MARION COUNTY HEALTH ADVISORY BOARD
Meeting Minutes
November 18, 2014
5:30 P.M. to 7:30 P.M.

Present: Patrick Vance, Mike Mann, Hanten Day, Sandra Echavarria, Sierra Nelson, Josh Sandeman, Tim Murphy, Renee Steward

Absent: Judy Scott, Josh Sandeman, Melinda Veliz

Staff: Rod Calkins, Scott Richards, Pam Hutchinson, Cary Moller, Polly Kuznetsov (Recorder)

Guests: Deborah Carlson, Laynie Smith, Flory Ericksen, Scott Eberz, Tracey Robichaud

Call to Order/Introductions/Approval of Minutes – Patrick Vance, Chair
Patrick called the meeting to order, introductions followed. Tracey Robichaud, an applicant to the Health Advisory Board. Flory Ericksen, part of the Partnership of Community Living a developmental disabilities community provider, and also a member of the newly developed Intellectual and Developmental Disabilities Advisory Committee (IDDAC). Scott Eberz, cares for a DD client, and is also a member of the newly developed IDDAC.

Tracey Robichaud introduced herself as an applicant to the Health Advisory. She has a well rounded background in psychiatric nursing. She works for the Oregon Health Authority. She had worked with the Addictions and Mental Health Division, but with the CCO development she has since been transferred to work with the Medical Assistance program.

Patrick, Chair, entertained a motion to approve last month's minutes, members voted, motion carried, and minutes were approved.

Announcements/Updates:

Community and Provider Services (CAPS) and Behavioral Care Network (BCN) – Cary Moller

Cary said that for almost twenty years, CAPS has been responsible for managing the outpatient mental health provider system in Marion County. BCN will take over the process starting January 1st, 2015. We have just closed an RFP process, where they will be contracting with an outpatient panel of providers. As a result of that reduction of work some of the staff have been reassigned. They will maintain their status as a Health Department employee, but will be reassigned to work at the BCN. Their roles will be to help access care and connect those to outpatient mental health providers. We will also have an exceptional needs coordinator to help those with complex needs access the care they need. Those two employees are Kristina McCollum and Patrick Brodigan

Mike was wondering if the County relationship with BCN will continue to be strong. Rod said that there will be some good things coming out of it, but there will be some losses. Cary has managed the system well and has been working together with Polk County. It is currently a unique system with multiple people managing it, and only a couple people will be sent over to the BCN to help continue manage the system. We are currently negotiating a contract with the BCN and it depends on how it comes out. There are non-billable services that only counties provide which the BCN may not be able to provide through

the CCO. It will be a struggle for a little while. Tim Murphy said that he expects it to work; we just may have to work together more diligently.

Tracey said that at her work as a Quality Coordinator she has worked with multiple counties through the CCO's. Since she does not work directly with the CCO for Marion County it would not be a conflict of interest.

Triennial Review – Pam Hutchinson

Pam said that every three years the state does an audit on each program area. They are planning on doing this again through Jan 5th through January 16th. We are in the process of planning for this. We have good systems in place and believe we will do well for the review. They do a review to check and see is we are meeting our contractual requirements. They will be looking at things like if are achieving certain percentages and making sure we are evaluating our employees.

Intellectual and Developmental Disabilities Advisory Committee (IDDAC) – Cary Moller

Cary reported that at a Board Session earlier this month the Board of Commissioners appointed nine of the twelve seats for the IDDAC. The Commissioners had approved the bylaws for the IDDAC which HAB had a hand in reviewing. Flory Ericksen has volunteered for Chair of the IDDAC and Scott Eberz volunteered for Vice Chair. The Health Advisory Board now gets to make a decision to approve the Chair and Vice Chair for the IDDAC. Cary said that they will first tell a little about themselves. Patrick said that that formally HAB will decide to approve the seats for IDDAC chair and vice chair for a six month term while IDDAC gets organized.

