Conference of Local Health Officials

December 15th, 2022
Meeting of the Conference of Local Health Officials
Meeting Began: 9:30 AM

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; 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, CLHO Legislative Committee Representative, Washington
Absent: Shane Sanderson, Medium County Representative, Linn;

Members Present (x if present):

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	X	Tillamook - Marlene Putnam
	Columbia – Jaime Aanensen	X	Klamath - Jennifer Little	X	Umatilla - Joseph Fiumara
X	Coos - Anthony Arton	X	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	X	Wheeler - Shelby Thompson
	Douglas - Bob Dannenhoffer	X	Linn – Todd Noble	X	Yamhill - Lindsey Manfrin
	Gilliam – Hollie Winslow		Malheur - Sarah Poe	X	HO Caucus - Pat Luedtke
	Grant – Kimberly Lindsay	X	Marion – Ryan Matthews	X	CLEHS Caucus - Joseph Fiumara
	Harney – Kelly Singhose		Morrow – Robin Canaday	X	PHAO - Lindsey Manfrin

OHA Public Health Division: Danna Drum, Andrew Epstein, Jamie Coleman-Wright, Tim Noe, Sara Beaudrault, Cara Biddlecom, Heidi Behm, Rachael Banks, Andre Ourso, Ryan Barker

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CLHO Committee Chairs: Kathleen Rees (CD Co-Chair), Bailey Burkhalter (CD Co-Chair), Kathleen Johnson (EH Co-Chair)

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

Guests: None

Motion: Jocelyn Warren moved to approve the November 2022 minutes. Jennifer Little seconded the motion. Unanimous vote, motion passed.

AGENDA ITEMS

Appointments: Naomi Adeline made the follow appointments to the Communicable Disease Committee:
Mike Takagi (Gilliam), Lillia Rodgers (Columbia), Bailey Burkhalter (Jackson) as the new CD Co-Chair

PE 03 Tuberculosis U4U Funding and Update on TB Screening for Venezuelan Arrivals: Kathleen Rees reviewed that there has been increased funding for Ukrainian TB screening (available in the meeting materials). The CD Committee reviewed this last week and voted to approve it.

Danna Drum: Because the CLHO Board approved this funding formula before, I don't think a vote is necessary because there are no changes, just additional funding. Because it was previously approved, this is more of just a FYI.

Naomi Adeline: Thank you, Danna. Any comments or questions from the Board.

No comments.

Heidi Behm added that this is the second round of funding that totals about $309,552.08 for LPHAs. Counties with over 200 sponsors are getting the bulk of the funding (Multnomah, Clackamas, Marion, Washington). Other counites can be reimbursed $100 (as of January 1, 2023 – was $50 in 2022 because of funding levels) for each immigrant that they provide TB screening to. They just need to contact OHA to request reimbursement – there no requirement to submit proof of the screening, OHA will just trust LPHAs.

Heidi Behm also reviewed the second update regarding Venezuelan arrivals, who are going through a similar process as Ukrainian immigrants. They are not being screened for TB in their home country, so they must complete a screening (through a private or public health care organization) in the US once they reach their sponsor's home and sign an attestation online. There is currently no federal funding through the CDC for Venezuelan arrivals, and they are not eligible for public benefits. Only about 20,000 Venezuelan are approved to come into the US. Counties that are not receiving this dedicated TB funding can also apply for reimbursement for any Venezuelan arrivals that they screen, though we do not anticipate many coming to Oregon.

OHA Lead Poisoning Prevention Program Updates: Ryan Barker with the Oregon Childhood Lead Poisoning Prevention Program presented on two topics: the proposed revisions to the OAR 333-017 on blood lead reference value and lead exposure screening for newly arrived refugees.

Blood Lead Reference Value Proposed Change: Ryan discussed that OHA is proposing to change the blood lead reference value in OAR 333-017. As background, the health effects of lead exposure for young children are well documented, including damage to the brain and nervous systems, slowed growth and development, learning and behavior problems, and hearing and speech problems. Elevated blood lead levels (EBLL) have been shown to negatively affect the child intelligence, ability to pay attention, and academic achievement. In October 2021, the Centers for Disease Control and Prevention dropped their blood lead reference value from 5 micrograms per deciliter to 3.5 micrograms per deciliter after unanimous approval from the Federal Lead Exposure and Prevention Advisory Committee. This level is based on data from the National Health and Nutrition Examination Survey (NHNES) in children with blood lead levels at or above the blood lead reference value (BLRV) represent those at the top two and a half percent with the highest blood lead levels. CDC recommends children with levels at or above the blood that reference value receive follow up case management services and recommended services such as WIC and early intervention, early childhood special education. CDC also noted that lowering the BLRV at the state level should be based on resource availability. CDC has identified populations at highest risk for lead exposure as children from low-income households and those identifying as African American and immigrant and refugee children.

