



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**

Produced December 2021

Table of Contents

Executive Summary	1
Short-term Plan Recommendations	1
Long-term Plan Recommendations	2
Border Public Health Infrastructure	2
Communicable Diseases	2
Environmental Health	2
Chronic Diseases	3
Maternal Child Health	3
1. Introduction	4
2. Background	5
3. Recommendations	8
Short-term Plan Recommendations:	8
Long-term Plan Recommendations:	9
Border Public Health Infrastructure	9
Communicable Diseases	11
Environmental Health	15
Chronic Diseases	18
Maternal Child Health	19
4. Conclusion	21
List of Acronyms	22
Appendix A. Members of Task Force of Border Health Officials	A-1

Executive Summary

The Task Force of Border Health Officials (TFBHO) was established by [Senate Bill 1680 in 2017](#). Its role is to address border public health concerns affecting residents who live along the 1,254-mile Texas border from Brownsville to El Paso. The TFBHO meets quarterly and produces recommendations to the Texas Commissioner of Health by November 1 of each even-numbered year. The Task Force is administratively supported by the Texas Department of State Health Services but is not an office in the agency.

Because COVID-19 significantly impacted border health in 2020, this report includes short-term recommendations pertaining to pandemic response. The long-term recommendations are based on the border public health priorities established in the TFBHO's 2018 inaugural year.

The TFBHO submits the following recommendations:

Short-term Plan Recommendations

1. Complete the border surveillance and laboratory capacity assessment and expand it to include capabilities for laboratories to report results and positivity rates directly to local health departments.
2. Establish and make available local laboratory and testing capabilities available to border public health departments that is regularly available and accessible at low to no cost including university agreements and state labs.
3. Strengthen and support strategies to improve coordination with Mexico via the Texas Department of State Health Services Office of Border Public Health.
4. Involve the School Health Advisory Council in the school response plans to communicable disease reporting and outbreaks, including COVID-19; school ventilation; food safety and preparation; and preventative measures.
5. Conduct a survey on ventilation and air-conditioning in coordination with the Texas Education Agency and Health and Human Services Commission in nursing home and school facilities.
6. Add COVID-19 surveillance of premature births to the Birth Defects Program at the Texas Department of State Health Services.

Long-term Plan Recommendations

Border Public Health Infrastructure

- A.** Require implementation of the Health Information Exchange with free access for border public health and providers with potential to serve as a regionwide/statewide electronic medical record and communication system.
- B.** Ensure funding to allow for permanent, full-time public health professionals (epidemiologists, microbiologists, sanitarians, entomologists) for border public health departments.
- C.** Representation of Task Force of Border Health Officials on task force/committees involving local health departments established by the Texas Department of State Health Services.

Communicable Diseases

- A.** Expand the Texas Department of State Health Services Office of Border Public Health Community Health Workers training curriculum and bilingual educational material for pandemic response, including mental health and COVID-19 fatigue.
- B.** Establish a Border Public Health Multi-Disciplinary Response Team with trained and bilingual staff, including epidemiologists, sanitarians, nurses and contact tracers.
- C.** Evaluate needs to support hospitals, nursing homes and long-term acute care centers.
- D.** Uphold vaccination requirements for school entry and add COVID-19 vaccine.

Environmental Health

- A.** Continue to provide resources to increase capacity for mitigation (i.e. staff, equipment, chemical, education, training); and use innovative methods for mosquito control such as Geographic Information System, year-round mosquito testing in targeted high-risk areas, and other evidence-based approaches for ongoing needs, emerging and new threats, emergencies, and disasters.
- B.** Improve recruitment and retention of Registered Sanitarians. Expand training and certifications to improve response and expansion opportunities with expert personnel to assist with the prevention of food, water, vector-borne and zoonotic diseases.

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

Chronic Diseases

- A.** Establish early intervention components of children’s obesity prevention and education.
- B.** Establish an educational component on pulmonary complications at advanced age.

Maternal Child Health

- A.** Support sharing medical knowledge and training of border health professionals in coordination with the Texas Medical Association and the Texas Border Health Caucus.
- B.** Establish and fund outreach to pregnant mothers that are more at risk of early delivery and complications due to COVID-19.

