licensing requirements; and**
- **Consider limiting the ability of staffing agencies from charging exorbitant prices during a public health disaster, similar to price gouging laws applied during a natural disaster.**

¹ Centers for Disease Control and Prevention (11 August 2022). CDC Streamlines COVID-19 guidance to help the public better protect themselves and understand their risk. <https://www.cdc.gov/media/releases/2022/p0811-covid-guidance.html>.

² Department of State Health Services, *Testimony before the Senate Health and Human Services Committee*, August 23, 2022.

³ Ibid.

⁴ Ibid.

⁵ Bryan Daniel, Texas Workforce Commission, *Testimony before the Senate Health and Human Services Committee*, August 23, 2022.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Hendrickson, Rachael. "Medical Surge Staffing Data." Received by Kody Smith. (July, 2022).

¹¹ Ibid.

¹² Ibid.

¹³ Ibid.

¹⁴ Scott Schachlin, Texas Health and Human Services Commission, *Testimony before the Senate Health and Human Services Committee*, August 23, 2022.

¹⁵ Ibid.

¹⁶ Ibid.

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¹⁸ Department of State Health Services (2022).

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²⁰ Bryan Daniel, Texas Workforce Commission, *Testimony before the Senate Health and Human Services Committee*, August 23, 2022.

²¹ Texas Higher Education Coordinating Board, *Testimony before the Senate Health and Human Services Committee*, August 23, 2022.

²² Townsend, C. (March 1, 2021). Solving Texas' nursing shortage. *D Magazine*.

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²³ Texas Workforce Commission, Senate Health and Human Services Committee follow-up questions. October 4, 2022.

²⁴ Ibid.

²⁵ Dr. James McCarthy, Memorial Hermann, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.

²⁶ Allen, K. (June 22, 2021). 153 Houston Methodist employees resign or are fired after refusing to get the COVID-19 vaccine, an official says. CNN.

²⁷ Dr. James McCarthy, Memorial Hermann, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.

²⁸ Texas Workforce Commission, Senate Health and Human Services Committee follow-up questions. October 4, 2022.

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

³² Texas Higher Education Coordinating Board, *Testimony before the Senate Health and Human Services Committee*, August 23, 2022.

³³ Kathy Thomas, Texas Board of Nursing, *Testimony before the Senate Health and Human Services Committee*, August 23, 2022.

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³⁶ Ibid.

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INTERIM CHARGE IV: COVID-19 PANDEMIC RESPONSE

Interim Topic Language: *Examine the impact of state and federal pandemic policies—including agency guidance, licensing and regulatory actions, and health care industry policies—on patient care and treatment delivery. Examine how regulatory guidance impacts the patient-doctor relationship. Recommend any changes needed to ensure Texas can develop its data-driven guidance during public health emergencies.*

Introduction

The COVID-19 public health emergency has been an unprecedented event in recent history. Attempts to slow the spread of the virus prompted all levels of leadership to implement extensive restrictions and limitations on daily activities. The efficacy of lockdowns, mask mandates, and vaccine requirements will continue to be debated for the foreseeable future, and while most of these restrictions have been lifted nationwide, states now must handle post-COVID-19 consequences—including labor shortages, increased mental health needs, learning losses due to school closures, delayed medical treatment, controversial regulatory guidance, and adverse events related to vaccine use.

State Agency Response

COVID-19 proved to be a unique disaster for general coordination efforts of state and local public health agencies. The State Medical Operations Center (SMOC) typically remains operational for a short period to handle a disaster (generally a hurricane). Since March 2020, SMOC has been in operation for over 860 days as of the Senate Health and Human Services Committee public hearing date.¹ SMOC operates in coordination with the State Operations Center (SOC) run by the Texas Department of Emergency Management (TDEM), whose mission is to monitor emergencies and relay information on the events to federal, state, and local officials.² Responding to resource requests was vital to ensuring the supply chain for PPE and other public health equipment remained open. DSHS and TDEM were able to complete over 16,000 requests with over 2,000 facilities served through the State of Texas Assistance Requests program (STARs).³ Sixteen facilities were opened across the state as regional infusion centers with the ability to provide monoclonal antibodies with over 53,000 infusions given.⁴

A particular challenge for DSHS during COVID-19 is the difference between the public health disaster and other disasters. COVID-19 has shown to be a more long-term disaster requiring statewide responses with a multipronged approach, whereas other disasters generally have a limited time frame, are regionally isolated, and create a limited scope of resource requests.⁵ Due to the long-term nature of the pandemic, public health expenditures have become a concern and a challenge. According to DSHS, COVID-19 pandemic expenditures for the agency totaled \$10.1 billion, which ranged from surge staffing to repatriation of resources and personnel.⁶ Overall

public health expenditures, including federal dollars, may continue to rise in the future due to unforeseen costs.

