North Central Public Health District

North Central Public Health District Full Board of Health Meeting

Date: Tuesday, October 10, 2023
Time: 4:00 p.m. to 6:00 p.m.
Virtually via Zoom: https://wascocounty-org.zoom.us/j/86899654066

AGENDA

1. **Call to Order**
   - Introductions
   - Establish a Quorum
   - Requests to add items to the Agenda
   - Requests for Public Comments

2. **Action Items**
   - 9/12/2023 Board of Health Meeting Minutes
   - A/P Check Reports

3. **Non-Action Items**
   - PHEP Presentation
   - IGA Discussion
   - Fiscal Update
   - Contracts Summary
   - Director's Report

Note: This agenda is subject to last minute changes.

Meetings are ADA accessible. If special accommodations are needed please contact NCPHD in advance at (541) 506-2626. TDD 1-800-735-2900. NCPHD does not discriminate against individuals with disabilities.

If necessary, an Executive Session may be held in accordance with: ORS 192.660(2) (a) to consider the employment of a public officer, employee, staff member or individual agent; ORS 192.660 (2) (d) Labor Negotiations; ORS 192.660 (2) (h) Legal Rights; ORS 192.660 (2) (e) Property; ORS 192.660 (2) (i) Personnel

NORTH CENTRAL PUBLIC HEALTH DISTRICT
419 East Seventh Street
The Dalles, OR 97058-2676
541-506-2600
www.ncphd.org

North Central Public Health District
Board of Health Meeting Minutes
September 12, 2023

Board Members In Attendance: Commissioner Joan Bird – Sherman County; Commissioner Phil Brady – Wasco County; Shawn Payne – Sherman County; Bill Lennox – Wasco County,

Staff Present: Shellie Campbell – Director NCPHD; Brita Meyer – Fiscal Manager NCPHD; Eric Grendel – Environmental Health Supervisor NCPHD; Gloria Perry - Office Manager NCPHD; Martha McInnes - Clinical Programs Secretary NCPHD; Paula Grendel – Environmental Health Supervisor NCPHD; Marta Fisher, Regional Epidemiologist NCPHD; Maria Peña - Community Health Worker NCPHD; Lori Teichel - Public Health Nurse NCPHD; Monica Romero – Community Health Worker NCPHD

Minutes by: Cynthia Rojas

SUMMARY OF ACTIONS TAKEN

MOTION by Shawn Payne, and seconded by Phil Brady to accept the August 8th, 2023 Board of Health meeting minutes.

Vote: 4-0
Yes: Commissioner Joan Bird – Sherman County; Shawn Payne – Sherman County, Bill Lennox – Wasco County, Commissioner Phil Brady – Wasco County,
No: 0
Abstain: 0
Absent: None
Motion: Carried

MOTION by Bill Lennox and seconded by Shawn Payne, to accept the August 2023 A/P Checks Issued reports as presented.

Vote: 4-0
Yes: Commissioner Joan Bird – Sherman County; Shawn Payne – Sherman County, Bill Lennox – Wasco County, Commissioner Phil Brady – Wasco County
No: 0
Abstain: 0
Absent: None
Motion: Carried

MOTION by Bill Lennox, and seconded by Shawn Payne, to accept the Bylaws Amendment Section 10 as presented.

Vote:	4-0
Yes:	Commissioner Joan Bird – Sherman County; Shawn Payne – Sherman County, Bill Lennox – Wasco County, Commissioner Phil Brady – Wasco County
Abstain:	0
Absent:	None
Motion:	Carried

CALL TO ORDER: Commissioner Joan Bird called the Public Board of Health meeting to order at 4:01 p.m.

Introductions:

1. None.

Establish a Quorum

1. A quorum of the board members present was established.

Requests for Additions to the Agenda

1. None.

Request for Public Comment

1. None.

ACTION ITEMS

1. Approval of past meeting minutes.
   a. A motion was made and carried to approve the meeting minutes from 6/13/2023 as presented
2. Approval of A/P Check reports.
   a. A motion was made and carried to approve the August 2023 A/P Check reports as presented.
3. Approval of Bylaws Amendment Section 10
   a. A motion was made and carried to approve the Bylaws Amendment Section 10 as presented.
   b. Shellie provided some background info on the issue. The amendment would add the work "ordinance" to be able to enforce.
   c. Next step is to work with legal and bring it back to the board

NON-ACTION ITEMS

1. IGA Update
   a. Phil Brady discussed how he met with 9 of 28 NCPHD staff members. They had very good conversations & legitimate concerns about employment accrued vacations, salaries, etc.
   b. Joan Bird sent an email to Mike Middleton to request a budget breakdown and hasn't received a response.
   c. What would funding look like? How would salaries look? How would finding look for Sherman County?
   d. Phil suggests scheduling a meeting with Mike, Joan & Shellie next week.
   f. Joan will send a meeting invite.
   g. Shellie suggested being prepared with all the information needed and that Brita Meyer be at the meeting.

2. Fiscal Update
   a. Brita presented the NCPHD recap from 7/1/2023 to 8/31/2023 we are right on par with where we need to be at this point in the budget.
   b. Some programs are not just, due to how the state sent their money.

3. Contract Summary
   a. There are only 2 contracts which are just some amendments to our ongoing contracts with OHA

4. Director's Report
   a. Along with Shellie's update, department managers included an update on what is going on within each department.

Commissioner Bird closed the Public Board of Health Regular Meeting at 4:50 p.m.

Commissioner Bird opened the Board of Health Executive Session at 4:53 p.m.

1. **Executive Session**
   - Executive Session pursuant to ORS 192.660 (2) (i) Personnel

Commissioner Bird Closed the Board of Health Executive Session at 5:03 p.m.

Commissioner Bird opened the Public Board of Health Regular Meeting at 5:04 p.m.

Being no further business to be conducted at this time, Commissioner Joan Bird adjourned the Board of Health meeting at 5:05 p.m.

___________________________________ _______________________

Signature *Date*

____

Printed Name

NCPHD
Accounts Payable Checks
Issued September 2023

Check Date	Check Number	Vendor Name	OK To Post	Amount	
9/8/2023	1155	IRS		$15,385.01	
9/8/2023	1156	ASIFLEX		$205.00	
Held in Que	1157	PERS		$18,026.14	
9/8/2023	1158	OREGON STATE, DEPT OF REVENUE		$4,225.58	
9/25/2023	1159	IRS		$15,509.22	
9/25/2023	1160	ASIFLEX		$205.00	
Held in Que	1161	PERS		$18,068.08	PAYROLL A/P (EFT)
9/25/2023	1162	OREGON STATE, DEPT OF REVENUE		$4,249.14	
Held in Que	1163	IRS		$60.29	
Held in Que	1164	PERS		$100.32	
Held in Que	1165	OREGON STATE, DEPT OF REVENUE		$3.40	
Held in Que	1166	OREGIB STAREM DEPT OF REVENUE		$19.96	
Held in Que	1167	OREGON STATE, EMPLOYMENT DEPT.		$2.66	
9/7/2023	15597	HOOD RIVER COUNTY, PREVENTION DEPARTMENT		$6,961.79	
9/7/2023	15598	LANGUAGE LINE SERVICES, INC.		$52.65	
9/7/2023	15599	MULTNOMAH EDUC. SERVICE DIST		$822.27	
9/7/2023	15600	OREGON STATE, DEPT OF HUMAN SERVICES		$26,428.73	
9/7/2023	15601	SATCOM GLOBAL INC.		$62.97	
9/7/2023	15602	SYNERGY HEALTH AND WELLNESS		$1,079.00	
9/7/2023	15603	THE DALLES DISPOSAL		$39.72	
9/7/2023	15604	U.S. CELLULAR		$999.15	
9/7/2023	15605	US BANK		$8,602.24	
9/7/2023	15606	WRAY, HAYDEN		$315.00	
9/8/2023	15607	AMERICAN FAMILY LIFE ASSURANCE		$15.34	
9/14/2023	15608	CA STATE DISPURSEMENT UNIT		$231.50	PAYROLL A/P
9/14/2023	15609	NATIONWIDE RETIREMENT SOLUTION		$1,326.19	
9/14/2023	15610	AHLERS & ASSOCIATES		$860.00	
9/14/2023	15611	ASD SPECIALITY, HEALTHCARE LLC		$290.07	
9/14/2023	15612	BEERY ELSNER & HAMMOND LLP		$6,372.14	
9/14/2023	15613	HENRY SCHEIN		$182.15	
9/14/2023	15614	OFFICE DEPOT		$1,069.79	
9/14/2023	15615	OR STATE PUBLIC, HEALTH LABORATORY		$120.40	
9/14/2023	15616	SAIF CORPORATION		$571.32	
9/14/2023	15617	SANOFI PASTEUR INC.		$575.69	
9/14/2023	15618	SHRED NORTHWEST, INC.		$130.00	

9/14/2023	15619	STRATUS AUDIO, INC.		$188.10
9/14/2023	15620	WASCO COUNTY		$452.63
9/21/2023	15621	ASD SPECIALITY, HEALTHCARE LLC		$2,840.57
9/21/2023	15622	CYTOCHECK LABORATORY LLC		$344.00
9/21/2023	15623	OREGON STATE, DEPT OF HUMAN SERVICES		$20,000.00
9/27/2023	15624	WASCO COUNTY		$35,077.50
9/28/2023	15625	ASD SPECIALITY, HEALTHCARE LLC		$262.20
9/28/2023	15626	CIS TRUST		$74,211.67
9/28/2023	15627	OPTIMIST PRINTERS		$205.75
9/28/2023	15628	OREGON STATE, DEPT OF HUMAN SERVICES		$220.00
9/28/2023	15629	R&S NORTHEAST LLC		$532.33
9/28/2023	15630	STERICYCLE INC.		$433.69
9/28/2023	15631	AMERICAN FAMILY LIFE ASSURANCE		$381.28
9/28/2023	15632	CA STATE DISPURSEMENT UNIT		$231.50
9/28/2023	15633	MASSMUTUAL FINANCIAL GROUP		$602.58
9/28/2023	15634	NATIONWIDE RETIREMENT SOLUTION		$1,326.19
			TOTAL	**$270,477.90**

PAYROLL A/P

NCPHD Board of Health authorizes check numbers 15592 - 15634 & payroll EFT
1155 - 1167 numbers totalling $ 270,477.90

Signature ______________________________ Date _____________

Printed Name __ ________________________________

PHEP

Public Health Emergency Preparedness

PE12

PHEP is Program Element #12 of NCPHD's contract with OHA.

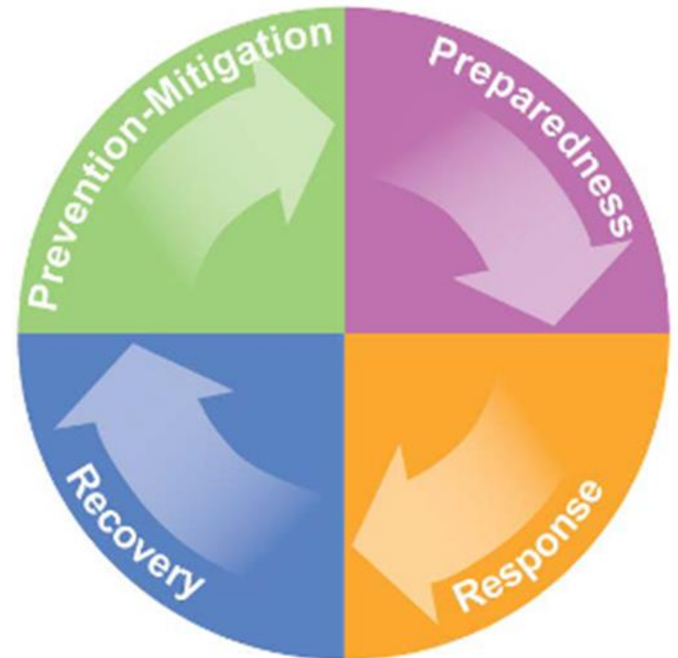
The PHEP program addresses:

- Prevention-Mitigation
- Preparedness
- Response
- Recovery

For emergencies that impact the health of the people in our jurisdiction, through:

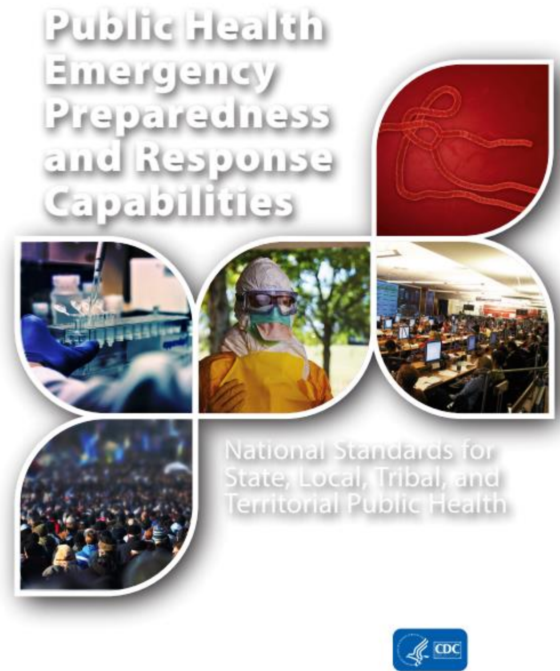
- Plan development & revision
- Exercise
- And response activities

Based on CDC PH Preparedness Capabilities.



15 CAPABILITIES

CDC developed 15 capabilities to serve as national public health preparedness standards:



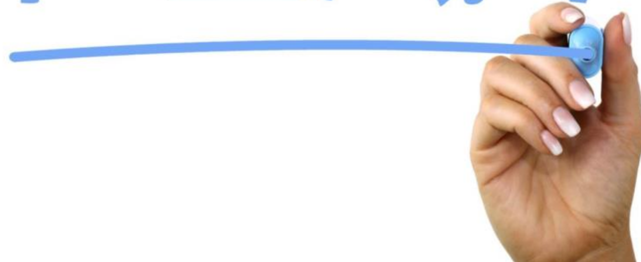
1. Community Preparedness
2. Community Recovery
3. Emergency Operations Coordination
4. Emergency Public Information and Warning
5. Fatality Management
6. Information Sharing
7. Mass Care
8. Medical Countermeasure Dispensing
9. Medical Materiel Management and Distribution
10. Medical Surge
11. Non-Pharmaceutical Interventions
12. Public Health Laboratory Testing
13. Public Health Surveillance and Epidemiological Investigation
14. Responder Safety and Health
15. Volunteer Management

Link:
https://www.cdc.gov/cpr/readiness/00_docs/CDC_PreparednesResponseCapabilities_October2018_Final_508.pdf

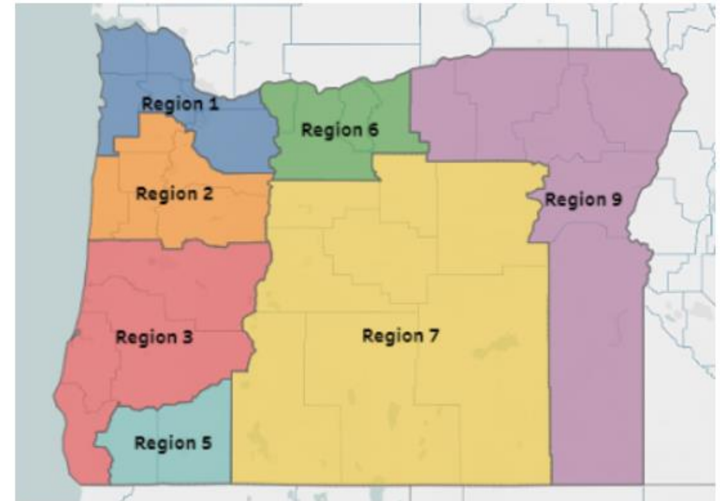
PUBLIC HEALTH SPECIFIC PLANS

NCPHD's has internal emergency response plans; including the All Hazards Base Response Plan, Emergency Communications Plan, Environmental Health Response Plan, COOP Plan, and Mass Prophylaxis & Immunizations Plan.

