



Task Force of Border Health Officials Recommendations Report

**As Required by
Texas Health and Safety Code
Section 120.101(c)**

**Task Force of Border Health Officials
November 2022**

**Administrative Support provided by
Department of State Health Services**

Table of Contents

Executive Summary	1
Border Public Health Infrastructure.....	1
Environmental Health.....	1
Chronic Diseases	2
1. Introduction	3
2. Background	4
Previous Report.....	4
Task Force Organization	4
Border Geography and Demographics	4
3. Recommendations	6
Border Public Health Infrastructure.....	6
Environmental Health.....	8
Chronic Diseases	10
4. Conclusion	12
List of Acronyms	13
Appendix A. Members of Task Force of Border Health Officials	A-1
Appendix B. Success Stories from the Border	B-1
Border Public Health Infrastructure.....	B-1
Communicable Diseases	B-3
Environmental Health.....	B-11
Chronic Diseases	B-11

Executive Summary

The role of the Task Force of Border Health Officials (Task Force) is to address public health concerns affecting border residents from Brownsville to El Paso. [Senate Bill 1680, 85th Legislature, Regular Session](#), established the Task Force in 2017. The Task Force meets at least quarterly and is required by [Texas Health and Safety Code, Chapter 120](#), to produce a recommendations report to the Commissioner of the Texas Department of State Health Services (DSHS) by November 1 of each even-numbered year. The Task Force is administratively supported by the DSHS Regional and Local Health Operations Division, Office of Border Public Health.

The Task Force submits the following recommendations organized by public health priority topic:

Border Public Health Infrastructure

Short-term Recommendations

1. DSHS will contact the binational community public health coalitions that existed prior to the COVID-19 pandemic to assess their activity levels and need for support in resuming normal functions. DSHS will offer assistance with organizing and facilitating binational meetings and reestablishing connections with group members and DSHS. The assistance may be limited by the resources and staffing available within each Public Health Region.

Long-term Recommendations

1. DSHS implements free access for border public health entities and providers to Health Information Exchanges (HIEs) with the potential to serve as regionwide/statewide electronic medical record and communication systems.

Environmental Health

Long-term Recommendations

1. DSHS improves 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.

Chronic Diseases

Long-term Recommendations

DSHS establishes early intervention components of childhood obesity prevention and education.

1. Utilize the DSHS website to share and make data available to the public on obesity in Texas and along the border, highlighting data by age and county.
2. Use the DSHS Office of Border Public Health's Community Health Worker Training Center to provide support and to promote education on the topic of obesity along border communities and how to prevent morbidity and mortality related to obesity.
3. Promote communication on healthy habits, behaviors, and prevention messages in Spanish and English along border counties with targeted messages for the audiences intended (children, parents, health care team).

1. Introduction

[Texas Health and Safety Code, Chapter 120](#), requires the Task Force of Border Health Officials (Task Force) to submit a report of recommendations to the commissioner for short-term and long-term border plans by November 1 of each even-numbered year.

Since its formation, the Task Force has developed the following vision and mission:

Vision: A healthy and equitable border community.

Mission: To identify and raise awareness of health issues impacting border communities and establish policy priorities to enhance border public health, creating a healthy-binational community.

The Task Force has studied health issues impacting the border regions related to:

- access to health care services,
- improving public health infrastructure; and
- disease surveillance, control, and prevention.

To address these issues, the Task Force has formed subcommittees to create recommendations for five border public health priorities:

- Border Public Health Infrastructure
- Communicable Diseases
- Environmental Health
- Chronic Diseases
- Maternal and Child Health

The recommendations in this report are organized by these priority categories.

2. Background

Previous Report

The Task Force of Border Health Officials (Task Force) was unable to submit their last mandated report by the deadline of November 1, 2020 due to members' involvement in COVID-19 response activities. The report was instead submitted in December 2021 [Task Force of Border Health Officials Recommendations Report](#).

Task Force Organization

Texas Health and Safety Code, Chapter 120, mandates that seven members of the Task Force be health department directors from counties in the border region and border municipalities that have neighboring sister-cities in Mexico. To ensure border-wide representation, three Texas Department of State Health Services (DSHS) Public Health Regional Directors were named as voting members. Statutorily, two ex-officio, legislative members were appointed by the Lieutenant Governor and the Speaker of the House of Representatives. Altogether, the Task Force currently includes ten voting and two non-voting members as shown in Appendix A.

Mr. Eduardo Olivarez of Hidalgo County is the current Task Force Chair, and Dr. Arturo Rodriguez of the City of Brownsville is the current Vice-chair. Their terms began on January 1, 2022 and will end on August 31, 2023.

