

Public Health Advisory Board (PHAB)
April 16, 2020
Meeting Minutes

Attendance:

Board members present: Dr. Jeanne Savage, Dr. Eli Schwarz, Kelle Little, Dr. Bob Dannenhoffer, Alejandro Queral, Rebecca Tiel (Chair), Dr. Sarah Present, Dr. Veronica Irvin, Dr. David Bangsberg, Eva Rippeteau, Lillian Shirley (ex-officio), Teri Thalhofer, Muriel DeLaVergne-Brown

Board members absent: Akiko Saito, Carrie Brogoitti, Dr. Dean Sidelinger, Rachael Banks

Oregon Health Authority (OHA) staff: Cara Biddlecom, Krasimir Karamfilov

Members of the public: None

Welcome and Agenda Review

Rebecca Tiel

Ms. Tiel welcomed the PHAB to the meeting. She invited the board members to introduce themselves.

- Approval of March 2020 Minutes

A quorum was present. Ms. Rippeteau moved for approval of the March 19, 2020, meeting minutes. Dr. Present seconded the move. The PHAB approved the meeting minutes unanimously.

Ms. Tiel informed the PHAB that OHA has asked for a three-month extension (until September 30, 2020) on submission of the biennial report to the Legislative Fiscal Office, which includes the accountability metrics report and the public health modernization funding formula. This will allow OHA more time to do the vetting and development needed with PHAB and local public health authorities.

Officer Position

Cara Biddlecom (OHA Staff)

Ms. Biddlecom reminded the PHAB that the board needed to elect a chair for the next two-year period. Ms. Tiel has been the PHAB chair for two years and has offered to reup her chair term for a second term. She asked the board members if they wanted to nominate themselves or other board members to be chair.



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Dr. Dannenhoffer moved for the nominations to be closed.

Ms. Biddlecom informed the board that she would roll call and invited the PHAB members to take a motion on the vote to have Ms. Tiel continue as a chair for another two-year term.

Ms. Biddlecom called Dr. Dannenhoffer. He voted yes.

Ms. Biddlecom called Ms. DeLaVergne-Brown. She voted yes.

Ms. Biddlecom called Ms. Tiel. She abstained.

Ms. Biddlecom called Dr. Savage. She voted yes.

Ms. Biddlecom called Ms. Little. She voted yes.

Ms. Biddlecom called Dr. Irvin. She voted yes.

Ms. Biddlecom called Mr. Queral. He voted yes.

Ms. Biddlecom called Ms. Rippeteau. She voted yes.

Ms. Biddlecom called Dr. Schwarz. He voted yes.

Ms. Biddlecom called Ms. Thalhofer. She voted yes.

Ms. Biddlecom called Dr. Present. She voted yes.

The PHAB unanimously elected Ms. Tiel to serve another two-year term as the PHAB chair.

Updates to PHAB Charter and Bylaws

Rebecca Tiel

Ms. Tiel remarked that, as seen in the packet, track changes have been provided to the PHAB charter and bylaws. These include more specific inclusion of racial equity per PHAB's discussion at the February retreat, and adjustments made to the vice chair position per recent guidance from the Department of Justice. She invited the board members to comment.

Ms. Biddlecom provided background on the charter. The document is based on PHAB's responsibilities outlined in ORS 431.123. Each PHAB duty has its corresponding set of PHAB objectives. Additional duties call out specific roles that the PHAB has taken on as it relates to its role of being an advisory committee for the Preventive Health and Health Services Block Grant



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and providing oversight for health equity initiatives across the public health system. The track changes are not many and are reflective of the board's conversation at the February retreat.

Ms. Biddlecom asked if board members had any changes or additions to the charter.

Dr. Schwarz asked if the board needed a motion to approve the charter.

Ms. Biddlecom answered in the affirmative.

Dr. Schwarz moved for approval of the charter as presented to the PHAB.

Dr. Savage seconded the move.

