

**Public Health Advisory Board (PHAB)  
November 21, 2019  
Meeting Minutes**

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**Attendance:**

Board members present: Dr. David Bangsberg, Akiko Saito, Dr. Jeanne Savage, Rebecca Tiel, Dr. Eli Schwarz, Kelle Little, Dr. Bob Dannenhoffer, Eva Rippeteau (by phone), Lillian Shirley (ex-officio), Teri Thalhofer (by phone), Tricia Mortell (by phone), Alejandro Qeral, Muriel DeLaVergne-Brown (by phone), Carrie Brogoitti (by phone)

Board members absent: Dr. Jeff Luck, Dr. Paul Lewis, Dr. Dean Sidelinger

Oregon Health Authority (OHA) staff: Cara Biddlecom, Krasimir Karamfilov, Sara Beaudrault, Dr. Emilio DeBess, Jude Leahy, Dr. Ann Thomas

Members of the public: None.

**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 October 2019 Minutes

A quorum was present. Dr. Schwartz proposed a correction to the minutes on page 28 related to a statement he had made. Dr. Dannenhoffer moved for approval of the October 17, 2019, meeting minutes. Dr. Schwarz seconded the move. The PHAB approved the meeting minutes unanimously.

- Update on PHAB Mini-Retreat

Ms. Tiel informed the PHAB that the PHAB mini-retreat has been scheduled on February 19, 2019. It will take place between 12:00 p.m. and 4:00 p.m. in Portland. The standing PHAB meeting on February 20, 2020, will be cancelled.

Dr. Schwarz asked if he could leave the retreat early, due to engagements in the afternoon of February 19, 2019. Ms. Tiel answered that it was fine. Ms. Biddlecom added that as soon as Dr. Schwarz knew his time of departure, he should inform the PHAB, so that the agenda for the retreat was adjusted.



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- December Meeting Schedule

Ms. Tiel stated that the PHAB meeting on December 19, 2019, would be held as a phone meeting, if the PHAB had to deal with committee business. If there is no committee business to attend to, the board meeting in December will be canceled.

Ms. Tiel acknowledged two PHAB members, Dr. Luck and Ms. Mortell, who would be coming off the board at the end of 2019. Commemorative plaques will be presented to Dr. Luck and Ms. Mortell. Dr. Luck was the first chair of the board's current version, taking the PHAB through many time-sensitive and important issues and legislative deliverables. Ms. Mortell represented the largest counties, which are a huge part of the state's public health system. Their service to the PHAB is appreciated.

Dr. Bangsberg remarked that the departure of Dr. Luck and Ms. Mortell was sad and that they would be missed.

- Volunteers for 2020 Public Health Accountability Metrics Report

Ms. Tiel explained that the Public Health Division (PHD) has been working on the 2020 Public Health Metrics Accountability Report. PHAB members are needed to work on the development of the report. The work could be done through the Accountability Metrics Subcommittee. Its current members are Dr. Schwarz, Dr. Savage, Ms. Thalhofer, Ms. DeLaVergne-Brown, and Ms. Rippeteau. The work could also be done through a small workgroup. Involved PHAB members will be committed from December 2019 through March 2020 and will work on the purpose, use, and relevance of the report, laying out the recommendations, reviewing 2020 data, identifying findings, and advising on the look and feel of the report.

Dr. Schwarz asked Ms. Beaudrault if she would be running those meetings as planned telephone meetings, as she had done so in the past. He was fine with continuing to be involved, if she still wanted him to be. The board erupted in laughter.

Ms. Tiel asked Ms. Beaudrault if she wanted new people to work on the report. Ms. Beaudrault answered that some PHAB members had a hard time making the meetings and it was difficult for the subcommittee to do their work last year. The request for volunteers is to make sure that people who are interested can be involved and the subcommittee can get the work done.

Ms. Rippeteau admitted that she was one of the guilty, almost non-participants, which always made her feel terrible. Last year was difficult mostly because of the legislative session. She hoped that everybody knew that when she was a part of a group, her intention was to be fully committed. She didn't want to be problematic in causing work not getting done. She was happy to build in the time, if she could. She would like to be productive when and where she could. If

others were interested, she would be happy to step aside and let somebody else take her spot, or she could continue and work better to make the meetings.

Ms. Tiel volunteered to be a part of the subcommittee. She asked if the current Accountability Metrics Subcommittee members wanted to remain involved. All members agreed to stay involved.

Dr. Savage noted that it was nice not to add another meeting or another small group. She would like to participate and keep the work within the Accountability Metrics Subcommittee instead of having a subgroup of a subgroup.

### **Public Health Modernization Initiatives**

*Heather Kaisner (Deschutes County Public Health), Teri Thalhofer (North Central Public Health District), Dr. Emilio DeBess (OHA Staff)*

Ms. Tiel pointed out that now that public health modernization funds have been allocated to LPHAs, the PHAB will be hearing more in-depth about these projects. These presentations should be grounded in the Public Health Modernization Manual (PHMM). The state, local, and state/local joint roles for assessment and epidemiology and communicable disease control have been described in the PHMM. She introduced the first presentation and invited the presenters to introduce themselves.

Ms. Kaisner gave credit to Tri-County epidemiologist Dr. Jennifer Faith, who created the presentation, but could not be present today. She provided some background on the needs of the Tri-County partnership (i.e., Jefferson, Crook, and Deschutes counties). A key focus of the partnership is communicable disease epidemiology. Deschutes County has had an epidemiologist for a few years, with the position focusing on behavioral health and public health. A need was felt all around Central Oregon to develop a position that would be focused on communicable disease epidemiology, as well as on environmental health and emerging public health threats. The partnership made that a priority when going after the original funding for modernization.

Ms. Kaisner showed the primary roles of the partnership's communicable disease epidemiologist. Dr. Faith has expanded her role to include enhanced surveillance and risk communication to providers, partners, and the public, as well as a focus on internal data quality and using the ORPHEUS reports to drive quality improvement with CD staff in each of the three counties. Dr. Faith provides ad hoc data presentations, creates content for the 2019 Central Oregon Regional Health Assessment, and provides surge capacity for outbreak response and emerging threats.

Ms. Kaisner showed an example of a flu surveillance report created by Dr. Faith. The data in the colorful report was presented in both tabular and graphic forms. The flu report aggregates

Central Oregon data to help healthcare providers in the tri-county area. Although the reports initially targeted healthcare providers, they are now posted online for public viewing and media use. Another report Dr. Faith creates is a quarterly communicable disease (CD) report with topics that change every quarter. An annual summary of CD cases/rates is prepared during the first quarter of every year.

Ms. Kaisner shared that Dr. Faith supports CD staff with local data and cross-jurisdictional communication. Dr. Faith creates and disseminates an internal QI (Quality Improvement) data report, using the Orpheus system, which is used for reporting and tracking CD cases. These reports are created on a monthly basis for Deschutes County and on a quarterly basis for Crook County and Jefferson County. The CD staff from the three county health departments and the Confederated Tribes of Warm Springs convene weekly for a surveillance check-in call to share information and discuss cases and emerging threats.