Border Geography and Demographics

According to the Texas Health and Safety Code, Section 120.001, the border region is defined as counties that are immediately adjacent to the international boundary between the U.S. and Mexico. Additionally, Article 4 of the La Paz Agreement of 1983 defines border counties as counties within 100 kilometers from the U.S. and Mexico border, which results in a total of 32 border counties, some of which don't directly abut to the boundary line. The constant flow of international commerce and border migration makes the Texas portion of the U.S. Mexico border one of the busiest international boundaries in the world.

The Texas border consists of almost 3 million residents.¹ Of those residents, 83.7 percent are Latino compared to 34.7 percent of Texas residents in non-border counties.² Additionally, 50.3 percent of adults aged 18-64 lack health insurance coverage compared to 26.7 percent in non-border counties.³ However, overall adult cancer prevalence and skin cancer prevalence are lower in border counties than in non-border counties.⁴ Border counties have led the state in vaccinations throughout the COVID-19 pandemic.⁵

Like most of Texas, the border continues to grow. The growth has the potential to exacerbate limited and unequal access to primary, preventive, and specialty care. However, the border region is also making notable advances and investing in commerce, technology, hospitals, and universities, which will benefit border residents in the future.

¹ The total population of the border counties was calculated from the 2018 Texas Population Projections for 2020, Texas Demographic Center, released July 18, 2019. These are the most recent projections as of May 13, 2022. Accessed at <https://demographics.texas.gov/Data/TPEPP/Projections/>

² The population with Hispanic ethnicity was calculated from the total population and population of Hispanic ethnicity fields in the 2018 Texas Population Projections for 2020, Texas Demographic Center, released July 18, 2019. These are the most recent projections as of May 13, 2022. Accessed at <https://demographics.texas.gov/Data/TPEPP/Projections/>

³ The uninsured among adults 18-64 years old in border counties was tabulated from Texas Behavioral Risk Factor Surveillance System (BRFSS) data for 2020. These are the most recent estimates as of May 13, 2022. Accessed at <https://healthdata.dshs.texas.gov/dashboard/surveys-and-profiles/brfss>

⁴ The age of adults 18 years and older who have been told by a doctor, nurse, or other health professional they had any type of cancers was tabulated from Texas Behavioral Risk Factor Surveillance System (BRFSS) data for 2020. A similar tabulation was done specifically for skin cancers. These are the most recent estimates as of May 13, 2022. Accessed at <https://healthdata.dshs.texas.gov/dashboard/surveys-and-profiles/brfss>

⁵ The age of Population Vaccinated for COVID-19. Viewed on May 13, 2022. Accessed at https://tabexternal.dshs.texas.gov/t/THD/views/COVID-19VaccineinTexasDashboard/Summary?percent3Aembed=y&percent3AisGuestRedirectFromVizportal=y&percent3Aorigin=card_share_link

3. Recommendations

Some of the following recommendations were submitted in the previous report and have been revised for further consideration. Others are new recommendations.

Border Public Health Infrastructure

Short-term Recommendations

- 1. The Texas Department of State Health Services (DSHS) will contact the border community public health coalitions that existed prior to the COVID-19 pandemic to assess their activity levels and need for support in resuming normal functions. DSHS will offer assistance with organizing and facilitating binational meetings and reestablishing connections with group members and DSHS. The assistance may be limited by the resources and staffing available within each Public Health Region.**

Discussion: There are many sister cities and binational communities along the Texas portion of the U.S. - Mexico border. Sharing similar health challenges, they may be considered one epidemiological zone. The first official U.S. - Mexico health associations were formed in the early 1940s. The first Binational Health Councils, known in Spanish as COBINAS (Consejos Binacionales de Salud) were formed in 1965.

These groups promote collaboration between health officials on both sides of the border. Over time, their purpose has evolved to address many different health issues. For example, many communities have developed plans for health emergencies and disasters. Some conduct joint mosquito-borne disease surveillance. There are always new opportunities to work together to solve public health problems.

Since the COVID-19 pandemic started in 2020, border community public health coalitions faced many challenges and barriers which disrupted their communication and joint activities. Now that communities are starting to shift their focus back to other public health concerns, these coalitions may need assistance with reconstitution and reconnecting their members.

