**January 19th, 2023**

**Meeting of the Coalition of Local Health Officials**

**Meeting Began: 11:46**

**Executive Members:**

Present: Naomi Adeline, CLHO Chair, Polk; Jocelyn Warren, Past CLHO Chair, Lane; Carrie Brogoitti, Vice-Chair, Center for Human Development Union; Philip Mason-Joyner, Secretary/Treasurer, Clackamas; Dr. Pat Luedtke, Health Officer’s Rep; Jackson Baures, Large County Representative, Jackson; Shane Sanderson, Medium County Representative, Linn; Katie Plumb, Small County Representative, Crook; Joseph Fiumara, Coalition of Local Environmental Health Specialists, Umatilla; Lindsey Manfrin, Public Health Administrators of Oregon, Yamhill; Marie Boman-Davis, Legislative Committee Representative, Washington

Absent:

**Members Present (x if present)**

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| --- | --- | --- | --- | --- | --- |
| X | Baker – Meghan Chancey | X | Hood River - Trish Elliot | X | Multnomah – Jessica Guernsey |
| X | Benton - April Holland | X | Jackson - Jackson Baures | X | North Central PHD - Shellie Campbell |
| X | Clackamas - Philip Mason-Joyner | X | Jefferson - Mike Baker | X | Polk – Naomi Adeline |
| X | Clatsop – Jiancheng Huang | X | Josephine – Janet Fredrickson  |  | Tillamook - Marlene Putnam |
|  | Columbia – Jamie Aanensen | X | Klamath - Jennifer Little | X | Umatilla - Joseph Fiumara |
| X | Coos - Anthony Arton |  | Lake - Judy Clarke | X | Union - Carrie Brogoitti |
| X | Crook – Katie Plumb | X | Lane - Jocelyn Warren | X | Washington – Marie Boman-Davis |
| X | Deschutes – Tom Kuhn | X | Lincoln - Florence Pourtal |  | Wheeler – Shelby Thompson |
| X | Douglas - Bob Dannenhoffer | X | Linn - Shane Sanderson | X | Yamhill - Lindsey Manfrin |
|  | Gilliam – Hollie Winslow | X | Malheur - Sarah Poe | X | HO Caucus - Pat Luedtke |
| X | Grant – Jessica Winegar | X | Marion – Katrina Griffith | X | CLEHS Caucus - Joseph Fiumara |
|  | Harney – Sarah Laiosa | X | Morrow – Robin Canaday | X | PHAO - Lindsey Manfrin |

**Public Health Division:** Danna Drum

**Coalition of Local Health Officials:** Sarah Lochner, Executive Director; Laura Daily, Program Manager

**Guests:** Betty Bekemeier, Paula Kett, and Megan Rogers (NWCPHP)

**Motion:** Katie Plumb made a motion to approve the December 2022 minutes. Shellie Campbell seconded the motion. Unanimous vote, motion past.

**Agenda Items**

**Appointments:** No appointments.

**NWCPHP: PH WINS Rural Data:** Betty Bekemeier and Paula Kett from the NorthWest Center for Public Health Practice reviewed findings from the PH WINS data, particularly around rural health departments in Region X.

Betty Bekemeier: We don't need to give any background to you all to say that that rural public health is different than then public health in urban areas. And for a long time, I've been super interested in raising up and doing more for and with our rural public health practice partners because I think too often we sweep up public health system. under the same umbrella and without really understanding the nuances of what rural public health practice partners might need and bring etc. With this research we wanted to look more deeply at comparing the differences and similarities around competencies and training needs, the impact of COVID, and turnover in rural areas. The data we used came from you all with the Public Health Workforce Interests and Needs Survey that we lovingly call PH WINS. Northwest Center worked with a lot of you to make sure we got more data and that included rural areas – in the previous iterations of this workforce survey (de Beaumont Foundation has done this for every three years or so for a few iterations), but it's always been a national sample survey of state health department of all state health departments and large or medium sized health departments. Only a handful of Oregon departments participated last time. We worked with the Beaumont Foundation to say hey, can we pilot something whereby we try to involve all local health departments in our region, Washington, Oregon, Alaska and Idaho, and really start to gather data that depicts rural public health too. So many of you have participated in this and we're really grateful for that. This study also included data from the NACCHO Profile Survey. So I'm going to hand it over at all, Paula here to talk about what we did.

Paula Kett: We looked specifically at local health department data (PH WINS also includes state's health department staff data), and that was about 30,000 staff, non-supervisors, supervisor, manager level and then executives. So the first thing was looking at competencies - staff were asked to evaluate their own proficiency on a number of different skills on the survey, and they were asked to say on a scale of one to four whether they had no proficiency at a one level all the way up to being an expert in that skill (level four). And we looked at kind of this as a two-sided thing, whether they evaluated themselves as proficient (proficient or expert) in this skill, or not proficient (no proficiency or just low, low level). And then staff were also asked to evaluate how important that skill was for their daily work. And if they rated a skill as being very important but rated themselves as being not proficient on that skill, then we evaluate it as a training need. We looked at these separately for non-supervisors vs. supervisors and executives.