It's been 14 months since they've lowered the BLRV, and OHA is approaching this as a potential rule change. Currently, Oregon's case definition for child lead poisoning is greater than or equal to 5 micrograms per deciliter (OAR 333-017). Oregon children with blood lead levels between 3.5 and 4.9 micrograms per deciliter are currently ineligible for public health case management services and other direct service referrals that can assist families in reducing the negative health outcomes or and eliminating lead exposure sources. OHA is proposing to lower the case definition to 3.5 micrograms per

deciliter for children less than 18 years of age. This would increase access to important public health, nutrition and education services for Oregon's highest risk children. Additionally, OHA is proposing to change the condition name from lead poisoning to elevated blood lead level (EBLL) recognizing the fact that the CDC has identified no safe level of lead and blood.

Due to the increased number of confirmed cases of children with elevated blood lead levels expected with this rule change, fiscal and economic impacts are expected for public health agencies, health care providers and laboratories. For example, between October 1, 2021 and September 30, 2022, there were 141 children with a venous blood lead level in Oregon of 5 micrograms per deciliter or higher, which is the current criteria used for a confirmed case of lead poisoning. If the criteria had been 3.5 micrograms per deciliter or greater, there would have been an additional 112 cases requiring case management and investigations by local public health authority.

Further rulemaking activities for this change are expected in the first quarter of 2023. We will be coordinating these efforts with OHA Acute and Communicable Disease Prevention program, which will be revising some significant communicable disease definitions and criteria also in OAR 333-017. If you're interested in participating on this rulemaking effort, you can contact Ryan. Some of you may receive a direct invitation to become involved in this, and EH staff at LPHAs will also receive invitations.

In summary, OHA is proposing a rule revision and OAR 333-017 to change that condition known as lead poisoning for children under 18 to EBLL and is proposing to lower the case definition from 5 micrograms per deciliter to 3.5 micrograms per deciliter.

Lead Exposure Screening for Refugees: Ryan also discussed lead exposure screening for newly arrived refugees. As background, refugee children arriving in the United States have higher average rates of EBLL than US-born children. Exposures in the country of origin or country of last residence include things like leaded gasoline, industrial emissions, lead based paint, environmental pollution, occupational exposures, cosmetics, foods, or products used for food preparation and serving. Data analyzed from Multnomah County's Mid County Health Center from 2013 to 2017, showed EBLL rates for refugees ranging from 7-18% compared to about 2.6% of children under six years of age in the US (Oregon has even lower rates).

Refugee children are at a continued risk for EBLLs from ongoing exposures after arrival to the United States. CDC analysis has shown that approximately 6% of refugee children had an EBLL after three to six months when the initial test upon arrival

to the US was not elevated. Exposure to lead is frequently caused by hand to mouth contact and pre-1978 housing that contains lead-based paint or dust. Other common exposures include things like adult occupations and hobbies, imported consumer products, such as spices and cosmetics, and cooking or eating from vessels such as glazed pottery, and metal pressure cookers from Afghanistan. Additionally, malnourished and anemic children may be at a greater risk for EBLLs due to micronutrient deficiencies.

The CDC is Division of Global Migration and Quarantine provides domestic medical screening guidance for state public health departments and health care providers in the US who conduct the initial medical screening for refugees. These guidelines include an initial lead exposure blood lead test for all refugee children 16 years of age and under. Additionally, these guidelines provide a recommendation for a follow up blood lead test within three to six months after the initial test for all refugee infants and children six years of age and under regardless of the initial test result. CDC reaffirmed this recommendation in the letter to state refugee health coordinators and partners last year when they also announced the lowered blood that reference value.

Ensuring that medical providers follow this retesting recommendation from CDC will provide the best health outcomes for refugee families. Data analyzed from Multnomah County in 2018 show that only about 10% of refugee children had a second blood test in that year. This shows that Oregon needs to take additional steps to ensure refugee children and families are provided this recommended medical service to reduce and prevent further exposures to lead. In a recent AJPH article on blood lead level testing for refugee children in Pennsylvania, there is the following quote: *"Health care providers should be frequently reminded about the importance of repeat lead screening of children aged 6 years and younger, irrespective of their initial blood test results, and retesting of children aged 7 to 16 years with EBLLs. Health care provider education on the importance of follow-up testing needs to be enhanced to ensure compliance with CDC recommendations, especially for this high-risk refugee population…The CDC's recommended screening is especially important in the case of refugee children because they often arrive in the United States with significant overseas exposure and are more likely to have continued exposure to lead because of sociocultural issues after resettlement."*

