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

Task Force of Border Health Officials Meeting
1100 W. 49th Street, Austin, TX (M-100)
June 27, 2018

Member Name	Yes	No	Professional Representatives (non-members)
Esmeralda Guajardo, MAHS	✓		
Hector Gonzalez, MD, MPH	✓		
Steven M. Kotsatos, RS	✓		
Josh Ramirez, MPA, CPM	✓		
Eduardo Olivarez		✓	
Arturo Rodriguez, MPH, CPM	✓		
Robert Resendes, MBA, MT (ASCP)	✓		
Emilie Prot, DO, MPH	✓		
Lillian Ringsdorf, MD, MPH	✓		
State Representative Bobby Guerra	✓		Arrived late and with Anne Drescher
Senator Eddie Lucio	✓		Via conference call and represented by Daniel Esparza and Elsa Garza

Attendees Present

Dr. John Hellerstedt, David Gruber, Ronald J Dutton, Francesca Kupper, Allison Banicki, John Villarreal, Jordan Hill, Chris Van Deusen, Alberto Perez, Adriana Corona-Luevanos, Edith DeLaFuente, Brianna Mendoza, Henry Presas, Allie Lefkowitz, Jennifer Smith, Sebastien Laroche, Bernadette Ebanks, Elizabeth Lippincott, Karen Zysk, Camron Scott.

Agenda Item I: Call to Order, Welcome and Chair Remarks

Chair Guajardo called meeting to order at 1:15 p.m. Chair Guajardo thanked and welcomed everyone to the Task Force of Border Health Officials (Task Force) Meeting. Chair Guajardo reminded Task Force members that Valley residents continue to be very busy handling active EOC operations and expressed that she also had to evacuate her home due to recent flooding. Response efforts in South Texas are still in full force; our thoughts and prayers are with them. Chair Guajardo asked Task Force and audience members to introduce themselves.

Dr. Hellerstedt thanked Task Force members for their dedication and stated that vector control-related efforts and South Texas leadership has support from the Governor and DSHS.

Agenda Item II: Meeting Logistics and Roll Call
Ms. Kupper completed roll call to confirm a quorum. A quorum was established.

Agenda Item III: Approval of 4-13-18 Meeting Minutes
Chair Guajardo asked Task Force members to review the April meeting minutes. A motion to approve minutes was made by Steven Kotsatos and Dr. Hector Gonzalez seconded the motion. Minutes were unanimously approved with notes to correct Dr. Prot's first name and a request was made to number pages for future meeting minutes.

Agenda Item IV: Review of timeline for Executive Commissioner's legislative report due September 1, 2018
Ms. Guajardo introduced Dr. Dutton who spoke of the legislative requirements for the Executive Commissioner to submit a report of the Task Force actions by September 1 (and every even-numbered year thereafter). He also reported that that there was a DSHS deadline to submit the report for internal review by July 15.

Agenda Item V: Review of timeline for the report of recommendations to the Commissioner (short/long-term border health improvement plans) due by November 1, 2018
Dr. Dutton reviewed the requirement that the Task Force submit a report of recommendations to the DSHS Commissioner by November 1, 2018 (and every even-numbered year thereafter). This report will be posted on the DSHS website along with all other legislative reports. Dr. Dutton let members know that the DSHS internal deadline for preparation of this report on behalf of the Task Force was September 15.

Agenda Item VI: Workgroups report out draft problem statements
Communicable Diseases work group - Dr. Prot reported on the draft problem statements and stated that updated versions could be printed and distributed tomorrow. She was in the process of drafting a stronger problem statement and prospective recommendations.

- Senator Lucio announced that it was becoming difficult to hear. He planned to convene with his staff to ensure he was engaged in current Task Force activities.
- Dr. Gonzales suggested that the different subcategories of the Communicable Disease workgroup to break up in groups to amend work as needed. He also mentioned the need to improve surveillance on the border, including syndromic surveillance and that it should be included in recommendations. He also stated the need to increase HPV vaccinations and consider the possibility of mandatory vaccinations.

- **Communicable Diseases Work Group** - Dr. Prot read problem statements and asked for comments per sub-topic.

  Tuberculosis
  - Mr. Resendes suggested that students and staff should be tested to improve TB surveillance. He also mentioned the importance of Quantiferon and how to make legislators know that Quantiferon is better due to BCG false positive tests.
  - Dr. Gonzalez stated that a goal should be to test high-risk populations due to lack of funding for such countermeasures and lab support in border regions.

  Immunizations
  - Dr. Gonzalez asked if a survey in schools with private physicians might be possible in order to reduce bureaucracy of vaccine requirements and make federal partners aware of over-reporting.
  - Dr. Prot stated that Dr. Banicki showed data vaccinations for children had good results but that adult vaccination numbers could be improved with possibilities of increasing the number of providers, especially when reaching difficult-to-reach populations.
  - Mr. Rodriguez suggested that expensive vaccines be prioritized to reduce that burden and have them covered by Medicaid or insurance.

  STD/HIV

  - Dr. Ringsdorf suggested adding a statement to reflect HIV border population.
  - Mr. Rodriguez asked to consider teens as a targeted population, with an emphasis on tracking numbers as statistics change.
  - Dr. Gonzalez concurred and asked to highlight adolescent health in relation to STIs and including Chlamydia and Hepatitis C, to look at models that integrate other issues associated with clinics.
  - Chair Guajardo mentioned the funding challenges associated with STD/HIV testing. While Dr. Ringsdorf concurred that some funding exists at the local level but there isn't significant funding statewide.
  - Dr. Prot agreed to add language to reflect teen populations and priorities regarding funding and tracking data specific to border health.

- Chair Guajardo welcomed Representative Bobby Guerra at 2:13pm.

  Food and waterborne Diseases

- Mr. Rodriguez mentioned how flooding incidents are critically related to infections (personal experiences from recent flooding event in Rio Grande Valley).
- Task Force members also suggested that water contamination be addressed in its relation to septic tanks and well water and the collaboration with other agencies such as TCEQ.
- Dr. Ringsdorf mentioned related certification requirements and training for sanitarians.

