

Public Health Advisory Board (PHAB)
January 21, 2021
Meeting Minutes

Attendance:

Board members present: Dr. Eli Schwarz, Kelle Little, Dr. Bob Dannenhoffer, Dr. Sarah Present, Dr. Veronica Irvin, Eva Rippeteau, Muriel DeLaVergne-Brown, Rachael Banks, Carrie Brogoitti, Alejandro Queral, Sarah Poe, Dr. Jeanne Savage, Dr. David Bangsberg

Board members absent: Dr. Dean Sidelinger, Rebecca Tiel (Chair)

Oregon Health Authority (OHA) staff: Cara Biddlecom, Sara Beaudrault, Rex Larsen, Krasimir Karamfilov

Members of the public: None

Welcome and Agenda Review

Cara Biddlecom (OHA Staff)

Ms. Biddlecom welcomed the PHAB to the meeting and reviewed the agenda.

- Approval of November 2020 Minutes

A quorum was present. Mr. Queral moved for approval of the November 19, 2020, meeting minutes. Dr. Schwarz seconded the move. The PHAB approved the meeting minutes unanimously.

Nominations for New Chair

Cara Biddlecom (OHA Staff)

Ms. Biddlecom informed the board that the OHA team was working with the Governor's office to find a new state employee representative on the PHAB, following Ms. Saito's departure from the board, and a new local health administrator role, which Ms. Banks vacated when she became the new State Public Health Director. In addition, Ms. Tiel has agreed to stay on the board as chair for a few months while a new board chair is being recruited.

Ms. DeLaVergne-Brown announced that her last meeting with the PHAB would be in May.

Ms. Biddlecom remarked that board members interested in volunteering for the chair role should contact her.



Public Health Advisory Board
Meeting Minutes – January 21, 2021

Ms. Brogoitti noted that the OHA team that supported the board chair provided great support, which made the job easier.

Review 2021 Public Health Advisory Board Workplan

Sara Beaudrault (OHA Staff)

Ms. Beaudrault presented the board's workplan for 2021 and asked the board members to provide feedback on whether the workplan was hitting on the PHAB priorities, or whether there were other themes that needed to be included in the plan, which would be approved by the board in February. The plan includes three work categories: (1) board structure, (2) statewide population health priorities and policies, (3) public health modernization.

Dr. Irvin appreciated the work that went into the design of the plan. She asked if it was possible to be more specific about the deliverables (indicated with a blue diamond).

Ms. Beaudrault stated that for the subcategory *leading with race to achieve health equity*, OHA had a contract with an organization that would be supporting ongoing learnings for the Public Health Division staff throughout the year that also included the PHAB. Later in the year, the board will look at its health equity review policy and procedure and consider whether it is making impact or it needs to change.

Dr. Schwarz remarked that he sent an email to the board about the opioid crisis in the state prior to the meeting. Because it is a serious public health problem, it must be included in the workplan. The opioid situation is changing from not as many overdose deaths due to prescription drugs to the use of illicitly manufactured drugs like fentanyl.

Dr. Present agreed with Dr. Schwarz and added that there was a place for opioid work in the State Health Improvement Plan (SHIP). She asked if the board needed to work on this problem separately, and if yes, how. Climate change resiliency is another big public health issue, which is also addressed in the SHIP. She asked how the board's role could be different in relation to climate change resiliency.

Ms. Rippeteau pointed out that since OHA was connected to Measure 110 (Drug Decriminalization and Addiction Treatment Initiative (DDATI)) and the local public health authorities would not have any oversight, maybe there was a need to measure whether the money was getting to the populations that needed to be served. Some variables could include reduced wait times, access to culturally specific providers, undocumented and other underserved communities. The PHAB can partner with organizations to measure the success of DDATI and other existing programs to ensure that services are received where they are needed.

Ms. Biddlecom responded that Healthier Together Oregon was designed to do that type of cross-sector work. Within OHA, Measure 110 is led out of the behavioral health program. The



service-level work will be approached in collaboration with that program. Other topics related to Dr. Schwarz's email include secondary and tertiary impacts of COVID-19, and some other work related to Healthier Together Oregon, but focused on health services.