Border Community Public Health Coalitions include:

- Paso del Norte Binational Health Council (El Paso/Juárez/Las Cruces, NM)
- Presidio-Ojinaga Binational Health Council
- Trinational Epidemiological Workgroup (Eagle Pass/Piedras Negras/Del Rio/Ciudad Acuña and the Binational Health Council/Kickapoo Traditional Tribe of Texas)
- Los Dos Laredos y Nuevo León Binational Health Council (Laredo/Nuevo Laredo/Nuevo León)
- SMAC Binational Health Council (Starr County/Miguel Aleman/Camargo)
- HIDAREY Binational Health Council (Hidalgo County/Reynosa)
- BROMA Brownsville-Matamoros Binational Health Council

Long-term Recommendations

- 1. DSHS implements free access for border public health entities and providers to Health Information Exchanges (HIEs) with the potential to serve as regionwide/statewide electronic medical record and communication systems.**

Discussion: During the COVID-19 pandemic response, border public health departments were faced with delays in receiving confirmatory COVID-19 reports from healthcare providers which limited response efforts. This was partially due to the overwhelming amount of work placed on the medical community at the time. However, it was in larger part due to the lack of a regionwide electronic medical record and communication system between healthcare providers and local health departments (LHDs). 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 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 system. As a result, border public health relied on antiquated methods to receive reports, primarily fax machines and often, reports were received four to six days after the case was identified.

HIE⁶ data collection allows for meaningful use and system innovation that fosters and creates informational hubs. Local public health authorities pursue prevention of disease and emerging disease outbreaks. Utilization of HIE would assist in allowing for rapid, up-to-date access to health information. As HIEs are designed to connect physicians, hospitals, and specialists in sharing critical patient health information in real-time, access to HIE by border LHDs could alleviate delays in case reporting.

Unfortunately, medical providers and public health departments alike must pay to have access to the HIE information. Because border public health departments do not have the financial means to access HIE, providing them with free access to HIE would allow for real-time case reporting and prompt case investigations to avoid further transmission during public health threats.

Accessing public health data is necessary for providing meaningful use of services and to improve population health measures. Early access to HIE, including clinical case data, is critical in identifying disease cases in local communities during a pandemic. Epidemiological surveillance is better at detecting infectious disease presence at a community-wide level when using HIE data.

A barrier facing many LHDs is the high cost required to be a member of an HIE. This financial barrier impacts the current public health system, and the need for it to be more effective, especially at the population health level. As state and private sectors work on implementing HIE, we must include local public health departments in the critical development of HIEs. While the full impact of HIEs is still unclear, LHDs lack the financial resources to participate in the current HIEs.

Therefore, our recommendation is for DSHS to amend policies or create reform giving LHDs the opportunity to be active in their local HIE by 1) providing funding or 2) creating policy that will allow LHDs to participate at little or no cost.

Environmental Health

Long-term Recommendations

- 1. DSHS improves recruitment and retention of Registered Sanitarians. Expand training and certifications to improve response and**

⁶[About the Texas Health Services Authority, learn more about us today! \(thsa.org\)](https://www.thsa.org), [Health Information Exchange \(texmed.org\)](https://www.texmed.org)

expansion opportunities with expert personnel to assist with the prevention of food, water, vector-borne and zoonotic diseases.

Discussion: To improve recruitment and retention of sanitarians in border communities, it is recommended to develop a tiered curriculum with certification tests that work in tandem with current entry-level pathways for Sanitarians. Develop and grow a workforce of trained Community Environmental Specialists (CES) that can segue into the Sanitarian profession or other certified environmental related positions. These CES positions could work within local health entities and be capable of performing a basic work scope of food safety and environmental health inspection services as well as training and outreach education.

A two-tiered process might look as follows:

- **Create First-level certification – Create a certified Community Environmental Health Specialist (CEHS).** Focus the scope of technical expertise on basic food safety, water and wastewater safety, vector borne and zoonotic diseases. Once certified, these CEHS could conduct food service education and training or work in a regulatory setting under the auspice of the local government entity and a Professional Sanitarian if needed. The exam will certify the individual has successfully obtained technical training and knowledge giving them the skills and abilities to conduct a limited scope of regulatory inspections to enforce local codes, ordinances/orders, and conduct limited health training and education. CEHS certification would also require at least a high school diploma and either two years of college and/or applicable work experience related to food safety, water/wastewater microbiology, vector-borne microbiology, and zoonotic diseases.
- **Maintain Second level certification to Registered Sanitarian.** Continue to build a border wide workforce of Community Environmental Health Specialists (CEHS) and link the certification program to four-year college degree programs. Individuals can work as an CEHS while obtaining additional education to sit for the Registered Sanitarian exam and license. Network and promote the CEHS in border counties, adjacent and regional counties, throughout community college and university programs.

Chronic Diseases

Long-term Recommendations

DSHS establishes early intervention components of children’s obesity prevention and education.