Matt is working to get these updated!



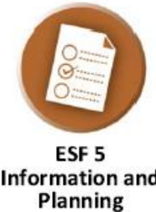
PHEP REGION 6



- Region 6 includes Wasco, Sherman, Gilliam, and Hood River Counties
- NCPHD hosts a quarterly PHEP/HCC meeting with Region 6 preparedness partners including:
  - Hospitals/Clinics
  - Behavioral Health
  - Fire & EMS
  - Emergency Management
  - LTCF
  - OHA
  - And more
  - Response partners from Klickitat Co. are also invited.
- Subcommittees created as needed. (Past subcommittees Access & Functional Needs, Exercise, LTCF, and an HCC Steering Committee)
- R6 response partners work together on training, exercises, events, other projects… and emergencies

ESF8

- There are 18 Emergency Support Functions (ESFs) in Oregon.
- Plans for each of these are in a County's Emergency Operations Plan (EOP).
- NCPHD is a primary agency for ESF8 Public Health & Medical Services.
- NCPHD is a supporting agency for other ESF's, such as ESF6 Mass Care.
- ESF's coordinate with one another for preparedness, and during emergencies.



ICS

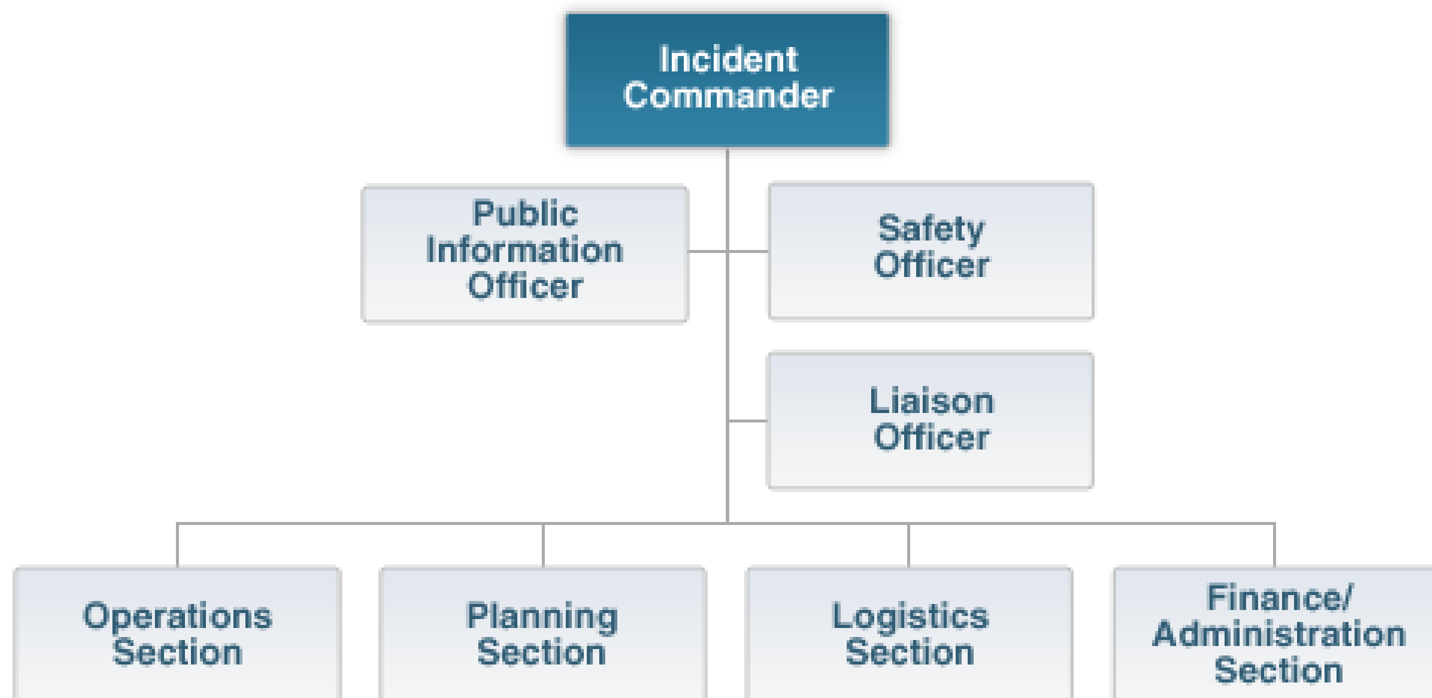
The Incident Command System (ICS) is the model tool for coordination of a response and provides a means to coordinate the effort.

FEMA offers many independent study courses on-line.

All NCPHD Staff are required to take ICS100 and IS700 training. Some staff are required to take additional training based on their potential role in an emergency.

I would encourage board members to take ICS100 & 700. If any BOH members are interested in further ICS training, please let me know.

The link to on-line classes is: https://training.fema.gov/is/crslist.aspx



EMERGENCY OPERATIONS CENTERS (EOC)

PH AS A SUPPORTING AGENCY - WILDFIRE

- **EH Staff Inspect Red Cross Evacuation Shelters**
- **Smoke Inhalation Prevention PSA's are sent pre-wildfire season and again during wildfire smoke incidents**

  Educational materials are shared on our website, and social media
- **As needed, information sharing with schools, medical partners, etc.**
- **Cleaner-Air Centers**

  Air-purifiers and scrubbers can be deployed. In the past we've set these up at the senior center, public library, houseless shelter, or LTCF's. PSA's direct citizens to go these locations, if needed
- **Vulnerable populations**

  Work to identify those that may need more help evacuating, are power dependent, or have special needs in a shelter

PH AS A SUPPORTING AGENCY - SOLAR ECLIPSE

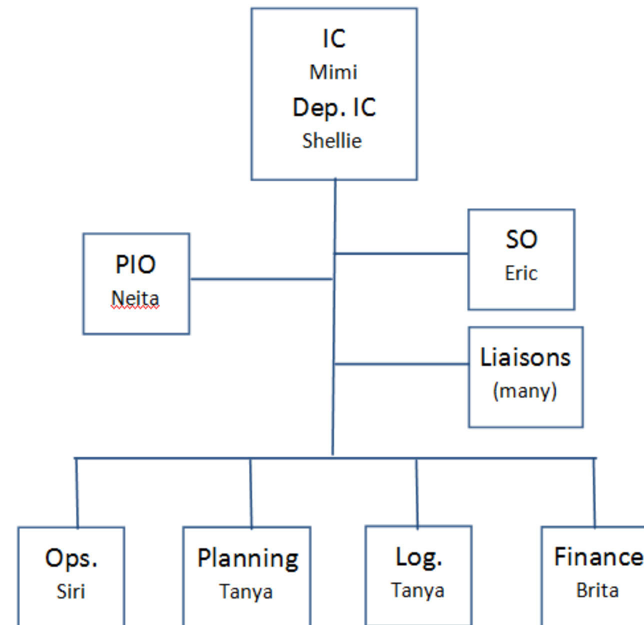
Oregon was expecting as many as 1 million visitors for the solar eclipse week-end!

- ❑Participated in preparedness meetings with response partners; LE, EMS, EM, etc.
- ❑Media sub-committee, including creating a preparedness flyer for local residents, and a flyer for visitors
- ❑Set-up a first-aid/triage center in Maupin with 4 SERV-OR medical volunteers
- ❑3 ALS ambulances with crews stationed in South County

PH AS A PRIMARY AGENCY - COVID-19

COVID-19 PANDEMIC – PHEP COORDINATOR ROLES

- **Incident Command**
  - Planning Section Chief
  - Liaison to EM's
  - Assist & back up to; PIO, Logistics, vaccine POD Operations, etc.
  - AAR team member
- **Coordinate MRC Volunteers**
  - Onboarding/credentialing/training
  - Weekly schedules for PODs
  - Tracking, etc.
- **Fit Testing**
  - Staff Annually
  - Community Partners – guidance/training/ assistance



MEDICAL RESERVE CORPS (MRC)

- Following the attacks on 9/11/2001, more than 40,000 volunteers arrived at the scene wanting to help, but they were not trained or credentialed, so they had to be turned away
- The Medical Reserve Corps (MRC) was created to provide the necessary infrastructure for volunteers to be a part of a cohesive disaster relief effort
- The mission of the MRC is to improve the health & safety of communities across the Country by organizing and utilizing public health, medical, and supporting volunteers
- MRC's are community-based and can address a wide range of community needs
- Wasco Co. MRC was formed in 2011

WASCO CO. MRC PROJECTS

Annual Blanket Drive

- For 9 years in a row, we were able to donate over 100 blankets, as well as coats, hats, gloves and socks to The Warming Place in The Dalles
- Other recipients have included, Sherman & Gilliam Co. EM's, and HAVEN
- In 2022 we transitioned to a coat drive based on a need addressed by MCCAC

WASCO CO. MRC PROJECTS

- With a NACCHO grant, we implemented a walk-to-school program at participating grade schools.
- MRC volunteers chaperoned the kids to school on the first Wed. of each month.
- Through this program we encouraged walking as a part of a healthy lifestyle for all; Students & Chaperones, as well as teachers, parents, grandparents, and the whole community.

WASCO CO. MRC PROJECTS

Infection Prevention with Henry The Hand!

- Through a SERV-OR mini-grant we were able to fund a Champion Handwasher booth at children's fairs in Wasco, Sherman, and Gilliam Counties.
- Our goal was to teach kids the importance of routine hand washing in an effort to stop the spread of infectious disease.

WASCO CO. MRC PROJECTS

First-Aid Tent Project

- Through a State Homeland Security Grant, we were able to purchase an inflatable tent & accessories, trailer, first-aid supplies, and first-aid training

- Planned to provide first-aid at local events like walk/runs as a way to train the group to be prepared to assist with response should a disaster overwhelm our medical community

WASCO CO. MRC - COVID-19 PANDEMIC

I don't know what we would have done without them! ♥

WASCO CO MRC – POST PANDEMIC

Working to:

- Re-engage volunteers
- Extend the reach of the MRC in Region 6

We have always accepted volunteers from all around our region:

- During COVID we learned that we do not have the capacity to oversee the deployment of volunteers in more than the counties that we serve
- This FY year we will work with preparedness partners interested in determining the best way to extend the reach of the MRC in our region

PHEP WORK IN PROGRESS

Build/rebuild relationships with response partners

- Many new agencies/CBO's
- Many new people in existing roles
- Newer staff members at NCPHD, as well

Healthcare Coalition (HCC) & subcommittees

- Continue regular meetings/ check-ins with ESF8 partners
- Reconvene LTCF subcommittee
- Decedent trailer-housed at MCMC
- Extend reach of MRC (regionally)

Update all NCPHD plans

- General updates completed in a few plans
- Upcoming Foodborne Outbreak exercise may inform additional updates to EH plan
- COVID-19 gap matrix/improvement plan (from AAR) will inform update of Mass Prophy Plan
- May hire contractor to make all plans concise & uniform

Education/training opportunities

- Matt is trained to provide Stop the Bleed, and First-Aid/CPR training! Training for NCPHD staff, MRC volunteers, public
- Do1thing project monthly at staff meeting
- Public Info/Education – PSA's, website, social media
- Additional trainings as known/available

Modernization work

- PHEP is a foundational capability
- Area 51 (PHEP, EH & CD staff) meet monthly
- Foodborne outbreak exercise

Response

- COVID-19 recovery – post pandemic
- 2023 wildfire season
- Hopefully no other responses needed! ☺

Personal Preparedness

- ❑ Be Informed
  (About what might happen in your area)
- ❑ Build A Kit
  (Of emergency supplies)
- ❑ Make A Plan
  (For what you will do in an emergency)
- ❑ Get Involved
  (In preparing your community)

GET ✓ READY
THE DALLES

Held Sept. 16, 2023 (Nat. Preparedness Month)
Hope to enhance this event for 2024!

Link: Emergency Preparedness for Individuals - Emergency Preparedness (do1thing.com)

https://www.ready.gov/

Oregon Health Authority : Preparedness Tools for Oregonians : Get Prepared : State of Oregon

QUESTIONS

PHEP Coordinator
Matt Johnston
mattj@ncphd.org

Community Outreach Programs Supervisor
Tanya Wray
tanyaw@ncphd.org

AFTER ACTION REPORT

COVID-19 RESPONSE

Public Health
Prevent. Promote. Protect.
NORTH CENTRAL PUBLIC HEALTH DISTRICT

An After Action Review of

North Central Public Health District

Serving Wasco, Sherman, and Gilliam Counties

TABLE OF CONTENTS

Executive Summary.....2

Background on Emergency.....10

Scope and Objective of Review.....13

Methods.....14

Findings.....16

- Surveillance.....16
- Emergency Response/Coordination.....18
- Infection Prevention and Control/Countermeasures.....22
- Communication/Community Engagement.....27
- Internal Organization.....30

Conclusions.....33

Annexes.....37

- Improvement Matrix.....38
- Acronyms and Terms.....51
- Map of Jurisdiction.....53
- Staff Wellbeing.....54
- Health Equity.....64
- Timeline.....67
- Acknowledgements.....71
- AAR Team.....72

1. EXECUTIVE SUMMARY

Situation

In December of 2019, the earliest cases of Coronavirus Disease 2019 (COVID-19) were detected by health authorities in Wuhan, China. Initial COVID-19 cases were categorized as a form of atypical pneumonia until the virus was later identified as Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), a novel form of SARS-CoV. In January of 2020, the first case of COVID-19 on United States (U.S.) soil was identified in the state of Washington. COVID-19 rapidly spread throughout the U.S. in the following months, with the Oregon Health Authority (OHA) confirming Oregon's first case in February of 2020. On March 13th, 2020, President Donald Trump declared the COVID-19 outbreak a national emergency; there were 491 positive cases at the time. Over the past two and a half years, COVID-19 has continued to mutate and move across the world causing death, serious long-term illness, business and school closures, layoffs, and much more. As of the writing of this report (June 2022), an estimated 86.7 million U.S. citizens have been diagnosed with COVID-19 at some point during the pandemic, and 1.01 million U.S. citizens have died as a result of COVID-19. UPDATE: May 11, 2023 marked the end of the National Public Health Emergency Declaration.

Assessment

Although the pandemic is still actively affecting the lives of many people and periodically surging, health departments across the country have begun generating After Action Reports (AARs) in order to review and analyze their organization's response to COVID-19. An AAR seeks to identify the specific successes and challenges experienced by an organization during an emergency, event, or exercise. Following an in-depth review of the entity's response, key takeaways and recommendations can then be generated with the goal of better preparing the organization for future emergencies or drills. The purpose of an AAR is not to place blame or fault on individuals, but rather to examine the structures and policies

of an organization as a whole. Therefore, a strong commitment to non-attribution is established among all participants in the AAR process in order to lessen any feelings of blame or condemnation that may naturally arise.

This AAR will analyze North Central Public Health District's (NCPHD) response to the COVID-19 pandemic based on a series of key informant interviews and hot wash (Google form) surveys given to NCPHD staff members and community partners. Information gathered from interviews and hot washes will be organized into one of five categories or "pillars": Surveillance, Emergency Response/Coordination, Infection Prevention and Control/Countermeasures, Communication and Community Engagement, and Internal Organization. This AAR will then review the best practices, challenges, and recommendations identified for each pillar. In organizing feedback in this format, the AAR team has attempted to create a clear understanding of what methods and implementations were successful in the pandemic response, and what concrete steps can be taken to remedy the issues and challenges identified by staff and community partners.

