TEXAS Health and Human Services | Texas Department of State Health Services

Task Force of Border Health Officials (TFBHO) Meeting
HHSC Virtual Platform
October 21, 2021

Member Name	Yes	No	Professional Representatives (non-members)
Esmeralda Guajardo, MAHS	✓		
Richard Chamberlain, DrPH(c), MPH, RS		✓	
Steven M. Kotsatos, RS		✓	
Josh Ramirez, MPA, CPM	✓		
Eduardo Olivarez	✓		
Arturo Rodriguez, DNP, MPA, CPM	✓		
Angela Mora, M.A.Ed.	✓		
Emilie Prot, DO, MPH	✓		
Lillian Ringsdorf, MD, MPH	✓		
Rachel E. Sonne, MD, MPH	✓		
State Representative Bobby Guerra		✓	Represented by Jasmine Owen
Senator Eddie Lucio Jr.		✓	

Attendees Present
Francesca Kupper, Karin Hopkins, John Villarreal, David Gruber, Tony Aragón, Zach Flores, Úrsula Solorzano, Dr. Allison Banicki, Edith de Lafuente, Alberto Perez, Adriana Corona-Luevanos and Jasmine Owen.

Agenda Item I: Call to Order, Welcome, Chair Remarks, Meeting Logistics and TFBHO Roll Call

Chair Guajardo opened the meeting at 1:00 pm. She thanked HHS production staff and welcomed attendees to the Task Force of Border Health Officials (TFBHO) meeting. Chair Guajardo asked if Dr. Hellersdtedt was attending the meeting. She asked if Senator Lucio or Representative Guerra was attending the meeting. Jasmine Owen from Representative Guerra's office announced her attendance. Chair Guajardo asked Ms. Kupper to continue with logistical announcements. Ms. Kupper presented the meeting production staff and reminded members of the meeting/virtual platform guidelines. She proceeded to the roll call and seven members were present to establish a quorum and she turned the meeting over to Chair Guajardo. She continued by asking other attendees to introduce themselves and thanked them for attending.

Agenda Item II: Consideration of September 9, 2021, Meeting Minutes
Chair Guajardo asked members to review the September 9, 2021 Meeting Minutes. She asked for a request for a motion to approve the draft meeting minutes. Dr. Rodriguez provided the first while Dr. Emilie Prot and seconded the motion. Ms. Kupper initiated a roll call vote to approve the meeting minutes. The motion carried and the minutes were approved.

Agenda Item III: Update: Announcement and COVID-19 Vaccine
Chair Guajardo welcomed Mr. Gruber and Mr. Aragon to the meeting. Mr. Aragon, Immunization Unit Director (DSHS), provided the COVID-19 Vaccine Update by expressing that much has been discussed since the last meeting, particularly about boosters/third dose vaccines and the approval of the Pfizer vaccine for children 5-11 years of age. He continued by detailing that 32 million people have been vaccinated in Texas, since December 2021. Of those, 15 million are fully vaccinated (two doses of Pfizer or Moderna or one dose of the Johnson & Johnson vaccine).

He explained that a booster dose is defined as a vaccine given to people who are fully vaccinated but have experienced decreased immunity. An additional dose is described as vaccine dose for those who are immunocompromised. The following are FDA approved recommendations for booster doses:

Pfizer vaccine booster:
- People of ages 65 and older living in a long-term care facility can receive the booster (third) dose at least six months after the two initial doses.
- People of ages 50-64 with certain underlying medical conditions can receive the booster (third) dose at least six months after the two initial doses.
- People of ages 18-49 high risk of severe Covid-19 infection with certain underlying health conditions can receive the booster (third) dose at least six months after the two initial doses based on individual benefits and risks.
- People of ages 18-64 who are at increased risk for exposure or transmission because of their occupational or situational setting can receive the booster (third) dose at least six months after the two initial doses.

Moderna vaccine booster:
- People of ages 65 and older can receive the booster (third) dose at least six months after the two initial doses.
- People of ages 18-64 with severe high risk of Covid-19 infection can receive the booster (third) dose at least six months after the two initial doses.

- People of ages 18-64 who are at increased risk for exposure or transmission with frequent institutional or occupational exposure can receive the booster (third) dose at least six months after the two initial doses.