Flory introduced herself and gave her background. She started at Partnership in Community Living over twenty-four years ago. PCL was a small company, just two years old, and provided services in predominantly Polk and Marion County. At PCL, she has been able to bring closure to those and move them out into the community. She has learned housing skills and negotiating those kinds of things. She has met and worked with a lot of great people who receive services and their family members over the years. Her work includes working with supported living or shared housing; whether it's helping those live on their own through federal grants or shared housing with twenty four hour licensing. Flory said she was approached by Dawn Alisa to see if she was interested in being Chair of the IDDAC. Partnership in Community Living currently has about eighty seven homes in six counties. PCL also holds a contract with the State to provide stabilization to the most intensive support services to those with high medical and behavioral needs.

Scott introduced himself and gave his background. He has lived in Marion County in the last twenty-two years. He worked with the State of Oregon for the fifteen years. His son was born about thirteen years ago. He has two children on the opposite spectrum. His daughter is his oldest at eighteen years and has high functioning asbergers. His son is at the bottom end of the spectrum; he is severely autistic. His interest in this field started with his son. A few years ago he and his wife opted to reverse roles. His wife works as a Behavior Specialist for the SACU units. His son was eligible to qualify for CII (Children's Intensive In-home Services). Because they are in the CII program, Scott is able to essentially run a care home and is able to employ people. His success with the program has been recognized by others and he often gets requests for help. Through that involvement branched out into Developmental Disabilities services. Scott is really involved in coordinating his son's care. He believes he can bring the perspective of the consumer to IDDAC. He is excited to help shape the future of DD services. He has only had positive experiences with Marion County.

Patrick recommended to Flory and Scott that they be a liaison with the Health Advisory Board and be active with their committee. Cary said that with nine of the twelve positions filled on the IDDAC board they have enough of a quorum to start. Patrick, HAB Chair, entertained a motion to appoint Flory as

Chair and Scott as vice Chair for a term of six months, from November 12th, with the duties and obligations of the bylaws. Mike seconded, all others approved.

Marion County Tuberculosis (TB) Health Profile – Laynie Smith

Laynie Smith, Program Supervisor for Communication Disease Program, shared a two-page health profile on TB in Marion County, reporting that TB is still consistently found in the County. In the 1970's the goal was to eradicate TB but immunodeficiency diseases and conditions, foreign travel, and mobility has changed the face of TB. TB incidence is somewhat declining, but we continue to have five to sixteen active cases each year. TB is a bacterial disease which is slowing growing. It can take several weeks to grow out in a culture plate, and takes many months of medication to treat the patient. MCHD provides case management, and the Health Officer monitors all active TB cases in Marion County. We treat people for a minimum of six months. In best case scenario, they are treated with four drugs for two months and two drugs for the remaining four months. They receive the standard of care which is direct observation by nurses and paraprofessional staff when they take their TB medications. This observation is done with all clients and is very labor intensive. By using this method we are able to ensure that the patient is taking their medications appropriately. Once we determine if patient has contagious TB (pulmonary or laryngeal), we initiate a contact investigation. This includes testing household and other contacts to see if they also have active TB disease or if they've been infected and have latent (inactive) TB.

Because active TB may cause respiratory symptoms, by the time they are diagnosed, the person may have been treated a couple times for pneumonia without responding to treatment. Persons with TB usually have additional symptoms such as weight loss, bad cough, coughing up blood, night sweats, feeling tired, no appetite, and fever/chills. The MCHD investigation includes collecting sputum to do a culture to confirm whether they are contagious. We also screen the household and sometimes the workplace to check ventilation, if person has been three feet away from other people and if person has been coughing. We have had good cooperation with work places. Five to ten percent develop active TB within the first two years after exposure. We try to find, test and treat contacts, because, after an exposure, TB can remain latent and develop into active TB years later if the person is not treated with preventive medications. We have not had any recent cases in homeless shelters but we do test that population routinely. In 2005, we had the highest number of cases, primarily in a group that were connected by drug use. Because of the sharing of drugs in enclosed spaces and the unwillingness to come forward it was hard to do case finding. Other people at risk for TB include those who work and live in hospitals, homeless shelters, correctional facilities, nursing homes, etc. Those who are in these areas are closely monitored. Having a weakened immune system is another risk, for example, those with medical condition such as HIV, diabetes, and kidney disease are at greater risk of developing TB after latent infection.

