

Public Health Advisory Board (PHAB)

June 18, 2020

Meeting Minutes

Attendance:

Board members present: Dr. Jeanne Savage, Dr. Eli Schwarz, Kelle Little, Dr. Bob Dannenhoffer, Rebecca Tiel (Chair), Dr. Sarah Present, Dr. Veronica Irvin, Dr. David Bangsberg, Eva RippetEAU, Lillian Shirley (ex-officio), Teri Thalhofer, Muriel DeLaVergne-Brown, Carrie Brogoitti, Dr. Dean Sidelinger, Akiko Saito, Rachael Banks, Alejandro Queral

Board members absent: None

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

Members of the public: None

Welcome and Agenda Review

Rebecca Tiel

Ms. Tiel welcomed the PHAB to the meeting and invited the board members to take a moment to recognize the power that the PHAB had and should use to move racial equity work ahead in light of the murders of George Floyd, Breonna Taylor and Ahmaud Arbery and the over 1,000 people killed by police each year. There have been longstanding inequities in public health work due to systemic racism and oppression and the PHAB started this work initially with its equity review policy and procedure, the funding formula, the investment in public health modernization being focused on health equity and cultural responsiveness, and the board is by no means finished. She asked if board members had any other thoughts about how the PHAB should shape its work ahead.

Dr. Present remarked that public health had always been rooted in social justice. The PHAB has the ability to talk both about the pandemics right in front of us, like COVID-19, and long-term issues, like chronic disease and racism. For a while, people have been calling on the public health community to name racism as a public health crisis and emergency. Many of the public health solutions are geared towards that. The public health community understands the social determinants of health and has been advocating for a long time for more investment and prevention in upstream strategies. Out science and overall approach can be offered to people looking for a different type of investment that divests from downstream and tertiary interventions in criminal justice and other things and reinvest that in the upstream and the prosocial assessment.



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Dr. Schwarz stated that he had been very happy and proud that the PHAB had wide-ranging discussions three years ago about health equity and how to include the discussions about health equity and the different structures in our society in the board's discussions. He had to look at that document yesterday, because the Health Share board was discussing something very similar. He informed the Health Share board that the PHAB had a document from 2017 but couldn't remember if the document had been updated. He wondered if the present situation required of the PHAB to look at the document and see if it was still current and whether it needed changes.

Ms. Tiel agreed and suggested that this could be a future agenda item.

Teri Thalhofer shared that she had been thinking a lot recently about the benefit her white privilege had given her, and really thinking about sitting back and listening to members of communities of color and not trying to instinctively justify their responses, and just sit in the discomfort of listening. Even when those of us in a position of power, who are white, go out and listen to communities of color, we then want to interpret for them, and say, "We went out and listened to these community-based organizations and they told us X, Y, Z." It's really important that we start to yield the power and not be the ones interpreting the experiences, but letting those communities of color speak for themselves. That's going to take a shift in Oregon. It's not going to be comfortable, because nobody likes to yield power, but we are going to have to sit in our discomfort for quite a while to make a difference. She is ready to do that, and really ask her colleagues, who have experienced that white privilege, to do it as well.

Ms. Tiel noted that it was really important to recognize that when convening people from the public health perspective, the process was beyond cocreation. As Ms. Thalhofer pointed out, it was about sitting back and listening.

Ms. Tiel informed the PHAB that Ms. Thalhofer was retiring at the end of the month. This is Ms. Thalhofer's last board meeting. She has been on the PHAB since its current iteration and has been a public health leader since before the board was created in statute. She thanked Ms. Thalhofer for her contributions to the board, the public health modernization, and representing her region and the state.

Ms. Thalhofer thanked Ms. Thiel and added that it had really been an honor to be a part of public health modernization and it had been great working with all board members. She will not disappear. She will be listening to the board to see what happens. It's a really exciting time, and she is stepping out with a lot of mixed emotions in the midst of a pandemic, but no time would have been perfect. She thanked the board.

Ms. Biddlecom added that the other retirement (in the fall) during this pandemic, Ms. Lillian Shirley, was shared in an email this morning. The board is very excited for Ms. Shirley and Ms. Thalhofer to be able to do something else and spend more time with their loved ones and doing

the things that they care about. The PHAB appreciates their dedication to public health for such a long time.