And then we looked at turnover risks, so whether they intended to leave in the next year, and then reasons for intending to leave. The options included things like pay or lack of opportunities, stress, work overload, burnout, organizational culture, etc. And finally, we looked at COVID-19’s impact and there were a couple different areas that we looked at for whether COVID 19 made them want to leave their jobs - that was a separate question on the survey. Apart from the turnover and reasons to leave, we looked at experiences of bullying or harassment, for their work as a public health professional. And then we also looked at symptoms of post-traumatic stress disorder and the survey asked about four different symptoms there. We looked at the turnover risk from COVID-19 across everyone.

We also looked at additional factors, and there are differences right between rural and urban communities among a number of characteristics, and these characteristics are influential for the outcomes that we're looking at. In our sample, rural staff tended to be white and have a higher proportion of female identifying staff. The health departments were also less likely to be accredited. Those are kind of the biggest differences between the rural and urban portions of the sample. And then we found overall that proportionally more rural staff tended to report that they were less proficient in skills compared to urban staff. So across the board, we found that more often rural staffer saying you know, I don't feel like I have proficiencies in these skills. We actually did find that rural staff were more likely to report competencies in areas related to community engagement, cross-sectoral partnerships and systems and strategic thinking. They were also more likely to report needing training related to data-based decision-making and skills around justice, diversity, equity and inclusion.

For turnover risk, they were less likely to report intent to leave overall, but they were more likely to report wanting to leave due to stress if they did report planning to leave in the next year. Something that's interesting is they were less likely to report planning to leave for lack of opportunities and lack of flexibility, as compared to the urban staff. For COVID-19’s impact, rural participants were more likely to report being bullied or harassed due to their role as a public health professional, and more likely to avoid situations that made them think about COVID-19. There were a couple questions related to PTSD or PTSD symptoms: having nightmares about COVID-19, feeling numb or detached from others, being on constant guard and watchful. We didn't find differences there between urban and rural staff.

So overall, we find that the rural public health workforce brings important assets to public health work and this needs to be built on and affirmed. We also find that when we're thinking about workforce development and training, areas of data-based decision-making and Diversity, Equity and Inclusion should be priority areas. Efforts are really needed to address rural stress and burnout among this population of the workforce, including increasing staff capacity, and then really just want to affirm the importance of data collection partnership around data collection for surveys like this, because it's only possible for us to know and be able to continue to examine what's working and what's not working and development needs among this workforce if we have participation. Happy to answer questions.

Marie Boman Davis: I wanted to ground myself in my understanding that rural, for the purpose of this national survey, was every county in Oregon except Multnomah County, is that correct? Because it's based on population size? Because Washington County is not big enough to be considered big on the national survey, but it is the second biggest county in Oregon and wouldn’t be considered rural by state standards.

Paula: This includes any small rural health department that participated in this survey.

Betty: I think with PH WINS, normally these health departments with less than 25 staff, and/or serving a population of less than 25,000, would not be included at all. So I think that's who we were considering rural if, if I recall correctly, Paula, right?

Paula: Yes, that's who we were considered rural. I would say that there's probably some slightly larger health departments that were also considered rural, but anyone within that category was also considered.

Betty: And it’s a squirrely thing, frankly. It always comes up - we had many discussions how we were going to parse this out, because there are many different ways to do it. This isn't just Oregon - in order to have enough data to do this, we included data from rural health departments in Washington, Idaho and Alaska, and also Region Five, which is the Upper Midwest. So this includes data from a lot more than Oregon. But I would say for our purposes here, you know, if you feel like you're a rural health department, hopefully, these findings kind of resonate. They ought to reflect in general, what rural health departments experience. And I see there's questions coming up.

Pat Luedtke: If I understand the study population, it is persons currently employed in public health. Is it possible to study those who left public health during the pandemic...….or those who left in the two years leading up to the pandemic?

Betty Bekemeier: Yeah, good question, Pat. So this, these were data collected in 2021. So some of these people I'm sure have left and there's new people among you. We have to take that into account. A lot of what we see though at the Northwest Center - we've been doing workforce assessments for a long time, and frankly, needs don't change that quickly. Over the recent period they would have changed more because of the pandemic, but we hope they still resonate even though the workforce is really kind of morphing right now, and never have we really had the opportunity to, on a scale, be able to really look at these urban and rural differences.

Paula Kett: Just to add to that, too, is we had a lot of discussions around kind of the intent to leave question versus actually knowing who ends up leaving because this intent to leave question has been asked on all the surveys, which previously haven't included this sample of smaller health departments, but they have had some evaluation of larger health departments looking at intent to leave and this percentage was high pre pandemic. And it remained high, but it's unclear who actually left and what ends up happening. So it's an important question that we don't have an answer to right now.

Betty Bekemeier: I want to address Jennifer’s question in the chat about Klamath being lumped in with Lane. And I think you're talking about the data specific to Oregon and providing and delivering those data back to Oregon. That's separate from this larger study that Paula and I did with the data as a whole. But Megan Rogers and Laura Daily can speak to why those were lumped together.

Megan Rogers: Yeah, so de Beaumont did have a minimum response rate for any size health department to get an individual report. And if health department's that didn't get that minimum response rate, they weren't going to get a report. But we did not feel that was helpful to the health department, so after a few conversations, it was decided that one way to kind of get that higher response rate was to combine with other counties. It was not an exact science, but we had to lump counties together that might not really want to be lumped together but they were just all over the state. So we just kind of did our best with some of the guidance from the public health professionals that helped us in Oregon.

