

Obstetrical and Neonatal Care Coordination Related to Infectious Diseases in Pregnancy

Report of Workgroup Findings

Prepared by UT System Population Health for the Texas
Collaborative for Healthy Mothers and Babies.

Texas Collaborative for Healthy
Mothers and Babies (TCHMB) Annual
Conference | **January 22-23, 2018**
AT&T Conference Center, Austin, Texas

Suggested Citation:

Texas Collaborative for Healthy Mothers and Babies. (2018). Obstetrical and Neonatal Care Coordination Related to Infectious Diseases in Pregnancy: Report of Workgroup Findings. Austin, Texas.



tchmb
Texas Collaborative for
Healthy Mothers & Babies

Contents

● Findings

- Introduction 3
- Identified Barriers and Gaps in Care Coordination 3
- Foundation and Community Infrastructure 4
- Identified Model for Care Coordination – Texas Perinatal Centers of Excellence 4
 - Overview of the Centers of Excellence 4
 - Role of the Community 6
 - Structure and Activation of the Centers of Excellence 7
- Case example: Zika 9
- Conclusion 9
- Disclaimer 10
- Further Information 10
- References 10

● Appendix

- Appendix A. Barriers and gaps in care coordination identified by the three workgroups 11
- Appendix B. Maternal care and coordination of newborn evaluation 13
- Appendix C. Community supports, resources, social services and navigators 15
 - 1. Community Needs Assessment: 15
 - 2. Medical record/data sharing 16
 - 3. Communication Plan 16
- Appendix D. List of attendees in the workgroup sessions 18
 - Group A Facilitators & Attendees 18
 - Group B Facilitators & Attendees 19
 - Group C Facilitators & Attendees 20

Findings

Introduction

The Texas Collaborative for Healthy Mothers and Babies is a multidisciplinary collaboration of over 150 healthcare providers, scientists, hospitals, state agencies, advocates and insurers that was founded in 2013. The TCHMB's mission is to advance health care quality and patient safety for all Texas mothers and babies through collaboration with healthcare providers and community stakeholders in the development of joint quality improvement (QI) initiatives, the advancement of data-driven best practices, and the promotion of education and training. In January 2018, TCHMB hosted a conference on obstetrical and neonatal care coordination of infectious diseases during pregnancy.

Using the recent Zika experience as an example, this event provided a forum for key local, state, and national experts to discuss how coordination of care for pregnant women and babies in response to established and emerging infectious diseases could be improved. Workgroups were convened to make recommendations and create a generalized guide for improving maternal and neonatal care coordination with respect to established and emerging infectious diseases. Three workgroups were assigned a specific focus along the perinatal timeline, from preconception through postpartum and inter-conception periods. All groups were tasked with identifying barriers to coordination and proposing a new, feasible model of care coordination based upon lessons learned from previous models of care. Workgroups consisted of 20 - 27 participants, and included experts in the fields of medicine, nursing, social services, public health, academia, and community health.

- **Group A:** Coordination from preconception through the inter-conception period, including coordination between maternal care and neonatal care.
- **Group B:** Coordination from birth to the end of infancy with a focus on coordination between neonatal, specialty, and pediatric care.
- **Group C:** Coordination of community resources for maternal and infant care from preconception through postpartum/inter-conception.

This brief report summarizes the recommendations of the workgroups.

Identified Barriers and Gaps in Care Coordination

The workgroups identified four main themes regarding barriers and gaps in the care of pregnant women and neonates affected by infectious disease:

- 1) **Technology** (e.g., communication across different electronic medical records platforms, access to telemedicine, ease of disease reporting, communication of CDC guidelines)
- 2) **Healthcare Providers** (e.g., lack of provider education, mistrust of medical community, lack of incentives for providers/hospitals, lack of communication between providers)

3) Social Factors (e.g., race, immigration status, income, transportation, access)

4) Policy and Finance (e.g., communication between all levels of health agencies, Medicaid funding, fragmented medical and political systems)

A detailed description of the barriers identified by the workgroups can be found in Appendix A. These barriers were identified through robust discussions in which participants focused on their experiences within their own model of care. Following two days of discussion, the result of these discussions was the proposal of Texas Perinatal Centers of Excellence for Infectious Diseases (hereafter referred to as CoEs). This report describes the overall structure, functionality and activation of the model, and provides a case example of how the CoE could work. This proposal is not intended to be a TCHMB consensus statement; rather, it reflects ideas and views that emerged through conference discussions.

Foundation and Community Infrastructure

The community constitutes the basis or foundation of any healthcare initiative. The World Health Organization defines community as a group of people, often living in a defined geographical area, who may share a common culture, values and norms, and are arranged in a social structure according to relationships, which the community has developed over a period of time¹. Any successful healthcare initiative requires a formidable community framework or infrastructure. Consequently, the workgroup identified the importance of having a strong collaboration with the community and of using the available and relevant community infrastructure for any proposed models of care.