OHA does not currently have an official list of children that are refugees, so we cannot currently determine what is the retesting rate for this population. To determine this rate and develop strategies to implement the CDC recommendations we requested access to the CDC's electronic disease notification system, which is a centralized electronic reporting system that notifies state and local health departments screening clinics of the arrival of refugees. This requires approval from the DHS State Refugee Health Coordinator, which is expected in the coming weeks. We can then use this data to compare blood lead

test records within Orpheus. We may contact the local public health authorities for assistance or to develop ideas to better implement the CDC recommendations.

Ryan concluded his presentation and asked for questions.

Florence Pourtal: I appreciate the lowering of the lead levels, and to your point, this will increase the caseload and an increase in case management for LPHAs – is there a plan for increased funding for LPHAs? Second, I heard that children in this program will be eligible for nutrition programs like WIC, which is normally based on income – will kids with ECLLs be eligible even without meeting the income requirements?

Ryan Barker: WIC income eligibility guidelines will not change, but OHA is trying to work collaboratively with state programs to insure that children with EBLLs will be referred to programs they may be eligible for, and WIC is one of those. There are some plans to share data with WIC to ensure children with EBLLs can get services they are eligible for quickly. However, most children with EBLLs are on OHP which is means automatically eligible into nutrition programs. These kids are also often eligible for Healthy Starts. For the funding piece, this is outside the scope of what I can answer, but OHA is always supportive of ensuring LPHAs can provide services. Please reach out if you are experiencing additional caseloads – OHA will not leave you hanging.

Jennifer Little: Does WIC have a question in their screening questions about blood lead? For example, “has your child been screened for blood lead levels?”

Ryan Barker: EBLL is a risk-factor under the WIC risk screening questions. WIC also created some communications materials about EBLLs to help families get information quickly. That specific question, I am unsure. The goal is to work closely with WIC to ensure we are catching all the kids through both programs and can quickly refer them.

Pat Luedtke: Some organizations, such as FQHCs and LPHAs are using equipment that does not reliably detect lower levels of lead in the blood. To Florence’s point, it would be helpful to have funding or support to upgrade equipment at these organizations.

Ryan Barker: Yes, this is a point of concern across the nation. When CDC lowered the reference value, there was a lot of concern that the point-of-care testing equipment, which is manufactured by a private company, would turn the screening test

into a binary because it detects EBLL reliably to 3.3 micrograms per deciliter. CDC has no follow-up or suggestion on this, but for now, we would recommend a venous draw and verifying with a lab if there are concerns about a test.

Danna Drum: Thank you for the thorough information. It is good for all of us to hear about the work in this area and what we need to be doing.

Tim Noe: Regarding WIC Screening. Here's the preliminary response. I don't believe there is a mandatory question about lead screening – I don't see it in TWIST. I know some counties do ask about lead screening if the HGB screen (mandatory in TWIST) ends up a low value; i.e. on the referral page they send to the primary care provider they do ask the parent if the child has a lead test but that is only on the referral form after the HGB screen comes up low, and I cannot say for sure that all local agencies ask it.

Jennifer Little: Thanks, Tim. My WIC manager came from WIC in Kentucky and they said in that state tested all kids at age 1 and 2.

Tim Noe: We can discuss how to improve this screening for WIC. More to come.

ADPEP PE Update: Jennifer Little reported that the HPP Committee has been reviewing the ADPEP PE 36 update. There has been one point of contention around requiring a Certified Prevention Specialist (CPS) certificate for ADPEP coordinators. The committee was not able to reach consensus, so Jill Quackenbush and Belinda Ballah have formed a subgroup to discuss it further. The next full HPP meeting is on January 5th, and we would encourage you to come or talk to your representative on the committee. The committee plans to vote at that meeting and forward the PE to the Board at the January Conference meeting.

Lindsey Manfrin: You have done a great job with this process. Thanks, Jennifer!

Florence Pourtal: I want to understand the rationale. Right now, I am opposed to this big time. It limits the scope of work and brings up a conversation that we have had in the past when we removed this requirement. Requiring this certification is a step backwards, in my opinion, and Lincoln is opposed to it unless there's a very compelling case to require a CPS.

Jennifer Little: Yes, it has been helpful to have Lindsey on the committee because most newer folks did not know that this requirement had been removed before. There are concerns about language in the ORS about having a certification. However, there doesn't seem to be any enforcement of that. Once the subgroup and HPP committee review it and vote, the Board will review it, and the HPP Committee is clear on the fact that, whichever way the HPP Committee votes, the Conference Board may vote otherwise.