- 1. Utilize the DSHS website to share and make data available to the public on obesity in Texas and along the border highlighting data by age and county.**
- 2. Use the DSHS Office of Border Public Health’s Community Health Worker training center to provide support, promote education on the topic of obesity along border communities and how to prevent morbidity and mortality related to obesity.**
- 3. Promote communication on healthy habits, behaviors and prevention messages in Spanish and English along border counties with targeted messages for audience intended (children, parents, health care team).**

Discussion: From 2017-2018 data, the National Health and Nutrition Examination Survey reported 16.1 percent of children and adolescents are overweight, 19.3 percent are obese, and 6.1 percent suffer from severe obesity.⁷ According to the American Community Survey, 40.5 percent of the population aged 18 years and younger live below the poverty level in border counties compared to only 22.6 percent in non-border counties.⁸ A striking total of 50.3 percent of adults aged 18-64 have reported not having any health insurance compared to 26.7 percent for non-border counties.

In 2013, the University of Texas Health Science Center in Houston initiated the “MEND Community Based Obesity Prevention Program” to address the obesity epidemic on the border. The project utilized evidence-based MEND (Mind, Exercise, Nutrition...Do It!) developed in the United Kingdom in 2001 to support and coach underserved and minority families to achieve better nutrition and physical activity habits. The goal was to reach more than 1,000 children with a large majority of the

⁷ <https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity>

⁸ [American Community Survey Data \(census.gov\)](#) 2015 data

children who receive Medicaid/CHIP (75 percent) to participate in the MEND project for the prevention of chronic diseases.

Over the past two years, chronic conditions and comorbidities such as obesity have been a major risk factor for not only contracting COVID-19 but are also associated with disease severity and death.⁹ More than half of adults in the U.S. have one chronic condition and more than 20 percent have multiple chronic conditions. Disparities have been evident in race and income level, placing Hispanic populations and Black populations living in poverty more at risk of mortality and living with chronic conditions affecting their quality of life.

Most evidence points to the need for early childhood intervention to address obesity from nutritional, physical activity, and behavioral standpoints. Without a three-prong approach, previous interventions have had limitations. Therefore, it is essential to start early during childhood to educate and prevent disease. Primary prevention with a focus on obesity is needed in border counties that have a higher diabetes burden and obesity rates compared to the rest of Texas and the U.S.

⁹ https://www.cdc.gov/pcd/issues/2020/20_0130.htm

4. Conclusion

The Task Force of Border Health Officials (Task Force) worked hard throughout the COVID-19 pandemic in their respective jurisdictions. This leadership has been especially successful as evidenced by higher-than-average vaccination rates throughout the state. While still working to protect people from the current challenges of COVID-19, Task Force members are focused on pre-pandemic and ongoing public health issues along the U.S.-Mexico border.

The Task Force subcommittee work groups continue to study public health data that impact border public health. The Task Force values and respects the collaboration and coordination of its state and binational partners and invites their input and advice. Members will continue to invite subject matter experts to present and participate in public and subcommittee meetings to ensure that the most current and accurate information is used in the formation of all recommendations.

The Task Force is committed to developing short and long-term recommendations that will make a positive impact on border public health priorities. Members are dedicated to improving access to healthcare in border regions and advancing the well-being of border residents.

List of Acronyms

Acronym	Full Name
BROMA	Brownsville-Matamoros Binational Health Council
CES	Community Environmental Specialist
CEHS	Community Environmental Health Specialist
CHIP	Children's Health Insurance Program
COBINAS	Consejos Binacionales de Salud (Spanish for Binational Health Councils)
COVID-19	Coronavirus Disease of 2019
DSHS	Department of State Health Services
HIDAREY	Hidalgo County/Reynosa
HIE	Health Information Exchange
HHSC	Health and Human Services Commission
LHD	Local Health Department
OBPH	Office of Border Public Health
SARS	Severe Acute Respiratory Syndrome
SMAC	Starr County/Miguel Aleman/Camargo
TFBHO	Task Force of Border Health Officials

Appendix A. Members of Task Force of Border Health Officials

Members	Task Force Positions/Title
Eduardo Olivarez	Chair/Chief Administrative Officer, Hidalgo County Health and Human Services
Arturo Rodriguez, DNP, MPH, CPM	Vice-chair/Director, Public Health and Wellness, City of Brownsville
Richard Chamberlain, DrPH, MPH, RS	Member/Director, City of Laredo Health Department
Esmeralda Guajardo, MAHS	Member/Health Administrator, Cameron County Public Health
Steven Kotsatos, RS	Member/Director, Health and Code Enforcement, City of McAllen
Shannon Harvill	Interim Member/Interim Director, Health Department, City of Harlingen
Hector Ocaranza, MD, MPH	Interim Member/Interim Director, City of El Paso Department of Health
Emilie Prot, DO, MPH	Member/Medical Director, Public Health Region 11, Texas DSHS
Lillian Ringsdorf, MD, MPH	Member/Medical Director, Public Health Region 8, Texas DSHS
Rachel Sonne, MD, MPH	Member/Medical Director, Public Health Region 9/10, Texas DSHS
The Honorable Eddie Lucio, Jr.	Ex-Officio Member/Texas State Senator, District 27
The Honorable R.D. (Bobby) Guerra	Ex-Officio Member/Texas State Representative, District 41

Appendix B. Success Stories from the Border

The Task Force of Border Health Officials would like to highlight some of the important work being conducted in the border region and share best practices related to the public health priority areas.