Ms. Tiel invited the PHAB members to vote on the updated charter. The board approved the charter unanimously.

Dr. Dannenhoffer suggested for the board to ask for the nays first when voting online, because the nays get drowned by the yeas.

Ms. Biddlecom noted that the bylaws had not be updated since they were originated in 2017. The track changes primarily concern the role of the co-chair, with the PHAB moving forward with only having a board chair, rather than having a co-chair position, due to public meeting law. There are minor changes pertaining to elections and timeframe. The bylaws help the board understand its membership, who the ex-officio members are, and how the PHAB meetings will be run.

Mr. Queral pointed out that there was nothing in the bylaws that spoke to setting up the agenda. This might be an area for the board as a whole to have more say. The PHAB chair and OHA staff are deciding the agenda and there are no other voices from the PHAB that are helping the drafting of the agenda. He asked if there was a place in the bylaws for that. Maybe the bylaws are not the appropriate place for that.

Ms. Biddlecom answered that Mr. Queral's proposition would fit under Article III and potentially under Article II, in terms of the role of the chair in soliciting agenda items. Since the February retreat, we have worked into the board's meeting some time at the end of the meeting to identify agenda items for the next meeting. If desired, language could be added under Article II and Article III.

Mr. Queral stated that it would be useful to have that institutionalized under this agreement.

Ms. RippetEAU supported Mr. Queral's suggestion and wondered if there could be a living document where the board could provide suggestions, a document that all PHAB members

could access. Then either the chair or OHA staff would determine what is appropriate to bring up in a specific timeframe and board members have a way to check back in on agenda item ideas as well.

Ms. Tiel remarked that one of the things the board would be doing at the end of the agenda was to list new agenda items. The board hasn't done it because it has had only one meeting since the February retreat. She asked if Ms. Rippeteau's idea was to have an offline way to propose ideas, instead of having it in the bylaws that the agenda items happen through the chair in partnership with OHA staff.

Ms. Rippeteau responded that what she meant was a way of board members to say, "I've thought of this," and have some informal way of communicating ideas, or they experienced something in between meetings, something important enough for them to bring up sooner rather than later. Ideas might fall into "things to check at legislative time." This can be created so that the board members are not throwing out ideas and having them lost in an email string. She asked if the board had a living document, or spreadsheet, where the board members could suggest things and get feedback on them. Maybe it happens at the end of meetings and that is just the way it is.

Ms. Tiel asked Ms. Biddlecom if the board should bring the document back or take the proposed direction and vote to approve and then bring back a revised version at a future meeting.

Ms. Biddlecom answered that she would be happy to do whatever the board would like to do in terms of reviewing the final version with these additions or moving it forward with additional text to be added around soliciting agenda items and adding agenda items being the role of the full board.

Dr. Schwarz asked the PHAB members if anybody has had any trouble communicating with Cara about possible agenda items or things they wanted to discuss. He has had a couple of issues or questions and Ms. Biddlecom has been extremely responsive. He wasn't sure what the board would be gaining by having this discussion around the bylaws. The other possibility is to ask the board, at the beginning of the meeting, to approve the agenda and ask if anybody has anything to add to the agenda. That could be taken up during the meeting.

Ms. Rippeteau remarked that her opinion was not meant to reflect the PHAB chair or OHA staff. She meant finding a way for the board to be engaged in and having things listed somewhere, in a way for all to have access to. If some board members have the same question, how do they address that without having the quorum issues? Lengthy discussions about issues over email are also possible.

Mr. Queral clarified that it was about institutionalizing the practice, not about the OHA staff or the chair or the composition of the PHAB. It is to ensure that future boards are able to do that as a matter of practice.

Ms. Tiel supported the idea and proposed to the PHAB to take action on the bylaws with the track changes and the direction to OHA staff to include institutionalizing the board's practice around how the board builds its agendas. The PHAB can take an action now and see a final version in a future meeting packet. If there are still questions, they will be addressed at a future meeting.