Summary of Findings

After analyzing the responses gathered through key informant interviews and hot wash forms, the AAR team was able to identify common themes of best practices, challenges, and recommendations for each pillar. Many staff members and community partners reported experiencing similar issues throughout the pandemic, while also praising similar successes. The most common themes for each pillar were elaborated upon in the body of the AAR, while less common themes were organized into the improvement matrix (Annex 1).

I. Surveillance

Regarding surveillance, most participants identified NCPHD's COVID-19 testing as a strong success. Participants reported that NCPHD's COVID-19 testing provided a convenient way for clients to get tested quickly and efficiently, as well as being an effective way to

spread information about how to properly isolate and quarantine. Another positive result of COVID-19 testing was that it provided NCPHD with data regarding clients' infection status and demographic information, which aided in case reporting to the OHA (Oregon Health Authority). Contact tracing was identified as both a success and a challenge; while it was another effective way to communicate important COVID-19 related information, it was also regarded as inefficient, extremely labor intensive, and questionably effective at preventing or reducing the spread of COVID-19. Other surveillance challenges included having to use the inefficient At Risk Identification Alerting System (ARIAS), experiencing difficulty maintaining surveillance during surges, and keeping up to date with constantly changing COVID-19 guidelines.

II. Emergency Response/Coordination

Participants reported that some of the best practices related to emergency response/coordination were centered around the coordination and management of the Medical Reserve Corps (MRC) volunteers. Particularly of note was having a consistent and knowledgeable group of MRC volunteers working at the vaccine clinics, and the utilization of MRC volunteers to aid with COVID-19 testing during surges in the pandemic. Another success was the strengthening of relationships among NCPHD and community partners; weekly meetings brought together many different community based organizations and medical facilities in order to continually provide updates, identify needs, and coordinate emergency response tactics. The activation of Unified Command also helped bring together key leaders from Wasco, Sherman, and Gilliam Counties, as well as other community partners such as Mid-Columbia Fire and Rescue. The creation of Unified Command further established positive relationships among certain community partners, and implemented a standardized framework for the emergency response. Over time however, some community partners made the decision to no longer participate in Unified Command, which in some cases contributed to a strained partnership with NCPHD. Other challenges in emergency

response/coordination included confusion regarding role expectations for community partners, missteps in coordination and communication between NCPHD and other entities, and the lack of direct internal liaisons to providers.

III. Infection Prevention and Control/Countermeasures

When asked about NCPHD's role in infection prevention and control/countermeasures throughout the pandemic, interviewees and responders had largely positive reactions. NCPHD's mass vaccination clinics/Point of Distributions (PODs) were highly praised for their organization, safe environment, efficiency, and continual improvement over the course of the pandemic. Participants also lauded NCPHD for making COVID-19 vaccinations as accessible as possible; NCPHD consistently hosted vaccine clinics in all three counties within its jurisdiction, and set up PODs in high traffic areas such as schools, churches, and downtown. However, the mass vaccination clinics also came with many complex issues, such as keeping staff and volunteers up to date on constantly evolving information, distributing multiple vaccines (with multiple lot numbers and multiple doses), and managing the allotted vaccine supply given from the state, especially during the initial rollouts when there was high demand. Another significant challenge was related to NCPHD's implementation and enforcement of preventative guidelines. While some organizations (businesses, schools, workplaces, etc.) were willing to comply with the OHA mandated policies, others refused to comply and/or consistently violated the policies. A few organizations continually voiced their displeasure about these policies with NCPHD staff, which took a mental and emotional toll on those responding to disgruntled and angry clients on a semi-regular to regular basis.

IV. *Communication/Community Engagement*

Communication and community engagement were essential tools for conveying accurate and up to date information regarding COVID-19, as well as promoting awareness

and advocating for the benefits of COVID-19 vaccinations. AAR participants reported that NCPHD staff worked diligently to identify vulnerable populations in order to ensure all community members received important COVID-19 updates, including those from traditionally underserved/underreached communities. In an effort to reach people of all backgrounds and identities, NCPHD used an incredibly wide variety of communication methods, including but not limited to print media, radio spots, internet pop-ups, websites, and road signs. Another frequently mentioned success were the strong relationships NCPHD built and/or maintained during the pandemic with established community partners. Organizations such as the Community Meals Program and the Sherman County Medical Clinic have pre-existing connections to community members, and NCPHD worked hard to leverage these relationships in order to spread up to date information about COVID-19 and vaccinations through trusted sources. Challenges regarding communication and community engagement came primarily in the form of working with community members who were extremely vaccine hesitant. Participants noted that there was a small, yet very vocal minority of community members who responded to almost all public services announcements regarding COVID-19 with misinformation or significant pushback. While NCPHD attempted to reply to these comments with accurate information, the sheer amount of misinformation being spread made it difficult to reply to every commenter. Participants also noted that it was difficult to reach communities that NCPHD did not have established relationships with prior to the pandemic; these gaps in communication were then exacerbated as a result of COVID-19. Finally, a major challenge for NCPHD was the absence of a process to gauge whether messaging approaches were effective. While a myriad of communication methods were used in NCPHD's response to the pandemic, the results of their effectiveness is unknown.

V. Internal Organization

The Internal Organization "finding" was created out of the AAR team's desire to include best practices, challenges, and recommendations that centered primarily around

NCPHD's internal functions. These functions include processes, policies, and communication procedures that were established both prior to and during the pandemic. Participants noted NCPHD's success in continuing to provide many essential public health services during the pandemic, as well as its ability to prioritize which services were most needed at the time. NCPHD was also praised for creating a healthy, and supportive work environment for staff. The primary challenges pertaining to internal organization were role clarity, communication, and burnout. Many participants reported struggling to understand what exactly was expected of them and other co-workers in relation to the COVID-19 response. Participants also described experiencing gaps in communication among departments and difficulty accessing experts within NCPHD who possessed critical and up to date COVID-19 information. Lastly, as a result of working at one of the epicenters of the local COVID-19 response, many staff expressed feeling constantly burnt out and left without adequate tools to combat their mental, emotional—and occasionally—physical exhaustion.

Recommendations

After a thorough examination of interview responses and hotwash forms, the AAR Team compiled lists of recommendations from participants on how to improve the identified issues in NCPHD's response to the pandemic. A broad analysis of the most common recommendations for each pillar is included in its respective "Finding" report, while a comprehensive list of every recommendation made during the AAR process can be found in the Improvement Matrix annex. Below is a summarized account of the primary recommendations for each pillar.

I. Surveillance

- Create designated "teams" or "sections" in order to better allot surveillance-related work
- Stockpile COVID-19 testing equipment when possible to account for surges and/or slow production from test kit companies

- Prepare for potential outbreaks as soon as possible (set up appropriate lines of communication, establish staff responsibility for outbreak surveillance, consolidate necessary COVID-19 information, etc.)

II. *Emergency Response/Coordination*

- Response-related meetings with CBOs should continue to maintain relationships and communication
- Update, streamline, and revise emergency response plans
- Research volunteer management systems that might better facilitate the management of volunteer schedules/trainings/licensures/etc.
- Create a training course or module to help NCPHD staff better understand the expectations of volunteers
- Educate community partners about the duties and goals Unified Command
- Work with community partners to establish more isolation/quarantine services that do not involve NCPHD

III. *Infection Prevention and Control/Countermeasures*

- Continue to promote and encourage COVID-19 standard sanitation
- Encourage businesses and schools to keep masks available at their entrances

IV. *Communication/Community Engagement*

- Strive to form relationships with the faith-based communities
- Actively keep channels of communication open with community partners and Community Based Organizations (CBOs)
- Educate the public that information, guidelines, and policies are likely to change, especially when the public health emergency is novel and recommendations continuously update
- Hire an in-house Canva/Photoshop specialist or graphic designer
- Use clear and concise language in all communication methods

V. *Internal Organization*

- Create a better on-boarding system/process for new employees
- Create a work group or task force that puts together a “pandemic playbook”
- Continue to work with Wasco and Sherman Counties to allot appropriate funding for public health needs
- Train more staff in preventative and preparedness work

- Continue to provide education and resources to combat the pandemic
- Hire a consultant to aid in the updating of current systems/processes/plans

Conclusion

COVID-19 has been one of the largest threats to public health and safety in the 21st century, spreading to almost every corner of the world and leaving extreme destruction in its wake. Although COVID-19 outbreaks continue, an initial review of NCPHD's pandemic response is being performed in order to make recommendations where issues have been identified. The goal of this report is to recognize what changes should be made within the organization to make continued improvements to emergency response plans, and to identify the successes and best practices NCPHD implemented in the fight against COVID-19.

GLOBAL PANDEMIC KEY MILESTONES	DATES (AS REPORTED BY THE WHO)
Date of start of outbreak or event	Dec. 12th, 2019
Date of detection of outbreak or event	Dec. 31st, 2019
Date of notification of outbreak or event	Jan. 5th, 2020
Date of verification of outbreak event	Jan. 7th, 2020
Date of laboratory confirmation	Jan. 7th, 2020
Date of outbreak or event intervention	Jan. 7th, 2020
Date of public communication	Jan. 10th, 2020
Date outbreak or event declared over	May 11, 2023

2. BACKGROUND ON EMERGENCY

"Beginning in late 2019, cases of an unidentified atypical pneumonia began surfacing in Wuhan, China. Given the name SARS-CoV-2, the virus that causes the disease that would become known as COVID-19, began spreading beyond the borders of China. The first identified occurrence of SARS-CoV-2 on American soil was on 1/20/2020 in Washington State" (NCPHD, 2022)[1]. This virus was posed to be a major public health threat and thus, the World Health Organization declared COVID-19 as a pandemic on 03/11/2020 and then U.S. President Donald Trump declared a nationwide emergency on 03/13/2020. Similarly, many state and local health authorities in the United States recognized the severity of the issue and declared similar states of emergency. Wasco County declared a state of emergency on 03/16/2020, Gilliam County on 03/18/2020, and Sherman County on 03/20/2020. Eventually, after changing extensions to the Oregon state of emergency, Governor Kate Brown ended the emergency declaration on April 1, 2022. It is important to note that during this timeline full Emergency Operations Center (EOC) activation began on 03/20/2020 at 1800 hours and that Wasco County Unified Command (UC) worked in partnership with Gilliam and Sherman Counties (NCPHD, 2022). Furthermore, NCPHD was one of the lead agencies in UC from March 20, 2020 to November 4, 2020. On November 4, UC ended and NCPHD began internal Incident Command (NCPHD, 2022).

Because of the scope and circulation of the pandemic, countless individuals and their quality of life were affected. In fact, according to the Oregon COVID-19 Testing and Outcomes by County Summary Table generated by the Oregon Health Authority (OHA) using Tableau software, there are 5,597 cumulative reported case counts of COVID-19 for Wasco County, 332 cumulative reported case counts of COVID-19 for Sherman County, and 288 cumulative reported case counts of COVID-19 for Gilliam County. The COVID-19 case

[1] North Central Public Health District, "NCPHD COVID-19 Situation Report #57"

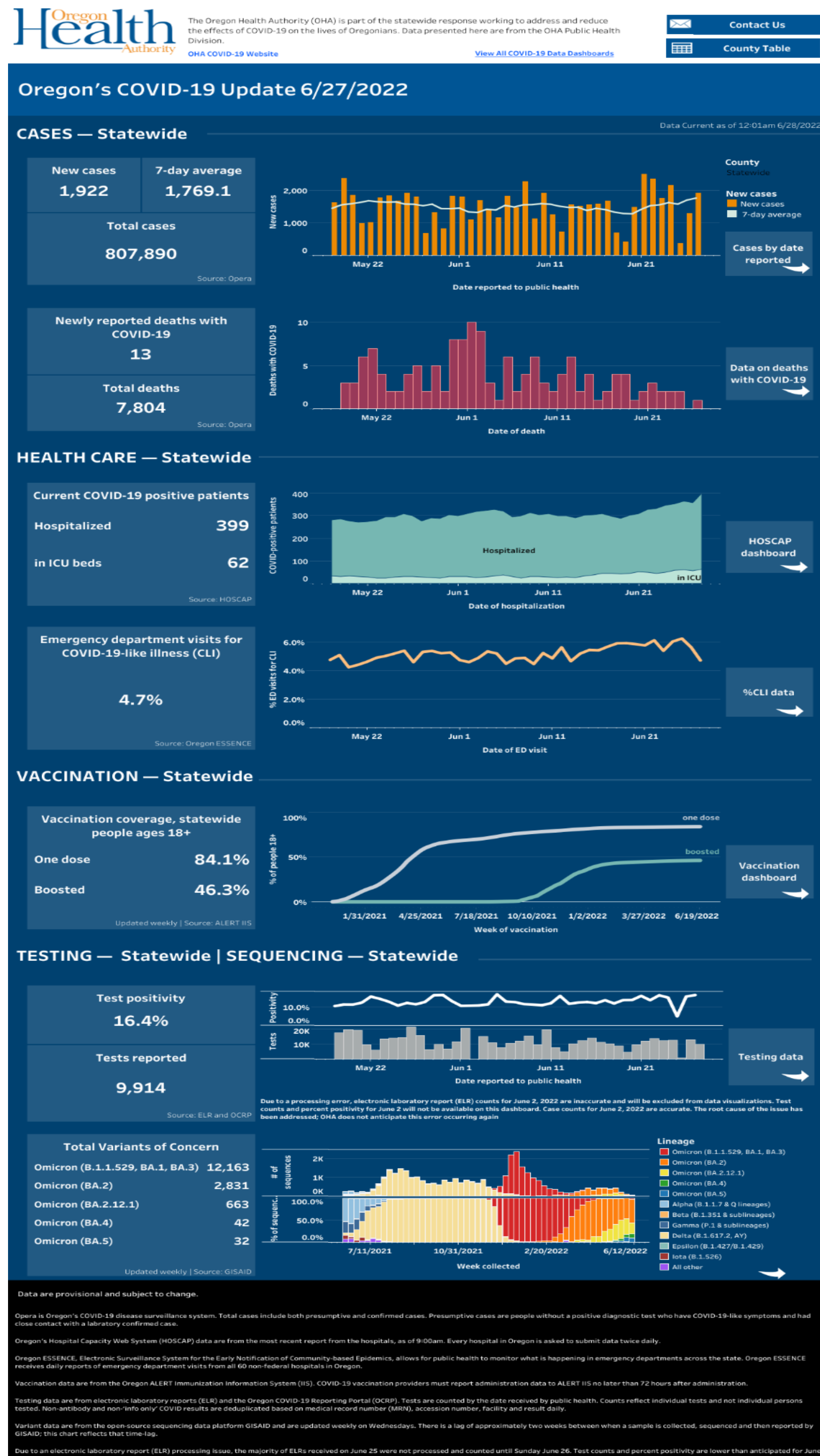
rates per 100,000 people are also shown to be 20,505.6 per 100,000 people for Wasco County, 14,472.4 per 100,000 people for Gilliam County, and 18,495.8 per 100,000 people for Sherman County. There are also 63 reported deaths and 239 hospitalizations related to COVID-19 for Wasco County, 6 deaths and 22 hospitalizations related to COVID-19 for Sherman County, and 6 deaths and 21 hospitalizations related to COVID-19 for Gilliam County as shown from the COVID-19 County Dashboard listed for Oregon Pandemic Emergency Response Application (OPERA) users. In regards to statewide statistics, there are more than 798,000 cumulative COVID-19 cases, 7,744 reported COVID-19 related deaths, and 31,994 COVID-19 related hospitalizations. All of these statistics mentioned are reported and up to date as of 06/29/2022.