Border Public Health Infrastructure

City of Laredo

New Electronic Medical Records System

In June 2021, the City of Laredo Health Department began the process for a new electronic medical records system. After evaluating submissions for this critical infrastructure project, Patagonia Health was selected for the City of Laredo Health Department Electronic Medical Records (EMR) System. The estimated five-year cost of implementation and subsequent maintenance is \$419,985.00.

Patagonia Health has a wide degree of experience interfacing with a variety of Public Health registries, diagnostic labs, Health Information Exchange (HIE) and other custom interfaces, including state HIEs, State Immunization Registries and medical devices. E-prescription capability is built into Patagonia Health and is connected to the Surescripts network (via New Crop). More than 95 percent of U.S. pharmacies are connected to the Surescripts network including local independent pharmacies, nationwide pharmacies, and mail order pharmacies which follow nationwide standard protocols. Information contained in the e-prescription system is automatically updated and maintained by Patagonia Health and requires no maintenance.

Their system offers an integrated patient portal and is included at no additional cost as is required to become an Office of the National Coordinator for Health Information Technology (ONC) Certified system. Patients can access the following: allergies, labs, meds, immunizations, diagnosis, clinical visit summaries, health summary in CCDA (Consolidated-Clinical Document Architecture) file for download, secure messages with the provider. Due to their interoperability, Patagonia Health was the best choice and is in line with the future goal of connecting with a region/state-wide communication system. It is expected to commence in July 2022.

The City of Laredo initiated a formal request for proposal (RFP) in November 2020 soliciting a comprehensive laboratory information system (LIS) for the City of

Laredo Health Department to enhance laboratory capacity and connectivity to improve processes for testing and diagnostic services, including COVID-19 testing capacity. This solicitation required information and cost for services, including installation, configuration, testing, training, and technical support during and after the initial development period. Key features included but were not limited to capability for submission of patient demographic and testing ordering, workflow and data tracking support, customizable data fields architecture, laboratory supply inventory management, and data exchange interfaces. The LIS features and uses should have functions starting from simple sample tracking to electronic communication and a reporting tool that manages multiple aspects of laboratory informatics. The City of Laredo chose LabWare, Inc., as the vendor. LabWare, Inc., also provides support to the Texas Department of State Health Services (DSHS), which will provide City of Laredo Health Department improved compatibility and connectivity to State systems.

Cost of implementation is \$500,141.00 for the first year of installation and a subsequent yearly maintenance amount of approximately \$104,236.00. Startup costs for this project were supported via DSHS funding and COVID-19 Relief funding. It was initiated on June 1, 2022.

Mobile Health Clinics

On November 4, 2021, the City of Laredo Health Department unveiled the Mobile Health Clinic. This vehicle was purchased to ensure health equity by providing access to vaccinations and health education to all populations of our community, including our most vulnerable.



Mobile Health will also be used for COVID-19 testing and as an anchor for other programs and partners to use to develop a Mobile Healthcare Village. Moreover, this vehicle will serve the community by providing health assessments, screenings, and referrals to other health and wellness programs.

The Mobile Health Clinic staff have partnered, planned, and implemented vaccination clinics with other agencies, such as: community-based organizations and businesses, local colleges and universities, religious institutions, community health centers, pharmacies, long-term care facilities, independent living facilities, assisted living centers, nursing homes, and first responder organizations. Non-traditional

providers, local high-risk areas and underserved populations were also served, and the unit was used for various City of Laredo events. Mobile Health is the gateway for preventative services, health education, primary care, and on-the-go clinical services. The motto of the Mobile Health Clinic is “If you can’t come to us for any of these services, thanks to Mobile Health, we can come to you!”

The Mobile Health Clinic is a 22-foot-long Ford F550 utilizing a 6.7L Diesel Engine. To serve all clients, this vehicle has double wheelchair doors as well as a Braun Century wheelchair lift device. It is equipped with grab bars and sanitizing stations as well as two separate air conditioning systems.