- **Environmental Health Work Group** (formerly known as "Arbovirus Work Group" – Dr. Gonzalez read problem statements and asked for comments.
  - Task Force members asked that the Arbovirus Work Group include zoonosis or other communicable diseases while Dr. Ringsdorf suggested that it incorporate environmental health issues. Chair Guajardo suggested that the group change its name to "environmental health." Mr. Ramirez admitted that subject matter had already done so. Task Force members agree with the name change.
  - Task Force members raised the issue of the prospective state-wide initiative to dispose tires responsibly and how it was left out during the last legislative session.
  - Mr. Rodriguez recommended better coordination/span of control among state and local agencies.
  - Dr. Prot mentioned issues regarding local transmission of Zika and specific regional recommendations for best arbovirual control, especially for climate events to include preparedness components while Mr. Rodriguez mentioned the concept of strike teams as an idea.
  - Representative Guerra asked about the response to recent rain event in South Texas leading to mosquito problems as a crisis and how he doesn't want such events to be reactive but proactive.
  - Dr. Prot mentioned explained issues of state assets and protocols while Chair Guajardo added how city/county relationships work and what their roles are and spraying protocols that are in place.
  - Mr. Rodriguez explained that his city was trying to address the issue beforehand and was trying to be proactive to bring awareness at the state level.
  - Mr. Rodriguez stated that such efforts aren't refunded due to proactivity.
  - Chair Guajardo explained that municipalities communicated with county government to request state assets to ensure adequate testing supplies mechanisms are in place regarding an increase in mosquito population.
  - Mr. Resendes suggested that the problem statement include emerging diseases such as Dengue, etc. and mentioned public and social media awareness.

- **Infrastructure Work Group** – Chair Guajardo read problem statement and asked for comments.
  - Task Force members discussed issues regarding lab capacity. Chair Guajardo stressed the importance of increasing geographical lab capacity (including weekends) on the border due to high risk areas and constant migration.

- A conversation of a virtual border region "Region 12" included opposing comments. Mr. Rodriguez stated the sensitivities involved with the issue and mentioned OBPH as a sort of pseudo region. Dr. Dutton mentioned OBPH was there to offer support. Dr. Gonzalez felt a need to designate the area for its uniqueness in relation to women's health issues, infrastructure, housing, educational and workforce challenges.

- Mr. Esparza, Senator Lucio's representative, expressed that this topic had been proposed in the past without success and described the geographical, regional and environmental challenges among the border from El Paso to the coast. He noted the example of the key difference of the Rio Grande Valley not having a health district while El Paso did and, as a staffer supported Senator Lucio's directive, of not watering down region-centric issues regarding the border's uniqueness from region-to-region. Representative Guerra agreed.
- Chair Guajardo stated that such a concept may be able to acquire more funding and carries a lot of weight for the state to recognize that they need to handle Border Health a little bit differently, daily addressing border crossings and constant transmigration issue, for example. Mr. Rodriguez expressed that there were different mechanisms to make such an impact.
- Mr. Esparza had concerns of painting the border with a broad stroke, resulting in not having the best impact. No other region that has an advisory group about unique challenges that we face as a border region. He urged Task Force members to take account uniqueness of the border while embracing the differences to address border public health funding on the border.
- Dr. Gonzalez suggested putting this issue on the parking lot, recognizing that all agreed that border data is unique. Mr. Ramirez requested members to examine historical data to look at pros and cons.
- Chair Guajardo supported the issue and moved to evaluate impact for all border regions and continued with problem statements.
- Mr. Rodriguez asked if the Center of Excellence concept is something the Commissioner can endorse. Mr. Esparza thought that it could be considered as part of the short term recommendations.
- Dr. Gonzalez mentioned issues of support and resources for basic surveillance and the need in order to improve healthcare access, including support for hospital districts to address indigent care, etc.

Agenda Item VII: Public Comment (break taken afterword)

Chair Guajardo and Ms. Kupper asked for Public Comment.

- Ms. Elizabeth Lippincot represents the Texas Border Coalition. She thanked Task Force members and introduced her agency as a resource to the Task Force. The Texas Border Coalition is comprised of border mayors, county officials from border regions, and other stakeholders. She mentioned healthcare priorities and collaboration with Dr. Gonzalez. They are currently in process of developing border public health priorities for 2019:

- Tire dumping
- Monitoring arbovirus
- Child health
- Telemedicine to reach underserved communities

The coalition, based in Austin, works with behavioral health professionals and looks forward to working with all Task Force members.

- Mr. Camron Scott represents the American Cancer Society. He mentioned cervical cancer as a Task Force-related need. His agency supports vaccines for cervical cancer - HPV vaccines as potential to eradicate cervical cancer and pre-cancer infections. Their interest was to reduce healthcare dollars and increase vaccinations to prevent cancer for boy and girls. He expressed that Texas ranks 47 out of 50 states (rates are low -33% for HPV vaccines). Their goal is be be at 80% by 2026. American Cancer Society is ready to serve as resource.

    - Mr. Resendes thanked him for his presentation and asked if they were currently supporting legislation to increase vaccine rates. Mr. Camron stated that they are working on grass roots campaign to increase education with advocacy groups. He stated that evidence does not support vaccine mandates as the most impactful way to increase HPV vaccines. They are promoting it via education with a hope to support legislation to advance HPV in the future.

Agenda Item VIII: Review of past Border Health Recommendations

Dr. Dutton prefaced Dr. Banicki's presentation by letting members know of past border health recommendations and how the data might assist with short and long-term border health recommendations. Chair Guajardo thanked Dr. Banicki for the summary and consolidation of so much information. She noted the need to pin-point exactly what the Task Force would recommend. Dr. Prot also referenced the need to review national reports for to specify border needs.