If a medical provider suspects TB, they will call the Marion County Health Department to take over the case and do a workup. Tim asked why Marion County has a higher rate of TB incidence. Multnomah, Washington and Marion County have higher rates of TB because of foreign population and number of institutions. Many other Oregon counties do not have cases for years. Each year, in addition to the 5-16 TB cases, we have had a number of suspected cases which were eventually ruled out. In 2013 we had sixty people ruled out, in 2012 thirty three people and in 2011 we had seventy-four. Those are people who have a positive skin test or positive smear and TB-like symptoms. For each of these cases, we go through the same intensive process that

happens with an active case. This ends only if it is determined that the case is not Mycobacterium Tuberculosis. If the culture (which may not come for 8-12 weeks) shows that they actually have a different Mycobacterium, we then refer them to a primary care provider for treatment. Patrick said that TB has been found in the past as far back as in Egyptian mummies. Deborah asked if there are any pediatric cases. Laynie said pediatric cases for those who are under six have a higher risk; there were seven cases last year under the age of eighteen. If patient refuses to cooperate with their treatment, the legal system allows us to take them to court and isolate them if needed to protect the public. A new reportable disease is Mycobacteria of the skin. It may be found in skin lesions from tattoo parlors and nail salons where they do not clean correctly.

While our current case load includes many foreign born, in earlier years the average TB client was often an elderly person who'd been exposed as a child, and later developed the active disease. Renee remembers as a child she had a relative who was in a sanitarium. Laynie said that back in the day placing people in a sanitarium was thought to help since a higher elevation and ultra violet (UV) rays seemed to help. We have had clients be resistant to one drug, but not all four. The different types of cases we had in Marion County in 2013 included one eye case, three lymph cases, and twelve lung cases. We have had TB cases in the kidney, spine, skin, eye and bone. Laynie said that we get the drugs from the State TB program for free.

Latent TB is when a person has been exposed to TB and the immune system walls off the bacteria for duration of time, frequently years before it becomes active TB. TB is contagious to others when it infects the lungs. Active TB creates cavities in the lungs, which is the reason that the person coughs up blood. BCG vaccine which is given in other countries with higher TB rates can cause a false positive TB test for about two years. If a person who had a BCG vaccine tests positive, we will treat as latent TB because it is unknown whether it was a positive test due to BCG or latent TB. A blood test is now available that is more reliable than the skin test when we need to verify that the person has been infected. We have a good relationship with the prisons and corrections, so that they refer people to us to continue their preventive treatment after release.

What we can do in the community: We make sure that those who may have TB have access to medical care. We educate providers to think TB and rule out TB when they are treating a person. Family members and friends can know the symptoms of TB disease and find medical care. TB occurs in all socioeconomic levels and can develop many years after an exposure.

Ebola Update - Pam

Pam presented a few slides which contained information off the CDC website about Ebola. We have been having weekly calls with the State and currently have no cases in Oregon. The fatality risk or the risk of dying has decreased to thirty-six percent. At one point it was fifty percent. Travelers from countries with Ebola outbreaks are being routed to five US airports and where they will be screened. Mali has just been added to the list of those countries. The other countries are Guinea, Liberia and Sierra Leone. The screening process includes an interview for symptoms and a kit contacting a thermometer. Wherever the traveler's destination is they will need to contact their local health department. For those travelers from those specified countries who are due to arrive in Oregon the local health department is notified first.