Pandemic Regulations for Child-Care, Long-Term Care, and State-Managed Facilities

State Supported Living Centers (SSLCs), Long-Term Care (LTCs), and child-care facilities faced added burdens in responding to the pandemic with multiple sets of guidance from the federal, state, and local governments related to infection control. Many facilities received guidance from the Centers for Medicare and Medicaid Services (CMS), HHSC, and local public health departments. Mandates from all levels of government created problems with understanding how to handle infection mitigation and proper reopening of facilities.

Guidance on public health decisions was provided through DSHS, who sourced their advice according to CDC guidelines.⁷ While CDC guidelines have been considered inconsistent, they have informed additional federal guidance and rules. CMS, which provides nearly 75% of funding for nursing homes and other similar facilities, requires certain mitigation efforts—including masking—for facilities it funds.⁸

Consequently, facilities often issued blanket responses, including prohibiting visitation from family or caregivers. The Legislature addressed this issue in the 87th Regular Session through passage of Senate Bill 25, Senate Bill 572, and House Bill 2211.⁹ Nearly 75% of all deaths related to COVID-19 have occurred in individuals over the age of 60.¹⁰ Those who experienced heavier restrictions within facilities likened it to being incarcerated due to their limited mobility and access.¹¹

The pandemic also contributed to serious staffing shortages at many facilities regulated or managed by HHSC. In testimony before the Senate Health and Human Services Committee, HHSC Deputy Executive Commissioner for the Health and Specialty Care System, Scott Schalchlin, stated that more than 700 state hospital beds were offline due to staffing shortages.¹² Child-care facilities faced difficulties that may prove hard to overcome in a post-pandemic setting. Since 2020, there has been a 9.2% decrease in the number of permitted day-care operations.¹³ Currently, there are over 15,692 licensed facilities compared to February 2020 with 17,291.¹⁴ As Texas continues to see a surge in new residents and additional economic opportunities, the demand for licensed child-care facilities will continue to grow.

Treatment Policies, Regulatory Guidance, and Patient Care

Throughout the early variant surges during the pandemic, various early treatment options emerged including hydroxychloroquine, ivermectin, Paxlovid, plasma infusions, and the use of steroids. Yet, there was little effort by agencies to catalog patients according to treatments received.¹⁵

In most cases, the National Institutes of Health (NIH) and National Institute of Allergy and Infectious Diseases (NIAID) have been the primary decision-makers in terms of treatment policy and guidelines during the COVID-19 pandemic with little input from independent and or practicing physicians.¹⁶ Multiple studies submitted by physicians across the country have shown through the use of early treatment options there is a 95% reduction rate in hospitalization and death among those infected.¹⁷ Data reflecting the success rate of early treatment of the virus provide a potential blueprint for future outbreaks and infectious disease responses.¹⁸

Instead, federal guidance, and subsequent guidance from DSHS, touted the need for mass vaccination against COVID-19. Little to no data on early treatment efficacy were collected from hospitalized patients, making effective treatments difficult to track.¹⁹ The use of early treatment measures varied according to federal guidelines and hospital policy.²⁰ With the extension of Emergency Use Authorizations (EUAs) for the COVID-19 vaccines, the development of repurposed drugs and other strategies to combat the virus have been blocked by NIH and the Food and Drug Administration (FDA) due to requirements within the statutory language of EUAs.²¹

Current numbers place the antibody rate for the state of Texas at 98%.²² The rate is considered a combination of prior COVID-19 infections and vaccinated individuals. Despite the high antibody rate, and other factors associated with natural immunity, some hospitals continued to require vaccinations for employees.

