**CLHO Communicable Disease Committee Minutes**

**June 9, 2023**

**Time: 10:00 a.m. – 11:00 a.m.**

**Committee Attendees present:**

Members: Gerald Dyer, Allison Portney, Lisa McClean, Rita Bacho, Bailey Burkhalter, Nicole Pierce, Kellie Hansen, Katharine Carvelli, Nichole Sticka, Callie Lamendola-Gilliam, Nikki Jasper, Rachel Posnick, Robin Canaday, Russell Barlow, Emily Brateng, Amy Manchester Harris, Kathleen Rees, Brian Leon, Abigail Gray.

Additional Staff: Michelle Ashby, Carolee Asher, Andy Bloom, Mathew Christiansen, Sarah Hohenshelt, Adrienne Hoyt, Kyra Pappas, Lynne Rogers, Faith Soto, Wendy Taylor, Marta, Sarah Zia,

OHA Attendees: Emilio Debess, Meagan McLafferty, Michael Nugent, Rex Larsen, Sheri Hearn, Akiko Saito, Alessandra Karson-Whitethorn, Jennifer Brown, Amanda Faulkner, June Bancroft, Tasha Martin, Collette Young, Nora Zimmerman

|  |  |  |  |
| --- | --- | --- | --- |
| **Agenda Item** | **Detail** | **Action Item** | **Presenter** |
| Welcome and roll call | Quorum is 50% +1 of committee membership.  No quorum met at roll call. |  | Bailey |
| Approve minutes | Discuss any needed changes.  No quorum to approve April minutes. |  | Bailey |
| Small Numbers Policy Change | **Discuss feedback related to proposed change in data suppression standard used in immunizations.**  Rex presented a slide deck to provide an overview of Alert IIS, race and ethnicity (R/E) data in response to the many questions he received in relation to the small numbers policy change.  Data sources:  Vital records (very complete R/E data)  Provider reports  Health plan reporting (OHP reports R/E)  Covid data as of 6/2023 included rarest race (combined and unknown R/E 3.73%, very low, but a complete data set)  Two-yr. old data set as of 12/2022, 90% have R/E (reported directly from Vital records).  The challenges for ALERT IIS race and ethnicity data:  Records accumulate R/E over time with many records with more than one R/E.  Comparison of ALERT IIS numerator with static Census denominator.  Oregon Census undercount issues, specifically impacts NHPI communities.  Different methodologies for different data sets; only using rarest race for COVID.  ALERT IIS has a very complete data set so we feel confident to report small numbers, but the problem is having inadequate denominators and undercount issues. With no viable solution, we are proposing to change something above 95% as simply greater than 95% rather than the actual number because we know there are issues with that.  **Discussion:**  **Russ Barlow:**  There is a layering of multi-ethnicities and we found over 40% of all entries in ALERT had three or more races listed, and Other was a large category. COVID was a problematic data collection system, especially for R/E. There are concerns with small numbers, scenarios with distorted estimates of groups.  **Rex Larsen:**  If using the early COVID data files, and data from mass vaccinators, it had a default to Other or Unknown, and did not report R/E, but went to Other. We cleaned that up, and the final COVID data set does not have Other and Unknown rates as high as 40%.  We improved race and ethnicity reporting throughout the pandemic.  We do report rarest race for COVID, which can amplify some of the problems.  For the NHPI community with those high rates, it doesn't look that different if you use nonexclusive over rarest race.  **Brian Leon:**  Do we assume the most recent entry for an injection and the data entered about R/E is correct?  **Rex Larsen:**  No, it does not. OHA categorizes by what is rarest race in Oregon but does not use the most recent. For example, if a person has black African American and Latino, they would be listed as black African American instead of Hispanic, Latino.  Generally, for R/E we do not make the assumption that the most recent entry is the most accurate one.  We either report using rarest race or using nonexclusive without specifying which entry is most accurate.  Vital records is likely most accurate since it comes from the parent.  **June Bancroft:**  Is nonexclusive the same as alone and in combination? Counting people twice in whatever group they identify with?  **Rex Larsen:**  Yes, once under each entry.  There are drawbacks to the new small numbers policy, and data reliability, when you get below the 50 denominator, becomes an issue. When there are data rates above 100%, we know that it could be denominator undercount.  Most of the small counties have very complete race and ethnicity data in ALERT, so we don't have a lot of missing data or other unknown data in these counties.  The value is being able to use the data for PH interventions and measure improvement. Data should be released despite the shortcomings.  **Russ Barlow:**  What is the use case, the motivation for releasing smaller numbers, who is the target audience?  **Rex Larsen:**  For many years, small rural counties have requested that we publish R/E data for their counties. We have redacted two-thirds of R/E data in Oregon, impacting small counties, CBOs and those counties. The LPHAs also asked us to publish it. With COVID we made the standards change down to the smaller number minimum of 10. The goal is to provide smaller counties with the data they need for PH intervention. That is the use case.  We are responding to the demand from counties who have asked for it and the public demand for more data and more granular data. That public demand is comprised of community groups, advocacy groups, nonprofits that work with the marginalized communities.  **Kathleen Rees:**  Reminder to send Rex your feedback or questions by Friday, June 16.  **Rex Larsen:**  Many thanks for the thoughtful comments and feedback. | Members: Questions and feedback due to Rex Larsen by Friday, June 16th. | Rex Larsen |