Ms. Rippeteau moved for approval of Ms. Tiel's proposal.

Ms. Tiel asked the board members if anybody was opposed to the motion. The PHAB approved unanimously the bylaws with track changes and additions.

Review PHAB Work Plan

Cara Biddlecom (OHA Staff)

Ms. Tiel remarked that the workplan had been updated to reflect the priorities discussed at the February retreat. Deliverable dates have also been adjusted due to the COVID-19 response.

Ms. Biddlecom stated that the workplan was shared with the board at the last PHAB meeting, but time ran out to discuss it. As a result, some dates have been shifted around. In terms of leading with race to achieve health equity, one of the things we wanted to do after the board approved the charter and bylaws was to go back to equity review policy and procedure and ensure that the tool was updated in a way that helps the board further its goals and is reflective of the leading with race framework to equity.

Ms. Biddlecom added that the preventive health and health services block grant would be coming in future months. OHA is receiving guidance from CDC around deadlines and submission in light of COVID-19, which is something OHA has provided to LPHAs, in terms of trying to adjust deliverable timeframes.

Ms. Biddlecom noted that under public health modernization, in previous years, OHA has brought forward the regional public health modernization grantees to talk about their work. In late 2019, OHA started a different framework for bringing those presentations and information to the PHAB, with the focus on programs and core system functions of public health. This will be brought forward when there is more bandwidth for staffing and longer meetings. Two of the other deliverables are around the public health modernization funding formula and the annual accountability metrics report. Due to staffing and the need to fully vet both of these items more broadly with the public health system, OHA has asked the legislature for a 3-month extension on submission of the biennial report to the Legislative Fiscal Office that includes the new public

health modernization formula for the next biennium and the accountability metrics report, among other things. We hope to get started back on that with the PHAB subcommittees this summer and hit the September 30 submission date for those four products.

Dr. Schwarz asked if there was any prioritization in the workplan or if it was captured by the calendar at the top of the timetable.

Ms. Biddlecom answered that the OHA team didn't sort the items by priority, but by the timeframes the deliverables had to hit. These are deliverables associated with the legislature, deliverables associated with public health accreditation, CDC, and general board operations that happen in a cyclical fashion. Everything that is on the timetable has something guiding it to make it a priority.

Dr. Schwarz shared that he would imagine somebody asking about public health funding in a situation where the lack of preparedness has become so evident for everybody that a lot of that has got to do with funding public health at a level where it can respond to emergencies. He wondered if that might be of interest to the PHAB, as well as to the legislature, when they come back.

Ms. Biddlecom explained that the second page of the timetable gave a little bit more detail about the purpose of each of the workplan items and the associated decisions, deliverables, and agenda topics that are anticipated to go along with them. We are pushing those back a couple of months to adjust for more time for sufficient vetting of PHAB work and decision making.

2020-2024 State Health Improvement Plan

Elizabeth Gharst (OHA Staff)

Ms. Gharst introduced herself as the social influences on health strategist in the Director's office of the Public Health Division. She had been filling in for Ms. Christy Hudson as project manager for the SHIP. It's been over a year since the last SHIP update to the PHAB. At the last update, the work was at choosing the priorities. As shown in the presented model, there are five priority areas that have been developed within the SHIP: institutional bias; adversity, trauma, and toxic stress; behavioral health; access to equitable preventive services; economic drivers of health. The focus is on affecting change on three levels: individual, community, policy. Priority populations include people of color, people with low-income, people with disabilities, people who identify as LGBTQ+, and people experiencing geographic disparities (e.g., people in rural areas). The strategies for each priority area focus on the whole lifespan, with emphasis on the needs of children and older adults.

Ms. Gharst added that the five subcommittees included 97 representatives from 62 organizations. The partners included community-based organizations, tribal partners, state



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agencies and other implementation partners, subject matter experts, health system partners (e.g., CCOs, LPHAs), and people with lived experience.