Ms. Shirley shared that she would be around for a couple of more board meetings. She negotiated with Director Pat Allen to identify a time for retirement in the future, so that he would have enough time to do recruitment and get somebody in to get their feet on the ground, as the pandemic is continuing. As opposed to two months ago, when OHA had a workplan, now we are very stretched in terms of resources, communications, and many other things. But public health has landed on a framework: we know we have to test, investigate, trace, and support. This was a good time for her to bring up her retirement plans and respect both Director Allen and her colleagues with whom she works, to give them some time in this transition. Unlike Ms. Thalhoffer, she won't listen (to see what happens).

- Approval of May 2020 Minutes

A quorum was present. Ms. Rippeteau moved for approval of the May 21, 2020, meeting minutes. Dr. Present seconded the move. The PHAB approved the meeting minutes unanimously.

COVID-19 Response Update

Dr. Dean Sidelinger, Lillian Shirley, Akiko Saito

Dr. Sidelinger provided an update to the PHAB with the latest COVID-19 developments:

- 148 new cases today; total around 6400; 4 additional deaths
- Oregon continues to have one of the lowest case rates in the country
- Increased cases seen since reopening the state on May 15; workplace outbreaks and congregate care facilities account for most of the increase
- The percentage of cases not traced back to a source is increasing, which indicates community spread
- The weekly surveillance report comes out on Wednesday
- Age group 20-29 has the most cases, due to workplace outbreaks
- The data for Hood River, Polk, and Marion counties, which applied for entering Phase 2, looks good; the data for Multnomah County, which applied for entering Phase 1, looks good
- Seven counties will enforce mandatory face covering guidance: Multnomah, Clackamas, Washington, Marion, Polk, Lincoln, Hood River
- Due to the outbreak in Union County, the county's board of commissioners voted for residents and businesses to revert to Phase 1 to minimize spread
- Traveling around the state is not recommended

- Funds and resources are being directed to LPHAs and community-based organizations (CBOs) to help in the response effort
- The state response is being restructured

Ms. Saito added that the COVID-19 response needed to have a cross-agency unit. It's called COVID Response and Recovery Unit (CRRU). The unit had a footprint in Salem at a Health and Human Services branch. The agency operation center (AOC) is in Portland. The response effort will continue from the AOC. Some of the work that has come out of CRRU includes work around playbooks. The food production playbook is ready and posted on the OHA website. The farmworker playbook is close to being finalized. The CRRU will lead with health and service equity focus and will try to be more nimble and more integrated. The CRRU will work over the next 12-24 months.

Dr. Sidelinger noted that the focus on health equity was huge in this response. The inequities are seen in communities of color. Some of the disability communities are also overrepresented in the data. OHA is working with OR-OSHA and the Department of Agriculture partners to ensure that there are workplace protections. LPHAs are trying to get outreach in the community to ensure testing occurs where people live from organizations and people that they trust. In terms of data, there is a significant amount of missing data in the negative test results. Some of the data that is there doesn't seem to be accurate. More testing is needed in all these communities, regardless of what the data shows.

Ms. Rippeteau expressed gratitude for using COVID response money for the quarantine and having a lot of support in ensuring that people have financial support for housing, food, and services like childcare. One of the things the community partners are finding is that people don't have access to paid time off. The federal COVID family and medical leave doesn't cover everybody. People who work at places with fewer than 50 and more than 500 employees are no covered. If these people don't have access to paid time off, that's still a barrier for them to feel comfortable taking the time off or coming forward when they are sick. She asked if there was a way for public health to elevate and highlight this issue. It was hoped that this would be covered in the COVID-related special session that is happening next week, but it didn't make the list.

Ms. Shirley agreed with Ms. Rippeteau and recognized that public health was not in control of a lot of these funding streams. It doesn't mean that OHA can't influence the conversation. Some of the work Ms. Saito called out is exactly to see how some of these dollars can be braided. It's an enormous barrier for people to admit that they don't feel good, or if they are contact that they have to be tested. This has become evident in the last 10 days cross communities. It is not easy administratively do make these changes. Mistakes will be made and people will misinterpret some of the work. OHA is changing its understanding of what needs to be done to achieve equity and ensure that Oregonians can achieve their maximum health regardless of who they are and where they live.