Identified Model for Care Coordination – Texas Perinatal Centers of Excellence for Infectious Diseases

Overview of the Centers of Excellence

Based on their experiences with existing models for care coordination, the three workgroups proposed to establish a statewide network of CoEs that can provide comprehensive healthcare to mothers and infants in response to existing and emerging infectious diseases.

CoEs will be grounded in the following key guiding principles:

- CoEs will use the One Health and the Patient-Centered Medical Home (PCMH) principles to guide their development and the creation of comprehensive culturally sensitive, patient-centered care.
 - One Health, as defined by the Centers for Disease Control and Prevention (CDC), is the concept that the health of all people in the community is related to the health of its animals and environment. The goal of One Health is to encourage multi-sector collaboration to promote health for all².
 - The PCMH was developed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA). It encompasses providing comprehensive primary care in a health care setting that facilitates partnerships between patients, their personal physicians, and when appropriate the families of the patients³.
- CoEs will provide care to all patients, irrespective of insurance or immigration status. They will have universal screening for travel history.

- CoEs can build upon the existing strength and infrastructure of the existing 22 state Regional Advisory Councils (RAC) for the Texas trauma care system. In some settings, multiple CoEs may exist within a RAC.
- All payers would cover referrals to the CoE.
- CoEs will act as knowledge repositories for local practitioners.
- Capacity, infrastructure (e.g., telemedicine, scale-up), and networks (e.g., trust and rapport between providers) should be established by the CoEs.
- CoEs will have active collaborations among themselves as well as with the state and local health departments, and national physician organizations (e.g., American College of Obstetricians and Gynecologists (ACOG), AAP, AAFP).

CoEs will be divided to handle three levels of infectious diseases:

- Common disease outbreaks and congenital infections (e.g., influenza, measles, Chagas)
- New emerging infections (e.g., Zika)
- Catastrophic disease outbreaks (e.g., Ebola, pandemic influenza)

There is evidence in the literature that CoEs are better equipped to manage morbid medical conditions from infectious diseases to surgery to cancer, even in perinatal health. For example, the National Perinatal HIV Hotline and Clinicians' Network is a Health Resources and Services Administration-funded initiative operated from California⁴. It provides free 24-hour consultation for US clinicians on HIV care from preconception through pregnancy and birth⁴. Additionally, HIV-positive pregnant women and their exposed infants are referred to local experts for care through the Perinatal HIV Clinicians' Network⁴. The network is a directory of perinatal HIV experts nationwide. The services by the providers in the Network are tailored to each location and clinical situation. These may include one-time consultation, co-management, transfer of care, and follow-up⁵.

Similar regionalized CoEs in the United States and globally have been suggested in the aftermath of recent Ebola outbreaks. These CoEs should have the necessary infrastructure and capacity to rapidly respond to highly contagious infectious diseases like Ebola⁶. Systems should be in place for early detection, evaluation, isolation, and treatment of these diseases (e.g., effective travel screening, infection control procedures) in obstetric populations⁶.

Another example is the placenta accreta CoE. Placenta accreta and other abnormally adherent placenta are better managed if delivery is accomplished in CoEs with multidisciplinary expertise and experience in the care of the condition⁷. The accreta CoE team includes specialists from maternal-fetal medicine, gynecologic surgery, gynecologic oncology, vascular, trauma and urologic surgery, transfusion medicine, intensivists, neonatologists, interventional radiologists, anesthesiologists, specialized nursing staff, and ancillary personnel⁷.

Another great example of CoEs is in the field of surgery. The American Society for Bariatric Surgery (ASBS) established CoE programs that conduct bariatric surgery efficiently and safely⁸. These CoEs link together bariologists with resources, database systems, and allied researchers⁸.

Role of the Community

The community has a fundamental role to play in the proposed model, and because each community is unique, the roles and needs may differ from one community to another. Thus, a thorough understanding of the characteristics of each population is imperative, specifically for women of childbearing age and their babies.

Communities will identify the needs and sociodemographic characteristics of women from preconception to postpartum. This assessment should identify available resources in place to establish an effective and efficient care coordination system that serves all phases of care for mothers and babies. In the event of an infectious disease outbreak or epidemic, these items are intended to be customized to the specific infection or disease. Three specific items were identified as requirements for the foundation of a care coordination model:

I. Community Needs Assessment

The goal of the community needs assessment is to ensure that, within a given region, 1) the demographics and characteristics of childbearing women, including the burden of disease and risk factors, are understood, 2) entities that provide services to pregnant women and infants are accounted for and are aware of each other, and 3) community resources are identified. An updated assessment may be necessary during an emerging threat. In addition to the identification of health providers (OB/GYNs, pediatricians, psychiatrists, and emergency physicians), ancillary services like labs and family planning clinics, and public health officials should be identified.