Ms. Tiel asked whether the counties were asking the state for the data to compile these reports or the counties shared the data with each other.

Ms. Kaisner answered that the counties are sharing data among each other and Dr. Faith could view the data for the three counties in Orpheus.

Ms. DeLaVergne-Brown clarified that the public health administrator from each county signs the security documents with Orpheus once a year, which allows the addition of other counties. The counties also sign Memorandums of Understanding (MOUs) among each other. It is truly a tri-county partnership.

Ms. Kaisner added that Dr. Faith also provided local data to an Infection Prevention Nurse for use in infection prevention trainings. In addition, Dr. Faith created the demographic, immunizations, CD, and STD sections in the 2019 Central Oregon Regional Health Assessment. She also participated in the Regional Health Assessment (RHA) Steering Committee. Dr. Faith's ad hoc activities include ad hoc reports and presentations, after-action outbreak reports and meetings with facilities for each outbreak in the tri-county area, and surge capacity when needed (e.g., measles exposure).

Dr. Schwarz asked how the data was transmitted between providers and the LPHAs.

Ms. Kaisner explained that Orpheus was a statewide database used by state labs and healthcare providers to report information. The county health departments have access to the database. Every disease that is reportable is entered into Orpheus. The LPHAs respond locally based on those data. All data are in the statewide system.

Ms. DeLaVergne-Brown added that once a county got a case, it was the LPHA's responsibility at the local level to interview the case, or talk with the physician, and put that information into Orpheus. That's how it happens in real time.

Ms. Thalsofer introduced herself as the director of the North Central Public Health District (NCPHD), which is the fiscal agent for the Eastern Oregon Modernization Collaborative (EOMC). The EOMC partnership includes 11 LPHAs, 13 counties, the Eastern Oregon Coordinated Care Organization, and Mid-Columbia Health Equity Advocates. The partnership serves 240,850 Oregon residents. The partnership covers one third of the state, but nowhere near that portion of the residents in the state.

Ms. Thalsofer noted that the staff working at the EOMC included a regional epidemiologist (Ms. Lamendola-Gilliam) and a regional systems liaison (Ms. Zimmerman). These two staff were trained to be able to add capacity for communicable disease reporting, response, analysis, and prevention. Many of the LPHAs in the EOMC don't have anyone who is dedicated to do communicable disease work. For many EOMC members, CD work is assigned in addition to their full-time work. For example, a home visiting nurse could do the reproductive health program. Oftentimes, the administrator could do the CD work as it comes in. In the past, whenever there was an outbreak or an unusual disease in a jurisdiction, all work stopped. The collaborative staff provides Orpheus backup and surge capacity, has recorded over 150 hours of case management activities, provides one-on-one training to local staff in use of DUDE, a system the partnership uses for outbreak work, and Orpheus data entry and case management, and provides opportunity for regional partners to be "off the grid" to enhance wellness.

Ms. Thalsofer stated that the regional epidemiologist, Ms. Lamendola-Gilliam, developed policy for use of email, texting and social networking sites as a means to contact CD/STI cases and improve partner notification. She increased capacity to respond to West Nile virus in the region and facilitated testing to confirmation for a case. She facilitated and participated in Passport-to-Partner services training which enhanced STI response. Because this training is offered once a year by state partners in the metro area, it proved very difficult for Eastern Oregon partners to participate due to limited number of participants. Providing this training in the region allowed all Eastern Oregon partners to send at least one staff member, which increased comfort for partner interviews when talking to people about STI contact.

Ms. Thalsofer noted that in terms of analysis capacity, Ms. Lamendola-Gilliam produced monthly CD/STI reporting by county and by region. This has been very helpful because, for most staff, part of the data has been suppressed. She provided annual reports describing the burden of disease by county with historical comparisons and provided data analysis as requested by LPHAs and tribal partners. She worked hard to develop a good relationship with Yellow Hawk tribal clinic on the Confederated Tribes of Umatilla reservation. She also provided data to inform the Columbia Gorge CCO Community Health Assessment that serves Wasco County and Hood River County.

Ms. Thalhoffer added that the staff has added outreach capacity by developing a fact sheet regarding the increase of gonorrhea/chlamydia/syphilis infections in Eastern Oregon that included treatment recommendations and the link to increased risk for HIV infection and burden of disease based on race and ethnicity. The fact sheet was mailed to every provider in the region during the STI awareness month. Feedback from residents showed that they didn't know how high the rates had climbed. Ms. Lamendola-Gilliam distributed toolkits for use by long-term care facilities that provided guidelines for outbreak response to influenza and norovirus. She provided capacity to either visit those facilities, if jurisdictions would prefer, or she would coach them in sharing the toolkit with their partners. She also provided data analysis to LPHAs and partners for use in PSAs (Public Service Announcements) and outreach efforts.

Ms. Thalhoffer pointed out that neither Ms. Lamendola-Gilliam nor Ms. Zimmerman worked out of the North Central Public Health's office in the Dalles. Ms. Zimmerman works out of Pendleton and drives around the region as needed. Ms. Lamendola-Gilliam works out of Portland and drives to the region as necessary. It's interesting how the North Central Public Health District has gained capacity through the use of technology.

Dr. Savage asked if the epidemiologist of the Tri-County Central Oregon partnership was the same epidemiologist for the NCPHD.

Ms. Thalhoffer answered that each partnership has hired its own epidemiologist. There is a little crossover work between the partnerships because the majority of the Warm Spring Reservation is in Wasco County, but the majority of the tribe population is in Jefferson County.

Dr. Savage asked if the modernization funding used for this work was from the last biennium or from the new biennium.

Ms. Thalhoffer answered that it was both for the NCPHD. This project was created during the last biennium. The funding for the regional project in the 2019-2021 biennium is less than the funding in the last biennium, but each county in the district used part of their local funding to continue to support the regional effort.

Ms. Kaisner added that it was similar for the Tri-County Central Oregon partnership. The funding was from the last biennium, but the work continued into this biennium with the regional funding, which was less for infection prevention.

Mr. Queral asked Ms. Thalhoffer about the increased capacity to respond to the norovirus in the region and whether that was by virtue of having an epidemiologist who could focus on that disease or whether it was a process that was set. He asked why she highlighted the West Nile virus as increased response capacity and if each communicable disease required the development of capacity specific to that disease response.

Ms. Thalhofer answered that when the presumptive case happened, it was new to the country it was happening in and it took all their time. Ms. Lamendola-Gilliam was able to step in, take over the work, and allow the communicable disease staff in that county to pay attention to everything, so she could focus on the West Nile. She helped get the testing done and transported for confirmation and worked with the state. That was the focus of her work at that point in time without the distraction of the regular CD workload that was coming in.

Dr. DeBess explained that when there was a West Nile case, there were many implications. One was the human case, but also there was the veterinary component and the mosquito component. These components create a ton of work. The counties have done an amazing job in putting out press releases, so the public and the veterinary community could be informed. He praised the staff for stepping up and doing the work.