Dr. Savage echoed Ms. Rippeteau's gratitude. She solicited some questions from the leaders in the CCO world. One of the biggest questions is about how CCOs and public health can communicate around the work that public health is doing with the contact tracing and the coordination of that care. She asked about the best practices for contract tracing going forward and asked whether the PHAB could suggest best practices for helping the communication between public health and the CCOs.

Ms. Shirley answered that one of the things OHA didn't do from the beginning was to bring in the CCOs around the spectrum of services that needed to be done. OHA's work with the CCOs in the hospitals was figuring out how to protect them with access, as well as capacity and PPE. Right now, OHA is trying to reconcile all these work streams in some places of the state (e.g., Eastern Oregon). In the small counties there, it is all hands on deck for the response, including the hospitals and the CCO. In different parts of the state, people are solving those problems locally themselves. Also, the state has refocused its regional hospital system and regional hospital work with the healthcare system. Now that challenge is in connecting them with both the public health system and the CBOs, as the state moves forward and implements new models for public health. Ultimately, it will protect the population and give better access across the system.

Ms. DeLaVergne-Brown added that in Central Oregon they involved the CCO very quickly. For example, Crook County, Jefferson County, and Wheeler County initiated a conversation about doing a fast clinic during an outbreak with St. Charles Health. The work is a collaborative effort.

Academic COVID-19 Surveillance Studies

David Bangsberg (OHSU-PSU), Javier Nieto (OSU)

Ms. Tiel stated that at the last PHAB meeting, the board asked for an overview of each of the COVID-19 surveillance studies going on in Oregon. Dr. David Bangsberg will share about the Key to Oregon study and Dr. Javier Nieto from OSU will share about the TRACE study.

Dr. Bangsberg explained that the objective and goal of the Key to Oregon study was the understand the prevalence of COVID-19 throughout the state regionally and over time, in order to give OHA and Governor Kate Brown the information they need for evidence-based health policy, as we adapt to rolling back the physical distancing and other interventions that have been so effective. The initial approach to the Key to Oregon study was to invite 150,000 households throughout Oregon with the goal of recruiting 100,000 people. Households are randomly selected throughout the state. Households were oversampled for zip codes where prevalence of underrepresented minorities was greater than 50%. Households were also oversampled if they were in a rural zip code. The individuals who agree to participate are asked to engage in daily symptom monitoring, with the addition of a smart, Bluetooth-enabled

thermometer to track symptoms. Individuals who develop symptoms that are consistent with COVID-19 are offered a free COVID-19 test by mail for self-administration.

Dr. Bangsberg added that OHSU was planning to provide testing to up to 10,000 people without symptoms over time to examine the prevalence of asymptomatic COVID-19 infection. Households were invited with a postcard and were provided with a letter. They signed up on the website and provided consent. In the rush to launch the study and provide as much data as possible as Oregon starts to reopen, OHSU made some important mistakes. One of them was announcing the study before seeking out the input of communities of color and tribal communities. OHSU received a letter from community leaders who addressed that concern. Based on that feedback, OHSU has put additional recruitment and engagement activities on hold until OHSU added new recruitment strategies or changed existing recruitment strategies. Currently, there are 8,600 individuals who have consented and enrolled in the study.

Dr. Savage asked about the process for managing the collected information and the exchange of information between the individual and their PCP (primary care provider).

Dr. Bangsberg answered that the individual results of the COVID tests were reported to the OHA. Each participant has a participant navigator. The navigator will ask the participant whether they have a primary care provider. If an individual is feeling sick, the navigator helps with the hand-off to the clinical care system and their PCP. If they don't have a PCP, OHSU will help them find a new PCP. The positive tests are received by OHA, whose team follows up with contact tracing and works with community health workers, who talk to the participant about home isolation.

Dr. Savage asked if there was something the participants had to sign that said that they agreed to release their information to their PCP.

Dr. Bangsberg answered that it was written in the consent form that all COVID test results would be released to OHA. There is no disclosure to clinical providers unless the participant requests it.

Dr. Schwarz asked how long it would take to recruit 100,000 people.

Dr. Bangsberg answered that it depended on how OHSU adapted, modified, or changed its recruitment strategy based on community engagement. Initially, OHSU planned several reminder mailings for the first collection of 150,000 households. OHSU sent one postcard and one mailing. This resulted in just under 10% of the intended sample. It's quite feasible to recruit 100,000 with reminders and additional sampling over a few months.