Agenda Item IX: Convene workgroups to initiate recommendations

Ms. Kupper described the process for recommendation development. Work groups intended to gather work on strengthening problem statements for each work group, leading to recommendations. However, Chair Guajardo and Dr. Gonzalez agreed to continue specific work on the Chronic Disease and Maternal and Child Health work groups to provide a leveled workload among all work groups.

Chronic Disease Work Group – Dr. Prot reported on the proposed problem statement. Members expressed the need to support DSHS interagency advisory councils in relation to policies on school-aged children (link between obesity and diabetes).

- Dr. Gonzalez raised issues of safety barriers (safe areas for children to exercise). He also focused on the fact that healthier foods tend to be more expensive to purchase- cheaper to purchase processed foods.
- It is crucial to promote 30 minutes of physical activities per day and that a larger disparity exists with gestational diabetes, leading to amputations, etc. Collaboration between TEA, TDA, DSHS should expand on "walk to school" programs, etc.
- Explore potential to alter SNAP policies for buying healthier food (i.e. if one buys fruits/veggies, received $10 more, as an example – SNAP currently does not provide such guidance). Utilizing the Community Health Worker model was also discussed.

Maternal and Child Health - Dr. Ringsdorf reported on eligibility requirements and challenges in border regions in relation to different disparities. She mentioned the possibility of asking legislators for a safety net legislation to reduce barriers that get in the way of reimbursement and working with medical providers to improve the system. The issue of independent school districts making decisions on how they educate (advocate for sexual education and increase of evidence-based education, etc.) was raised and discussed.

- Explore ways to build consensus and promotion of improved/more effective sex education and the potential to increase ability to provide LARCs and family planning, as the current system is not enough to provide needed care for communities.
- Maternal women's healthcare – mothers' healthcare ends after giving birth.
- After childbirth, infant care begins but there is not a lot of focus on continued care for mothers.
- Explore ways for pediatricians to screen for post-partum depression; not enough care for border populations.
- There is potential for medical school residency programs to work with communities as part of their education.
- Expand mobile clinics that already exist.
- Provide broader menu of services.

- Chair Guajardo mentioned how difficult it was to introduce recommendations when so many political sensitivities exist regarding family planning.
- Dr. Gonzalez expressed that most maternal and child health issues are centered again on the huge issue of access to care.

Agenda Item X: Public Comment

There was no more public comment.

Agenda Item XI: Adjourn/Thank you

Chair Guajardo adjourned the meeting at 5:45pm and announced that members would reconvene tomorrow at 8:30 am.

Task Force of Border Health Officials Meeting
1100 W. 49th Street, Austin, TX (M-100)
Thursday, June 28, 2018

Member Name	Yes	No	Professional Representatives (non-members)
Esmeralda Guajardo, MAHS	✓		
Hector Gonzalez, MD, MPH	✓		
Steven M. Kotsatos, RS	✓		
Josh Ramirez, MPA, CPM	✓		
Eduardo Olivarez		✓	
Arturo Rodriguez, MPH, CPM	✓		
Robert Resendes, MBA, MT (ASCP)	✓		
Emilie Prot, DO, MPH	✓		
Lillian Ringsdorf, MD, MPH	✓		
State Representative Bobby Guerra		✓	
Senator Eddie Lucio	✓		Via conference call and represented by Daniel Esparza and Elsa Garza

Attendees Present
David Gruber, Ronald J. Dutton, Francesca Kupper, Allison Banicki, John Villarreal, Alberto Perez, Adriana Corona-Luevanos, Edith DeLaFuente, Gilberto Cedillo, Brianna Mendoza, Henry Presas, Bernadette Ebanks, Allie Lefkowitz, Sebastien Laroche, Tommy Driem, Stephen Williams.

Agenda Item I: Call to Order, Welcome and Chair Remarks
Chair Guajardo called the meeting to order at 8:38 a.m. and thanked and welcomed everyone to the Task Force of Border Health Officials (Task Force) Meeting.

Agenda Item II: Roll Call
Ms. Kupper completed roll call to confirm a quorum. A quorum was established.

Agenda Item III: Workgroups to report out on draft border health recommendations

Work groups convened to review strengthened problem statements and to continue working on draft recommendations.

Agenda Item IV: Reconvene workgroups to discuss draft border health recommendations

Work groups continued to work on draft recommendations.

Agenda Item V: Break (followed by Public Comment)

Members took a lunch break. Public Comments were received from Stephen Williams and Bernadette Ebanks.

Mr. Stephen Williams is the Chair of the Public Health Funding and Policy Committee. He presented an overview of his committee, some historical context, examples of recommendations they had made and a willingness to work together with other groups such as the Task Force. He answered questions from Task Force members and Chair Guajardo thanked him for attending the meeting.

Ms. Bernadette Ebanks is the Director of Program Quality and Performance for the Women's Health and Family Planning Association of Texas. She informed members that their association is the sole Title X grantee for the state of Texas and represent a network of 100 clinics statewide, which served a total of 193k clients last year. She referenced the "access to care" issue and mentioned her commitment to create strategies that meet people where they are, providing care outside clinic walls, telehealth, utilizing community health workers, coordinating mainstream provider training based on best practices. She expressed interest in removing barriers to receiving care and mentioned the importance of culturally appropriate care and the need to lead to a cost-savings for healthier communities. Chair Guajardo thanked her for her time and dedication.

Agenda Item VI: Report final draft of border health recommendations

Border Public Health Infrastructure Workgroup

Workgroup members:
Esmeralda Guajardo, Health Administrator, Cameron County Public Health
Senator Eddie Lucio, Jr.
Josh Ramirez, Director of Public Health, City of Harlingen
Robert Resendez, Director of Public Health, City of El Paso
Arturo Rodriguez, Director of Public Health and Wellness, City of Brownsville, TX

Background

Being situated along the Texas-Mexico border, addressing health issues bring its own unique challenges. Access to care and health professional shortages, coupled with high rates of poverty have major impacts on public health. Transmigration presents further challenges with surveillance and coordination of response efforts during public health emergencies. In addition, the lack of health districts, university hospitals and large corporate areas serving the majority of the Texas-Mexico border create a financial hardship in establishing the means for adequate health care in these areas. New opportunities specifically targeting border population challenges due to lack of access to healthcare, high poverty and unemployment which form barriers to achieve optimal health and wellness levels as in non-border communities must be created.