Ms. Gharst noted that the subcommittees began meeting in August 2019. The first thing they worked on was to identify goals and determine outcome indicators. Starting in November 2019, the work has been focused on identifying policy, community, and individual level strategies and process measures. In mid-March, the SHIP was presented to the PartnerSHIP, which is the external body that is helping guide the development of the plan, and they approved it to go out to community feedback. Originally, the community feedback period was going to happen in April and the intent was to try to get a lot of in-person feedback. Because of COVID-19, plans and timeline had to be readjusted. Everything is shifted back a month.

Ms. Gharst remarked that the community engagement period is going to happen in May. The OHA team is exploring ways with the community-based organizations to provide feedback on the plan. Next month, the subcommittees will meet to develop process measures, which will help us be accountable for each of the strategies. In June, the subcommittees will incorporate the community feedback into the plan. In July, the PartnerSHIP will meet and approve the final SHIP. In August, the SHIP will be launched and implementation will begin.

Ms. Gharst highlighted the SHIP components and how they worked together. There are goals for each of the priority areas. OHA asked the subcommittees to focus on developing 2-3 goals per area. There are broad strategies on how the goals will be achieved. Each of the process measures will be separate data points that will indicate the progress on each strategy. Underneath the goals, there are also outcome indicators that will provide accountability for tracking progress. The outcome indicators are also useful for communication and will represent examples when talking about the work and its progress.

Ms. Gharst explained that as the subcommittees had been meeting and developing strategies, the process was to come up with a brainstorm of strategies. Most subcommittees came up with 50 to 70 strategies. Then the subcommittees narrowed down the strategies to 10-15 by using eight criteria. The criterium *relevant to community* will be the focus during the community-engagement period in May. The hope is for the organizations to contact people and give them information about the SHIP work and see if the information resonates across communities.

Ms. Gharst clarified that the aim was to assemble 10-15 strategies per priority area for a total of 50-75 strategies. It is understood that the priority areas are interconnected and their division is artificial. Many of the sub-priority areas overlap (e.g., housing, food insecurity) and many of the strategies may be in more than one layer of the framework. The working SHIP is not the final plan, as it will evolve after the community engagement and vetting period. Once the plan is finalized, the aim is to create a logic model or driver diagram to illustrate connections between strategies in different priority areas.

Ms. Gharst presented the selected strategies under each goal for each of the five subcommittees. She asked the PHAB to review the strategies and provide general feedback or feedback on specific strategies. Board members can send an email to Ms. Biddlecom, who will pass the feedback onto the SHIP team. The team will gather the feedback and bring it to the subcommittees in May for discussion and incorporation into the final plan.

Ms. Gharst presented the proposed outcome indicators. The reason Economic Drivers of Health has five indicators, instead of three, is because the strategies were divided into three subgroups: economic viability, food insecurity, and physical environment. The new SHIP is a shift from the 2015-2019 SHIP, which was more focused on meeting specific targets and different data points. The targets in the 2020-2024 SHIP will be the strategies. The outcome indicators will be used to monitor work progress.

Dr. Savage acknowledged the enormous amount of work done by the OHA team and praised it.

Dr. Schwarz seconded Dr. Savage's praise and added that the SHIP framework was very useful. He asked how the SHIP aligned with Healthy People 2020, which was much broader, and if the outcome indicators aligned with the accountability metrics. The only area that is overlapping is access to equitable preventive health care. The outcome indicators are somewhat different than the indicators in the public health report.

Ms. Biddlecom answered that, for this year, intentionally, the accountability metrics would get a basic update and not an overhaul. When OHA first set out to develop the accountability metrics, the team used the SHIP, the CCO incentive measures, and the early learning measures as guideposts for aligning across systems. The new SHIP will challenge the PHAB to look at how we move a little bit further into the space of social determinants of health, potentially using some of the new SHIP measures and making adjustments to the measure set in the future. There are a lot of nuances to work out, but the hope is for the board to go on that journey.

Dr. Dannenhoffer commented that he saw the subcommittees and who was in them, but he didn't see many people from the local public health authorities.