Furthermore, COVID-19 is a communicable disease required to be reported under the Oregon disease reporting requirements. Health care providers are required to report "all cases or suspected cases of disease" and licensed laboratories are required to report "all test results indicative of the disease" (OHA, 2022)[2]. These reports can be submitted directly to the local health authority (such as NCPHD) or through an online and secure reporting system called the Oregon COVID-19 Reporting Portal (OCRP) which reaches both OHA and the Local Public Health Authority (LPHA). The full sets of rules and regulations regarding reporting can be found in the Oregon Health Authority Public Health Division - Chapter 333 from the Oregon Administrative Rules. These submitted reports come in the form of electronic laboratory reports (ELRs) or electronic case reports (ECRs) which are then managed in OPERA that is used by both LPHAs and OHA.

[2] Oregon Health Authority, "Oregon Disease Reporting Requirements",https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/REPORTINGCOMMUNICABLEDISEASE/Pages/reportable.aspx

Graphs and Figures

Figure 1: Oregon's COVID-19 Update 06/27/2022[3]



[3] OHA COVID-19 Data Dashboard (includes relevant statistics on statewide numbers)

3. SCOPE AND OBJECTIVE OF REVIEW

The COVID-19 pandemic has been an unprecedented emergency for NCPHD. While emergency response plans existed and were utilized, some of the response was improvised. Evaluation is necessary after all responses to analyze whether the existing emergency response plans were effective and useful as well as looking at the adaptations staff made in the midst of the incident to see if they could be implemented better or carried over in a future incident.

The overall objective of this AAR is to identify strengths, weaknesses, areas of improvement and then to provide recommendations on how response capacity could be improved. Other objectives include establishing a timeline of events and milestones of the response, evaluating health equity efforts, and examining NCPHD's staff wellbeing. This is a stand-alone report.

Five "pillars" have been established to categorize our findings based on functional areas. These pillars include:

- Surveillance
- Emergency Response/Coordination
- Infection Prevention and Control/Countermeasures
- Communication/Community Engagement
- Internal Organization

Trigger questions were formulated and based upon these pillars.

4. METHODS

We chose to employ the standardized World Health Organization (WHO) framework for AARs, thus this AAR was driven by the WHO Key Informant Interview Toolkit. As such, the methodology we used was the Key Informant Interview approach for AARs. We utilized interviews of key players in the response as well as hot washes (google forms) in order to get feedback from as many staff members and partners as possible. The interviews used adapted WHO trigger questions and employed root cause analysis to analyze the fundamental causes of identified gaps.

Key informant interviews often involved “screening interviews" prior to the formal interview with the intent of establishing the interviewee’s responsibilities and notifying them of the information we were requesting. Interviews would typically take 1-2 hours, usually in two sessions:

- Key informant interviews conducted: 8

Two hot wash forms were created, one for NCPHD staff and one for community partners:

- NCPHD Hot Wash Responses: 18
- Community Partner Responses: 8

Participating organizations included:

- NCPHD
- Wasco County
- South Wasco County School District
- Wasco County Medical Reserve Corps
- The Springs at Mill Creek
- Sherman County Emergency Management
- Columbia Gorge Health Council
- Oregon Veterans Home

Reader's Note

Please note that observations came from the perspective of individuals, who each had their own perspective and biases on the events of the response. Answers occasionally contradict each other or, sometimes, are simply misinformed. Please read with grace and understanding that none of us, at any time, had the full picture of what was going on. Lastly, not all comments were able to be incorporated due to space constraints. Thank you.

5. FINDINGS

5.1 Surveillance

Disease Surveillance has been a critical part of the COVID-19 response since before cases even emerged in our region. Surveillance encompasses strategies such as testing, contact tracing, case investigations, and reporting systems. This section will examine the strategies that worked well and the challenges that were encountered by staff responsible for COVID surveillance.

Best Practices

In terms of best practices and successes, the feedback received from the hotwash forms submitted by NCPHD staff were limited on the topic of surveillance as most of the feedback was centered on other findings. However, one of the common themes was that case investigation and contact tracing were effective surveillance tools in conveying COVID-19 information on transmission and prevention to individuals who tested positive for COVID-19, or who were exposed to COVID-19. For example, one of the hotwash responses stated that case investigation allowed the COVID team to give positive reinforcement to individuals who may have been fearful about the ambiguity of the virus. Another important and commonly identified best practice was that NCPHD's COVID-19 testing services were offered in a timely and accessible manner. These responses centered on the fact that drive-through testing was offered on same-day or next day availability and that the at-home test kits were in popular demand by the community and distributed widely across the jurisdiction.

Challenges/Recommendations

The challenges facing surveillance were emphasized heavily relative to the successes. For example, one of the issues noted was that tracking COVID cases at the beginning of the pandemic response was unorganized since OHA did not have a surveillance system that was as comprehensive or developed as it would eventually become. Another comment stated that the lack of a secure email setup at NCPHD didn't allow for transmitting secure patient data, placing an undue burden on communication for surveillance purposes. There was also the common theme of how changing guidance made surveillance difficult because new and developing guidelines on masking, indoor capacity, and COVID-19 information caused credibility issues and frustration from the public. Many participants reported that contact tracing and case investigation had multiple drawbacks, which differs from the previous section of best practices. For example, there was a comment stating that ARIAS (At Risk Identification Alerting System) was an ineffective system for contact tracing and not a sufficient use of time. Contact tracing was further elaborated to be ineffective in school settings since it was stated to be a drain on staff time and resources, and that there wasn't conclusive data that the intervention was successful. Other drawbacks for contact tracing and case investigation mentioned centered on data collection and how privacy, reluctance to answer questions, sensitive demographic information, and COVID-19 surges made it cumbersome. Specifically regarding surges, the problems of case overload for case investigation/contact tracing timeliness and lack of testing resources during these times were emphasized.

The volume and breadth of recommendations mentioned were limited for this portion of the surveillance findings when compared to the challenges portion of the surveillance findings. However, they still highlight some important takeaways and opportunities for action. For example, these recommendations included ideas of building stronger relationships with facilities/partners for reporting of disease in a timely manner, stockpiling COVID-19

resources such as at-home test kits to ensure accessibility during COVID-19 surges, and preparing for potential outbreaks as soon as possible.

5.2 Emergency Response/Coordination

Emergency Response/Coordination is referring to both the public health emergency preparedness roles in responding to COVID-19 and the coordination between NCPHD and community response partners.

NCPHD found many successes within its Incident Command (IC) framework. Unified Command (UC), established at the beginning of the response, was an effective way to communicate key information between agencies and coordinate interventions. At an appropriate time in the response, NCPHD moved to agency IC, while still maintaining coordination with partners. Respondents mentioned that section chiefs were effective within the IC system and also stated that previous experience with IC was useful practice for this response. Deployment of a consistent group of Medical Reserve Corps (MRC) volunteers was also a common success mentioned, especially at vaccine PODs, and at testing sites. Existing, as well as new relationships between emergency response partners and NCPHD staff were strengthened and built throughout the COVID response, while role clarity was sometimes an issue.

As with most emergency response efforts, challenges were often remedied during the response and best practices were discovered. Summarized below are recurring emergency response/coordination challenges, best practices, and recommendations mentioned by respondents. Gaps and recommendations for improvement will be listed in the improvement matrix.

Best Practices

Establishing Unified Command early in the response proved to be a good decision. Many relationships with emergency response agencies/partners were made stronger through this structure and many tasks were accomplished through the coordination of the lead agencies and supporting partners. The UC meetings and Incident Action Plans (IAPs) were a good answer to how to communicate and disseminate information to all partners. Section Chiefs were responsible for their section and kept things efficient and effective. The transition to NCPHD IC was smooth and the IC framework was consistent and useful. In particular, those with previous IC experience (whether from previous emergencies or exercises) were helpful in keeping things running smoothly. Respondents also mentioned that any previous experience and/or training they had, as well as emergency response plans that were already in place, were helpful in their role in this response, especially in setting up and running the PODs.

Previous relationships with emergency response partners were noted as a success, as well as the successful formation and/or strengthening of these relationships throughout the response. The PHEP Coordinator's relationship with Emergency Managers and other response partners, for example, was well established and proved helpful in this response. Other relationships between NCPHD staff and partners, like Mid Columbia Medical Center and others from the medical community were equally as valuable. Having the Agriculture branch during UC was also noted as a best practice, as that coordination with community partners proved successful in coordinating and serving the Migrant and Seasonal Farm Worker (MSFW) population. Sufficient financial support from state and federal partners was also mentioned as a success, and assistance from OHA staff when needed, should not go unrecognized.

The utilization of Wasco Co. MRC volunteers were often mentioned as a success or best practice. Having a volunteer structure in place was a big win, and the use of these

volunteers was consistent and organized, and helped make it possible for NCPHD to have efficient vaccination PODs with large and consistent throughput of patients. They were also utilized to support COVID-19 testing and allowed NCPHD to expand the time frame that people could sign up to be tested. MRC volunteers were also trained, later in the response, to assist NCPHD staff with weekend wrap-around services, but were not utilized. Community partner volunteers (made up of staff from community partner agencies) also filled gaps at PODs when not all positions at a POD could be filled with MRC volunteers.

Other best practices mentioned were; the safe and appropriate location of the main PODs (Readiness Center), the efficiency, dedication and comradery of NCPHD staff in meeting all the needs throughout this response, and the ability to provide Long Term Care Facilities (LTCFs), churches, businesses, local events, etc. with PPE.

Challenges

One of the challenges NCPHD faced in the realm of emergency response/coordination was related to role clarity between organizations. For example, there were many instances of confusion over not knowing which organization was responsible for paying for a certain item or service. Similarly, staff reported difficulties around coordination with community partners when there was turnover of the main point of contact. The glue that held the coordination effort together during the pandemic was the relationships between staff members and individuals at community partner organizations, rather than the organizations themselves.

There was an expectation for NCPHD staff that wrap-around services would continue during weekends. This placed a lot of strain on staff. A solution that NCPHD attempted was bringing in community partners to help share the load on weekends; however, these efforts fell through and the partners were generally unable to provide support. Vulnerable

populations were likely underserved and better wrap-around services needed to be established.

It was difficult for some emergency response partners to participate in Unified Command. The time commitment during such a busy time was a challenge for some partners including behavioral health partners and some clinics. For others, not understanding the Incident Command/Unified Command structure and meeting schedule was an issue. In the initial set-up of Unified Command, Sherman and Gilliam Co. struggled a bit with how to best participate in the Unified Command Structure, and some felt that the pandemic might not affect the more remote counties as much. Respondents expressed that the pandemic may have further strained the relationship between NCPHD and Gilliam Co.

Managing volunteers, especially in the beginning of the response, was challenging. Although Wasco Co. MRC was already established, many of those volunteering for the COVID response were new volunteers needing to meet a number of onboarding requirements (training, background check, etc.) and deploying volunteers for a response also requires additional protocols be in place prior to deploying volunteers for service. With a large influx of interest in volunteering, there was a lot of work to be done as we worked to determine which volunteers would complete the necessary training and paperwork. Scheduling volunteers, especially in an ever changing environment, was also not without its challenges and likely could have been more efficient with the use of a volunteer management system.

Understanding IC and emergency management roles was noted as a challenge for some, as was keeping track of who was assigned which task, where the task was in the process, knowing where to report out, etc. Other challenges mentioned were the need for a direct internal liaison to providers, uncertainty of which partners needed to be kept in the loop, and the ability to staff-up quickly when needed so as not to overburden existing staff.

Recommendations

A common recommendation noted was to hire a consultant to update our emergency response plans, implementing any recommendations from this AAR and/or other updates needed. Many of our plans have not been updated for a number of years and are in need of revision. There were several recommendations around volunteer management. First, a better volunteer management system would streamline deployment and ease the burden on PHEP staff to coordinate volunteers. Also, NCPHD staff should understand the role of volunteers and what is expected of them for a particular response or task. In terms of coordination, many staff echoed the need for better isolation/quarantine services that are NOT directly run by NCPHD. Staff involved with direct patient care expressed that there should be a better system for the transportation of isolation/quarantine patients, if NCPHD were to continue to be responsible for this. For the sake of staff safety and comfort, we should have a dedicated isolation vehicle that is properly equipped and spacious enough to safely hold patients. Other recommendations included continuing existing meetings and workgroups that began during the pandemic to build more trust and cooperation between organizations, and continuing to learn/understand ICS. Also, while Annex C provided sufficient PPE storage for this response, a plan for future storage capabilities should be addressed. Ideally this would be in the same location where drive-up PODs could occur.

5.3 Infection Prevention and Control/Countermeasures

Infection prevention and control/countermeasures were a critical part of North Central Public Health District (NCPHD)'s response to the COVID-19 pandemic. This finding reviewed what measures NCPHD implemented throughout the pandemic in order to slow, minimize, and prevent the spread of COVID-19 throughout Wasco, Sherman, and Gilliam Counties. With guidance from the Oregon Health Authority (OHA), NCPHD aided in the implementation

and enforcement of preventative guidelines such as masking, social distancing, and sanitation policies within the community. NCPHD also organized points of dispensing (PODs) from which to give community members COVID-19 vaccines once they were authorized, in December of 2020. This finding will detail the successes and challenges NCPHD faced while implementing infection prevention and control/countermeasures throughout the pandemic. Following this analysis, recommendations and suggestions for improvement will be included in order to best advise what concrete steps should be taken in order resolve the identified issues.

Best Practices

One of NCPHD's most commonly mentioned success throughout all interviews and hotwash forms was its mass vaccination clinics/PODs. While these clinics took collaborative effort from staff in all departments, their main purpose was to distribute vaccines to as many community members as possible, and have therefore been included as an infection prevention and control/countermeasure. Participants praised staff's ability to quickly transform plans for the mass vaccination clinic into a reality, with little time in between their conception and implementation. Some respondents mentioned that having existing plans for the PODs as a part of the emergency response/coordination efforts were integral to setting up the successful vaccine clinics, as the plans provided an initial "blueprint" for how the clinics should function. Participants also mentioned that the location of the early mass vaccination clinics (in reference to The Dalles Readiness Center) was almost ideal due to its capacity. The size of The Dalles Readiness Center allowed for social distancing guidelines to be followed while also providing vaccines to a large number of people at once, resulting in a considerable throughput of patients (the largest mass vaccination clinics saw over 400 patients during their operating hours). Staff working at the mass vaccination clinics also detailed the "behind the scenes" successes that helped them achieve their smooth operation and high throughput. These included weekly meetings focused on process improvement,

debriefings with multiple departments within NCPHD to encourage internal communication, continual utilization of Medical Reserve Corp (MRC) volunteers, and developing waitlists to avoid vaccine waste.

NCPHD was also lauded for their PODs set up outside of the Readiness Center, such as those in Sherman and Gilliam counties, the schools, and downtown The Dalles. Staff working at the vaccine clinics stated that their goal was to make the vaccines as "accessible as humanly possible," and prioritized eliminating as many barriers as they could in terms of distribution. This included creating a new website specifically for COVID-19 vaccine scheduling to reduce the call burden on staff and allow making an appointment to be quick and private. NCPHD staff also set up vaccination clinics in well-known and/or highly frequented areas such as fairgrounds, schools, and in downtown areas, in addition to the larger clinics taking place at the Readiness Center. The result of these efforts can be seen within the community, as NCPHD was responsible for distributing 20,477 doses of COVID vaccine in February of 2022. Presently, Wasco County has a "fully vaccinated" rate of 68.51%, just under Oregon State's fully vaccinated rate of 70.80%[4]. However, Wasco County has a Republican majority, and in September of 2021 there was a 12.9 percentage point difference in vaccination rates between majority Democratic voting counties (52.8%) and majority Republican voting counties (39.9%)[5]. Wasco County's vaccination rate has surpassed its rate of Republican voters, which can perhaps in part be attributed to NCPHD's efforts to successfully plan and implement vaccine clinics.