John & Johnson vaccine booster:

- People of ages 18 and older can receive the booster (second) dose at least two months after receiving their first dose.

FDA approved that vaccine boosters don't have to be from the same manufacturer [initial two doses (primary series) of Pfizer or Moderna; or the initial John & Johnson vaccine]. People can mix/match booster vaccines, but not from initial dose(s) (primary series), whether it's a third dose after receiving the Pfizer or Moderna vaccines or your second dose after receiving the John & Johnson initial vaccine. No mix/match of primary initial two doses (primary series) of Pfizer or Moderna.

As far as pediatric Covid-19 vaccines for children 5-11, Pfizer is expected to receive approval in early November. Health care providers can pre-order the vaccine although the first couple of weeks are expected to be by allocation, the same way it occurred during the first phases of vaccine distribution in the first part of the year. Afterward, it should return to the open order scenario we currently have.

Associate Commissioner David Gruber provided an overview by mentioning that with a decrease in cases and hospitalizations, the state's status looks a lot better than a couple of months ago. He also praised the great public health efforts of TFBHO members to have some of the highest vaccination rates along the border from El Paso to the Rio Grande Valley. As long as we keep this current trend, the future is positive for Texas and the border. He expressed the need to continue to promote vaccinations and boosters to keep Texas moving forward.

Chair Guajardo and other members asked questions about boosters and guidance. Mr. Aragon answered the questions and offered an e-mail follow-up to clarify anything else. Chair Guajardo mentioned that some areas along the border are hitting a 100 percent vaccination rate for certain age groups. She asked if there were other parts of the state hitting that mark, especially taking into account the low census completion rates compared to the realistic denominator regarding the actual count of people living along the border. Mr. Aragon stated that there are other parts of the state that are reaching very high vaccination rates but not necessarily as high as some border communities, especially when compared to a census denominator, when it's not always a true reflection of the number of people living in certain areas. He offered to send members data regarding this topic.

Chair Guajardo raised the issue to offer perspective in cases where some vaccination rates are higher than 100 percent, due to census undercounting or lack of completion of the census. Vice-chair Olivarez offered clarification on this point because there may be some that may assume that this overage due to migrant populations receiving vaccinations. He continued by stating that the denominator based on the census count is inaccurate. Many border counties have a very large scale of permanent residency that don't always follow

through with the census. He wanted to ensure that there was no assumption that any vaccination rates higher than 100 percent isn't due to immigration. He reiterated that there is a high number of permanent residents that don't partake in the census.

Dr. Rodriguez commented that, as public health officials, we need to continue to tell have that narrative about high vaccination rates. Recently, some Covid-19 vaccines were sent to other states who needed it. In the future, we should ensure that the border continues to receive the allotments due to them, especially when we consistently vaccinate at rates of 95 percent amid of border fluidity. Just like hospital trauma service centers keep antibiotics in stock, we may consider strategizing something similar, whether by deep freezing or other means to ensure future resources are allocated appropriately.

Dr. Sonne also agreed with Dr. Rodriguez regarding the concept of resources and we should have capacity for long periods of storage to serve as a better landing point so that we more dependably transport medications with dry ice, for example because El Paso is the only place that has dry ice throughout most of the region. A great example of the census denominator issue in Health Service Region 9/10 is Presidio County, which has a partial vaccination rate of 118 percent and their full vaccination rate is 99 percent. Partners in the area including Presidio, Brewster, Jeff Davis Counties are very pro-active in the tri-county area and called her yesterday already asking about booster allocation. Most residents have a deep trust and respect for the public health system, which may also account for high vaccination rates.

Dr. Rodriguez also mentioned that even with high vaccination rates, some border areas still have higher mortality rates per capita due to diabetes, hypertension and obesity levels. Those factors continue to be an issue from the wellness perspective. The census denominator will play a role in the future if allocations are based on old or undercounted data when quotas for allowances are referenced. If that is the case, the amount of resources will continue to be less than what is needed for border communities. The only way to improve the issue is if decision makers have relevant data.