Ms. Biddlecom remarked that local public health was represented on the PartnerSHIP, which is the bigger community-based group that has provided leadership. It was intentional, based on feedback from CLHO early on, that local public health representation included jurisdictions of various sizes and geographic areas of the state, so that different perspectives on the work are expressed.

Ms. Gharst added that the local public health representation had been really helpful, particularly in bringing in the rural health perspective. All subcommittees relied on that. These representatives brought their valuable perspective in terms of their unique needs. The local public health has been great in helping the subcommittees understand those needs and

formulate and create some of the strategies. A number of strategies are specific to rural populations and affecting change in rural areas.

Dr. Dannenhoffer stated that he had gone through the rosters of all subcommittees and he couldn't see a single local public health administrator. He asked if he had missed them.

Ms. Biddlecom answered that there were local public health representatives on the subcommittees who were not administrators.

Ms. Gharst agreed with Ms. Biddlecom and noted that there was one local public health administrator on one of the subcommittees, but she had to step off. It was allowed for all levels of administration to join a subcommittee or send a delegate. If there was someone who the administrators wanted to join a subcommittee in their stead, the administrators were able to have a delegate join. That might be part of what happened.

Dr. Dannenhoffer pointed out that if the OHA would be asking now the LPHAs to implement the SHIP, with the LPHAs not having been deeply involved in the process, the plan would be a much harder sell.

Ms. Shirley responded that it was only fair to say that a lot of the invitations went out. It's not just a governmental public health plan. As evident from the subcommittee rosters, it is a state health improvement plan. OHA has been moving into best practices for public health to identify what its role is, not to just work within its own confines, but also to provide for populations as a whole in different sectors and how they can contribute to the health in their communities. That's why the subcommittees have such robust participation across the education sector and the transportation sector and so on. It's not a limiting factor, but a widening factor, an opening factor to having real public health practice and public health's contribution to the overall health be broader than just healthcare or just specifically around governmental ORSs.

Ms. Thalsofer shared, in the spirit of transparency and honesty, that the first time this process was presented, she had concerns. Looking at today's presentation to the PHAB, she is thrilled. This is a great plan. She loves that there is so much thought about rural engagement and people of color. It really meets what the board talked about at the February retreat, namely, leading with racial equity. It is impressive. What is going to be a real struggle until the state is fully funded for a modernized public health system is the implementation of many of these strategies by the governmental public health system because of the siloed funding streams currently in place. Just raising the policy needs between health and economic drivers is huge. She praised the presentation and was excited to see the final version.

Ms. Shirley thanked Ms. Thalsofer and added that given what OHA has learned about the impact of coronavirus on the economic health of working families, looking at the economic

drivers of health, food insecurity, adversity, trauma, toxic stress – these are areas that are going to have an exponential impact on the health of Oregonians during and after this pandemic.

Ms. Rippeteau asked if the OHA team was considering the metrics with coronavirus and the impact on the indicators across the board, specifically the economic impacts.

Ms. Biddlecom answered that the way the SHIP had been discussed was born out of a critical community need before coronavirus was in the picture. It was already known that there were significant disparities that needed to be addressed and that the work needed to move upstream in order to tackle them. It has become even more critical now that coronavirus is devastating communities that were already left behind relative to others. The OHA team has not set benchmarks for each of the proposed outcome indicators. If the OHA team had done that prior to coronavirus, they might have looked much different than they would now for the 5-year SHIP.

Ms. Rippeteau echoed Ms. Thalhofer's comment and excitement about the many different issues covered by the SHIP.

Dr. Irvin asked why the outcome indicators were limited to three and whether there were plans for broadening them. For instance, in the economic drivers of health area, there is a question that is asked of students in the Oregon State University student health survey that might be able to supplement that area.