Dr. Nieto thanked Dr. Bangsberg for his comments. What Oregon State University is trying to do with its TRACE study is very complimentary to the Key to Oregon study. Similarly to the Key to

Oregon study, the TRACE study will examine the prevalence of COVID-19 in the population. The goal is to take a pulse of the state of the epidemic in the population. That's where epidemics occur, not in individual cases. We cannot manage a pandemic in a way that is rigorous and evidence-based without knowing what's happening in the community. That's because there are so many asymptomatic cases. Simply counting the symptomatic cases will not give us a full picture.

Dr. Nieto clarified that TRACE stood for *team-based rapid assessment of coronavirus epidemics*. The study's objectives included estimating the prevalence of COVID-19 infection in a community in near real time, developing a scalable system that can be rapidly deployed in other communities, and harnessing untapped potential in universities to adapt and respond to COVID-19. The sampling strategy is rapid health assessment. Assessment area is identified by political boundaries or sections of specific communities. The area is divided into non-overlapping sections (i.e., clusters). The sampling frame is the list of all clusters. Probability sampling will allow the collection of data that are representative. The field teams will include traditional health workers or other community health workers, as well as OSU students.

Dr. Nieto explained the experience at the doorstep for participants in the study. Once samples are collected, they are brought to a lab for analysis. So far, five data collection sessions have taken place (4 in Corvallis and 1 in Bend), all including 30 neighborhoods. The average participation rate has been 76%. Overall, the prevalence has been very low, but not zero. The estimate of city-wide prevalence is 1 per 100,000 people. The study also tracks coronavirus in municipal wastewater that will serve as an early alert to identify localized spikes. Future sampling sites include Bend (repeat), Marion County (Salem), and Lane County (Eugene).

Dr. Dannenhoffer asked about the neighborhood sampling in Newport for the TRACE study. In Corvallis, where there are not many cases, random sampling makes sense. In Newport, here is going to be a varying variable, depending on which neighborhoods are sampled.

Dr. Nieto answered that the county health department provided OSU with a map of the distribution of the cases. Because the city has uniform distribution of cases, random sampling will be used. The study will reveal the impact of the concentration of cases at a local packing plant on the community.

Dr. Irvin asked Dr. Bangsberg and Dr. Nieto if their respective studies were antibody studies and, if not, would that be something happening in the future.

Dr. Nieto answered that three issues prevented the TRACE study to take that route: (1) antibody testing requires blood samples, which requires for participants to be touched, which necessitates the use of PPE, (2) the antibody tests have been questionable in terms of validity, (3) it is unclear what a positive antibody test means in terms of immunity and how lasting it is. OSU is considering antibody testing for Fall 2020, but only if these issues have been resolved.

Dr. Bangsberg answered that no antibody testing had been planned for the Key to Oregon study. Study participants have consented to be approached for additional studies. OHSU anticipates interest in add-on studies in addition to the core study.

Dr. Savage asked whether the test results from the TRACE study went to OHA.

Dr. Nieto answered that the Willamette Toxicology Lab reported to OHA and the local health department. It is conveyed in the informed consent form that both positive and negative cases are reported to the local health department.

Dr. Dannenhoffer noted that in areas with very low prevalence anything other than perfect specificity (i.e., number of false positives) could really make the results difficult. Other studies have reported test specificity as low as 97%. He asked about the specificity of the TRACE study. For example, the Abbott ID has 3.3% false positives or 33 positives in 1000 people.

Dr. Nieto answered that for PCR of the person with the virus, the specificity was virtually perfect (i.e., close 100%). The sensitivity is more questionable. The problem is false negatives, which for this test is around 90%.

PHAB Member Discussion

Rebecca Tiel

Ms. Tiel remarked that this was the time for the PHAB to discuss key issues that board members should be aware of or should help problem-solve on behalf of the public health system. It is also time to discuss PHAB member roles and liaison responsibilities. One thing that was expressed was a desire to look at PHAB's health equity policies and procedures. Another was the long-term infrastructure and system changes that go beyond the initial COVID-19 response.

Dr. Savage commented that the CCO community would like to hear the public health strategies going forward, given the increased need for behavioral health. How would the PHAB look at this and help guide the public health response to not only identification, but also any treatment options, looking at how the board would recommend going forward? Another area to look at is decreasing immunization rates. It would be good if the PHAB had a strategy on how to deal with decreased vaccination rates.