Chair Guajardo asked if other members had any other comments or questions. Dr. Prot asked about the timeline for pediatric vaccines because she's received questions from partners. Mr. Aragon answered that pre-orders are being received and the timeline for pediatric vaccines is October 26, for approval and recommendations, followed by final approvals during November 2-3. Vaccination allocation may happen as early as November 4. Chair Guajardo thanked everyone for their comments, thoughts or concerns.

Associate Commissioner David Gruber commented that the House Public Health Committee met with border public health leaders to assess to health care services and asked Vice-Chair Olivarez to expand, since he spoke to the committee. He mentioned that some highlights were provided by representatives from the Texas Medical Association and border partners from El Paso, the Big Bend area down to the Rio Grande Valley. A big concern was the number of licensed beds vs. the number of actual staff to serve those beds. He referenced Hidalgo County, as an example. The county has 2,000 hospital beds vs about 1,000 staffed beds. There were also conversations on how to support rural communities and other

programs and educational institutions to recruit health care professionals to border areas. There were also concerns about what can be done to encourage paramedics and ambulance systems and staff. They also heard testimonies and discussed transportation issues, especially for border communities that are between 30-50 miles from closest hospital or doctor, with areas with no public transportation systems in place. They also discussed the possibility on funding to enhance the healthcare system along the border. The topics weren't new to border public health, but the pandemic helped uncover major needs that must be addressed to improve border public health.

Mr. Gruber mentioned that some legislators referenced the importance of the TFBHO and what could be done to help. Mr. Gruber shared that the recommendations report was forthcoming and that they may be able to assist based on those recommendations.

Vice-chair Olivarez added that he expressed concern about the undercounted census denominator, detailing that Hidalgo County has a current population count of 870,000 people but school enrollment shows registrations closer to 1.2 million. The county census only increased by about 10,000 people from ten years ago, which is grossly undercounted, including permanent residents that don't want to be counted. Chair Guajardo thanked everyone for their contributions and mentioned that many were looking forward to a post-pandemic time to allow for them to run their health departments.

Agenda Item IV: Review Recommendations Narratives (COVID-19) as part of the short-term plan

Chair Guajardo deferred to Mr. John Villarreal, Binational Coordinator for the Office of Border Public Health and TFBHO Coordinator for assistance in review of the short and long-term recommendations. Mr. Villarreal had previously sent the proposed the recommendations to all members and explained that they'd be reviewing the entire recommendations report page by page until they reached page 8, the recommendations portion of the report.

Mr. Villarreal and members discussed the proposed recommendations and provided comments and edits during the discussion to finalize the report. The short-term recommendations are as follows:

1. Complete the border surveillance and laboratory capacity assessment and expand it to include capabilities for laboratories to report results and positivity rates directly to local health departments.
2. Establish and make available local laboratory and testing capabilities available to border public health departments that is regularly available and accessible at low to no cost including university agreements and state labs.
3. Strengthen and support strategies to improve coordination with Mexico via the Texas Department of State Health Services Office of Border Public Health.

4. Involve the School Health Advisory Council in the school response plans to communicable disease reporting and outbreaks, including COVID-19; school ventilation; food safety and preparation; and preventative measures.
5. Conduct a survey on ventilation and air-conditioning in coordination with the Texas Education Agency and Health and Human Services Commission in nursing home and school facilities.
6. Add COVID-19 surveillance of premature births to the Birth Defects Program at the Texas Department of State Health Services.

Agenda Item V: Discussion: Long-term Plan Recommendations

Chair Guajardo and Mr. Villarreal continued with long-term recommendations. Mr. Villarreal and members discussed the proposed recommendations and provided comments and edits during the discussion to finalize the report. Some comments were tabled for the following report due on November 1, 2022. The long-term recommendations are as follows:

Border Public Health Infrastructure:

A. Require implementation of the Health Information Exchange (HIE) with free access for border public health and providers with potential to serve as a regionwide/statewide electronic medical record and communication system.

Discussion: During the COVID-19 pandemic response, border public health departments were faced with a lag in receiving confirmatory COVID-19 reports from healthcare providers which limited the response efforts. This was partially due to the overwhelming amount of work placed on the medical community during this time. However, it was in larger part due to the lack of a regionwide electronic medical record and communication system between healthcare providers and the border health departments. With identification of COVID-19 cases being the key to the control of its transmission, the inability to receive timely confirmatory reports limited public health's ability to initiate case investigations promptly, contributing to the increases in COVID-19 cases.