When COVID-19 vaccine requirements for employees were first implemented, the initial understanding was immunity from vaccinations was much stronger than natural immunity, yet new information currently calls that understanding into question. Current data demonstrate that the vaccine has only reduced 20-30% of hospitalizations and deaths.²³ With Omicron and its subvariants becoming the dominant strain, the evolution of the spike protein within the virus raises concern for the future efficacy of the vaccine along with the onset of immune imprinting.²⁴ According to Dr. Robert Malone, immune imprinting occurs following a prior infection with the original COVID-19 strain, followed by vaccinations, and reinfection with Omicron which reveals a paradox in a reduction in neutralizing antibodies among an estimated 30% of the immunocompromised.²⁵ This leads to a relatively selective immune deficiency leaving the specific population with a higher chance of chronic reinfection.²⁶ Data from *Lessons from COVID-19* suggests continual boosting exacerbates the reinfection rate, particularly due to the focus on the spike protein which has a high rate of mutation.²⁷

Additionally, the push for the expediency of the vaccine resulted in agencies bypassing long-standing clinical and nonclinical trial protocols.²⁸ Vaccine trials failed to follow the normal process for clinical observations of at least 24 months with COVID-19 observational trials lasting two months.²⁹ The vaccines remain listed as Emergency Use Authorization Investigative, which means they are unsure as to what adverse events may occur after a person receives the shot.³⁰ As of June

2022, the CDC's VAERS data system, which catalogs adverse events from vaccines, reported 13,388 deaths in the United States associated with the COVID-19 vaccine.³¹ Worldwide, the largest vaccine databases have reported 40,000 deaths associated with the vaccine.³² According to Dr. McCullough, in less than one year the polio vaccine was recalled after 10 reported deaths, and the swine flu vaccine was recalled after 53 deaths.³³ Yet no legislative body within the U.S. federal or state government has acted upon a global call to recall vaccines from the market following 28,000 reported associated deaths.³⁴

For patients, some hospital officials have reported they were treated regardless of vaccination status.³⁵ During the Omicron surge, patients were tested before entry/treatment but were not denied treatment based on test results.³⁶ Some reports indicated during the pandemic individuals were denied treatment due to their vaccination status.³⁷ However, there are no data to determine if it was widespread or simply an isolated event. In the case of many hospitals in Texas, treatment protocols and infection mitigation were based on CDC and NIH guidance.*

The vacillating guidance on COVID treatments throughout the pandemic left unanswered questions as to why off-label treatments were deemed unsafe despite signs of efficacy during early treatment. Multiple medical associations, including the American Medical Association, have issued statements cautioning medical professionals from prescribing off-label treatments for COVID-19 patients.³⁸ In certain cases, similar statements included language threatening the suspension or revocation of their medical license.³⁹ Complaints associated with COVID-19 and patient care received by the Texas Medical Board (TMB) accounted for 1,863 from March 2020-June 2022.⁴⁰ Of the 1,863 complaints, 16 received remedial plans and three agreed to disciplinary orders.⁴¹

Under the current administrative code, TMB allows physicians to prescribe off-label use, so long as full disclosure is provided to the patient and paperwork is included.⁴² The lack of clarity around board rules as well as media stories led physicians to fear disciplinary action for prescribing off-label drugs. In response, TMB issued a statement clarifying the board does not prohibit any drug or treatment and that licensed physicians should not fear reprisal for their support of one or more COVID-19 treatments.⁴³ Despite the TMB statement, medical professionals experienced reprisals for their actions related to COVID-19. Physicians across Texas have experienced complaints associated with their prescription of COVID-19 treatments and offering alternative narratives in opposition to the CDC and the FDA. TMB reports that, as of June 6, 2022, 361 complaints were filed pertaining to hydroxychloroquine and ivermectin, this includes complaints for both the prescribing and refusal to prescribe these medications.⁴⁴

Physicians and other health professionals have experienced a negative reaction to public comments related to vaccine efficacy and COVID-19 treatments. In a May 2021 Senate Health and Human Services Committee hearing, public statements by Dr. Peter McCullough have been deemed as misinformation and subject to reprisal by the American Board of Internal Medicine (ABIM) despite citing reputable medical sources.⁴⁵ U.S. officials have attempted to create an open dialogue