Dr. Schwarz added that the current SHIP was not as precise in terms of the length of a particular disease or chronic diseases. It is much more conceptual in many ways. There are two SHIP presentations in the workplan, one in April and one in October. If the board wants to track several concepts in the SHIP, there should be at least one SHIP presentation or discussion every quarter, each one highlighting a different SHIP concept.

Ms. Beaudrault noted that the board needed to confirm member participation on the various PHAB subcommittees. It will be a lighter year for the Incentives and Funding subcommittee because the subcommittee did the bulk of its work last year when the deliverable for the public health modernization funding formula was due. There will be two meetings in late spring or early summer to revisit the topic of directing funds to local public health authorities based on incentives and matching funds in the next biennium. Another conversation is related to directing some funds to regional partnerships or other new structures for sharing service delivery between state and local or between counties.

Ms. Beaudrault explained that the Accountability Metrics subcommittee would be meeting monthly for the first half of the year. At the end of last year, the subcommittee decided to pause and look at the accountability metrics report and clarify the intent and use of the accountability metrics. There is an opportunity to look at the public health modernization manual and talk about how the public health system should be using the data, who it should be accountable to, and what it is accountable for. The subcommittee will make recommendations for changes to the annual report. The subcommittee will also review and update metrics for communicable disease control and environmental health as they continue to be priority areas with public health modernization funding. The PHAB agreed to expand participation in this subcommittee with community partners.

Ms. Beaudrault remarked that the work of the new Strategic Data Plan subcommittee would start in late winter or early spring. The subcommittee will provide direction to OHA on developing a strategic data plan that covers everything from how public health and community health data are collected and analyzed to how they are reported and made available to the communities represented in those data. This subcommittee will invite community partners to join.

Mr. Queral asked how the board would identify and invite community partners to the subcommittees.

Ms. Beaudrault answered that after the PHAB meeting in November 2020, OHA put out a call for community partners to join several committees, including the two PHAB subcommittees.



Around 80 interest forms have been received from candidates to join one or both of these committees.

Mr. Queral asked how the board members would be involved in the selection of the community members.

Ms. Beaudrault answered that other groups had convened subgroups to review the interest forms and gave numerical scores to candidates. One important point in these reviews is to open the state geographically, so that community partners that cover different parts of the population are brought in, ensuring that there is a diverse group and diverse perspectives brought into the PHAB. It would be great if a couple of board members could be a part of that review process. The time commitment is two hours.

Mr. Queral, Dr. Irvin, Dr. Savage, and Dr. Schwarz expressed interest in reviewing the interest forms.

Dr. Schwarz asked if Ms. Beaudrault had a global perspective of the 80 candidates, in terms of geographical location or organizational representation.

Ms. Beaudrault answered that most people were organization-based and it was a very diverse group of applicants. OHA put out the application in both English and Spanish. A number of people completed the interest form in Spanish and that would be the primary language they would be using if they joined any of the subcommittees.

Dr. Irvin asked if more board members were needed on the Strategic Data Plan subcommittee.

Ms. Beaudrault responded that the goal was to have board members on all subcommittees.

Dr. Irvin expressed interest in serving on more than one subcommittee.

Mr. Queral confirmed his participation on the Incentives and Funding subcommittee and expressed interest in joining the Strategic Data Plan subcommittee.

Dr. Dannenhoffer and Dr. Irvin confirmed their participation on the Incentives and Funding subcommittee.

Ms. RippetEAU, Dr. Savage, Ms. DeLaVergne-Brown, and Dr. Present confirmed their participation on the Accountability Metrics subcommittee.

Ms. Beaudrault noted that the final versions of the three subcommittees would be presented to the board in the next meeting.

Mr. Queral added that one thing he would like to see more of was more opportunities to hear from community partners that were advocating public health issues. The board generally hears from the OHA team on where things stand. If the board wants to have a community-focused approach to its work, it would be helpful to see how the communities see the legislative session, as well as the work of the Incentives and Funding subcommittee and the availability of funding, and begin to anticipate what different perspective the board might be able to get.