The delayed reporting issue was further complicated for border public health departments as most lacked the technological infrastructure and financial means to maintain an electronic health record (EHR) system. As a result, border public health relied on antiquated methods to receive reports, primarily fax machines, and, more often than not, reports were received 4-6 days after the case was identified. To address this void, the utilization of the Health Information Exchange (HIE) would assist in allowing for rapid, up-to-date access to health information. As the HIE is designed to connect physicians, hospitals and specialists in sharing of critical patient health information in real-time, access to the HIE by border public health would alleviate the lag of case reporting. Unfortunately, medical providers and public health departments alike must pay to have access to the HIE information. As border public health departments do not have the financial means to access the HIE, providing border public health departments with free access to the HIE would allow for real-time case reporting and prompt case investigations to avoid further transmission of a public health threat.

B. Ensure funding to allow for permanent, full-time public health professionals (epidemiologists, microbiologists, sanitarians, entomologists) for border public health departments.

Discussion: One of the greatest risks to public health is the lack of resources to be able to meet the demands of a community and its emerging public health threats. With its low socio-economic status, the inability of border public health departments to maintain the needed public health infrastructure and personnel can have a detrimental effect on the community. During the COVID-19 response, this was evidenced by the lack of epidemiologists within the border public health region. Epidemiologists undertake the most critical aspect of disease containment: case investigations. A thorough case investigation provides insight on the emerging public health threat, surveillance, implementation of mechanisms to minimize transmission, and development of interventions for prevention and control of the disease.

Border public health departments handled the peak of COVID-19 with a minimal number of epidemiologists and experienced a high turnover rate of epidemiologists due to employment opportunities elsewhere with higher salaries. Also, many had to employ contract epidemiologists who were limited by their lack of cultural awareness and inability to speak Spanish. Unfortunately, the lack of staff with specialties within border public health departments is not limited to epidemiologists; entomologists, microbiologists, and registered sanitarians are also lacking. To allow for prompt public health intervention these specialties lend their expertise to, ensuring funding to allow for permanent, full-time public health professionals within border public health departments is essential.

C. Representation of Task Force of Border Health Officials on task force/committees involving local health departments established by the Texas Department of State Health Services.

Discussion: The creation of the Task Force of Border Health Officials (TFBHO) stemmed from the concern of border public health officials that they faced issues unlike other parts of the state, and it called for a different approach in responding to public health threats. The overarching goal of the task force was to establish a mechanism to ensure that those issues were brought to the forefront in the effort to be prepared against an imminent public health threat. While some recommendations raised by the task force are sought implementation via legislative action, the need to address these issues in a proactive approach during policy development remains. A means to address this is through the representation of TFBHO on task force/committees involving local health departments established by the Texas Department of State Health Services. TFBHO representation in task force/committees will assure that the needs and the dynamics of border public health are considered in the development stages rather than requiring adjustments after the fact and when it may be too late to do so.

Communicable Diseases:

A. Expand the Texas Department of State Health Services Office of Border Public Health community health workers training curriculum and bilingual educational material for pandemic response, including mental health and COVID fatigue.

Discussion: During the COVID-19 pandemic response, education of the community became key in gaining trust of the community to fight transmission of the virus. COVID-19 response has not only been a fight against the virus, it has equally shown to be a fight against misinformation. Unified messaging from the Centers for Disease Control and Prevention down to the local level has been used by local health departments in the communities. The Texas Department of State Health Services'(DSHS) Community Health Worker or Promotor(a) Training and Certification Program (texas.gov) is a key to leverage public health education across our vulnerable populations. CHWs/Promotores are an essential asset in Texas and an emergent workforce during this pandemic response. The effect of the Covid-19 pandemic on disadvantaged communities has had a great impact on all aspects of underserved communities or those of low resources. The growth of insecurities such as food and jobs have left many communities vulnerable with greater psychosocial, material, and physical instabilities that CHWs/Promotores can help improve with education and available resources. CHWs/Promotores are needed to bridge communities and systems of health and mental care that are currently available. CHWs/Promotores have been shown to reduce the burden of illness among people with chronic diseases and to improve their ability to manage their own conditions. As we know, some chronic conditions and comorbidities can make a person become severely ill when contracting Covid-19.