Ms. Thalhofer added that the NCPHD was putting some money aside in the new biennium from a local project to think about how to continue these efforts if regional funding didn't happen in the next biennium and all the money comes out in the LPHA funding formula. It's one thing when there is money to be shared among groups.; it's different when the money comes to each county.

Ms. Tiel invited Dr. DeBess to introduce himself to the PHAB. Dr. DeBess introduced himself as the state veterinarian for the state of Oregon. He is a veterinarian by training and holds a Master's in Public Health degree. His job involves working on communicable diseases, food-borne illnesses, and diseases borne by ticks, mosquitoes, and other animals. Although his job is wide in scope, he gets a lot of support from the local health departments. He praised Ms. Kaisner and Ms. Thalhofer for the great work they have been doing in their partnerships.

Dr. DeBess explained that the job of OHA's Public Health Division was to promote and encourage healthy behaviors for Oregonians to protect themselves against diseases and potential injury. Beyond that, it is about working with communities to educate them and provide them with the base that they need so that they can be a healthier population.

Dr. DeBess stated that communicable disease prevention and control was a cooperative effort of the larger community and the local health departments. The effort includes communicating information that has been obtained and analyzed to understand what populations have been affected and how to prevent disease. The focus of the work in communicable disease is not only on surveillance, but also on prevention. Communicable disease prevention is the key and is a foundational program of modernization.

Dr. DeBess clarified that modernized disease response included two components: community partnership and assessment and epidemiology. The work is viewed through a health equity lens. The community partnership work involves supporting LPHAs, medical providers, and

infection control nurses to identify and stop disease transmission. It involves creating partnerships to develop new systems to track patient clinical and risk information, as well as educating and providing training to protect patients and communities. The assessment and epidemiology work entails maintaining informatics systems to track cases and identify outbreaks. It also involves identifying risk factors for disease transmission.

Dr. DeBess remarked that developing state and local public health capacity to respond to emerging threats depends on information. It all starts with a sick patient. An interesting statistic from the CDC (Centers for Disease Control and Prevention) is that only 1 in 21 people go to a doctor to get diagnosed. This is the tip of the iceberg of what is actually happening. For example, a case of E.coli connected to a particular supermarket selling ground beef means that there is a group of individuals who became ill, and had similar symptoms to the one case, but didn't go to the doctor. This is important because it informs what needs to be targeted and dealt with. Once a patient visits a medical provider, the provider collects a sample and performs a test. That information goes to the county health department. The county health departments receive the information electronically and do an investigation. There is an electronic system that connects the local labs with the Orpheus database. The information is in the form of a laboratory report that says that an individual has been diagnosed with E.coli, or Hepatitis A, or the measles. This information is transmitted daily and in real time to the county health departments.

Dr. DeBess explained that the investigation involves talking to the individual with E.coli and recording their experience. The Orpheus database, which can be accessed from every computer at every county health department, has a set of clinical questions and a set of risk questions that are asked of the patient. The questions could cover multiple pathogens, such as E.coli and salmonella. When all answers have been collected and entered by the county health departments into the system, the information shows up in the OHA system in real time. There is a communication system within Orpheus that allows OHA staff to send a note to the county that says, for example, "Could you ask the patient when they went to the supermarket?" That message pops up on the screen, and if a local public health staff member happens to be with the patient, they ask that question.

Dr. DeBess noted that the electronic communication system had been modernized to the point where real-time interactions were possible, which was above and beyond anything anybody could have thought. In addition, OHA works with LPHAs to improve education and outreach, with the education component being done on the local level. The modernization work also includes modernizing laboratory identification to detect outbreaks. For example, instead of talking in general terms about salmonella, it is now possible to do whole genome sequencing (WGS) to identify which type of salmonella it is. WGS involves looking at the genes in the salmonella bacteria. As most states in the U.S. can do this type of work, salmonella bacteria can be compared across states. As a result, a patient in California could be linked to a patient in

Portland, only to discover that they ate at the same restaurant in Portland in recent past. Such connections explain why people are getting sick and what were the risk factors involved.

Ms. Shirley shared that, a few years ago, whole genome sequencing equipment was not known to public health laboratories across the nation, but the PHD administrators decided to invest in it. Some of the changes in the healthcare industry made it difficult on the public health side, because people were sending things to commercial labs. The health insurance was no longer paying for these tests and the hospitals and labs were not doing the type of public health analysis OHA needed to look at the protection factor for large scale outbreaks.

Dr. DeBess stated that one of the tools used to link laboratory and epidemiology data was the DUDE system which housed the Orpheus database and an outbreak database. When two or more cases of a particular illness have been reported, an outbreak number is created. The outbreak report contains information such as what caused the outbreak, how many people have been affected by it, what carried the pathogen (e.g., ground beef), and the factors involved in the investigation. In this way, the CDC gets all the information needed to understand why outbreaks happen.

Dr. DeBess pointed out that OHA supported LPHAs with real-time training and surge capacity. It's a necessary activity within the process of modernizing our view of public health and communicable disease. For example, if a county employee left a position in communicable disease and a new employee started the job without a lot of knowledge of what was going on, OHA provides real-time distance training through a surge capacity epidemiologist. It is active training that happens on all levels, not only on the level of the county health department.

Dr. DeBess explained the importance of increasing surge capacity, both for OHA and LPHAs, not only to get their work done, but also help with any other conditions that may take a lot of time, such as the West Nile virus, or measles, or a food-borne illness. OHA ensures that LPHAs have everything they need to move forward. There are a few counties, however, that have had ongoing difficulties in meeting their needs for case investigations. The surge capacity, as well as the teams led by Ms. Kaisner and Ms. Thalhofer, have improved the ability to do case investigations. By providing assistance, OHA learns what is going on in areas of the state that don't have the ability to do their investigation. For example, when Lyme disease is discussed, the typical affected areas are west of the Cascades. Now cases have been identified east of the Cascades. This shows OHA staff that there is an expansion of vector-borne disease due to climate change that could potentially be leading to an expansion of illnesses in different areas in the state of Oregon. He presented examples with Colorado tick fever, with Oregon reporting four cases in one month to CDC, and with measles, with Oregon reporting four cases in 2019.

Dr. Dannenhoffer remarked that he was impressed by the presented work. He thought it interesting that the three presentations talked about surge capacity. The Douglas County region

is doing surge capacity work as well. The counties work together, but there is much overlap between the regional players.

Dr. Schwarz echoed Dr. Dannenhoffer's praise about the presented work. He noted that while Dr. DeBess talked about food-borne diseases and other infections, the first two presentations indicated the sharp increase in STDs. He asked if the improved surveillance capacities can also be used for epidemiological evaluation of preventive activities, and if this improved knowledge of things in real time can be used for interventions and the surveillance system can then show the effect of the interventions.

Dr. DeBess answered that it all started in the laboratory, with the cases being diagnosed in real time and the information being given to the county health departments. Beyond that, there are multiple levels: contacting the patients, performing antibiotic susceptibility, ensuring that the individual is treated correctly based on the available information, so that more prevention can be done. The idea is to include all those layers and then provide information about prevention. Prevention could be as simple as indicating that a particular antibiotic doesn't work anymore. When a patient has resistance to an antibiotic, he/she is switched over to another antibiotic to protect the individual and all the contacts around the individual.