Problem Statement: Public Health Laboratory Capabilities

Human Testing

Given border health departments operate in high-risk areas, the goal is to support providers to test, diagnose and treat in a short time frame. When health providers fail to do this, the risk of a patient not returning for results and treatment increases and poses substantial risks of exposures to the general public. Border health departments seeking testing for high-risk conditions are no exception to this. As local health departments along the border, the risk for exposure increases even more so due to the lack of access to health care combined with the general public recognizing that these health departments are a resource for testing for high risk diseases. The problem is further compounded by the lack of existing public health laboratory capabilities along the border.

With the exception of El Paso, the existing public lab capabilities along the border areas are not equipped to test for immediate reportable conditions and requires that the specimens are packaged and transportation is sought for overnight delivery to a state lab approximately 6 hours away, potentially compromising the specimen. In addition, the issue exists that the local public laboratory is not able to complete all of the testing levels for one single specimen, thus, requiring the specimen to still be sent to Austin to complete all of the testing. As the local state laboratories have limited staff, they have a set maximum number of specimens they can accept per day. This poses a problem as local health departments are not the only agency utilizing the local state lab.

Vector Testing

The areas along the Texas-Mexico border are high-risk areas for vector-borne diseases and the lack of access to a state lab to test specimens in this respect also poses a problem as specimens currently need to collected and sent to Austin. The possibility of collaborating with the local educational institutions would allow efficiency in laboratory results; however, mechanisms need to be in place to ensure confidentiality to avoid any public health drawback that may occur as a result of a research data perspective.

Recommendations

- Public health laboratory capabilities along the lower Texas-Mexico border for human specimens needs to be expanded to allow complete and timely result interpretation and allowance of adequate number of specimens to be submitted.
- Establish agreement between Department of State Health Services and local educational institutions for testing capabilities that ensure cost-effective and confidential means to submit specimens for testing.
- Recognizing that "mosquito season" does not exist among most areas along the Texas-Mexico border area to allow for year-round mosquito testing to the state lab.

Problem Statement: Border Health Designation

Texas currently has eleven (11) public health region designations within the Department of State Health Services infrastructure. Of these regions, regions 8, 10 and 11 include counties which are situated along the Texas-Mexico border; however, Region 8 also includes San Antonio and Region 11 includes Corpus Christi, two large populated areas (1.5 million and 325K, respectively) which are not situated along the Texas-Mexico border. The inclusion of these larger areas (in addition to the smaller counties which are not situated along the border) into the public health regions with border counties creates confusion when addressing health through the lens of "public health region" needs. This has an impact on border health as it also skews health care statistic and research data specific to the border. A mechanism must exist to designate border public health areas in Texas which allow for a consistent and standardized interpretation of public health data, statistics and research.

Due to the inconsistency in statistics and data specifically for the border areas, this adds to the misconception that border health is similar and not very different from other parts of the state. This poses a problem in addressing public health challenges as many do not realize that the majority of the border areas lack the resources available in other parts of the state such as hospital districts, medical educational institutions, corporate foundations and strong

economic tax base. Understanding this is critical when addressing public health response efforts as the perception is to handle a public health threat along the border as anywhere else, overlooking the dynamics of the lack of resources combined with the large numbers of people crossing to and from Texas and Mexico on a daily basis and as a "way of life". A mechanism needs to exist so that an effective and efficient public health response is implemented specifically for the true and identified border health areas.

While highlighting the border area with DSHS may address public health challenges in Texas, highlighting border areas also needs to be emphasized to ensure an all-encompassing strategy across several disciplines, including DSHS, TCEQ, TWDB, DADS and the like. There needs to be a means to adopt the zoning of the border health area on the federal level to best address issues affecting public health and enable health departments to leverage this in their approach to procuring various funding streams to address border health challenges.

Recommendations

- Creation of Texas Department of State Health Services Public Health Region 12 to encompass the counties along the Texas/Mexico border. This would highlight the significance of managing public health policy, response and funding differently from other regions within the state.
- Federal government currently recognizes Treaty of La Paz as a zone designation for the definition of the border region when addressing environmental health. Adopting the same concept when overlapping work by Texas multi-agencies would compel all state agencies (i.e., DSHS, TCEQ, TWDB, DAD, etc) to recognize the border zone as priority status when funding allocations or geographical areas are being considered for public health matters.
- Commission a report by the Office of Border Public Health to address the development of initiatives within the proposed region to include the coordination of the following:
    a) Communication strategies,
    b) Centralized data exchange,
    c) Funding mechanism,
    d) Policy development,
    e) Public-private partnerships,
    f) Education initiatives for community and providers,
    g) Binational policies and
    h) Outreach strategies.

Problem Statement: Border Health Representation

As the areas along the Texas-Mexico border face challenging issues associated with poverty, access to care, low per capita income, trans-migratory populations and high unemployment, state health officials must take into account the impact the creation of state policies, funding allocations and program processes will have on the border areas. With the large number of crossings between Texas and Mexico, local health departments are on the frontline to safeguard not only Texas, but the rest of the nation from new and emerging public health threats.

- **H1N1** ***NEED HISTORICAL INSERTS FROM OTHER BORDER COUNTIES***
  - In May 2009, the first H1N1 death in Texas was a woman from Cameron County

- **ZIKA** ***NEED HISTORICAL INSERTS FROM OTHER BORDER COUNTIES***
  - In November 2016, the first locally acquired Zika case in Texas was confirmed in Cameron County.
  - Since then, all of the locally acquired Zika cases in Texas have been from Cameron and Hidalgo counties.