According to the Rural Health Information Hub, CHWs/Promotores may perform the following roles:

- Create connections between vulnerable populations and healthcare providers.
- Help patients navigate healthcare and social service systems.
- Manage care and care transitions for vulnerable populations.
- Reduce social isolation among patients.
- Determine eligibility and enroll individuals in health insurance plans.
- Ensure cultural competence among healthcare providers serving vulnerable populations.
- Educate healthcare providers and stakeholders about community health needs.
- Provide culturally appropriate health education on topics related to chronic disease prevention, physical activity, and nutrition.
- Advocate for underserved individuals or communities to receive services and resources to address health needs.
- Collect data and relay information to stakeholders to inform programs and policies.
- Provide informal counseling, health screenings, and referrals.
- Build community capacity to address health issues.
- Address social determinants of health.

According to the American Community Survey (ACS), over 25 percent of border counties are foreign born compared to 15.5 percent in non-border counties in Texas. Furthermore, a total of 31.7 percent responded speaking English less than "very well" in border counties

compared to 12.2 percent in non-border counties. CHWs/Promotores not only bridge the communication gap but also break cultural barriers of communication. Institutions that utilize CHWs/Promotores have shown that they have helped uncover and take action to address social determinants of disparities in Covid-19 infections and outcomes. CHWs/Promotores served as cultural brokers and navigators between community members and local systems of care while mitigating fear and correcting misinformation in disadvantaged communities. It is It is very important for DSHS to educate CHWs/Promotores with current, factual and culturally appropriate content that will help prevent misinformation among our communities.

Urban and rural underserved communities on the border were faced with reduced access to care, misinformation, and lack of inadequate supplies, such as food and other essentials. Investing time and funds in CHWs/Promotores and in their education can help address the social determinants of poor health that disproportionately affect low-income, minority populations and that are magnified during times of crisis such as the Covid-19 pandemic. Not only is it important to create curriculums to help CHWs/Promotores disseminate proper information, it is also imperative to help fund those organizations to hire CHWs/Promotores. It is important for grants and funds to made available to local health departments and health entities for the hiring of CHWs/Promotores to help disseminate the information that was taught to them. When CHWs/Promotores have the proper knowledge and education, about their local resources (through curriculums), they can help in improving mental health issues by referring patients to help by helplines or local clinics. They can help community members apply for aids that are available to them and they provide a support structure for families along the border. CHWs/Promotores educate, support and follow-up with community members when they are at risk or have certain chronic diseases. They provide the support system and resources needed to deal these conditions.

B. Establish a Border Public Health Multi-Disciplinary Response Team with trained and bilingual staff, including epidemiologists, sanitarians, nurses and contact tracers.

Discussion: It was essential to grow the public health infrastructure to mitigate spread of disease and protect our vulnerable community. Bilingual public health professionals are needed to conduct case investigations, educate and inform communities. Additionally, an outbreak investigation and mitigation necessitate multiple public health professionals with different training and skills.

During the COVID-19 response, an outbreak investigation is involved in gathering information from a positive case, understanding disease transmission, specific risk factors either environmental or medical dependent specific to the setting. Epidemiologists, sanitarians, nurses and contact tracers each possess specific skills and knowledge to protect the community and mitigate disease transmission.

Other communicable diseases such as tuberculosis, affect disproportionally border counties. Locally, there have been several large contact investigations in schools and universities when an infectious case attended in-person classes. This requires testing of close contacts and is very staff intensive. A deployable multidisciplinary team would help augment local health department’s capacity to respond to disease outbreaks for contact investigations.

C. Evaluate needs to support hospitals, nursing homes and long-term acute care centers.

Discussion: Border health counties are designated as Medically Underserved Areas either rural or partial rural by the Health Resources and Service Administration (HRSA). Throughout the pandemic, we have seen a shortage of medical personnel and hospitals reaching their own staffed bed capacity disproportionality worse in the border counties compared to non-border counties.