II. Medical Records/Data sharing

The workgroup identified data sharing as vital to the ability to triage and care for women of childbearing age in the event of an infectious disease outbreak or epidemic. To effectively manage the care and coordinate services through both traditional and nontraditional providers, it is imperative to have the ability to provide seamless, effective communication between providers. To do so, the community will need to adopt the state repository or portal. Additionally, the community will work with CoE to establish a central repository or portal for sharing patient information between healthcare providers in a safe, legal, and user-friendly manner. The portal can be shared by anyone in the network of the CoE that provides care to pregnant mothers or infants.

III. Communication Plan

Established and prepared communication resources and strategies prior to an emerging disease outbreak are essential in establishing trust within the community and effective communication in the event of an infectious disease outbreak or epidemic. An effective communication plan leverages media partnerships, but also entails engaging with medical providers, city employees and elected officials, faith-based organizations, community liaisons, local businesses, and the public health department. The communication strategies can be modified to fit the specific infectious disease and should be linked to the CoE to keep partner community providers educated during an outbreak. Each CoE should develop a multi-sector community-appropriate communication plan.

Structure and Activation of the Centers of Excellence

The CoEs will depend on a multi-sector collaboration to ensure that patients receive the highest quality of care. CoEs will work with clinical physicians, behavioral specialists, public health officials, social workers, community health workers, case managers, and regional hospitals and clinics. The CoEs will include specialists that will also vary with the co-morbidities and complications associated with a disease. The success of the CoEs will depend on their ability to seamlessly facilitate communication between these entities.

Any physician, but most commonly primary care physicians or OB/GYNs, can provide universal screenings for males and females. If appropriate, individuals will undergo testing for the infection (e.g., Zika) per a clinical protocol, and their care will be managed according to their testing results. If clinically indicated, pregnant women who test positive will then be referred to the regional Texas Perinatal CoE. Neonates will be screened at their hospital of birth. The perinatal CoEs will be utilized for clinical questions and consultation via telemedicine, including screening guidelines, testing parameters, and interpretation of results. The network of perinatal CoEs will be activated when a pregnant woman or neonatal has a confirmed diagnosis of the infectious disease in question. Based

on the diagnosis, the pregnant woman or neonate will be directed to the appropriate level of CoE.

Diagnoses will be reported by physicians, laboratory, or the public health department. The CoE will assume the lead on a patient's case management, coordination, and treatment. The CoE will foster and develop bi-directional communication and data systems with all partners to optimize the care of the patient (Figure 1). CoEs will have an electronic data repository for all providers, and patients will carry a 'passport' that carries the most pertinent information for their care in the event that there is an error accessing the electronic health record. CoEs will act as an interim medical home for infants during the acute phase of their disease, but will transition to an alternative primary care home for long-term management and follow-up.

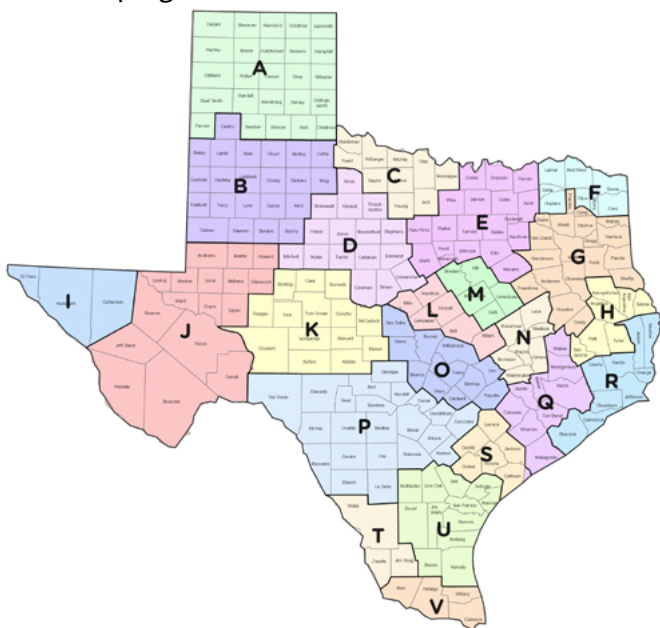


Figure 2. Regional Map of Texas RACs

Texas Perinatal CoEs will exist throughout the state, following the regionalization pattern laid out by existing RACs. RACs are charged with coordinating with regional hospitals to build initiatives that improve infant and maternal health; thus, CoEs are logical partners with the RACs. In total, there could be approximately 22 CoEs in Texas, mirroring the number of RACs. Conference participants chose to utilize the existing infrastructure of RACs to avoid re-drawing lines of regionalization across the state. If placed strategically, CoEs could also represent a bridge between academic centers and private medical communities (Figure 2).