Enhanced Laboratory Capacity and Expanded Testing Platforms



In September 2021, City of Laredo Health Department moved forward with the purchase of the laboratory equipment Ion Genexus Integrated Sequencer from sole source Fisher Healthcare in the amount of \$176,917.00. This enhanced our laboratory capacity and expanded testing platforms to test for COVID-19 quickly, accurately, and safely.

This was the first fully integrated, next-generation sequencing (NGS) platform featuring an automated specimen-to-report workflow in our region. It can sequence the entire SARS-CoV-2 genome with a one-day turnaround. It can identify variants of concern, increasing our epidemiological surveillance. It is also able to detect and isolate individuals of public health concern with a faster turnaround time. Cost for this equipment was supported through the DSHS Laboratory Expansion funds. Laredo Health began testing in this capacity in February 2022.

Communicable Diseases

City of El Paso

COVID-19 Education and Cluster Management

The COVID-19 Pandemic response set the stage for activating the City of El Paso’s Department of Public Health (DPH) Education Task Force (ETF) to educate the

community on the COVID-19 virus and infection. The ETF promoted preventative measures and vaccinations, among other activities. The DPH proudly deployed the COVID-19 ETF prior to the detection of the first case in the community and targeted travel spots and grocery stores to capture high-risk individuals and as many community members as possible. The ETF was initially composed of DPH Educators but quickly expanded and welcomed staff from other DPH programs, city departments, volunteers, and temporary staff to ensure information was provided throughout the County.



The COVID ETF also partnered with the El Paso Police Department (EPPD) and together visited workplaces, schools, and congregated settings to educate facilities on the Health Authority Community Orders and address non-compliant facilities with an educational approach.

Once COVID-19 vaccinations were available, the ETF hit the ground and conducted door-to-door community outreach to promote vaccinations registering individuals in socioeconomically disadvantaged zip codes. It also targeted zip codes with low vaccination rates. Because of this, we

were able to reach 8,123 people.

We called all 1,866 county meal delivery participants. All city and county senior centers were served, and we conducted 181 provider visits to promote the COVID-19 vaccine and provided resources regarding patient information and public awareness.

The ETF performed IgM and IgG testing in 125 randomly selected households as part of the DPH's COVID-19 Antibody Community Project to identify community infection immunity prior to vaccination availability.

The ETF developed and delivered 199 COVID-19 presentations to schools, businesses, and other facilities.

DPH addressed the new clusters in congregate facilities by creating a Cluster Management Task Force (CMTF). The CMTF aimed to provide resources and

services to decrease the spread of COVID-19. Clusters were identified by the epidemiology program and a team was deployed to conduct an assessment to provide recommendations for Infection Prevention and Control. The CMTF conducted 1,538 visits to a wide variety of facilities including LTCF, businesses, schools, restaurants, shelters, jails, etc.

The CMTF aimed to prevent the spread of COVID-19 and conducted baseline Infection Prevention and Control (IPC) assessments in all shelters, long-term care, assisted living facilities, and correctional facilities. These assessments provided each facility with tailored information on case investigation, contact tracing, disinfection, testing, cohorting options, and layout suggestions for disease containment. It also served as a comparison point for follow-up visits when a cluster was identified.

The CMTF also targeted additional facilities serving vulnerable populations such as home health care, schools, daycares, dialysis centers, and blood and plasma banks to ensure IPC practices were in place. Patient education resources were shared, and meetings were held to coordinate and provide the most up-to-date information.

The CMTF also partnered with the fire department to provide regular, universal testing to assisted living facilities as ordered by the City of El Paso Health Authority. The CMTF monitored test results for nursing homes and assisted living facilities and conducted educational visits to promote preventative measures, health order adherence, and available resources such as PPE.

Collaboration Between Public Health and School Districts During the COVID-19 Pandemic

Since the beginning of the COVID-19 Pandemic, the DPH understood the importance of making our students a priority. Consequently, we immediately began to schedule and organize weekly meetings with all school district nurses and superintendents within El Paso County, including private and public schools. This was done to identify and respond to their needs in a coordinated and efficient manner. In addition, the DPH designated a special epidemiology team to support school during the COVID-19 pandemic. This team consisted of an epidemiologist in charge of the school team, Director of the Department of Public Health (Angela Mora, M.Ed.), and our health authority (Hector Ocaranza, M.D.), emergency preparedness and immunizations staff, as well as fire department staff. This team provided school district nurses with guidance, updates, and recommendations based on certain scenarios.

First and foremost, the school team developed a COVID-19 school district form, which included student demographics such as school, grade, parent contact information. The form also provided student sports/activities, list of additional contacts, test type, collection date and test results. This provided the epidemiology program with pertinent information to conduct case investigations. To accommodate the surge in school cases, the epidemiological team assigned a group of 15-20 staff to assist with case investigations and contact tracing at schools. An e-mail (schools_inquiries@elpasotexas.gov) was created specifically for school nurses to report positive cases to the DPH to further streamline reporting. The meetings provided a well-structured reporting system and open communication with school nurses and administrators on an ongoing basis.