* Treatment protocols authorized under an EUA allowed the FDA to approve previously unapproved drugs to treat, diagnose, or prevent serious illness. COVID-19 vaccines were approved under EUAs along with certain drugs for use against COVID-19. The nature of the EUAs limited authority for use of certain treatments for COVID-19, restricting medical professionals from using unapproved treatments without an EUA.

with ABIM, the American Medical Association (AMA), and other medical organizations to mediate between the medical entities and physicians facing reprisal.⁴⁶ According to Dr. McCullough, the effort appears to have failed and the medical entities have strengthened their resolve.⁴⁷

In conjunction with TMB, the Texas State Board of Pharmacy (TSBP) offered the same statement regarding the filling of prescriptions by pharmacists.⁴⁸ TSBP had previously issued a ruling limiting the distribution of early treatment drugs like hydroxychloroquine but the ruling later expired and was not renewed.⁴⁹ As for complaints, TSBP saw an increase of 43.08% submitted during the pandemic as opposed to the same time frame before the start of the public health emergency.⁵⁰ According to the agency, only 234 out of 13,776 complaints were related to COVID-19.⁵¹ However, the keyword search used was limited, and the 43.08% increase from the previous two years raises the question of what the additional complaints were for if not COVID-19 related. Some of the complaints were likely a result of reports of pharmacists denying prescription requests from physicians related to COVID-19 treatments.⁵²

Questions were raised on this issue based on previous legislation authorizing pharmacists to overrule prescription requests based on their conscientious objection.⁵³ Current statute provides pharmacists across the state with the authority to overrule any prescription request but encourages them to contact the physician, provider, and/or patient for further clarification.⁵⁴ COVID-19 allowed for greater flexibility within pharmacies and their operational abilities, but it also revealed areas for review, including the possibility for on-call pharmacy staff.⁵⁵

Federalism in Pandemic Response

Federal and quasi-federal agencies have remained the dominant voices within the pandemic conversation. Yet the CDC has been found to have withheld information on vaccine adverse events out of fear of creating vaccine hesitancy.⁵⁶ To avoid further vaccine hesitancy, there is evidence that the CDC and NIH retaliate against independent physicians through social media censorship targeting information related to adverse events and other COVID-19 treatments (i.e. Ivermectin, vitamin cocktails, etc.), according to Dr. Robert Malone.⁵⁷ Florida state officials reported that the federal government withheld disbursement of additional monoclonal treatments to the state for failing to follow federal protocols related to the pandemic.⁵⁸

The expansion of federal oversight and the encroachment into the practice of medicine has left states scrambling as to how they can manage their health care systems. A likely remedy to some of the confusion is to seek an independent state-based public health monitoring analysis of infectious disease risks and outcomes due to the unreliability of the CDC to provide transparent, timely, and accurate data for Texas physicians to treat patients.⁵⁹ Texas must have the capability to collect the data, analyze it promptly, and provide guidance to the state on how to handle current and future public health crises. Recently, Florida's surgeon general issued a warning against further vaccination for young men due to adverse events related to cases of myocarditis.⁶⁰ This warning contradicts accepted CDC guidance on vaccines and is an acknowledgement of the additional information that is surfacing about the problems of COVID-19 vaccines. Twitter determined the study

referenced by Florida's surgeon general to be misinformation and subsequently censored him from their platform.⁶¹

Consequences of COVID-19 Response

As was the case of early lockdown efforts, the decision to shut down the nation and the economy led to more harm than good.⁶² The economic and physical toll of non-pharmaceutical interventions (NPIs) are difficult to overlook, and the full reasoning behind some NPIs raises additional questions as to their real intention.⁶³ The shifting of NPIs, such as the governor's executive orders restricting elective medical procedures, will likely lead to future strain on the state's health care system.⁶⁴ Currently, there is no data being collected on the effects of delayed treatments due to the COVID-19 pandemic.⁶⁵