Jennifer: Yeah, and it's totally fine. I assumed that we were going to be lumped with other rural counties but Lane is not typically considered rural although they do have rural areas in the county. So, that one just kind of stood out to

me.

Megan: So it's likely that you didn't have enough rural counties around you that also participated in PH WINS and Lane was closest, from a geographical standpoint.

Laura Daily: We had talked about going by CCO coverage, but that can get really messy because different CCOs cover multiple counties, and it's just hard to divide it up that way. So we went with emergency preparedness regions. And in some of those circumstances, we still had to combine two different regions because there weren't enough people in that region who responded. So I think that's probably what happened with Lane and Klamath.

Betty Bekemeier: Yeah, as Megan said, that this part of the process was not an exact science, but we're doing our best with data that's never existed before. So we're really excited about that.

Florence Pourtal: Thank you so much for doing this. I think it is very valuable. To answer the question about what we think the findings could mean for public health practice. Well, with the conversation we were just having at a previous meeting, I think for those of us who work in rural health departments, it's really good to see that, yes, the practice and the workforce is absolutely different. And hopefully, that will help us advocate for strategies at the state level that are not necessarily all the same for how we provide services. So I think it's super helpful. You're wondering about further research questions, and maybe it's very difficult to do, but ss there a way we could research the differences in public health practices between rural and urban outside of the workforce and the resources available or not available? I just wonder if we could see going a little bit deeper - in the experience I've had in two rural health departments, people tend to be very flexible and cover more ground, and not be as specialized as maybe the workforce in larger, more urban departments might be. I just wonder if there's any way that this could be looked at because then we can make some points also back to our other CLHO meeting by saying, this is what the research is showing. Now we have data that will hopefully help us build those points moving forward.

Betty Bekemeier: Thank you, Florence. I mean, I'm very passionate about this. It's helpful to us we want to do the research that is useful for you all in doing just the advocacy you're talking about. And I can tell you this research that we've done here seems to be of great interest - I'm presenting on this next week, in Alaska, and we've had national abstracts accepted where people want to hear more about this and also in a variety of different settings. So there's a lot of interest in this, and I think partly what we want to get across is that rural health departments have something to contribute to urban settings - there's a lot we can learn from what urban public health practice folks do well, in terms of collaboration, building partnerships, etc, etc. We also don't want to paint workforce development and other work with such a broad brush that everybody gets the same thing because clearly, some of the needs are different in in rural areas, and we really want to advocate for what's specifically needed. And like you suggest, Florence, some of that might be in part because the practice is different, and better understanding that would help here. We do have some data that could help us get that and those would be interesting questions. I also just put in the chat here – the NWCPHP does Hot Topics in practice. It's a regular series monthly series. We are sharing this same research. It will be recorded. You could share the recording with people with this same link.

Paula Kett: I think it's a really interesting question. I think it's interesting how we think about skills. Maybe being an expert across multiple skills isn't quite the right way to think about if we think about the value of knowing a lot in a rural setting and the need to kind of have a much wider span of skills, maybe it could be interesting to look at those a little bit differently. So appreciate that.

Mike Baker [in chat]: Research in rural health is seriously lacking in general. Research in rural public health is constantly identified as a major need to identify both limitations and opportunities!

Naomi Adeline: Thank you so much, Betty, Paula and Megan. This was really useful - if others have other suggestions, are there any contact details that they can use to send in suggestions,

Betty Bekemeier: Yes, feel free to email us, and we’ll be back any time you want. And to Mike’s point, we totally agree. This is why we're so excited about doing this work and really want to do more of it. Because so little has been done in terms of studying rural public health. Thank you for having us.

[In chat]: bettybek@uw.edu and pmk@uw.edu

**HB 2652:** Item skipped since guest was unable to attend.

**Legislative Equity Resources:** Sarah Lochner, April Holland, and Armando Jimenez shared about the equity resources the Legislative Committee is recommending for the CLHO lobby team.

April Holland: Armando may jump on here around 12:30, but I can kick it off. An equity subcommittee of the Legislative Committee was created in an attempt to find some resources to be used in CLHO lobbying efforts, as we want to ensure that all of these efforts are done intentionally through a lens of health equity. A small group of folks came together and provided some resources that we’ve used in our own work. One of them I did provide from King County. And the other is a basic checklist that's very helpful in terms of reminders for folks when setting meetings, convening people to ensure that accessibility and equity are considered. So, we've got two things to bring for, for your approval. The first is a blog post: [Be the Change: 5 Ways to Create Safer Spaces](https://www.autostraddle.com/be-the-change-how-to-create-and-cultivate-safer-spaces-for-all/) that hits some of the high points to always have in mind. The second is the Equity Impact form (on the CLHO website) is from King County and is more oriented towards going through new policy and initiatives to assess the equity impacts. It’s a great all-in-one resource.

Armando Jimenez: I was part of this committee to identify these resources and tools – there are a lot of tools out there, and we tried to find the sweet spot of finding something meaningful/aligned with our values and practical utility for our lobby team. This was about being intentional about our equity efforts and how we engage with our partners. These are the resources we recommended to start for framing equity. So these are the two resources that we would like our lobbyists to use to center equity. It doesn’t mean they have to use it for every legislative concept because we do need to remain efficient and fluid, but it is to help ground the group in equity.