Ms. Gharst answered that the number of outcome indicators was related to efforts to deemphasize the data. In the previous SHIP, the focus was on meeting targets. With the new SHIP, it's a transition in the way we are thinking and the way that we are working. We will be still accountable to certain targets, but we want to try to affect change through the strategies. The process measures will be very important, as they will be tracking either new and different ways of working or scaling up existing interventions. The process measures will track if we are making progress on these strategies. With the outcome indicators, rather than being the actual target of where we are trying to go, we are changing and shifting a little bit, so that we are still trying to make changes and move forward, but we are not having this be the sole focus. The tracking will answer questions such as: Are we making changes? Are we building partnerships? Are we getting out of our siloes as state agencies and working together to affect changes in these areas? Are we bringing in different partners that we haven't brought to the table before? That's how we ended up having only a few data points, in comparison to what we had before with the last plan.

Ms. Tiel shared that she appreciated the conversation about how public health would use metrics and indicators in the future.

COVID-19 Response Update

Lillian Shirley

Ms. Shirley shared that in addition to the updates, the board members could access and find on the OHA website the daily update, which gives real-time information on COVID-19. The report provides the new cases and deaths in the last 24-hour period, as well as cumulative testing results, age, sex, hospitalizations, race and ethnicity, and other select symptoms. OHA is working with local public health to obtain race and ethnicity data more robustly into the reporting system. This week, OHA assembled a team of students – which we call the Recovery Team, who are interviewing people who have been ill and have recovered to fill in better case investigation reports, so we have better understanding of who and what the underlying conditions are and the circumstances of people who are positive.

Ms. Shirley noted that the epi curve was looking good. We have flattened the curve quite a bit. We originally anticipated that the state would hit the surge at the end of April. It looks like the state may have already hit the surge, if all goes well and people stay home and maintain the social distancing activities, which cause a lot of hardship to the people of Oregon, but the directive seems to be working. The COVID-like visits make up a very small proportion of reported emergency department visits. The percentage of COVID-like visits has been decreasing. These are all good indicators.

Ms. Shirley stated that OHA was now engaged in updating a lot of its guidance. While testing capacity has expanded, the state is not where it should be. Testing is not just simply a test done in a lab. We have to get the right collection materials, the right transport media, and get it to the lab. All of these elements of getting a test have been, in a variety of times and places along the way, in short supply. We are increasing our capacity in the state. OHA is also working on guidance to expand the testing priorities, as the state has additional capacity.

Ms. Shirley pointed out that OHA was also working on Reopen Oregon. Dr. Dannenhoffer is a member of Governor Brown's medical advisory panel that will be reviewing and reflecting on recommendations that have come forward for things like opening for non-urgent hospital procedures and the next stage, which has to be active surveillance. Just good, old-fashioned, shoe leather public health – find the case, find their contacts, isolate them, put them in quarantine and, whether they are in isolation or quarantine, support them and their family in their circumstances while that is happening. OHA is putting together its own version of a public health workers army to be able to do that and we have a short deadline to get a plan together, which will be next week. If the plan gets approved, then OHA will move forward with the implementation. This will take up a tremendous amount of public health visibility and workforce energy over the next 4-8 weeks, if not longer.

Ms. Shirley informed the board that, today, OHA received a document from the White House, the White House's opening guidance to Governors. The guidance looks a lot like the models



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OHA has been looking at. We are getting aligned. OHA is in close communication with its West Coast partners, including Alaska. OHA is looking forward to moving into active surveillance and opening up the economy in a reverse engineering way, but also being very careful about identifying cases and identifying contacts, so that we know if we have gone too fast. We don't want to put people at risk.

Ms. Shirley explained that the other special population that OHA has spent a tremendous amount of energy on and achieved good outcomes with systems changes was the population in congregate care settings. OHA is very encouraged by the fact that the Department of Human Services and public health will come out of this with a really strong structure of collaboration and working together to protect elders in congregate housing, not just from COVID-19, but also from all other risk factors in those settings.