Ms. Beaudrault asked if the interest was about the advocacy and funding or broader.

Mr. Queral responded that it was broader. He was curious about how advocates of public health were talking about where the needs were and where the emphasis was. It is also important for the PHAB to understand how public health advocates in the community see and understand public health modernization and how it impacts their lives and communities.

Dr. Bangsberg noted that this had been included as a standing agenda item for the Oregon Health Policy Board. There has been a lot of demand and enthusiasm, which has put some work on the OHA staff to figure out how to sequence and triage the community members who want to present each month. Overall, it is a very valuable activity.

Dr. Schwarz commented that Ms. DeLaVergne-Brown and Ms. Thalhofer used to connect the PHAB with the Coalition of Local Health Officials (CLHO). He asked who would connect the board with the CLHO when Ms. DeLaVergne-Brown left later this year.

Ms. DeLaVergne-Brown answered that it would be Ms. Poe and Dr. Dannenhoffer.

COVID-19 Response Update

Rex Larsen (OHA Staff)

Ms. Biddlecom stated that the first doses of the COVID-19 vaccine from Pfizer came to Oregon in mid-December 2020. She recognized the work of the PHAB members around the COVID-19 vaccine.

Mr. Larsen introduced himself as the deputy operations lead in the vaccine planning unit within OHA. Currently in Oregon, there are two vaccines that are being distributed broadly to providers: the Pfizer vaccine and the Moderna vaccine. Both are mRNA vaccines and have high efficacy rates (i.e., 95% effective with two doses). One logistical challenge is that the vaccine requires two doses. Another challenge is the unique storage and handling requirements for the vaccines.

Mr. Larsen pointed out that, nationwide, the vaccine rollout had been divided into three phases: (1) Phase 1A (current phase), focused on healthcare providers, long-term health facility residents, and long-term care facility employees, (2) Phase 1B, focused on teachers and



Public Health Advisory Board
Meeting Minutes – January 21, 2021

educators and age groups based on risk (starting February 8, 2021). There is limited supply of vaccines for Phase 1A and Phase 1B. The state receives about 50,000 first doses of vaccine per week. Phase 1A encompasses around 400,000 people and 40-50% of them have been vaccinated. People in the Phase 1A cohort that need to be reached include home healthcare workers, translators, and traditional healthcare workers who don't have access to the vaccine in a hospital.

Mr. Larsen added that it was expected in late-spring or summer to have sufficient supply of doses available to meet demand. That will probably happen with the additional vaccines that will come to market. It won't happen with the two vaccines available right now. A Johnson & Johnson vaccine may come to market in April and an AstraZeneca vaccine possibly in May. These two additional vaccines will drive the increased demand. This will allow a return to normal where people go to their primary healthcare provider and get the vaccine.

Mr. Larsen noted that, as of today, the state had given 253,711 doses out of the 479,000 doses delivered to Oregon, with 155,000 doses scheduled for delivery this week. The 7-day rolling average for delivery is 12,260 doses per day and 53% of the doses delivered have been administered. There has been a lot of work from counties and hospitals to do mass vaccination. It is expected the administration rate to outstrip the supply. Last week, there were 112,000 doses administered reported to the state IIS (Immunization Information System). Administration has slowed a bit because of low inventory of first doses in some places.

Mr. Larsen remarked that as more eligible people were added to the pool of people who needed to be vaccinated, expectations must be managed with the amount of vaccine that would be available. The focus is still on mass vaccination events to maintain high throughput. Current work also includes updates to IT tools and a website, so that the state can communicate better with the public about vaccine availability. A call center is now open, with a scheduling website and an app in the works. Before the rollout to educators next week, information will be available about mass vaccination in their area. The bottom line is that the federal supply will not equal the current demand in the state.

Dr. Savage asked if teachers would be risk-stratified.

Mr. Larsen answered that teachers would not be risk-stratified and they would be vaccinated all at once.

