

# AGENDA

## PUBLIC HEALTH ADVISORY BOARD

**November 21, 2019 2:00-5:00 pm**

Portland State Office Building

800 NE Oregon St.

Conference Room 177

Portland, OR 97232

Join by conference line: 1-877-873-8017

Access code: 767068#

Meeting objectives:

- Discuss public health modernization funding to federally-recognized tribes and NARA during the 2019-21 biennium.
- Discuss public health modernization work underway with local public health authorities.
- Learn about how syndromic surveillance is being used to determine Hepatitis C prevention activities in Eastern Oregon.

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**2:00-2:20 pm**

**Welcome and agenda review**

- ACTION: Approve October meeting minutes
- Update on PHAB mini-retreat
- PHAB member transitions and acknowledgments
- December meeting schedule
- Solicit volunteers to develop 2020 Public Health Accountability Metrics Report

Rebecca Tiel,  
PHAB Chair

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**2:20-3:05 pm**

**Public health modernization initiatives**

- Learn about 2019-21 public health modernization efforts underway to improve local, regional and statewide capacity for routine and surge epidemiological functions.
- Understand unique and interrelated functions of state and local public health authorities.

Heather Kaisner, Deschutes  
County Public Health

Teri Thalhofer, North  
Central Public Health District

Emilio DeBess, Oregon  
Health Authority

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**3:05-3:35 pm**

**Tribal public health modernization**

- Discuss plans for funding to federally-recognized tribes and NARA for public health modernization during the 2019-21 biennium

Kelle Little,  
PHAB member

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**3:35-3:50 pm**

**Break**

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**3:50-4:20 pm**

**Eastern Oregon Hepatitis C prevention initiative**

- Discuss efforts to prevent Hepatitis C in Eastern Oregon using a syndemic approach

Jude Leahy and Ann  
Thomas,  
Oregon Health Authority

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**4:20-4:35 pm**

**Public comment**

Rebecca Tiel,  
PHAB Chair

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**4:35 pm**

**Adjourn**

Rebecca Tiel,  
PHAB Chair

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Public Health Advisory Board (PHAB)

**DRAFT** October 17, 2019

Meeting Minutes

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**Attendance:**

Board members present: Dr. David Bangsberg, Dr. Jeff Luck (by phone), Akiko Saito, Dr. Jeanne Savage, Rebecca Tiel, Dr. Eli Schwarz, Kelle Adamek-Little (by phone), Dr. Paul Lewis (by phone), Dr. Bob Dannenhoffer, Dr. Dean Sidelinger, Eva Rippeteau, Lillian Shirley, Teri Thalhofer (by phone), Tricia Mortell, Carrie Brogoitti

Board members absent: Alejandro Queral, Muriel DeLaVergne-Brown

Oregon Health Authority (OHA) staff: Cara Biddlecom, Krasimir Karamfilov, Dr. Kusuma Madamala, Dr. Julie Maher, Kirsten Aird, Dr. Bruce Austin, Amy Umphlett, Karen Girard, Cate Wilcox

Members of the public: Sierra Prior (CLHO)

**Welcome and Agenda Review**

*Rebecca Tiel, PHAB Chair*

Ms. Tiel welcomed the PHAB to the meeting. She introduced herself. The PHAB members introduced themselves.

- Approval of September 2019 Minutes

A quorum was present. Dr. Savage moved for approval of the September 19, 2019, meeting minutes. Ms. Rippeteau seconded the move. The PHAB approved the meeting minutes unanimously.

Ms. Tiel followed up on two items from the PHAB meeting on September 19, 2019. First, she hoped all board members received the link to and took the 3-item survey related to the presentation on water strategy. Second, she directed the PHAB to page 23 in the meeting packet, which explained the funding for OHA public health responsibilities in Wallowa County.

- Update on PHAB Mini-Retreat at November Meeting

Ms. Tiel informed the PHAB that there is a scheduling conflict with another conference that several board members will be attending in November. Scheduling requests for the retreat will be coming soon from OHA.



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Ms. Biddlecom added that OHA staff are trying to identify the guest speakers, who previously had been able to make the November 21, 2019, date, and see whether they could participate on another date. As soon as the new date is confirmed, OHA staff will inform the PHAB.

- *Fair Housing Coalition of Oregon Bus Tour Discussion*

Ms. Tiel remarked that on September 26, 2019, several PHAB members participated in the Fair Housing Coalition of Oregon Bus Tour. She asked the board members for their reflections on the experience as it related to the PHAB.

Dr. Schwarz stated that it was very emotional experience. When he received the invitation, he thought that the PHAB was going to look at housing units. The tour took the board members to all dark corners of Oregon's history. He thanked Ms. Tiel for arranging the tour. It was fascinating and a little bit eerie. The three guides on the bus had their own experiences to share. He had nightmares during the night after the tour.

Dr. Sidelinger noted that the bus tour was very interesting and thought-provoking. One needs to know one's history to move forward. The board members saw a few successful new projects. Maybe a few more successful projects could have been peppered in, so it wasn't such a down day.

Dr. Savage noted that the tour opened up a discussion with a lot of people who weren't in public health and hadn't had that experience. She had more conversations after the tour – starting with the tour, but then moving forward to what public health was, why she was there, and what the PHAB did. The tour started a conversation not just about the amazing history, but also about what public health was and what it did. It was fantastic. She thanked Ms. Tiel and shared that she felt lucky that she was able to go.

Ms. Tiel commented that, initially, she thought the tour would be focused on Portland and the Portland metro area. The tour guides presented a few examples from the history across the state, including Ontario and Southern Oregon. The guides did a great job talking about Oregon's history and the institutional history Oregon had. It's great for the PHAB, as the board is starting to think about big systems changes and their intended and unintended consequences. It was also very emotional and hung with her. She thanked the OHA staff for giving the PHAB that opportunity. If any PHAB members wanted to take their staff at their organizations on the bus tour, they should reach out to the Fair Housing Council and arrange it.

Ms. Tiel introduced the next agenda item, Public Health Modernization Evaluation, presented by Program Design and Evaluation Services staff at OHA. The group is heading up the development of the 2019-2021 evaluation project. The intention of the presentation was to elicit feedback from the PHAB, as OHA staff are planning the evaluation, and make sure that the

types of questions that PHAB members may have would be answered in the design of the evaluation.

### **Public Health Modernization Evaluation**

*Dr. Kusuma Madamala (OHA Staff)*

Dr. Madamala introduced herself and shared that it was her first week in Program Design and Evaluation Services at OHA. Her background is in public health systems and services research. She outlined the main points that she would cover in her presentation and showed the PHAB a conceptual model for measuring the performance of a public health system by [Handler, Issel, & Turnock \(2001\)](#). She called attention to the outcomes, which included effectiveness, efficiency, and equity. These outcomes are articulated in OHA's models for performance used by the Public Health Accreditation Board and in the foundational public health services model, which is the model for Oregon. It's about improving consistency of service delivery.

Dr. Madamala asked the PHAB three questions: Who are the priority audiences for the evaluation? What would successful modernization implementation look like at the end of the 2019-2021 biennium? What would the PHAB want to see in a final report? The state is collecting for the workplans' performance management data, which includes the regional government structure, partnerships, communicable disease outcomes, and how resources are used. That's being collected for the performance management piece. What can we collect for evaluation that's different than what's already being collected in their workplans?

Ms. Tiel remarked that, based on her experience in healthcare and public policy, the evaluation services is a tool that is shared with decisionmakers, whether that is legislators or local elected officials. It's an important tool to talk about.

Dr. Bangsberg stated that each CCO has a Community Advisory Council and there was going to be a broader representation of the community, including public health representation. That would be an important group to include.

Dr. Luck added that audiences outside Oregon could be included, such as researchers in public health, as well as practitioners at ASTHO (Association of State and Territorial Health Officials) or NACCHO (National Association of County and City Health Officials).

Dr. Savage said that she didn't know what the role of a school system would be in terms of evaluations. There is an effort to get more schools involved with health. Is there an intersection?

Ms. Rippeteau noted that the legislators would be an appropriate audience. It could be organized as a committee hearing, but the PHAB could probably invite legislators to have a discussion more broadly than just having a presentation at the legislative office.



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Dr. Bangsberg remarked that the Oregon Health Policy Board had several listening sessions throughout the state and had productive meetings with members from different parts of the community. The PHAB could spend time with the representatives from the Office of Equity and Inclusion and think about how to access the most marginalized groups, such as people of color, the homeless, and people who usually may not make it to the table. They would be the most important people to contribute towards changes in health equity.

Dr. Madamala invited the PHAB members to provide feedback on the second question, related to successful modernization implementation.

Dr. Schwarz stated that successful modernization implementation would be something like ensuring that the gap of \$200-\$300 million that was needed for building out the public health infrastructure, is transformed into a state where all public health agencies had the foundational capabilities and programs in place.

Dr. Lewis suggested doing a before-and-after to see what got better. It's probably going to be spotty, but that could be informative.

Ms. Thalhoffer noted that the PHAB needed to continue to use the assessment that was done and continue to go back to the modernization manual and use it as an assessment to see whether things are getting better. This might be the last biennium with funding for regional projects. As the fiscal agent for a very large regional project, there needs to be some attention to how that transition is going to take place. Although all the funding will roll out based on the funding formula, how would the PHAB maintain and support the cross-jurisdictional efforts where it doesn't have to be LPHA by LPHA?

Dr. Luck echoed Ms. Thalhoffer's words about remaining anchored in the assessment. One of the one-page summaries from the assessment was the patchwork quilt that had columns for counties and rows for foundational programs and capabilities. The PHAB could look at that again, potentially zooming in on the rows that were priorities for the biennium. That would be an important way to present results and, of course, using the accountability metrics that Dr. Schwarz, Ms. Thalhoffer and others developed.

Ms. Rippeteau pointed out that successful modernization implementation leads to the legislature. The PHAB could back to the analysis and be able to say, "Here's what we have been able to do with this little bit of money that you have invested," and really make the case for the larger investment, with the needs assessment being so much larger than what the legislature funded. In a way, saying, "We were successful in doing this little bit with this much, but if you continue to expect more and need more from us, you are going to have to make these bigger investments, and here's why."

Ms. Mortell added that, for her, without disparaging what Ms. Thalhoffer said about regional, [successful modernization implementation] was moving from projects to systems change. How do we tell that story when we are barely there, scratching the surface, but need to keep moving in that direction? The PHAB should not think of implementation as projects.

Ms. Rippeteau agreed that we were barely there, but some programs had to let go of frontline workforce as of July 1, 2019. How do we say [to legislators], 'What you are giving us isn't enough to maintain the staff that we need to do this work and build on it'?

Dr. Bangsberg explained that there were two types of outcomes: (a) outcomes, which are public health metrics, on which the PHAB members spend a lot of time on and are well-established, and (b) process measures that measure whether the capabilities really are in place. The PHAB hasn't spent much time thinking about how to measure that. He hasn't heard a discussion about what those process measures are and how to measure them throughout the state. That would be a good project.

Dr. Madamala stated that some of these process measures were in and came from the work plans, but they were related to the partnerships and regional governance structures. Following up on what Ms. Mortell said earlier, she wondered how we could measure the interaction between the local public health performance and the state work on public health performance as a system. Some examples include timely input of local data into the state system, braiding or blending funds, shared advocacy for state and local policy change, and exploring areas in the modernization manual where state and local depend on each other. Oregon is unique in having a modernization manual, which is like a roadmap, compared to other states. We can use the manual to look at the intersection between the two levels of government. She asked the PHAB if that was a good area to explore and if there were other areas where the local and state system interacted.

Dr. Schwarz pointed out that what would be particularly powerful in that regard was having some case examples. He remembered from the time when the PHAB was discussion cases for collaboration between CCOs and the public health agencies that there was member in the group, Safina from Columbia Pacific CCO, who exposed a lot of collaborative efforts. There's nothing as powerful in a report, because these reports could be extremely dry. They have boxes that highlight successful and not successful collaborations, or examples of what went wrong and why it went wrong. Oftentimes, we get brief descriptions. The PHAB has done a lot of work over the last couple of years with the regional projects and the two annual reports to the Metrics [Committee]. There is a lot of material that should be presented in an appetizing way.

Ms. Mortell remarked that timely input of local data in to the state system is not enough. We need to know what we are going to do with the data, how we are sharing it, and how we are communicating it to the public.

Dr. Madamala shared that another thing she was thinking about was cross-sector partnerships that related to systems change, so it isn't just the governmental. She could explore the alignment across sectors of financial structures, governmental structures, and partnership structures that play a role in the advancement of the system. The next potential evaluation area is around changes in capacity and expertise in the capabilities and programs. It's about going back and possibly developing a map to see the changes in capabilities and programs over time. Because those were self-reported metrics, it would be good to validate some of those measures. Possible examples include response time, accurate reporting, screening and follow-up treatment to back up the self-reported data in both the capacity and expertise areas.

Ms. Tiel asked if Dr. Madamala was proposing options, or if that was a suite of options that she wanted to do.

Dr. Madamala answered that those were options. She wanted to see the reaction of the PHAB members to them and if they were things the PHAB would like to see moving forward.

Dr. Schwarz pointed out that the first and the second evaluation areas should be reversed, so that the work is linked to where we came from and then look at the system change and so on. System change is one of the consequences of what the PHAB is doing.

Dr. Madamala commented that the areas are interconnected and took a note of Dr. Schwarz's suggestion.

Ms. Tiel asked about the difference between a system's change evaluation and capacity evaluation. She would be more interested in how to move from programs and projects to systems. She was not sure what additional information the second potential evaluation area would reveal. She would be more interested in how investments are being made. In thinking about an audience of legislations and decisionmakers, she leaned more toward the first evaluation area. She wondered what an additional evaluation of capacity and expertise would tell us.

Ms. Rippeteau stated that she liked, under the first potential evaluation area, the evaluation to not review state and local public health activities separately, but rather the interaction between them. Under the second potential evaluation area, she could see leadership and governance working together. Although there isn't a one-to-one comparison between state new hires for the work versus LPHAs, maybe there is one-to-one, just to see where the investment is going and how it is working system-wise, and whether it is helping the local public health, as well as the state level.

Ms. Morell stated that the stronger message in this section would be the outcome-based measures, like the CD measures, which would be of interest mostly to legislators and

policymakers that were getting information more quickly and getting people into treatment more quickly. That resonates with what is expected of the system.

Dr. Madamala remarked that the third potential evaluation area is improvements in service delivery, such as time savings, improved quality of service or programs, expanded reach to target populations, quality enhancements of data systems, among others. Also, the potential to look at stories, which relates to Dr. Schwarz's idea of a case study approach. The three evaluation areas are connected to each other.

Dr. Luck noted that, in listening to the discussion and thinking about the areas, the second area was really about capacity and expertise and programs and capabilities, which was what the original assessment assessed. The third area seemed to be more about outcomes. They could be outcomes, as Ms. Mortell mentioned, in particular performance metrics, such as time savings or cost savings or other measurable outcomes, in addition to the accountability metrics. He was thinking about capabilities and programs compared to the original assessment and then measurable outcomes in a quantitative sense. The first area seems like it's potentially about the evaluation process or the organizational changes. For example, to what extent did modernization improve the collaboration between local health departments, or between the state and local health departments, or between health department and community organizations. Neither of those institutional, organizational changes are captured in the capabilities, expertise, and outcomes. Stories would illustrate that. That's just gestalt – stepping back after the discussion.

Dr. Madamala explained that the proposed improvements in service delivery in the third potential evaluation area were results from the NPHII (National Public Health Improvement Initiative) program, started by CDC (Centers for Disease Control and Prevention). Those were used in the quality improvement projects for the state and local health departments across the country and they were adapted to cross-jurisdictional sharing among public health agencies. They still have relevance here and can be used to demonstrate the outcomes that are not captured in the first and second area.

Dr. Savage added that if Dr. Madamala presented this again, she should look at the improvements in the third area, such as quality costs and satisfaction, and incorporate some of the feedback from the people who were receiving the services. This would be key, because Dr. Madamala is bringing the triple language, which Dr. Savage doesn't want to talk about anymore. She would like to talk about quadrupling (i.e., improving the patient experience of care, improving the health of populations, reducing the per capita cost of healthcare, improving the job satisfaction of care provider staff), because tripling is outdated, but everybody likes talking about it. If Dr. Madamala talked about satisfaction for both patients and providers and the people whom public health is serving, she would bring it full circle and then come back to something that brings it all together, so we don't see public health as a separate entity, but we see it as part of a health system change.

Dr. Madamala stated that purpose of the evaluation was to characterize the outcomes of a legislative investment in the governmental public health system to address communicable disease control and related health disparities. Given the discussion thus far, she asked the PHAB if it recommended any changes to the evaluation purpose for 2019-2021.

Dr. Schwarz remarked that the goal is still to get more money. That also means that the PHAB needs to target the legislature, because that's where the money is coming from. It could be because of all the activities that the PHAB has been doing and the legislators got convinced that there was something there. If that is the case, the PHAB needs to press its case and show how much it is there. The goals should not be changed, but rather they need to be pushed a bit.

Ms. Mortell pointed out that there may be a secondary goal around how the organizations are learning, growing, and changing. What are the organizations doing to improve the system? What is working in one area of the state might not work in other areas, but we have lessons to share across state and local organizations. That's a secondary purpose.

Dr. Madamala noted that, as an evaluator, she wanted to go back and prove the program. It's one of the challenges and roadblocks to implementing the program and how that can be improved. The general evaluation process will proceed as follows: (a) OHA will convene a stakeholder evaluation group that would help to (b) develop the evaluation plan, (c) OHA will produce an interim report in September 2020, (d) OHA will produce a final report in June 2021.

Dr. Madamala thanked the PHAB members for their feedback. Ms. Tiel reminded the PHAB that over the last two meetings the board discussed the modernization investment in this round and that the OHA is using a portion of the funds to look at modernizing how survey data is collected, reported, and used.

### **Public Health Survey Modernization**

*Dr. Julie Maher (OHA Staff)*

Dr. Maher introduced herself as the director of program design and evaluation services (PDES). It's an inter-agency applied research and evaluation unit that is part of both OHA's Public Health Division and Multnomah County Health Department. Her background includes a Master's in Science degree in biostatistics and a Ph.D. in epidemiology from the University of Michigan. She has worked at CDC and Kaiser Permanente. She's been at PDES for 17 years.

Dr. Maher informed the PHAB that her presentation was about modernizing the adult public health survey system. She introduced Vivian Larson, a senior research analyst at PDES, who is working with Dr. Maher and will be the project manager. Dr. Maher took a moment to recognize all partners inside and outside of public health who provided feedback over the years on the survey system. This is a unique opportunity for PDES to be able to make changes that the



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unit has been wanting to do for quite some time. She gave a quick preview of her presentation, starting with some background on why there is a need for modernizing the survey system, then providing some planned solutions, and finishing with a discussion.

Dr. Maher remarked that OHA's Public Health Division has been overly reliant on the Behavioral Risk Factor Surveillance System (BRFSS) over the years. It is an annual telephone survey of Oregon adults. It is a part of a national survey (PDES receives partial funding from the CDC) that covers a large range of topics. Every few years, the PDES has traditionally done a racial and ethnic oversample in order to get sufficient numbers of participants from communities of color for analysis.

Dr. Maher explained that the BRFSS had some challenges with sustainability and data quality. The world is changing a lot around us. The BRFSS is very expensive. It's about \$1 million a year in cost for the BRFSS. The racial and ethnic oversample is costing OHA over \$400 for a completed survey. The survey lacks estimates for smaller geographic areas on the county level, in part because it is expensive to collect that much data. The survey is long, about 24 minutes. That's because there has been increased dependence on it. People want a lot of the indicators collected this way. It's hard to get people to agree to be on the phone for half an hour. If the interviewers feel rushed to get through it, it creates a conflict with the culturally responsive approach doing surveys. There are also concerns around the representativeness of the data, in terms of who will answer the phone if a researcher called randomly, especially with communities of color in Oregon.

Dr. Maher added that a quote from a focus group that the PDES did for the Office of Equity and Inclusion at OHA illustrates the point: "I'm not going to answer your phone call 9 out of 10. You are someone I don't want to talk to." There are also issues with the accuracy and validity of information around sensitive questions asked over the phone, considering the changing perception of privacy in the world, as well as variability of cultural responses. There is also a lack of consistent community engagement in BRFSS analysis, interpretation of results, or dissemination of results. PDES recognizes that the input from the community is critical for making sure the results are accurate and useful. Lastly, there are insufficient number of BRFSS participants from Pacific Islander communities to calculate reliable estimates, even when PDES does a race oversample or provides years of data.

Dr. Maher stated that the PDES staff want to remain open to learning new things and want to be proactive about it. The PDES used the modernization framework to think through some solutions, not just the assessment and epidemiology foundational capability, but also thinking about health equity, cultural responsiveness, community partnership development, and also trying to gather data that is going to be useful for policy and planning and analyzing it in a way that's useful for policy and planning. PDES staff hopes to continue building on work that programs are already doing, in order to do this.

Dr. Maher explained that the PDES would do this by allocating funds differently. Traditionally, the unit got about \$750K per biennium for surveys and collecting data for specific communities. Usually, the staff does the racial and ethnic oversample. This time, instead of conducting the BRFSS race oversample, the unit will combine 3-4 years of standard BRFSS data for analysis of communities of color. As things have evolved, the unit has over 300 participants from African American and Black, Latinx, Asian American, and Native American communities. If we combine these few years of data, it allows PDES to estimate indicators with some precision.

Dr. Maher pointed out that PDES wanted to invest in improving its system by collaborating with communities. Collaborating with communities is essential to ensure PDES has valid data; to ensure that communities can be deciding what data to analyze, how to interpret the data, and to inform new methods for improving the work of PDES. PDES is starting with communities of color, with the hope of doing the work in the future with other specific populations. PDES also wants to compliment this by identifying innovative survey and statistical methods from the scientific literature and research experts. There is only a year and half for this work and these pieces will be happening in parallel and informing each other.

Dr. Maher noted that, as she mentioned, PDES lacked estimates for smaller geographic areas because it was very expensive. Instead of these estimates, the PDES will be using statistical methods to calculate BRFSS estimates as feasible for smaller geographic areas within counties without having to collect more surveys. There are methods developed that CDC has used, called the 500 Cities Project. It's a small area estimation approach, where data is used from other sources to get more reliable small area estimates. PDES is talking to CDC and other states that have done this work, in order to adapt the methods for Oregon. The resulted sample will be used to create maps and indicators across Oregon.

Dr. Maher remarked that PDES would be looking at the scientific literature for addressing other challenges, specifically thinking about how PDES can modify the adult survey system overall to shorten the survey, increase representativeness of the data, and increase the validity of the measures, while, at the same time, controlling cost. That's a big task. Other states in the U.S. are faced with the same kind of issues. It's not about getting rid of BRFSS, but it is important to decrease PDES's reliance on it as it's currently implemented. The PDES's approach is to work with the Oregon Public Health Division Science and Epidemiology Council, which is a council that has existed for a long time and there are representatives on the council from different centers across the Public Health Division.

Dr. Maher added that that PDES was in the process of exploring additional survey methods from the scientific literature, conducting interviews with survey research experts, and looking to other states for what they are doing. The plan is also to incorporate recommendations from the community collaboration. The information learned from all projects will be summarized for discussion, considering advantages and disadvantages, costs, and sustainability. The PDES will develop methods to pilot and pilot them during next fiscal year.

Dr. Maher stated that in terms of collaboration with communities of color, PDES is looking to work with the communities to learn how to address some of the same issues related to the length of the survey, the representatives, and the validity, while also addressing the lack of community engagement historically. This is a starting place for a plan that is expected to change, as PDES is collaborating with communities. PDES will be using a different approach for Pacific Islanders. As mentioned, there are sufficient data for African American and Black, Latinx, Asian American, and Native American communities to analyze BRFSS data, if a few years of data are combined.