| IGs Discussion | **Discuss process for creating new IGs, updating existing documents.**  The investigative guidelines (IGs) are documents created so the county health departments could assist with investigations of different conditions.  Not all diseases have IGs because they are uncommon and also because creating them is very time consuming.  We used to have a schedule for updating IGs, but because of COVID, and the burden of work, we are behind. Revisions are significant and take a lot of people. We are revisiting that schedule again to review IGs in the fall to get all up to date (UTD).  For many, the IGs are lengthy and LPH departments may not get through them or find them helpful.  We are asking for input on how the IGs should look going forward.  **Discussion**  **Kathleen Rees:**  We have had some cases of rare disease (i.e., tick-borne, histoplasmosis) and found it hard to find guidance. We often referred to WA state for their IGs.  Would OHA consider make modified, shorter IGs for diseases of potential PH significance that do not have full IGs?  **Emilio DeBess:**  Yes, we have considered the same thing for conditions that are not common but are of public health importance. It is a question of time and availability. For example, for histoplasmosis, we can create a simple guideline taking components from CDC.  **Wendy Taylor:**  Could there be something available on the drop down in Orpheus, even just for surveillance, or for what we should do with it? For example, histoplasmosis is not mentioned or listed anywhere.  **Emilio DeBess:**  Yes, certainly.  **June Bancroft (from the chat):**  In Orpheus we do have a space to document case definitions and a data cheat sheet - we can take a look and see if these are being populated by our subject matter experts.  **Tasha Martin (from the chat):**  For those rare diseases, we often look at the CSTE website for case definitions:  [*https://ndc.services.cdc.gov/*](http://?)   This might be helpful to use while we are in the process of creating new IGs.  **Rachel Posnick:**  I would also like to mention brucellosis, with a lot of work a county needs to get done.  We use CSTE and CDC for case definitions and that is a lot of information, not like having guidance from OHA about what our responsibilities are.  **Meagan McLafferty:**  I am the brucella epi (OHA) and am currently working on that guidance. There is a lot of need for it as it is coming up more.  **June Bancroft:**  We are working on a contract with Portland State to review and update the following guidelines with an eye to person-centric language as well as an equity component. We do have an SOP for updating our IGs every 2 years, but the pandemic has put us behind schedule. The public health lab also has to weigh in with services they can provide.  from the chat:  Cyclosporiasis(new guidelines)  1. Shiga toxin-producing E. coli (STEC)  2. Shigellosis  3. Enterotoxigenic E. coli (ETEC)  4. Hepatitis A (acute)  5. Hepatitis B (acute)  6. Hepatitis B (chronic)  7. Hepatitis C (acute)  8. Hepatitis C (chronic)  9. Pertussis  10. Mumps  11. Giardiasis  12. Cryptosporidiosis  13. Listeriosis  14. Meningococcal disease  15. Lyme disease  16. Taeniasis and Cysticercosis  17. Yersiniosis  18. Vibrio  **Emilio DeBess:**  Creating the guidelines requires a lot of people and a lot of research with CDC and our lab. It can be done and we will keep working on it.  The list of IGs that need to be updated is ready; we need to find the time to meet and work on those.  **Bailey Burkhalter:**  If you have more feedback, give it to Bailey or Kathleen. | Members: Send feedback to Bailey or Kathleen. | Emilio DeBess |
| Accountability Metrics Workgroup | **Update on status of workgroup.**  We have gone through the first round and are now into process measures.  We are asking you if you want anyone from your county to be involved. Bring it back to your teams and assess what that would look like.  We will send out another communication about this.  We have the two priority areas: syphilis, immunizations.  The process measures work needs to be done quickly so they can be reviewed by counties by early fall, so this means summer work.  We would like workgroups to meet in July and August to align with the triennial feedback. The sessions will be short and decisions will be made quickly.  We are looking for representation from different county sizes, with different types of staff to be involved (epi, frontline, policy pieces).  Once we decide, we will bring it back to this group.  **Questions/Discussion:**  None | Kathleen:  Send out more detailed info on these workgroups | Kathleen Rees |
| CD Triennial Review Feedback | **Update on process for providing feedback for the Triennial Review**  The process is in the early planning stages with OHA. We hope they will start in the fall so it won’t overlap with the accountability metrics workgroup. |  | Bailey Burkhalter |
|  | **Other topics:**  **Brian Leon:**  There are many things coming up that affect our work.  There have also been meetings this year when we did not have a quorum.  We have an opportunity to start shaping the work we do, to provide constructive feedback. Then we could have a more collaborative relationship with OHA instead of getting things handed down to us and not being able to do anything other than complain.  We can be more engaged in meetings and give feedback to improve the processes that will impact us. We might not get such opportunities on some topics for several years.  **Amy Manchester Harris:**  I agree with Brian and think we might reach out to people not attending these meetings to bring about better dialogue.  We have talked about combining some meetings. Often it is the same people attending.  We welcome your feedback.  **Kathleen Rees:**  It could be helpful if we did a survey with the counties. Let us know your priority areas so we can plan discussions and work groups over the next few years, and what to bring to big CLHO. |  |  |

**Facilitator: Baily Note Taker: Jennifer L Brown Next Meeting: Friday, July 14, 10-11 am**