Dr. Savage asked why the teachers were not risk-stratified. Was it because of the attempt to get as much vaccine out as possible quickly?

Mr. Larsen answered that a big part of it was to get as much vaccine out as possible quickly. When Phase 1A was stratified into four groups of 100,000, the uptake was low. Part of it was because the systems were not ready to administer the doses and part of it was demand. The

vaccine team at OHA is still learning how to match the pool of demand with the actual vaccine administration capacity. That's part of the reason why teachers were not risk-stratified. Also, the demand pool must be maintained up for the mass vaccination events to have the flow of people that they need.

Dr. Present stated that, as far as teachers went, she had heard that many educational service districts were working with health systems in trying to prioritize when kids would be going back to school. The recommendation in Clackamas County is to start with the youngest learners first, as well as with the educators who will be in-person with the youngest learners. There are many ways in which vaccine distribution is being addressed across the state. In the Portland Metro region, there is a large group of Phase 1A people who have not had access to vaccine. The communication around moving to educators and to Phase 1B before having the access has been challenging.

Ms. Poe remarked that there was a lot of pushback about vaccinating educators at this time. In the rural communities, such as Malheur County, where there is a considerable elderly and very young population, getting kids back into schools is the way equity is provided to essential workers who can't stay home and do their job. In Malheur County, where 34% of the population is Hispanic and almost 40% of the population is non-White, that translates to the greatest hardships and pressure the county has had over the past year. Kids had to go back to the classroom. No other professionals are asked to go into a setting with that much exposure. There is a huge support in the rural communities for putting teachers in front of elderly people.

Ms. Poe added that in a small jurisdiction, such as Malheur County, having the sequencing within each category had not been effective, because the county didn't have that many people. Instead of being micromanaged a great deal, the phased vaccine administration strategy for smaller counties should be a suggestion. The strategy makes sense for bigger counties.

Ms. DeLaVergne-Brown agreed with Ms. Poe and added that a clinic had been set up in Crook County for all educators who wanted to be vaccinated on Monday, January 25, 2021. Although smaller counties don't have the giant numbers of people, they can create a large pod with lots of staff and get through the vaccinations very quickly.

Ms. Rippeteau shared that it had been a struggle for her role in advocating for childcare, and education, and getting kids back into school, or being able to be with other kids in guided activities at the very least so they could have the social and emotional connection that they needed. The childcare providers who have been able to get an emergency license have continued to work and have taken care of some of the kids who are doing distance learning. They are now working full-time care throughout the day with groups of kids. If anybody is getting pushback about educators broadly and they need to prioritize that within their community, it is good to remember that childcare providers have been working and providing care for children whose parents are essential workers throughout the pandemic.

Ms. Rippeteau added that she was in awe of the work done by board members. She got feedback from various members and employers about how things were communicated and how everything happened quickly. As per the mass vaccination events, when people haven't been in large crowds for so long, some of them feel shocked, weird, and uncomfortable. The American Federation of State, County, and Municipal Employees (AFSCME) has offered to do a mini vaccination site for childcare providers.

Ms. Rippeteau asked if there were other community partners that could do similar small vaccination events and how we can bridge the gap between what is being accomplished now and what could be done. She also asked if nursing students could be recruited to administer vaccines.

Mr. Larsen answered that communication had been OHA's biggest struggle throughout the early stage of the response. OHA is working to get a handle on it. Things are not running perfectly, but they are working better than they were. As far as plugging in local venues, OHA is doing a lot of coordination work with large hospitals, but the local public health authorities (LPHAs) are the best go-to places for standing up small, local venues. Local public health members on the board can talk about how to plug in with unions and other organizations that might have resources that LPHAs can leverage and volunteers that they want to provide.

Mr. Larsen noted that in terms of using volunteer students, everybody who wants to volunteer – healthcare provider, future healthcare provider, retired healthcare provider – is encouraged to register on SERV-OR or for a local medical reserve corps. There is an existing system to route those volunteers to local public health. Links to those websites can be provided.