Dr. Maher remarked that the plan was to fund communities to collaborate with PDES and to conduct a participatory analysis of both BRFSS and the youth surveys data. In this kind of process, the vision is to have communities choose which indicators they want to be analyzed and what kind of analysis they want done. PDES will do the analysis and then give the data back for the community to interpret and provide context. In addition, PDES will fund communities to design some supplemental data collection. It will be up to the communities to decide what the gaps and the priorities are and how to collect those data. PDES will be providing teaching assistance around the advantages and disadvantages of different approaches. PDES will also support communities with writing briefs and summarize recommendations from this process for new survey methods.

Dr. Maher reiterated that there was not sufficient data for the Pacific Islander communities to analyze the BRFSS data by ethnicity. PDES is planning a different approach, which involves doing a culturally responsive survey with the Pacific Islander communities. The plan is to fund the communities, summarize existing data on Pacific Islander communities (Multnomah County Health Department has done a lot of work in this area recently), and invite the communities to design the data collection methods. PDES will conduct participatory analysis of newly collected data, support communities in writing up the results, and summarize recommendations for new methods and lessons learned.

Dr. Maher elaborated that the idea was to combine the ideas from collaborating with communities of color and identifying innovative methods from the scientific literature and research experts to develop a plan for improving the system by the end of the biennium (June 2021). In its effort, PDES will be relying on collaborations both within and outside of public health for support, advice, and vision on this work. PDES staff are recognizing that they are trying new things and doing new things and, in that process, they will make mistakes along the way. PDES staff are committed to doing things differently and trying to improve the system.

Dr. Luck thanked Dr. Maher for the overview of the comprehensive set of changes. He was glad to hear about the smaller area estimates. He asked whether other states, particularly with regard to collecting data from communities of color, have taken steps to supplement or tailor

their BRFSS survey, or to do collaborations with communities of color around more tailored data collection.

Dr. Maher answered that PDES staff are looking at what other states have done. There is a listserv for BRFSS. PDES staff have reached out to all different coordinators across the states. PDES has been involved in similar work in other states. It's generally been topic-focused, like for tobacco control, but PDES is looking at that.

Dr. Luck added that he had done work in this area several years ago, when the California Health Interview Survey (CHIS) started. There were committees that focused on targeting the questionnaires in languages other than English. He asked Dr. Maher if she had reached out to the CHIS staff to inquire about approaches or tools that PDES could use. These are really big issues in California.

Dr. Maher answered that PDES staff had not reached out to CHIS, but they would do that.

Dr. Schwarz stated that BRFSS was one of 60 different surveillance programs that the PDES was running. He wondered what was happening to other programs, such as PRAMS and other programs PDES was running. He wasn't sure if that was a start of a process or it was because BRFSS was so central to a lot of different things.

Dr. Maher answered that the modernization funding that came to PDES was allocated for the survey specifically. PDES staff are hoping that this can be part of a larger data strategic planning effort and have a model. That's why PDES is engaging the Science and Epidemiology Council for the Public Health Division. The council is very eager to learn as well. She hoped that it could be applied to other areas.

Ms. Biddlecom clarified that the idea for this work came from the 2016 Public Health Modernization Assessment that the Public Health Division completed. OHA staff did a lot of thinking about what needed to be done in terms of modernizing OHA's surveillance system. This is the biggest survey. It's critical that the work starts with it. OHA has many programs that rely on it. OHA still has some federal funding that has to go the smaller piece that Dr. Maher mentioned. OHA will try to make the survey shorter. It will still need to continue in its form, but with the other pieces, it will become a better, more representative, and more affordable whole.

Dr. Schwarz remarked that BRFSS was one of the few surveillance programs from which users get oral health information, such as people who had lost their teeth, people who had gone to the dentist, and what people were eating, among others. He has been using BRFSS since 2008. There are 5-6 biennial measures that can be put together to show the improvement of the oral health situation. If BRFSS would be changed so dramatically, how do we ensure that we can look back and find any trends that are taking place?

Dr. Maher answered that that would be the essence of the question PDES staff would be asking. This is an opportunity for the PDES staff to be thinking about [many things]. The world is changing around us. The use of phones is changing. The poll researchers are not recommending phones as a starting place. All those things are changing, so the sample is changing. It's unclear how comparable the sample is. It's a part of the larger discussion. There is a lot of variability in how good represented existing panels are in the survey. It is a lot cheaper. Is that a way that the PDES might be able to do some methods? The Center for Health Promotion and Chronic Disease Prevention at the Public Health Division already does that for measures.

Dr. Maher explained that PDES staff were talking to survey experts like Dr. Don Dillman and thinking about how they were assessing trends and whether the trends they are seeing now were reflective of the population. PDES staff will be also talking to CDC about their plans and to one of the survey research experts who served on CDC's expert panel a couple of years ago. CDC hasn't moved much [in that direction] other than the cell phone moving to more cell phone sampling. PDES will be looking at the sampling frame (i.e., how the information is obtained), as sampling frames are getting better, as well as the sampling mode, such as phone, web, and the overall design. PDES will be looking at all these things. Trying to understand trends and ensuring PDES has good data over time is critical. The change would have its advantages and disadvantages.

Dr. Savage wondered about collaboration, because different entities are trying to get to the same communities. There is a large Pacific Islander community around Salem. Willamette Valley Community Health (WVCH) has done some work locally with the community to get information from it about how WVCH can help. She wondered about collaboration in the areas where health entities are overwhelming people with questions. Maybe some of the questions that PDES needs answered have been asked by WVCH and WVCH can share that data.

Dr. Maher answered that that would be fantastic. PDES staff are trying to collect what data is existing and build on partnerships. That's great to know.

Dr. Schwarz added that the Oregon Department of Consumer and Business Services (DCBS) just had a RFP out for a dental project for the COFA population, which is a Pacific Islander population. He had long discussions with DCBS staff, who don't have money to do anything sensible. The project was linked to a legislative mandate that DCBS needed to support the oral health programs for the COFA population, together with the medical program.

Dr. Maher stated that she and Dr. Schwarz should talk about that, because PDES worked on a project with the Office of Equity and Inclusion in the Public Health Division and APANO (Asian Pacific American Network of Oregon) and Virginia Luka, who is now at Multnomah County Health Department, and partners from the Chuukese community to look at the COFA medical benefits. PDES did a modified respondent-driven sampling approach for that and there were 120 participants in that survey.

Dr. Bangsberg asked about the timeframe for doing the work and how many people statewide were planned to be surveyed during that time period.

Dr. Maher answered that PDES has a year and a half, until the end of June 2021. There are different components. The hope is that the community collaboration and participatory analytic process would happen this fiscal year to the extent possible, with the supplemental data collection in the communities next fiscal year. There is a plan in place for data collection with the Pacific Islanders next fiscal year. It is unknown what their priorities will be for the community, in terms of which Pacific Islander communities [will be involved], and if there would be a certain topic. This will be left up to the communities to decide. It is unknown what the sample size will be for the pilot for the alternated methods for the overall system. It depends on the approach, but since PDES staff are hoping to do a less expensive approach, the sample size might be 1000 people, but it all depends on which method is chosen. PDES has a big chunk of money set aside for the pilot next year.

Ms. Tiel shared that it all sounds very exciting. It's been talked about for a long time. Modernizing the data system that drives everything is very exciting.

Dr. Maher echoed Ms. Tiel's excitement. She loves that people are excited about data and the survey. It's a challenge. It's also daunting. It's also very exciting to have new challenges and have the opportunity to step back and think about what PDES should be doing differently. She thanked the PHAB for its feedback.

### **Oregon Health Policy Board Health Equity Definition**

*Cara Biddlecom (OHA staff)*

Ms. Biddlecom informed the PHAB that she attended the Health Equity Committee (HEC) meeting last week where there was a discussion about rolling out the definition of *health equity* from the Oregon Health Policy Board (OHPB). The HEC appreciates the work the PHAB has done to put health equity at the forefront of its work. The Oregon Health Policy Board's Health Equity Committee drafted the definition of *health equity*, relying heavily on the PHAB's definition that was included in the health equity policy review tool. The definition was adopted by the OHPB on October 1, 2019, with the expectation that all health policy committees would use this definition and move health equity forward collaboratively.

Ms. Biddlecom read the definition of *health equity*. Dr. Bangsberg asked whether it had been figured out how to measure health equity. Ms. Shirley answered that there had been progress.

Ms. Biddlecom presented the framework for health equity, which included three components: (a) recognition of the role of historical and contemporary oppression and structural barriers facing Oregon communities, (b) engagement of a wide range of partners representing diverse



constituencies and points of view, (c) direct involvement of affected communities as partners and leaders in change efforts. Component (a), she noted, fit nicely with PHAB's earlier conversation about the Fair Housing Council of Oregon bus tour.

Ms. Biddlecom stated that the goal of this agenda item was for her to share the definition of *health equity* with the PHAB and get the board's insights on how the PHAB wanted to utilize the definition and the framework going forward. There are specific things that the PHAB needs to do, such as going back to the health equity policy review tool and updating it with the new definition. The PHAB should also update the funding principles, which also included a piece focused on health equity.

Dr. Luck thanked Dr. Bangsberg and the OHPB. The definition was discussed at the Health Plan Quality Metrics Committee (HPQMC) meeting last week and it was very well received. The HPQMC members thought that the definition was very good and it was consistent with Robert Wood Johnson Foundation's (RWJF) national definition. It's a definition that forms a good basis for measurement.

Dr. Bangsberg asked Dr. Luck to help him understand how the definition would be measured. He liked the definition conceptually, as it described how the PHAB understood health equity, but he didn't understand how one would start measuring it.

Dr. Luck reiterated that the definition provided a good basis for measurement, as it had specific elements that related to disadvantage, which allows the definition of a benchmark for comparison of the most socially disadvantaged groups. The definition lists several specific dimensions for measurement. The concept of health equity has an underlying definition of health as a goal and it includes health system as an opportunity to achieve it, which allows for choosing particular outcome metrics or process metrics that are linked to outcomes. Fundamentally, it has the foundation in saying that disparities across groups are based on historical and contemporary injustice and not on personal characteristics of the members of those groups. Those are some of the things that people who worked on developing performance metrics decided on as foundational principles, which are needed in the development and the evaluation of measures. This definition provides a clear framework for constructing and selecting metrics.

Dr. Bangsberg asked Dr. Luck if it was a conceptual framework by which one would evaluate measures. Dr. Luck confirmed.

Dr. Schwarz asked Dr. Luck whether the metrics subcommittee that convened a few months ago and worked on developing a health equity measure would be convening again, now that there was a definition of health equity. Dr. Luck confirmed.

Ms. Tiel pointed out that Ms. Biddlecom's comment about updating the health policy review tool and the funding principles was on point. The definition could be part of the discussion during the PHAB retreat and during the discussions with the guest speakers and be used to reference the language and the framework the PHAB would be using when addressing health equity. The first sentence of the definition states that "Oregon will have established a health system." It doesn't specifically say "public health and health system". This was either intentional or not intentional, but it must be recognized that it is all-encompassing, and the PHAB members need to talk about that a little bit more in their work.

Dr. Dannenhoffer shared that at the June PHAB meeting, Dr. Charles Brown had railed at people taking five years to come up with a definition for health equity. The speaker said that that gave people five years to not really think about it. Dr. Dannenhoffer praised the HEC for formulating the definition so quickly. Ms. Biddlecom added that now the PHAB can do something about it.

Dr. Schwarz remarked that he has been involved with CCOs and they might be in the same situation as well. They are now working with the concept of *social determinants of health*. He asked if the definition spoke about that in the last part of the definition's paragraph. It would be nice to have the two concepts aligned, so it's clear when the conversation is about one and when it is about the other. He asked if social determinants of health were something that needed to be addressed in order to achieve health equity. The PHAB needs to figure out how to deal with these different concepts. Social determinants of health are going to control the next five years of CCO work.

Dr. Savage agreed with Dr. Schwarz. She wondered if the definition could be laminated so PHAB members had it in front of them during the PHAB meetings. It would keep board members focused when they made decisions and looked at goals and outcomes. Also, as the PHAB members took that information to their respective organizations, they should look at social determinants of health with this focus. It is unknown whether or not the two definitions can be intertwined in one all-encompassing definition. Every decision about how the board members use their resources for social determinants of health should have this perspective. The CCOs should adopt the definition as well, so everybody has the same definition, as opposed to each one of the 15 CCOs coming up with something different. Maybe the PHAB can give permission to the CCOs to use the definition.

Dr. Dannenhoffer suggested that a strategy could be that the PHAB gave two months to the CCOs to come up with a definition for health equity. If they come up with something better, they can use it. If they don't, they have to use the PHAB's definition.

Dr. Bangsberg noted that Ms. Tiel's comment about health systems was well-taken and was reinforced by Dr. Schwarz's comment about social determinants of health. So much of health equity is determined by things outside the health system.

Ms. Mortell clarified that it was rather outside healthcare. Dr. Bangsberg agreed.

Dr. Sidelinger added that it was outside the health system as well. Dr. Bangsberg agreed that it was outside both.

Ms. Shirley explained that the HEC specifically took out health care. The committee was thinking about the health system as the system that achieved health for all – from the work that OHA does to the far upstream. If Dr. Bangsberg wanted to take it up, the PHAB would be with him.

Dr. Bangsberg stated that it was not intuitively obvious to a CCO. He suggested to include that distinction in the digest.

Dr. Sidelinger remarked that the PHAB could always ask for a split. He saw it as public health and health care. If one truly thought like a public health person, everything was public health. There is nothing beyond the health system. The way the first sentence is right now works well. Maybe the definition needs an addendum that states that health system includes public health, so that the CCOs see themselves as the public health professionals already see themselves.

Dr. Luck agreed with Dr. Sidelinger. Defining health system separately is not making the definition more complicated.

Ms. Shirley pointed out that the OHPB adopted the definition and health equity was included in the contracts with the CCOs. This was part of the expectation of every CCO that gets money to take care of the population. This is already in the contracts and CCOs will be held accountable for it.

Dr. Luck asked if the new SHIP (State Health Improvement Plan) would be using the definition.

Ms. Biddlecom answered that there was no choice but to use the definition. It is the expectation not only for the OHPB and the other committees, but also for OHA. This definition will be included in the SHIP.

### **Public Health Response to Wildfires**

*Kirsten Aird (OHA staff)*

Ms. Aird introduced herself at the Acting Senior Operations Manager in the PHD. Her previous position was with OHA's Health Promotion and Chronic Disease Prevention center. In both roles, she has been the OHA's representative on the Governor's Wildfire Council (WC), which was initiated this last spring and was set forth to put forward a proposal on how we would address what was happening with wildfire in the State of Oregon, both from a response and recovery perspective and involving things well beyond. The council addresses how we suppress



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fire and put fires out, which is in statute in the State of Oregon. The number one goal is to put fires out, as well as mitigating wildfire and the human and economic side of it.

Ms. Aird noted that the Wildfire Council has been meeting and would be making recommendations to the Governor on where investments should be made moving forward, both financial and staff, and some legislative ideas as well. Dr. Bangsberg served on the Health Subcommittee, which Ms. Aird chaired. The goal of the today presentation was to make PHAB aware of the conversation and the recommendations. The recommendations are not only going to the legislature and the Governor's Office, they are also going to the Board of Forestry and the Environmental Quality Commission.

Ms. Aird stated that the health subcommittee had a lot of conversations and did a lot of assessments, and Dr. Bangsberg made it clear that one of the most important ways we could address wildfire was through recognizing that it was a climate change problem. If we don't get at the heart and soul of climate change, we are not going to see significant decline in wildfire and the intensity of wildfire. The number one health recommendation was address climate change. This piggybacked off of the work that PHD staff did with several community partners related to the Climate Action Plan.

Ms. Aird added that the first recommendation was *immediately protect all community members, with special focus on vulnerable populations, during wildfire and smoke events*. The emphasis of this recommendation is getting people into clear air spaces. The infrastructure for that to happen is growing, but it isn't solid, particularly in rural areas that are experiencing a lot of wildfire. The recommendation is to put a real investment in community preparedness. Mr. Eric Hunter, who works with CCOs, made the recommendation that CCOs should be looking to use their health-related services dollars to purchase air purifiers for their members who meet the criteria for vulnerable populations, such as individuals with lung disease, heart disease, young children, and older adults. The recommendation also includes a significant financial investment to cover public and community airspaces as well, such as public libraries and other public buildings, to ensure that they have proper air filtration systems and air-conditioning units.

Ms. Aird pointed out that another thing that came out of the Wildfire Council conversation, which was a crossover with the work happening through the SHIP and the work on social determinants of health, was that 40% of Oregonians rent their homes, with 50% in rural communities. Tenants don't have the ability to make adjustments to their properties to protect their health. They legally could be in conflict with their rental agreements. They don't have the ability to put their own purification system, even if they had the money, or even if they had it donated or their doctor gave it to them. They cannot make alterations in many situations.

Ms. Aird stated that one aspect that was highlighted in the conversation was the importance of evaluating the state statues around rental properties and what renters and tenants' rights were

about this. That was mind-blowing for the group, which is predominantly individuals who represent rural communities and landowners. All these aspects were included in the recommendations and they tie into health equity and getting to the social determinants of health, and who are the big losers when wildfire happens, and how we make sure that it doesn't happen anymore.

Ms. Aird remarked that the other recommendation was to continue to shore up the state's emergency response and recovery and to put a greater lens on wildfire as something that we need to practice and do more intently. That involves a lot of work around public water systems and the lack of infrastructure that exists to respond to a significant amount of silt and ash entering the water system. A new recommendation around that is in the works. The Governor has seen the preliminary recommendations. She seems excited and pleased by them. They were focused on the exposure to fire. The conversations from the health perspective brought about a focus on smoke, not just fire.

Ms. Aird pointed out that the mitigation strategies to reduce wildfire also have a significant health impact. For example, when the power is turned off to protect from or prevent wildfire, there are health impacts. This presents an opportunity for the WC to find solutions on how to do that without harm. Power cannot be turned off without having good solutions on what should be done. The problems with turning off power were evident recently in Los Angeles. The other mitigation strategy is to do more prescribed burning. Prescribed burning at the pace and scale to reduce how much stuff is on the land that could catch on fire during a wildfire is going to create a lot of smoke, which has a health impact. The discussion with the WC was about holding two truths at the same time, one of them being putting smoke in the community on purpose, in order to have less smoke or less impactful smoke during wildfire season.

Dr. Dannenhoffer noted that Oregon has had 2-3 years of intermittent experiments in poor air quality. We can check the ESSENCE database and see what happens in emergency rooms. He asked if there were specific data about the short-term effects of wildfire smoke other than that it isn't good for people.

Ms. Aird answered that there was a high-level study that was done for the Chetco Bar Fire, which was just submitted to OHA and it can be shared. It is known that there is immediate health impact from smoke within an hour. OHA did a loose study after the Chetco Bar Fire and has some data that can be shared. One of the conversations that occurred at the WC was that it isn't always the tangible things we can count that impact health. It's people not showing up for school because they don't feel good, or not being able to go to their sporting event, or show up for work – all these things that are hard to capture. The WC is very interested in how to capture them.

Ms. Aird explained that part of what OHA is doing in collaboration with the Department of Forestry and DEQ (Department of Environmental Quality) is trying to put some infrastructure in

place that helps us evaluate that. OHA is working on a memorandum of understanding with these two agencies right now to think about how we respond to smoke intrusions into communities. OHA is looking into doing that not only for wildfire season, but also for prescribed burning season, which is right now. When we think about managing the forest lands and using burning during fall and springtime when it's not going to spread into a wildfire, there idea is to do more burning. The new rules are allowing communities to seek the opportunity to exceed a lower health standard and go so far as to push up to the border of the 24-hour ambient air quality standard, which would make it unhealthy for the general population, not just unhealthy for vulnerable members, if that much is burned. The questions are: how to measure that, what health outcomes should we look for, how to help communities get prepared, how to communicate and let people know when the burns will be happening. Local public health authorities have an opportunity to engage in that. They are not required to engage in that by the rules, but the rules do call them out as the first point of reference. They have the first right of refusal to be able to address or leave this conversation.

Ms. Aird added that public health has never been part of these conversations until this current set of rules. Now public health has a role in making sure community members understand their risk and know how to mitigate and take care of themselves and protect themselves.

Dr. Schwarz asked what kind of program elements (contracts with local public health authorities) covered this field, area, or activities.

Ms. Aird answered that no program elements covered them. She considered that an amazing opportunity for a modern public health system to be able to demonstrate leadership in community and have conversations. There aren't any step-by-step requirements. The emergency response individuals who are located throughout the counties are great resources and they have been used as resources in the early conversations. The idea is that the local public health authorities have the greatest knowledge around their community, who their community partners are, and what their community needs are. What the WC didn't want was a bunch of foresters, for all the right reasons, going out and creating community health messaging to tell people what was going to happen from their perspective. The WC wanted to make sure that they knew who their counterparts were in their regions, which was naturally the local public health authority. But there are not requirements or program elements for it.

Ms. Mortell shared that one of the things locals often did was to look for grant opportunities and other opportunities that provided resources to do this work. Both she and board member Dr. Lewis are part of a regional grant opportunity, based in Washington County, which is the connection between what's happening at the state level and what's happening at the local level. The grant is around 10K and is for work on smoke from wildfires. That's what locals are looking at – how they can source it differently and add resources from other places.

Dr. Schwarz said that he didn't know about it, but now that he did, he got very concerned. When the PHAB discussed performance metrics and accountability metrics last year, and when the board discussed one of the dental health metrics, the response from the LPHAs was that it wasn't a program element. If they don't get any resources to do it, they don't get involved with it. It's understood if it's not a program element, because they have a million other things that they have to do with the small portion of funding they get. If this affects asthma attacks or chronic diseases, it is not clear if we are doing the right thing.

Ms. Aird responded that the stated needed local infrastructure for implementing the health recommendations. A big fiscal ask is moving forward. The Wildfire Council made it clear that the infrastructure at the local level for response, for both the mitigation issues and the recovery issue, was limited and lacking. An investment in local jurisdictions to address health more comprehensively around wildfire is being put forward. In the legislative session this year, because of Representative Marsh, DEQ (Department of Environmental Quality) received \$250,000, which will be going out through requests for proposals for local governments to apply to seek support and prepare communities to mitigate and address prescribed burning. OHA is collaborating with DEQ and sharing with it examples of how OHA uses RFPs to get money out the door.

Ms. Shirley added that this was an opportunity to talk about the foundational capabilities. OHA would not be at the table if it didn't step into it. OHA doesn't have money for that either. The effort was toward getting people to understand that the emergency response and the work OHA has done is what public health does in their communities. Any future investment is based on what OHA has done and where it has stepped up and proving added value to the process. In terms of the asthma and the chronic disease, OHA has data that it uses and has shared with all LPHAs, which they have never looked at. It's about the foundational capabilities. It's not about being programmatic. It's about providing leadership, assuring that communities have health equity as one of their criteria when design things, and bringing that lens to the foresters and to the DEQ, among others.

Dr. Bangsberg pointed out that this why public health modernization was created – for new and emerging threats. To relate this discussion to the prior discussion, how do we know whether public health modernization works or not?

Ms. Saito stated that one the things related to program element, although it was not specific around smoke, was that OHA had a program element that was the emergency capability emergency preparedness that went out. The work is about determining the hazard vulnerability of local communities. This is done every five years in conjunction with emergency managers. There is a smoke protocol which has been used for many years with OHA, ODF (Oregon Department of Forestry), and DEQ. There are triggers in place that activate if smoke comes to a certain level, which prompts calls with local and tribal emergency managers to understand what areas are most affected.