Ms. Kaisner added that with STD cases, the LPHA not only collects the lab reports, but a communicable disease nurse conducts an intensive interview with each case. Then an epidemiologist combs through the data in Orpheus ask questions, such as "Are there connections here based on demographic or geographic information? Do we need to be targeting the reach-out efforts and doing very targeted approaches in different regions, or different areas, or with different populations, or age groups?" All that data is collected when a case investigation is done. Having a dedicated epidemiologist to look at those data has helped the partnership create more targeted interventions.

Dr. Savage asked Ms. Kaisner if she could correlate the rise in STIs with the use of the LARC (long-acting reversible contraception), which has become popular. Although chlamydia infections are on the decline, if people are using more LARCs and not the barrier method, are they increasing their infection risk?

Ms. Keisner answered that the CDC recently put out a [report](#) on the rise of STDs in the county and indicated a few reasons for that, including the use of LARCs.

Ms. Thalsofer remarked NCPHC distributed condom boxes across Umatilla County to help prevent the spreading of STDs. The staff at the Yellow Hawk tribal clinic reported that many of the women on the reservation preferred condoms as their birth control method. The women were very happy to be able to access condoms in the community.

Ms. Akiko praised the positive approach of the modernized system. With issues such as Ebola, Zika virus, and vaping, it makes a difference to have a flexible modernized system that could take on new surveillance systems. Both Ebola and vaping were huge lifts. The outcomes wouldn't have been so positive, if effort was not put into modernizing at the local, tribal, and state levels for epidemiological systems.

Dr. Bangsberg asked if the LPHAs did contact tracing and partner notifications for HIV.

Ms. Keisner answered that they did.

Ms. Tiel thanked the presenters. She echoed Ms. Akiko's comments and introduced the next presentation.

### **Tribal Public Health Modernization**

*Kelle Little*

Ms. Little thanked Ms. Danna Drum in OHA's Policy and Partnership team for putting together the presentation slides, spearheading the tribal work at the OHA level, being an advocate for tribes, and ensuring that tribal nations had access to modernization funding to improve their public health systems and integrate them with LPHAs. She also thanked the partners involved in the tribal public health modernization work.

Ms. Little stated that funding was legislated in 2015 for LPHAs to begin public health modernization, while tribes were excluded. There was no mandate to participate in assessment, planning, and implementation of PHM (Public Health Modernization) due to respect for tribal sovereignty. There were also no funds designated to support tribal PHM assessment. In 2016, Ms. Drum had several conversations with tribal representatives who had expressed interest in PHM and improving and implementing the tribal systems. One of the most important things is that tribal culture is different when it comes to public health. There's no funding for public health within tribal organizations, and if there is, it is very small. It all depends on the tribe's priorities and ability to raise additional funding and partner with local public health partners.

Ms. Little noted that three tribes expressed interest in pursuing PHM efforts and work. The tribes worked with Dr. Victoria Warren-Mears at the Northwest Tribal Epidemiology Center and Ms. Drum on the development of a PHM assessment that was tribal-specific. It was based on an assessment that was done by Washington State and Berk Consulting for a tribe in Washington state. Because there was not financial support from OHA, the tribes took it upon themselves to do the work. The Northwest Portland Area Indian Health Board supported the work and did the data analysis. The work took place from August 2016 through July 2017.

Ms. Little remarked that while there was no PHM funding for tribes in the 2017-2019 biennium, conversations began in 2019 with Ms. Drum to develop different funding models as to what it would look like if there were funding for tribes at \$5 million, \$10 million, or \$20 million. The funding models were forwarded to various tribal partners. It's not that other tribes or urban Indian organizations are not interested in this work – it's about priorities and capacity and being able to get the work done. In 2019, the legislative allocation for PHM included funding to support tribal PHM work. Because there was funding now, more intensive work began in summer 2019. A tribal workgroup with representatives from tribal health directors and NPAIHB developed scope of work and funding proposal with OHA in fall of 2019. The proposals were presented to the tribes and, at the end of October, the tribes and tribal organizations approved the tribal PHM.

Ms. Little explained that six tribes have not completed the PHM assessment and they would be doing that. The tribes that have completed the assessment, which is now two years old, will update it and begin work on developing an implementation workplan. Tribes and NARA (Native American Rehabilitation Association) will determine how they want to engage in Oregon's modernized public health system and whether they will participate in regional partnerships with LPHAs in their service areas.

Ms. Little reviewed the scope of work for the tribes, NARA, and NPAIHB. The Northwest Tribal Epidemiology Center will be doing the learning collaborative for the tribes.

Dr. Savage asked Ms. Little if she could provide more information about the Northwest Tribal Epidemiology Center.

Ms. Little responded that the Northwest Tribal Epidemiology Center was housed within the Northwest Portland Oregon Health Board. Tribal epidemiology centers are funded through the Indian Health Service (HIS) across the various regions. The Northwest was the first to have a tribal epidemiology center and it is one of the most robust centers in the country.

Ms. Little highlighted the deliverables in the 2019-2021 biennium. Each participating tribe/NARA will complete PHM assessment by September 1, 2020, and an action plan by February 1, 2021. There is no mandate for these deliverables. Tribes may find that the funding won't meet their needs and doing the work with their current staff could be quite a challenge. The tribes/NARA that are implementing one or more action plan priorities will submit a tribal program plan to OHA, describing activities to be completed by June 30, 2021. The goal is to complete all reporting requirements.

Ms. Little pointed out that the reporting requirements included aggregated and deidentified assessment and action plan report across all participating tribes/NARA. The assessment will describe Indian country in Oregon, as well as urban Indian challenges. The requirements also include aggregated progress reports in June 2020, December 2020, and June 2021, describing

accomplishments, challenges, lessons learned, and recommendations for future work. Individual tribe/NARA quarterly progress reports on accomplishments, challenges, and deliverables will also be submitted.

Ms. Little stated that the direct funding to the nine tribes/NARA was \$833,000 for the biennium, split evenly across participating tribes/NARA. There's no guarantee that all tribes will participate. The average funding per tribe per year is \$41,500. It would be challenging for many tribes to recruit, train, and hire staff for this type of work. If the funding is discontinued, the tribes will have to figure out how to continue the work, which would be challenging, especially for remote tribes. Tribes could partner with other tribes or combine the PHM funding with other similar types of funding to create positions such as public health nurse, public health manager, and public health emergency preparedness, among others. There will be a contract with NPAIHB, totaling to \$443,982, to provide technical assistance and training. The funding sources include PHM 2019-2021 legislative approved budget and Preventive Health & Health Services Block Grant (federal).

Ms. Little remarked that the tribes/NARA were reviewing the program element and would notify OHA if they were opting in by November 27, 2019. The program element and funding will be included in the December 2019 Tribal Public Health Intergovernmental Agreement Amendment. OHA's public health division is developing agreements for training and technical assistance with NPAIHB and each individual tribe. Each tribe has unique contracting requirements as a sovereign nation.