Ms. Rippeteau explained that her comments and questions about communications were not to place blame. This is a huge undertaking. It was more about how the PHAB can communicate and be more supportive in that effort.

Dr. Schwarz remarked that CNN had been talking about the lack of a national distribution plan. It sounds like Oregon has a very effective plan running. He asked how the lack of a national plan affected Oregon.

Mr. Larsen answered that he would never say that Oregon had a very effective plan, but the state was getting there. It has a huge impact. One example is the news about the release of the federal stockpile and what we had been led to believe might be hundreds of thousands of doses, which ended up being no doses. The federal uncertainty has been one of the biggest barriers, in terms of a lack of resources. It is hard, because OHA has to pass down that uncertainty to its local partners and local public health. OHA is working on forecasting the allocations in advance, so that more than a week at a time can be planned. In the short term,

that might mean transitioning to a 3-week planning cycle for allocations and, hopefully, having more advanced planning after that.

Ms. Biddlecom stated that one of the challenges from a communications standpoint was that every state was prioritizing groups in a slightly different way. This makes it difficult to manage the expectations from different groups.

Dr. Present thanked Ms. Poe for her comments. Getting kids back into school is a huge part of the overall public health issues right now. Something public health is looking at is trying to further prioritize within Phase 1A the healthcare worker. The healthcare worker category is very broad in Oregon. That's where the number of available vaccines is a challenge. Prioritizing the healthcare worker with an equity lens would make it easier. This is what is being considered for the Portland Metro area. She added that people going through SERV-OR was great, because that was a good method for finding volunteers. She thanked Mr. Larsen for his work.

Ms. DeLaVergne-Brown remarked that the state had vaccine issues during the N1H1 epidemic as well. It was a lot easier back then to get vaccines to partners, and pharmacies were on board. In Crook County, Mosaic Medical FQHC has signed up. St. Charles finally signed up, but they didn't want their clinics to do vaccines, because they have a big event at the fairgrounds. It doesn't help in Prineville, where people can't drive to Redmond, and not everybody can go through the computer sign-up system. These are the things that are being worked through, but the question is how the system can ensure that there are other providers. For example, if Crook County received 500 doses for the 80+ population, 200 would go to Mosaic, 200 to St. Charles, and 100 would go to people who had a hard time accessing their primary healthcare provider. Many local public health departments are looking into how to help them, especially in counties with limited providers.

Mr. Larsen explained that the CDC had a federal pharmacy program. OHA can send out the specific pharmacy sites that are enrolled in the program. CDC's plan is to roll out three pharmacies initially – Costco, Albertsons/Safeway, and Health Mart. It will probably happen in late-February or March, depending on vaccine supply. The CDC has no plans to distribute to pharmacies until then. Oregon can begin allocating doses to those federal pharmacy partners in advance. OHA is working on figuring out how that fits in with the current strategy. Unfortunately, it would take a significant portion of the doses the state is receiving.

Mr. Larsen added that, right now, doses are being passed on to the long-term care facility vaccination partnership, which takes 40% of the doses each week. Until this phase passes, the state won't have enough doses for retail pharmacy partners. The plan is to roll it out and identify the highest throughput pharmacies in each county with the hope to activate at least one pharmacy per county. This will be a critical access point, particularly as the state starts to vaccinate older adults.

Ms. DeLaVergne-Brown noted that Walgreens had done a really good job. CVS withdrew in Crook County. The local public health department will take care of the CVS customers next week. Because it is a federal program, it is not controlled at the state level. There is an accountability problem with some of that. Some pharmacies are doing a great job, while others have forgotten rural Oregon.

Mr. Larsen pointed out that OHA was working with those pharmacy partners. It is very likely that there will be a state program that will follow up on the federal program to sweep back and reach some of those facilities that were missed. It is likely to include a different set of partners that really want to participate in the program.

Ms. DeLaVergne-Brown noted that some counties would just do it, because they were concerned.