Additionally, there has been a rise in mental health concerns—as well as other issues including higher rates of crime, human trafficking, learning losses, and drug abuse—associated with COVID-19 since the initial outbreak. For example, according to the Texas Children's Hospital Association, there has been an increase in children seeking mental health care, with at least 350 mental health crisis patients per month since August of 2021 and more than 400 per month since February 2022.⁶⁶ As variants of SARS-CoV-2 emerged school closures fluctuated prompting uncertainty for parents and particularly students. Dr. Thomas Kim on behalf of the Texas Medical Association referred to the rise in mental health crises as having more than one cause.⁶⁷ Furthermore, the rise in referrals and cases is not novel. The upward trend is associated with multiple crises and has been an area of concern for the mental health profession for many years.⁶⁸ When asked whether NPI measures like the masking of school children, despite low efficacy among adolescents, have a substantial mental impact Dr. Kim showed support for masking if the situation warranted their use.⁶⁹ In recommending areas of improvement to handle "non-medical drivers of health," further codification of regulations supportive of telehealth care would help facilitate ease of access to proper care in a timely fashion.⁷⁰ Additional investment in health and wellness measures for Texans before a crisis would support the effort in avoiding the "after the fact" approach to mental health care.⁷¹

Conclusion

The COVID-19 pandemic appears to be entering the endemic phase where it could follow a similar trajectory to seasonal influenza as reports indicate COVID-19 booster shots will be offered annually.⁷² Nothing is for certain when illness and humanity intersect, but it is paramount that efforts are made to limit the worst of human nature and its influence on policy. Many of the consequences of decisions made during the pandemic cannot be undone, but they can be used as a learning opportunity. It is inevitable there will be another viral outbreak in the future, along with other public health emergencies. Reviewing previous decisions through an unbiased lens will aid in crafting plans to weather future emergencies and avoid the mistakes made over the course of the pandemic that ultimately caused more public health damage than it prevented.

NPIs have their need, but the pandemic revealed sweeping mandates create unintended consequences like economic hardship, delayed preventative treatments, and at times death. Preference for one treatment over another led to confusion and corporate steerage in the medical profession and led the populace to lose trust in the medical industry. To slow the spread and prevent severe illness, government and medical officials hastily distributed vaccines without proper clinical trials, possibly leading to additional unforeseen consequences. The consequences of the pandemic, both natural and man-made, have led many to lose trust in the health care system. However, leadership and experience through COVID-19 have laid a path to take the first few steps toward protecting Texans from future emergencies.

Recommendations

- **Assess the capacity by which infectious disease control services are provided in Texas. Ensure the state has transparent, data-driven recommendations on public health matters; and consider establishing an independent, transparent state-based regulatory authority for developing and distributing disease treatment.**
- **Examine statutory changes to ensure patients have access to prescriptions submitted by licensed physicians in Texas related to COVID-19;**
- **Prohibit future mask mandates;**
- **Prohibit COVID-19 vaccine mandates and maintain that vaccines remain voluntary;**
- **Form a special committee/working group on medical censorship; and**
- **Establish a grant program accessible to Texas-based independent entities to conduct research on the adverse events of the COVID-19 vaccines directly associated with vaccine use.**

¹ Texas Department of State Health Services, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.

² Texas Department of Emergency Management, State Operations Center.

³ Texas Department of State Health Services, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Department of State Health Services (2022). Coronavirus Disease 2019 (COVID-19). COVID-19 Home. <https://dshs.texas.gov/coronavirus/>.

⁸ Texas Health and Human Services Commission, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.

⁹ SB 25, 87R, 2021; SB 572, 87R, 2021; HB 2211, 87R, 2021.

¹⁰ Texas Department of State Health Services COVID-19 dashboard.

¹¹ Droze, R. (2020). 'It feels like you are in prison': What it's like to live in a nursing home during a global pandemic. We Are Iowa. <https://www.weareiowa.com/article/news/health/coronavirus/what-its-like-to-live-and-work-in-a-nursing-home-long-term-care-facility-during-a-pandemic-coronavirus-covid19-iowa-des-moines/524-b68cae54-7883-41a7-899a-41007df44054>

¹² Texas Health and Human Services Commission, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.

¹³ Ibid.