Ms. Saito explained that the difference now was the intensity and probability of having these fires based on climate change. Oregon has the infrastructure. One of the recommendations that Ms. Aird talked about was understanding and educating people about what the emergency operation system was. On the response side, we have a fairly good piece. If the discussion is about responding to wildfire every single summer, and the actual time for the wildfires is May through October, we are talking about a lot more resources than the small resources OHA used to have to respond to once-in-a-while wildfires. Now the fires are stronger, take longer to contain, and there's more smoke.

### **State Health Improvement Plan: Oral Health and Tobacco Priority Updates**

*Dr. Bruce Austin (OHA staff), Amy Umphlett (OHA staff), Karen Girard (OHA staff), Cate Wilcox (OHA Staff)*

Dr. Austin introduced himself as OHA's Dental Director. He introduced Cate Wilcox, section manager of the Maternal and Child Health section at the PHD under which the oral health unit (OHU) lives. He presented three key questions: (a) How do we ensure that oral health is integrated into all priority areas for the 2020-2024 SHIP? OHA has oral health partners engaged in the Access to Equitable Health Care subcommittee, but the OHU would like to insert oral health into the other four priority areas of the upcoming SHIP. (b) What community levers should we be using to continue the momentum built around oral health, given finding and partnerships challenges? (c) How do we move towards more population-based oral health efforts across the system of care? The state is doing good work on (b) and (c) with Medicaid patients, but the question is how to move that up to the rest of public health in the population.

Dr. Austin presented a slide with OHU's priority targets with children, adolescents, and older adults. Third graders with cavities in their permanent teeth rate decreased from 15.5% in 2012 to 7.6% in 2017. The rate for 8<sup>th</sup> graders who have had one or more cavities decreased from 70.1% in 2013 to 68.7% in 2015, while the rate for 11<sup>th</sup> graders increased from 74.0% to 75.1% in the same period. This point out that OHU's efforts have been around younger kids (i.e., elementary and middle school kids) with the school-based programs and screenings and school-based sealant programs. There's still work to be done with older kids and adolescents. The rate for adults over 65 who have lost all their natural teeth decreased from 17.7% in 2010 to 13.7% in 2017, although oral health isn't covered by Medicare. There's a national discussion about getting Medicare to cover oral health.

Dr. Austin presented a data chart of the 2017 Oregon Smile Survey. The data is gathered from schools around the state over two school years every five years. Progress was achieved in each of the three examined categories (i.e., had a cavity, untreated decay, rampant decay). The biggest statistically significant change from the previous survey was with rampant decay (i.e., 7 or more teeth with decay in them). Unfortunately, a lot of the children with rampant decay are the ones who go to the operating room and have general anesthesia to treat their rampant decay. Anything that can be done to reduce that exposure is excellent. Although the rate for

children who had a cavity has decreased, it's still at 49%, which means that one out of two kids had a cavity. There's more work to be done there.

Dr. Austin showed a map of Oregon with seven regions and their corresponding cavity rates from the 2017 Oregon Smile Survey. The numbers have improved since the last Smile Survey, but the map points out the geographic disparities of dental care in Oregon. The more removed a region from the Portland metro area and the Willamette Valley, the higher the incidents of decay. There's a lot of work to do in the rural and frontier areas. There are programs in place to spread the use of tele-dentistry and to spread the practice of dental hygienists. The cavity rates in the eastern most counties are higher than the rates in the Willamette Valley with statistical significance.

Dr. Austin presented a data chart showing race and ethnicity data from the 2017 Oregon Smile Survey in the same three categories. Compared to the rates of white children, all other ethnic groups have higher rates than white children in the three categories. This is a stark representation of the racial disparities in oral health among children in Oregon.

Dr. Austin remarked that the CDC (Center for Disease Control and Prevention) suggested two population-based activities that might lower dental decay in the population. One is community water fluoridation; the other is school dental sealant programs. Water fluoridation has been a challenge in Oregon, primarily because Portland is the largest unfluoridated city in the county. It's a public health issue that could quickly become a political issue. OHU is meeting with a monthly workgroup and tries to move the needle on the issue. In 2000, the Surgeon General, Dr. David Satcher, came out with the first-ever special report on oral health. In early 2020, the current Surgeon General, Dr. Jerome Adams, is coming out with a second special report on oral health. Dr. Adams will point out that we have made gains since the 2000 report. Dr. Austin participated in a listening session to help inform the current report and he pointed out that there were still states like Oregon where access to fluoridated water was a challenge. The OHU had to spend more money and manpower to overcome the deficit in fluoridated water and still make the gains in decreasing decay in Oregon.

Ms. Umphlett introduced herself as a policy analyst in the OHU in the Maternal and Child Health section in PHD. She stated that there has been a significant increase in the number of school dental sealant programs that have operated statewide since 2015. During the 2018-2019 school year, OHU served 92% of eligible elementary and 79% of eligible middle schools. A school is eligible if at least 40% of the student population qualifies for the national school lunch program. This can be attributed to the CCO financial incentive metric for dental sealants for children ages 6-14. That incentive metric is going away at the end of 2019. The programs will be watching closely to see if there would be a decrease in the number of schools served by a school dental sealant program. Efforts could switch to a more low-cost dental service, such as fluoride varnish, even though dental sealants are evidence-based.

Ms. Umphlett informed the PHAB that the OHU also operated a statewide school fluoride tablet/rinse program. There has been a significant decrease in the number of participating schools, from 70 in school year 2013-2014 to 43 in 2019. Not only are we seeing the decrease due to anything fluoride, but there is also only one fluoride tablet manufacturer in the U.S. This not impacts those school programs, but pharmacies are having difficulties filling prescriptions for fluoride supplements that are provided during child checks from primary care providers.

Ms. Umphlett pointed out that OHU's capacity at the state level was still limited. The unit had a HRSA (Health Resources and Services Administration) oral health workforce grant since 2009, but the grant went to the OHA Primary Care Office in 2018. The unit lost 1.5 FTE, which impacted its research analyst capacity. Now the unit has a part-time position that has to serve all data and evaluation needs for the entire unit. The unit hoped to get more capacity by applying for a CDC state oral health infrastructure grant in 2018, but it didn't receive the grant. This limits the unit's capacity moving forward. There are not funding opportunities on the horizon, but the unit will be looking. At the local level, Title V Maternal and Child Health block grant funding is the primary source for oral health work. There has been an increase in grantees from nine in 2017-2018 to 17 in the current grant cycle. These are 15 county health departments and two tribes working to increase dental visits for pregnant women and children. This could be attributed to the developmental accountability metric for modernization around dental visits for children aged 0-5.

Ms. Umphlett explained that some oral health partners were also struggling. National organizations that states rely on for technical assistance or donated supplies have been struggling or have ceased operations (e.g., Oral Health America). Many states are trying to fill that void. At the local level, the future of the statewide Oregon Oral Health Coalition (OOHC) is uncertain. The OOHC is changing its business model due to extremely limited funding. OOHC had tremendous challenges trying to raise funding as historically strong funding partners reduced their commitments or sponsorships. DentaQuest Foundation is an example of a foundation that reduced its funding. The foundation's board of directors is developing a new business model with a focused strategic plan, but it is uncertain what the future of some of their initiatives will be. Local public health departments, nurse-home visiting programs, WIC (Women, Infants, and Children), and medical offices relied on *First Tooth* and *Maternity Teeth for Two* training programs to help with oral health integration efforts. Local regional oral health coalitions have also relied on the statewide coalition for technical assistance.

Ms. Umphlett asked the PHAB members for their feedback on how to ensure oral health integration into all priority areas for the 2020-2024 SHIP. The OHU has representation on the Access to Equitable and Preventive Care subcommittee, but oral health impacts all priority areas.

Ms. Tiel suggested to move to the discussion to preventing and reducing tobacco use and then return to the questions.

Ms. Girard introduced herself as the section manager for the Health Promotion and Chronic Disease Prevention section in PHD. The key questions for preventing and reducing tobacco are: (a) Are there opportunities for tobacco control to work with other entities to achieve prevention goals? (b) How do we maintain urgency for comprehensive tobacco prevention? (c) How best can we address tobacco prevention fatigue? These are perennial questions in tobacco prevention, but with the current vaping crisis, the answer to all these questions is that there are opportunities, and there's urgency, and there's also fatigue.

Ms. Girard presented the priority targets for tobacco prevention: cigarette smoking among 11<sup>th</sup> graders, other tobacco use (including e-cigarettes) among 11<sup>th</sup> graders, and cigarette smoking among adults. The rate for cigarette smoking among 11<sup>th</sup> graders is down from 10% in 2013 to 5% in 2019, with a target of 7.5% in 2020. The rate for cigarette smoking among adults is also down from 18% in 2013 to 17% in 2017, with a target of 15% in 2020. The rate for other tobacco use (including e-cigarettes) among 11<sup>th</sup> graders is up from 18% in 2013 to 24% in 2019, with a target of 15% in 2020. Other tobacco products include large or little cigars, hookah, smokeless tobacco, and e-cigarettes and vaping products.

Ms. Girard emphasized that tobacco use was still a problem in Oregon. It's the number one cause of death in Oregon and disproportionately affects people of color, youth, and those with low socioeconomic status. The tobacco industry spends over \$100 million annually in Oregon, much of it in targeted marketing to these populations, especially in the regional environment. Emerging products, such as Juul, are leading the way in the drastic youth increase in vaping in Oregon and across the country.

Ms. Girard pointed out that the burden of tobacco was unevenly distributed in Oregon. People with low income, certain racial and ethnic groups, members of the LGBTQ community, and people with mental illness use tobacco at a higher rate. They are more likely to suffer from tobacco-related illnesses. The tobacco industry targeting has led to these higher rates of cigarette smoking, especially among youth and these targeted communities. One of the most important interventions for reducing tobacco disparities is raising the price of tobacco to help those priority populations the most, especially when funds are dedicated to prevention and services. The uneven distribution is the same for any tobacco product use among Oregon adults.

Ms. Girard read the message that OHA communicated to the public: Oregon Health Authority is participating in the investigation of a nationwide outbreak of respiratory illnesses associated with use of vaping devices and is working with local public health and health care partners to track any illnesses in Oregon. She explained that the rate for electronic cigarette use among 8<sup>th</sup> graders increased from 6% in 2017 to 12% in 2019. The rate for 11<sup>th</sup> graders increased from 13% in 2017 to 23% in 2019. In comparison, current adult e-cigarette prevalence is 5%. Nearly three-quarters of all 11<sup>th</sup> graders in Oregon who have ever used tobacco started with e-

cigarettes. The concern is that starting these kids off with a very strong nicotine addiction can lead to their using combustible tobacco.

Ms. Girard elaborated that the Governor's executive order targeted the use of flavored products, which was the key in this discussion. The Governor's executive order banned the sale of flavored vaping products, both THC and non-THC products, of which non-THC products are currently under a temporary stay. She invited Dr. Sidelinger to provide more information about the Governor's executive order and the vaping response.

Dr. Sidelinger remarked that he had been at OHA for a month and a day. He was extremely proud of the nimbleness and responsiveness of the team within public health, OHA, the state, and the LPHAs. The current status of the outbreak of severe lung injuries associated with vaping products is 1,479 cases nationally with 33 deaths across 49 states, Washington D.C., and territories. Alaska is the only state not reporting cases. In Oregon, only hospitalized cases are reported. That includes 11 cases and 2 deaths. Nine of them were adults, two were children. Nationally, 79% of these cases nationwide are under 35 years old. These are children and young adults, previously healthy, many of whom will likely have lung disease for the rest their lives.

Dr. Sidelinger provided some history on the vaping response. On August 21<sup>st</sup>, the first health alert about the vaping issue was sent out. OHA started managing this as an incident command on August 29<sup>th</sup>. The incident management team sent additional alerts to OHA's health care and public health partners on September 17<sup>th</sup> and September 26<sup>th</sup>. On September 26<sup>th</sup>, OHA held a press conference and warned the people of Oregon to stop vaping. Governor Kate Brown then asked OHA for options on how to address the vaping crisis. The public health team, working with OLCC (Oregon Liquor Control Commission) and others, turned around recommendations in 24 hours and gave them to Governor Brown on September 27<sup>th</sup>. On October 4<sup>th</sup>, Governor Brown issued the executive order for the flavor ban for both THC and nicotine products, as well as consumer warnings, working on ingredient disclosures, an emergency rule for provider reporting, removing and remediating barriers to cessation, supporting FDA-cessation products, supporting linkage to substance use disorder treatment, a statewide prevention and education campaign, and legislative proposals to more permanently address this issue. Governor Brown is starting a vaping public health workgroup that will work on many of these recommendations. On October 9<sup>th</sup>, the new provider reporting rule was filed. On October 11<sup>th</sup>, both OHA and OLCC adopted flavored vaping product ban rules, which went into effect on October 15<sup>th</sup>. The non-THC flavored vaping ban rules were challenged in the morning of October 17<sup>th</sup>, and the emergency state was granted in the afternoon of October 17<sup>th</sup>.

Dr. Sidelinger stated that for public health professionals, the interesting part about this outbreak was that it was still linked to an unknown ingredient, or ingredients, or products. Initially, some of the discussions focused on Vitamin E, but that wasn't in all the products. There were some publications on Vitamin E acetate, which are fat-soluble additives that are in some vape products. A recent article that looked at pathology specimens from 12 individuals showed

a direct chemical burn, but the cause of the burn was unknown. OHA is waiting to see what the product is. Products that may have been adulterated by friends or families are from smaller manufacturers that may have never had the same standards that a larger manufacturer may have. OHA still doesn't have a definitive answer.

Dr. Sidelinger shared that for him, as amazing as it was to see people come together and come up with these options for Governor Brown, that enforcement plan that was stepped up in a very short order as a partnership between OLCC, OHA and LPHAs. OLCC has strong relationships with their retailers, but they also stepped up on non-THC products because there is overlap with their alcohol retailers, and then the LPHAs stepping up and developing a system where we could provide information to 4,000 tobacco retailers in three weeks and step up an enforcement campaign in a system that was unregulated two weeks ago. That work is on hold, but, hopefully, OHA could be successful in the courts and turn that back on fairly quickly, and then use this experience to further some of the longer-term evidence-based strategies that OHA and the LPHAs have been working on.

Ms. Girard added that, as Dr. Sidelinger indicated, this pointed to some gaps in Oregon's laws. OHA is not like OLCC in that OHA does not register licensed tobacco retailers. OHA does not know where these products are being sold at a moment's notice to pull them off of the shelves, or to hold retailers accountable for selling products that are illegal, while the OLCC has that option. Then the link to flavor and youth use in trying products, whether it's e-cigarettes, or little cigars, or chewing tobacco, or menthol, or mint, or other cigarettes is a real issue for tobacco control. This crisis has brought attention to the role of flavors and the role licensure can play in protecting our public's health.

Ms. Girard stated that she would be remiss if she didn't mention price. Currently, e-cigarettes in Oregon are not taxed. It is known that price is linked to consumption of tobacco products. House Bill 2270, the bill that referred tobacco tax to the voters next year, includes e-cigarette tax for the first time in Oregon.

Dr. Dannenhoffer commented that he hoped the PHAB used this as an opportunity to push for statewide tobacco retail licensing. It is the perfect time to do it. It was interesting to him that the oral health and the tobacco prevention presentations were together. As a pediatrician, he spends most of his time in the clinic and he can attest that the measure at age 5 of whether there are cavities in the mouth or the parents are smoking, and then the teens, whether they are smoking or whether they have cavities, is almost a perfect predictor of social class. One almost never sees a well-off family where the kid has cavities or the parents smoke and so often one sees that among the poor parents. The socioeconomic differences are enormous and the PHAB should continue to work on that. That fits in perfectly with the new SHIP, which is about getting rid of inequities.

Dr. Schwarz noted that he noticed in both presentations that BRFSS was used as a strong measure of outcomes. He wondered that with the change in BRFSS, the reported numbers might be difficult to continue. He asked if the last slide of the oral health presentation could be shown.

Ms. Tiel clarified that the BRFSS wasn't going away.

Dr. Schwarz explained that he asked the question of how we were going to ensure that we continued to look at change over time. With differences in methodology and population and sample frames, that would be very difficult. He wanted to respond to the concerns about oral health. The PHAB looked at the SHIP earlier in 2019 and it is known that oral health is not one of the seven priorities in the present SHIP and it won't be more comprehensive in the new SHIP. He remembered that the last time the OHU presented to the PHAB, he tried to be more optimistic about the situation. He still felt that there were some amazing opportunities in the CCO 2.0, even in the SHIP. Maybe the time has come for the state to take more leadership and have a consultancy group that pulls experts from CCOs and local coalitions, with the group working on some of the things the OHU would like to do.

Dr. Dannenhoffer shared that he met Dr. Schwarz and Dr. Luck when they were together on the metrics committee for the CCOs. One of their proudest moments was the dental sealants metric, because the dental sealants metric was upstream and could really benefit from a system change. The system changed by getting the dental sealant programs, but the metric was retired this year, because most of the CCOs met it. That is tremendously unfortunate. This will be a natural study to see what happens when incentives go away. If incentives go away, and those programs go away, it would suggest that metrics only work while they are still there. This is going to be tragic. One can see the difference in the number of kids with sealed teeth. Every time he does a dental exam on a kid who comes to the clinic, he could tell the kids who had their sealants from those who had not. He had not seen a cavity in a sealed tooth in the last year. The preventive power of sealants is remarkable. It is sad to see the metric go away. It will be sadder if the programs go away now.

Ms. Umphlett responded that the OHU staff is very optimistic that there wouldn't be a decrease in the cavity rates because of the kindergarten readiness metric. Dental sealants will still be considered a preventive dental health service. It will be wrapped in with fluoride varnish, teeth cleaning, and some other services. There hasn't been a decrease in the 2019-2020 school year. The OHU will be watching the rate closely. The OHU definitely sees the opportunity in CCO 2.0. The unit still wants to focus on the public health system and the struggles that the unit has at the health department and tribal representation around oral health.

Ms. Shirley thanked the presenters for their presentations. She assured them that OHA would track those numbers. OHA will tell both the CCOs and the providers how they are doing. That's part of the advantage of being the state health department and getting all that data. OHA can

turn it around and give it back to people. If things slide, OHA can say that we need to get a metric back, because it is a very significant metric for overall health and also for health equity. She was even more distressed about the slide that listed all the national things that were going on, to which people were not paying attention anymore. She asked Dr. Austin to share his ideas, if he had any, about what the public health people and OHA could do to advocate for that work nationally and through organizations.

Dr. Austin thanked Ms. Shirley. He remarked that the OHU has also been concerned with the dental sealant metric going away. The unit has been worried about that for the last several years. The OHU will watch it, and make sure it spreads the word about how effective it is. He thanked Dr. Dannenhoffer for his efforts and added that there were no fluoridated communities in Douglas County. If there is no water fluoridation, the focus should be on emphasizing sealants. As far as having a national voice, Dr. Austin is a member of the Association of State and Territorial Dental Directors (ASTDD) and sits on the board of the organization. The ASTDD is talking to national partners about things like changing Medicare coverage and other national issues, and comparing basic screening surveys from state to state. There are some national voices, but the OHU will stay on this.

Dr. Savage stated that looking at the second question in Dr. Austin's presentation about the community levers OHU could be using and momentum-building, obviously health equity would be very important going forward and there were funds set out in CCO 2.0 specifically for that. When the disparities are shown, it is easy to say to the CCOs, "Let's target those funds for the ongoing sealant program that is already in place. Why wouldn't we continue it and continue to fund it?" It's really easy for a CCO to say, "Oh, it's going and it has good outcomes. Let's just keep funding it. We should be using that momentum." The other one is around diet and nutrition, because, obviously, a lot of those teeth problems are coming from sugary beverages and so forth. There is a lot of momentum in health equity talk and diet and nutrition talk about making sure that healthy food is getting to CCO members and food deserts. That's another dental avenue to say to CCOs, "Look, we need to make sure we have this, because there's a food desert here and poor nutrition, and the only way we are going to get to these teeth is to put sealants in them." These are momentums and community efforts that OHU can leverage to keep getting funding in these areas.

Dr. Austin thanked Dr. Savage for her idea.

Ms. Tiel noted that the conversation naturally has led to where the new SHIP will be, in terms of the up-level economic indicators, addressing all different barriers that communicators have. She didn't see tobacco prevention and oral health not being part of the SHIP going forward. The PHAB can highlight and keep talking about these important health outcome issues related to the SHIP. She thanked the presenters for their presentations.

## **Public Comment**

Ms. Tiel asked if members of the public on the phone or in person wanted to provide public comment. No public comment was provided.

## **Closing**

Ms. Tiel thanked the PHAB for their time and adjourned the meeting at 4:45 p.m.

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

**November 21, 2019  
2:00-5:00 p.m.  
Public State Office Building  
Room 177  
800 NE Oregon Street  
Portland, OR 97232**

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Krasimir Karamfilov at (971) 673-2296 or [krasimir.karamfilov@state.or.us](mailto:krasimir.karamfilov@state.or.us). For more information and meeting recordings please visit the website: [healthoregon.org/phab](http://healthoregon.org/phab)

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# Local and state roles for routine epidemiological functions and surge capacity



# State and local roles for Assessment and Epidemiology (from the Public Health Modernization Manual)

<b>State</b>	Maintain and operate statewide information and public health surveillance systems.
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<b>Local</b>	Access statewide information and surveillance systems and report into these systems in a timely manner.
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<b>State and local</b>	Ensure (state/local) public health capacity to respond to emerging threats.
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<b>State and local</b>	Promptly identify, analyze and respond to disease exposures, outbreaks and epidemics.
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# State and local roles for Communicable Disease Control (from the Public Health Modernization Manual)

<b>State and local</b>	Investigate and control disease outbreaks, in collaboration with partners.
<b>State and local</b>	Provide communications with the public about outbreak investigations
<b>State and local</b>	Coordinate disease control efforts with federal and state partners.
<b>State</b>	Support LPHAs by providing technical assistance and surge capacity as they investigate and control reportable diseases and outbreaks.