Regarding infection control methods, participants believed NCPHD succeeded in building strong partnerships with the Shilo Inn and the Oregon Motor Motel. During the pandemic, houseless and unsheltered patients who tested positive for COVID-19 were put up in the Shilo Inn or the Oregon Motor Motel by NCPHD until their infectious period was

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[4] Springfield News-Leader, "Oregon COVID-19 Vaccine Tracker," https://data.news-leader.com/COVID-19-vaccine-tracker/oregon/41/

[5] Kates, Jennifer, Jennifer Tolbert, Kendal Ortega, "The Red/Blue Divide in COVID-19 Vaccination Rates," https://www.kff.org/policy-watch/the-red-blue-divide-in-COVID-19-vaccination-rates/

over. In doing this, houseless and unsheltered patients were able to isolate themselves safely away from others, particularly during the winter months when they normally (pre-pandemic) would have stayed in a warming shelter or congregate living facility. As a result, NCPHD was able to better limit/control COVID-19 spread between the positive patient and other potential contacts.

Challenges

Before COVID-19 vaccines had been developed and approved, the first challenge faced by NCPHD in relation to infection prevention and control/countermeasures was implementing and enforcing preventative guidelines. These guidelines were developed and issued by the OHA, and included policies on masking, social distancing, and hygiene practices. NCPHD would communicate with organizations such as businesses, workplaces, schools, restaurants, etc. and make them aware of the actions they needed to take in order to be in compliance with the OHA's COVID-19 guidelines. Some organizations complied with the issued guidelines, while others refused and/or consistently failed to comply. Participants reported that some organizations—primarily businesses and restaurants—felt as though these guidelines were arbitrary, and at times would direct their displeasure to NCPHD. Calls from disgruntled business owners (and occasionally customers) took an emotional toll on staff who regularly answered the phone. While NCPHD was not expected to enforce preventative guidelines by intervening or calling the police when violations occurred, it was expected that staff consistently provide organizations with up to date COVID-19 regulations from the OHA. If a prominent figure within an organization, such as a principal or director, refused to meet COVID-19 guidelines, they could be reported to the Occupational Safety and Health Administration.

One of the most commonly cited challenges regarding infection prevention and control/countermeasures was working with widespread vaccine hesitancy. Vaccine hesitancy related to the COVID-19 vaccinations was particularly prevalent during the pandemic, in part

due to people's perception of them being developed "too quickly" and "with not enough prior testing," as well as the perception that COVID-19 vaccines were tied strongly to political alliances. A study by the Center for Disease Control (CDC) in 2021 estimated that at least 14.31% of Wasco, Sherman, and Gilliam County residents felt "Hesitant or Unsure" in regards to receiving a COVID-19 vaccine[6]. Many participants reported feeling frustrated and confused as to why clients who trusted them for other medical advice refused to trust their recommendations for COVID-19 vaccinations. While many attempts to reach vaccine hesitant populations were made, participants expressed that one-on-one conversations with vaccine hesitant individuals seemed to be the only effective way to address their fears surrounding COVID-19 vaccines—a method that is particularly labor intensive and inefficient for reaching large groups of people.

Further regarding COVID-19 vaccinations, another significant challenge that NCPHD encountered was the difficulty of keeping the constantly changing vaccine information up to date. Emergency Use Authorizations (EUAs) for the COVID-19 vaccines would update constantly, as well as the legislation regarding what populations qualified for what vaccine. Participants reported that working with the OHA's tiered roll-out system brought up many challenges, such as patients being untruthful about their age or health status in order to receive a vaccine before they were eligible, or patients berating staff for not allowing them a vaccine they were not yet qualified to receive. Participants also mentioned that when mass vaccination clinics began to carry multiple brands of COVID-19 vaccines, managing the unique age restrictions, doses, and waiting periods in between injections became a significant difficulty. NCPHD's vaccine appointment scheduling website did alleviate some of these complications; however, the building of a website itself that was able to manage multiple restrictions and calendars took a long time and a substantial amount of effort to build.

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[6] Center for Disease Control and Prevention, "Estimates of Vaccine Hesitancy for COVID-19," https://data.cdc.gov/stories/s/Vaccine-Hesitancy-for-COVID-19/cnd2-a6zw/

Recommendations

Participants did not have many recommendations for improvement concerning Infection Prevention and Control/Countermeasures, which may in part be due to the success with which the mass vaccination clinics were run. One participant did recommend a way to combat the challenges associated with the constantly changing vaccine information, which was to generate a QR code for each EUA. Rather than having to print out hundreds of new EUAs whenever there was an update, a new QR code would simply be generated to reflect the most current vaccine information—cutting down on printing time and paper waste. Another participant's suggestion was related to the increased sanitary practices during COVID-19, and encouraged public areas, businesses, and restaurants to continue to provide masks and hand sanitizer even as the pandemic starts to wane. Lastly, an AAR team member suggested that all staff receive specialized training on how to deescalate conversations, cope with belligerent clients, and understand when an interaction must be shut down for the safety of the employee and/or the client.

5.4 Communication/Community Engagement

The communication and community engagement of NCPHD during the COVID-19 response was robust, but not without its challenges and gaps. Communication refers to the messaging between NCPHD and the public while community engagement is more about how communities were reached and the ways in which they were involved in the response. This section explores the successes and challenges faced in the realm of communication and community engagement and the ideas that staff had to address some of the identified gaps.

Best Practices

In terms of successes and best practices, one of the major focuses of NCPHD was identifying and working with vulnerable populations. This was exemplified by how the agency

employed a wide variety of communications methods to reach as many populations as possible. Social media, website, mailers, radio, newspaper ads, banners, google ads, flyers, emails, digital signs and more were all utilized to reach populations from across the jurisdiction. Immense Imagery was a huge help in this respect and we couldn't have reached nearly as many people without them. They were also instrumental in website creation and marketing campaigns.

One population of note is the unsheltered, who were reached through strong relationships with the individuals running Community Meals. Another major success was the partnership cultivated with Sherman Co. Medical Clinic, which allowed us to disseminate information through an already trusted community organization. A last commonly reported success was the pop-up vaccine events such as Friday Night Lights, which helped NCPHD reach younger demographics with both information and vaccines.

Challenges

On the other hand, there were a multitude of challenges faced by NCPHD staff when it came to communication and community engagement. Chief among these challenges was vaccine hesitancy. Not only were the vaccine hesitant the hardest population to reach effectively, they were also the most vocal minority that pushed back against messaging efforts. Staff found that the most effective way to address vaccine hesitancy was through one on one conversations. However, this approach is resource intensive and is not ideal for reaching a wide swath of people, not to mention, draining for staff on the front line. Similarly, misinformation was extremely prevalent during this response and addressing it took a toll on staff and resources alike. The critical issue connecting these two challenges was a lack of trust between certain populations and NCPHD, especially in rural communities. While NCPHD made a concerted effort to reach Spanish speakers, gaps still existed, partially evidenced by significantly lower vaccination rates in these communities. That being said, there was a lot of engagement with MSFW through coordination with orchardists and other

community partners, especially during harvest seasons. Other groups that participants thought could have been better reached included young people, the elderly, and low income families without internet access.

A fundamental challenge that NCPHD faced was the lack of a dedicated and trained mass communications specialist. This resulted in Health Promotion staff needing to double up on their duties as well as do a significant amount of on the job learning. As a result, this department was put under a lot of strain during the response and was forced to deprioritize a significant amount of their previous work. Important to note was the lack of a COVID-19 specific communication plan. A general emergency communications plan does exist. COVID specific communication efforts were largely improvised, placing extra strain and pressure on staff. Lastly, there was a difficulty in evaluating the effectiveness of communication efforts, meaning that little can be safely assumed about the influence of the messaging.

Recommendations

Recommendations around communication and community engagement ranged widely and often contradicted each other. The most prominent recommendation was to hire a designated communications specialist who is trained in mass communication. This would help alleviate the burden on health promotion and split the work more equitably between staff. Not to mention, this role could be instrumental in developing underlying communication plans and relationships with other organizations that were lacking during COVID-19. In addition, more care should be taken early on in the pandemic to make clear that information will be constantly evolving and that no one could know exactly what will happen. This is especially valuable for maintaining credibility among the public when there are changes in guidance or new discoveries are made. Other suggestions included being more proactive about combating misinformation, working harder on creating a relationship with faith based communities, keeping staff trained on new information, and the need to keep communication channels open with CBOs and partners into the future.

5.5 Internal Organization

In the process of performing the AAR, our team encountered a significant number of best practices and challenges that did not fit with the other findings. Rather, they were all related to the fundamental organization and structure of NCPHD. As a result, we created a fifth finding to capture these themes and review what existing structures within NCPHD influenced the effectiveness of the response to COVID-19. Overall, participants felt that NCPHD's ability to continue to provide essential services and cultivate a healthy work environment were bright spots while major challenges centered around role clarity and the onboarding process. This finding elaborates on successes and challenges encountered by staff relating to internal processes within the organization followed by recommendations for improvement.

Best Practices

Pre-pandemic, NCPHD was successful at creating strong relationships among staff and promoted a healthy work environment, resulting in its ability to weather the pressures of the pandemic. Many participants felt that they were supported by their supervisors and coworkers and felt empowered to ask questions when necessary. Participants also reported a strong sense of teamwork and cooperation with colleagues. Another frequently mentioned best practice was the organization's capacity to both prioritize and continue to provide essential services for the public. NCPHD's leadership and staff rapidly and efficiently made decisions around prioritizing their work to simultaneously address COVID-19 and continue their traditional duties. Interventions to make staff safer were successfully implemented such as temporarily moving to remote work, placing air filters around the workspaces, and installing plastic panes at the front office's greeting windows.

Challenges

The two primary challenges identified by participants were related to role clarity and the new employee onboarding process. Regarding role clarity, many participants recalled a lack of understanding around their duties and expectations in the response. It was often not clear to staff what they were expected and allowed to manage. Occasionally, when responsibilities weren't specifically delegated to an individual, staff were unsure of who was obligated to take on the task. As a result of the lack of role clarity, many staff members expressed a perception that there was an inequitable distribution of COVID-19 related work among departments. Granted, there is a natural disparity in the intersection of infectious disease work with that of certain departments.

In addition, employees who were onboarded during the pandemic frequently did not feel adequately trained and oriented to their new position. Along with this, some new staff reported that job descriptions often did not align with the bulk of the work that ended up being assigned to them. Meanwhile, employees who were present prior to the beginning of the COVID-19 response reported difficulties in balancing their traditional work with their new COVID assignments. Another issue that was detected was the lack of documentation recording what training/certification employees were required to complete as well as what was actually complete. Without a dedicated employee keeping track of this, necessary training/certifications often fell through the cracks.

The lack of infrastructure was an additional theme that multiple staff pointed out, yet the specifics of what infrastructure is referring to were not generally discussed. The only detail brought up was the lack of internal capacity to scale up efficiently during the response. Lastly, both staff and community partners found it difficult to access the experts within NCPHD who possessed critical and up to date COVID-19 information. This was likely a result of the strain that the emergency placed upon these experts, especially during surges when their time was most limited. The combination of all of these factors led to the perception of a high turnover rate, damaging staff morale and causing the loss of institutional knowledge.

Recommendations

The foremost recommendation is to revamp the onboarding process for new staff. Participants brainstormed a variety of ideas to accomplish this ranging from checklists, explicit onboarding plans for each role, flowcharts, more comprehensive training, a consolidated source for logins, programs, etc. Some people speculated that the lack of role clarity and structure in the onboarding process contributed to the perceived high turnover rate and difficulty integrating into the workplace. Hiring someone to keep track of licenses, certifications, and required trainings could help alleviate these issues. Beyond this, it was recommended that more work be done around pandemic preparedness and that perhaps a dedicated task force be created to continuously update NCPHD's emergency response plans. This is a task that seems to have fallen through the cracks previously, but the necessity to prepare for infectious disease outbreaks has become abundantly clear during COVID-19. Similarly, it would be ideal for more staff to be hired who are dedicated to preparedness, whether it be to help on the above mentioned task force or assisting PHEP more broadly. In addition, one participant recommended NCPHD consider designating a "second in command" or deputy to members of leadership to facilitate communication and step in during the event that a supervisor is absent/unavailable. It should also not be forgotten that COVID-19 is still with us, and we must continue to provide education and resources to keep the public informed.

Some specific recommendations given by participants included improving and clarifying the existing documentation within the shared drive. This could be accomplished by hiring a consultant to review current operating procedures within departments and make suggestions for improvements. Along the lines of system improvement, a major step forward could be to acquire a method to transmit protected health information via secure email. Internal communication could be improved as well, some staff felt it was easy to be left out of the loop in regards to decision making and COVID news; it should be formally decided what

information needs to be disseminated among different departments ahead of time. In reference to the challenge regarding infrastructure, participants recommended creating a system where NCPHD can quickly staff up during surges or times of necessity. Another aspect of this is for leadership to gain a better understanding of departmental needs, including resources, capacity, and insufficiencies.

AAR Team Additional Recommendations

One observation of a potential weakness made by the AAR team was the lack of an established exit process for employees. An exit survey or interview of some kind would be invaluable to the organization since so much knowledge is lost when an employee leaves. This would help to preserve institutional knowledge and ease the transition of responsibilities to new staff.

6. CONCLUSIONS

Overall, NCPHD's COVID-19 response was multifaceted; it utilized expertise from multiple departments and emphasized efficiently allocating resources in the best interest of the community. Understandably however, there were plenty of challenges that arose. This AAR categorized NCPHD's best practices and challenges into five pillars that were thoroughly explored during the interview and hot wash process: Surveillance, Emergency Response/Coordination, Infection Prevention and Control/Countermeasures, Communication/Community Engagement, and Internal Organization. This conclusion will summarize the main themes from each of these pillars and describe potential next steps to address the challenges that arose.