1. Introduction

[Texas Health and Safety Code, Chapter 120](#), requires the Task Force of Border Health Officials (TFBHO) to meet at least quarterly and submit a report of recommendations to the commissioner for short-term and long-term border plans by November 1 of each even-numbered year. Recommendations should positively affect residents living in the Texas-Mexico border region. The TFBHO concentrates on major border public health priorities, including:

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

TFBHO also collaborates with local, regional, and state partners for the betterment of border residents.

The TFBHO met quarterly in 2019 as required by statute. The TFBHO met on February 20, 2020, but the other planned meetings in the spring and summer were cancelled due to the COVID-19 pandemic. A waiver was granted by the Office of the Governor allowing TFBHO more flexibility in meeting at least four times before the end of 2020. The TFBHO fulfilled the waiver by meeting on October 15, October 30, November 18, and December 10, 2020.

Due to TFBHO members' involvement in COVID-19 response, the TFBHO did not prepare the report due November 1, 2020. Each Task Force member is a local or regional health director working collaboratively with other entities, including emergency operations centers. The unprecedented scale of public health activities related to the COVID-19 pandemic took precedence over TFBHO duties and prevented the members from working within subcommittees and completing the recommendations on time.

Because COVID-19 significantly impacted border health in 2020, this report includes short-term recommendations pertaining to pandemic response. The long-term recommendations are based on the border public health priorities established in the TFBHO's 2018 inaugural year.

2. Background

[Texas Health and Safety Code, Chapter 120](#), mandates that seven Task Force of Border Health Officials (TFBHO) members be health directors from a border municipality that have public health departments with 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 TFBHO currently includes ten voting and two non-voting members as shown in [Appendix A](#).

At the December 13, 2019 meeting, DSHS Associate Commissioner for Regional and Local Health Operations David Gruber announced that Chair Esmeralda Guajardo and Vice Chair Hector Gonzalez would continue in their roles for the next two years, as supported by TFBHO bylaws. However, Dr. Gonzalez retired shortly thereafter, and the Vice Chair position was filled by Mr. Eduardo Olivarez.

While fighting the COVID-19 pandemic, the TFBHO members have continued their work to improve the broader health and well-being of border residents, including binational efforts with Mexican counterparts.

Since its formation, the TFBHO maintains 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 most vital foundational need for the border region continues to be access to primary, preventive, and specialty health care. The TFBHO established workgroups for each of the five border public health priorities:

1. Border Public Health Infrastructure
2. Communicable Diseases
3. Environmental Health
4. Chronic Diseases
5. Maternal and Child Health.

The TFBHO realizes the need for essential improvements to address border public health infrastructure, disease surveillance, control and prevention. They continue to collaborate with local, regional, and state partners as well as with public and private entities to improve health conditions along the border. Although the border region has lower infant mortality rates, along with lower cases of heart disease and stroke, it continues to have disproportionate levels of obesity, type 2 diabetes and other diseases like tuberculosis and other public health concerns when compared to such statistics in non-border counties.

[Texas Health and Safety Code, Section 120.001](#) defines the border region 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.¹ Because of the ebb and flow of international commerce and border migration, the Texas border continues to be recognized as one of the busiest international boundaries in the world. This has both its benefits and challenges, which affect public health in a unique way, especially in municipalities that lack health departments.

The Texas border consists of almost 3 million residents². The following table illustrates demographic differences between border and non-border counties in Texas:

¹ Department of State Health Services. Definitions of County Designations. Department of State Health Services. <https://www.dshs.texas.gov/chs/hprc/counties.shtm>. Last updated April 29, 2020. Accessed November 23, 2021.

² The total population of the border counties was calculated as 2,861,555 from the 2018 Texas Population Projections for 2020, Texas Demographic Center, released July 18, 2019. These are the most recent projections as of October 8, 2021. Accessed at <https://demographics.texas.gov/Data/TPEPP/Projections/>

1 Texas Border County Data

Demographic Characteristic	Border Counties	Non-Border Counties
Latino ethnicity	83.7%	34.7% ³
Dental visit in the past year, ages 18 and older	48.4%	60.3% ⁴
No health insurance coverage, ages 18-64 years	50.3%	26.7% ⁵

³ The percent of 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 October 8, 2021. Accessed at <https://demographics.texas.gov/Data/TPEPP/Projections/>

⁴ Texas Behavioral Risk Factor Surveillance System, 2018. Accessed October 8, 2018 at <https://healthdata.dshs.texas.gov/dashboard/surveys-and-profiles/behavioral-risk-factor-surveillance-system>

⁵ Texas Behavioral Risk Factor Surveillance System, 2018. Accessed October 8, 2018 at <https://healthdata.dshs.texas.gov/dashboard/surveys-and-profiles/behavioral-risk-factor-surveillance-system>

3. Recommendations

The recommendations developed by the Task Force of Border Health Officials (TFBHO) are outlined in the subsequent pages of this section.