Florence Pourtal: I just want to understand who or what is bringing this forward. Is it OHA or is it from the counties? Having firsthand experience of this CPS certification, it narrows our work. I am curious about OHA's stance on this.

Jennifer Little: Yes, this is difficult because each county does everything a little bit differently. The two people who brought it forward work with MHACBO.

Katie Plumb: We should acknowledge the good intent behind the request to require CPS. It has resulted in some differing opinions, but the question does come down to "how can we support these staff?". Everyone has had challenges with hiring, and these staff have been through a lot. I've been hiring staff right out of high school, and they have valuable lived experience but need additional support and training. I think what is being brought to this group is "if CPS is not the answer, what is a good structure to support these program staff?"

Florence Pourtal: I agree, but perhaps we can look at frameworks for prevention programs rather than a compulsory certification. This will lead to ADPEP being very specific and narrow, and for staff who are covering ADPEP and other programs, it is challenging for them to get an additional certification. I would like us to move forward as a modernized public health system and not backwards.

Jocelyn Warren: Health administrators don't have certification requirements.

Naomi Adeline: Is there a timeline for this work?

Jennifer Little: The PE doesn't have to be updated, so there is no rush. The next meeting is January 5th, and we will be discussing and voting (via roll call to fully capture the votes). Whatever that result is, I will bring it to this Board in January.

Naomi Adeline: Thank you, Jennifer, for leading this work.

Danna Drum: Thank you, Jennifer, for you skilled leadership as we navigate through this challenging conversation.

PHAB Workgroup: Modernization Policy Option Package Scenarios: Cara Biddlecom reviewed that the PHAB requested OHA pull together a representative workgroup of PHAB members, LPHAs, CBO, and OHA Staff to review the different POP funding scenarios and priorities. This is a standard exercise that all state agencies are asked to do to prepare for the event that the Legislature does not fund the full amount requested in the POP ($286 million for Public Health Modernization). They had an optional introductory meeting for background on Monday of this week and held Meeting #1 to discuss the POP priorities on Tuesday. Meeting #2 will be held tomorrow (12/16). They will hold meeting #3 on Monday, January 9th, and PHAB will review and vote on the recommendations of this workgroup on January 12th.

Mike Baker (PHAB member on this workgroup) added that the conversation at the first actual workgroup meeting was heavily steered by LPHAs because there weren't many CBOs on the first discussion call (more at the intro meeting). At meeting #1, the group discussed how they would prioritize at different levels of funding: $200 million, $150 million, $100 million, and $50 million. Because Meeting #1 was steered by local public health, the priorities proposed at each funding level are local public health focused (materials available here for review). At the PHAB meeting on 12/8, there was a lot more input from PHAB members, so they anticipate additional workgroup meetings to have more involvement. The one caveat to the discuss is that many of the members of the workgroup had not read the COVID After Action Report, so much of the discussion was around what the recommendations were from the report. OHA staff did a good job of taking a bunch of random ideas from the workgroup and combining them into a coherent document.

Cara and Mike opened it up for questions.

Florence Pourtal: For the meeting tomorrow, will we build on what PHAB offered at the 12/8 meeting?

Cara Biddlecom: Yes, tomorrow the workgroup will be reviewing what OHA presented to PHAB on 12/8 showing what work will be prioritized and phased in at each funding level and PHAB's feedback. The meeting tomorrow will be focused on the roles of each organization at these funding levels. The last meeting on January 9th will look at funding partners across the health system.

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PHAB Accountability Metrics Committee Update: Sara Beaudrault introduced this topic by discussing that both the CD and EH Committees have been working with the PHAB Accountability Metrics subcommittee to identify accountability metrics for Public Health Modernization. One tension that the subcommittee is considering is how to ensure that the metrics are flexible so each LPHA can apply it to their work appropriately while still demonstrating progress as a state. They are also discussing how to identify metrics that allow us to demonstrate change while also having metrics that are aspirational and set the roadmap for where we want to be in years to come.

Jocelyn Warren added that the tension is difficult to navigate, and both CLHO committees have done a great job in looking at all the options and considering the county-level priorities and focusing on the context of behavior and the social determinants of health.

Kathleen Rees provided an overview of the CD Committee's work. PHAB has guided this work towards establishing accountability across all levels of the system (local level, state level, health systems, leadership/legislative). They are working to establish metrics that span these levels while also selecting indicators that LPHAs can have an impact on. The indicators CD is discussing include: ability to respond to seasonal/novel pathogens, STIs, Hepatitis, HIV, TB, and vaccine preventable diseases. The CD and EH Committees are having a joint meeting on Friday, and they welcome additional people to attend to provide feedback.