Naomi Adeline: Are there any questions before we move onto a vote?

**Motion:** The Legislative Committee has brought a motion to recommend these two resources on centering equity to CLHO’s lobby team. Florence Pourtal seconded. 0 nay votes, 0 abstentions, all present in favor, motion passed.

**Legislative Support of Opioids Package:** Sarah Lochner provided an overview of the opioids package brought by Rep Dexter.

Sarah Lochner: Representative Dexter, who is a physician, is championing a package of common sense non-controversial, bipartisan bills, and she hopes that there will be such wide support for them that she can roll them all into one bill. They are all individual standalone items. And so bear with me as I go through all of these. Most of the concepts are all fairly simple, and the legislative committee did put forward a recommendation that we support these a priority one as a package. So the concepts included are:

1. Drug paraphernalia reform: after voters passed ballot measure 110 small quantity possession of certain drugs was decriminalized. In Oregon, however, paraphernalia remained criminalized. This criminalization extends to the distribution of test strips and pipes which are proven interventions to reduce the risk of overdose and drug related deaths. If you were on the last meeting, you heard Carrie talk about the opioids Task Force and how smoking your drug is a harm reduction tool because you can control how much you're taking and essentially, so that's why pipes are considered harm reduction. And so this bill reforms the drug paraphernalia statute to decriminalized items not associated with the distribution of opioids.
2. And the second concept is about making naloxone available in public buildings kind of similar to different defibrillators are available in public buildings. And so there would be a partnership between OHA and publicly accessible buildings to make sure that we could they could place the Naloxone where it's readily available, and there are provisions in this bill that would protect whomever uses that from civil and criminal liability.
3. The third concept is around first responder distribution of naloxone. So this allows police fire and EMS to distribute opioid antagonists kits for future use to anyone who may need or request one. The idea here is it should free up capacity for them to respond to other emergency situations and better ensure access to the community if naloxone is more widely distributed. There will be an amendment to this bill, changing the definition of kits to include single and multi dose antagonists. Some kits come in packs of two, and so they want to make sure that they're covering for that. The amendment also redefines opiate overdose to mean a medical condition that causes depressed consciousness, depressed respiratory function, or the impairment of vital bodily functions as a result of consuming opiates. So that's that bill.
4. The next one is OHA standing orders for naloxone. So many harm reduction clinics and treatment centers and schools encounter unreasonable barriers to having sustained and reliable access to Naloxone due to a requirement for local prescribers or county health officials to repeatedly write and renew prescriptions for naloxone. So, this concept allows a OHA to issue standing orders for Naloxone to any entity within the state and then would require pharmacists to dispense Naloxone kits upon an order from OHA. And it also provides civil and civil immunity from liability for the storage, administration and distribution.
5. The next one is a way OHA administers a public health campaign around trying to educate the public and our communities about the risks of illicitly manufactured fentanyl and the ways to prevent harm or improve our chances of saving many hundreds of lives each year. So the idea is to make it a coordinated and accessible public safety campaign. So that we can educate and have a much better understanding of the risks and also how to administer Naloxone to save life.
6. The next one is around accidental youth overdose reporting. So young people are using opioids and accidentally overdosing because fentanyl is included in in the drugs and without their knowledge. And so the assumption is we're seeing a lot of accidental overdoses. And often these can happen in clusters. So if county health departments and schools and other relevant providers are communicating about this, then hopefully, speedy action can be taken to notify youth and hopefully their families and to make sure that we can hopefully save lives through better communication about these things. There's already youth suicide communication in a very similar way. So this is more on the accidental drug use side.
7. There’s a bill around standardized opioid overdose data. So right now, Oregon counties have various practices for recording the impact of opioid overdoses across the state. And so because we're reporting different sets of data, this bill would establish a commission to develop, maintain and oversee a system for the standardization of reporting opioid overdoses. And then there's a couple of technical fix bills - the first one is about a minor’s access to substance use treatment. Currently, youth under 15 must have a parent or guardians consent to receive treatment, and in most cases, their care teams are able to receive this consent safely. There are rare instances, especially in environments of intergenerational substance use, where requiring consent may put a child who wishes to have access to treatment at risk of harm. So this bill would allow providers to give confidential treatment to minors under 15 years of age, if they disclose their desire for treatment and it would put them at risk with their parents or guardians. So this would include protection from disclosure in the insurance explanation of benefits.
8. School staff administration of Naloxone is the next bill. So this would essentially allow school administrators or staff to administer Naloxone and would shield them from civil and criminal liability. That's pretty much it.
9. The next bill is short acting opioid antagonist language. So right now statute references the term Naloxone repeatedly and so this bill would just change that term to a more generic term to allow more drugs that are identical to be utilized in the same way so changing that to short acting opioid antagonist instead of naloxone.

The CLHO legislative committee recommended this package at a priority one with wide broad support. And it was noted that if we support the whole package, it will reduce the load on the lobbyists specifically need to have to write testimony for 10 different bills. We can just write one set of testimony, referencing all of them and saying that we support all of them. If there is an amendment that is brought forward to one of the bills that we don't agree with, we can always just put in a caveat. So we do have some flexibility there. All the attendees of the legislative committee agreed with this approach. I personally also think that supporting this was a great opportunity for us to build rapport with Representative Dexter. So with that, I will turn it over to all of you to discuss.