Ms. Shirley responded to a question about the risk factors that were seen the most. This information is reported in OHA's weekly COVID-19 update. She invited the PHAB members to make use of the OHA website and encouraged them to provide feedback on guidance or other information that OHA was failing to provide for the community at large. Everybody at OHA is trying their best to be transparent and also trying their best to get input from communities. We have over 500 community-based organizations that participate in a weekly call. OHA meets twice a week with local public health and tribes for two-way information and trying to make the COVID-19 response a whole system response.

PHAB Member Discussion

Rebecca Tiel

Ms. Tiel remarked that this was the time for the PHAB to discuss issues it should be aware of or should help problem-solve on behalf of the public health system. It is also the time for board members to suggest agenda items for future meetings.

Ms. Biddlecom stated that the topic of PHAB member roles and liaison responsibilities came out of a discussion at the retreat about the constituencies each member represented. There was a request to better understand expectations. Broadly, the role each PHAB member represents is in Oregon statute and is designed to comprise the board with different types of public health expertise. There isn't a specific requirement that each member should be representing every single person in their constituency. Bringing the expertise to bear from the role each member has in their individual work is what is important.

Mr. Queral commented that in relation to the SHIP area connecting economic well-being with health, it was important to understand from a public health perspective what that meant, what role public health had in framing that message, and what were the metrics public health might focus on as proxy indicators or direct indicators of social determinants of health. He would like to see a more robust discussion around that, with the discussion using an equity lens.



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Dr. Dannenhoffer remarked that modernization had been brilliantly prescient at picking out the issues that we would see with COVID-19. One is the tremendous racial disparity in deaths in this outbreak. The second is the need for good, old-fashioned public health work, especially working as regions. The third is good connection between LPHAs and the state. This has shown how important modernization is.

Dr. Schwarz noted that there were a couple of other webinars that were running in parallel with the PHAB meeting. There was one on COVID-19 just before the PHAB meeting with Dr. Dana Hargunani (OHA's Chief Medical Officer). One of the things that Dr. Schwarz has been missing is the relationship to the Medicaid population. Oftentimes the PHAB has discussed that the board is focusing on the entire population, and the Medicaid population is taken care of by the CCOs, and the collaboration between LPHAs and CCOs has been highlighted a number of times. In a situation like this, it is hard to imagine that we will not be faced with a very serious situation over the next year or so, hopefully a little bit less. All CCOs are waiting for another 300,000 people to join Medicaid, even though not all have arrived yet. With such a huge number of people in economic distress, one would expect the Medicaid population to be growing. It is starting to look like a population-wide problem – not only for Medicaid, but something that has to be addressed by both the public health system and the CCO system in general. It is something the PHAB needs to be aware of and find a way to talk more about it directly.

Ms. Tiel asked the board members to propose specific agenda items for the PHAB meeting in May.

Dr. Schwarz asked for a longer COVID-19 update and orientation during the next meeting.

Dr. Bangsberg welcomed more discussion around how we move towards surveillance and contact tracing strategy with COVID-19 that would be critical for the back-to-work strategy.

Dr. Savage suggested looking at the data across the state on how COVID-19 was affecting disparities and different populations, and what CCOs and public health were doing in those populations in response to those differences. Also, a discussion and presentation about what some of the CCOs are doing in their areas, whether they are partnering with public health in projects, or what difference CCOs are making. OHA has been eliciting feedback from the PHAB. A presentation on what the different CCOs are doing would be valuable.

Ms. Tiel thanked the board members for their suggestions.

Public Comment

Ms. Tiel proposed the public comment to be kept to three minutes per person.



Ms. Biddlecom suggested two minutes per person, because there were questions in the chat box. The comments will alternate between the phone and the chat box. She instructed members of the public on the phone to state their name before speaking.