Dr. Bangsberg shared that the Oregon Health Policy Board (OHPB) was required to do one meeting outside of Portland every year. This year, OHPB had four out-of-town meetings. One of the visits was with the Federated Tribes of Umatilla, where OHPB did a deep dive. The visit was impressive as it showcased the integration with CCOs and public health. It was one of the stellar examples in Oregon. The OHPB also visited a tribe in Coos Bay that had also done some great work. It is worth for PHAB to consider making a field trip for one of its meetings, because one gets a different perspective as to what the challenges and the resources are and also appreciation for the great work that has been done.

Dr. Schwarz asked if Ms. Little used the model from the Public Health Needs Assessment, which was the basis for the modernization report. He asked if the language was the same as with the bigger systems.

Ms. Little answered that the assessment that was developed for Oregon was based upon the PHM model. It was first developed to be used with tribes in Washington state by the Department of Health in consultation with tribes in Washington. It was adapted. It is based upon the PHM model and foundational capabilities. It is very similar to the LPHA document, but it is specific for tribes in recognition of sovereignty.

Dr. Schwarz asked whether the tribes were as bad off as the counties in the assessment.

Ms. Little answered that the tribes were much worse off. Most tribes, in general, rely on counties to do the heavy lifting for public health work. No tribes have communicable disease or environmental health investigative capabilities. The NPAIHB is assuming environmental health responsibilities from the Indian Health Service and will be working with tribes. Tribes have different sizes and most tribes invest significant amount of their funding that is discretionary in some capacity into doing direct health care, because of the significant health disparity. Public health is often at the lower end of the tier.

Ms. Shirley noted that OHA staff were very excited about the PHM funding to tribes. The tribes were not factored in in the first round of funding. The new funding is important for the ongoing work and for the future. As per the capacity issue, which was also discussed by Ms. Thalhoffer, she asked if Ms. Little had thought about academic partnerships for some of the assessment work. If Ms. Little wrote a proposal in which she described what kind of academic partnerships could be helpful, the PHAB or OHA could make that happen.

Ms. Little answered that academic partnerships had been discussed as opportunities, as now tribes relied heavily on the Northwest Tribal Epidemiology Center to support the assessments because that has been its business historically with tribes and the center has standing relationships. If there are opportunities to recruit academia to support some of this work, the tribal representatives will have to explore what that would look like. She represents the Coquille Indian Tribe and tribal interests in Oregon and can't speak for other tribes.

Dr. Schwarz mentioned that, two weeks ago, he gave a class to one of OHSU's programs that recruited Native Americans into OHSU's medical school. The dental school at OHSU has the same shortage of Native American students. It would be smart to build on the existing program than try to make something else. It probably has to start at a very early stage. Some of the students might end up in the OHSU-PSU School of Public Health and come out with an epidemiology degree. It's a long-term prospect. The class he taught had 10 students who were very interested in health and had great backgrounds.

Ms. Saito remarked that this last year OHA's Emergency Preparedness program worked with two tribes in Oregon and Barbara Hershey, a tribal law expert at the University of Pittsburgh. The program did a tabletop exercise with OHA's general council around isolation and quarantine. Those are good project and there are some national projects that are going around. It would be great for the tribes and OHA to think about how they might engage them with the modernization work.

Dr. Schwarz asked if the tribal PHM updates could be added to the updates of other modernization activities, instead of having separate update for tribal PHM.

Ms. Tiel answered that it could be done. She asked Ms. Little if her partners would be willing to come to a PHAB meeting and present.

Ms. Little answered that her partners would love to come and present to the PHAB. The NPAIHB will be assisting with gathering of information. The NPAIHB will be hiring two public health positions to support some of this work and some of the public health activities.

Ms. Biddlecom thanked Ms. Little for her presentation. She noted that the last two presentations were about how the \$15 million for PHM was being utilized. Based on some feedback that Ms. Tricia Mortell had provided to OHA after the last round of funding in the last biennium, today's presentations tried to tie the topic together. She asked the PHAB members for their feedback on focusing future conversations on specific bodies of work that were shared across the governmental public health system.

Ms. Mortell stated that she appreciated the PHAB's consideration of her feedback. One of the goals of public health modernization is the systems approach, not the local, state, or tribal singular approach.

Dr. Bangsberg remarked that this gave him a much better understanding of what public health modernization was. It is practice, implemented. It's not reading OHA's beautiful report, which is top-notch, but it's theory. The presentations were about practice. It is nice to see PHM happening.

Ms. Little noted that she would like to see the themes for the various topics. It helps articulate how the work occurs and how it works in the communities, and that becomes translatable.

Dr. Bangsberg added that what the PHAB saw in the presentations were investments that led to best practices. It's not identifying gaps in the state. It's important for the PHAB to figure out a way to find the holes. OHA is funding the best programs that do the best work through a competitive process, but it's not homogeneous across the state. There must be holes. What is the mechanism for the PHAB to detect those holes?

Ms. Thalsofer commented that as the NCPHD staff develop the funding workplans, both for the regional and the local work, they are using the knowledge they have from where their gaps were in their assessment. It should be noted that Deschutes, Kirk, and Jefferson counties didn't do exactly the same things as some modernization collaboratives did. When the NCPHD staff are filling out the workplans, they are using the assessment data NCPHD has. She shared that, unlike Ms. Tiel, she had the modernization manual opened all the time, looking at what the local roles are and where NCPHD is doing that work. It may be a way to tie that back in, but that's how NCPHD is proposing the work it does to the state.

Ms. DeLaVergne-Brown agreed with Ms. Thalsofer. Crook County used that assessment and is in the process now of taking a look at it again, looking for gaps. When the LPHA developed the workplan, they looked at it, but now they will do an assessment of the whole thing.

Ms. Mortell appreciated Dr. Bangsberg's reminder that this was a very small sliver of the gap LPHAs have identified. Although everybody is doing good work, LPHAs need to track all the places where they are not able to build new systems and move forward.

Dr. Savage shared that in terms of collaborations between OHA, LPHAs, and tribes, it would be nice to have similar metrics across jurisdictions, and each entity to put in prevention and treatment strategies that might be similar, and measure them in a similar way to find out how they work across populations. Applying this model to tribal areas and LPHA areas would be fascinating, rather than having different metrics across jurisdictions, with one working here and one working there. Having consistency across jurisdictions would be great.

Dr. Schwarz stated that in a month a half, CCO 2.0 would begin. One of the features of CCO 2.0 is a higher focus on social determinants of health and collaboration between public health organizations and CCOs. The PHAB should continue to be interested in this collaboration because it is about the leveraging of resources. While public health didn't have resources in the past, CCOs now have resources of their own and we are seeing how these resources are being utilized. On the other side, there are CCOs that can use flexible health dollars for public health work. The PHAB needs to figure out how to monitor what is happening and how these collaborations continue to develop.