Jessica Guernsey: Can you repeat the portion about drug paraphernalia?

Sarah Lochner: Yes, so after voters passed a ballot measure 110, small quantity and possession of certain drugs was decriminalized in Oregon. However, paraphernalia remained criminalized. And this criminalization extends to the distribution of test strips and pipes, which are proven interventions to reduce the risk of overdose and drug related deaths. And so this bill reforms the drug paraphernalia statute, to decriminalize items not associated with or used for the distribution of drugs.

Philip Mason-Joyner: Well, I think this is a great omnibus list of ideas and maybe I missed it, Sarah, but I'm curious of funding. A lot of these things like here take resources to implement. I'm curious as the bigger picture strategy for us - how will this be funded? Is it with the state general funds, and how will that impact our other priorities for this legislative session around the workforce, modernization, etc.? And then also made me think about Carrie’s update earlier with the opioid board. This will be a lot of things that the opioid settlement board will be looking at and making sure that that connection is there and I’m just thinking to put a call to not have duplication of effort going on here.

Sarah Lochner: Yeah, so I don't know how much this bill is, or these bills are going to cost yet. Typically, in the legislative process, in order for any bill to be voted out of the policy committee, OHA would have to issue a fiscal impact statement, which essentially tells the legislature how much it will cost to implement. And then that fiscal impact statement is attached to that bill moving forward. And if it does cost typically like over $50,000 that will then be sent to the Ways and Means Committee, where it's weighed against all the other bills that cost money to implement and is decided whether it will be funded. OHA typically does not do this work in advance to many people's frustrations, and so they will wait to see if the bill has legs before they analyze it for the cost. So, we can always if we decided to support it in concept, and if we found that it was going to cost $40 million, and it was this or our workforce bill, we could certainly reevaluate it at that time if we needed.

Marie Boman-Davis: I'm hoping you can help spur my learning. This is my first long session in Oregon. When you identify OHA’s process, is that OHA as an organization, their government relations office, or where is it that would occur?

Sarah Lochner: Government Relations staff will look at all the bills that are introduced and assign them to a subject matter expert who will analyze the effects of the bill, particularly on the agency. And then they will sit on that until a committee decides to have a work session on the bill, which means a vote. And so then in the few days before that vote is scheduled to happen and OHA will put together a fiscal impact statement for that bill. And almost always the committee will have to have that paperwork before they voted out of committee. Occasionally they'll make an exception. But that is how it works.

Marie Boman-Daivs: Thank you, and for additional clarification - a subject matter expert could be anywhere within OHA?

Danna Drum: Let me jump in here. It will sometimes get assigned to multiple divisions if it touches multiple divisions. We already do a lot of cross divisional work around this topic. We were already doing this on some other bills where we do what's called a unified bill analysis, in which you know, multiple divisions will work together to kind of do the bill analysis and then the fiscal impact statement will get rolled up. If there are costs to multiple areas, which is often the case (CLHO workforce bill, for example). And also just to let y'all know, we do not typically share our bill analyses out. Those are contents considered more internal documents.

Katie Plumb: Who is the legislative sponsor again?

Sarah Lochner: Representative Maxine Dexter

Naomi Adeline: And you did mention that that's a good one to build that relationship with?

Sarah: Yes. If you all recall, she actually was the chair of the House COVID committee for the last several years. So she definitely has lots of opinions about public health. And she's a doctor so you know, extra opinions.

Mike Baker: Just to clarify, are we voting on this just as a concept? I’m not sure what we are voting on.

Naomi Adeline: So I believe we're voting for the Coalition to support that whole package and if something happens in between where we don't want to support something specific, we can add that.

Sarah Lochner: Right, the Legislative Committee has brought forward a recommendation to support this at a priority one, which means we would testify on it, and we would also potentially lobby actively for these items with the caveat that if an amendment was brought forward that we did not agree with we can always carve that out of our support and say we support all the bills but that we do not support the -1 amendment to this bill, so we have the ability to change and modify or support as this is the process.

**Motion:** The Legislative Committee has made a recommendation to support Rep Dexter’s full opioid package. Katie Plumb seconded. 0 opposed, 0 abstained, all present in favor, motion passed.

Sarah Lochner: Okay, the next recommendations from legislative committee is the tobacco master settlement fund. The attorney general brought forward a bill on the tobacco master settlement fund. There are certain tobacco manufacturers who pay into the tobacco master settlement fund, and there are other manufacturers who have not settled with the state of Oregon, and they make payments into an escrow account. And that escrow account has been sitting there for a very long time just collecting interest, and the interest is then sent back to the tobacco retailers. And so the AGs office thinks that that escrow money should be used for smokers in the state of Oregon to pay for their Medicaid health care. She is proposing that that escrow account essentially be closed and the money paid in be sent back to the manufacturers. But then the state of Oregon will put an assessment on each one of those manufacturers, potentially requiring them to send back a direct payment to the state of Oregon, which will then be utilized for Medicaid costs. And then moving forward, those eight manufacturers will just make regular monthly payments to the state of Oregon for that same purpose. She does have some nice language in the bill around public health and the responsibility of manufacturers and the responsibility of the state of Oregon to the public's health, which I thought was nice. But given that this is typically something you all care about, the legislative committee recommended supporting the bill at a priority 2 which means we would provide testimony and our logo in support.