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- ¹⁴ Ibid.
- ¹⁵ Dr. Peter McCullough, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.
- ¹⁶ Dr. Robert Malone, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.
- ¹⁷ Ibid.
- ¹⁸ Ibid.
- ¹⁹ Brett Moran, Parkland Health, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.
- ²⁰ Dr. James McCarthy, Memorial Hermann, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.
- ²¹ Ibid.
- ²² Texas Epidemic Public Health Institute, *Testimony before Senate Health and Human Services Committee*, June 27, 2022.
- ²³ Ibid.
- ²⁴ Ibid.
- ²⁵ Ibid.
- ²⁶ Ibid.
- ²⁷ Patel, V., Shirbhate, E., & Rajak H. (2022). Chapter two - Coronavirus reinfections: An outlook on evidences and effects. *Lessons from COVID-19: Impact on Healthcare Systems and Technology*. Academic Press. pg. 19-40. <https://www.sciencedirect.com/science/article/pii/B9780323998789000133>.
- ²⁸ Ibid.
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- ³¹ Ibid.
- ³² Ibid.
- ³³ Ibid.
- ³⁴ Ibid.
- ³⁵ Dr. James McCarthy, Memorial Hermann, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.
- ³⁶ Ibid.
- ³⁷ Senator Lois Kolkhorst, *Senate Health and Human Services Committee*, June 27, 2022.
- ³⁸ American Medical Association (September 1, 2021). AMA, APhA, ASHP statement on ending the use of ivermectin to treat COVID-19. <https://www.ama-assn.org/press-center/press-releases/ama-apha-ashp-statement-ending-use-ivermectin-treat-covid-19>
- ³⁹ Federation of State Medical Boards (July 29, 2022). "Spreading COVID-19 vaccine misinformation may put medical licenses at risk. <https://www.fsmb.org/advocacy/news-releases/fsmb-spreading-covid-19-vaccine-misinformation-may-put-medical-license-at-risk/>
- ⁴⁰ Chris Palazola, Texas Medical Board. *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.
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- ⁵¹ Ibid.
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- ⁵³ Senator Dawn Buckingham, *Senate Health and Human Services Committee*, June 27, 2022.
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- ⁵⁵ Senator Charles Perry, *Senate Health and Human Services Committee*, June 27, 2022.

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- ⁵⁶ Dr. Robert Malone, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.
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- ⁶⁷ Dr. Thomas Kim, *Testimony before the Senate Health and Human Services Committee*, June 27, 2022.
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- ⁶⁹ Ibid.
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INTERIM CHARGE V: MONITORING

Interim Charge Language: *Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 87th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure intended legislative outcome of all legislation.*

Per request by the Lieutenant Governor, the Senate Health and Human Services Committee was directed to monitor the status of agencies and programs overseeing the implementation of relevant legislation passed by the 87th Legislature. Several bills that are now law, including SB 969, are covered in previous charge reports. Eight pieces of legislation were included with summarized updates of their progress featured below.

SB 1137

Relating to the required disclosure of prices for certain items and services provided by certain medical facilities; providing administrative penalties.

- **Summary:** Requires a facility to compile and maintain a list of all standard charges for certain hospital items and services. The list must be available to the public and updated at least once a year. The list is required to be displayed in a prominent location on the facility's website.
- **Implementation Status:** At this writing, the Health and Human Services Commission (HHSC) is on track to issue proposed rules in the register in November with a target adoption date of February 2023, which according to HHSC, is an aggressive timeline as the agency expects a high volume of comments related to the proposed rules that will need to be addressed.

SB 809

Relating to health care institution reporting of federal money received for the coronavirus disease public health emergency.

- **Summary:** Requires health care providers that receive federal money for assisting providers during the coronavirus public health emergency to report the money received to HHSC monthly. The bill requires HHSC to compile the information into a report on a quarterly basis and provide it to the OOG, the Legislative Budget Board (LBB), and standing committees over finance and public health.
- **Implementation Status:** SB 809 is fully implemented and the Health and Human Services Commission has been collecting the data and reporting expenditures since

2021. The most recent report by HHSC as of the Committee reports completion can be found on the agency's website. [Coronavirus Disease \(COVID-19\) Public Health Emergency Reporting \(texas.gov\)](#) (see appendix A). Ongoing reports will be submitted until the end of the biennium. All other implementation activities are complete.

SB 454

Relating to mental health services development plans as updated by local mental health authority groups.

- **Summary:** This legislation adds Section 531.0222 to the Government Code. It requires groups of Local Mental Health Authorities (LMHAs)/Local Behavioral Health Authorities (LBHAs) established under Government Code Section 531.0221 to continue meeting at least quarterly to collaborate on implementing regional strategies to reduce costs related to mental health crisis care, including specifically (1) costs to local governments of providing services to persons experiencing a mental health crisis; (2) transportation to mental health facilities of persons served by a local mental health authority; (3) incarceration of persons with mental illness in a county jail; and (4) emergency room visits by persons with mental illness. It further requires each group to annually update the regional plan made under 531.0221 and submit the plan to the Health and Human Services Commission.