Dr. Bangsberg remarked that one thing he had been advocating for at the OHPB was a CCO-wide summit to see how the CCOs were investing in social determinants of health and compare notes across CCOs to determine best practices. Right now, the policy is written a little ambiguously. It says that a CCO has to invest something in social determinants of health – *something* – and involve its community advisory council, its community health assessment, its community health improvement plan, and its LPHA in some unspecified way. Freedom is good, but we want more specificity about the local public health. Let's create a sense of accountability and best practices through the CCO-wide summit. There is some enthusiasm for that. It would be great to have the PHAB at that CCO summit to ask the public health questions, such as "Is that really a social determinant of health?"

Ms. Tiel thanked the PHAB members for their feedback. In the coming year, the PHAB will think about how to structure this type of information sharing – maybe similar to today's presentations, maybe through looking at the PHM manual, or looking at other ways to have these presentations be in partnership, rather than presentations on individual workplans.

Ms. Rippeteau clarified that she would like to stay on the metrics subcommittee. She was a little bit confused about the ask. She acknowledged her guilt for not being able to attend as

often. She doesn't want to be in the way of progress. She would be happy to stay on and continue serving. She is also staying on the PHAB.

Ms. Tiel thanked Ms. Rippeteau for her clarification.

Ms. Mortell thanked the PHAB members and stated that it had been an honor and a pleasure to work with them as the large county representative to the PHAB. It's always important to look for opportunities for others to provide input and leadership. The large county community group and CLHO (Coalition of Local Health Officials) have endorsed Rachael Banks, Multnomah County's Director of Public Health, to move forward her application as the representative for the large county local public health jurisdictions in Oregon. She will remain in her role as the public health administrator in Washington County.

### **Eastern Oregon Hepatitis C Prevention Initiative**

*Jude Leahy (OHA Staff), Samantha Byers (OHA Staff), Dr. Ann Thomas (OHA Staff)*

Ms. Leahy introduced herself as the adult bio-Hepatitis prevention coordinator for OHA in the acute and communicable disease prevention program.

Ms. Byers introduced herself as the opioid rapid response project coordinator for the Health Systems Division.

Dr. Thomas introduced herself as a public health physician in the acute and communicable disease prevention program.

Ms. Leahy noted that the presentation would be about a project her team was doing in Eastern Oregon, in Klamath County, using a syndemic approach for Hepatitis C prevention. She read a quote by Alan Muskat that appeared in an [article](#) on The Fix blog: "If we only look at addiction on an individual level, we are missing the forest for the trees. If you don't heal the forest, it gets harder and harder to heal each tree." She added that her team is working on both the forest and the trees. The work aligns with the public health advisory's guiding principles, values, and strategies. The interventions are multi-level and cross-sectorial and they involve academic researchers, hospitals, public health organizations, and community-based organizations. The team is leveraging existing opportunities to plan, implement, and share their learnings and, hopefully, improve systems, communities, and the lives of individuals affected by substance use disorder. The team hopes that the presented interventions build evidence for no-barrier, harm reduction, peer-intervention that would get people who are currently using drugs into medical care, MAT (medication-assisted treatment), and hepatitis C treatment in Oregon.

Ms. Leahy presented a conceptual model that described the relationships between substance abuse, overdose, STIs, and associated conditions and IDU-related infections. When combined, these epidemics make a syndemic (from Greek *syn* "together"). Syndemics are two or more

interacting and synergistic epidemics that share a common cause, consequence, and needed response. They arise from conditions of health inequity and harmful social conditions. The base of the syndemic in Oregon is substance use, substance misuse, and disordered use. The inputs are substances that have misuse potential (i.e., they are legal), as well as those that are not legal. Some of the outcomes that happen are neonatal abstinence syndrome and fetal alcohol spectrum disorder. Other outcomes include morbidity and mortality and suicidality. Suicide is the leading cause of death for people with substance use disorder. Substance use, misuse, and disordered use lead to sexually transmitted infections (STIs). Injection drug use leads to infections in skin and soft tissue.

Ms. Leahy explained that underpinning this model were root social and economic issues that created health inequities and the harmful social conditions, such as adverse childhood experiences and toxic stress that affect access to and availability of resources to prevent recovering respond. The issues influence the existence of protective factors that shape individual resilience and health.

Dr. Thomas presented visual representations of the geographical distribution of disease in Oregon in the last few years. For years, OHA would look at frequencies of hepatitis C in Oregon and Multnomah County had the highest number of cases. It wasn't until OHA started looking at the data and calculating rates that it became clear that substance abuse was a big problem in rural areas. For opioid overdose hospitalizations, there are many cases in Multnomah County, but the rest of the counties in the metro area are not in the top 10. The results are similarly overwhelming for methamphetamine/psychostimulant hospitalizations in rural areas.

Dr. Thomas stated that injection drug use related hospitalizations by infection have also risen over the last ten years, especially *bacteremia sepsis* and *skin/soft tissue infections*. The distribution of new cases of HIV and hepatitis C in Oregon between 2012 and 2016 is concentrated in the metro counties and down the I-5 corridor. For chronic hepatitis C cases, the data reflects only cases in people below 30 years of age. Due to lack of resources, LPHAs cannot interview all new 5000-6000 cases every year. The rates for people under 30 are a marker for recent infections that are most likely acquired through injection drug use. The increase in hepatitis C has gone up 30% over the last five years. In the same time period, the rate of HIV diagnoses has gone down, but when broken up to Portland area versus the rest of the state, the HIV rate is increasing in the rest of the state.

Dr. Thomas provided an overview of the HOPE study. The goal of the study was to increase outreach to people who inject in rural settings and offer them a rapid test for HIV, hepatitis C, and syphilis. A peer-based model was used. Individuals were accessed through HIV Alliance and needle exchanges in Roseburg, Cottage Grove, and southern Lane County. Personal data were collected quantitatively via a survey and a small group of individuals participated in in-depth qualitative interviews. Study participants worked with their peers to drive them to the local food pantry, or help them get on the Oregon Health Plan, among other activities.

Dr. Thomas pointed out that this was a multi-level intervention. At the individual level, OHA worked with clients. At the provider level, OHA worked with the AIDS Education Training Center, trying to provide training on both addiction medicine and Hepatitis C care to primary care providers in those areas. At the community level, OHA distributed community-level factsheets that showed drug overdose hospitalizations and deaths in cases of hepatitis C, HIV, and neonatal abstinence syndrome in every county, so that individuals can use the sheets locally to inform the local advisory committees that have been set up with the opioid funds. The sheets are also useful for advocacy purposes. The HOPE study was done as a pilot in Douglas and Lane counties, with the goal to expand to seven counties. In the next three years, without funding, the pilot will expand to Coos, Curry, and Josephine counties.

Dr. Thomas remarked that in Douglas and Lane counties, OHA would pilot an ATTILA (Assistive Technology and Telecare to maintain Independent Living At home) health intervention, where people who tested positive for hepatitis C would be recruited through a rapid Hepatitis C test in an outpatient setting. OHA will work with them to get on the Oregon Health Plan and take them to a local hospital lab for an initial evaluation prior to treatment. Then the individuals will be referred to a community provider or a telehealth provider at OHSU. The peers will sit down with the individuals and load up an iPad and have them meet with a doctor from OHSU, who will fax a prescription to a local pharmacy for them.