Florence Pourtal: Will we have the tools to be able to pull that data?

Kathleen Rees: That is a great question. This has been a challenge that we are talking through. OHA is discussing a registry that is probably five years out.

Kathleen Johnson also provided an overview of the EH Committee's work. Access to data is also a topic of discussion, especially around what OHA's role is in helping LPHAs accessing data. There is also discussion around how OHA can ensure that data being reported into ESSENCE by health care systems is accurate (it is reported by providers, not the patient). While ESSENCE is one of the better databases we have, there are still limitations to the information we can pull for climate/environmental-related emergencies (such as health risk factors during extreme heat events). The EH Committee has arrived at some agreement around health indicators: extreme heat-related morbidity and mortality and asthma/allergic disease related to air quality morbidity and mortality. These are the indicators used by CSTLTS and the metro-area counties for their Regional Climate and Health Monitoring Report. The EH workgroup is discussing what these indicators look like

across the foundational capabilities – there are challenges with identifying an indicator for policy development. The PHAB subcommittee has brought up questions about how these metrics will be applied to different counties where some climate-related concerns may be more pressing than others or where a county covers a large, diverse geographic area (Lane County has both coastal and valley regions which may have different concerns). There are also discussions around how these metrics will be used and what they will be compared to.

Sara Beaudrault recognized that both committee workgroups have been meeting every two weeks to do this work. It is exciting work, but it has also taken some dedication from these two groups.

Marie Boman-Davis: If not done so already, can the group talk about applying a targeted universalism approach to address the statewide goals and local approach conversation? https://belonging.berkeley.edu/targeted-universalism

- Jocelyn Warren: Thanks, Marie, this will be a very helpful resource!
- Kathleen Rees: Yes, thank you Marie!
- Rachael Banks: Thank you Marie. I think the goal of ending health inequities by 2030 is a really good opportunity to apply a targeted universalism lens.
- Lindsey Manfrin: I really like this framework. We are using it with prevention work with our CCO.
- Jocelyn Warren: I thought I heard John Powell say they were going to use a word other than "targeted" but maybe that's what folks know now.

CDC Infrastructure Grant: Danna Drum shared that Oregon saw a small reduction in the CDC Infrastructure Grant amount because CDC changed the funding formula and process. OHA has started revising their budget, and they are keeping the amounts for LPHAs ($14.5 million), Tribes ($4 million), and the capacity-building CBOs ($4 million) the same as originally proposed. The PE and the funding formula approved at the November Conference Meeting stand, so there is no need to revise. Andrew Epstein will be sending out some budget guidance and a survey soon to ask LPHAs when they want the funds this fiscal year. The PE has already gone through the Office of Contracts and Procurement, and once DOJ reviews it, the updated PE will be added to the IGA (which LPHAs will likely see in an amendment). The funds will be back-dated to December 1st, 2022. However, because these are one-time funds to be used over 5 years, each LPHA should assess whether they want them this fiscal year.

Florence Pourtal: Do we need to tell you if we want the funds?

Danna Drum: Likely in early January, we will send out a survey to LPHAs to ask if they want funding this fiscal year.

Jennifer Little: So, in the IGA amendment, the PE will be in there, but not the budget?

Danna Drum: Correct. PE 51-05 approved in November.

Florence Pourtal: Will there be an option to ask for them for FY24?

Danna Drum: Yes, the amount on the funding formula spreadsheet belongs to the LPHAs. So LPHAs can request those funds for any fiscal year within the 5-year period. They carry over within these 5 years, but they are gone after the 5 years is up.

Jennifer Little: Does OHA have a recommendation to use funds in a certain order? For example, should we use Modernization funding first before this funding?

Danna Drum: Right, Modernization, ELC and ARPA funds all have a sooner end date than the CDC Infrastructure funds, so those should be prioritized first.

Cara Biddlecom: Right, PE 51-01 funds (from General Fund) are the priority to use (by June 30, 2023). After that, PE 51-03 (ARPA Workforce funds) is available through 2024, so those are the next priority. If you have positions that you have hired through these funds and don't have the ongoing budget to keep them, this new CDC can backfill and keep those positions on.

Danna Drum: PE 01-07,09 funds last through 2024, so these funds should be used for COVID-related needs first because they are narrower than these other funds.

Jennifer Little: Big thanks to whomever at OHA applied for this grant for us!

Danna Drum: It was a group effort, and thank you to everyone who participated in the JLT+ Workgroup to help with the application.

Meeting Adjourned at 11:40 AM