Our health care systems would benefit from an evaluation of the support needed to bolster our hospital infrastructure in personnel and acute care facilities. Some border counties are isolated with populated areas several hours from large metropolitan areas with higher levels of medical care. Transferring patients to other Trauma Service Areas has been merely impossible during the COVID-19 response, yet a significant expense to the state of Texas.

During the COVID-19 response, local health officials reported that hospitals facilities along the border lacked either medical staffing, specific specialties, or bed space. There was increased mortality and a lack of morgue space as well. An evaluation of the needs to support acute care facilities and long-term care facilities along the border would benefit the border community.

D. Uphold vaccination requirements for school entry and add COVID-19 vaccine.

Discussion: COVID-19 vaccines are highly effective at preventing severe disease, hospitalization, and death from COVID-19. Their efficacy rates against hospitalization are 93 percent for Pfizer, 88 percent for Moderna, and 71 percent for Janssen.

Children less than 18 years of age are making up a greater proportion of cases. Over the course of the pandemic children have made up about 16 percent of cases but during the week ending October 14, 2021 they made up 25.5 percent of cases. Although less commonly than adults, children can become severely ill and require hospitalization and children with underlying medical conditions such as asthma or diabetes are at enhanced risk. Furthermore, children can spread the virus to other family members and friends sustaining transmission. Vaccinating them is an important part of the effort to reduce transmission of the virus.

Currently the vaccines are approved by Emergency Use Authorization for children 12-16 years of age (Pfizer) and 12-18 years of age (Moderna, Janssen). Pfizer is Federal Drug Administration (FDA) approved for adolescents 16-18 years old. When the vaccines receive full FDA approval, the Task Force of Border Health Officials recommends that they be added to the school vaccination requirements. Vaccines are a crucial part of stopping the pandemic and allowing life to return to normal.

Environmental Health:

A. Continue to provide resources to increase capacity for mitigation (i.e. staff, equipment, chemical, education, training); and use innovative methods for mosquito control such as GIS, year-round mosquito testing in targeted high risk areas, and other evidence based approaches for ongoing needs, emerging and new threats, emergencies, and disasters.

Discussion: In order to address vector-borne and zoonotic diseases and standardize practices in counties located along the international border with Mexico, it is important to address the following: (1) studying the ongoing and potential needs of border counties related to vector-borne and zoonotic diseases, (2) the availability of and capacity for vector mitigation and control, including increased staffing, equipment, education, and training, (3) creating strategies to improve or develop continuing education and public outreach initiatives for vector-borne and zoonotic disease prevention, including sanitation, removal of standing water, use of repellant, and reporting to health authorities of rashes and other symptoms of vector-borne and zoonotic diseases, (4) develop rapid local and regional response and support plans, (5) encourage ongoing vector-borne and zoonotic disease control activities (6) preparedness for disasters, including flooding, hurricanes, and outbreaks of vector-borne diseases.

These resources are crucial for the Texas-Mexico border because of the endemic mosquito species. The border counties are at an increased risk due to a longer mosquito season, warmer temperatures in Border regions, and subtropical conditions. To meet the surge capacity, we need these resources and we also need to know the mosquito type and sensitivity.

The Texas Department of State Health Services (DSHS) currently does not accept mosquito samples for testing of Zika, West Nile, and Chikungunya viruses from November to March. It is important for border counties to have year-round testing due to year-round subtropical weather. The Task Force of Border Health Officials (TFBHO) is proposing the funding of vector borne zoonotic disease mitigation efforts, including testing capabilities, resistance studies, and insecticide rotations, for year-round surveillance and management of vectors in urbanized areas in subtropical climates along the border.

There are multiple organizations along the Texas border with these varying capabilities. The TFBHO respectfully requests that DSHS entomology convene these organizations for coordination of vector borne disease mitigation efforts along the Texas border.