Dr. Savage asked if any of the presented data overlapped with the data in the PDMP (Prescription Drug Monitoring Program). She asked if Dr. Thomas's team worked with that program.

Dr. Thomas answered that if OHA had access to those data, the team would most likely incorporate them with OHA's data. Recently, OHA received funds from the State Opioid Response funding to do a vulnerability assessment. The team did a lot of modeling and looked at data from PDMP, as well as social determinants of health data, such as availability of transportation, income, and education, among others, to find out the best predictors of a Hepatitis C outbreak at a county level. The determinants had to do with the county's rate of risky prescribing, or the rate of people with more than 90 MME (morphine minimum equivalent) dose, and years of potential life loss, which is more of a sequelae of injection drug use. If a lot of people are dying of overdoses and acquiring hepatitis C, more deaths will occur among people in their 40s and 50s. That is a good predictor, along with lack of transportation. These are people who are not accessing health care and not accessing needle exchange.

Ms. Leahy added that, in relation to the syndemic model, as the PDMP reworked the opioid dashboard, they would be including more programmatic data. The PDMP is operating in a somewhat syndemic way, both with OHA's Health Systems Division's partners and the injury violence prevention program to incorporate hepatitis C, because it affects so many people, who are also affected by overdose.

Ms. Leahy noted that the peers who worked on the HOPE site were Larry and Joanna. Both have lived experience with substance use disorder and both are peer recovery mentors. They are certified by the state in one of the five types of care. They are both supported and employed by HIV Alliance. They go into the community, they go to trailer parks, they knock on doors, they hang out in parks, they build relationships with people who are currently using drugs who are completely disengaged from the health system (they are not people showing up at HIV Alliance's door), they bring them harm reduction "gift bags" that include syringes, safe injection equipment, and information. They bring these things to people and they keep going back and around and meet people. After a while, people trust them. They also can conduct rapid hepatitis C/HIV/syphilis testing in the field. They help people register for CCOs. They are a link to treatment, transportation, and housing assistance. They say to people, "What do you need to make your life better? How can I help you reduce the risk of substance use?" They clear the deck for someone to be able to have the stuff that are really important to them taken care of, so then they have the space to say, "What can I do next about my health?"

Dr. Thomas stated that over the last two years, OHA has recruited 177 participants into the Oregon HOPE study in Lane and Douglas counties. The first step is getting them the very basic things. These people have a lot of overwhelming needs. The data showed that 68% were homeless in the past 6 months, 51% were incarcerated in the past 6 months, 50% were hepatitis C positive, and 45% shared syringes/equipment in the last 30 days. Although the funding is for opioids, there is still a lot of methamphetamine use in the state. In terms of drug of choice, 44% used heroin, 49% used meth, and 7% used another drug. Over the past 30 days, 78% had used an opioid, with 96% of them using meth in the past 30 days. In terms of getting naloxone, 73% even witnessed an overdose, 42% ever overdosed, and 28% currently have naloxone. The top two reasons for not accessing medical care were: 50% did not have transportation, 49% were afraid they would be treated with disrespect because of their drug use. Of the people who hadn't engaged in some kind of substance use disorder treatment in the past, 18% of the peer-outreach clients engaged in substance use within the next 3 months.

Dr. Thomas pointed out that some of the lessons learned from this model included barriers, such as stigma, transportation, access, and housing instability – all things needed to develop a successful intervention. The peer-led interventions are a way to make inroads with this hard-to-reach group. A lot of the peer-led research has not been done in rural settings. Oregon is in the forefront in this. The syndemic approach is the way to go.

Dr. Savage asked if the HOPE study was over or it was still going.

Dr. Thomas answered that it has been more of a data collection effort and piloting the use of peers for two years in two counties. The next stage in Douglas and Lane counties is a push to get them into care both for hepatitis C. It's the telehealth intervention, trying to get them to substance use disorder treatment. In the three new counties, OHA will be doing the work that

has been done in the first two counties, with a lot more of the initial recruitment and in-depth data collection that will inform community efforts in Coos, Curry, and Josephine counties.

Dr. Savage asked if the study was still funding the peers.

Dr. Thomas answered that the study would continue for three more years.

Ms. Leahy reiterated that the first two years were a pilot to show that OHA could find people and get them in and the peers could provide service. The CDC released some funding with the prompt “How can you reach people who are using drugs in rural areas and get them tested and treated for hepatitis C?” Taking the syndemic approach and wanting to leverage what exists, the team approached all partners to figure out how to make it better. The OHA team used the vulnerability data and identified counties that had high vulnerability and didn’t have HIV prevention funding from the state or have access to at least using the money they had to screen for hepatitis C.

Ms. Byers pointed out that the work wrapped around House Bill 4143 that was geared toward reducing overdoses by placing recovery peers in emergency departments. Ms. Samantha Byers leads that project, as well as the 2019 State Opioid Response Expansion, which expanded recovery peer work to 14 counties. A lesson from the HB 4143 pilot was that the peers needed flexibility to work in emergency departments, primary care, urgent care, and county health department clinics. Because of the peer expansion, the OHA team decided to wrap the hepatitis C screening and linkage to care around the overdose work. The OHA team approached people at the health system level and they wrote the grant together and were successful in obtaining it. The funding is for one year, and it is called Peer Recover Initiated in Medical Establishments (PRIME). The place where peer work could be wrapped around hepatitis C work is called PRIME Plus for testing and linkage to care. The rural counties were approached based on their high vulnerability to complications of injection drug use, they are not OR-HOPE counties, and they don’t have other funding that could be used for HIV/hepatitis C testing.

Ms. Saito asked how the peers got paid for their work.

Ms. Byers answered that the grant from the CDC was for half a million dollars per year. Most of the money was disbursed to the counties. It takes about 90K to support the peer and the peer work. The OHA team went through CLHO to help identify what the team would do. During the writing of the grant, instead of telling the counties how to use the funding, the OHA team approached the counties as the grant was being written and asked them how they would use the money. In the three different counties, the money is going in three different ways. In Klamath County, the money is going to a community-based agency. In Malheur County, the money is going to the public health department. In Umatilla County, the money is going to the county’s behavioral health addiction program.

Ms. Saito asked if the peers got paid per person they were working with.

Ms. Byers answered that the peers were full-time, salaried, and hopefully with benefits. The project has primary and secondary aims. The primary aims are to conduct the hepatitis C and B testing and provide peer support. The secondary aims are linked to other types of syndemics through support of participants to access preventive care and substance use treatment and provide harm reduction counseling and support. The peers will engage with clients and help them enroll in Medicaid or find a medical home. If the clients are hepatitis C positive, the peers will support obtaining confirmatory testing. The peers would help the clients make medical appointments. They would go to medical appointments with them and, hopefully, the clients would be engaging with a medical provider, who would provide them hepatitis C treatment.

Ms. Byers remarked that the community advisory work included aligning community supports by engaging with local and cross-site community advisory groups, as well as sharing program and evaluation data, outcomes, and experiences with community stakeholders; training of PRIME peers across the state in infectious disease prevention, regardless of whether the peer is in a PRIME+ county; supporting sustainability by integrating with existing programs (PRIME and CCO peer initiatives).