Surveillance

- Contact tracing and case investigations were administratively inefficient interventions, however, they were effective in getting up to date information regarding quarantine and isolation out to the contacted individuals
- The overwhelming number of cases put strain on surveillance systems and staff alike
- Information regarding COVID-19 surveillance strategies and systems changed rapidly and was challenging to remain updated on
- Surges in COVID-19 cases resulted in REALD data collection and other important case investigation details falling through the cracks, which diminished the quality of the surveillance intervention

Emergency Response/Coordination

- Staff felt there was a lack of role clarity between NCPHD and other community partners/organizations resulting in some services being duplicated or absent
- Acquiring temporary staff during surges was difficult and while some were brought on, the strain on existing staff was still high

Infection Prevention Control/Countermeasures

- NCPHD's mass vaccination clinics were efficiently organized and executed, and were well-received by the public
- Working with vaccine-hesitant populations at clinics was labor intensive and required a significant amount of energy from staff
- The tiered rollout of the COVID-19 vaccines proved to be extremely challenging due to the unpredictability of vaccine acquisition, as well as managing the scarcity mentality of the public
- Information regarding COVID-19 vaccines was constantly developing and expanding to encompass more of the population, and therefore was difficult to remain updated on both internally and externally

Communications/Community Engagement

- Staff encountered difficulty when creating messaging for vaccine hesitant populations
- Political polarization divided the community and implied a correlation between political loyalty and health choices
- Staff had difficulty communicating with the public when tensions were high and emotions were strained resulting in more combative interactions
- NCPHD needs a dedicated communications specialist whose primary focus is mass communication
- NCPHD had no way to evaluate the effectiveness of messaging and how it was received by specific communities
- Countering misinformation was a labor intensive and arduous process

Internal Organization

- Staff felt unclear about what duties they and others were responsible for in relation to the response
- Many staff expressed that the onboarding process was insufficient in preparing them for their role in the organization as well as the response
- Internal communication channels between departments could have been better established and more consistently utilized to disseminate updated information
- Staff felt overwhelmed by their responsibilities and often felt as though not enough action was taken by the organization to alleviate their stress
- Many staff members expressed a perception that there was an inequitable distribution of COVID-19 related work among departments
- Staff lauded the sense of teamwork and comradery that existed among employees that NCPHD cultivated prior to and during the pandemic

In examining NCPHD's response to the COVID-19 pandemic, the AAR team has created an extensive list of recommendations that may help better prepare the organization for future emergency responses. These recommendations range from broad changes to more specific adjustments, and would require a large amount of effort and time in order to

be implemented. Therefore, the AAR team has suggested that NCPHD consider forming small, departmental teams to plan and execute the recommendations.

The most commonly identified and overarching issues were in regards to role clarity (both internal and external) and the new employee onboarding process. The existence of these issues highlights the importance of planning and preparedness; having pre-established policies and procedures, that are continually reviewed and updated, contributes heavily to the success of an organization's response to an emergency. Not to mention, it reduces the strain on staff as less effort is put into improvising various aspects of the response. Overall, this makes the response more efficient. As such, the AAR team recommends contracting with an external consultant to update existing plans, as current staff do not have the capacity to do so. This would greatly benefit future response efforts and improve the preparedness of the organization.

As for the next steps for this document, additional effort will be required to assign responsibilities for improving the various sectors that we have identified, using the improvement matrix attached as Annex 1. The improvement matrix includes some of the most pressing issues and any recommendations that staff made to address them.

Please note that updates to this AAR may be necessary in the future to account for any further developments. This is a living document and we expect changes and corrections to be made.

7. ANNEXES

Annex 1: Improvement Matrix

Annex 2: Acronyms and Terms

Annex 3: Map of Jurisdiction

Annex 4: Staff Wellbeing

Annex 5: Health Equity

Annex 6: Timeline

Annex 7: Acknowledgements

Annex 8: AAR Team

Annex 1: Improvement Matrix

	NCPHD COVID-19 AAR/Improvement Plan Matrix					
	Pillar	Identified Gap	Recommendation for Improvement	Who's responsible	Estimated Timeline	Complete
1	Surveillance	Tracking COVID cases at the beginning was haphazard, OHA surveillance systems were not well set up	Developing stronger relationships with disease reporting institutions			
2			Preparing for potential outbreaks as soon as possible			
3		NCPHD shortcoming is we don't have secure email, no way to transmit secure data; one way to save secure pdfs	Acquire encrypted email service			
4		Arguably the biggest problem is collection (REALD, time pressure, privacy, case overload)				
5		ARIAS was massive time suck, not a good use of resources				
6		Contact tracing - it was an inefficient system, sporadic, compliance reduced, schools spent tons of time contact tracing, not even much data to support its effectiveness	More accessible public information campaign would have been much more effective, making it inescapable for people to know what to do			
7		Guidance on masking was developing as pandemic evolved	As OHA eventually did, set up hotline for people to call			

8		As information changed, people felt like it wasn’t credible	Concerted effort for reliable source of update to date information			
9		Most contentious mandate to implement - indoor capacity				
10		Supply chain issues, uncertainty of resource availability (especially tests)	Stockpiling/ensuring enough covid-19 test kits for the community during surges			
11		Surges made surveillance very difficult, testing shortage	Stockpiling/ensuring enough covid-19 test kits for the community during surges			
12	Emergency Response/ Coordination	No direct internal liaison to some providers				
13		Unclear which community partners needed to be in the loop	Update emergency response plans, streamline and revise			
14			Educate community partners on UC			
15		Difficult to mobilize additional staff				
16		Difficult to staff up quickly while not overburdening existing staff	Divide trainings into smaller, more manageable tasks rather than large ones			
17		Didn't have established community connections to quickly disseminate info to communities				

18		NCPHD should be better at coordinating with community partners	Educate community partners on UC			
19		Role clarity of organizations; who is doing what; who will pay for what	IGA should mean more focused meetings with county reps			
20		Communication between organizations relied too heavily on relationships with a single POC	Some larger group meetings should be continued to maintain relationships			
21		Could not meet the expectation that work had to continue over the weekends	Need better isolation/quarantine service systems that don't involve ncphd			
22		Tried to have community partners help with weekend but didn't work out	Need better isolation/quarantine service systems that don't involve ncphd			
23		Vulnerable populations (unsheltered, disabled, etc.) were underserved, better wrap-around services needed	Should have worked harder at beginning to get more systems set up around transportation, etc. (for COVID + patients, quarantining patients)			
24		Not sufficient human resources, we were well understaffed				
25		Not sufficient materials overall, forcing us to figure out a lot on the go and requiring support from the counties	Would have been awesome to have a location to store stuff (PPE)			
26		Difficult transition to remote work				

27		Some staff needed to be in person during remote operations, often leading to an inequitable work distribution				
28		Not all emergency managers and clinics in jurisdiction participated in IC	Educate community partners on IC			
29		Coordination with mental health services was poor	Educate community partners on IC			
30		Sherman and Gilliam chose not to participate in IC as they were hesitant about the potential impact of the pandemic	Educate community partners on IC			
31		Missteps in coordination, split between MCMC and OCH in vaccine distribution meant different communication				
32		Pandemic strained relations with Gilliam Co.				
33		Coordination with Wasco Co. leadership could have been better				
34		Struggle to get MRC volunteers to stay engaged and complete trainings	Keep in contact with MRC volunteers/keep effort into MRC program			

35			Help staff better understand expectations of volunteers			
36		Volunteer management was tricky, especially with the influx of new volunteers at the beginning of the pandemic	Purchase a better volunteer management database system			
37		Staff not understanding role of emergency manager				
38		Additional...	Have ability to hold pods or drive ups in them			
39			Dedicated isolation vehicle			
40			Ideally teams or sections would have worked on goals and objectives and reporting back			
41			Hire a consultant to write plans			
42			Inventory management system			
43	Infection Prevention and Control/Countermeasures	Difficulty enforcing preventative guidelines such as masking, social distancing, business requirements, etc	Encouraging continued improved sanitation, follow droplet precautions regularly			
44		Addressing vaccine hesitancy was a constant struggle				
45		Managing supply/demand for vax from the state				

46		Keeping info up to date, continuous system improvements, not having backup, multiple vaccine doses + boosters, brands/types (vaccines)	QR code to see EUA			
47		Creating a blueprint for PODs with multiple types and doses of vaccine was a unique obstacle				
48		Had to build a scheduling system from scratch that accounted for different types/multiple doses of vaccines				
49		Tiered rollout was a challenge				
50		Hard to manage system where people were screened based on age, health conditions etc				
51		Tiered rollout created a lot of strife in community among who was first				
52		People tried to manipulate staff to get in early				
53	Communication/ Community Engagement	Differences in community attitude towards COVID, and lack of participation meant high effort for minimal outcome	Better established presence for communicating directly to the public			
54		Hard to get messaging through to vaccine hesitant individuals	Focus more on educating people at the beginning that we don't know everything and that			

			things will change over time, allow people to voice their skepticism			
55			If public health had better system of getting information out to certain races, ethnicities, socioeconomic status			
56		Polarizing politics and misinformation made messaging more difficult and divisive	Trying to be clear and concise as possible			
57			Transparency and persistence			
58		Constantly received backlash on social media from a vocal minority				
59		Could make recommendations to public, but no way to enforce them			Statements early on should have been more careful	
60		This pandemic brought a unique sense of antagonism towards us	We don't know what will happen, allowing for skepticism			
61		Hard for staff to remain professional when individuals would try to argue	Deescalation training			
62		Didn't have trust of some communities prior, harder to gain that trust in the middle of a crisis	CHW that is directly responsible for keeping communication open with different agencies and organizations			
63		Difficulty reaching Spanish speakers, NCPHD Spanish facebook page did	Better relationship with faith based communities			

		not have a lot of visibility				
64		Mailers were sent to every house but didn't feel effective				
65		Struggle to communicate with people in poverty or without wifi access				
66		Couldn't really target messaging at people with pre-existing conditions with vaccine information				
67		Individual communication was resource intensive	Pre-education for the public			
68		Besides one on one conversations, there were no identified effective strategies for addressing vax hesitancy	Pre-education for the public			
69		Weak relationship with outer counties meant there were communication failures	Need to actively keep communication channels working with organizations and different agencies and public as well			
70		There are certainly populations that we haven't found super effective way to communicate with	Should have more connection with senior center to reach more elderly			
71		MSFW misinformation: around testing, cultural issues with vaccine safety and hesitancy	Be more proactive around misinformation			
72			Keep staff trained on new information as it comes out			

73		Communication efforts sucked up a lot of resources	Wish we had in house canva designer, graphic designer			
74		Difficult to manage cultural differences that could increase resistance to recommendations				
75		No dedicated communications personnel meant that Health Promotion staff needed to double up	We should definitely have at least a part time employee devoted to communication			
76		Exhausting to constantly vet information for accuracy				
77		No real gauge/measurement to see whether messaging was effective				
78		Not reaching young people				
79		During crisis, people's capacity to receive information is reduced				
80		Health Promotion staff received no training in mass communication	We should definitely have at least a part time employee devoted to communication			
81		Was hard to develop new systems while already feeling unsure and overwhelmed				
82		Difficult to walk the tightrope of being concerned but not alarmed	Let people know that this information is constantly evolving and we are learning more			
83		High volume of phone calls was overwhelming	Keep staff trained on new information as it comes out			

84		Additional....	Having updated list of community partners			
85			Not just an opt in method to better reach public during times of emergency (communication to the public)			
86	Internal Organization	Little to no orientation	Systems creation for better new employee onboarding process			
87			Onboarding plans for each individual role: programs, login, who do you talk to, CPR training, Flowchart of roles, typically there is someone that keeps track of licenses, certifications, etc.			
88			Add dedicated block of time to reviewing the Shared Drive during orientation			
89			Rejuvenating onboarding committees			
90		Poor clarity of role/vague job description when onboarding	Creating toolkits, checklists, onboarding plans, etc.			
91			Onboarding plans for each individual role: programs, login, who do you talk to, CPR training, Flowchart of roles, typically there is someone that keeps track of licenses, certifications, ect.			
92			Rejuvenating onboarding committees			

93		Poor documentation	Having a specific place where everything lives, shared drive issues			
94			Improving and clarifying existing documentation			
95		High turnover of employees and leadership during pandemic	Group discussion or an onsite therapist?			
96			Gain better understanding of departmental needs (resources, capacity, staff)			
97			Improve systems for which employees can communicate that they are at capacity/overwhelmed, and then receive support in a timely manner			
98			Reminding about EAP			
99			NCPHD could implement floating holidays once a month to take advantage of services			
100						
101		Staff had concerns over safety				
102		Emergence of omicron on top of delta was challenging for all people involved due to exhaustion, really hard for people to keep working and stay focused	Continue to provide education and resources to combat the pandemic (don't ignore rises in cases)			
103		Boundaries should be better defined as to responsibilities of NCPHD staff	Improving systems for when weekends/extra hours are worked, and consider			

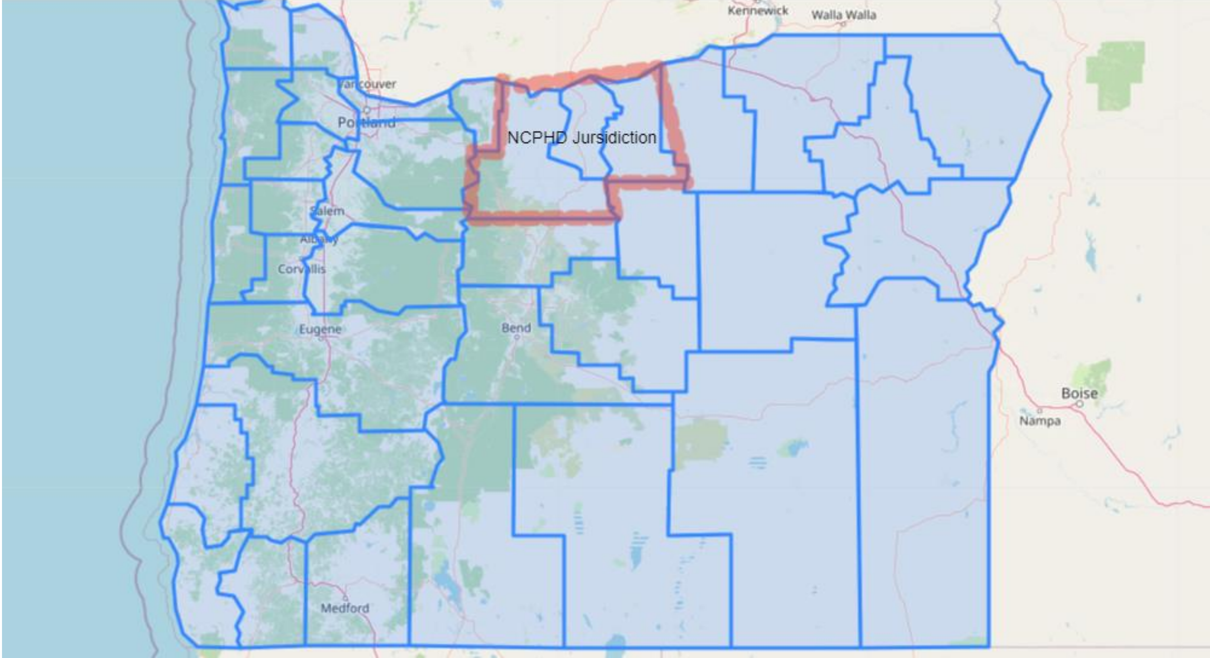
			increasing compensation for said work			
104			Being more conscientious about breaks			
105			Should have tried harder to enforce rules on staff			
106		Got influx of money but didn’t have infrastructure to channel it towards everything that was necessary	Building employee infrastructure			
107		Hard to get access to people with correct information and so not all misinformation could be addressed				
108		Sometimes NCPHD gave inconsistent info was given to public/community partners	Shoring up internal communication: easy to leave someone out of the loop, between groups easy to leave out, maybe formally decide who need to know			
109		Inequitable work distribution	Would be helpful to have a secure email or way to transmit protected health information			
110		Basic compliance and enforcement sometimes fell through the cracks	Hire a consultant? (for reviewing current operating systems)			
111		COVID caused a lot of fiscal difficulties with tracking and new funding streams				
112		Turnover of people with institutional memory creates problems	Exit process			

113			More people trained and doing more preventative work, preparedness			
114			Work group or task force that puts together our pandemic playbook			
115		Additional....	Staffing up and down appropriately for surge capacity			
116			Increased communication between NCPHD staff and board would be appreciated, would help NCPHD staff understand why certain decisions are made			
117			County - continue to look at funding for better infrastructure for PH			
118			Should invest with current funds to make changes for the future			
119			Continue to provide pandemic related services			

Annex 2: Acronyms and Terms AAR	After Action Report/Review
ARIAS	At Risk Identification Alerting System
CBO	Community Based Organization
CDC	Centers for Disease Control
COVID-19	Coronavirus Disease 2019
ECR	Electronic Case Report
ELR	Electronic Laboratory Report
EOC	Emergency Operations Center
EUA	Emergency Use Authorization
FEMA	Federal Emergency Management Agency
IAP	Incident Action Plan
IC	Incident Command
LPHA	Local Public Health Authority
LTCF	Long Term Care Facility
MRC	Medical Reserve Corps
MSFW	Migrant and Seasonal Farm Workers
NCPHD	North Central Public Health District
OCRP	Oregon COVID-19 Reporting Portal

OHA	Oregon Health Authority
OPERA	Oregon Pandemic Emergency Response Application
SARS-CoV-2	Severe Acute Respiratory Syndrome - Coronavirus - 2
PHEP	Public Health Emergency Preparedness
POD	Point of Dispensing
PPE	Personal Protective Equipment
RC	Readiness Center
REALD	Race, Ethnicity, Age, Language, Disability
UC	Unified Command
WHO	World Health Organization

Annex 3: Map of Jurisdiction



Annex 4: Staff Wellbeing

Staff wellbeing isn’t typically within the scope of an AAR. However, the duration of the COVID-19 response, its intensity, and the many professional and personal challenges associated with the pandemic had too large an impact on responders for us to ignore. NCPHD conducted a staff wellbeing survey in October of 2021, acquiring responses from 25 staff members. The results can give us an insight into the mindset of responders and how their wellbeing fared during the response, as well what strategies they used to cope and function in a high stress environment. We would like to recognize the inherent difficulty in sharing this information and are very appreciative of the staff who participated. Your answers were both heartbreaking and inspiring.