# Central Oregon Public Health Partnership: Tri-County Epidemiology

Oregon Public Health Advisory Board Meeting  
November 21, 2019

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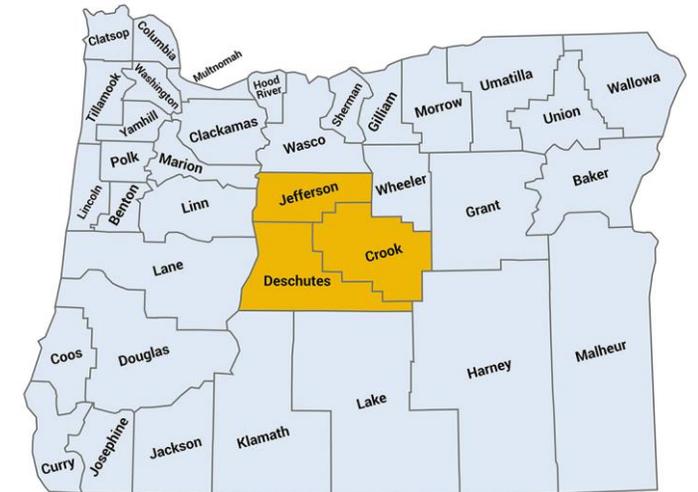
Heather Kaisner

Deschutes County  
Public Health Manager

# Background

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- Limited capacity in Central Oregon to focus on CD prevention, surveillance, and outbreak response
- Used modernization funding to create a tri-county Outbreak Prevention, Surveillance, and Response team
  - Tri-County CD epidemiologist
  - Tri-County Public Health Nurse focusing on Infection Prevention



# Tri-County CD Epidemiologist: Primary Roles

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- **Epidemiologist provides:**
  - Enhanced CD surveillance and risk communication to providers, partners, and the public
  - Internal data to CD staff from each county
  - Ad hoc data presentations
  - Content creation for the 2019 Central Oregon Regional Health Assessment
  - Surge capacity for outbreak response and emerging threats

# Tri-County Flu Surveillance Report

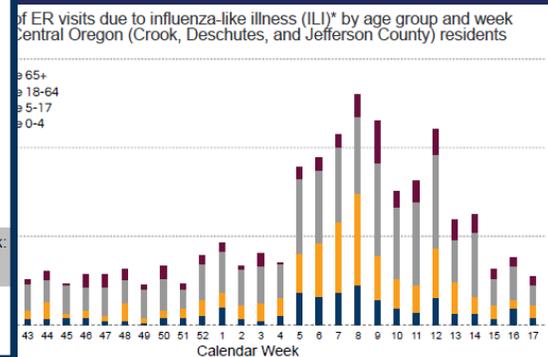
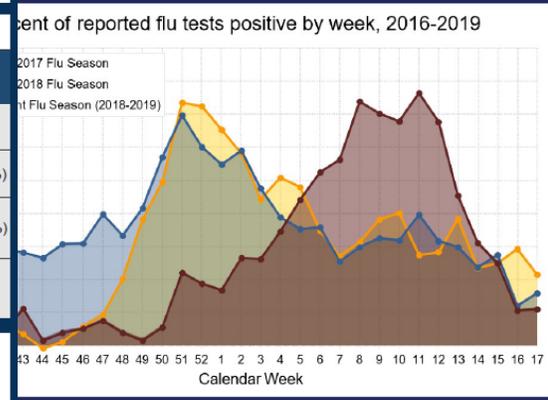
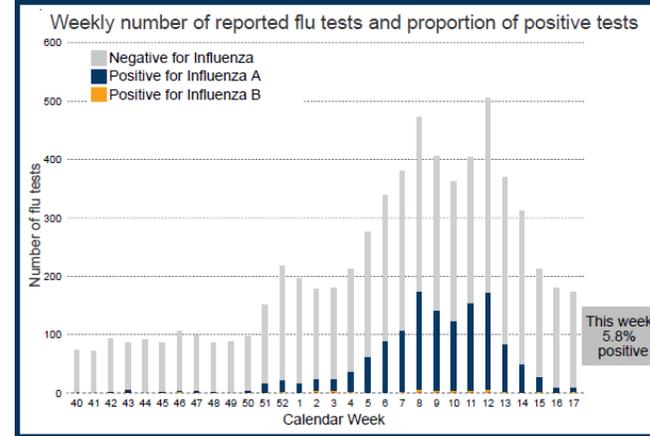
## Creates weekly flu reports during flu season

- Collects and analyzes local data, creates report, and provides context and interpretation
- Disseminating report via Constant Contact this flu season, which allows people to subscribe
- 248 subscribers so far during the 2019-2020 flu season (10/1/19-11/6/19)

### Central Oregon Weekly Flu Report May 3, 2019



Flu surveillance summary				
	4/7-4/13 (Week 15)	4/14-4/20 (Week 16)	Current Week 4/21-4/27 (Week 17)	Cumulative 2018-2019 flu season
Total number of influenza tests from reporting labs	212	180	172	6484
Number of positive influenza tests (% positive)	27 (12.7%)	10 (5.6%)	10 (5.8%)	1365 (21.1%)
Number of Type A positive influenza tests (% of all positive tests)	25 (92.6%)	10 (100.0%)	8 (80.0%)	1317 (96.5%)
Number of Type B positive influenza tests (% of all positive tests)	2 (7.4%)	0 (0.0%)	2 (20.0%)	48 (3.5%)



Number of ER visits by county		
	Last week	This week
Crook County residents	5	8
Deschutes County residents	22	14
Jefferson County residents	11	5

\*Influenza-like illness (ILI) is monitored through the ESSENCE syndromic surveillance database. This report includes visits by Crook, Deschutes, and Jefferson County residents to any ER across the state of Oregon.

This report is compiled by Deschutes County Health Services - Public Health. Data are preliminary and might change as additional reports are received. Thank you to our local labs and clinics who provided data for this report. If your lab or clinic would like to submit influenza data, please contact Jenny Faith at Jennifer.Faith@deschutes.org

# Tri-County Flu Website

Maintains flu website: [www.deschutes.org/flu](http://www.deschutes.org/flu)

- 2,897 website hits during 2018-2019 flu season (10/1/18 - 5/1/19)
- Targeted to providers, but the public and local media are interested, too

*“I truly appreciate your weekly reports and the insights offered!” – Clinic administrator in Madras*

*“We so appreciate you sharing your work with us. It has really helped drive our flu program this year.” – Infection Prevention staff member, St. Charles*

## Local Flu Surveillance

The Central Oregon Weekly flu surveillance report is updated by Friday every week during flu season. The flu report includes flu test data and ER visit data from the previous week.

Click the links below to show a full size graphic, or download the full PDF report from the Supporting Documents section toward the bottom of the page.

For state-wide data, please visit the [Oregon Health Authority's Flu Bites Report](#), which is also updated weekly during flu season.



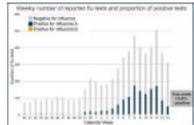
### Flu surveillance summary table (CLICK FOR LARGER IMAGE)

This table shows information about flu tests reported to us from participating labs and clinics across Central Oregon for the previous three weeks, including the total number of tests and total number of positive tests. This information allows us to see if flu has been increasing or decreasing recently, as well as whether we are seeing more influenza type A or influenza type B.

Flu surveillance summary					
Flu surveillance week	Week 1	Week 2	Week 3	Total	Percent Positive
Total number of tests	171	168	171	510	10.0%
Total number of positive tests	17	16	17	50	10.0%
Influenza A	10	10	10	30	10.0%
Influenza B	7	6	7	20	10.0%
Other	0	0	0	0	0.0%

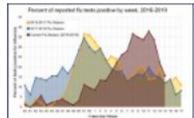
### Weekly flu tests and positive tests (CLICK FOR LARGER IMAGE)

This graph shows the total number of flu tests reported to us from participating labs/clinics and the proportion of positive tests each week throughout the entire flu season. The height of the bar allows us to see whether the number of people in our community getting tested for flu is increasing or decreasing. The colored part of the bar shows us the number of positive tests, which allows us to see if flu is increasing or decreasing over the course of the entire flu season.



### Comparison to previous flu seasons (CLICK FOR LARGER IMAGE)

This graph shows the percent of flu tests positive each week reported to us from participating labs/clinics for this season and the previous two flu seasons. This graph shows us how flu this year looks compared to the previous two years, including whether we are seeing flu peak earlier or later in the season.



### Weekly ER visits for influenza-like illness (CLICK FOR LARGER IMAGE)

This graph shows the weekly number visits for influenza-like illness (ILI) by Crook, Deschutes, and Jefferson County residents to any emergency room across the state of Oregon. The bars are broken into age groups so we can see if any age groups might be impacted more than others by flu this year.



### Flu Facts & Prevention

The annual flu shot is the best way to protect yourself from the flu. If you're sick, the best way to prevent spreading illness is by staying home and limiting contact with others.

[Read more](#)

# Tri-County CD Epidemiology Reports

## Creates quarterly CD reports:

- Annual summary of CD cases/rates
- Local flu season recap
- Rising STD rates
- Emerging topics
- Highlighted demographics and disparities

**Central Oregon Public Health Quarterly**  
Communicable Disease Update for Crook, Deschutes, and Jefferson Counties  
2018: Quarter 1

24/7 Communicable Disease reporting lines:	Crook County: 541-447-5165	Deschutes County: 541-322-7418	Jefferson County: 541-475-4456
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### 2017 Communicable Diseases Year-in-Review

The table below summarizes 2017 case counts and estimated rates for select reportable communicable diseases with Central Oregon regional case counts of 5 or higher.

Reportable Disease or Condition	Oregon		Crook Co.		Deschutes Co.		Jefferson Co.	
	Case count	Rate per 100,000 population	Case count	Rate per 100,000 population	Case count	Rate per 100,000 population	Case count	Rate per 100,000 population
Campylobacteriosis	1,059	25.6	14	63.3	67	36.6	7	30.2
Chlamydia	18,723	452.1	91	411.7	675	369.0	161	694.3
Cryptosporidium	274	6.6	<5	--	10	5.5	<5	--
E. Coli (STEC)	211	5.1	<5	--	12	6.6	<5	--
Giardiasis	339	8.2	<5	--	17	9.3	<5	--
Gonorrhea	5,039	121.7	14	63.3	65	35.5	49	211.3
Hepatitis B (Chronic)	492	11.9	<5	--	8	4.4	<5	--
Hepatitis C (Chronic)	6,007	145.1	37	167.4	232	126.8	62	267.4
Elevated Blood Lead Level	975	23.5	<5	--	15	8.2	<5	--
Salmonellosis (non-typhoidal)	483	11.7	<5	--	14	7.7	<5	--
Shigellosis	122	2.9	<5	--	<5	--	<5	--
Syphilis	861	20.8	<5	--	11	6.0	<5	--
Vibriosis	32	0.8	<5	--	9	4.9	<5	--
Yersiniosis	48	1.2	<5	--	5	2.7	<5	--

Case counts include both confirmed and presumptive cases. Case counts are preliminary as of February 1, 2018. When case counts are <5, county-level data is suppressed and county-level rates are unreliable. Rates calculated using 2017 mid-year population estimates from the Population Research Center at Portland State University.

### Central Oregon Year-in-Review Highlights

- The total number of chlamydia and gonorrhea cases in Central Oregon increased by 21.2% and 33.3%, respectively, since 2016.
- The highest number of chlamydia and gonorrhea cases in Central Oregon were in Deschutes County; however, the largest rates of chlamydia and gonorrhea (cases per 100,000 population) were in Jefferson County. (Details can be found on the next page.)
- Giardiasis cases (n=24) decreased 36.8% from 2016 (n=38).
- Salmonellosis cases (n=17) decreased 32% from 2016 (n=25).
- The number of cases of cryptosporidium, chronic hepatitis C, and syphilis in 2017 were similar to the number of cases in 2016.

### Disease Spotlight: Chlamydia

#### Chlamydia cases are on the rise in Central Oregon.

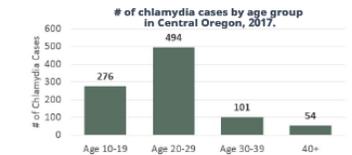
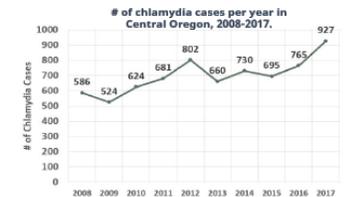
The increase in cases over time is partially due to our increase in population; however, rates of chlamydia (# of cases per population) peaked in 2017 (406.2 cases per 100,000 population for the Central Oregon region).

In 2017, the largest number of cases in Central Oregon were in Deschutes County (15), followed by Jefferson County (161) and Crook County (91).

Of the three Central Oregon counties, Jefferson County had the highest rate of chlamydia in 2017 (694.3 per 100,000 population), followed by Crook County (411.7 per 100,000 population) and Deschutes County (369.0 per 100,000 population).

#### Chlamydia affects young adults and females the most.

Most (53%) chlamydia cases in Central Oregon in 2017 were among those aged 20-29. Most (83%) cases were female.



### Disease Spotlight: Gonorrhea

#### Gonorrhea cases are on the rise in Central Oregon.

The increase in cases over time is partially due to our increase in population; however, rates of gonorrhea (# of cases per population) peaked in 2017 (55.1 cases per 100,000 population for the Central Oregon region).

In 2017, the largest number of cases seen in Central Oregon were in Deschutes County (65), followed by Jefferson County (49) and Crook County (14).

Of the three Central Oregon counties, Jefferson County had the highest rate of gonorrhea in 2017 (211.3 per 100,000 population), followed by Crook County (63.3 per 100,000 population) and Deschutes County (35.5 per 100,000 population).

#### Gonorrhea affects young adults and males the most.

Most (56%) gonorrhea cases in Central Oregon in 2017 were among those aged 20-29. Slightly more than half (55%) of all cases were male.

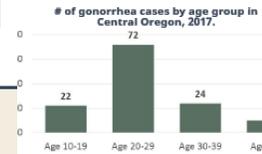
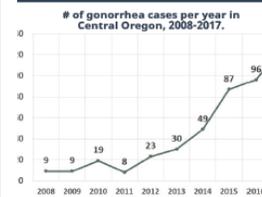
**The number of annual gonorrhea cases has rapidly increased in Central Oregon.** Gonorrhea rates have increased from 3.5 per 100,000 population in 2008 to 55.1 per 100,000 population in 2017 in the Central Oregon region. Rates have more than doubled since 2014.

In 2017, the largest number of cases seen in Central Oregon were in Deschutes County (65), followed by Jefferson County (49) and Crook County (14).

Of the three Central Oregon counties, Jefferson County had the highest rate of gonorrhea in 2017 (211.3 per 100,000 population), followed by Crook County (63.3 per 100,000 population) and Deschutes County (35.5 per 100,000 population).

#### Gonorrhea affects young adults and males the most.

Most (56%) gonorrhea cases in Central Oregon in 2017 were among those aged 20-29. Slightly more than half (55%) of all cases were male.



#### Are STD cases increasing in Central Oregon?

There is more readily available and anonymous, partially due to dating apps. This makes tracking and partner notification more difficult. (Use of condoms has decreased.) STDs are spreading more broadly and into populations not traditionally affected by STDs. We have become better at detecting cases. This is due to many reasons including changes in national screening guidelines, more sensitive tests, and increased access to healthcare services, including STD services.

- Our local health departments have experienced decreased funding for STD services.

#### What can be done to slow or stop the increase?

- **Providers:** make STD screening and timely treatment a standard part of medical care, especially for pregnant women, MSM, and young adults.
- **Local health departments:** increase prevention efforts through targeted outreach and messaging, and use innovative methods to conduct partner services.
- **Everyone:** talk openly about STDs, get tested regularly, and reduce risk by using condoms or practicing mutual monogamy if sexually active.

# Local Data and Communication

## Supports CD staff with local data and cross-jurisdictional communication

- Creates and disseminates internal data reports:
  - Orpheus data quality reports for county CD staff using OHA triennial review tool
  - Monthly (Deschutes) and quarterly (Crook & Jefferson) case count reports
- Convenes weekly surveillance check-in call with CD staff from three county health departments and Confederated Tribes of Warm Springs

PUBLIC HEALTH DIVISION  
Center for Public Health Practice  
Acute and Communicable Disease Prevention Section

Oregon Health Authority

Date: April 1, 2019 through June 30, 2019

Local Public Health Authority: Deschutes County      Participants: \_\_\_\_\_

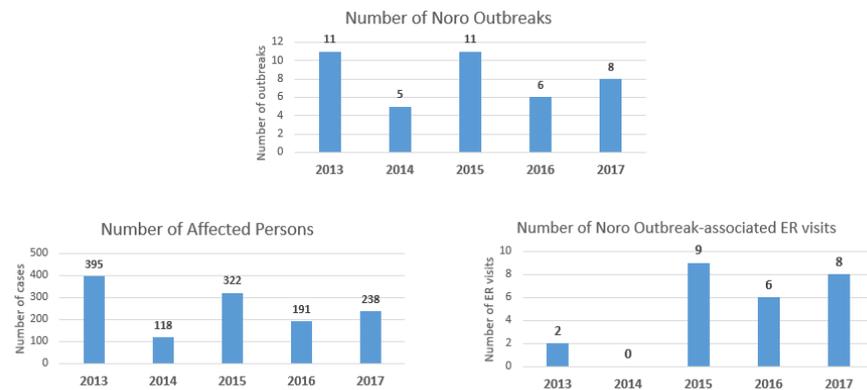
Local Public Health Administrator: \_\_\_\_\_      Reviewer: \_\_\_\_\_

A. Criteria for Compliance	Compliant			Comments/Documentation/Explanation/Timelines
	Y	N	N/A	
<b>I. BLOOD BORNE PATHOGEN PROTOCOLS AND TRAINING</b>				
1. The Local Public Health Authority (LPHA) has a Blood Borne Pathogen (BBP) protocol ( <i>Exposure control plan</i> ) <a href="#">29 CFR 1910.1030 (c)(1)(G)</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	N/A
2. There is documentation that the Blood Borne Pathogen (BBP)/ exposure plan is reviewed and updated annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions and occupational exposure <a href="#">29 CFR 1910.1030 (c)(1)(iv)</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	N/A
3. All communicable disease employees with potential occupational exposure to <b>bloodborne</b> pathogens participate in an infection control training at time of initial work and at least annually thereafter. <a href="#">OAR 437-002</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	N/A
<b>II. ROUTINE COMMUNICABLE DISEASE INVESTIGATION AND CONTROL</b>				
1. Proportion* of cases in which interview is conducted [ <i>interview by proxy is acceptable</i> ] ( <i>Looking at cases for which investigation is required</i> ) OAR 333.019.000 (1); Public Health (PH) Modernization Manual: Communicable disease control	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	XXX.X% (XX out of XX)
2. Proportion* of cases with complete date of birth or age ( <i>Looking at all cases that require an investigation</i> ) OAR 333.019.000 (1); PH Modernization Manual: Communicable disease control	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	XXX%

# Local Data and Communication

- Provides local data to Infection Prevention Nurse for use in infection prevention trainings
- Provides ad hoc data as requested/needed from CD staff

Crook, Deschutes, and Jefferson Counties:  
Noro Outbreak Data, 2013-2017



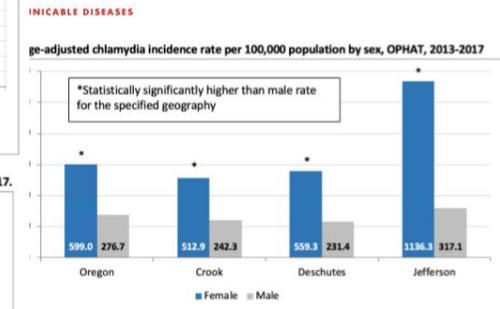
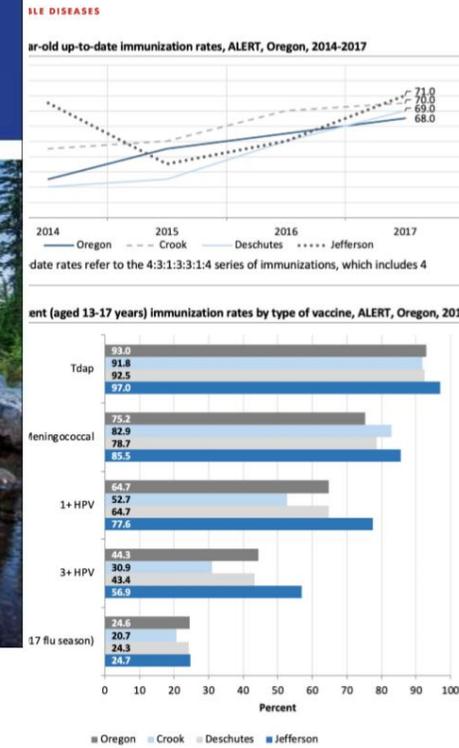
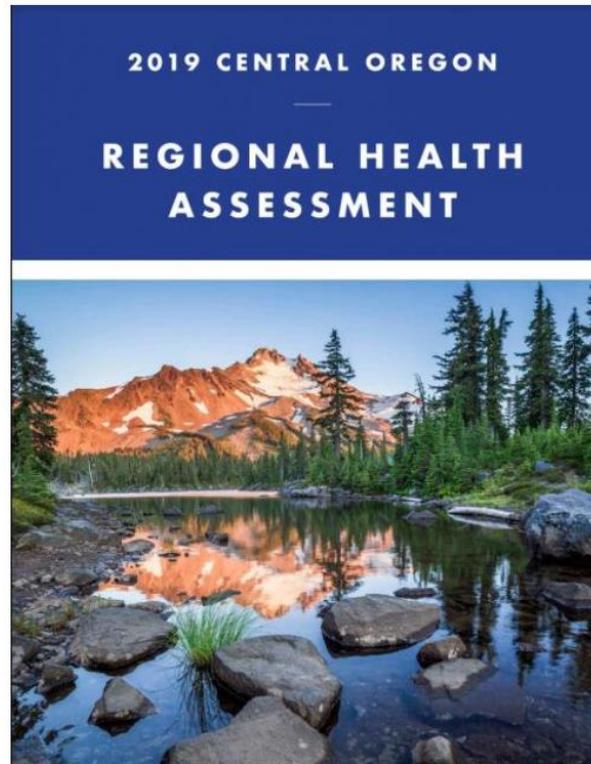
Setting of norovirus outbreaks reported in Crook, Deschutes, and Jefferson Counties, 2008-2018

Outbreak Setting	Number of Outbreaks	Percent of all Outbreaks
Long term care facility, nursing home, or assisted living facility	51	68.0%
Reception facility, caterer, or sit-down restaurant	7	9.3%
School	5	6.7%
Child Daycare Center	4	5.3%
Hospital	2	2.7%
Prison or jail	2	2.7%
Other or unknown	4	5.3%
<b>Total</b>	<b>75</b>	<b>100%</b>

# Central Oregon Regional Health Assessment

## Created sections of the 2019 Central Oregon RHA

- Created Demographic, immunizations, CD, and STD sections
- Participated in RHA Steering Committee



Syphilis is another common STI that is treatable yet has serious long-term effects if left untreated. Both gonorrhea and syphilis can be present in the same person, so women and men with syphilis should be tested annually. In 2017, the gonorrhea rate was 87.7 per 100,000 population, which is higher than the rate in Oregon (79.4 per 100,000 population) and Jefferson County (29.4 per 100,000 population), but lower than the rate in Deschutes County (119.7 per 100,000 population). Jefferson County's rate was higher than Oregon's rate, and Deschutes County's rate was significantly higher than Oregon's rate (87.7%). In addition, in Jefferson County, the gonorrhea incidence rate for males was significantly higher than for females (87.7% vs. 77.1%).

Syphilis is a rare but serious STI. The number of new syphilis cases has been increasing in Central Oregon since 2012 (Figure 80). Like gonorrhea, syphilis has serious long-term effects if left untreated (dementia, paralysis, severe headaches, blindness).

Human Immunodeficiency Virus (HIV) is transmitted via infected bodily fluids, such as blood, semen, vaginal secretions, and breast milk. If not appropriately treated, HIV can lead to the development of Acquired Immune Deficiency Syndrome (AIDS) and is a serious chronic disease that makes a person susceptible to many other infections and diseases. Over the past ten years, there were 55 new HIV cases diagnosed among Central Oregon residents. The number of newly diagnosed HIV cases per year in Central Oregon has ranged from 2 in 2015 to 9 in 2017 (Figure 83). Nearly a quarter (23.7%) of Central Oregonians living with diagnosed HIV are over 60 years of age, and only 4.5% are younger than 30 years old (Figure 81). Most (85.3%) Central Oregonians living with diagnosed HIV are male (Figure 82).

Among males, in Deschutes County and across Oregon as a whole, the male rate was higher than the female rate (Figure 79). When broken down by age, the gonorrhea incidence rate in the 20-49-year-old age groups in Central Oregon was significantly lower than the Oregon age-specific rate (Figure 78).