Dr. Savage asked if community partners included the police, the county sheriff, and the law enforcement system.

Ms. Byers answered that the OHA team asked each of the counties to organize their own community advisory board. All will be involved with their LPAC (local programs advisory committee) that deals with their CCO. The people involved in the LPACs, at least in two counties, are meeting with the police because they will be talking about syringe exchange. The third county has had a syringe exchange on and off (now is off). She is working on supporting syringe exchange in each of the counties, so there will be a place for the peers to work.

Dr. Savage stated that the biggest obstacle and barrier to put in the syringe exchange program in the Marion and Polk areas was the county. It is because the local commissioners have different feelings about how that works. It is good that CCOs are not bound by those rules. She recommended to the OHA team to collaborate with the CCOs for that backing.

Ms. Byers expressed hope that the CCOs would be encouraged enough to support syringe exchange programs. A syringe costs 8 cents. The OHA team just finished a syringe service program manual that included a budgeting section. A CCO can run a syringe exchange program for 128K, with 70K going to supplies. This would prevent each one of the infections, with an infection costing 23K on average (a lot more for endocarditis). How many little infections does a CCO need to prevent to support a total syringe exchange program that benefits the community?

Dr. Dannenhoffer shared that Douglas County was one of the early counties and it had been great. Substance users are a tough crowd to get. They are fearful of police and public health. Having the peers would be great.

Ms. Thalsofer asked if there was any support for the peers, in terms of sending them back to the substance use culture.

Ms. Byers answered that for the work on HB 4143, or PRIME/PRIME+, one of the requirements was that whoever got the funding had to have peers contracted through agencies that already have the structure for supervision and support of the peers. There are existent peer-run agencies and peer-run structures. The peers do have support, such as one-on-one supervision and group supervision. They also will be receiving additional training that OHA is organizing in each county, so that the peers don't have to travel to Portland.

Ms. Leahy added that for OR-HOPE, the peers were certified as recovering mentors and they had clinical supervision with a behavioral health specialist at HIV Alliance.

Ms. Shirley commented that the presented work met many of the PHM goals. The focus of the PHAB and in other venues has been on getting modernization money to the counties for specific work. This work is an example of how OHA is trying to take OHA's day-to-day work that public health does around these issues and diseases, understanding the impact and what public health can do to interject on the course of some of these diseases. This is one of OHA's attempts to change the culture at the state health department and do things in a modern way. Another goal is to have an overlap with the CCOs. OHA used the actual numbers provided by the CCOs to identify the cost and benefit of a syringe exchange program. That is the beginning of this prevention work.

Ms. Shirley added that, to Dr. Savage's point, there were county commissioners who were against this, but the CCOs objected that they could be spending 100K instead of over a million dollars. That got everybody's attention. We need alliances and we need to figure out how we identify our goals beyond specific public health data. The point of all this work is the people the public health system serves and how we get them to have a better life. This project is a great example of how the Oregon Health Authority, not only the Public Health Division, should be doing its work. OHA will be using the project as an example when it kicks off OHA's strategic planning process. One thing about this team is that when they did their hepatitis C work and went to prisons, the CDC people told them that they couldn't do that. They did it anyway and got their outcomes. Now everybody is coming to public health and asking them how they got into the prisons. It is that sense of innovation and leaning in that is, very often, how we operate to do what we need to do.

Ms. Thalsofer remarked that while this was great and finding the CCOs as a partner was really helpful, the missing piece was that LPHAs had to have this discussion every time with every

CCO. She did not understand the role of the innovator agents, because she hadn't seen them. It would be great when an LPHA approached a CCO with a project like this, the CCO had already heard how well it worked in another region and they were teed up to be ready to work with the LPHA. There are many examples across the state where great projects have come out and saved money, but LPHAs have to fight that battle every time. Whatever can be done at the OHA level to get that understanding spread across all CCOs, that would be incredibly helpful.

Dr. Savage agreed with Ms. Thalhofer and added that this OHA team presented at Que Hawk in a small portion of the hepatitis C treatment part. All medical directors and CCOs were there. Presentations like this one have been given to CCOs. Ms. Thalhofer's frustration is justified. CCOs don't equally provide the same uptake or enthusiasm for those projects, as each CCO does its own thing. Some vision and leadership from OHA are definitely great, but also buy-in and follow from each CCO is really important. She promised to continue to work with the CCO medical directors in that setting.

Ms. Shirley pointed out that the reason the team was successful at the bottom line with the counties in the rural areas was because they followed the money and demonstrated the return of investment. OHA had to get better about even interim gains and successes.

Dr. Dannenhoffer agreed with Ms. Shirley and praised the approach taken by the OHA team. These diseases are the perfect ones to follow, because they happen soon after the use of the drugs, they are identifiable, and they are very expensive. Douglas County had a few endocarditis cases that were problematic, because it's 100K the first time and, if they forget the antibiotics, they get it again, and some patients need a valve replacement. These diseases are incredibly expensive to treat.

Ms. Leahy remarked that the challenge with endocarditis was that as soon as someone gets endocarditis from rejection drug use, we might as well start a clock, because in terms of recovering their health and getting better with all the obstacles, it makes the 4143 peer program in the hospitals really important. Even if only endocarditis was prevented, it would be both healthy for the person and health for the community. One of the challenges is that Oregon has one of the highest morbidity and mortality rates for hepatitis C. It should be known that the funding from CDC for hepatitis C is very little. That's why the team is thinking hard about what it is doing, because the CDC is not coming. Once that phase is passed and the team leans in, there are many people who want to help, because many people are affected by substance use disorder and infections, including hepatitis C.

Ms. Byers added that in terms of the primer 4143, the OHA team asked the CCOs to sit at the table with them. The CDC money is startup money to build the infrastructure and then they would carry on the project through the CCO. The Health Systems Division puts a lot of weight on CCO 2.0, because it is very significant. It will be the first time that CCOs are not allowed to carve out the behavioral health benefit and that they are held accountable to integrate it,

which is where this project becomes even more powerful. There is a little bit more push from the substance use disorder (SUD) side to be able to leverage some partnerships that the team leveraged for smaller projects not quite as large as PRIME. Secondly, one of the structural areas that is not related to the CCO is that hospitals are incredibly reluctant to allow peers in. This pilot project was initiated by the legislature and inspired by Rhode Island's AnchorED program, but the legislation didn't mandate the medical community to participate in it. It is not specified what to do when the hospitals are not ready to participate. The peers are creating partnerships, they do panel discussions so they can meet people in recovery and feel comfortable around them, but the way it worked was through champions at medical locations. If that barrier was removed, more people would be accessed and served and not driven to the point where they are on a time clock.

Ms. Tiel expressed excitement about cross-division projects like this at OHA. She reminded the PHAB that the board meeting in December would be either canceled or be over the phone.

### **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 4:48 p.m.

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

**January 16, 2020  
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)



Public Health Advisory Board  
Meeting Minutes – November 21, 2019