Each CoE will address the unique needs of its community and foster community engagement. Further, each CoE will have divisions dedicated to case management and coordination, public health, and clinical care. Select CoE will have a division dedicated to basic science laboratories. Every CoE will be provided with a basic emergency response protocol to address an emerging outbreak and select CoE will subspecialize in the management of one or two specific diseases, depending on the level of CoE. In the event of an outbreak or epidemic, every center will initiate the

basic management protocol, and the center that specializes in the specific disease will take the commanding leadership role. It will disseminate knowledge and expertise as necessary among all CoEs. Similarly, medical resources will be distributed among CoEs during times of an outbreak and epidemics, as necessary. The terms of resource sharing will be established under a memorandum of understanding at the time of CoE creation.

Roles and Responsibilities of the Perinatal Center of Excellence:

- Care coordination
- Case management
- Patient care transition and provider communication
- Emerging disease management protocol (e.g., Zika)
- Patient education and outreach
- Provider education and outreach (cultural sensitivity and disease management)
- Basic science laboratories and research
- Timely, responsive, and effective communication and coordination across network of all CoEs
- Collaboration with CDC disease experts

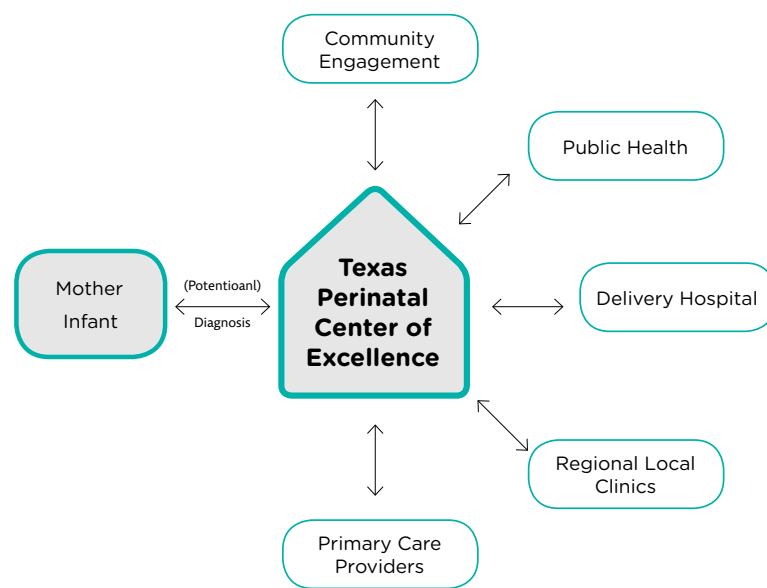


Figure 1. Model of Texas Perinatal Center of Excellence

Roles and Responsibilities for Public Health:

- Patient triage and referral (e.g., assess patient in the community and refer accordingly)
- CoE collaboration; assistance with performance standards and evaluation
- Disease surveillance
- Activation and coordination of an emergency based response model
- Veterinary Medicine (vector control)

Case Example: Zika

To illustrate how the CoE would operate in the event of an emerging infectious disease, we describe the model when a patient is being tested and treated for Zika infection (Figure 3).

All patients (male and female) should receive universal screening to assess travel to areas with risk of Zika. Those who screen positive are at risk of infection and should be further tested for Zika, according to the local health official's recommendations. If individuals test positive for Zika, they should be referred according to need. Men will be referred to a health education specialist and advised against unprotected sexual intercourse for at least six months, even if asymptomatic.

Children above age 2 will be referred to follow-up with their pediatricians.

Non-pregnant women and their partners (if appropriate) will be referred to appropriate education and counseling (for example, to wait six months before trying to conceive). Pregnant women with a confirmed Zika infection would be immediately referred to a CoE.

Zika management requires a number of medical and non-medical specialists to engage in transparent and open communication about patient care which can be facilitated by the CoE. Examples of the specialists that would be involved in care of a Zika infected patient include:

- Maternal-Fetal Medicine specialists
- Infectious Disease specialists
- Pathology/Lab medicine
- Neonatologists
- Pediatric neurologists
- Pediatric ophthalmologists
- Pediatric audiologists
- Case managers
- Perinatal epidemiologists
- Social workers
- Behavioral health workers