B. Improve recruitment and retention of Registered Sanitarians. Expand training and certifications to improve response and expansion opportunities with expert personnel to assist with the prevention of food, water, vector-borne and zoonotic diseases

Discussion: This is recommended following the same pattern in SB 1312 Section 1 Texas Legislature Online - 86(R) Text for SB 1312: to develop a tiered curriculum and test for public health sanitarians to grow the workforce of sanitarians capable of performing basic and critical food safety inspection services. 1) Create a first-level certification Sanitarian I or Environmental Protection Specialist exam that will give authority to inspect restaurants. Requires at least a high school diploma AND either 2 years of college and/or experience

assisting with preventing food, water, vector-borne, and zoonotic diseases; and 2) maintain the second-level certification test that has a minimum requirement of a 4-year college degree with 30 hours of science coursework, and can test for the full Sanitarian license. The Lower Rio Grande Valley has a low number of registered sanitarians compared with the populations served, which requires rising demands due to industrial and economic growth.

Given more people have died from severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) during this pandemic than from any viral respiratory illness in 100 years, and given other recent pandemics—SARS in 2003, Highly Pathogenic Avian Influenza virus (HPAI) A, H5N1 in 2003, Influenza A H1N1 in 2009, Middle East Respiratory Syndrome (MERS) in 2012--resulted in high mortality rates, one significant preventive intervention that has not yet been mainstreamed is indoor air ventilation. The American Association of Pediatrics continues to recommend that "in person school is best when it is safe" and that in-person school means prolonged exposure to classmates in enclosed spaces, adequate ventilation and air handling is imperative to resuming in person classes. The Centers for Disease Control and Prevention (CDC) and the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) have issued guidance for optimizing ventilation in schools to reopen them during the COVID-19 pandemic. By implementing measures recommended by CDC, ASHRAE, and others, it is possible to decrease the risk of infections in schools and daycares while continuing in-person education.

C. Conduct school surveys on ventilation and air conditioning in coordination with the Texas Education Agency. Implement environmental air filtration measures to mitigate the spread of COVID-19 and other infectious respiratory pathogens in public and private schools.

Discussion: Some of the interventions listed by these organizations include:

- Optimize architectural design of the physical plant.
- Remedy crowding to allow for social distancing.
- Optimize humidity levels to reduce transmission of virus.
- Optimize window ventilation in classrooms where outdoor air quality is reasonable.
- Supplement outdoor ventilation with indoor fans to better distribute air.
- Disable demand-controlled ventilation (DCV) controls that reduce air supply based on occupancy or temperature during occupied hours.
- Ventilation considerations are also important on school buses.
- Use portable high efficiency particular air (HEPA) fans/filtration systems to help enhance air cleaning.

Cost estimates for additional heating, ventilation, and air conditioning (HVAC) hardware range from $500 to $1500 per classroom. Increasing classroom space, for example, standing up temporary trailers would also incur additional costs. Most other interventions mentioned total costs between $0 – $99 per classroom.

Chronic Diseases:

A. Establish early intervention components of children's obesity prevention and education.

Discussion: According to the American Community Survey (ACS), 40.5 percent aged 18 years and younger live below the poverty level in border counties compared to only 22.6 percent in non-border counties. A striking total of 50.3 percent adults aged 18-64 have reported not having any health insurance compared to 26.7 percent for non-border counties, please see Table 1 on page 7.

It is essential to start early during childhood to educate and prevent disease. Primary prevention with a focus on obesity is needed in our border counties that have a higher diabetes burden and obesity compared to the rest of Texas and the U.S. As we know, chronic conditions and comorbidities such as obesity have been a major risk factor for not only contracting COVID-19, but also associated with disease severity and death.

B. Establish an educational component on pulmonary complications at advanced age.

Discussion: During the early stages of the COVID-19 pandemic until today, we have increased our medical knowledge and understanding of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the way it enters our bodies, how it causes disease and we are starting to understand the long COVID-19 symptoms post recovery. Our border population has been especially hard hit by COVID-19 with a high percentage of fatalities and morbidity during the pandemic. Border residents are disproportionately likely to have no health insurance, so education is our main public health goal to help decrease the morbidity and mortality in border counties.

Advanced age and underlying pulmonary disease placed patients at higher risk of severe COVID-19 disease, hospitalization and being placed on a ventilator.

Establishing an educational component on pulmonary complications at advanced age would help individuals in the healthcare setting and in the community understand the risks that complicate the disease.