The ENR version requires that HHSC use federal funds to implement this section. The Health and Human Services Commission must produce an annual report posted to the agency website by December first of each year containing updated regional plans, although a report is not required in 2021.

The bill requires the local mental health authority groups to meet at a minimum quarterly to continue planning and implementing identified strategies. The local mental health authority groups will be required to provide quarterly updates to the Health and Human Services Commission.

- **Implementation Status:** Final report will be published on the Health and Human Services Commission website by December 1, 2022. All other implementation activities are complete.

SB 968

Relating to public health disaster and public health emergency preparedness and response; providing a civil penalty.

- **Summary:** Requires DSHS within existing resources to disseminate relevant immunization information during a declared disaster and make those materials available to certain entities. The materials should include CDC recommendations and

vaccine availability by local providers. The Executive Commissioner requires the reports of polymerase chain reaction tests from clinical or hospital laboratories to contain the cycle threshold values and their reference ranges. The office of the Chief State Epidemiologist is established. The Preparedness Coordinating Council is required to examine the roles of DSHS, HHSC, and TDEM relating to public health disaster and emergency planning and response efforts and determine the efficacy of the state emergency operations plan in appropriately identifying agency responsibilities.

- **Implementation Status:** The requirements for disseminating relevant immunization information along with CDC recommendations and vaccine availability are only active during a declared public health disaster.

SB 25/SJR 19

Relating to the right of certain residents to designate an essential caregiver for in-person visitation.

- **Summary:** One of the countless heartbreaks Texans faced this past year was the inability to visit their loved ones in Long Term Care Facilities. Across the state, people were locked out from visiting their loved ones, even as they lay dying.
- SB 25 amended state law to require that a resident or their guardian or legal representative be allowed to designate one essential caregiver with whom in-person visitation may not be prohibited. SB 25, stated that all residents of an assisted-living facility, a nursing facility, an immediate care facility as well as individuals receiving services through a home-and-community-based services (HCS) program provider in a residence have the right to designate an essential caregiver and have essential caregiver visits.
- SJR 19 proposed an amendment to the Texas Constitution to codify a long-term care resident's right to designate an essential caregiver.
- **Implementation Status:** The Health and Human Services Commission finalized rules to implement SB 25 in [Texas Administrative Code Chapter 570](#) on June 1, 2022. An essential caregiver is defined as a family member, friend, guardian, volunteer, or other person designated for in-person visits by an individual, resident, or client or the individual's, resident's, or client's guardian or legally authorized representative (LAR). If there is a conflict between an individual's, selection and a guardian's selection on behalf of the individual, resident, or client, the guardian's selection prevails, in accordance with the terms of the guardianship. An essential caregiver visit is an in-person visit between an individual, resident, or client and a designated essential caregiver. The rules do not specify when or how the essential caregiver is designated, nor do they prescribe a form for designating an essential caregiver.

In addition, HHSC Appeals developed a process for caregivers to appeal a facility's decision to deny ECG visitation back in October 2021, in accordance with the requirements of the bill, effective June 1, 2022 (26 TAC Chapter 570), to fully incorporate the new requirements into regulatory requirements. At this writing, HHSC has not cited any facilities for violation of essential caregiver visitation rules, and HHSC Appeals has not received any appeals requests

- SJR 19 was added to the November 2021 statewide ballot and was approved by Texas voters to enshrine an essential caregiver right in the state's constitution.

APPENDIX (WITNESS LIST)

Senate Health and Human Services Committee Witness List

June 27, 2022

I. Public Health Data: Review the processes for public health data collection and coordination by local and state entities as well as regional trauma centers. Identify any continuing barriers to the real-time dissemination of data concerning health care facility capacity—including data that can expedite timely care—and mortality rates, as well as other information that can assist in public policy decisions.