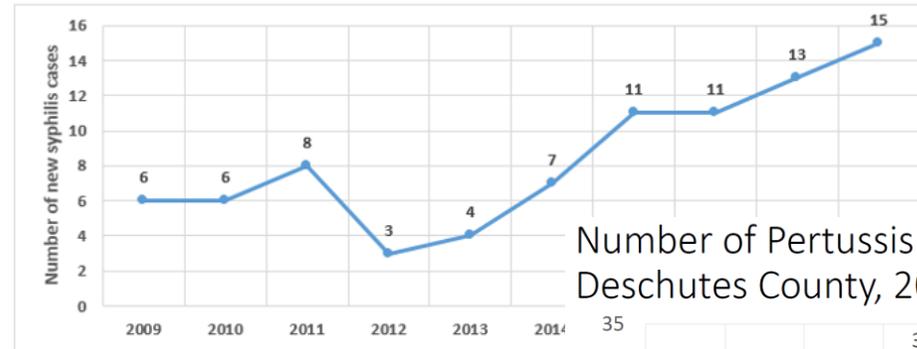
# Other/Ad Hoc Activities

## Provides:

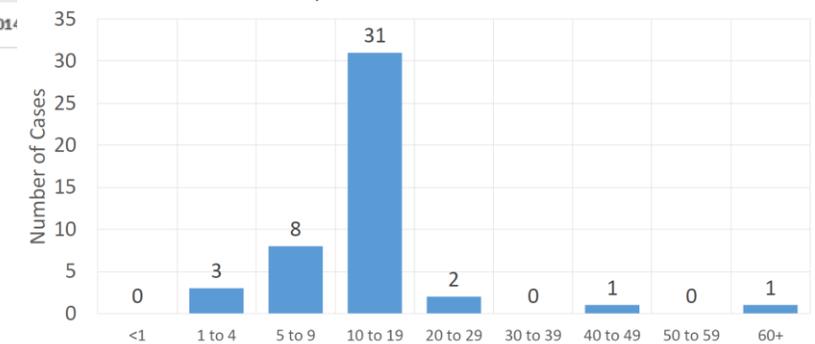
- Ad hoc reports/presentations
- After-action outbreak reports and participates in meetings with facilities for each outbreak in the tri-county area
- Surge capacity when needed (e.g., measles exposure)

## Sexually Transmitted Disease

Figure 80. Number of new syphilis cases diagnosed per year, Central Oregon Counties, 2009-2018.



Number of Pertussis Cases by Age Group, Deschutes County, 2019\*



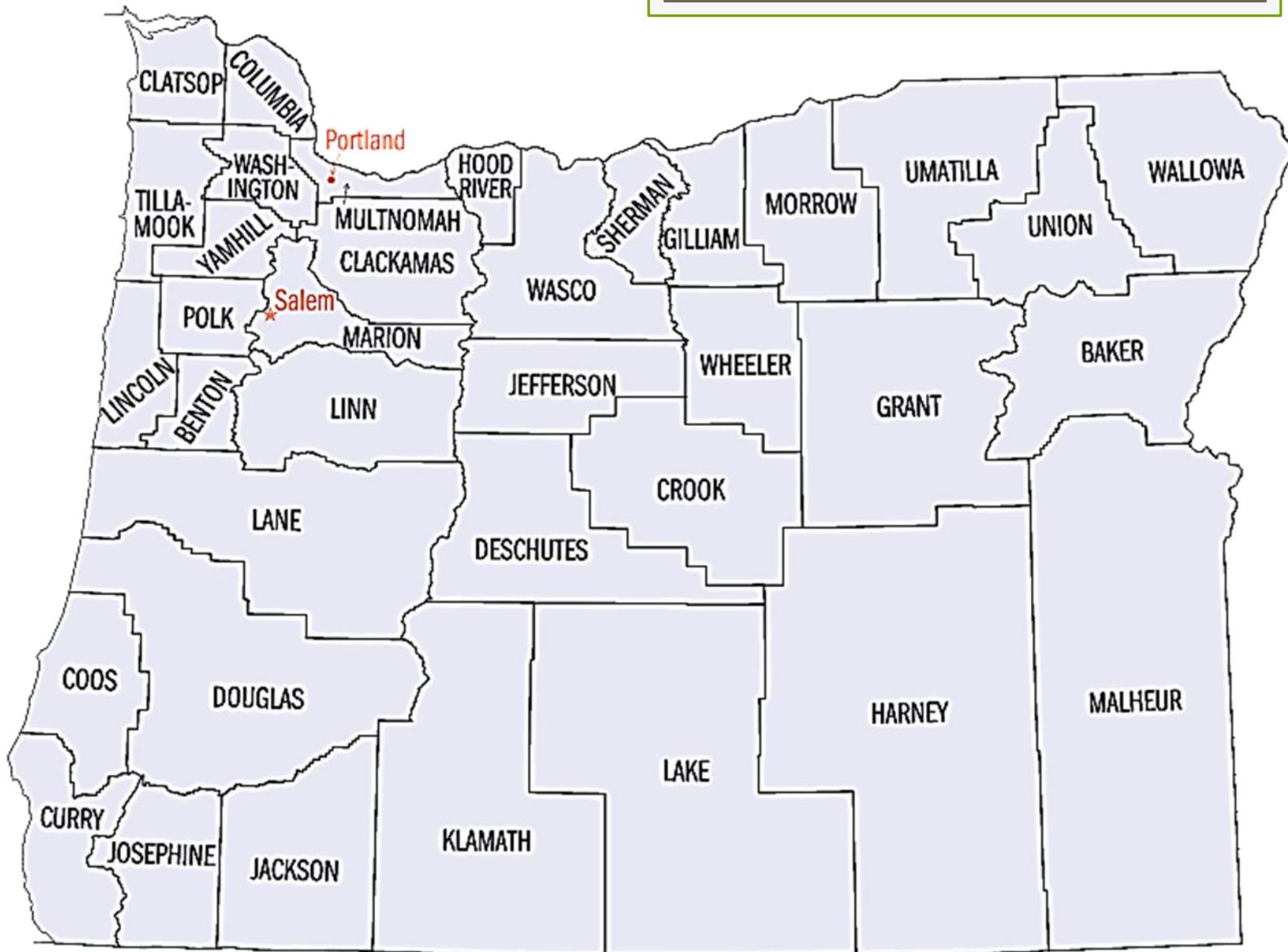
\*Cases as of September 27, 2019

# Eastern Oregon Modernization Collaborative

- Cross-Jurisdictional Sharing for a Healthier Eastern Oregon
- Public Health Advisory Board
- November 21, 2019
- Teri Thalhofer, RN, BSN
- Director, North Central Public Health District

# The EOMC Partnership

- 11 Local Public Health Authorities
- 13 Counties
- Eastern Oregon Coordinated Care Organization
- Mid-Columbia Health Equity Advocates
  
- Serving 240, 850 Residents



# EOMC Communicable Disease

- Regional Epidemiologist
- Regional Systems Liaison
  
- Capacity added for reporting, response, analysis and prevention

# Reporting Capacity

- ORPHEUS backup and surge capacity
  - Recorded over 150 hours of case management activities
- Local staff one on one training in use of DUDE and ORPHEUS data entry/ case management
- Provided opportunity for regional partners to be 'off the grid' to enhance wellness

# Response Capacity

- Developed policy for use of email, texting and social networking sites as a means to contact CD/STI cases and improve partner notification
- Increased capacity to respond to West Nile Virus in the region and facilitate testing to confirmation
- Facilitated and participated in Passport to Partner services training which enhanced STI response

# Analysis Capacity

- Produce monthly CD/STI reporting by County and by Region
- Annual reports developed describing the burden of disease by County with historical comparisons
- Provided data analysis as requested by LPHA's and tribal partners
- Provided data to inform the CGCCO CHA

# Outreach Capacity

- Developed fact sheet regarding increase of gonorrhea/chlamydia/syphilis infections in Eastern Oregon, including treatment recommendations, link to increased risk for HIV infection and burden of disease based on race/ethnicity. Mailed to every provider in the region during STI awareness month

# Outreach Capacity

- Distributed Toolkits for use by Long-term Care Facilities providing guidelines for outbreak response to influenza and norovirus
- Data analysis provided to LPHA's and partners for use in PSA's and outreach efforts

# Thank you!

- [Terit@ncphd.org](mailto:Terit@ncphd.org)
- Callie Lamendola-Gilliam:  
[callielg@ncphd.org](mailto:callielg@ncphd.org)
- Nora Zimmerman: [noraz@ncphd.org](mailto:noraz@ncphd.org)

**Oregon's public health division promotes and encourages healthy behaviors for Oregonians to protect themselves against disease and potential injury.**

**We collaborate with health care providers and local health departments, as well as state and national government agencies, to help communities and individuals in Oregon protect their health.**



# WORKING TO KEEP OREGONIANS HEALTHY

- Disease prevention and control is a cooperative effort involving health care providers, local and state health department personnel and members of the community. We collaborate with our local public health partners to prevent the emergence and spread of communicable diseases. This includes collecting and analyzing disease reports, studying risk factors, protecting exposed individuals and families, developing guidelines for disease prevention and control, and planning and responding to public health emergencies.
- Communicable Disease Protection is a foundational program of **modernization**.

# MODERNIZED DISEASE RESPONSE



## **Community Partnership**

Support local health public health authorities and medical providers to identify and stop disease transmission



## **Assessment and epidemiology**

Maintain informatics systems to track cases and identify outbreaks



Partner to develop new systems to track patient clinical and risk information



Identify risk factors for disease transmission



Educate and provide training to protect patients and communities

**State and local**

Ensure (state/local) public health capacity to respond to emerging threats.

# It all starts with.....



Sick patient



Visit to a medical provider



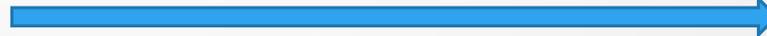
Collect a sample

Test at the laboratory



# HOW DO MODERNIZE DATA COLLECTION FOR PUBLIC HEALTH ACTION?

## ASSESSMENT AND EPIDEMIOLOGY – CORE WORK IS EPIDEMIOLOGY OF INFECTIOUS DISEASE



QUESTIONS	Who	Parent	by A
Risk questions			Answer
Travel outside home area			No
Grocery Stores			New S
ground beef in home			Yes
Leftovers			No
ground beef			Yes
Rare or raw meat			Yes
Raw (unpasteurized) milk			No
Eat any soft cheese made with raw			No
Venison, other game, hunting			No
Animal farm contact (livestock, farms)			No
Dried meat (salami, jerky, etc.)			
eat any spinach			No
eat any fresh lettuce			No
Sprouts (alfalfa, clover, bean, ...)			No
Unpasteurized juice/cider			No
Restaurants, fast food, vendors			Yes
Food at gatherings (potlucks, events)			No
Occupational exposure to excreta			No
Diapered children or adults			No
Recreational water			No
Drinking untreated surface water			No
Zoos, petting zoos, county fairs, 4H			No



Clinical Questions/Symptoms	Answer
Illness duration	5
Diarrhea	Yes
Bloody Diarrhea	Yes
Fever	Yes
Vomiting	No
HUS	No
TTP	No
Any Antibiotics	No

# MODERNIZING COMMUNICATION SYSTEMS

## COMMUNITY AND PARTNERSHIP DEVELOPMENT

- Improving education and outreach

**FOLLOWUP**

**QUESTIONS** Ask Followup Questions

Question

Similar Illness

Prepare Food

Restriction

Restaurant inspection

Dairy inspection

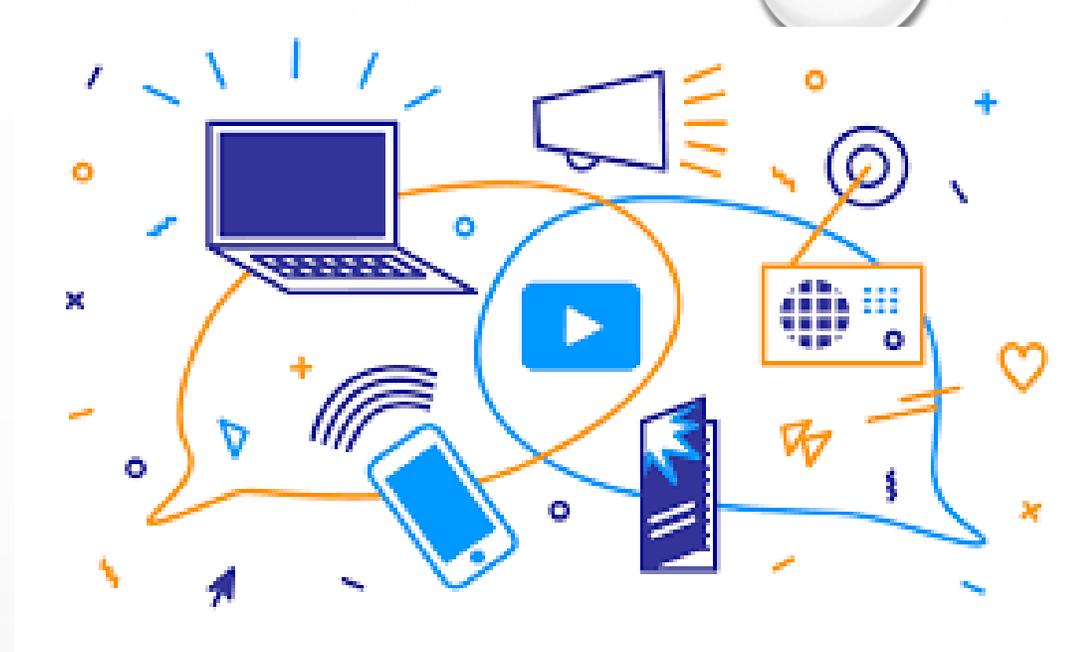
Daycare

Case Education

Household restrictions



- Developing real-time electronic communication systems

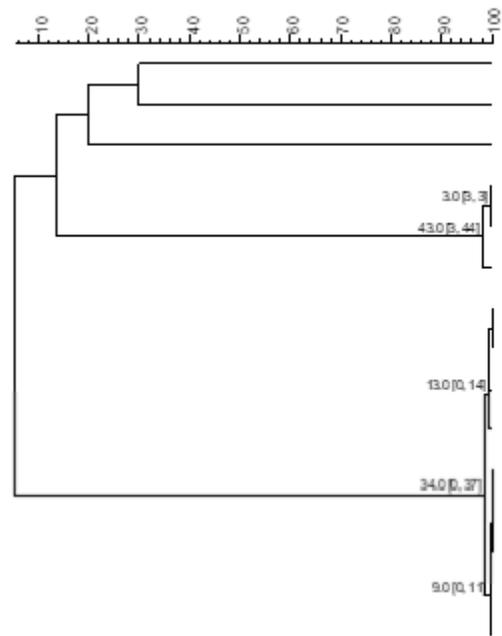


**NOTES** Please do not use notes for data

Add a QuickNote...

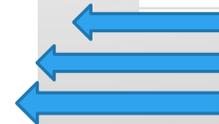
Done	Date	Assigned To	Created By
<input type="checkbox"/>	11/04/19	Alicia Hills	Renee Harger
<input checked="" type="checkbox"/>	11:17 AM	Baker CHD	OPHD
<input checked="" type="checkbox"/>	11/01/19	Alicia Hills	Alicia Hills
<input checked="" type="checkbox"/>	4:51 PM	Baker CHD	Baker CHD
<input checked="" type="checkbox"/>	11/01/19	Alicia Hills	Alicia Hills
<input checked="" type="checkbox"/>	4:31 PM	Baker CHD	Baker CHD
<input checked="" type="checkbox"/>	11/01/19	Renee Harger	Emilio
<input checked="" type="checkbox"/>	3:08 PM	OPHD	OPHD

# MODERNIZING LABORATORY IDENTIFICATION WHOLE GENOME SEQUENCING AND OTHER INNOVATIONS TO DETECT OUTBREAKS



Key	WGS_id	Serotype_wgs	Toxin_wgs
●	19102507512	PNUSAE039485	O103:H2 stx1a
●	19103108825	PNUSAE039479	O26:H11 stx1a
●	19103109094	PNUSAE039477	O121:H19 stx2a
●	19110100213	PNUSAE039475	:H16
	19092707128	PNUSAE036194	:H16
●	19102908172	PNUSAE039483	:H16
●	19103108824	PNUSAE039480	O157:H7 stx2a; stx2c
●	19102908064	PNUSAE039484	O157:H7 stx2a; stx2c
	19100200425	PNUSAE037026	O157:H7 stx2a; stx2c
●	19103008677	PNUSAE039481	O157:H7 stx2a; stx2c
●	19103008666	PNUSAE039482	O157:H7 stx2a; stx2c
●	19110400601	PNUSAE039474	O157:H7 stx2a; stx2c
●	19110100199	PNUSAE039476	O157:H7 stx2a; stx2c
	19091804475	PNUSAE034812	O157:H7 stx2a; stx2c
	19092606794	PNUSAE036197	O157:H7 stx1a; stx2a; stx2c

Analysis	Allele differences to meet cluster criteria	Time Range	Isolates in this cluster	Serotype	Cluster Confirmed?				
Fastmatch wgMLST (cgMLST)	0-5	60 days	19110100199 19103008666 19110400601	O157:H7	yes				
			19102908064	19103008666	19103008677	19103108824	19110100199	19110400601	
			19102908064	0	37	14	0	37	37
			19103008666	37	0	36	36	0	0
			19103008677	14	36	0	14	36	36
			19103108824	0	36	14	0	36	36
			19110100199	37	0	36	36	0	0
			19110400601	37	0	36	36	0	0



**State and local**

Promptly identify, analyze and respond to disease exposures, outbreaks and epidemics.

2017-4613 **Salmonella Newport 1711WAJJP-1** *Salmonella Newport* This report is: incomplete  
Who has the ball? Renee Harger

Home List Record New OB Find OB People Reports Print Help Bugs

Basics Etiology Cases Methods PFGE Documentation Vehicle Factors Animal

Initial impetus: other state HD

1st notification to LHD: 11/30/17  
1st notification to OPHD: 12/01/17  
Investigation start date: 12/01/17

Syndrome: gastroenteritis

Location Details: Exposure Sites: More Detail

Exposure: Oregon  single county  multi-county  
Locations: USA  other states

Residence: Oregon  single county  multi-county  
Locations: USA  other states

City\*:  \*where applicable

EBS:

Location/facility name\*:

Contact info for group, facility, etc.\*:

Setting(s) of exposure: Private Home

Total: 3 0 Outbreak duration (days):

1 Etiology	Conf.	Pres.	Sus.	Ext.	Size	1st Onset	2nd Onset	Last Onset
Salmonella	3	0			3	11/06/17	11/07/17	

County Review (if known)

Earliest date of exposure:   
Latest date of exposure:

Primary mode of transmission: foodborne

Secondary mode of transmission:

EFORS/NORS #: 888888

Likely etiology: Salmonella

Specimens expected: 2

Brief overview (update before submitting final report)  
Multistate cluster of Salmonella Newport, first identified by Washington state and associated with pre-cut fruit consumption. Currently there have been 17 WA cases (6 hospitalizations and 1 death, unknown if due to Salmonella) and 3 OR cases (0 hospitalizations, 0 deaths). Onsets for the entire cluster range from Oct. 29 - Nov. 14, 2017.

Public Health Participants

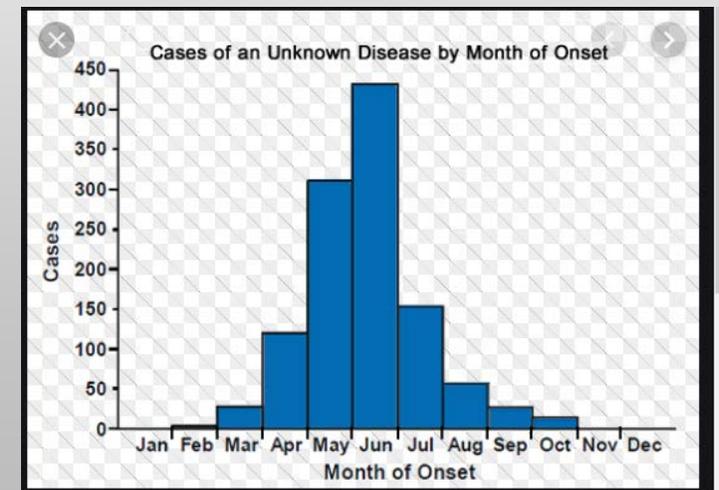
L	R	Public Health Participants	Agency	Role
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Emilio DeBess	OPHD	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Nicole West	OPHD	

Relevant URLs:

Vehicles: Unspecified

Report submitted: State approved: 12/28/2018 Emilio DeBess  
Finalized:

# NEW APPROACHES TO LINK LABORATORY AND EPIDEMIOLOGY DATA



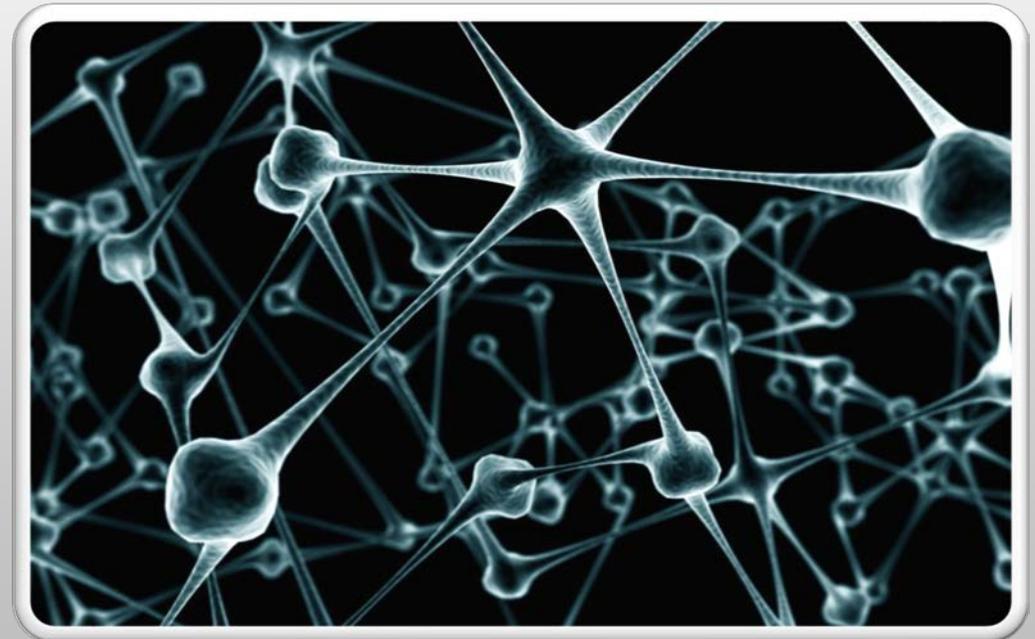


# SUPPORTING LPHAS WITH TRAINING AND SURGE CAPACITY

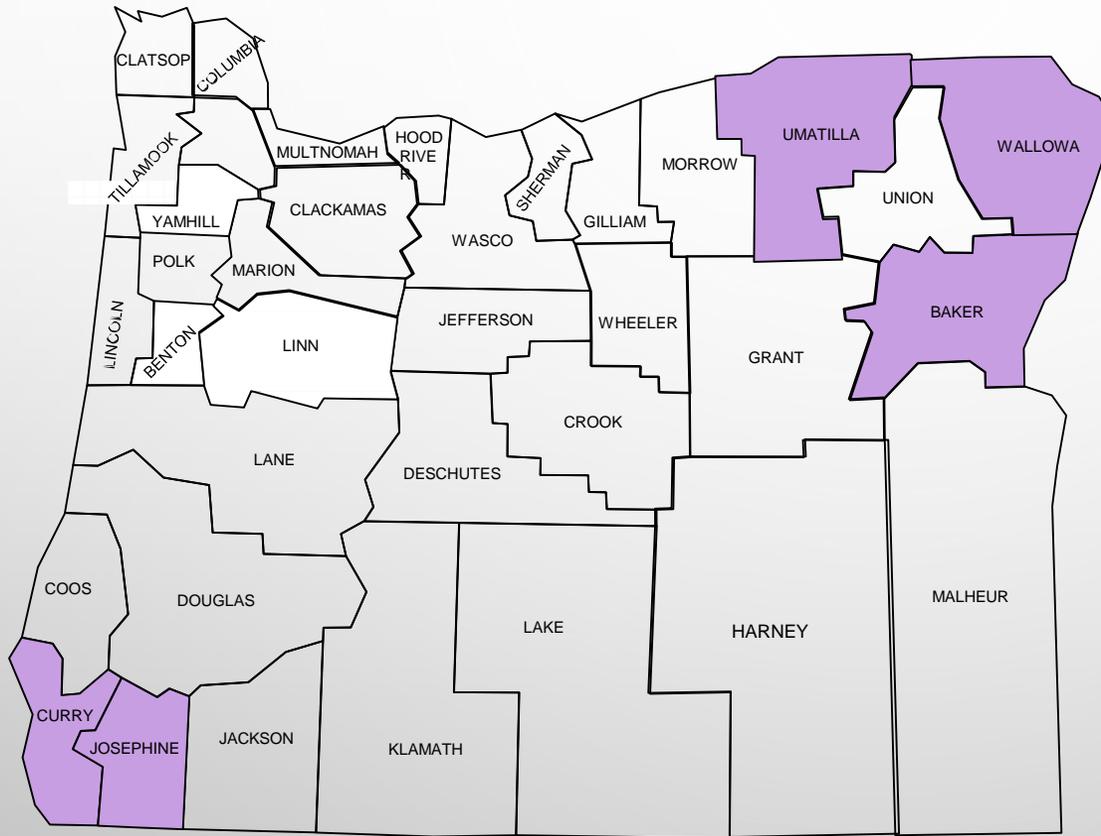
**Training**  
*on the go!*  
A blue silhouette of a person running, positioned below the text "on the go!".