Philip Mason-Joyner: Is there opportunity to have a discussion or amendment around the role of prevention and allocating a portion of this money to that effort. There's a lot of resources going to Medicaid in the state and for me, in the public health field, it worries me that it's like we're going to put this money towards once someone smokes and becomes chronically ill and we're going to pay the health costs associated with that, and I think looking at the role and need to invest in prevention to address this problem of stream and for future generations is critical. I would advocate that that'd be part of our advocacy, not to support it as is.

Sarah Lochner: Philip, do you have a proposal on a percentage or something?

Philip Mason-Joyner: Well, I want all of it, but I'm not close enough to this to have any idea if this is even starting conversation that could happen. I don't even know how much money it is, but something like 5 to 20%

Marie Boman-Davis: I mean, there are other states that have proportional allocation models that can be leveraged in this conversation instead of us brainstorming on the spot, Sarah.

Katie Plumb: Oh, I am probably was going to derail us. I was going to gripe about the fact that there's radio announcements about the legislative proposal to ban flavors happening in Central Oregon. It was a country station. And the only statement about it is that the American Cancer Society says that about 26,000 people are affected by cancer related illness. So there's an illness statement, but not a prevention statement. I don't know. It struck me as there's not a framing around prevent. I fully support dollars going prevention.

Pat Luedtke: So I am curious, not that I am untrusting, but I'm just curious, does this proposal include the entire pot of funds or just the principle? Because the master settlement was 1998 - that's 25 years ago, and if they've been paying in for 25 years, there's a fair amount of interest there. So I'd wonder if indeed its principal and interest or just principle and the drug companies get to keep the interest. So I would advocate that the entire pot got to Oregon if we have the opportunity for such advocacy. Thanks.

Sarah Lochner: Got it. And yes, it is just the principal, the interest does go back to the tobacco companies, that's part of the complaint is that they have just been using this fund as like an investment fund.

Pat Luedtke: So that's very bothersome. You know, in the meantime, it's almost like saying nobody died from tobacco related illnesses in the last 25 years. So, you know, why worry about that? And, of course, millions of people died in the last 25 years from tobacco related illnesses.

Marie Boman-Davis: So, I'm understanding this was already discussed in legislative committee. And Committee is putting forward a recommendation for priority two, is that correct? And all those present voted in favor of that – how many need to be present for that?

Sarah Lochner: That’s correct – all those present voted in favor, and we need 8 people for a quorum.

**Motion**: The Legislative Committee has made a motion to support the attorney general’s bill on the tobacco master settlement at a Priority 2. Pat Luedtke seconded. 0 opposed, 1 abstained (Marie Boman-Davis), remaining present in favor, motion passed.

Sarah Lochner: Also from the Legislative Committee: there’s been a bill brought forward to allow the sale of raw milk at farmer's markets. This is House Bill 2616. And it does have the democratic sponsor. So, in the Oregon Legislature, that means it could potentially move. So, I think we want to be prepared in advance of that and do some legwork in advance to let people know that we are potentially, if you all agree, that we're not supportive of this. The CLHO legislative committee voted that we should oppose this bill at a Priority two which means we could testify against it and put our logo on materials against it. And I’d just like to add if anyone would like to help with testimony on this or volunteer to testify on this, that would be wonderful. So right now, the interstate sale and distribution of raw dairy is prohibited by the US FDA and has been since 1987. But the intrastate sale of and distribution is up to states, so 20 states explicitly prohibit raw milk sales. 30 states allow it in different situations, with some allowing retail sales and others permitting direct sales from farm to consumer through cow share programs. Oregon largely does not allow the sale of raw milk except from small farms. And that means farms with fewer than three cows, nine sheep or nine goats. But those farms may sell raw milk for consumption only from their premises, where it's produced. And the sale of milk is not advertised, and raw milk must be displayed separately and carry a warning label from regular pasteurized milk. Gary, our environmental health specialists on the legislative committee was adamant that this is a very dangerous thing for kids because E.coli is no joke. And he shared with us an article sharing that between 1993 and 2012 at least 1900 illnesses and 144 hospitalizations were recorded in the US from outbreaks attributed to unpasteurized milk consumption. A substantial number of these outbreaks involve children. At least one child under the age of five was involved in 59% of the outbreaks, and one to four year olds accounted for 38% of the salmonella illnesses and 28% in E. coli, which can cause kidney failure, long term health consequences and death. So all those present at the Legislative Committee voted to oppose this at a priority two.

Pat Luedtke: I'd be happy to speak to this. Those numbers you just quoted are significantly under reported. I can tell you in Utah when I was a state epidemiologist, we fought for 10 years to prevent raw milk from passing and it ultimately did pass and literally six months later we had a massive Campylobacter outbreak. There have been rabies outbreaks - rabies has passed through unpasteurized milk, and entire herds have been quarantined and killed. It's absurd fundamentally, to have this bill passed in this day and age. It'd be great, whoever the democratic sponsor is, if we could find the HA or the HO to speak to him or her. We might lose - this might be an inertial thing and the inertia may be going in that direction. But we really need to push that this is this is not a benign issue when you're talking about things from salmonella to Campy to rabies. It's just kind of nonsensical to put people at risk.

Jessica Guernsey: Totally agree. You might even be able to get Paul Lewis. I know he’s not part of CLHO, but we had we had a pretty bad outbreak here related to raw milk, I think seven years ago that was pretty terrifying. So totally agree.