- **DENGUE** ***NEED HISTORICAL INSERTS FROM OTHER BORDER COUNTIES***
  - HISTORY INSERT

To ensure that health protocols are set in place which will help to effectively and efficiently address this threat, communication with federal agencies and Mexican health officials must also be in place.

Recommendations

- To ensure that border health is provided representation and input on state policy decision making processes, a mandate to include a border health official on state committees would help to address this issue. This includes committees set forth by legislative mandates and state-led committees affecting public health. The exception to this would be for issues specifying geographical areas not within the vicinity of the border areas.
- The existing Public Health Funding and Policy Committee does not have any representation from a health department along the border. As this committee addresses critical public health issues which impact public health, it is recommended that a legislative mandate be authorized to include a border health official to serve on this committee.

- The establishment of meetings between border health official(s) and Homeland Security agencies to ensure health protocols/guidelines and communication are in place to address the potential threat of a new and emerging public health threat.
- Communication and collaboration with Mexican health officials as established through the Office of Border Health must continue.

Communicable Disease Workgroup

Workgroup members:
Steven Kotsatos RS, Director of Health and Code Enforcement, City of McAllen
Lilian Ringsdorf MD MPH, Regional Medical Director, Public Health Region 8, DSHS
Eddie Olivarez, Chief Administrative Officer, Hidalgo County, Edinburg, TX
Emilie Prot DO MPH, Regional Medical Director, Public Health Region 11, DSHS

Communicable Disease Priorities:

Problem Statement: Tuberculosis (TB)

TB continues to be a concern for border areas in both Mexico and the United States. In 2016, the Center for Diseases and Control (CDC) estimated over 300 million legal crossings from Mexico into the U.S which plays an important role in communicable diseases such as tuberculosis (1). People immigrating to Texas are concentrated in border and urban areas, and complicated multidrug-resistant TB cases are more commonly seen in this foreign-born population. In 2016, the CDC compared the top five countries of origin for foreign-born persons in the U.S reported with TB disease. According to the study, Mexico ranked number one with a total of 1,194 cases, 18.9% of all foreign-born cases (2). To illustrate that number in Texas, a total of four out of the top ten counties reporting the most cases of TB are along the border.

The overall TB incidence in the Texas border region is 10.5 cases per 100,0000 in population, double the Texas average of 5.5 cases per 100,000 in population. Moreover, in Mexico, the BCG vaccine is recommended at birth. With a higher incidence of TB in addition to a more prevalent population with BCG, an interferon- γ release assay (IGRA) is recommended according to the updated 2017 Guidelines on Diagnosis of Tuberculosis in Adults and Children by the CDC and the American Thoracic Society (4). Screening and prevention of disease is very costly for border counties compared to a Tuberculin Skin Test (TST) (5).

There is an extreme health professional shortages accounting for 1.53 times less primary care physicians per capita compared to non-border counties and lack of access to adequate health services. In addition to the professional shortage, hospitals and clinics are not equipped with negative pressure rooms and ultraviolet lights. Substandard medical infrastructure presents a particular management challenge placing the care of TB in border counties heavily reliant on health departments to protect the community.

In general, important challenges in border areas for successful control of TB include: 1) high incidence of TB infection and disease heightened by frequent border crossing delaying detecting and reporting cases of TB; 2) lack of healthcare infrastructure and maintaining clinical and public health expertise 3) high cost of screening tests in a population in which guidelines recommend IGRA testing.

Recommendations

- Commission a report on tuberculosis data on border counties to educate our border providers. This report would include the number of TB/HIV co-infections, TB meningitis, TB in populations less than 5 years of age and drug resistant tuberculosis.
- Include border counties as a factor/indicator in the funding formula to increase funding along the border counties.
- Regulate medical hospitals to maintain negative pressure rooms and UV lights to accommodate TB patients and maintain good standard of care.
- Establish education training centers targeting regional and local public health authorities, academia and private health-care providers and provide bilingual educational materials and training sessions to improve the recognition and the evaluation of TB.
- Ensure that health-care providers along the Texas-Mexico border have current guidelines for the care, treatment, and referral of active TB case-patients and for seeking expert consultation for drug-resistant cases.
- Support policies at schools and universities requiring TB screening in the public school.
- In collaboration with public health preparedness programs establish TB Deployment Teams so that resources can be directed and target at-risk communities in underserved areas with enhanced testing, treatment and control.

Problem Statement: Immunizations (vaccine preventable disease)

The border area is composed of 27 rural counties and only 4 urban counties. In Texas, the total number of Texas Vaccine for Children (TVFC) providers is 3100. The border counties have a lower number of providers with a total of 351 TVFC providers compared to 545 providers in non-border states. A total of 66 Adult Safety Net (ASN) providers serve border counties compared to 470 providers in non-border counties and a total of 536 statewide. Therefore, border adults significantly lag behind their non-border counterparts in vaccine coverage for diseases; for example, low immunization rates in adults for influenza are due to 44.3% lacking health insurance compared to only 24.8% in non-border counties.

Providing immunization services in rural areas also presents additional costs compared to metropolitan or urban areas. With the physician shortage in rural areas, the population relies on safety net programs for their care. Additionally, transfer of vaccine near expiratory time is more challenging due to 1) the lack of close providers in surrounding areas to redirect doses 2) in cases of severe weather, many small rural clinics do not have backup power capabilities and causing an increased risk for vaccine loss 3) staff mileage to cover rural communities.

Immunization remains a critical public health issue and there is a need for continuous health promotion and education for selected vulnerable border populations.