Ms. Little stated that decreasing vaccination rates would be an issue for all communities, not just for childhood vaccinations, but also for adult vaccinations. She asked how OHA and the Public Health Division were thinking about flu immunizations in the fall and how the flu related to potential increasing cases of COVID-19. The thinking within the tribal communities is to increase promotion, not just the flu vaccine, as well as other adult vaccinations.

Ms. Drum responded that CDC had been producing more flu vaccine than they had ever had before. OHA was recently notified that it was receiving \$1.7 million in supplemental funds related to immunization for the purpose of high-risk populations receiving flu vaccination, because of the concerns related to COVID-19. OHA is in the early stages of figuring out what that will look like. In addition, there will be additional 60,000 flu vaccine doses that OHA will receive as a result of that.

Dr. Irvin requested more updates on the development of the SHIP.

Ms. Rippeteau asked how the board could support resiliency in the workforce and how the PHAB could set up protections for its members and all the people who work with the board members in the public health offices and agencies across the state.

Dr. Savage stated that the board needed to work on the communication and cross-coordination between PCPs, counties, and CCOs, and how to get the information from OHA to the providers who were taking care of those members.

Ms. Biddlecom answered that public health didn't share case information with providers unless it had to do with an individual case. She invited local public health administrators to share more broadly how they are coordinating in the healthcare setting.

Preventive Health and Health Services Block Grant

Danna Drum

Ms. Drum reminded the PHAB that this was a noncompetitive grant that was issued to all states and territories to address state and territory determined public health priorities. It's the only flexible funding the state has received from the Centers for Disease Control for public health. By federal law, there is a Block Grant advisory committee and the PHAB in Oregon serves that role. The state gets an allocation every year, based on a formula. A portion of the allocation must be used for rape prevention and victims' services. Currently, the funding goes to the Oregon Coalition Against Domestic and Sexual Violence (OCADSV). The work has to be tied to Health People 2020 objectives. Historically, the Block Grant has been used to support public health infrastructure, including public health modernization. OHA is proposing this year to remove one of the Health People 2020 objectives in the workplan. Some of the work related to public health accreditation doesn't need to continue to be in the Block Grant. In its place, OHA is proposing to use these funds to support the SHIP implementation. The work will be also moved under the quality improvement objective.

Ms. Drum explained that OHA would support SHIP implementation. That includes a staff person who has been funded through this grant to oversee the SHIP work; support for convening of the PartnerSHIP and all partners that come together to provide strategic direction and oversight;



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support of the community-based organizations that are represented on the PartnerSHIP; provide grants to support SHIP strategy implementation. In addition, OHA is working on a SHIP implementation website, which will be launched soon. Grant funds will also supplement some of the state funds that OHA receives for public health modernization to help support tribal work, as well as local public health training and technical assistance. The total funding is little over \$1.1 million, with 86K designated for the OCADSV.

Preventative Health and Health Services Block Grant Public Hearing

Ms. Drum opened the public hearing for the Preventive Health and Health Services Block Grant regarding the proposed workplan concepts for October 1, 2020, through September 30, 2021. She invited members of the public to provide comments on the Block Grant.

There was no public comment.

Ms. Sierra Prior from the Oregon Coalition of Local Health Officials (CLHO) asked for clarification around how OHA's Public Health Division and CLHO worked together on accreditation.

Ms. Drum answered that the accreditation work was done by an OHA staff member who worked with CLHO and the accreditation workgroup. That staff person works with LPHAs and tribes when they need specific documentation from OHA to support their own public health accreditation efforts. There is no financial agreement with CLHO for that work.

Ms. Drum closed the public hearing for the Block Grant.

Public Comment

Ms. Tiel invited members of the public to provide comments or ask questions in the chat box.

Ms. Jill Lake introduced herself as the director of clinical strategies at the Oregon Health Leadership Council. She read a statement on the communication between public health and the healthcare community regarding COVID-19 patients. She recommended that COVID-19 data from the Orpheus registry was shared with the collective platforms, where cases could be quickly identified and patients could be provided with the assistance they needed from their PCP.

Next Meeting Agenda Items and Adjourn

Rebecca Tiel

Ms. Tiel adjourned the meeting at 3:48 p.m.

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



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**July 16, 2020
2:00-4:00 p.m.
Join Zoom Meeting
<https://zoom.us/j/730818593>**

Meeting ID: 730 818 593

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