**CLHO Communicable Disease Committee Minutes**

**Date: February 10, 2023**

**Time: 10:00 a.m. – 11:00 a.m.**

Committee Attendees:

Members: Gerald Dyer, Anna Summer, Allison Portney, Lisa McClean, Bob Dannenhoffer, Laura Turpen, Andrea Krause, Bailey Burkhalter, Nicole Pierce, Kellie Hansen, Katharine Carvelli, Callie Lamendola-Gilliam, Tyra Jansson, Rachel Posnick, Robin Canaday, Sara McCall, Russel Barlow, Gretchen Kellermann, Amy Manchester Harris, Kathleen Rees, Abigail Gray; Emily Brateng, Wendy Zieker.

Additional Non-LPHA Staff: Carolee Asher, Christine Keating,

OHA Attendees: Paul Cieslak, Danna Drum, Meagan McLafferty, Melissa Powell, Kelly Cogswell, Orion McCotter, Nora Zimmerman, Stephen Ladd-Wilson, Lee Peters, Michael Nugent, Carrie Brogoitti, Adelina Mart, Joanna McClain, Emilio Debess, Angela Phan

Guests: KC Thompson and Alex Muvua, Rede Group

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| **Agenda Item** | **Lead** | **Detail** | **Action & Responsibilities** |
| Welcome and roll call | Co-chairs | Quorum met. |  |
| Approve minutes | Co-chairs | Any additions or changes: none  Motion to approve: Tyra Jansson, Linn  Seconded: Amy Manchester Harris, Washington |  |
| Rede Group  COVID-19 Challenges | KC Thompson – Rede Group. | This study looks at OHA’s response to the COVID-19 pandemic. It is part of a larger study legislatively mandated Nov. 2022. There are three reports, one already submitted, and the other two due April 2023 and Sept. 2023. The study covers March 2020 to July 2022. The intent is for the report to facilitate policy action to improve response to PH emergencies.  Question/Comment:  Request for clarification on who responds: All LPH staff, administrators, leaders can respond.  How was the timeframe chosen: It ends 7/2022 because we had to cut the off the timeframe to before we started the first interviews.  **Q1: What were the most significant challenges to recruiting, onboarding, and retaining public health staff during the pandemic?**  Availability of Epi staff  Hiring people with no background in PH, but no time for training them either  Using temp staff and constantly training temps and new hires  Hiring large # people, hundreds, in a short time  Different classifications doing similar work but paid differently.  Remote environment challenging  Contracts process too slow for speed of hiring needed  Internal HR processes had to change  Precedents set around recruitment that need to now be undone  Building training as we go  Burnout and turnover of existing staff and the new ones we hired. Other CDs to respond to  HR policies that only allowed hiring short-term positions without benefits.  Competing with OHA for staff since they offer short-term with benefits.  Different phases of the pandemic had specific challenges: at first trying to train as fast as possible internally, an emergency response. Then trying to hire externally qualified people and how to find time for current staff to train the new people.  Hires on contracts and they didn’t know if it would be extended.  COVID funding at county level changing  High expectations for workloads, thresholds, outbreaks during pandemic.  HR slow with approvals for new positions  Patching together FTE across positions  Recruiting from limited pool with not necessarily qualified people  The evaluations of new staff postponed, but it is required to become permanent  Burnout in leadership since they had excess work based on their experience and knowledge.  With hiring of so many CI/CT we had to prioritize processes and resources to do more formative work. It narrowed the scope of PH response. CI/CT outside of high-risk outbreak settings is low yield.  **Q # 2. What were the skill sets that were hardest to recruit for?**  Epidemiologist, scientists  Some were able to do workarounds: recruited students, CSTE fellows. Others could not fill positions so staff had to double-team for some programs  Hard to backfill positions requiring technical expertise and so were unable to fill.  Hard to put anyone not already in CD into the positions, everything changed constantly and so fast, and the hours are demanding. Challenging to recruit externally into an emergency response, need flexibility and leadership.  Challenging for core group of leaders to develop what was needed and keep up with the changes.  Not enough PH people to set up emergency command systems. The struggle of doing the IMT work and teaching others to do the work.    **Q3. What were some best or promising practices you employed to recruit, onboard and retain staff during this period?**  With a limited, rural workforce we used volunteers, many were retired nurses and we trained them for some of the CT roles.  We had a pipeline of recent nursing graduates at the beginning of the pandemic. We worked with the school, had some student workers, and some graduated and stayed with us. The program director helped connect us and bring the students into PH.  At the beginning, we were able to use public school nurses who were out of work since the schools were closed.  **Q4. Did you work directly with CBOs on COVID-19 response?**  **If you did –** **What are the lessons learned from the LPHA and CBO partnerships that should be applied in the future?**  The ones that worked best were the ones we cultivated ourselves. With others there were barriers or different expectations. Helpful to have the OHA funding to pay the CBO for the work.  We reached out to all funded CBOs, got a varied response, community engagement coordinators tried to bridge gaps, but it got more difficult as people got tired. Was hard to keep up the relationships, especially if the CBO was not in our geographic area. We need locals to help locals and eliminate those barriers.  But also, there were CBOs who received funding but did not work with our CD team. | Notetaker: Put the questions asked in the minutes.  Rede Group: Provide email for Rede Group so people comment, ask questions or follow up. |