Recommendations

- Develop public-private partnerships and seek funding for private immunization stocks for rural and hard to reach border residents. DSHS should maintain a state stock of vaccine to broader immunization coverage at the regional and local level.
- Commission a report on morbidity and mortality of vaccine preventable disease specific to border counties.
- Partnerships with medical professionals and university administrators should be implemented to initiate or enhance mobile clinics in rural areas, incentive to pharmacies.
- Develop vaccine campaign to increase adult vaccination rates and maintain child vaccination rates along the border. These should include bilingual (English/Spanish) social media, health education, and promotion programs
- Reduce TVFC requirements for providers in border counties

The Communicable Disease Work Group continues to conduct research and gather data on the following associated with immunizations:

Cost of vaccines

HPV rates

Reimbursement consistency issues among doctors in border regions

Problem Statement: STD/HIV

Although, historically HIV and AIDS prevalence in the Texas border counties has been lower than in other parts, more recently, it has been increasing. A total of 37% on average (2006-2015) of total HIV cases diagnosed in the border area have been, diagnosed late, pointing to a clear border health disparity. Many plasma centers conduct screening for HIV; health departments conduct contact investigations of positive cases, however due to the transient population, many reside in Mexico and are lost to follow up. As HIV treatment is improving the lifespan of patients, binational coordination is needed to improve the health of HIV/AIDS along the border. The dramatically high number of late diagnoses of HIV along the border reflects the difficulty patients experience accessing specialty providers whom often must travel great distances to urban areas for services and the stigma associated with the disease in a majority Hispanic community. Young adults and adolescents living with STD/STIs and HIV are particularly at risk.

The Communicable Disease Work Group continues to conduct research and gather data on the following associated with STD/HIV issues:

HPV rates

Inclusion of both men and women regarding sexual health

Recommendations

- Conduct research and needs assessment to identify high risk groups (age, gender, occupations etc.) for HIV/STD on the border.
- Develop awareness, prevention and outreach campaigns to reach these specific populations at particular risk for sexually transmitted infections.

- Build capacity among health care practitioners in border counties, inform/educate them about specific populations at risk.
- Develop binational policies and facilitate binational platform to address the epidemiology of HIV/STDs, facilitate care for the border mobile population.
- Develop bilingual outreach and communication strategies to address concerns over confidentiality and stigma that keep people from getting tested for HIV or seeking care if infected.

[P(1]For adults or just children

References:

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Environmental Health Workgroup

Workgroup members:
Hector Gonzalez MD, Director or Health for the City of Laredo
Josh Ramirez, Environmental Health Director, Harlingen, TX
Arturo Rodriguez, Director of Public Health and Wellness, City of Brownsville, TX

Background:

Many arbovirus-related diseases can be problematic for some border regions since mosquito season is continuous in some parts of the border. Food and water-borne diseases are also a challenge in the border region. The recommendations are critical to the border region because it works to minimize current gaps and would be an initial step towards to solve the regions need for additional assistance to improve health conditions along the border by providing a public health system that will provide solutions to the benefit of all border residents along the US- Mexico border region.

Problem Statement:

Vector, zoonotic, food and water borne diseases and contaminants serve as unique health risks on the Texas/Mexico Border due to inadequate infrastructure for surveillance, testing, personnel, enforcement standards and international risks. In addition, vectors (mosquito, fleas and ticks) are endemic to the region, illegal food entry and illegal food vending and inadequate infrastructure for potable water systems adds to the threat.

Underdeveloped and undeveloped communities with unincorporated areas (Colonias) along with urban communities also add to the potential risks. Lack of adequate solid waste management (illegal dumping of trash, debris and tires), integrated pest management contributes to vector breeding. Inadequate food and waterborne disease surveillance, inspection and investigation, laboratory testing locally further promote disease threats.

New and emerging diseases, such as Zika, pose new threats, such as birth defects which is another health burden in our already overburdened communities.

Recommendations: <u>Vector borne & Zoonotic Diseases:</u>

- Standardize vector control standards.
  - Enhance enforcement.

- Increase mosquito trapping, identification, sensitivity testing, and mosquito speciation testing on the border.
- Implement use of Larvacide via both chemical and natural methods.
- Continue education on preventive methods, such as sanitation, removal of standing water, use of repellant and reporting rashes and fever to health authorities.
- Continue education on vector issues to local jurisdiction professionals and community members.
- Improve sanitation in undeveloped and underdeveloped areas.
  - Improve solid waste management including for tires and other debris.
  - Enhance enforcement including
  - collection and tire fees to keep tires.
  - Staff training is necessary for human and vector surveillance and vector trapping.
- Increase resources for staff to conduct vector control efforts and for human surveillance on a continuous basis.
  - Binational coordination and cooperation is needed
- Resources for staff to apply insecticide as well as equipment (sprayer) and vehicles are necessary (supplies, larvacides, insecticide).
- Create dedicated certifications for Vector Control Officers or Vector Control Applicators to address specialization in spraying (should be more user friendly and simpler for public health).
  - Need better coordination between state agencies working with locals to improve response (Texas Department of Agriculture, Texas Commission for Environmental Quality, Texas Department of State Health Services and local public health)
  - State officials also need to enhance coordination with federal agencies (Health and Human Services, Centers for Disease Control and Prevention, Environmental Protection Agency)
- Increase number of vector control staff.
- Simply vector control trainings.
- Develop a Center of Excellence for Vector borne Diseases in partnership with local universities and DSHS.
  Develop a regional response and support system for ongoing vector and zoonotic control activities and develop response during disaster/flooding.

- Improve education and training to entities on Vector, zoonotic, food and water borne disease (Texas Medical Association, Texas Nursing Association, Vector Control Districts)

Recommendations: Food and Water-borne Disease and Air Quality:

- Enhance surveillance, testing, and enforcement (illegal entry).