Mr. Larsen responded that if counties had the capacity, they should go for it. One thing to remember is not to expect a big expansion in the supply until other vaccines come to market. It all depends on what happens on the federal level. The new administration may take dramatic action in the coming weeks. If supply expands, it will allow OHA to enroll the pharmacies and other points of care (e.g., walk-in vaccinators), which will make a difference in rural areas. There is going to be a lot of work moving forward to achieve equity with vaccination. When the focus is on mass vaccination, equity drops off. A significant amount of future allocations will be devoted to projects that specifically address the needs of marginalized communities.

Ms. Rippeteau asked if the rabies vaccine shortage was because manufacturers were shifting production, so that more COVID-19 vaccines were produced.

Mr. Larsen answered that he didn't know who manufactured the rabies vaccine. The current manufacturers have not shifted any capacity from other vaccines to the COVID-19 vaccines. The two manufacturers that are supplying the U.S. are Pfizer and Moderna. Both have very large capacity. As the other vaccines get on the market, there may be an impact, because some vaccines use the same raw materials. Syringes and needles for distribution have been key supplies. It is likely to see some of those markets tighten up even further. Syringes and needles have already been impacted. The federal government is watching that closely and seem to do what it can to stabilize those markets.

Dr. Savage thanked Mr. Larsen for the discussion and for stating that health equity could get dropped in mass vaccination if the state was trying to go quickly. Hopefully, that will not lead to further gesticulation in the board's discussions about health equity, as it happened with the health equity definition. It is known who is suffering the most and getting hit the hardest. She recommended getting the vaccine in those arms. The farm workers are suffering horrifically. She expressed appreciation for the work done by Mr. Larsen.

Mr. Larsen agreed with Dr. Savage and added that for the allocations delivered in the week of January 18, 2021, OHA worked with 18 LPHAs and partners, specifically focused on individuals with IDD (Intellectual Development Disorder). They are in the Phase 1A eligible individuals, but it is known that they struggle with access. OHA distributed 18,000 doses of the Moderna vaccine for that population. As things move on, it is expected that similar types of things will happen with migrant seasonal farm workers and other populations that struggle with access.

Ms. Biddlecom thanked Mr. Larsen for taking the time to be with the PHAB.

PHAB Member Discussion

Cara Biddlecom (OHA Staff)

Ms. Biddlecom encouraged the board members to share or discuss issues or topics.

Dr. Schwarz asked when the board members would receive the charter for the Strategic Data Plan subcommittee.

Ms. Beaudrault answered that charters had not been drafted for the subcommittees. The subcommittee members will need to look at the charter together. The OHA team will have drafts in place before the subcommittees convene.

Ms. Little shared that the Coquille Indian Tribe would be rolling out its first large vaccination clinic tomorrow. The Indian tribes in Oregon have been prioritized to receive a particular amount of allocation due to the disproportionate impacts of COVID-19 within tribal communities. She had been planning and problem-solving.

Dr. Schwarz asked where the event was taking place.

Ms. Little answered that it was in Coos Bay. The event will be using a large event room at a casino. A mass vaccination plan, shared among the tribes, will be used. There will be stations and four individuals who will be providing vaccinations at one time. There will be walk-ins and scheduled appointments. Tomorrow will be a trial run, with a walk through tonight. Ten staff will be doing registration, screening, data entry, vaccination, and observation. She thanked the board members for their support and work.

Ms. Biddlecom thanked Ms. Little for sharing and wished her good luck.

Public Comment

Ms. Biddlecom invited members of the public to provide comments or ask questions.

There was no public comment.



Next Meeting Agenda Items and Adjourn

Cara Biddlecom

Ms. Biddlecom remarked that at the next meeting Ms. Beaudrault would be revisiting the subcommittee work and there would be time for legislative session updates.

Dr. Schwarz asked if Ms. Biddlecom would be sending the board a list of legislation that may be of interest.

Ms. Biddlecom answered that she could send out that information, as well as information about upcoming general partner sessions on what was happening in the legislature, so that PHAB members could be added as well.

Ms. Biddlecom adjourned the meeting at 3:20 p.m.

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

February 18, 2021

2:00-4:00 p.m.

ZoomGov

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