Several of the previously suggested recommendations were submitted as proposed legislation. The TFBHO respectfully requests that Texas Department of State Health Services leadership considers year-round mosquito testing in limited south Texas border counties (testing from November – March) due to documented spread of mosquito borne diseases during cooler months.

Short-term Plan Recommendations:

1. Complete the border surveillance and laboratory capacity assessment and expand it to include capabilities for laboratories to report results and positivity rates directly to local health departments.
2. Establish and make available local laboratory and testing capabilities available to border public health departments that is regularly available and accessible at low to no cost including university agreements and state labs.
3. Strengthen and support strategies to improve coordination with Mexico via the Texas Department of State Health Services Office of Border Public Health.
4. Involve the School Health Advisory Council in the school response plans to communicable disease reporting and outbreaks, including COVID-19; school ventilation; food safety and preparation; and preventative measures.
5. Conduct a survey on ventilation and air-conditioning in coordination with the Texas Education Agency and Health and Human Services Commission in nursing home and school facilities.
6. Add COVID-19 surveillance of premature births to the Birth Defects Program at the Texas Department of State Health Services.

Long-term Plan Recommendations:

Border Public Health Infrastructure

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

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

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

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

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

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

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

Discussion: The creation of the TFBHO stemmed from the concern of border public health officials that they faced issues unlike other parts of the state, and it called for a different approach in responding to public health threats. The overarching goal of the task force was to establish a mechanism to ensure that those issues were brought to the forefront in the effort to be prepared against an imminent public health threat. While some recommendations raised by the task force are sought implementation via legislative action, the need to address these issues in a proactive approach during policy development remains. A means to address this is

through the representation of TFBHO on task force/committees involving local health departments established by DSHS. TFBHO representation in task force/committees will assure that the needs and the dynamics of border public health are considered in the development stages rather than requiring adjustments after the fact and when it may be too late to do so.

Communicable Diseases

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

Discussion: During the COVID-19 pandemic response, education of the community became key in gaining trust of the community to fight transmission of the virus. COVID-19 response has not only been a fight against the virus, it has equally shown to be a fight against misinformation. Unified messaging from the Centers for Disease Control and Prevention down to the local level has been used by local health departments in the communities. The DSHS [Community Health Worker or Promotor\(a\) Training and Certification Program \(texas.gov\)](https://www.dshs.texas.gov/Community-Health-Worker-or-Promotor(a)-Training-and-Certification-Program) is a key to leveraging public health education across our vulnerable populations. Community Health Workers (CHWs), commonly known as “Promotores” in Spanish, are an essential asset in Texas and an emergent workforce during this pandemic response. The effect of the COVID-19 pandemic on disadvantaged communities has had a great impact on all aspects of underserved communities or those of low resources. The growth of insecurities such as food and jobs has left many communities vulnerable with greater psychosocial, material, and physical instabilities that CHWs/Promotores can help improve with education and available resources⁶. CHWs/Promotores are needed to bridge communities and systems of health and mental care that are currently available. CHWs/Promotores have been shown to reduce the burden of illness among people with chronic diseases and to improve their ability to manage

⁶ Solar O, Irwin A. (2010). A conceptual framework for action on the social determinants of health. *Social Determinants of Health Discussion Paper 2 (Policy and Practice)*. Geneva, World Health Organization.
https://www.who.int/social_determinants/corner/SDHDP2.pdf?ua=1

their own conditions.⁷ As we know, some chronic conditions and comorbidities can make a person become severely ill when contracting COVID-19.