Staff Wellbeing Survey Results

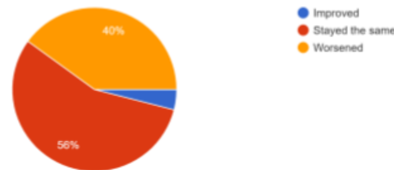
10/25/21 - 11/01/21

Overview

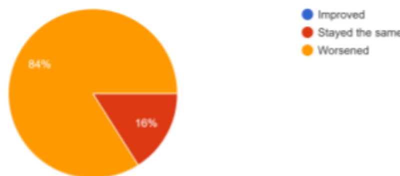
- Overall Health
- PHQ-2
- Work Situation
- Burnout
- Staff Comments
- Conclusions

Overall Health

Physical Health Average: 3.6/5



Mental Health Average: 3/5



What factors are having the biggest effect on your overall physical and mental health?

Examples

- keeping up with constantly changing guidance, and conveying that information to the public, more recently dealing with the very negative attitudes of some members of the public towards our work. It is a painful feeling to know many people do not trust our work.
- feeling of instability in the work place; lots of turnover; work-life balance; messaging
- Stress, anxiety, feeling overwhelmed or unsure at times, trying to balance work and homelife
- Work from home is no longer an option for staff, compassion fatigue, Seasonal Affective Disorder and Depression.
- The factors having the biggest effect are the general public and individuals who I interact with for work purposes such as their responses, verbal abuse, and rude comments. Other factors include general workplace environment interactions such as overhearing negative comments about myself from other coworkers and coworkers isolating me from their social activities they do together. This is the impact on my mental health but otherwise not much impact on my physical health.
- Additional work has created additional stress. No amount of money can compensate for the amount of time away from family. Flexible work schedules would be beneficial and certainly boost moral.

PHQ-2

What is the PHQ-2?

The PHQ-2 is a two question survey that inquires about the frequency of depressed mood and anhedonia (loss of interest) with the intent being a "first step" screening tool for depression.

How to Interpret

The responses are scored 0-3 with 0 being "not at all" and 3 being "nearly every day" . If the combined score for both questions is 3 or greater, major depressive disorder is likely. However, further evaluation is necessary to determine if the respondent truly meets the criteria for the disorder. Nevertheless, it can give a good indication of how people are generally feeling.

PHQ-2 Results

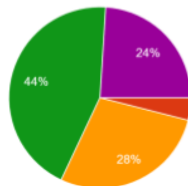
Fortunately, most NCPHD employees **do not** have aggregate scores over 3, meaning they are unlikely to have major depressive disorder. There are several exceptions to this and there are many individuals who are struggling and would likely benefit from further evaluation/intervention. It should be noted that those who score higher than 3 could be suffering from situational depression rather than chronic depression.

In addition, nearly every employee experienced anhedonia and/or felt down, depressed or hopeless at least several days over the last 2 months. Granted, any score 0-2 is within the range of normal, so this isn't necessarily concerning by itself.

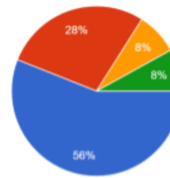
Number of respondents with total scores of 3 or greater: 6/25

Work Situation

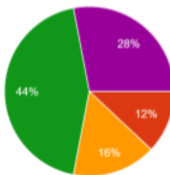
I feel safe from threats and physical hazards in my workplace.
25 responses



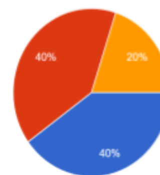
My supervisor helps and supports me.
25 responses



I feel satisfied and comfortable with my workplace.
25 responses

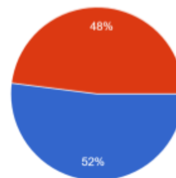


My colleagues help and support me.
25 responses



Continued

Have you considered looking for a different job in the past 18 months?
25 responses



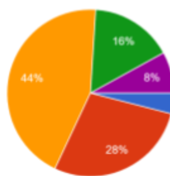
Reasons given

- Uncertainty with my own position, better opportunity.
- I feel like sometimes my role in public health isn't respected or wanted at the health department nor in the community. Could probably make more money with a less community oriented position where you don't get flak all day long for being 'the government'.
- Occasionally wonder if somewhere else might be less stressful, but I REALLY DO enjoy the basic purpose of my job and public health, in general, so I feel I can do the greatest good here.
- Stress of working in public health during Covid, constant changes
- instability in the workplace; lots of turnover; low morale in the workplace;
- Lack of pay, less flexibility i.e. work from home, and unable to adjust schedule. BURNOUT! Lack of order/leadership & lack of procedure/processes. Not feeling like I have someone that can do my tasks when I am in need of time-off, therefore not wanting to take time off because the pile of work just triples.

Burnout

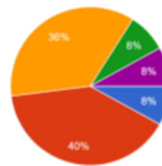
Burnout appears to be a big problem with the majority of respondents reporting moderate to severe burnout symptoms. Most employees sometimes or most of the time feel burned out and/or are emotionally drained. Some are easily irritated by small problems/coworkers or are easily upset or put on the verge of tears.

I feel burned out.
25 responses



Always
Most of the time
Sometimes
Rarely
Never

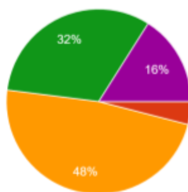
I feel emotionally drained.
25 responses



Always
Most of the time
Sometimes
Rarely
Never

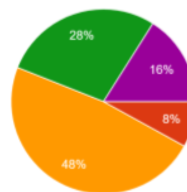
Burnout Continued

I am easily irritated by small problems or by co-workers.
25 responses



Always
Most of the time
Sometimes
Rarely
Never

I am easily upset or have been on the verge of tears/have cried?
25 responses



Always
Most of the time
Sometimes
Rarely
Never

Staff Comment Summary

There are many thoughtful comments that I wasn't able to include due to space limitations.

If you would like to view the full results yourself, ask Alex to add you as a collaborator.

What factors (work related or not) are currently causing you the most amount of anxiety?

Staff are facing many sources of anxiety, sometimes work related. Family, health/COVID, work/life balance are some of the most common responses.

Examples

- Family health both physically and mentally, ensuring the education of my children
- The main thing I get anxiety about is thinking about and coming up with a plan of what to do, work wise, if my kids end up being exposed at school and have to be quarantined. I know others have gone thru this and everyone makes due, but it's still something I think about.
- The political landscape in the US bleeding into healthcare. Family stress. Trying to juggle work and family is proving very difficult.
- Having to figure out how to shift back to regular duties fully, complete normal job duties that feel new again while expected to do more to improve work processes all of the time, feeling like I have big responsibilities while also slogging through feeling burnt out and unwanted. Having to feel guilty for the gaps in services for 2020-2021. Feeling like covid is never going to be over.

What could NCPHD be doing to better support you? Please list any ideas you might have.

Lunches are the most popular idea by far as well as wanting more flexibility in work hours. Additional optional get togethers and small group activities could be a good way to foster more connection between staff.

Examples

- I like the snacks that are provided to staff and providing lunch once in a while would be nice.
- More time to get together and connect. Especially with so many new faces. Talk about stuff that is not covid. Fun activites.
- Small group lunches, small group coffee hours,
- Flexible work schedule to allow for a better work/home balance
- Providing lunch is nice sometimes, I feel like that is already done. Individual shows of gratitude can be helpful.
- Get togethers really are not helpful for me, it just feels like one more thing I'm supposed to do. Maybe a yoga or meditation class? Not sure I would take advantage of it, but it would be more likely than just a general gathering. Continue to support 4 day workweeks, some flexibility to work from home, and a flexible work week. The move back to the office and removing the 4 day work week was ill-timed, and didn't feel logical or very supportive. In conversations with other employees, they confirm the same. It felt like there were a small number of people who were abusing the privilege, but instead of addressing this with employees directly a blanket retraction was done for everyone. Fewer meetings. There are days where I feel I get nothing done but move from meeting to meeting.

Would it be helpful for us to bring in outside professionals, trainers and/or one on one services? Is so, what would you suggest?

There are some mixed opinions on this question but many agree that generally it would be helpful.

Examples

- I think a mini-massage clinic/option would be amazing!! As I mentioned previously, I am horrible about making time for myself and I carry much of my stress/anxiety in my neck and shoulders.
- Yes I think so. Maybe a counselor to offer anonymous services?
- Leadership training, program management training, team building
- I don't feel like an outside professional/trainer will be significantly impactful at this point, and just feel like something we need to fit in, in an endless list of tasks.
- It would be good to reiterate availability of one on one services.
- I would suggest therapists to help communicate and process through issues
- I do NOT enjoy group-therapy type activities at all, they actually cause more stress, and I know I'm not alone in feeling that way, whether others admit it or not.
- It could be, especially for newer staff. Like having some trainings be optional as it fits into your schedule, already trying to juggle a lot.

Is there anything else you would like to share ?

- Overall there seems to be a lack of role clarity and predictable expectations for what each person is supposed to do. Therefore training is generally inadequate, not allowing people to feel competent at their job.
  There are few redundancies built into the system so people feel they can leave without having to cover their email/job duties/etc. because when they do take a break they come back to mountains of emails and work - that doesn't feel like a break.
  There has been so much turnover it feels chaotic. When institutional memory is not available and so many processes need to be recreated, it feels overwhelming.
- We are all individuals with very different likes and needs, there is not a one-size-fits-all way to boost morale; however, I think kindness, understanding, and transparency are the most important things to make us all feel less stressed.
- Working at NCPHD has been a great experience so far. It is fulfilling and I enjoy what I get to do.
- Thank you for putting together this survey to ask staff what is actually going on.

Conclusions

- Concern over the wellbeing of NCPHD staff is justified
- Staff were appreciative of being checked up on
- What can be done ? (based on responses)
  - Tactics to combat burnout
  - More flexibility in working hours
  - Provided lunches and optional opportunities to socialize
    - Suggestions like massage clinic, hiking and more flexible hours
  - Outside professional help
    - Many would appreciate this as long as it's optional
    - Can be implemented in different ways
  - Reiterate available benefits and resources
  - Repeat survey in 3 or 6 months to evaluate interventions now that we have established a baseline

Strategies

Throughout the interview and hot wash process, staff often shared the strategies they used to cope during the pandemic. They are listed here in no particular order.

- Support each other
- Take advantage of downtime
- Keep everything in perspective
- Watch humorous shows

- Yoga
- Massages
- Rest
- Family time
- Set up boundaries with work
- Cried a lot
- Run
- Coffee
- Rely on family, friends, and coworkers for support
- Laugh with each other
- Exercise
- Alcohol
- Working on work/life balance
- Venting
- Acupuncture
- Breathing exercises
- Meditation
- Mindfulness

Next Steps

NCPHD leadership has reviewed the results of the wellbeing survey and is taking steps towards addressing the gaps in wellbeing. The swellness committee has organized several optional hikes for staff to enjoy together, swellness bags were assembled and distributed to staff, and flowers with cheerful notes were shared. Talks are ongoing for additional improvements.

Annex 5: Health Equity

Health equity has been a major consideration in the global response to COVID-19. This has been true for NCPHD as well. Factors such as race, sex, socioeconomic status, disability, language, age, housing status, and health status were taken into account when NCPHD implemented COVID-19 interventions. While these factors were considered and NCPHD was successful in many applications of health equity, there remained gaps and communities that could have been better served. NCPHD placed an emphasis on understanding how the Latinx, Spanish speaking, and MSFW populations were impacted by COVID and what interventions would be most effective in reaching these communities. Other populations often considered in the response included low income families, the elderly, the houseless/unsheltered, and those who are immunocompromised. One population that did not have specific interventions tailored to was the LGBTQ community. Therefore, we examined some of the best practices that NCPHD used to promote health equity as well as identifying some of the existing gaps in care.

In terms of successes and best practices, one of the major focuses of NCPHD was identifying and working with vulnerable populations. This was exemplified by how the agency employed a wide variety of communications methods to reach as many populations as possible. Methods like print media, handouts, mailers, and radio spots were utilized to reach the elderly and those without access to internet whereas social media and digital advertising were used to reach younger populations and those who were less able to leave their home during the pandemic (e.g. immunocompromised and/or disabled people). Regarding mass communications, NCPHD was consistent in providing both English and Spanish versions of all messaging material and included in-person interpretation services whenever applicable. In terms of physical accessibility, there were many efforts made to remove barriers to care. As a few examples, wheelchairs were provided at all vaccine events, the RC possessed elevators as an alternative to stairs for those with mobility issues, in-car and in-home

vaccinations were available upon request, and free transportation to and from vaccine events was provided.

NCPHD organized several events aiming to serve traditionally marginalized populations, such as the Latinx, MSFW, and Samoan/Pacific Islander communities. In an attempt to better reach the Latinx and MSFW populations, NCPHD partnered with OCH, local orchards, OHA, and FEMA to provide information and vaccine access outside of common work hours. Spanish speaking staff members of NCPHD commonly visited workplaces with MSFW to provide in person and one on one communication. NCPHD also worked with UTOPIA PDX and First United Methodist Church to organize a vaccine clinic with an emphasis on reaching Samoan/Pacific Islanders in The Dalles. Another population that NCPHD focused on was the unsheltered/houseless community. Attempts to provide COVID-19 information and vaccine accessibility to the unsheltered/houseless population were made by establishing partnership with the community meals program, and conducting multiple vaccine events at the community meals center. NCPHD also distributed food boxes to low-income and/or houseless clients as an additional wraparound service. Lastly, quarantine/isolation services were provided for those who did not have housing or could not safely isolate themselves from others through NCPHD's partnership with the Shilo Inn and Oregon Motor Motel.

The first gap in health equity that we observed is in regard to sexual orientation and gender identity. NCPHD did not engage in any directed campaigns towards LGBTQ individuals to educate or involve them in the COVID-19 response. Studies have shown that members of the LGBTQ community are at higher risk for respiratory complications from COVID due to higher rates of tobacco use compared to the general population[7]. As such, it could have been beneficial for NCPHD to spend more resources engaging this community and fostering a better relationship.