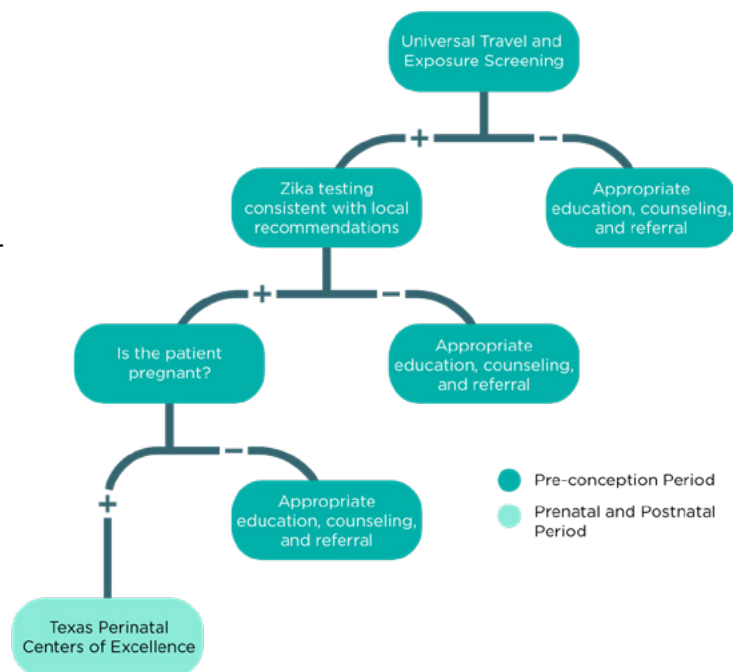


Figure 3. Screening of a potential Zika patient

Conclusion

Care coordination of established and emerging infectious diseases in pregnant and neonatal populations remains a challenge. The Zika outbreak in Texas has highlighted methods that the state can implement to better protect individuals' health from any new emerging disease, including Zika. The participants of the 2018 TCHMB conference were tasked with identifying and describing a model of care coordination that could improve pregnancy and birth outcomes. Following a robust discussion, participants came to describe a model that centered on the use of a network of Perinatal Centers of Excellence that would act as the fulcrum for patient care. The tasks and responsibilities of a CoE are extensive, and will require thorough planning to develop the infrastructure to meet the needs of affected families.

Disclaimer

TCHMB Executive Committee report was prepared based on (1) presentations by health care professionals with expertise in infectious disease and pregnancy; and (2) discussions among conference attendees. This report is not a policy statement of the TCHMB or the Texas Department of State Health Services, rather it is a summary of discussions of the workgroup sessions and is being shared

to inform and contribute to ongoing perinatal policy and program development with regards to obstetrical and neonatal care coordination related to infectious diseases in pregnancy in Texas.

Further Information

The conference agenda and recorded sessions can be found at:

<https://www.tchmb.org/conference-care-coordination-infectious-diseases-in-pregnancy>

References

1. World Health Organization. A Glossary of terms for Community Health Care and Services for Older Persons. http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf. Accessed April 4, 2018.
2. Centers for Disease Control and Prevention (CDC). One Health Basics. <https://www.cdc.gov/onehealth/index.html>. Accessed February 10, 2018.
3. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint Principles of the Patient-Centered Medical Home. 2007; https://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf Accessed March 12, 2018.
4. Weber S, Waldura JF, Cohan D. Safer conception options for HIV serodifferent couples in the United States: the experience of the National Perinatal HIV Hotline and Clinicians' Network. *Journal of acquired immune deficiency syndromes* (1999). 2013;63(4):e140-141.
5. Weber S. The National Perinatal HIV Clinicians' Network: Best Practices for Linking HIV-positive Women with Care. 2013; <https://aidsetc.org/blog/national-perinatal-hiv-clinicians%E2%80%99-network-best-practices-linking-hiv-positive-women-care>. Accessed May 11, 2018.
6. Haddad LB, Horton J, Ribner BS, Jamieson DJ. Ebola Infection in Pregnancy: A Global Perspective and Lessons Learned. *Clinical obstetrics and gynecology*. 2018;61(1):186-196.
7. Silver RM, Fox KA, Barton JR, et al. Center of excellence for placenta accreta. *American Journal of Obstetrics & Gynecology*. 2015;212(5):561-568.
8. Pratt GM, McLees B, Pories WJ. The ASBS Bariatric Surgery Centers of Excellence program: a blueprint for quality improvement. *Surgery for Obesity and Related Diseases*. 2006;2(5):497-503.

Appendix

Appendix A. Barriers and gaps in care coordination identified by the three workgroups

1. Technological barriers

- Fragmented health records (e.g., different Electronic Health Record (EHR) systems within and across institutions/systems; existing communication not complete or transparent; patient history not easily accessible)
- Lack of communication (e.g., Emergency Room (ER) and urgent care visits not included in the global health record of a patient)
- Lack of emerging technology (e.g., telemedicine)
- Inability to navigate CDC guidelines and website accurately and quickly
- Lack of mechanism to report or get information (multiple locations/not centralized)
- State has not been able to generate surveillance system that works at the community level

2. Provider level barriers

- Awareness and education (e.g., scarcity of medical experts, lack of knowledge, and resources in smaller communities; appeal to learn new information)
- Healthcare provider environment (e.g., unwelcoming; mistrust in medical community; inadequate staff/aid to assist patients with diagnosis/treatment plan/test results)
- Variation in clinical care/episodic care (e.g., ER visit versus primary care provider visit; pressure to perform thorough exams in limited time and patient encounter; sporadic medical care; gaps between care)
- Changes in health coverage (e.g., transition to Medicaid 60 days postpartum to another insurance provider)
- Perceived stigma with Medicaid
- Lack of buy-in or financial incentives from providers, particularly private practice obstetricians, private hospitals, and physician-owned hospitals to facilitate care coordination (e.g., limits care)
- Lack of communication and poor “hand-off” system between provider-provider, provider-patient, and provider-public health