Ms. Brittany Ruiz introduced herself as a parental rights advocate in Yamhill County. She has become a subject matter expert on the coronavirus antibody test and the PCR test, because all of us want to figure out what we need to do to help the vulnerable populations, and separate those from the non-vulnerable populations, and get people back to work. After listening to this entire phone conversation, she remains very concerned that the state is not focused on priorities, not only to focus on the at-risk populations, but also the fact that it took weeks for Oregonians to get the actual at-risk populations information. She would like to encourage, based on statutes she just read, the county public health departments made local decisions at this point.

Ms. Ruiz disagreed that Oregon was making decisions off of California's public health system, or Washington, or Alaska. In her view, the state needed to be making decisions on a by-county basis, based on state statistics and not on models. She kept hearing that OHA referred to models. The Attorney General said two days ago that models were a joke and completely not true. She would like to see more discussions and more focus on statistics in Oregon's counties and would like to encourage county public health departments to start making local decisions to get the communities back to work, based on their statistics and their at-risk populations being under control.

Ms. Ruiz added that, based on a call she was on earlier today with OHA and the Coalition of Local Health Officials (CLHO), she didn't see an urgency on funding both at a county level and by OHA to get full funding and facilities, both local and private, opened up to test folks for antibodies and PCR testing. That does not seem to be an urgent issue. When she asked about it, the state was only at capacity for 20,000 tests. That's very, very low. She would love to see more urgency over how the state can do localized public health versus broad or using other states' metrics. She would like the state to use Oregon's metrics and Oregon's statistics and make sure that the advice was getting to the Governor. It didn't seem to be getting to her.

Ms. Biddlecom read a comment from the public: "I'm a member of the public. Listening to this call today, I'm concerned about how little time on this call was devoted to serious discussion of COVID-19 next steps, etc. Feels like we need a lot more urgency here now." She invited the public member (Andrew) to add anything, if he wished.

Ms. Biddlecom read another public comment: "I'm a public education employee, trauma-informed education specialist, and autism specialist. Contact the school districts if you want input about what vulnerable populations are experiencing. We are speaking to them regularly. I'm wondering if OHA or Kate Brown is consulting with immunologists. I think COVID has been through our valley this winter. We need antibody testing."



Ms. Biddlecom read another public comment: “As I may not be able to stay on until public comments, I have an off-topic suggestion to present now. It is my understanding that Oregon medical providers do not need to keep records over 10 years. My suggestion is to have an archive of some sort that patients or medical providers could access medical records over 10 years of age.”

Mr. McDaniel from Crook County wondered if any PHAB members could share what some of the contact tracing options were.

Ms. DeLaVergne-Brown introduced herself as the public health director in Crook County. Public health staff in Crook County have been doing contact tracing for many years for lots of different communicable diseases. With the one COVID-19 case Crook County had, public health staff followed up and continued following up with that individual. That’s how that process has worked for years. Also, additional staff, who are nurses and know how to do contact tracing, are being trained specifically for COVID-19, so they can also be backup, if the county has more cases.

Mr. McDaniel asked if that satisfied Governor Brown’s ask, as far as being one of the issues on contact tracing, and if there was more to that.

Ms. DeLaVergne-Brown answered that all counties across the state were working on this. That is the definition of contact tracing. Part of what we are going to look at on the state level is to make sure that the state has a really robust system. If any of the counties felt overwhelmed by getting a lot of cases, there is backup to be able to help with that. In the tri-county area that includes Crook County, there is a tri-county nurse who helps with all three counties. There is already a system set up to do contact tracing. If the county got more cases, it would bring in more individuals who will be able to do that.

Next Meeting Agenda Items and Adjourn

Ms. Biddlecom thanked the PHAB members for the many agenda item suggestions for the May meeting. The proposed agenda items will be worked into the agenda. She expressed appreciation for everybody’s efforts in the COVID-19 response and for the time they took to join the meeting. She adjourned the meeting at 3:31 p.m.

The next Public Health Advisory Board meeting will be held on:

May 21, 2020

2:00-3:30 p.m.

Join Zoom Meeting

<https://zoom.us/j/730818593>



Public Health Advisory Board
Meeting Minutes – April 16, 2020

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