Weekly meetings were scheduled to review information on mandates, guidance, quarantine/isolation time periods, prevention methods and return to play protocols for student athletes. As the El Paso City-County resumed in-person instructions, recommendations were established regarding school openings and closures for in-person instruction. This guidance was implemented when a student, teacher, staff was symptomatic or if they encountered an infected individual who was diagnosed with COVID-19. School nurses reached out to school leadership for guidance to ascertain when to implement these recommendations. This type of communication was critical to quickly respond to the potential for COVID-19 outbreaks. The result was limited spread of the disease among school-aged children.

Testing and vaccine sites were provided to school nurses. DPH, in collaboration with the fire department, assisted schools to administer vaccines to school children as they became approved by the FDA and CDC.

This system made it easier and more effective for school nurses to report to DPH, which increased case reporting. School nurses continue to work closely and diligently to report clusters to DPH.

We are confident that the communication between DPH and district school nurses will continue to have good rapport not only for COVID-19 but for other notifiable conditions.

The COVID response team is operational seven days a week and is readily available to provide immediate assistance to school nurses and parents as needed. All protocols, guidance and forms can be found at www.epstrong.org.

Public Health Region 8

Edwards County Vaccination Effort

We held a vaccination clinic in Edwards County, which is a rural border county in Public Health Region 8. Just days before the clinic, only a few people had signed up to be vaccinated. Since Edwards County has a small population with high vaccine hesitancy, it was critical to think outside the box to spur interest.



Edwards County Vaccination Clinic

During the clinic, staff received a visit from the President of the HEB Foundation, which operates many camps for children in the area. He expressed thanks to staff for calling their office to promote the Rocksprings Clinic. Because of that one phone call, they were able to vaccinate more than 100 employees, making it possible for them to reopen camps the HEB Foundation supports. We also shared the information for clinics with the local area agency on aging.

The guidelines had just changed directing states to expand eligibility to include people who work in schools and childcare operations. Knowing that many rural area schools, daycares, and day camp employees were in dire need of getting employees vaccinated, staff started calling schools, daycares and camps in Edwards and surrounding counties. Because of those efforts, the clinic was filled to capacity, vaccinating 472 individuals with their first dose.



PHR 8 Team unloading in Edwards County

Public Health Region 11

Communication and Collaboration

Our success story is the overall effort that local people put into successfully getting their community vaccinated. Although the many multi-family dwellings contributed to a high number of cases early on, they also helped increase vaccination rates when vaccines became available. It is unfortunate our region had to suffer from the high levels of hospitalizations and deaths, but I believe that inspired more people to get vaccinated. They saw close family members die or be severely affected by the pandemic.

Public health leadership from local health departments (LHDs), regional and local governments were very proactive in advocating for the needs of the community. They met with regional leadership and the Texas Division of Emergency Management personnel to ensure needs and concerns were handled. Communications channels were open, which allowed for all entities to be informed of needs and effective strategies.

LHDs, local government and DSHS leadership involved existing partnerships, state health department field offices, schools, community clinics, civic leaders and state and local health programs to instill long-standing efforts to boost health care along the border.

Public Health Region (PHR) 11 held weekly conference calls and meetings with all local stakeholders including LHDs, hospitals, clinics, schools, mayors, county judges and other government leadership. We were in constant communication with community members that needed our support to provide COVID -19 testing and vaccinations.

PHR 11 staff were involved in COVID-19 response. It started by creating a strategy that incorporated all personnel. Staff planned clinics as vaccines became available and worked with local clinics and governments to support the effort. PHR 11 held several clinics in schools, community centers, local state health department offices, local establishments, and businesses to boost vaccination rates. Contractors were also a huge support to our daily operations.

Mass vaccination clinics in partnership with local health departments and universities helped immensely to increase vaccination rates. It helped that familiar locations were utilized in local communities, which made them feel safe to trust the process.

Social media and new technologies, such as applications for testing and vaccinations, helped reach a larger range of the population. It was very important to keep our community engaged throughout the entire process. Health education was being promoted through social media channels more than ever. Social media campaigns allowed stakeholders to understand their community's pulse and situation.

Achieving High Vaccine Coverage with the Nurse Group

Story 1.

Some of us had tired feet from standing long periods; some of us swollen had feet. No matter how we may have felt, no one would have noticed because we served the community by protecting them with vaccines and smiles. The people of Willacy County were humble and grateful for our service. Our hearts and dedication to protect communities was in full display.

Story 2.