- Reluctance to refer to another physician due to financial reasons
- Physicians unaware of most up-to-date recommendations on management of disease (e.g., lack of expertise to handle special patient populations)
- Lack of accurate and easily interpretable laboratory testing

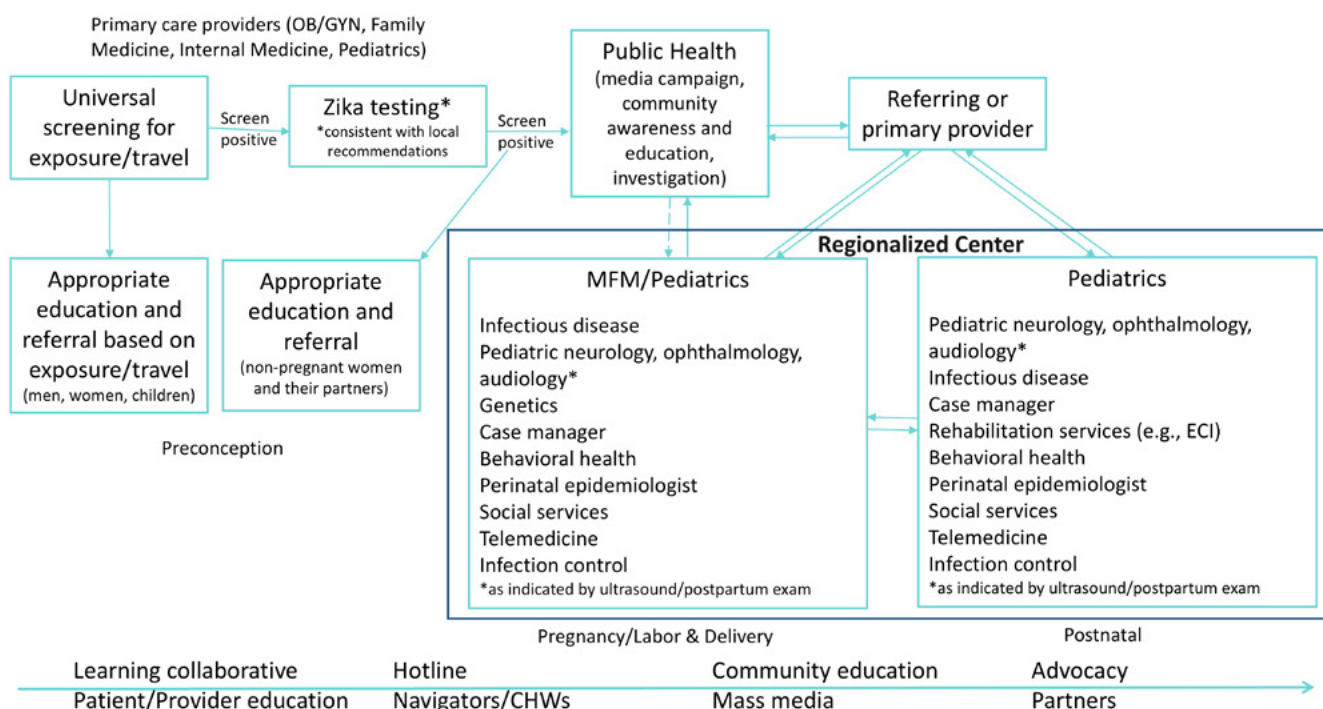
3. Social determinants of health

- Limited resources (e.g., payer mix, funding sources, insurance, lack of finances)
- Transportation to services, convenience (e.g., competing priorities for pregnant women)
- Access to healthcare (e.g., geographic barriers, absence of physicians in rural areas, preconception/prenatal counseling, uninsured, lack of access to medication)
- Lack of awareness, available services and education (patient and community; literacy navigation; preconception care)
- Stigma (travel history in relation to immigration status)
- Proximity to border, binational cities (e.g., El Paso, Laredo, Brownsville)
- Racial/ethnic and cultural disparities
- Religious barriers
- Socioeconomic status
- Late prenatal care
- Social and family commitments
- Lack of adherence to public health recommendations by medical providers
- Lack of availability of programs in the community (e.g., some programs are either at capacity or have narrow criteria for eligibility and/or transition between programs not coordinated)

4. Legislative/politics and financial issues

- Communication between state, regional, local, institution level
- Communication between local, state, and county health departments
- Information sharing
- Fragmented medical and political system
- Lack of funding if program loses public awareness or not very successful
- Lack of healthcare coverage
- Billing and coding issues
- Lack of Medicaid incentives for care coordination