According to the Rural Health Information Hub⁸, CHWs/Promotores may perform the following roles:

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

According to the American Community Survey⁹, over 25 percent of border counties are foreign-born compared to 15.5 percent in non-border counties in Texas. Furthermore, a total of 31.7 percent responded speaking English less than “very well” in border counties compared to 12.2 percent in non-border counties. CHWs/Promotores not only bridge the communication gap but also break cultural barriers of communication. Institutions that utilize CHWs/Promotores have shown that they have helped to uncover and take action to address social determinants of

⁷ Peretz, P. J., Matiz, L. A., Findley, S., Lizardo, M., Evans, D., & McCord, M. (2012). Community health workers as drivers of a successful community-based disease management initiative. *American journal of public health, 102*(8), 1443–1446. <https://doi.org/10.2105/AJPH.2011.300585>

⁸ <https://www.ruralhealthinfo.org>

⁹ U.S. Census Bureau, 2015

disparities in COVID-19 infections and outcomes.¹⁰ CHWs/Promotores served as cultural brokers and navigators between community members and local systems of care while mitigating fear and correcting misinformation in disadvantaged communities.¹⁰ It is very important for DSHS to educate CHWs/Promotores with current, factual and culturally appropriate content that will help prevent misinformation among our communities.

Urban and rural underserved communities on the border are faced with reduced access to care, misinformation, and lack of inadequate supplies, such as food and other essentials. Investing time and funds in CHWs/Promotores and in their education can help address the social determinants of poor health that disproportionately affect low-income, minority populations and that are magnified during times of crisis such as the COVID-19 pandemic.¹⁰ Not only is it important to create curriculums to help CHWs/Promotores disseminate proper information, it is also imperative to help fund those organizations to hire CHWs/Promotores. It is important for grants and funds to be made available to local health departments and health entities for the hiring of CHWs/Promotores to help disseminate the information that was taught to them. When CHWs/Promotores have the proper knowledge and education about their local resources (through curriculums), they can help in improving mental health issues by referring patients to help by helplines or local clinics. They can also help community members apply for aids that are available to them and they provide a support structure for families along the border. CHWs/Promotores educate, support and follow-up with community members when they are at risk or have certain chronic diseases. They provide the support system and resources needed to deal these conditions.

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

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

¹⁰ Peretz, P. J., Islam, N., & Matiz, L. A. (2020). Community Health Workers and Covid-19 - Addressing Social Determinants of Health in Times of Crisis and Beyond. *The New England journal of medicine*, 383(19), e108. <https://doi.org/10.1056/NEJMp2022641>

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

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

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

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

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

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

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

Discussion: COVID-19 vaccines are highly effective at preventing severe disease, hospitalization, and death from COVID-19. Their efficacy rates against

hospitalization are 93 percent for Pfizer, 88 percent for Moderna, and 71 percent for Janssen¹¹.

Children less than 18 years of age are making up a greater proportion of cases. Over the course of the pandemic children have made up about 16 percent of cases but during the week ending October 14, 2021 they made up 25.5 percent of cases¹². Although less commonly than adults, children can become severely ill and require hospitalization and children with underlying medical conditions such as asthma or diabetes are at greater risk. Furthermore, children can spread the virus to other family members and friends sustaining transmission. Vaccinating children is an important part of the effort to reduce transmission of the virus.

The U.S. Food and Drug Administration issued emergency use authorization for COVID-10 vaccines for children ages 5 – 18 years of age. The Task Force of Border Health Officials recommends that they be added to the school vaccination requirements once the vaccines are fully approved. Vaccines are a crucial part of stopping the pandemic and allowing life to return to normal.

Environmental Health

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

Discussion: In order to address vector-borne and zoonotic diseases and standardize practices in counties located along the international border with Mexico, it is important to address the following: (1) studying the ongoing and potential needs of border counties related to vector-borne and zoonotic diseases, (2) the availability of and capacity for vector mitigation and control, including increased staffing, equipment, education, and training, (3) creating strategies to improve or develop continuing education and public outreach initiatives for vector-borne and

¹¹ Self WH, Tenforde MW, Rhoads JP, et al., 2021

¹² American Academy of Pediatrics, Children and COVID-19: State Level Data Report, accessed October 19, 2021

zoonotic disease prevention, including sanitation, removal of standing water, use of repellent, and reporting to health authorities of rashes and other symptoms of vector-borne and zoonotic diseases, (4) develop rapid local and regional response and support plans, (5) encourage ongoing vector-borne and zoonotic disease control activities (6) preparedness for disasters, including flooding, hurricanes, and outbreaks of vector-borne diseases.