- Enhance infrastructure such as having quality access to potable water from the municipal water system, to hinder use of septic tanks.
- Support legislation to implement minimum housing standard requirements to improve sanitary conditions and prevent the spread of infectious diseases.
- Have better coordination between TCEQ and DSHS. Collaborate with TCEQ and TWDB on environmental health issues and on ways to prevent the spread of infectious diseases (e.g. joint communication on increasing enforcement).
- Train medical and midlevel providers to identify food and water borne diseases.
- Develop capacity of the sanitarian workforce.
- Prevent on-site sewage facility and private well contamination.
- Enhance food and water safety procedures during a natural disaster and post-disaster, particularly floods; ensuring people's safety during these emergency situations calls for less stringent procedures (inspections).
- Seek federal support and expand the Border Infectious Disease Surveillance (BIDS) program that is binational as well.
- Implement enhanced air quality surveillance and monitoring
  - Train and provide support for local indoor quality inspections and enforcement
  - Educate the public on air safety and contamination prevention
- Promote better urban planning to reduce industry air contamination

Chronic Disease Workgroup

Workgroup members:
Josh Ramirez, Environmental Health Director, Harlingen, TX
Eddie Olivarez, Chief Administrative Officer, Hidalgo County, Edinburg, TX
Emilie Prot DO MPH, Regional Medical Director, Public Health Region 11, DSHS
Hector Gonzalez MD, Director or Health for the City of Laredo

The Chronic Disease Work Group continues to address top chronic diseases affecting the Texas border, such as hypertension and cancer. For now, the problem statements and recommendations are focused on diabetes and obesity, as such public health issues can be synonymous.

Chronic Disease Priorities:

1. Cardiovascular Disease
    a. Diabetes
    b. Hypertension (pending)
2. Obesity
3. Cancer (pending)

Problem Statement: Diabetes

Diabetes is among the top ten leading causes of death in Texas and worldwide. In 2010, about 4,738 individuals died due to diabetes as the primary cause of death. The age-adjusted annual mortality rate (AAMR) was 21.7 deaths per 100,000 persons (1). The prevalence of diabetes along the border counties continues to increase in comparison to non-border counties at an alarming rate. In 2015, the diabetes burden in border counties was at 13.9% prevalence compared to 11.2% in non-border counties. Diabetes mortality (*deaths per 100,000 population*) from 2012-2014 in Border counties averaged 30 deaths per 100,000 compared to non-border counties at 21 deaths per 100,000. Data shows that mortality rates in border counties continues to increase as non-border counties rates seem to decrease or maintain a stable trend.

Many of the factors that influence the increase of diabetes are physical inactivity, high calorie diet, poverty, genetics, non-modifiable determinants, and lack of access to care to

diagnose, prevent and address the disease. Pre-diabetes in Texas can be preventable when addressed on time but, due to the lack of early detection pre-diabetes rapidly leads to diabetes. Public Health Regions (PHR) 8 and 11, which are along the border, have the highest prevalence in pre-diabetes in all of the State of Texas. Pre-diabetes prevalence in PHR 11 is at 12.4% and PHR 8 at 8.9% compared to the Texas average of 7.5% in 2015.

In general, important challenges to successful control of diabetes: 1) Delay in detection of pre-diabetes and/or diabetes 2) lack of access to low cost care 3) lack of community education on the disease 4) Not addressing childhood diabetes at a pre-diabetes state.

Problem Statement: Obesity

Texas has the eighth highest adult obesity rate of 33.7% in the nation, according to *The State of Obesity: Better Policies for a Healthier America* released August 2017 (1). In 2015, the obesity burden in border counties was at 35.1% prevalence compared to 31.9% in non-border counties. The border county prevalence rate of 35.1% can be compared to the top 5 states in the nation. Obesity leads to many other risk factors like: increased diagnosis of Type 2 diabetes, hypertension in heart disease, stroke, diabetes, asthma, and some forms of cancer. *Traditionally, nutrition and physical activity strategies have been behavior-based, and have targeted individuals, though the rise in overweight and obesity levels has occurred too quickly to blame individuals. Rather, the environment has become conducive to weight gain (busy schedules, larger portions, reliance on cars, unsafe neighborhoods) [2: DSHS – Community Health Workers/promotores (CHWs) data, cost effectiveness.]

Recommendations (both diabetes and obesity):

- Develop a report on the use of SNAP and WIC in border counties to better understand the trends in border population and identify areas to improve the health of border communities.
- Identify and assess border health chronic disease (as outlined in priorities) specific data to determine county level burden using demographics. Disseminate on an annual basis.
- Collaborate & support with border specific data local initiatives in urban planning/development efforts at the local level to increase green spaces, limit food deserts, increase local community exercise events and increase public transportation while incorporating safety.

- Support local and state policies to work with Independent School Districts to increase recess time in elementary schools.
- Develop local/state-based culturally appropriate diabetes prevention and control programs to ensure access to low-cost diabetes care and detection by improving outreach and expanding services in public health settings.
- Develop a campaign to increase CHWs in hospitals, outpatient clinics and public health sectors.

References:

(1) The State of Obesity: A project of the Trust for America's Health and the Robert Wood Johnson Foundation. https://stateofobesity.org/states/tx/

(2) http://www.dshs.texas.gov/region8/nutrition.shtm

The Chronic Disease Work Group continues to conduct research and gather data on the following:

Diabetes prevalence averages (border vs. non-border):

Border regions – 12.32% vs. non-border regions – 11.5% (2015)

Diabetes prevalence averages (Texas vs. USA):

Texas – 10.82% vs. USA – 9.76% (2011-2015)

Note:

There are policies in place to decrease the burden of obesity. However, even with such policies in place, there is a large prevalence in obesity. There may be a need for policies to be enforced, monitored more closely or strengthened.

Breastfeeding: Texas has regulations requiring licensed ECE programs to allow or encourage onsite breastfeeding

Drinking Water: Texas has regulations requiring licensed ECE programs to make drinking water available to children.

Healthy Eating: Texas has regulations requiring licensed ECE programs to have healthy eating policies.

Screen Time: Texas sets limits for screen time in ECE settings, or has regulations requiring ECE centers to set limits.