Joe Fiumara: This is another one of those areas where public health has done a really good job, and the memory of what it used to be like is not there, which is unfortunate. But it's a big thing.

Katrina Griffith: Does it have a good chance of passing? I saw Danna say in the chat that this bill comes up almost every session.

Sarah Lochner: It’s a little hard to tell. I believe it does have at least two Democrat co-sponsors. The lead is Rep Susan Mclean from Hillsboro. So I think we could have quiet conversations about it, if you all decide to oppose it, and hope that those conversations are enough to not have to discuss it in public, but it sounds like all the data is on our side on this. I've never seen this particular bill before, but you know, I also may not have been paying that close attention.

**Motion**: The Legislative Committee has made a motion to oppose HB 2616 at a Priority 2. Joe Fiumara seconded. 0 opposed, 0 abstained, all present in favor, motion passed.

Marie Boman-Davis: Sarah, can we connect? I want to see if there's anything our government relations team can do to support since one of the bill sponsors is here in our county.

Sarah Lochner: Yes, definitely. Next on my list is House Bill 2918, which is the next iteration of the racism is a public health crisis bill that passed last session with I believe $1.5 million dollars for the mobile units. So CLHO legislative committee recommends supporting this bill at a priority three which means we would provide our logo to the Oregon Public Health Association in support of this measure. OHA had put a fiscal on it to hire a staff person to administer or run this program, but they had a hard time getting someone hired and so the work has been delayed. So there is a workgroup around this and the money the RFP has not been posted - Danna, correct me if I'm wrong - and the money has not gone out the door. The end of the biennium as you all know, is the end of June and so folks are not confident that this money will be out the door or spent in time for the end of the biennium. So OPHA is asking for an additional $4 million to do this work because the staffing has been more expensive than anticipated (and they did ask for $3 million last time and they only got 1.5). I think it would be great for us to support this project moving forward, one, because OPHA is a sister organization and has been working with the BIPOC community on this. Two, we have supported this effort in the past. And three, I think it will tie in nicely to Jocelyn 's mobile unit that she is working on in Lane County and also our community paramedicine grant program that we are working on out in Malheur County. So I think, you know creating some synergy around these mobile units would be nice, moving forward to help really bring hard to reach populations into the traditional medical model and do warm handoffs to help get them into care.

Mike Baker: Where in the state are they talking about having mobile units?

Sarah Lochner: I don't know that it's been officially set. I think one at least is intended for the metro region. I don't know if Deanna has more particular information to share on that.

Danna Drum: I don't have any information on this particular bill or project.

Sarah Lochner: The main proponent of the bill is lives in the Portland area. I think she wants her organization to apply for it for example, but if they wanted, I don't think she intends to apply for two, so I think there is room for other entities to apply as well.

Naomi Adeline: I will ask that you read clarify what the motion is exactly.

Sarah Lochner: Yes, legislative committee recommends supporting this bill, House Bill 2918 at a priority three, which means that we would provide our logo in support on various supporting materials.

**Motion:** The Legislative Committee has made a motion to support HB 2918 at a Priority 2. Jocelyn Warren seconded. 0 opposed, 1 abstained (Mike Baker), remaining present in favor, motion passed.

Sarah Lochner: Those are all of the recommendations today, but I will just flag for you all is House Bill 2030. There's a fee that county clerk's charge to widowers and widows, and when they request a certified copy of their death certificates. That fee is $60 and county clerk's would like to not have to charge that fee. And what the proponent of the bill tells me is that this fee currently goes into the affordable housing funds because it's tied to real estate. Whenever a county clerk issues this document, it's so that the deceased can be taken off the property title. Now, I also understand that public health vital records people also charge a fee, which then goes to support the vital records programs. The proponent of the bill tells me that these two fees are separate and distinct, and one goes into the housing fund and the other one goes to support vital programs. And so, I think we're trying to firm up and in consultation with OHA and others that this is in fact the case because we obviously don't want this bill to pass if it's going to take money away from vital records. So if you all know how this works with those two different entities collecting a fee, shout it out or give me an email or something.

Jennifer Little: I was talking with our folks here in Klamath, and our clerk's office does not issue certified copies. Only public health - they refer folks to us, so I don't know if that's how it is in other counties doing vital records.

Danna Drum: In some counties, vital records sits with the County Clerk's office and in some other counties, it says with the local public health authority. I don't think it sits in both places in a particular county. And so, I think there's some confusion and I'm actually wondering if the sponsor of the bill may not be completely well-informed Sarah, about the situation.

Sarah Lochner: Right, which is why I'm trying to fact check this.

Danna Drum: So I actually think, Sarah, it might be good for you to work with Cynthia to see if there could be a conversation with Jennifer Woodward, who is the state vital records registrar because I think there are a couple of vital records related bills that could have impacts on local public health authorities. That analysis is still happening. But I think probably working with Cynthia to sort of start with that would be a good thing.

Sarah Lochner: I will do that. It's good to know, Jennifer and Joe, I saw you nodding to that it's how it works in your county. So that's helpful. So that is I think that is all I have for you all today.

Marie Boman-Davis: I request - is it possible to update the website to include the current representation on legislative committee that would help me answer some of my own questions.