# SURGE CAPACITY

- Ensure that basic PH services are met
- Ability to expand beyond normal services
- Meet sudden and sustained increase demand
- Meet public health resource needs as part of the response in a large scale event



# COUNTY ASSISTANCE AND MODERNIZATION SURGE CAPACITY



- Provide support in surveillance and investigation
- Provide surge capacity
- Provide real time training

# COLORADO TICK FEVER REPORTING

❑ OREGON REPORTED 4 CASES IN 1 MONTH

## BACKGROUND

❑ CTF NOT A NATIONALLY NOTIFIABLE DISEASE

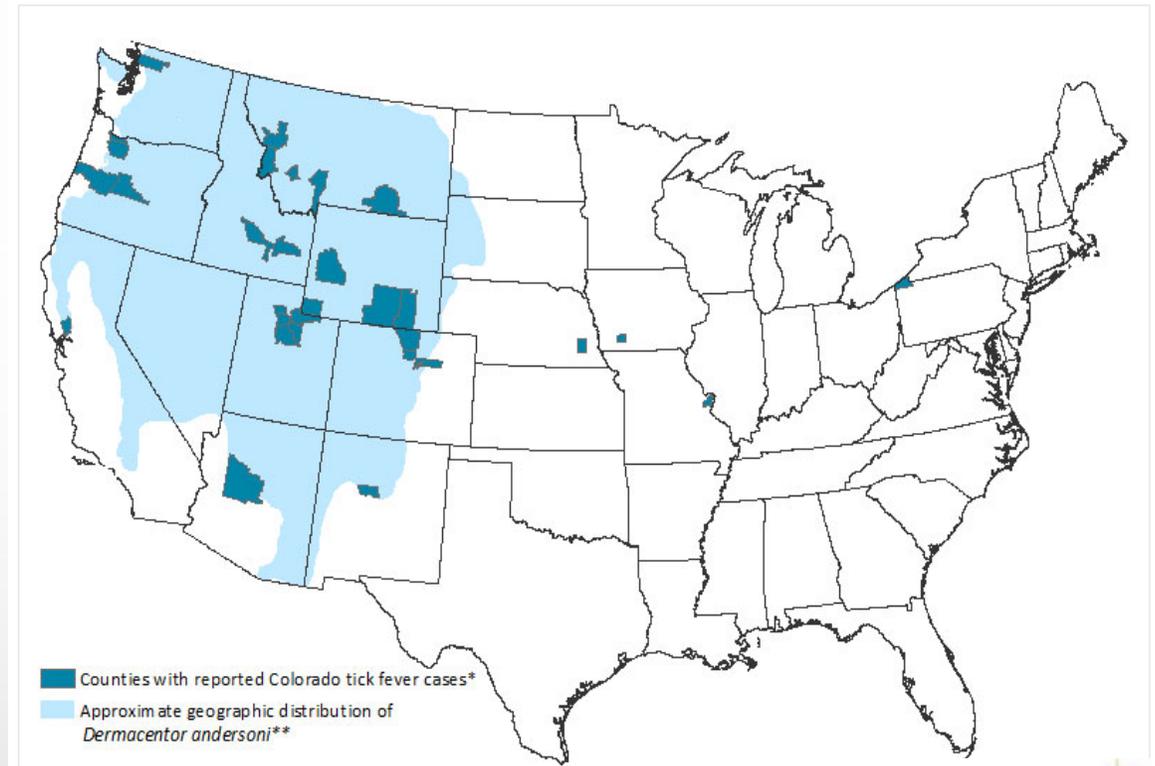
❑ REPORTABLE IN 6 STATES (AZ, MT, NM, OR, UT, WY)

▪ OTHER STATES REPORT ON VOLUNTARY BASIS

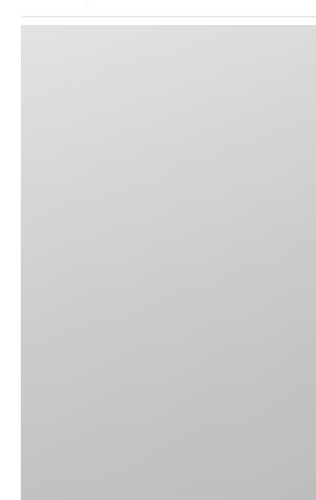
❑ 83 CASES REPORTED FROM 2002-2012

[HTTPS://WWW.CDC.GOV/COLORADOTICKFEVER/STATISTICS.HTML](https://www.cdc.gov/coloradotickfever/statistics.html)

Approximate geographic distribution of *Dermacentor andersoni* ticks and counties of residence for confirmed and probable Colorado tick fever (CTF) virus disease cases, United States, 2002–2012



Adult Female

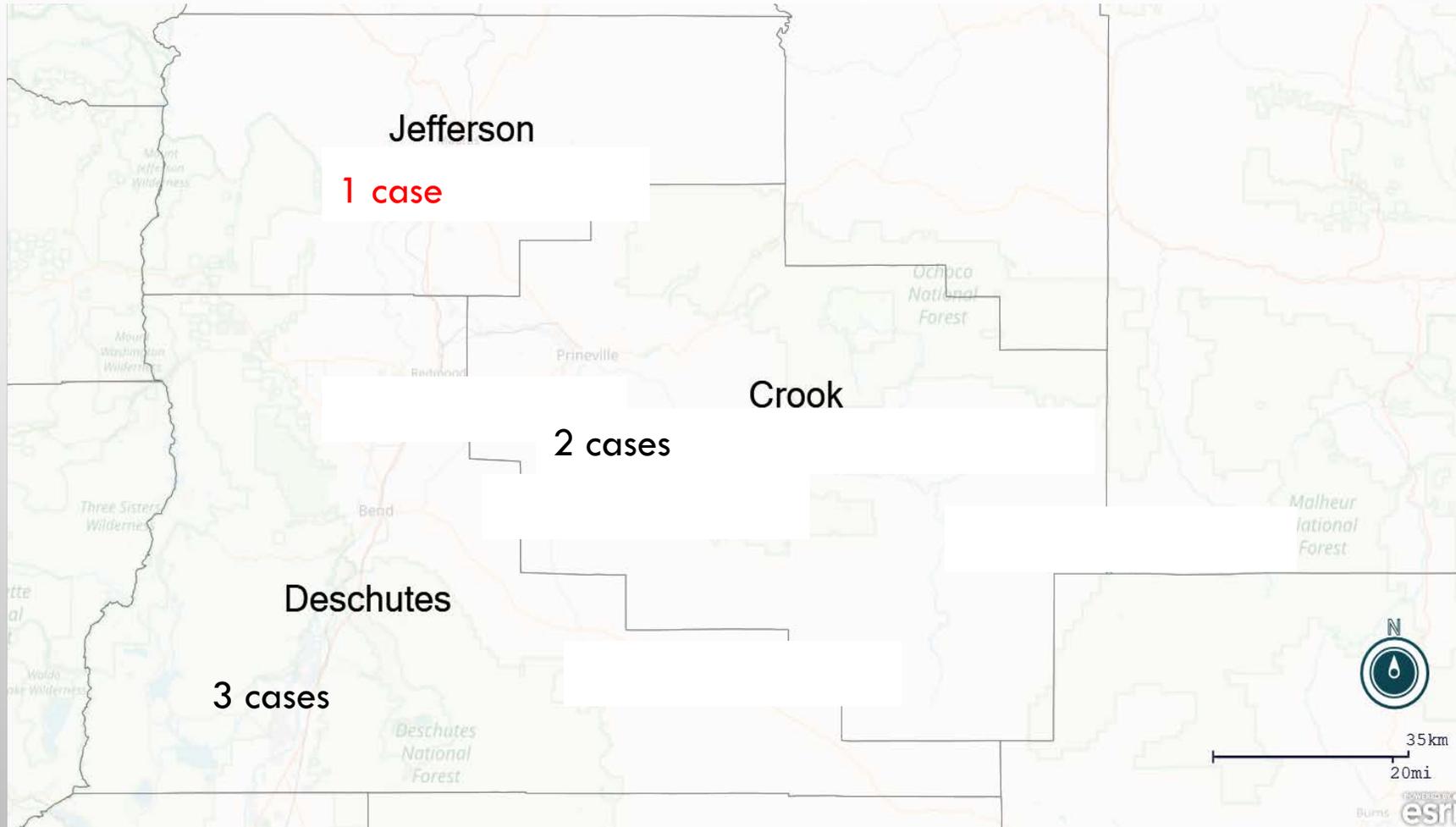


Adult Female

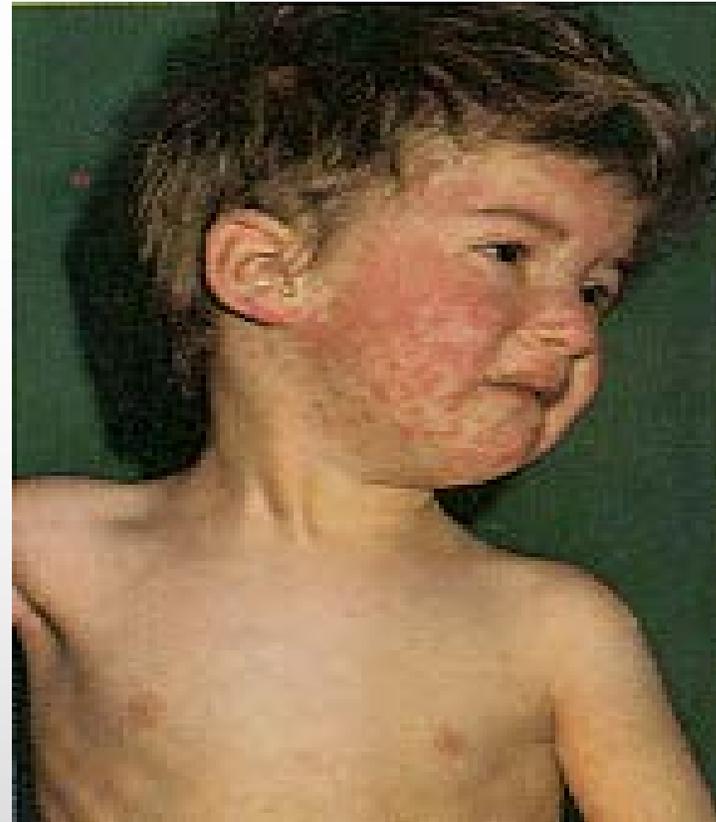
## CASE DESCRIPTION

- ❑ **Worked with Deschutes County communicable disease**
- ❑ **CDC interested in a field investigation**
- ❑ **Met with St. Charles Medical Center**
- ❑ **Got access to their medical records for review in 4 days due to cooperation**
- ❑ **Collected clinical and epidemiologic data on the 4 confirmed case-patients through:**
  - Medical record review using standardized chart abstraction tool and St. Charles Health System, Electronic Medical Record (EPIC)
  - Interviews using questionnaire tailored to CTF symptoms, potential tick exposures, and tick prevention activities
- ❑ **Used geospatial mapping to assess common geographic exposure location(s) prior to illness onset**

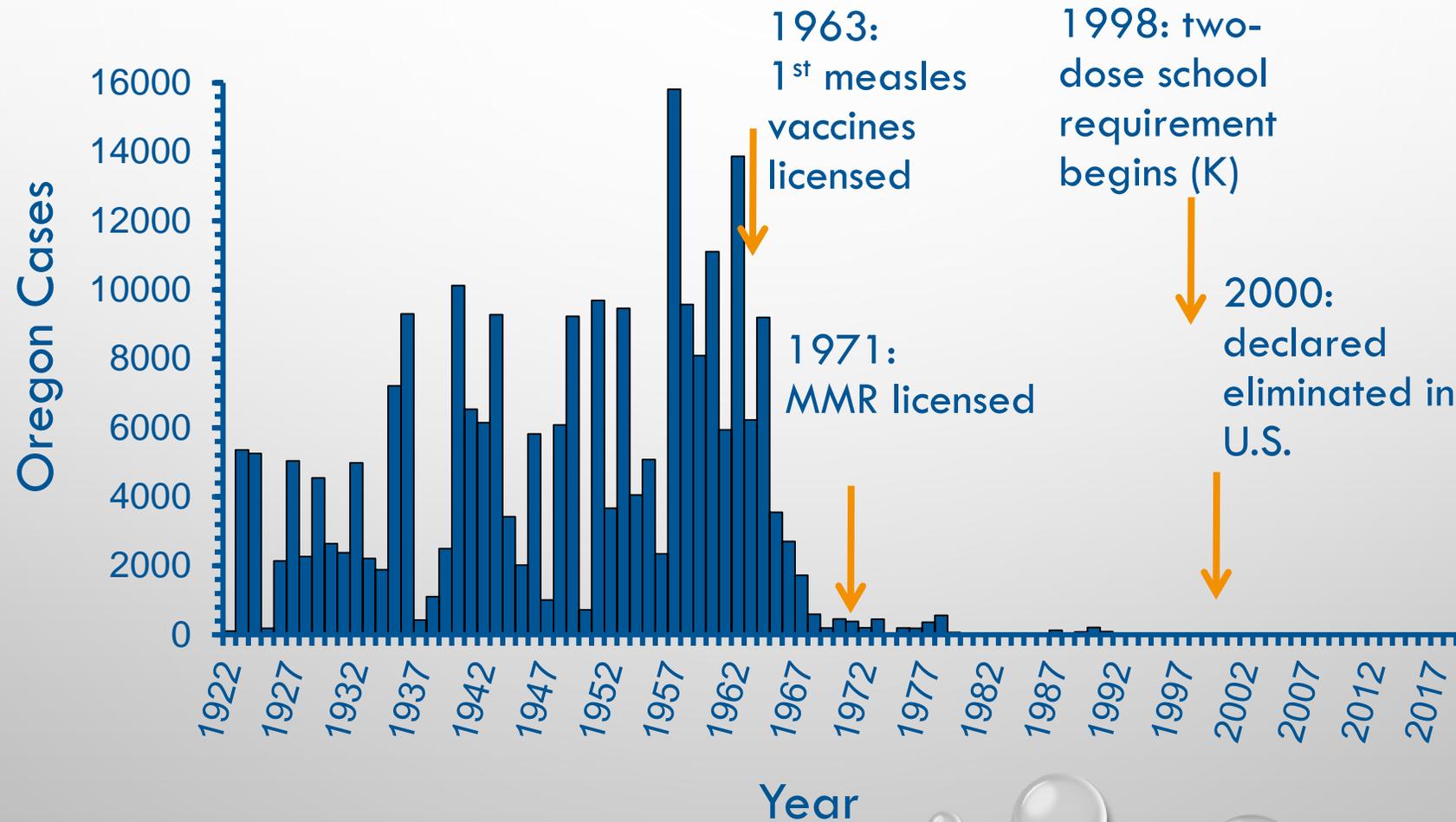
# CONFIRMED CASE-PATIENT LOCATIONS OF RESIDENCE AND REPORTED TICK EXPOSURE IN TRI-COUNTY AREA



# MEASLES



# Control of measles: a modernized public health system in action



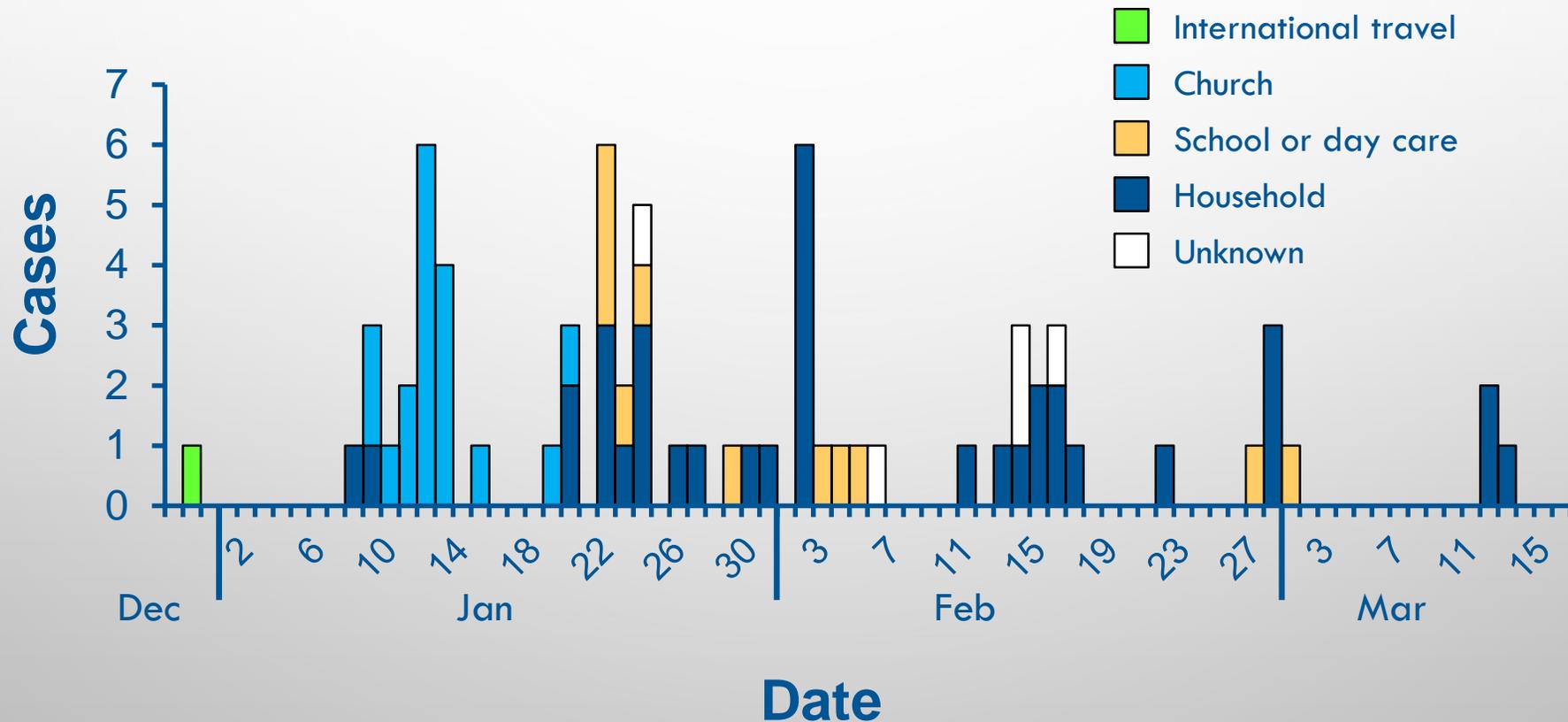
\*data as of 5 Nov 2019

# MEASLES: 2019 TIME LINE

- 4 Jan: Clark County announces confirmed case
- 15 Jan: Clark County announces 2 more confirmed, 11 suspect cases
- 18 Jan: Clark County declares local public health emergency
- 25 Jan: Governor Inslee declares state of emergency; OHA announces 1 confirmed case
- 30 Jan: OSPHL confirms Multnomah County case; OHA activates incident management team

# MEASLES, BY DATE OF RASH ONSET AND TRANSMISSION SETTING

## CLARK COUNTY, WASH., JAN-MAR 2019



# 76 CASES IN THE RECENT OUTBREAK

County	Confirmed Cases
Clark	71
King	1
Multnomah	4

All but 2 cases unvaccinated  
or no documentation  
of vaccination



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# Tribal Public Health Modernization Update

Public Health Advisory Board Meeting  
November 21, 2019

Kelle Little, Tribal Health Director  
Coquille Indian Tribe  
Public Health Advisory Board Member



Public Health Division  
OFFICE OF THE STATE PUBLIC HEALTH DIRECTOR

# History of PH Modernization & Tribes

- In 2015 legislation, Tribes were not included
  - Tribal sovereignty – no mandate to participate in assessment, planning and implementation of PH Modernization
  - Yet, Tribes are crucial part of the overall public health system in Oregon
  - No designated funding to support Tribal PH Modernization assessment
- In 2016, OHA had several conversations with Tribes and Northwest Portland Area Indian Health Board (NPAIHB) about PH Modernization
  - Tribes indicated desire to participate in a Tribal PH Modernization Assessment that was modeled and adapted from the State and LPHA Assessment completed in April 2016.
  - No designated funding to support Tribal PH Modernization assessment
  - Three Tribes and NPIAHB piloted and refined the assessment (August 2016 – July 2017)

# History of PH Modernization & Tribes

- In 2017-2019, Legislature allocated funds to LPHAs and OHA for PH Modernization, but not to Tribes
  - Some Tribes participated in LPHA regional partnership activities, but without funding to support the work
- For 2019-2021, Legislative allocation for PH Modernization includes funding to support Tribal PH Modernization work
  - Initial discussions with Tribes, Native American Rehabilitation Association (NARA) and NPAIHB in Fall 2018
  - More intensive planning began in Summer 2019
  - Tribal work group with representatives from Tribal Health Directors and NPAIHB developed scope of work and funding proposal with OHA – Fall 2019
  - October 2019 SB 770 Health Cluster Meeting – New Tribal PH Modernization Program Element and Funding approved

# Tribal PH Modernization Goals for 2019-2021

- All Tribes and NARA have opportunity to complete the Tribal PH Modernization Assessment and develop Action Plan to modernize their Tribal PH functions
- Some Tribes being implementing plan
- Tribes/NARA determine how they want to engage as part of Oregon's modernized public health system
- As desired, all Tribes/NARA participate in regional partnerships in their service areas with local public health authorities
- Tribes/NARA have the resources and technical assistance needed to achieve these goals

# Tribes/NARA

## Scope of Work for 2019-2021

- Complete or update existing Tribal PH Modernization Programmatic Assessment
- Develop Tribal PH Modernization Action Plan using assessment results – identify and prioritize areas of expertise and capacity for strengthening
- Participate in Tribal PH Modernization Learning Collaborative
- If updating an existing assessment, begin implementation of one or more Action Plan priorities
- Participate in Tribal PH Modernization reporting activities
- Funds may be used to support participation in PH Modernization initiatives with LPHAs in tribal service area and to support general tribal leadership education and buy-in about PH Modernization

# NPAIHB

## Scope of Work for 2019-2021

- Adapt existing Tribal PH Modernization Assessment for use with Tribes/NARA
- Support Tribes/NARA in completion of new or update of existing Assessment; deliver final individual Assessment reports for Tribes/NARA
- Provide individual and collective technical assistance to Tribes/NARA in developing Action Plan
- Convene Tribal PH Modernization Learning Collaborative – one in-person kick-off meeting, monthly virtual learning opportunities
- Work through existing mechanisms with each participating Tribe/NARA to share assessment and action plan data for aggregate, de-identified reports across all participating Tribes/NARA

# Deliverables

## 2019-2021

- By September 1, 2020, each participating Tribe/NARA will complete Assessment
- By February 1, 2021, each participating Tribe/NARA will complete Action Plan
- By October 1, 2020, Tribes/NARA implementing one or more Action Plan priorities will submit tribal program plan to OHA describing activities to be completed by June 30, 2021
- Complete all reporting requirements

# Reporting Requirements 2019-2021

- Aggregated and de-identified Assessment report across all participating Tribes/NARA
- Aggregated and de-identified Action Plan report across all participating Tribes/NARA
- Aggregated progress reports describing accomplishments, challenges, lessons learned, recommendations for future work – June 2020, December 2020, June 2021
- Individual Tribe/NARA quarterly progress reports on accomplishments, challenges and deliverables

# Funding Allocation 2019-2021

- Direct funding to Tribes/NARA
  - \$833,000 split evenly across participating Tribes/NARA
  - December 2019-June 2021
- Contract with NPAIHB
  - \$443,982 for all technical assistance and training
  - January 2020-June 2021
- Funding Sources
  - PH Modernization 2019-2021 Legislative Approved Budget
  - Preventive Health & Health Services Block Grant (federal)

# Next Steps

- Tribes/NARA are currently reviewing Program Element and notifying OHA if they are opting in (by November 27, 2019)
- Program element and funding will be included in December 2019 Tribal PH IGA Amendment
- OHA and NPAIHB are developing agreement for training and TA

# Discussion Questions

- How would PHAB like to receive updates on Tribal PH Modernization efforts?
- What opportunities do PHAB members see for new and/or continued partnerships between OHA, LPHAs and Tribes to modernize Oregon's public health system?