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

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

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

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

Discussion: This is recommended following the same pattern in Section 1 of [SB 1312 - 86\(R\)](#): to develop a tiered curriculum and test for public health sanitarians to grow the workforce of sanitarians capable of performing basic and critical food safety inspection services. 1) Create a first-level certification Sanitarian I or Environmental Protection Specialist exam that will give authority to inspect restaurants. Requires at least a high school diploma and either 2 years of college and/or experience assisting with preventing food, water, vector-borne, and zoonotic diseases; and 2) maintain the second-level certification test that has a minimum

requirement of a 4-year college degree with 30 hours of science coursework and can test for the full Sanitarian license. The Lower Rio Grande Valley has a low number of registered sanitarians compared with the populations served, which requires rising demands due to industrial and economic growth.

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

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

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

- Optimize architectural design of the physical plant.
- Remedy crowding to allow for social distancing.
- Optimize humidity levels to reduce transmission of virus.
- Optimize window ventilation in classrooms where outdoor air quality is reasonable.
- Supplement outdoor ventilation with indoor fans to better distribute air.
- Disable demand-controlled ventilation controls that reduce air supply based on occupancy or temperature during occupied hours.
- Ventilation considerations are also important on school buses.

- Use portable high efficiency particulate air (HEPA) fans/filtration systems to help enhance air cleaning.

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

Chronic Diseases

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

Discussion: According to the American Community Survey⁹, 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. A striking total of 50.3 percent adults aged 18-64 have reported not having any health insurance compared to 26.7 percent for non-border counties, please see [Table 1](#) on page 7.

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

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

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

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

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

Maternal Child Health

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

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

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

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

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

Discussion: It has been established that pregnant women are at increased risk of complications from COVID-19 and the risk is even greater with the Delta variant of the virus. If infected, pregnant and recently pregnant women are at an increased risk of developing severe disease requiring hospitalization. Pregnant women are also at increased risk of premature birth and may be at risk of other complications such as pregnancy loss due to COVID-19¹³. High COVID-19 case rates along the border coupled with higher birth rates in the Hispanic population than the non-Hispanic white population¹⁴ combine to put this group at increased risk.

Hispanic or Latino people are 1.9 times more likely to become infected, 2.8 percent more likely to be hospitalized due to COVID-19, and 2.3 percent more likely to die from COVID-19 than non-Hispanic white people¹⁵. Therefore, it is critical that pregnant women are well-informed about how the virus spreads, how to prevent infection, the risks of infection, and the benefits of vaccination. This population is unique with different needs and concerns than other high-risk populations. A plan to develop and roll-out an outreach effort focusing on pregnant and recently pregnant women is crucial to protect the health of both women and their babies.

¹³ <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnant-people.html>

¹⁴ [Texas Health Data - Live Births \(2005 - 2017\)](#)

¹⁵ <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>

4. Conclusion

Members of the Task Force of Border Health Officials (TFBHO) continue to respond to COVID-19 in their respective municipalities and areas of operation. They share the success of higher than average vaccination rates throughout the Texas border.

Subcommittee work groups have reviewed public health data and different factors impacting border public health. The TFBHO continues in their commitment to develop recommendations as part of short and long-term plans for the DSHS Commissioner. They are committed to further their cause as outlined in the statute and will continue to collaborate with all appropriate entities to support all five border public health priorities to achieve border and binational endeavors.

List of Acronyms

Acronym	Full Name
ASHRAE	American Society of Heating, Refrigerating and Air-Conditioning Engineers
CHW	Community Health Worker
COVID-19	Coronavirus Disease of 2019
DSHS	Department of State Health Services
HIE	Health Information Exchange
HHSC	Health and Human Services Commission
OBPH	Office of Border Public Health
SARS	Severe Acute Respiratory Syndrome
TFBHO	Task Force of Border Health Officials

Appendix A. Members of Task Force of Border Health Officials

Members	Task Force Position/Title
Esmeralda Guajardo, MAHS	Chair/Health Administrator, Cameron County Department of Health and Human Services
Richard Chamberlain, DrPH(c), MPH, RS	Member/Director, City of Laredo Health Department
Steven Kotsatos, RS	Member/Director, Health and Code Enforcement, City of McAllen
Eduardo Olivarez	Vice-Chair/Chief Administrative Officer, Hidalgo County Health and Human Services
Josue Ramirez, MPA, CPM	Member/Director, Health Department, City of Harlingen
Angel Mora, M.Ed.	Member/Director, City of El Paso Department of Health
Arturo Rodriguez, DNP, MPH, CPM	Member/Interim Public Health Director, Assistant City Manager, City of Brownsville
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