Related draft recommendations:

· Develop and maintain a coordinated nutrition, physical activity and obesity prevention program infrastructure working with state, local, regional, private and public partners including community residents

· Conduct obesity prevention activities that address and support change at the state, community, organizational and group level, and provide expert nutrition and obesity-related training and consultation to public health/other professionals from agencies and organizations, including community-based, local government, schools/daycare, worksites, etc.

· Identify and assess data sources to define and monitor the burden of obesity and impact of the program and monitor the nutritional health status of the population to identify priority nutrition and other obesity-related problems particular to Texas

· Support state program partnership efforts by serving on internal workgroups, supporting program projects, or assisting with the completion of action items Develop community-clinical referral mechanisms for improved obesity and related chronic disease systems of care

· Facilitate evidence-based education and training for providers, patients, and communities to ensure consistent messaging of reliable health information and collaboration

· Reduce barriers to accessing healthcare for prevention of disease, increased early detection, and reduction of complications through low-cost services

· Coordinate comprehensive data collection, analysis and management to evaluate activities and determine overall impact on health outcomes at the population level;

· Engage community and clinical partners to strengthen partnerships and increase sustainability

· Enhanced linkages between clinic systems and community-based resources, including enhanced training opportunities for Community Health Workers (CHW) on chronic disease prevention, and improving coordination for chronic disease self-management programs

· Encourage healthy lifestyles for individuals, families, and communities through health promotion, outreach, and marketing.

· Increase local outdoor activities through local city/county health departments, parks and recreation departments and school districts.

Diabetic amputations in the Hispanic community.

· Establishing education trainings targeting public health setting, school districts, and involve communities in improving diabetes care.

Maternal and Child Health Work Group

Workgroup members:
Lilian Ringsdorf MD MPH, Regional Medical Director, Public Health Region 8, DSHS
Robert Resendes, Director of Public Health, El Paso, TX
Esmeralda Guajardo, Health Administrator, Cameron County Public Health
Steven Kotsatos RS, Director of Health and Code Enforcement, City of McAllen

Problem statement: Access to Care and Funding Flexibility
Important measures of maternal and child health show that the state of health of women and children is much poorer in the border region than the rest of Texas. The Texas border region has significantly higher teen pregnancy rates, a higher percentage of births with late prenatal care, and higher rates of neural tube defects, which is a specific type often preventable birth defect. These disparities highlight the need for women and their children to understand services available and to have access to health and medical care. To ensure the healthcare system works for women and children, it is essential that providers and administrators understand eligibility and billing practices and that their reporting is streamlined.

Recommendations:

- Simplify and consolidate women's health funding streams to ensure ongoing coverage from pre-conception health, pregnancy, well women care, preventative care and chronic disease management. Building this flexibility into funding streams will allow local public health to respond to the needs of their communities. The result will be healthier moms and babies, lower NICU admission rates, and lower rates of Medicaid births.
- Designate border public health clinics as safety net providers (or other designation) to facilitate working with and billing Medicaid and other third-part billers.
- Review and re-evaluate funding formulas to ensure they are meeting the needs of the border region and allowing for allowing for transparency. Cities and counties need flexibility to utilize available funding to respond to local needs.

Problem statement: Teen Pregnancy/Repeat Teen Pregnancy
Rates of teen pregnancy and repeat teen pregnancies are significantly higher along the Texas-Mexico border than the rest of the state. Texas ranks fifth in the country for highest teen pregnancy rates and first in the country for repeat teen pregnancy rates. Along the border the teenage pregnancy rate is 57.9* compared to 35* for Texas as a whole. Research has shown that teenage parents are less likely to complete high school and more likely to be unemployed and live in poverty. Decreasing the numbers of teenagers becoming pregnant along the border is critical to improving multiple disparities along the border.

Recommendations:

- Through legislative mandate recommend that parenting adolescents can consent to their own sexual and reproductive healthcare allowing them to obtain contraception without parental consent.
- Expand school-based sexual education using evidence-based curricula through endorsements from Texas Medical Association and other influential partners.
- Require a public health representative be included on all School Health Advisory Councils.
- Develop teen advisory boards on a local level to ensure programing, messaging and services are "teen friendly."
- Increase access to long-acting reversible contraceptives by certifying nurses and other mid-level professionals provide these services.

Problem statement: Continuity of Clinical and Mental Health Support for Women in the Post-partum and Intra-Conception Period

Along the Texas-Mexico border 44% of adults do not have health insurance which is considerably greater than the rest of the state. Women receive healthcare while pregnant but once she gives birth her baby receives health services but she no longer does. Consequently, maternal medical and mental health needs go unmet. One such unmet need is awareness of and treatment for postpartum depression which is a well-researched condition that is debilitating to families.

Since mothers interact frequently with their babies' pediatricians, this is point of contact that could be utilized to screen for medical and mental health problems and to provide linkages to care. To meet these needs new strategies must be explored.

Recommendations:

- Educate pediatricians and provide streamlined questionnaires to screen for post-partum depression in mothers at well-baby and other child healthcare visits.
- Train providers and billers how to code for this reimbursable service.
- Create "warm" hand-offs with mental health professionals and organizations to ensure ease and efficacy of referrals.
- Establish partnerships with medical schools, nursing schools, physicians' assistants training programs, and residency programs to require students and residents to rotate at public health clinics for education and community services.
- Expand the services that mobile clinics, such as those for STD/HIV services, to provide family planning and other services.
- Utilize Community Health Workers to reach women in the community to educate on reproductive health and women's health and link to care.

(*pregnant 15-19-year-old girls divided by total number of girls multiplied by 1,000)

Agenda Item VII: Report Process/Timelines/Next Steps/Items for Next Meeting and Announcements

Chair Guajardo requested that work group leaders make final changes and send them to her by COB, Tuesday, July 3, 2018.

Agenda Item VIII: Public Comment

There was no public comment.

Agenda Item IX: Adjourn/Thank you

Chair Guajardo adjourned the meeting at 3:00pm.