Our teams drive an average of 25-75 miles from Monday–Thursday to setup clinics in rural areas. Many of us sat patiently for two hours without administering a single vaccine. The team wasn't discouraged knowing the same drill would repeat itself the next day at a different site, always being available in case clients came in for vaccines.

Story 3.

The team administered vaccines at a clinic in Willacy County. As the team began to close for the day, a client arrived requesting clinical services. They explained the reason for the late arrival; he had just finished his day at work. Although the team was tired, they proceeded to administer the COVID-19 vaccine. The client expressed their gratitude for the team's patience and understanding.

Story 4.

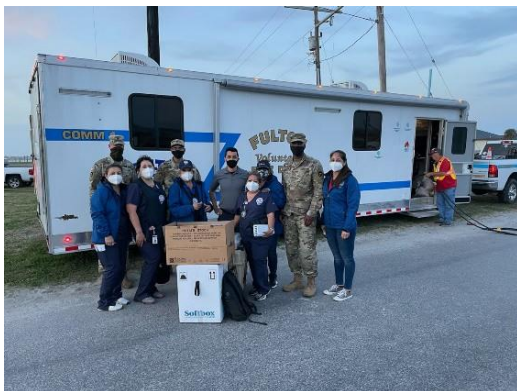


This story is about the only COVID-19 clinic in Texas that was held a couple of hundred feet from the Gulf of Mexico. The line of cars seemed to never end. The team worked long hours under hot and windy conditions with limited time for bathroom, food, or water breaks. There were a few community volunteers that received just-in-time training and military personnel assisted with traffic control and safety.

Melba Zambrano, Immunizations Director, and the rest of the team, as she provided a team huddle before the event.

The PHR 11 Team transitioned from assigned areas to help in other areas that required additional support throughout the day. By the end of the day, our team had sun burned mask imprints, achy, tired bodies only to face a long drive back to their homes.

As the team left Rockport, our hearts were full; we felt a sense of accomplishment for all the lives of families that would be protected from the COVID-19 virus because of our team effort.



Sonya and Nelda are based in Jim Wells County, though they service other surrounding counties as well. The motto is "One shot given is one life saved." A typical weekly schedule includes visits to EMS, schools, detention centers, nursing homes, and home bound clients.

COVID-19 Clinic in Rockport, Texas, March 2021

Environmental Health

City of Brownsville

HEPA Filtration System

The city of Brownsville and the Brownsville Independent School District (BISD) worked together during the COVID-19 pandemic. The community came together as it became evident that our situation required strong collaboration to achieve necessary outcomes to keep our border community safe!

The BISD school district, alongside the city's fire department, assisted local public health officials to conduct large-scale vaccination events. In addition, the local school district took bold steps to add large air quality indoor filtration systems, using the HEPA system, to maintain school classrooms and cafeterias safe for those who could not get vaccinated. The school district continued to find ways to keep students and teachers safe from emerging infectious diseases such as COVID-19 and other airborne agents. The focus of attention by the health services division continues to work with local city health officials in being a strong community partner.

Chronic Diseases

Public Health Region 8

Border Public Health Team Managing Supplemental Nutrition Assistance Program Education (SNAP Ed)

DSHS Public Health Region 8 Office of Border Public Health (OBPH) Team manages a Supplemental Nutrition Assistance Program (SNAP Ed) project in collaboration with community partners that include Maverick County and Eagle Pass, Pearsall, and Carrizo Springs School Districts. The program aims to implement community and school initiatives to promote healthy eating and increase physical activity among SNAP eligible individuals. DSHS Region 8 OBPH staff implemented the Coordinated Approach to Child Health (CATCH) Program in six elementary schools across the border.

As of April 2022, DSHS Region 8 OBPH staff:

- Provided partnering schools with two CATCH trainings,
- Surveyed 262 students pre-CATCH implementation,
- Surveyed 192 students post-CATCH implementation,
- Surveyed five physical education staff about barriers to teaching nutrition and physical activity in their campus,
- Conducted a total of 12 observations of the food environment at the Pearsall Intermediate, Carrizo Springs Elementary and San Luis Elementary,
- Conducted 12 CATCH lessons to third graders at San Luis Elementary and Carrizo Springs Elementary, combined.

As part of the community initiative, a steering committee was developed with stakeholders from Maverick County. The steering committee has met three times since the first meeting in July of 2021. The steering committee was developed to provide guidance and feedback for the types of interventions that will be implemented in Maverick County. In March 2022, the steering committee selected the [Teen Battle Chef Program](#) based on the results of community-based assessments, including five focus groups, a community survey (133 responses), and a literature review of effective community interventions. The Teen Battle Chef Program was implemented this summer.