# Eastern Oregon PRIME+ Project

(Peer Recovery Initiated in Medical Establishments + Infectious Disease Testing and Linkage to Care)

## BACKGROUND

### Substance Use Disorder and Hepatitis C: State Public Health Crises and Responses

Oregon has been severely affected by the opioid and methamphetamine crisis, leading to increases in substance use disorder (SUD), overdose, and injection drug use related infections, including hepatitis C in every part of the state, including rural and frontier counties. Oregon’s hepatitis C morbidity and mortality rates are among the highest in the nation.

In the 2018 Oregon legislative session House Bill 4143 was signed into law. The House Bill 4143 included the declaration that addiction was a public health crisis in Oregon and authorized state general funds for pilot hospital-based peer recovery support programs in Coos, Jackson, Marion and Multnomah counties. In the state’s 2019 legislative session, the passage and signing of House Bill 2257 declared Substance Use Disorder (SUD) a chronic disease for which treatment is available and provided. These legislative actions direct state governmental to address, fund, and increase access to effective SUD treatments. Oregon’s Medicaid program also responded to the state’s hepatitis C crisis by eliminating hepatitis C treatment fibrosis and substance use restrictions, making treatment for hepatitis C accessible for persons who are using drugs and hepatitis C elimination possible in Oregon.

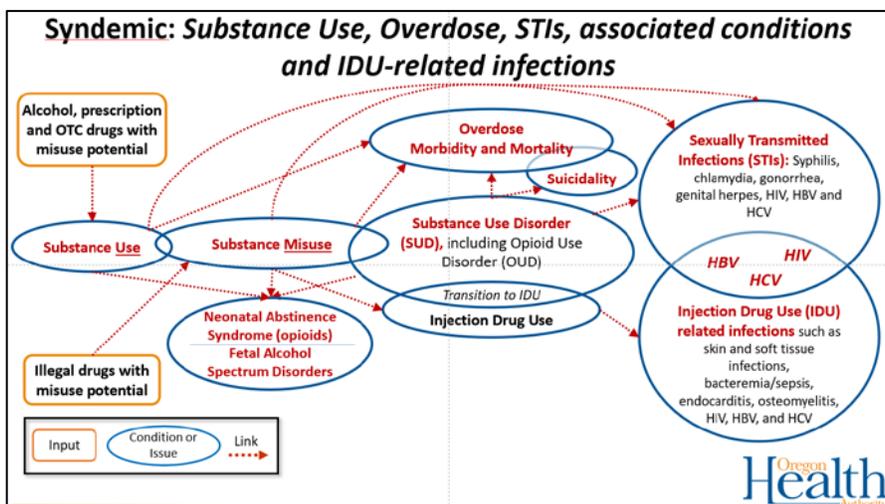
### Oregon Peer-led Program Models for SUD, Overdose and Hepatitis C

#### Peer Recovery Initiated in Medical Environments (PRIME)

The PRIME Program is housed in the Health System Division’s Substance Use Disorder Treatment, Recovery and Prevention Unit. The original aim of the PRIME pilot was to link people who presented to hospital emergency departments (ED) with evidence-based substance use treatment and community resources. Following the success of the pilot and leverage of federal SAMHSA State Opioid Response (SOR) funds, in 2019 the PRIME pilot expanded in scope to: (1) include people hospitalized for SUD related complications; and (2) add an additional 14 counties, including Columbia, Clatsop, Tillamook, Lincoln, Lane, Douglas, Josephine, Deschutes, Klamath, Morrow, Umatilla, Wallowa, Baker and Malheur.

#### PRIME+: Peers addressing Oregon’s Substance Use, Overdose and Infectious Disease Syndemic

When two or more linked epidemics occur at the same time and interact to intensify disease or issue burdens in a population, it is called a *syndemic*. The current prescription and illicit SUD syndemic links substance use, misuse and disordered use with overdose, suicide, unintentional injuries, neonatal abstinence syndrome as well as infectious complications such as HCV, HIV, syphilis and bacterial infections.

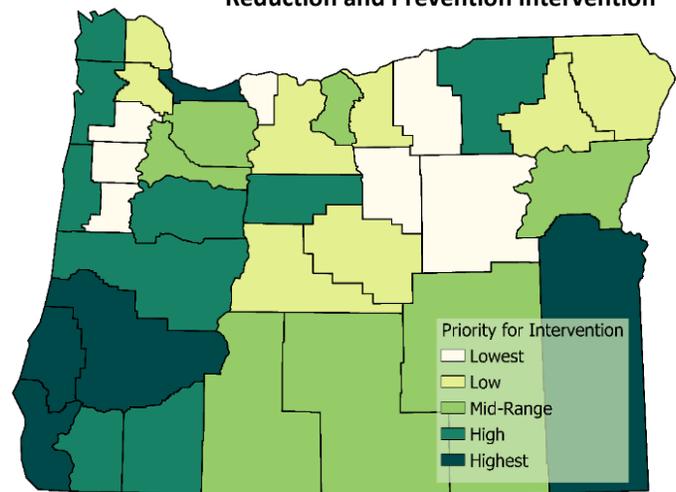


The PRIME + (Peer Recovery Initiated in Medical Environments + Infectious Disease Testing and Linkage to Care) pilot builds upon the successful PRIME model and the experience of another Oregon intervention called Oregon HIV, Hepatitis, Overdose Prevention and Engagement (OR-HOPE). The OR-HOPE intervention was piloted for two years in rural Lane and Douglas Counties, and is slated to expand to additional southwest Oregon counties. OR-HOPE is an individual-, provider-, and systems-level intervention. The individual-level component of OR-HOPE involves a peer-led, one-to-one harm reduction intervention initiated in the community, where peers provide rapid HIV, hepatitis C and syphilis screening, and work to link interested participants with SUD treatment, primary medical care and hepatitis C treatment.

## Rural and frontier Areas are vulnerable to injection drug Use (IDU) related outbreaks

Every part of Oregon is affected by the SUD syndemic. In 2019, the Acute and Communicable Disease Program conducted a vulnerability assessment to identify counties at high risk of IDU-related outbreaks. We identified county-level information about factors associated with risk of injection drug use related HCV infections and used statistical modeling to develop a predictive county vulnerability score for injection-drug use related outbreaks. The county vulnerability scores were grouped to indicate highest predicted risk and priority for intervention (Figure 1).

Figure 1: Priority for Injection Drug Use Harm Reduction and Prevention Intervention



## PRIME + PROJECT AIMS

The PRIME+ intervention wraps around the existing PRIME activities in the pilot counties. The PRIMARY infectious disease related aims of the PRIME+ are to:

- **Conduct testing of hepatitis B (HBV) and hepatitis C (HCV) among persons who inject drugs (PWIDs)** who present to four hospitals (Good Shepherd, St. Anthony, St. Alphonsus and Sky Lakes) in Umatilla, Malheur and Klamath counties for overdose, injection related infections or who have injection drug use in medical record; and
- **Provide peer support to persons who use illicit or injection drugs** to link to primary medical care, complete HBV and HCV diagnostic tests, and attend a medical appointment where the provider is prepared to provide counseling and comprehensive curative treatment for hepatitis C.

*The PRIME+ program adds capacity to communities and hospitals by providing peer-based Harm Reduction counseling and linkage to SUD, HIV and hepatitis testing and treatment.*

The PRIME+ project peers will:

- **Support participants to access preventive care and testing**, such as hepatitis A and B vaccination, STD testing, family planning, HIV testing and HIV Pre-exposure Prophylaxis (PrEP);
- **Support participants to access substance use treatment** for opioid, methamphetamine or other substances; and

- **Provide harm reduction counseling and support** participant access to naloxone, and new syringes and injection equipment through pharmacies, health departments, local community-based organizations or syringe service programs.

## PRIME + IMPLEMENTATION

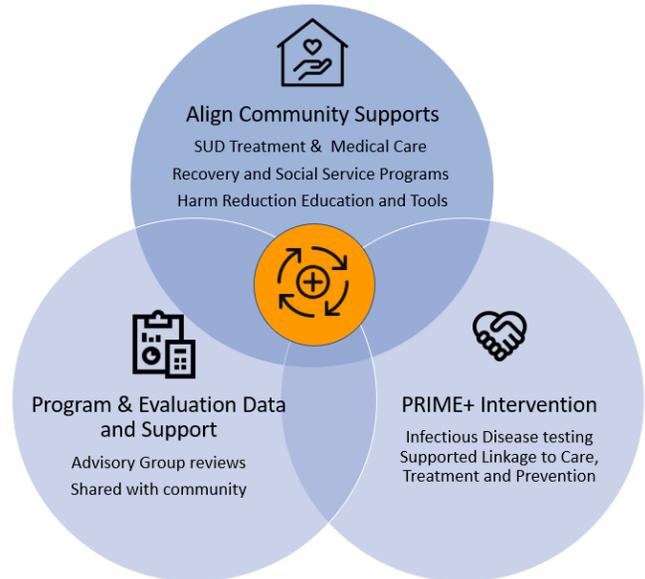
The PRIME+ Intervention staff will

### 1. **Align Community Supports by**

- Engaging with local community advisory groups in each county to share information about the intervention and develop partnerships and business agreements.
- Implementing a cross-site advisory group, made up of representatives from area Coordinated Care Organizations, hospitals, primary health care clinics, substance use disorder treatment, syringe service and opioid treatment programs, and county and state programs to share program and evaluation data; and
- Sharing program and evaluation data, outcomes and experiences with community stakeholders.

### 2. **Develop and implement the PRIME+ intervention with community partners**

- Collect, analyze and share program and evaluation information, including experiences with local and cross site advisory groups, community stakeholders and health system leaders.**



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# A Syndemic Approach to HCV Prevention in Eastern Oregon

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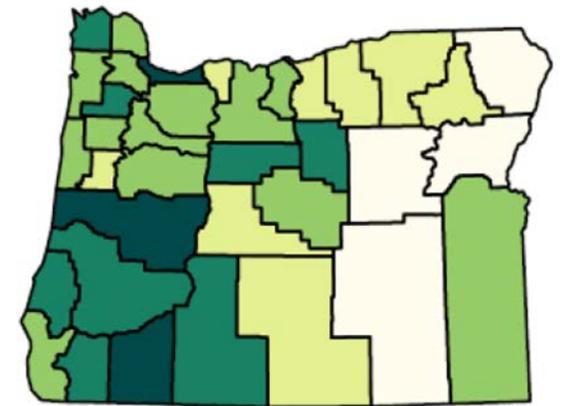
# Outline

## I. Background: *What we have learned*

- Overdose and Infections Related to Injection Drug Use Hospitalizations
- Oregon HOPE (HIV, Hepatitis C, Overdose Prevention and Engagement) Study

## II. Peer Recovery Initiated in Medical Establishments (PRIME): *Using what we have learned*

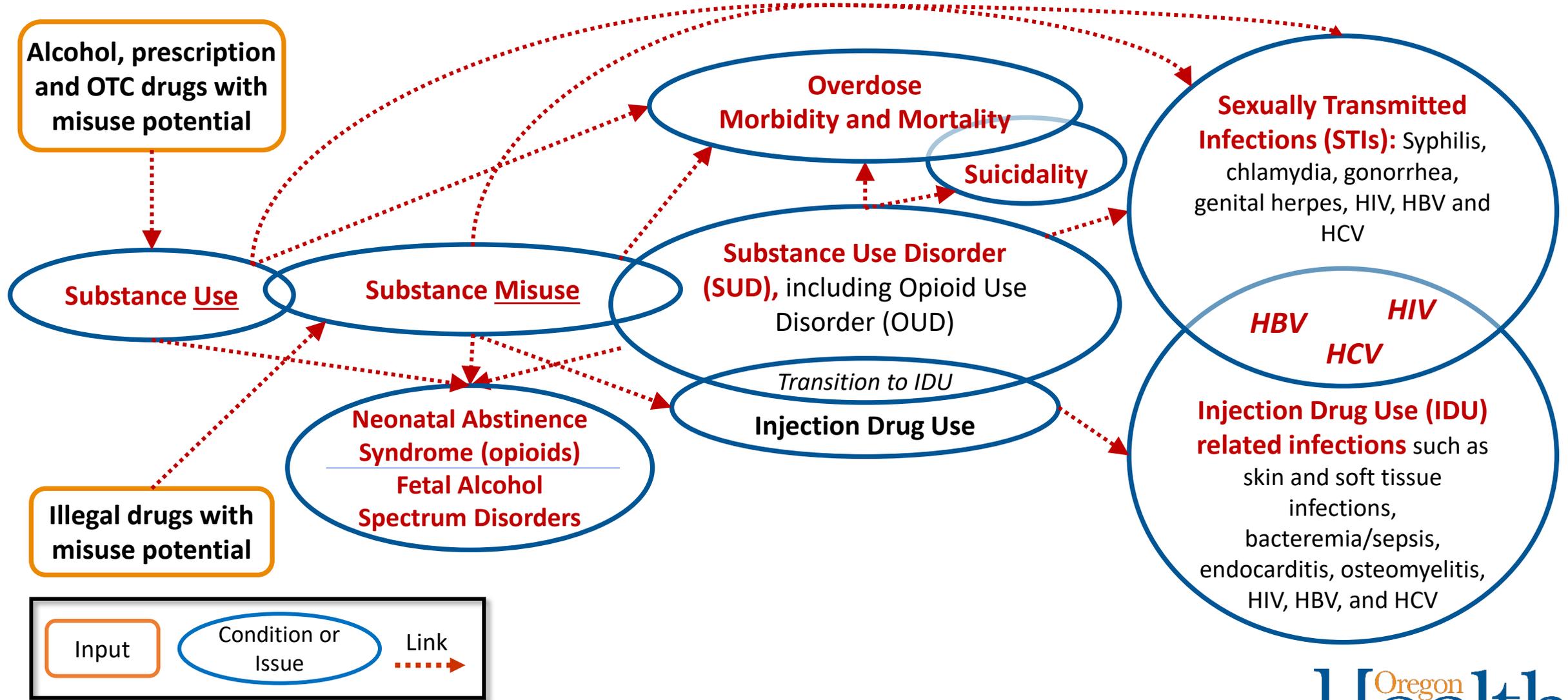
- PRIME Pilot and Expansion
- PRIME+ HCV/HIV screening and Linkage to Treatment



2008-2015

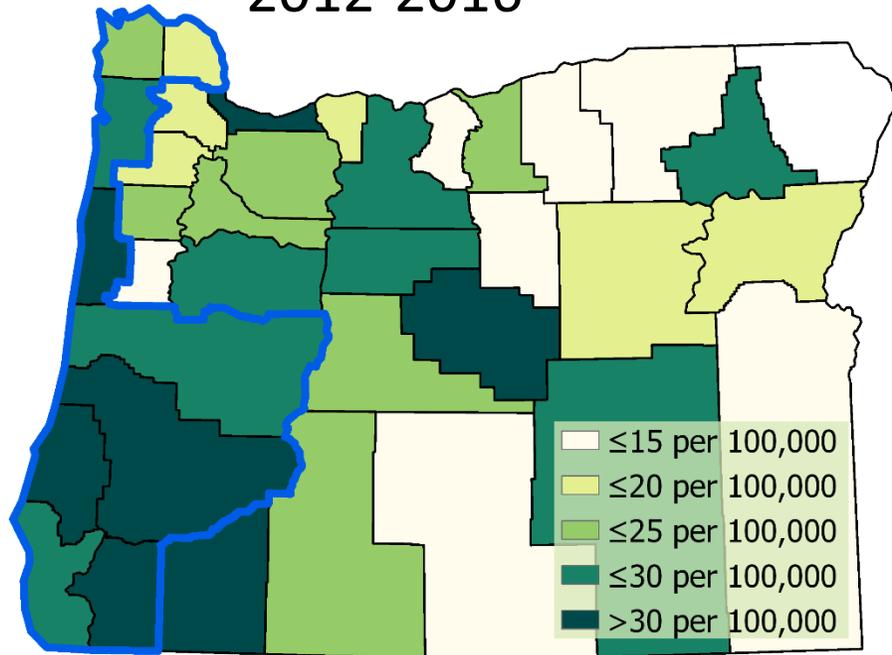


# Syndemic: *Substance Use, Overdose, STIs, associated conditions and IDU-related infections*

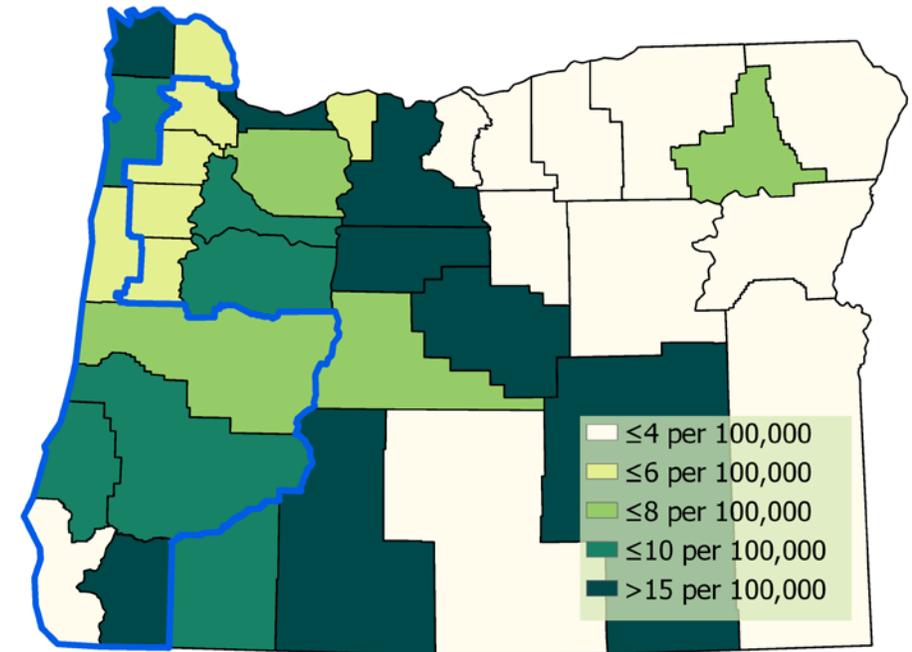


# Overdose Hospitalizations

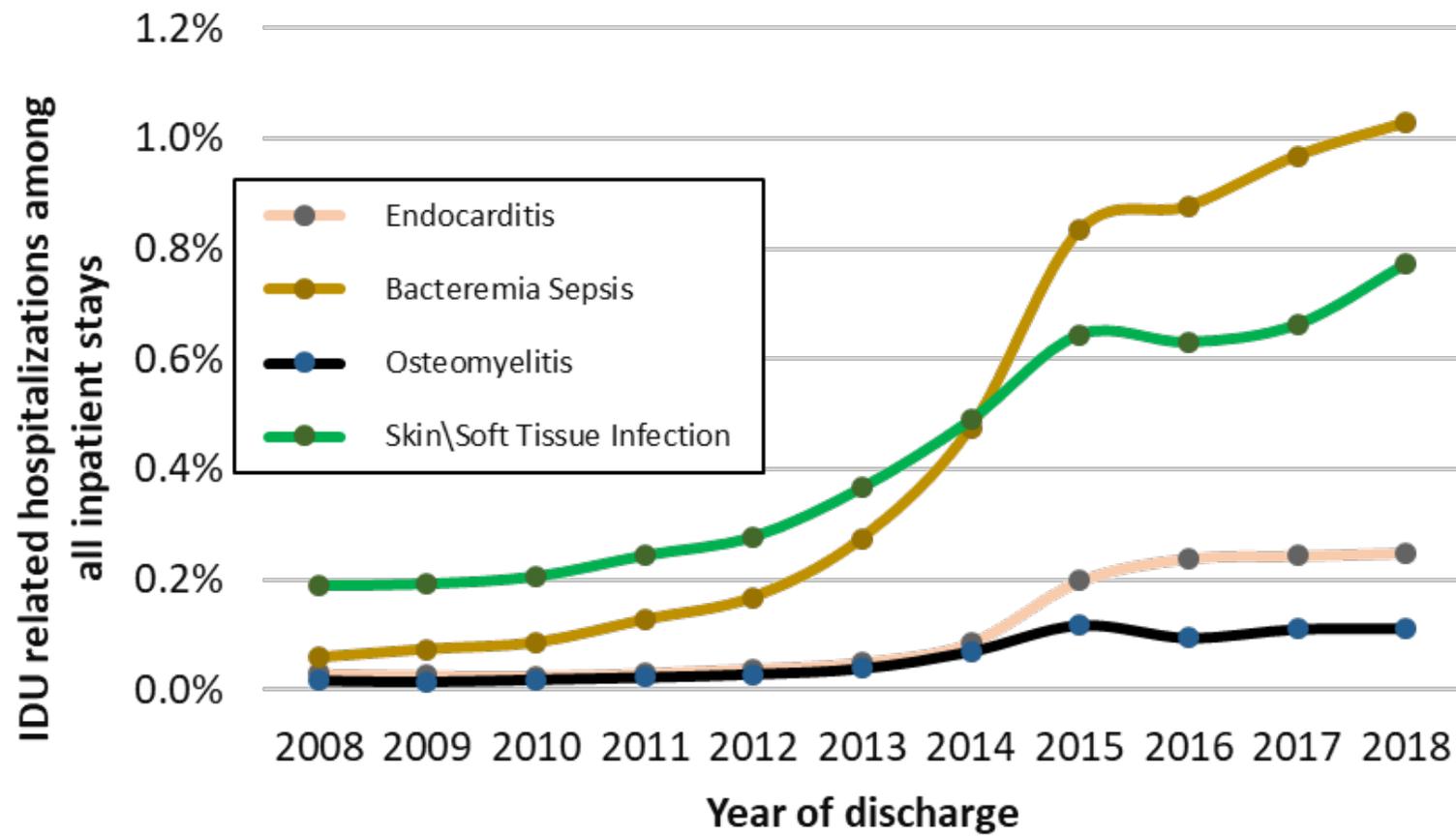
Opioid Overdose Hospitalizations,  
2012-2016