Sarah Lochner: Yes, we’ve been working with our communications contractor to try to get that updated. They have been prioritizing the legislative materials over the over the website thus far and we just had a staff change so we're also a little behind but yes, it is on the list.

**CLHO Budget Update:** Philip Mason-Joyner, CLHO Treasurer, provided the CLHO quarterly budget update.

Philip Mason-Joyner: I'll try to keep it really brief because I know it's been a long day. I’m happy to be your new treasurer – much thanks to Sarah and Katrina for helping with the transition. If you're still here, Katrina, thank you so much for training me last fall on my new role every month reviewing and approving payroll for flow and all of the expenses. We also worked last fall to transition all CLHO bank account access from Jocelyn and Katrina to Naomi and I. It was quite a bureaucracy and process to make that happen, but we did it. For folks who are newer, CLHO’s fiscal year restarts in May every year, so we are gearing up and already getting ready to prepare for next year's budget this spring. CLHO will not have a separate budget committee this year as we've done in the last couple years. It'll be through the executive committee, and we have dedicated meeting time in April to do that work. At this point, there's no real surprises with the budget. We're on track. Having the HRSA grant is the biggest change that you'll see within CLHO’s financials. They are on the website in the CLHO library - you do need an access code, and I believe you need to go to Laura Daily if you don't have access and would like to look at the budget actuals and the balance sheet. We do have one LPHA where we're awaiting their dues to be paid to us. But they are actively working on it. These budget updates are every quarter at the coalition meeting, and I will do my best to keep you all informed so there aren't any surprises. I really want to make these value-added and meaningful for y'all - we don't have to discuss it today, necessarily, but please touch base with me if you have specific things you're interested in hearing about or if there are things that would be helpful you want to know. That's all I really have to share at this point from my report.

Marie Boman-Davis: I have a couple of questions. I recall there was a pot of money to support with education or continued education or certification for public health administrators. And I'm just wondering how we promote that or make it available. I don't know whose bucket of work that falls into, but as you're monitoring that as Treasurer, I don't know how we promote it and support our colleagues.

Philip Mason-Joyner: Yes, that did come to the coalition earlier this year. There's one newer administrator who requested that, and we did approve that. I'd have to go and look in terms of how much funding is remaining, and how much has been spent. And yeah, I guess I would need Sarah’s help to think through what some mechanism are to continue to remind people as we get new administrators as a resource available to them, at least while the money's still there. Through our budget process and work for next year, there will be conversation about replenishing that funding as it gets used, so this is sustained over time. I’d be curious what the board thinks about that.

Sarah Lochner: Yeah, and we can have Laura include this in the weekly brief once a quarter, maybe, if that makes sense, to remind people that that money is there. We started out with just under 15,000. And now we have just under 10,000 in that funding pot, so still some money left.

Danna Drum: And just for some context, that money pre-dates me - I think we may have very well been DHS when it came to CLHO, and it has been sitting there for a long time. So, I think that's something to also consider as you have that conversation. Also, one thing I wanted to mention earlier again, we’ve heard from a number of you and your CD staff around the infection prevention training and resources things that Heather and Becca have talked about, and we sent out some information. There is a little bit of money that is going to be tied to that and so I'm working with them for those LPHAs that have opted in. We'll be putting that money in through a PE 01 sub element, and they'll provide a little bit of budget guidance, as well. It's like to cover that CIC exam resources and I think they're also looking at a kickoff meeting, and it can cover travel for that. So just know that will be forthcoming. A change the PE language isn't needed. And if there are LPHAs that haven't responded to that - I think it went to CLHO CD as well as health administrators and health officers - you can still opt in. I think there were one or two people, local staff that wanted to take the exam sooner rather than later, so we're going to be working to get the money out so that it's available to cover the exam costs. We are also going to do it in a lump sum because the expenses are going to come periodically, so doing like a 1/12 payment when it's not a lot of money doesn't make sense. I will be sending out some information as we get closer to that, but I did want to let folks know we'll date it back to February 1. My guess is you won't get an amendment until after that. But if you've got someone who's looking to take the exam soon, if they do it February 1 or later it'll be covered. And my understanding is that funding will be good through June 30 2024, I believe.

Philip Mason-Joyner: Question for Danna, since you're talking about program elements for funding, I was just curious if there's an update on the CDC infrastructure funding and when that's supposed to be coming.

Danna Drum: Good question. We are working to get the budget guidance and survey out to find out who wants that money this fiscal year. I will just say, we're going to go ahead and do that even though we're still going to be working with CDC on what we feel like our heavy lifts for you all and for us in terms of data reporting. I think that we'll we don't want to hold up getting the funding out to those who might want it this fiscal year. So that's where we are. Andrew is working on that. It is going through PE 51 as a sub element. That's what we agreed to, and we amended PE 51 to reflect that. We have only been funded so far for the one-time funding, which is the money that, I think 50% of that's going out to LPHA. So that's what we've been funded for that. And we've been funded for one year for the second component, which I want to say it was like a million dollars or a little more. Then there was the data infrastructure third component, and we have not been awarded that money. I don't think CDC has awarded any of it. We don't know if and when that will get awarded. I think it has to do with some of these funds were authorized in the continuing resolution but that one maybe wasn't. Kust to let you know, that wasn't much money – it was like $5-600,000.

**Meeting adjourned at 1:30pm.**