Appendix B. Maternal care and coordination of newborn evaluation and follow-up



Components of an ideal care coordination model

1. Standardization of care (e.g., health history, screening, CDC roadmap)

- Universal screening for travel/exposure
- Resource mapping

2. Regionalization of acute and long-term management of infectious disease (with local adaptation)

- Regional sharing of information on a quarterly basis (learning collaborative)
- Maternal health registry (e.g., line list of Zika positive moms)
- State summit on infectious disease (annual/ biennial)

3. Effective communication

- Closed-loop communication (e.g., provider-provider, provider-patient, and provider-public health)
- Redundancy of information

- Fully effective Health Information Exchange (HIE) system (e.g., Greater Houston Healthconnect)
- Common EHR system
- Delivery plan with updates at various time points in pregnancy (e.g., syphilis)
- Empower patients to inform providers of test results/Patient as own advocate (e.g., “Yellow Card”/Personal health list)
- Exchange of information (e.g., telemedicine, paper back up, cloud-based, build rapport/network)

4. State and local government support for transfer of information to regional center

Appendix C. Community supports, resources, social services and navigators

Specific Plan:

Assure that each community has one of the following items specific to women (pre-conception to inter-conception) and infants. Once an emerging infection occurs, customizing to the infection.

- 1) Community needs assessment with identified community assets and resources
- 2) Medical record/data sharing - combination of analogue and digital
- 3) Communication Plan

Establish measures for these items:

- 1) Process measures:
 - a) Are items in place
 - b) Are components in place
- 2) Outcome measures by subgroups and geographical areas:
 - a) Number/rates of tests
 - b) Number of referrals
 - c) Outreach performed
- 3) Qualitative measures:
 - a) Focus groups with population serves and providers

1. Community Needs Assessment:

Assure that all communities have access to CNA. For existing CNAs, incorporate an OB/GYN /new-born component.

When an emerging infection occurs, have an updated assessment consistent with the emerging infection.

The Community Needs Assessment can be maintained locally and at a State-level repository.

- 1) Clinical (primary and specialty providers) and community assets:
 - a) OB/Pediatrics
 - b) Primary care
 - c) Mental health
 - d) Emergency Room

- e) Medical labs
 - f) Family planning resources
 - g) Social determinant of health – housing, food, insurance
- 2) Population numbers, rates and mapping**
- a) Women of childbearing age
 - b) High-risk pregnancies
 - c) High-risk /special populations:
 - i. Substance use
 - ii. Co-occurring conditions
 - iii. Immigrants
- 3) Public health officials**
- 4) Experts in community**
- 5) Electronic health record**

2. Medical record/data sharing

- Identify repository / portal
- identify data source/system – electronic and paper
- Legal requirements
- Cost
- Managed care organization (MCO) data sharing, and development of mechanisms for billing for diagnostic tests and procedures and treatment if needed.
- Identify gate-keeper (Health Informatics Experts) that creates a system for short-term sharing of information during an emerging infection:
 - Providers can enter and access data on patients across different systems (e.g., Harris Health exchange) with permission from patients
- Local committee to determine the local sharing
- Use of personal digital devices by patient/clients, is it possible? (e.g., cell phone)
- Develop a data sharing system that is functional locally

3. Communication Plan

- 1) Develop communication plan using existing plan (e.g., state plan) (customized for the community) which includes**
- a) Media (PSAs – print and electronic)

- b) Advocates
 - c) Community and non-profit organizations – e.g., Head Start, March of Dimes, food banks
 - d) Medical society
 - e) CHW, LVN, SW,
 - f) Elected officials
 - g) Fire department and police
 - h) Faith-based
 - i) Public relations experts
 - j) Public health
 - k) Schools
 - l) Local businesses
-
- 2)** Assure that the plan has health literacy, culturally appropriate and is language appropriate
 - 3)** Method of messaging tailored and adapting to the community
 - 4)** Bring in stakeholders (see above) to implement the plan
 - 5)** Use social media

Appendix D. List of attendees in the workgroup sessions

Group A Facilitators & Attendees

Facilitators:

- Carla Ortique, MD, Texas Children's Hospital
- Divya A. Patel, PhD, University of Texas Health Science Center at Tyler / UT System Population Health

Attendees:

- | | |
|---|---|
| • Samavi Ahsan, MPH, CNI contracted to CDC | • Meagan Kirby, NA, Health and Human Services Commission |
| • Fred Buckwold, MD, Community Health Choice | • Elizabeth Krause, ScM, St. David's Foundation |
| • Luis Castagnini, MD, MPH, Baylor College of Medicine/The Children's Hospital of San Antonio | • Carrie Kroll, NA, Texas Hospital Association |
| • Luis Cerda, MD, City of Laredo Health Department | • Ryan Loftin, MD, Driscoll Health System |
| • Kendra Crawford, RN, NE BC, HCA | • Sharon Melville, MD, MPH, Department of State Health Services, PHR 7 |
| • Catherine S. Eppes, MD, MPH, Baylor College of Medicine | • Martha Payne, RN, APN, Texas Department of State Health Services |
| • Natlie Furdek, M.Ed, LPC, Texas Department of State Health Services | • Patrick Ramsey, MD, MSPH, University of Texas Health Science Center at San Antonio |
| • Imelda Garcia, MPH, Texas Department of State Health Services | • Janie Saucedo, RN, CNI/ HCPH |
| • Linda Gaul, PhD, MPH, Texas Department of State Health Services | • Ashley Steenberger, MPH, CHES, Waco-McLennan County Public Health District |
| • Moss Hampton, MD, Texas Tech University Health Sciences Center | • Elizabeth Stevenson, RN, Texas Department of State Health Services |
| • Jennifer Hensley, EdD, CNM, WHNP, LCCE, UT Austin | • Meliha Salahuddin, PhD, UTHHealth School of Public Health in Austin / UT System Population Health |
| • Kathy Hernandez, LVN, CNI/CDC contracted to Hidalgo County Health Department | |

Group B Facilitators & Attendees

Facilitators:

- Michael Speer, MD, Baylor College of Medicine
- Dorothy J. Mandell, PhD, University of Texas Health Science Center at Tyler / UT System Population Health

Attendees:

- Grady Asher, LMSW, Texas Department of State Health Services
- Ariana Garza, MPH, Chickasaw Nation Industries
- Charleta Guillory, MD, MPH, Baylor College of Medicine
- Manda Hall, MD, Department of State Health Services
- Noemi Hall, PhD, Texas Department of State Health Services
- Alexander Kenton, MD, Mednax
- Debra Lightfoot, RN, Texas Department of State Health Services
- Molly Lindner, MPH, Texas Department of State Health Services
- Sylvia Lopez, LBSW, TTexas Department of State Health Services
- John Loyd, MD, Mednax
- Janak Patel, MD, UTMB
- Carlos Plasencia, MD, MSPH, Department of State Health Services
- Flor Puentes, MPH, CDC/CNI-City of El Paso Dept of Public Health
- Karen Rose, RN, Texas Childrens Hospital
- Rebecca Rubinstein, MPH, Harris County Public Health
- Debra Seamans, MSN, RN, Texas Department of State Health Services
- Jennifer Shuford, MD, MPH, Texas Department of State Health Services
- Jane Siegel, MD, Texas Medical Association
- Linda Townsend, JD, CHRISTUS Health
- Katherine Velasquez, PhD, RN, Texas Department of State Health Services
- Vivek Vijayamadhavan, MD, MEDNAX
- David L. Williams, BS, Quality Oversight - Medicaid CHIP
- Hari Athreya, MD, University of Texas Health Science Center at Tyler / UT System Population Health

Group C Facilitators & Attendees

Facilitators:

- June Hanke, RN, MSN, MPH, Harris Health System
- Nagla Elerian, MS, UT System Population Health
- Mary Isichei, DNP, University of Texas Health Science Center at Tyler / UT System Population Health

Attendees:

- Willie S. Anderson, M.Ed., KAZI
- Lessely Brown-Shuler, RN, Chickasaw Nation Industries
- Nelda Caceres, BSN, RN, CDE, CNI
- Keila Castillo, MPH, CNI Advantage in support of CDC
- Jessica Cinque, none, Health and Human Services Commission
- Sam Cooper, LMSW-IPR, Texas Medical Association
- Evelyn Delgado, Healthy Futures of Texas
- Lesley French, JD, Health and Human Services Commission
- Andrea Gomez, RN, CCM, Texas Children's Health Plan
- Fernando Gonzalez, MPH, Department of Public Health
- Debbie Hart, RNC, CHRISTUS Santa Rosa Health System
- Benjamin Hornstein, PhD, Harris County Public Health
- Janette Ingram, MD, Texas Health and Human Services Commission
- Camille Jackson, MPAff, MPH, HHSC
- Penne Jaster, FNP-BC, Life Choices Medical Clinic
- Janet Jones, MPH, CHES, Waco-McLennan County Public Health District
- Tia Jones, MPH, Waco McLennan County Public Health District
- Martha Lujan, Outreach, LogistiCare
- Sharyn Malatok, MPA, March of Dimes
- Henry Presas, RN, City of Brownsville public health
- Deneice Pryor, RN, Texas Department of State Health Services
- J. Scott Simpson, MD, Seton-Dell Children's Health Plan
- John Teel, MS, RS, Williamson County and Cities Health District
- Darline Turner, BS, MHS, PA-C, Healing Hands Community Doula Project
- Meghan Young, Master of Public Affairs, Health and Human Services Commission
- Ana Navarro, UTHealth School of Public Health in Austin / UT System Population Health



THE UNIVERSITY *of* TEXAS SYSTEM
FOURTEEN INSTITUTIONS. UNLIMITED POSSIBILITIES.



UTHealth
The University of Texas
Health Science Center at Tyler