Methamphetamine/Psychostimulant  
Hospitalizations, 2012-2016

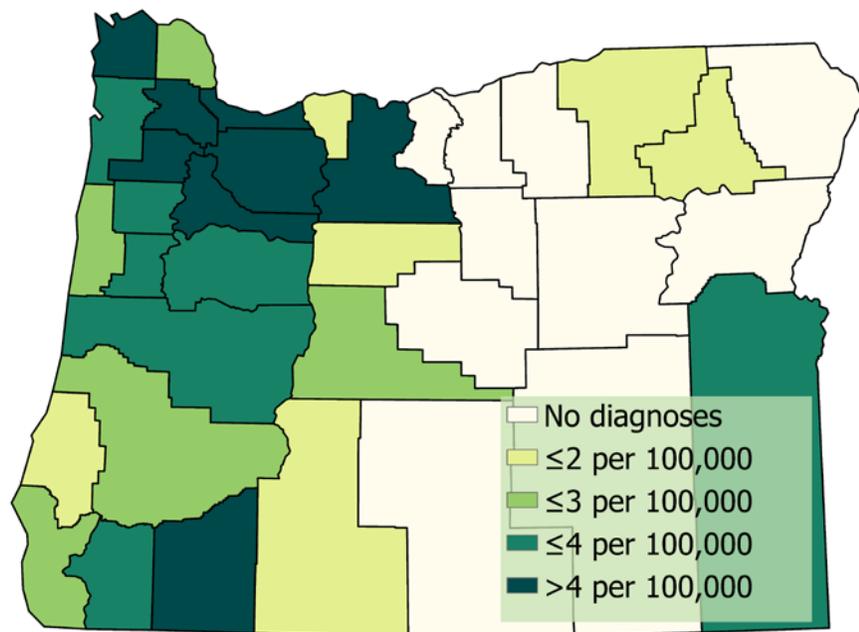


# Injection Drug Use Related Hospitalizations by Infection Among All Hospitalizations, Oregon 2008-2018

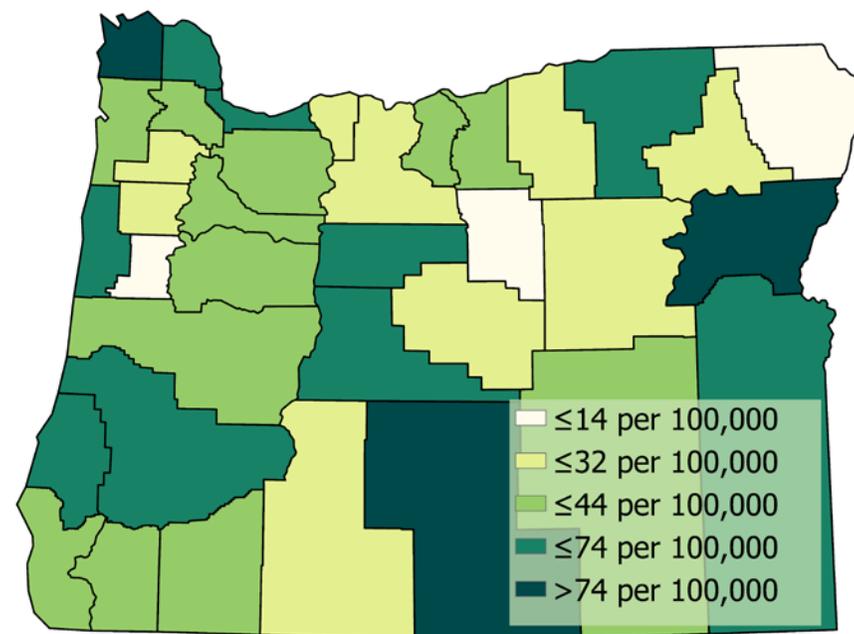


# HIV and Hepatitis C

HIV diagnosis by county, 2012-2016

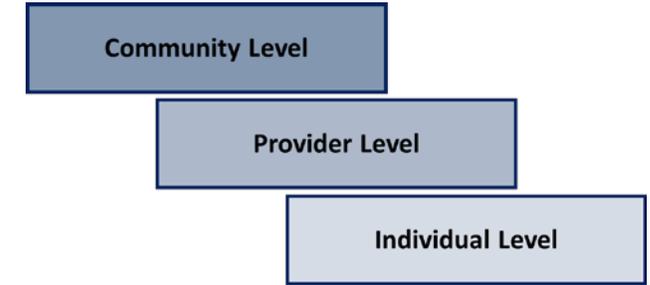


Chronic HCV cases in persons < 30 years by county, 2012-2016



# Oregon HOPE Study

HIV, Hepatitis, Overdose Prevention and Engagement



- Purpose
  - Improve understanding of substance use, hepatitis C, HIV and syphilis transmission and treatment access
  - Develop a unified response that increases access to care and treatment for SUD and infections related IDU in rural areas
- Two pilot counties: Douglas, rural Lane
- Expansion counties Winter 2019: Coos, Curry, Josephine



# Pilot Peer Intervention

## Who are they?

- Lived experience with SUD
- Completed Peer Support certification
- Supported by HIV Alliance



**Joanna**



**Larry**

## What do they do?

- **Build relationships**
- Harm reduction “gift bags”
- Rapid HCV/HIV/syphilis testing
- CCO registration
- Link to treatment
- Transportation
- Housing assistance



# Oregon HOPE Study

HIV, Hepatitis, Overdose Prevention and Engagement

## Survey Participant Results (N = 144)



**68%** homeless in past 6 months



**51%** incarcerated in past 6 months



**50%** hepatitis C positive



**45%** shared syringes/equipment in past 30 days

# Oregon HOPE Study

HIV, Hepatitis, Overdose Prevention and Engagement

Drug preference split between heroin and meth.  
People who use heroin also use meth.

(N = 144)



☰ Drug of choice: 44% heroin  
49% meth  
7% other

30 Past 30 day use:

78% used an opioid



Of these, 96% also used meth in past 30 days



# Oregon HOPE Study

HIV, Hepatitis, Overdose Prevention and Engagement

**Most have witnessed an overdose.**  
**Less than a third have naloxone.**  
(N=144)



**73%**

Ever **witnessed an overdose**

**42%**

Ever **overdosed**

**28%**

Currently **have naloxone**

# Oregon HOPE Study

HIV, Hepatitis, Overdose Prevention and Engagement

## Medical care barriers

“In the last 6 months I didn’t go for needed medical care because...”

Top two  
reasons:

50%

Did not have transportation

49%

Was afraid they’d treat me with  
disrespect because of my drug use

# Oregon HOPE SUD Initiation & Engagement

**18% of OR-HOPE  
peer-outreach clients  
engaged in substance use  
disorder treatment within 3  
months.**



# Oregon HOPE Study

HIV, Hepatitis, Overdose Prevention and Engagement

## *Rural Lessons Learned*

### Barriers

- Stigma
- Transportation
- Access
- Housing instability

### Approaches

- Peer led interventions, including harm reduction tools
- Address syndemically



# The PRIME Project

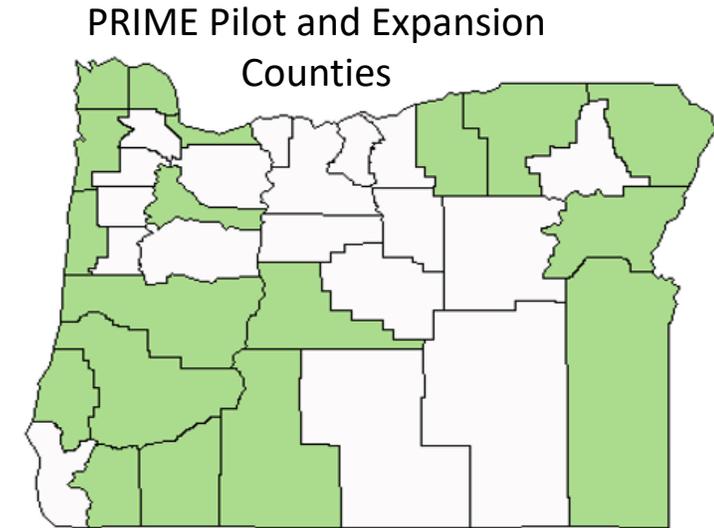
*Peer Recovery Initiated in Medical Establishments*

## 2018 Legislative session HB 4143

- Reduce overdoses by placing recovery peers in emergency departments
- Evaluate the benefit of peers in the emergency departments
- Legislature assigned counties: Multnomah, Marion, Jackson and Coos

## 2019 State Opioid Response (SOR) Expansion

- Expanded recovery peer work to 14 Counties:  
Columbia, Clatsop, Tillamook, Lincoln, Klamath, Josephine, Douglas, Lane, Deschutes, Morrow/Grant, Umatilla, Wallowa, Malheur and Baker
- Flexibility to work in emergency departments, primary care, urgent care and county health department clinics

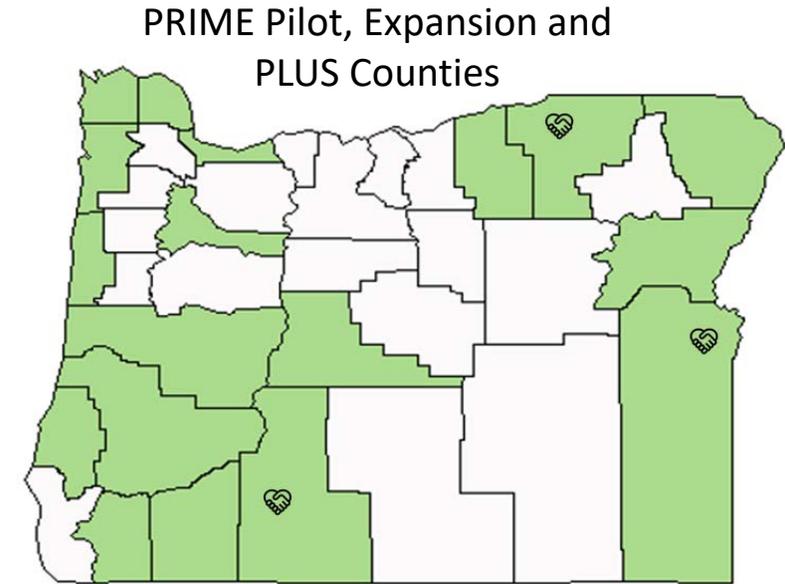


# The PRIME + Project

*Peer Recovery Initiated in Medical Establishments +  
HCV/HIV Testing and Linkage to Treatment*

CDC supplemental funding opportunity for rural  
persons who inject drug populations

- September 2019- August 2020
- Integrated syndemic approach
- Rural/Frontier counties approached based on
  - Participation in the PRIME Project (HB4143)
  - High Vulnerability to complications of injection drug use
  - Not an OR-HOPE county
  - Not a county with other funding that could be used for HIV/HCV testing



# The PRIME + Project AIMS

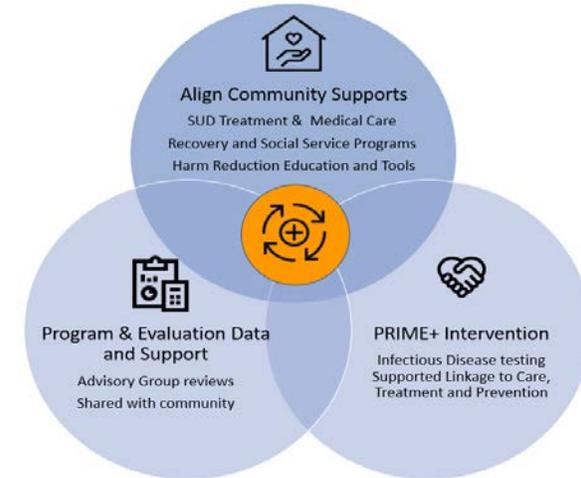
*Peer Recovery Initiated in Medical Establishments + HCV/HIV Testing and Linkage to Treatment*

## **PRIMARY AIMS**

- **Conduct Hepatitis B and C testing** among persons who inject drugs who present to hospitals for overdose, injection-related infections;
- **Provide peer support to persons who use drugs** to link to primary medical care, complete hepatitis B and C diagnostic tests and attend medical appointments to support hepatitis C treatment;

## **SECONDARY AIMS**

- **Support participants to access preventive care** and testing, such as hepatitis A and B vaccinations, STD testing, family planning, HIV testing and HIV Pre-Exposure Prophylaxis (PrEP)
- **Support participants to access substance use treatment** for opioid, methamphetamine or other substances
- **Provide harm reduction counseling and support** participant access to naloxone, and new syringes and injection equipment through pharmacies, health departments, local community-based organizations or syringe service programs.



# The PRIME + Project Methods

*Peer Recovery Initiated in Medical Establishments +  
HCV/HIV Testing and Linkage to Treatment*

Adding Peer Recovery Mentor to existing PRIME teams

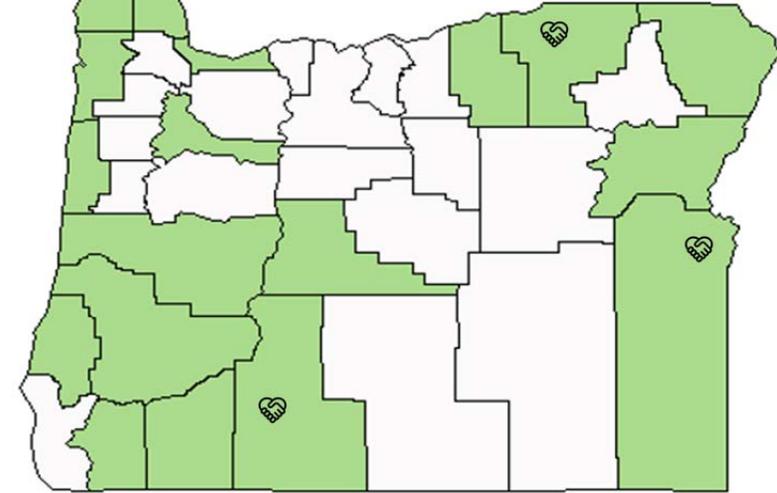
Focused on recruiting persons who inject drugs at hospital  
emergency departments

PRIME+ participants will be screened for hepatitis B and C  
in the hospital emergency department or when hospital  
inpatient

PRIME+ Peer will engage with clients after discharge to

- Enroll in Medicaid
- Find a medical home
- If hepatitis C positive, obtain confirmatory testing
- Provide harm reduction counseling and support
- Support access to substance use treatment

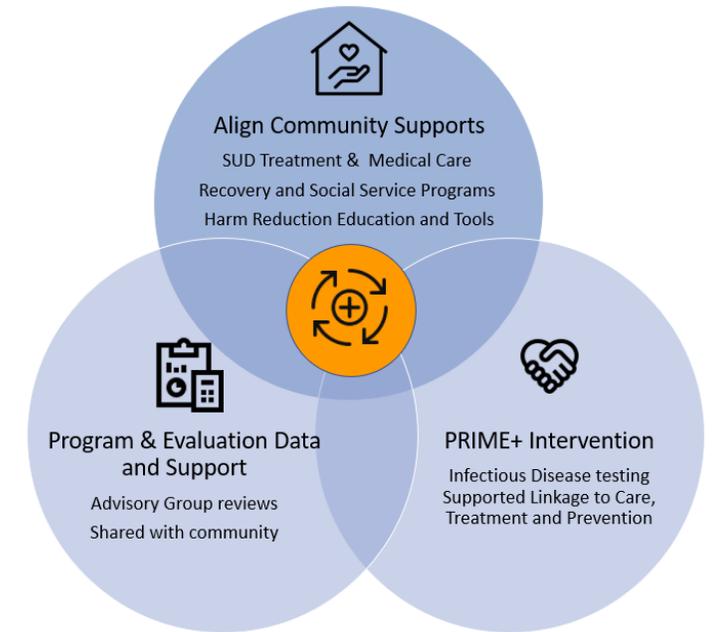
PRIME Pilot, Expansion and  
PLUS Counties



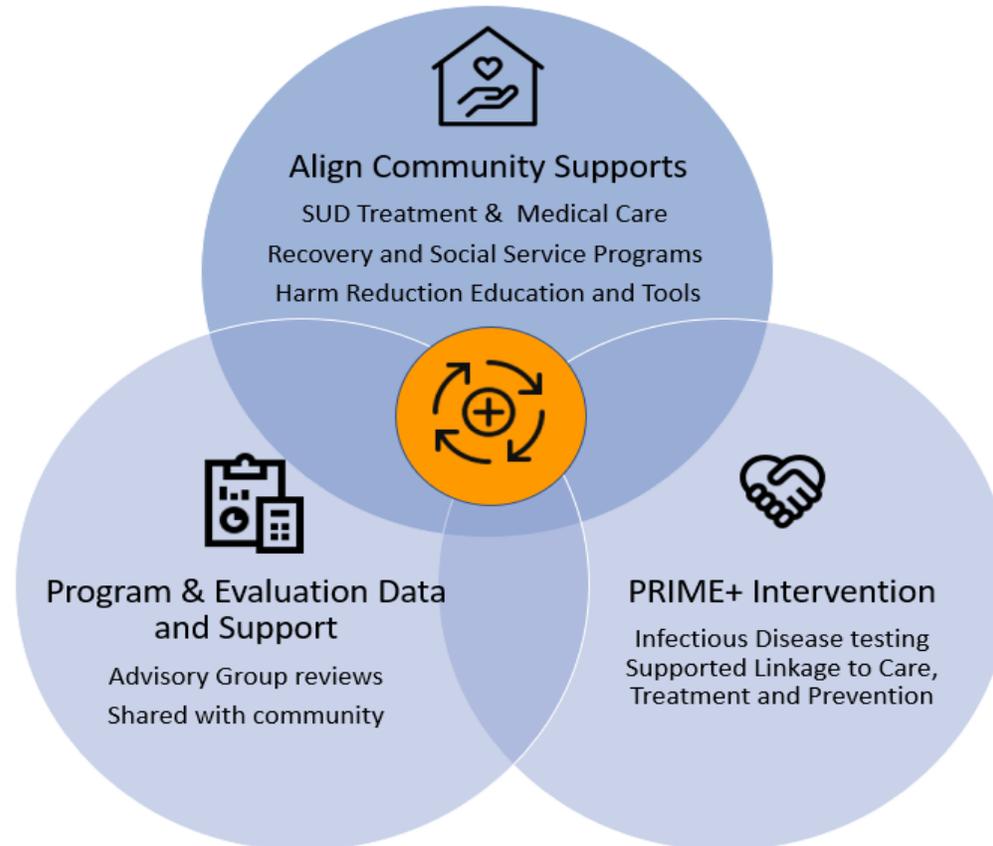
# The PRIME + Project Implementation

*Peer Recovery Initiated in Medical Establishments + HCV/HIV Testing and Linkage to Treatment*

- Align Community Supports by
  - Engaging with local and cross-site community advisory groups
  - Sharing program and evaluation data, outcomes and experiences with community stakeholders.
- Develop and implement the PRIME+ intervention with community partners
- Train PRIME peers across the state in infectious disease prevention
- Collect, analyze and share program and evaluation information with local stakeholders
- Support sustainability by integrating with existing programs (PRIME and CCO peer initiatives)



# Questions

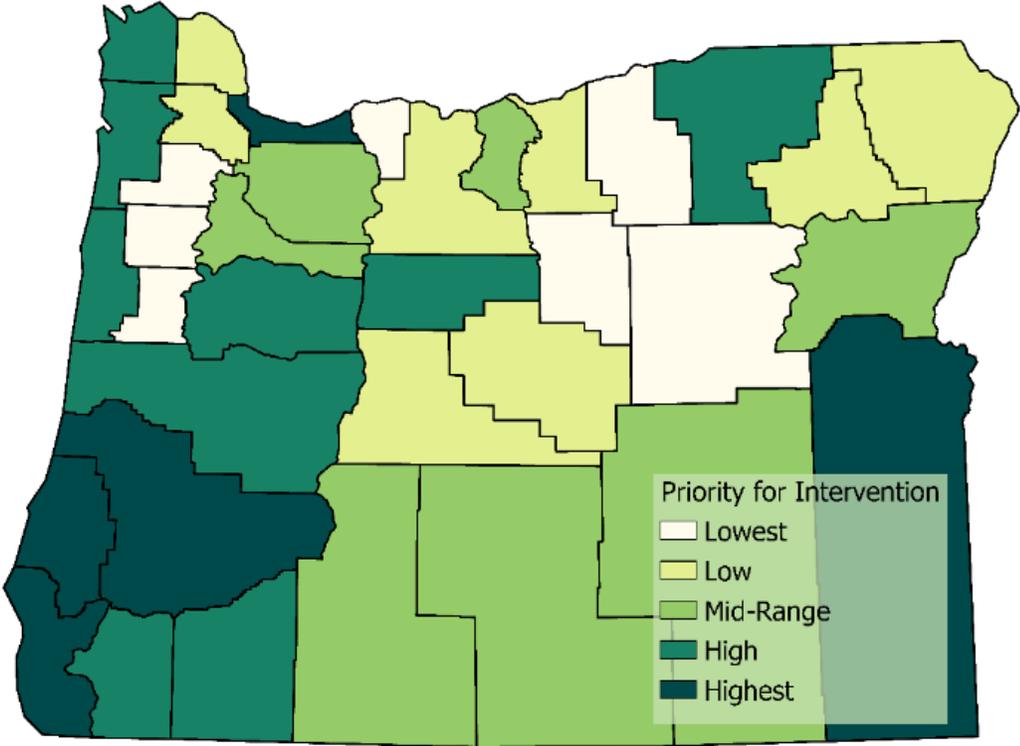


# Extra Slides

Selection Criteria for PRIME + Oregon Counties--\*Proposed intervention counties

County	Oregon Vulnerability Assessment	Bacterial infection related to IDU	HCV under 30 rank	OR-HOPE County	Other funds exist that can support HIV/HCV screening and linkage to care
Douglas	1	6	4	X	
Coos	2	8	10	X	
Multnomah	3	1	6		X
Malheur*	4	23	7		
Curry	5	20	13	X	
Jackson	6	3	14		X
Lane	7	2	18	X	X
Lincoln	8	16	9	X	X
Clatsop	9	4	1	X	
Linn	10	18	22		X
Jefferson	11	9	5		X
Tillamook	12	15	23	X	
Josephine	13	7	15	X	
Umatilla*	14	26	8		
Lake	15	30	3		
Klamath*	16	10	25		

# Vulnerability to IDU-related Disease Outbreaks by County



Vulnerability				
Highest	High	Mid-Range	Lower	Lowest
Douglas	Jackson	Lake	Wasco	Yamhill
Coos	Lane	Klamath	Crook	Polk
Multnomah	Lincoln	Baker	Union	Morrow
Malheur	Clatsop	Marion	Columbia	Grant
Curry	Linn	Sherman	Gilliam	Wheeler
	Jefferson	Clackamas	Deschutes	Hood
	Tillamook	Harney	Washington	River
	Josephine		Wallowa	Benton
	Umatilla			

# Syndemic Community Approaches

## Acronyms

- ACEs = Adverse Childhood Experiences
- AUD = Alcohol Use Disorder
- HAV = Hepatitis A Virus
- HBV = Hepatitis B Virus
- HIV nPEP = HIV Non-medical Post Exposure Prophylaxis
- HIV PrEP = HIV Pre-Exposure Prophylaxis
- IDU = Injection Drug Use
- MAT = Medication Assisted Treatment
- OD = Overdose
- OTP = Opioid Treatment Program
- PDMP = Prescription Drug Use Monitoring Program
- STI = Sexually Transmitted Infection
- SUD = Substance Use Disorder

## Key Strategies

-  Reduce stigma
-  Improve community infrastructure
-  Collaborate across sectors
-  Use evidence and data to make decisions
-  Increase protective factors
-  Reduce risk factors and support harm reduction