Maternal and Child Health:

A. Support sharing medical knowledge and training of border health professionals in coordination with the Texas Medical Association and the Texas Border Health Caucus.

Discussion: COVID-19 is a novel disease threat. The scientific and medical community is still learning about the virus as well as how to effectively treat COVID-19. Research is ongoing and new data is coming out continually. It can be difficult to keep up with all the new information especially for actively practicing healthcare professionals in healthcare shortage areas like the border. Therefore, it is critical that the dissemination of knowledge and the provision of training be accessible to border health professionals. The burden of COVID-19 cases has been high along the border which has strained healthcare resources and taxed healthcare providers. Assisting professionals by disseminating knowledge and training is critical during a pandemic.

In addition, continuing provision of information about scientific advances and new and different treatments as well as training on new topics is particularly important for border professionals who have busy practices in this healthcare shortage area. Keeping professionals updated on new medical data and advances will strengthen and maintain the border healthcare work force.

The Texas Medical Association is a trusted resource for reliable medical and scientific knowledge, and the Border Health Caucus is a well-respected group that supports and advocates for border physicians. The Task Force of Border Health Officials recommends partnering with the Border Health Caucus to coordinate an information sharing and training initiative for border health professionals.

B. Establish and fund outreach to pregnant mothers that are more at risk of early delivery and complications due to COVID-19.

Discussion: It has been established that pregnant women are at increased risk of complications from COVID-19 and the risk is even greater with the Delta variant of the virus. If infected, pregnant and recently pregnant women are at an increased risk of developing severe disease requiring hospitalization. Pregnant women are also at increased risk of premature birth and may be at risk of other complications such as pregnancy loss due to COVID-19. High Covid-19 case rates along the border coupled with higher birth rates in the Hispanic population than the non-Hispanic white population combine to put this group at risk.

Hispanic or Latino people are 1.9 times more likely to become infected, 2.8 percent more likely to be hospitalized due to COVID-19, and 2.3 percent more likely to die from COVID-19 than non-Hispanic white people. Therefore, it is critical that pregnant women are well-informed about how the virus spreads, how to prevent infection, the risks of infection, and the benefits of vaccination. This population is unique with different needs and concerns than other high-risk populations. A plan to develop and roll-out an outreach effort focusing on pregnant and recently pregnant women is crucial to protect the health of both women and their babies.

Agenda Item VI: Approval of November 1, 2020 Recommendations Report (pending completion of narratives)

Chair Guajardo open this agenda item by asking Ms. Kupper if any public comments were received about the proposed recommendations. Ms. Kupper confirmed that no public comments were received. She called for a motion to approve the November 1, 20202 Recommendations Report with the edits discussed. Dr. Rachel Sonne made a motion to approve the recommendations and Dr. Rodriguez seconded the motion. Ms. Kupper conducted a roll call vote. The motion carried and Chair Guajardo continued with the meeting.

Agenda Item VII: Public Comment

Chair Guajardo asked Ms. Kupper if there were any public comments submitted. Ms. Kupper confirmed that no requests for public comments were received. Chair Guajardo continued with closing remarks.

Agenda Item VIII: Closing remarks, thank you and Adjourn

Chair Guajardo congratulated members for their work in finalizing and approve the November 1, 2020 Recommendations Report. She mentioned that December would be the end of her second term as Chair. Mr. Villarreal stated that executive management will announce the new chair and vice-chair at the December 9th meeting.

Chair Guajardo expressed the possibility of having presentations at the next meeting. Mr. Villarreal stated that presentation suggestions will be accepted and that the next item that may take a while to catch up on is S.B 1312 of the 86th Legislature. Chair Guajardo asked all member to make any suggestions for the next meeting and invited other members to join the meeting in person if possible. She wished everyone a good Thanksgiving Holiday, since it will pass before members meet again.

Mr. Villarreal reminded members of the new rule requiring the new Chair and/or Vice-chair being present at the place where the meeting is held to entertain any potential public comments. Chair Guajardo expressed the great appreciation she has for her colleagues for their continued work that has taken place during the pandemic and how it's comforting to hear of people who understand her viewpoint since border public health has unique challenges that others may not understand. She adjourned the meeting at 3:20pm. Ms. Kupper asked production staff to end the recording.