If somebody comes into the state who had been in a situation of concern, the level of monitoring that person receives depends on the risk level. High risk is those who have direct contact with blood or bodily fluids of an Ebola infected person or unprotected contact with the known Ebola deceased. They would have direct active monitoring; we would be in visible contact with them. They would have restricted travel and restricted public activity. Those at some risk include those that shared a household with an Ebola infected person or provided care to an Ebola patient wearing personal protective equipment and will receive direct contact monitoring, but public activities and travel restrictions will be on a case-by-case basis. Research has showed that a person is only infectious when showing symptoms. The symptoms for Ebola include having a fever at first, then vomiting and diarrhea a few days later. It does help when a person isolates themselves from the public. A person is a low risk case if in the past twenty one days they either traveled thru or resided in one of the Ebola stricken countries. We would apply these risks and restrictions to those under monitoring.

People are currently under monitoring in the Tri-County area. Tim asked what happens is a person is uncooperative. If person under monitoring is uncooperative, we can then go to the courts as the risks to the community are weighed. There is a state isolation and quarantine statute that can be implemented. MCHD activated our Incident Command structure on October 21st, 2014. We planned and hosted a two-county Ebola seminar and invited the major hospitals, medical examiner, mortuaries, EMS providers, Public Information Officers (PIO), and a few others. There were presentations by Dr. Landers and Dr. Lehman from the state, followed by breakout workgroups to discuss key questions. Since then there has not been a lot of activity and we deactivated the incident command structure on November 18th, 2014. We will continue to monitor state calls and will reactivate as needed. The Communicable Disease Investigation (CDI) team will continue to monitor the state calls as they are held.

Patrick said that a difficult aspect in treating those affected is that they do not seek care due to denying the disease until disease has progressed which is then difficult to treat. Cultural beliefs and burial customs hinder treatment. Education and compassion is important to see where the client is coming from regarding their cultural bias.

Other Announcements:

HAB Applicant Recommendation: Patrick announced to the group that Deborah Carlson has attended and participated in three of our last board meetings. Rod asked Deborah Carlson if she is still interested in joining the Health Advisory Board. She said yes. Patrick asked the Board if they would like to recommend Deborah Carlson as a Health Advisory Board member to the Board of Commissioners. Health Advisory Board members agreed that she was a good fit and it was approved. Patrick will write a formal letter of recommendation to the Commissioners and invited Dr. Carlson to attend. The recommendation to HAB appointment for Deborah Carlson will be at a Board Session which is on Wednesdays at Court House square from 9:00 to 11:00.

Commissioner Cameron Preparation for Upcoming Meeting: Commissioner Cameron will be coming to visit the Health Advisory Board for our December meeting. He has been elected to a full term after finishing Commissioner Milne's term this last year. Rod wanted HAB's input on what topics we should have on December's agenda for Commissioner Cameron, including what HAB is about, what health issues we want him to know about, and what questions we want to ask him. Patrick suggested presenting the traditional functions of public health instead of the less experimental services. Tim suggested advising him of the needed building renovations. Rod said that there has already been information passed on to the Commissioners concerning the building renovations. The commissioners have approved the Health Department using Health Department funds and have found a loan to help cover part of the costs. Patrick

suggested that the accreditation process, which was an active part in what we are doing and that we were the first in the Country. Mike said that there are a lot of great things taking place that are strengthening and benefiting the community. Patrick said that a way to that could be to introducing each member and what interests them personally at the Health Department. Deborah suggested speaking about the services that only the Health Department provides for someone that does not know about what the Public Health Department provides such as TB and Ebola monitoring. Renée said that we need to tell and show the commissioner that we have discussions on issues; that we are doing more than just our statutory duty.

Rod said that Commissioner Cameron was able to visit a few of the service areas that the Health Department and came away with positive experiences. Commissioner Cameron had even reiterated an experience that he had with a home visit with one our Early Childhood nurses.

The chair motioned to adjourn, members voted and approved.
HAB Meeting Adjourned.

Recorder: Polly Kuznetsov
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2015 Meeting Schedule:

January 20, 2015	June 16, 2015
February 17, 2015	September 15, 2015
March 17, 2015	October 20, 2015
April 21, 2015	November 17, 2015
May 19, 2015	December 15, 2015