Panel I

- **Kirk Cole**, *Deputy Commissioner, Texas Department of State Health Services*
- **Nim Kidd**, *Chief, Texas Division of Emergency Management*
- **Dr. Mujeeb Basit**, *Assistant Professor, UT Southwestern Medical Center*

Panel II

- **Dr. Brett Moran**, *Senior Vice President, Associate Chief Medical Officer, Chief Medical Information Officer, Parkland Health*
- **Wanda Helgesen**, *Executive Director, BorderRAC Regional Advisory Council and on behalf of the Texas EMS, Trauma & Acute Care Foundation (TETAF)*
- **Melanie Richburg**, *CEO, Lynn County Hospital District and on behalf of the Texas Organization of Rural and Community Hospitals (TORCH)*
- **Katherine Wells**, *Director of Public Health, City of Lubbock and on behalf of the Texas Association of City and County Health Officials (TACCHO)*

III. Health Care Workforce: Study the impact of the global pandemic on the health care workforce in acute and long-term care. Identify health care staffing challenges and examine how staffing services and payment models changed the economics of the health care workforce. Identify and recommend ways to increase the health care workforce pipeline.

August 23, 2022

Invited Testimony

Panel I

- **Lisa Wyman**, *Director, Center for Health Statistics, Texas Department of State Health Services*
- **Bryan Daniel**, *Chairman, Texas Workforce Commission*
- **Elizabeth Mayer**, *Assistant Commissioner for Academic and Health Affairs, Texas Higher Education Coordinating Board*

Panel II

- **Kathy Thomas**, *Executive Director, Texas Board of Nursing*
- **Stephen Brint Carlton**, *Executive Director, Texas Medical Board*
- **Stephanie Allred**, *Director of Licensing, Long-Term Care Regulation, Texas Health and Human Services Commission*
- **Scott Schalchlin**, *Deputy Executive Commissioner, Health and Specialty Care System, Texas Health and Human Services Commission*

Panel III

- **Cindy Weston**, *Associate Professor and Associate Dean for Clinical and Outreach Affairs, Texas A&M University College of Nursing*
- **Michelle Trubenstein**, *Dean of Health Sciences, Blinn College*
- **Lori Rice-Spearman**, *President, Texas Tech University Health Sciences Center*
- **Jair C. Soares**, *Executive Director, UT Health Houston Behavioral Sciences Campus*

Panel IV

- **Steven Hines**, *Vice President, Client Solutions, ADASTAFF*
- **Kevin Warren**, *President and CEO, Texas Health Care Association*
- **John Henderson**, *President and CEO, Texas Organization for Rural and Community Hospitals*
- **Jennifer Banda**, *Senior Vice President, Advocacy and Public Policy, Texas Hospital Association*
- **Jack Frazee**, *Director of Government Affairs and General Counsel, Texas Nursing Association*

IV. Pandemic Response: Examine the impact of state and federal pandemic policies—including agency guidance, licensing and regulatory actions, and health care industry policies—on patient care and treatment delivery. Examine how regulatory guidance impacts the patient-doctor relationship. Recommend any changes needed to ensure Texas can develop its own data-driven guidance during public health emergencies.

June 27, 2022

Invited Testimony

Panel I

- **Kirk Cole**, *Deputy Commissioner, Texas Department of State Health Services*
- **Cecile Young**, *Executive Commissioner, Texas Health and Human Services Commission*
- **Chris Hilton**, *Division Chief of General Litigation, Office of the Attorney General*

Panel II

- **Dr. Thomas Kim**, M.D., *Psychiatrist on behalf of the Texas Medical Association*
- **Dr. James "Jamie" McCarthy**, M.D., *Executive Vice President and Chief Physician Executive, Memorial Hermann Health System*
- **Dr. Eric Boerwinkle**, Ph.D., *Interim Executive Director, Texas Epidemic Public Health Institute (TEPHI) and Dean, UT Health Science Center at Houston School of Public Health*
- **Dr. Robert W. Malone**, M.D., M.S., *President, International Alliance of Physicians and Medical Scientists and Chief Medical and Regulatory Officer, The Unity Project*

Panel III

- **Chris Palazola**, *Director of Operations, Texas Medical Board*
- **Dr. Timothy Tucker**, Pharm.D., *Executive Director, Texas State Board of Pharmacy*
- **Dr. Peter McCullough**, M.D., M.P.H., *Internist, Cardiologist*