| OAR Input Discussion | Paul Cieslak | Paul reviewed the rules that will be discussed at the March Rules Advisory Committee. (RAC). The draft rules have been released. Some were delayed due to COVID and we are proposing some new rules around reportability.  Rule changes involving healthcare acquired infections (HAI) are done at a separate HAI advisory committee meeting.  This RAC covers non-healthcare rules and is open to county PH, clinics and public groups. Some of the rule changes include:  **OAR 333-017-0000** defines terms used in OAR 333-018 and 333-019, which regulate reportable diseases and communicable disease control. The rule is being amended.   * to revise downward, consistent with updated national recommendations, the threshold for reporting of elevated blood lead levels (which term replaces the older “lead poisoning”); and * to change the time frame for exposure to COVID-19 prior to symptom onset for purposes of reporting suspected Multi-System Inflammatory Syndrome in Children (MIS-C), in keeping with an updated national case definition.   (Timeframe changed from 28 days to 60)  **OAR 333-018-0010** makes 3 references to OAR 333-018-0011 (REALD), which is proposed for repeal; therefore, these references will need to be repealed  (REALD reporting needs to be repealed since it was based on statutory authority reference to the state of emergency which ended 4-1-22. )  **OAR 333-018-0015** specifies reportable diseases and conditions. The rule is being amended:   * to make *Cronobacter sakazakii* infection in infants less than one year of age reportable, because it causes serious illness and has been associated with contaminated infant formula; * to clarify that tests demonstrating toxins of *Escherichia coli* should be reported as potentially indicative of shiga-toxigenic or enterotoxigenic *E. coli* bacteria; and * to change the term “lead poisoning” to “elevated blood lead level,” consistent with the national designation.   (this is for non-pregnant adults and children)  and has an addition:   * death in any child with COVID-19 is reportable.   (This aligns with the current standards for influenza and RSV)  **OAR 333-018-0018** specifies organisms and specimens that must be submitted to the Oregon State Public Health Laboratory (OSPHL). The rule is being amended to add:   * for culture and subtyping at OSPHL for comparison with other cases and potential food isolates: specimens that test positive by antigen-detection or nucleic acid testing   + for *Listeria*, *Salmonella*, *Shigella*, *Vibrio*, or *Yersinia*, for which culture has not been attempted; and   + for Shiga toxin, and from which *Escherichia coli* O157 has not been isolated; and * for subtyping for comparison with other cases and with isolates from infant formula: all isolates of *Cronobacter sakazakii* from infants under the age of 1 year.   (This is a new rule for this rare but serious disease)  **OAR 333-019-0010** specifies restrictions to control communicable diseases in school, childcare and worksites. On August 20, 2022, this rule was amended to eliminate a requirement to exclude from school and children’s facilities susceptible students and employees following exposure to COVID-19; but we neglected to delete definitions for “evidence of immunity” and “exposed” to COVID-19, which are now vestigial. The rule is being amended to eliminate them.  **OAR 333-056-0050** specifies disposal requirements for sharp instruments. An amendment to OAR 333-056-0020 on April 6, 2020, clarified that “syringes” were meant to refer to items fitted with hollow needles—but we neglected to add the term “syringe” to the list of sharp instruments required to be disposed of in puncture-proof containers. This rule is being amended to correct this oversight.  For reporting of COVID-19 positive test results, we are waiting on leadership.  Questions/Comments/Discussion :  Regarding reporting the death for children with COVID-19, how will that be entered in Opera?  We would get a report through the physician or we would get a call about the case. We are not expecting the county to do any investigation. The county would verify the COVID case and that the death information is entered. |  |
| STRF-Soft Tick Relapsing Fever | Stephen Ladd-Wilson | Stephen reviewed the new Investigative Guidelines (IG) for Soft Tick Relapsing Fever.   * It has been renamed as CDC separated it out and we aligned. * For a case with relapsing fever presentation, contact Stephen stat. * CDC testing is the best option. Try to get whole blood or serum for testing. * The IGs are focused on STRF. The soft ticks, very different from the hard ticks, live in the crevices of mountains 1500- ft and above. Seen mostly in Deschutes and Wallowa counties. They can live 15-20 yrs. and can be found in old cabins. They act quickly with the person not knowing they were bitten. * Many cases associated with clusters (same cabin.) For CI, ask about similar illnesses. | OHA would like feedback by next Friday, Feb. 17th. |
| CD Training | Anna Summer | CD training was part of the triennial.   * There was a part of the tool about new staff without prior CD training. This was removed. * Advocate that that stay in the tool, and those trainings be re-instated. * Advocate for more trainings from OHA. Specific disease trainings in any format.   Kathleen mentioned the orientations that OHA had, would be helpful to have.   * New staff wanting to know who to contact at OHA. * There is a desire to work between counties and CD people.   Danna noted that there is ongoing work with Amanda at OHA with the intention of getting training back up again over the year.   * Sometimes more tailored training is more effective. * OHA had training and tech assistance that was put on hold due to the pandemic. * We have received feedback to offer CD trainings. Very understaffed currently. * There will be more news coming out on trainings. |  |
| Closing | Kathleen Rees | Topics for next meetings?   * OR-Epi for 2024   + Danna said it is planning stages, and many miss having it.   + There will be more news on that for 2024. It will not happen for 2023. |  |
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**Facilitator: Kathleen Rees Note Taker: Jennifer L Brown Next Meeting: Friday, March 10th, 10-11 am**