[7] Human Rights Campaign, "The Lives and Livlihoods of Many In the LGBTQ Community are at Risk Amidst COVID-19 Crisis," https://hrc-prod-requests.s3-us-west-2.amazonaws.com/files/assets/resources/COVID19-IssueBrief-032020-FINAL.pdf

Another gap is NCPHD's underdeveloped relationship with local churches, especially the St. Peter's Catholic Church. Misinformation around the COVID-19 vaccine was being actively spread by leadership at St. Peter's Catholic Church despite NCPHD's educational efforts. This led to a more tenuous relationship between St. Peter's and NCPHD which diminished the effectiveness of accurate vaccine messaging. The misinformation contributed to vaccine hesitancy particularly within the Spanish speaking community who were members of the congregation. Due to the lack of a stronger relationship between NCPHD and the Catholic Church prior to the pandemic, NCPHD was not able to leverage existing trust to address the misinformation. This was a consistent theme with many other churches and vaccine hesitant populations.

Finally, a major inadequacy with NCPHD's health equity measures was the lack of a feedback system to gauge their efficacy. While there were a multitude of efforts made, it is largely unknown to what degree they were effective, making it difficult to predict which implementations would be the most useful in the future. That being said, while evaluation is important, it was a larger priority to push out messaging rapidly to reach the widest audience. Perhaps more emphasis on evaluating communication measures can be made for future equity efforts.

Annex 6: Timeline

Date	Decision, Action, or Directive
Dec. 12th, 2019	A cluster of patients in Wuhan, Hubei Providence, China begin to experience shortness of breath and fever
Dec. 31st, 2019	The WHO China Country Office is informed of a number cases of pneumonia of unknown etiology detected in Wuhan, Hubei Province
Jan. 7th, 2020	Chinese authorities identify and isolate a novel coronavirus as the causative agent of the outbreak
Jan. 10th, 2020	CDC publishes information about the novel coronavirus on its website
Jan. 20th, 2020	CDC confirms the first U.S. laboratory-confirmed case of COVID-19 in the U.S. from samples taken on January 18 in Washington state
Feb. 28th, 2020	Oregon announces first, presumptive case of novel coronavirus
Feb. 28th, 2020	Oregon Governor Kate Brown appoints the State of Oregon's Coronavirus Response team
Feb. 29th, 2020	Department of Human Services (DHS) issues strict guidelines restricting visitation at congregate care facilities
Mar. 8th, 2020	Gov. Brown declared an emergency due to the public health threat posed by the novel infectious coronavirus
Mar. 8th, 2020	Oregon Health Authority (OHA) announces interim public health recommendations for response to COVID-19 cases in Oregon schools
Mar. 10th, 2020	OHA releases new guidances directing long-term care facilities (LTCFs) to limit exposure of residents
Mar. 12th, 2020	Gov. Brown issues guidelines prohibiting gatherings of 250 or more people, and announces statewide closure of Oregon K-12 schools from Mar. 16th - Mar. 31st, 2020.
Mar. 13th, 2020	United States President Donald Trump declares the COVID-19 outbreak a national emergency
Mar. 14th, 2020	First known death due to COVID-19 in Oregon occurs in Multnomah County
Mar. 16th, 2020	Wasco County declares a state of emergency due to the COVID-19 pandemic
Mar. 17th, 2020	Gov. Brown prohibits gatherings of 25 or more people, banned on-site consumption of food and drink at food establishments statewide, and extended school closures until Apr. 28th, 2020
Mar. 18th, 2020	Gov. Brown suspends in-person instructional activities at higher education institutions through Apr. 28th, 2020

Mar. 18th, 2020	Gilliam County declares a state of emergency due to the COVID-19 pandemic
Mar. 19th, 2020	Gov. Brown orders the postponement of non-urgent health care procedures in order to conserve personal protective equipment (PPE) and hospital beds for the state's COVID-19 emergency response
Mar. 20th, 2020	Full EOC activation begins
Mar. 20th, 2020	Wasco County UC partners with Sherman and Gilliam Counties
Mar. 20th, 2020	Sherman County declares a state of emergency due to the COVID-19 pandemic
Mar. 20th, 2020	Gov. Brown issues the executive order "Stay Home, Save Lives," with updated statewide mandates and restrictions. Oregon is considered "in lockdown"
Mar. 22nd, 2020	OHA announces local public health and tribal funding for COVID-19 response
Mar. 25th, 2020	First confirmed case of COVID-19 in Wasco County is detected
Mar. 26th, 2020	Gov. Brown's "Task Force for Health Care Systems Response to COVID - 19" and the OHA release health care system action plan to fight COVID-19
Apr. 5th, 2020	First confirmed case of COVID-19 in Sherman County is detected
Apr. 21st, 2020	OHA revises COVID-19 testing guidelines to prioritize underserved populations and all frontline workers, and allows testing for people without symptoms
Apr. 25th, 2020	First COVID-19 death of a Wasco County resident occurs
Jul. 3th, 2020	First confirmed case of COVID-19 in Gilliam County is detected
Jul. 22nd, 2020	OHA updates guidelines to require "all adults and children 5 and up to wear a mask or face covering in all indoor public spaces and outdoors when social distancing isn't possible"
Aug. 26th, 2020	OHA announces a slight decrease in COVID-19 cases in Oregon
Sep. 16th, 2020	OHA's weekly report continues to show declining case count trend
Oct. 6th, 2020	Oregon receives between 60,000 and 80,000 Abbott BinaxNOW rapid antigen test from the OHA
Oct. 7th, 2020	OHA's weekly report shows increase in new daily cases
Nov. 2020*	The Alpha (B.1.1.7) COVID-19 variant is first detected in Great Britain
Nov. 4th, 2020	OHA posts highest weekly case count
Dec. 2020*	The Beta (B.1.351) COVID-19 variant is first detected in South Africa
Dec. 2020*	The Delta (B.1.617.2) COVID-19 variant is first detected in India

Dec. 7th, 2020	First COVID-19 death of a Gilliam County resident occurs
Dec. 9th, 2020	OHA reports that new weekly COVID-19 cases (10,355) and hospitalizations (494) are at an all time high
Dec. 11th, 2020	FDA issues Emergency Use Authorization (EUA) for Pfizer-BioNTech COVID-19 vaccine
Dec. 14th, 2020	First doses of the Pfizer-BioNTech vaccine arrive in Oregon
Dec. 16th, 2020	First doses of the Pfizer-BioNTech vaccine are given to health care workers in Oregon
Dec. 18th, 2020	FDA issues Emergency Use Authorization (EUA) for the Moderna COVID-19 vaccine
Dec. 18th, 2020	OHA publishes Oregon's Phase 1a vaccine sequencing plan
Dec. 20th, 2020	First doses of the Moderna vaccine are given to health care workers in Oregon
Dec. 27th, 2020	First Wasco County residents receive COVID-19 vaccine
Dec. 30th, 2021	NCPHD distributes 100 COVID-19 vaccines to emergency responders in Wasco, Sherman, and Gilliam counties
Jan. 15, 2021	First known case of the Alpha (B.1.1.7) COVID-19 variant is detected in Oregon
Jan. 27th, 2021	First COVID-19 death of a Sherman County resident occurs in another state
Feb. 27th, 2021	FDA issues Emergency Use Authorization (EUA) for Janssen (Johnson and Johnson) COVID-19 vaccine
Apr. 13th, 2021	CDC and FDA recommended a pause in use of the Janssen (Johnson & Johnson) COVID-19 vaccine in the United States out of an abundance of caution
Apr. 20th, 2021	North Central Public Health District (NCPHD) releases a PSA regarding the first COVID-19 death of a Sherman County resident, including the date of death (see above) and an approximation of when the death was confirmed by NCPHD (Apr. 15th -18th)
Apr. 23rd, 2021	CDC and FDA lift recommended pause of use of Johnson & Johnson (Janssen) COVID-19 Vaccine in the U.S. after a review by ACIP
Apr. 27th, 2021	Updated Recommendation from ACIP for Use of Janssen (Johnson & Johnson) COVID-19 Vaccine After Reports of Thrombosis with Thrombocytopenia Syndrome Among Vaccine Recipients
Mar. 24th, 2021	1 million Oregonians have received COVID-19 vaccines
May 10th, 2021	FDA expands the emergency use authorization of Pfizer-BioNTech COVID-19 vaccine to include adolescents 12–15 years of age

Jun. 3rd, 2021	Weekly cases COVID-19 cases decrease by 13%
Jul. 2nd, 2021	Oregon crosses 70% target of vaccinated adults
Jul. 27th, 2021	OHA recommends universal mask use for all public indoor settings
Aug. 18th, 2021	COVID-19 weekly cases rise by 53%
Aug. 23rd, 2021	FDA approves first COVID-19 vaccine Comirnaty (Pfizer-BioNTech) for individuals 16 and older
Oct. 28th, 2021	Oregon crosses 80% adults vaccinated against COVID-19
Oct. 29th, 2021	CDC published ACIP Recommendations for COVID-19 additional primary and booster doses
Oct. 29th, 2021	FDA authorizes EUA for Pfizer-BioNTech COVID-19 vaccine for children 5-11 years
Nov. 2021*	The Omicron (BA.1) COVID-19 variant is first detected in Botswana and South Africa
Dec. 13th, 2021	Oregon confirms three Omicron-variant cases of COVID-19
Dec. 30th, 2021	Oregon orders 12 million at-home COVID-19 tests
Feb. 24th, 2022	Oregon announces it will lift mask requirements for indoor spaces and school by March 19th
Mar. 29th, 2022	FDA authorizes and CDC recommends second boosters for certain individuals
Jul. 13th, 2022	FDA issues Emergency Use Authorization (EUA) for the Novavax COVID-19 vaccine
May 11,2023	Marked the end of the National Public Health Emergency Declaration

*Exact date unknown

Annex 7: Acknowledgements

The authors of this AAR extend our deepest gratitude and thanks to those who helped put this document together. We would like to recognize the time, effort, and difficulty in providing us with your perspectives and ideas.

Special thanks to:

- NCPHD Leadership and Staff
- Wasco County
- South Wasco County School District
- Wasco County Medical Reserve Corps
- The Springs at Mill Creek
- Sherman County Emergency Management
- Columbia Gorge Health Council
- Oregon Veterans Home

Annex 8: AAR Team

AAR Team Lead: Alex Ziontz

Technical Officer/Report Writer: Vikas Reddy

Interviewer/Report Writer: Avery Cardosi

Situation Lead/Report Writer: Gloria Alvarez

Technical Consultant: Tanya Wray

North Central Public Health District
"Caring For Our Communities"

NCPHD Contracts Summary for Board of Health Meeting of October 10, 2023

Submitted By: Shellie Campbell, Director

1. **PractiSynergy:** This is a contract between PractiSynergy and NCPHD for billing services rendered by PractiSynergy to NCPHD.

Fiscal Impact: Monthly fees are based on insurance collections. Amounts will vary.

   a.

2. **Gurney release of liability:** This agreement is between NCPHD and Jasen Tennison, which accepts the donation of the gurney "AS-IS" condition.
   a. *Fiscal Impact: None*

3. **Epipen MOA:** This agreement is between NCPHD and South Wasco, Dufur, Sherman Co., and St. Mary's Academy to manage allergies and anaphylaxis safely and effectively in schools.
   a. *Fiscal Impact: None*

4. **MOA OHSU Connect:** This Memorandum of Understanding is entered by and between Oregon Health and Science University (OHSU) and NCPHD. Allows NCPHD employees to remotely access PHI in electronic medical records for Public Health purposes.
   a. *Fiscal Impact: None*

North Central Public Health District
"Caring For Our Communities"

NCPHD Directors Report for Board of Health Meeting of October 10th, 2023

Presented by: Shellie Campbell, Director

September went by in a flash! After three years with only a few trainings and conferences, this September and October staff are busy making up for lost time. It is great! There are new ideas, networking, education, and sharing of programs for staff attending. Our October "staff" meeting was spent cleaning house! We filled two drop boxes (dumpsters) with old furniture, COVID junk, and many other items that we had held on to for way too many years. We then celebrated with a pizza lunch. The celebration included recognizing Maria Pena. Maria has been with NCPHD for 30 years. Her role as a community health worker, front office support, WIC staff, interpreter, and party planner has been invaluable! Congratulations and Thank You, Maria!

Here are a few more highlights from some of the program areas. Enjoy!

Tobacco Prevention and Education Program (TPEP)

Neita tabled at the Veterans Affairs Stand Down event on September 20, with cessation/nicotine replacement information and shared resources with the many other organizations tabling at this event. She also had a good visit at the monthly Kiwanis meeting, answering their questions about her program and tobacco usage in general. She is working on advertising (print/radio/social) for her cessation counseling and nicotine replacement work; newspaper ads will likely begin next month and run for nine weeks, alongside a month-long radio blitz. You may be hearing news Statewide about Flavor Bans; Neita has a request in to The Dalles City Manager, asking if she can present to City Council in the near future. She will ask that they consider approving a resolution urging the legislature to pass a flavor ban in the State of Oregon. You may have also heard about Corrective Statements that will be required in retail establishments that sell tobacco products, by October 1. Statements are stark, such as "Tobacco companies purposely made their products addictive." and each must be posted for 21 months. Neita will send a PSA soon with additional information about Corrective Statements.

Public Health Emergency Preparedness (PHEP)

September is National Preparedness Month and we kicked it off at the Sept. staff meeting by giving staff an item for their go-kits and announcing that all staff will be participating in a monthly do1thing project for the next 12 months. The do1thing program aims to help people simplify personal preparedness tasks by doing just one thing each month. Check it out at do1thing.com. We also tabled at the Get Ready The Dalles event on September 16, where we discussed the do1thing preparedness program with approximately 100 families, and assisted Red Cross with bringing the Pillowcase Project to the event to teach kids about being prepared. Matt is working with the Get Ready Committee to enhance next years' event in an effort to entice more people to attend and learn about preparedness. We've also scheduled a meeting with a City of Maupin staff member about the possibility of joining them for a similar preparedness event in Maupin next year. Matt is also working on an exercise plan that will include all NCPHD staff, focusing on EH and CD's response to a foodborne outbreak, called Cookie Chaos! Early in Sept. Matt met with partners from ODHS in Maupin to learn how to deploy air-scrubbers in case our assistance is needed during a wildfire smoke event. Now with the 2023 wildfire season nearly behind us, it's time to start thinking about winter preparedness and Matt is working to add emergency go-kits to NCPHD vehicles to enhance the safety of our staff.

Communications

We created booth materials, hand-outs and presentations for the various events that NCPHD participated in, as mentioned in TPEP and PHEP info, for September. We continue to work on hiring a Communications Coordinator, including some interviewing. Planning and organizing materials for future outreach events. NCPHD purchased a digital reader board for use at events, emergency and other events. We are working on having rolling updates and other communications displayed in the NCPHD lobby using a smart tv screen.

WIC

September brought Janna and I (Maricela) some grade school memories, specifically a little bit of testing anxiety! Janna worked hard throughout the year and dedicated any available time in September to study and prepare for her big test day on September 22nd . Janna is pursuing to become an International Board Certified Lactation Consultant (IBCLC).
For the 2022 year, we had a 93% initiation rate for Wasco and Sherman County but only 23% of moms were still breastfeeding exclusively at six months. Having access to an IBCLC in WIC will enhance the breastfeeding services already available. The WIC team is confident Janna will pass with flying colors and her results will be available closer to December.
I am happy to share that I am now a qualified medical interpreter! I took and passed my final exam on September 26th. This intensive 64-hour training program covered many topics like ethics, medical terminology, and several others. Using a qualified medical interpreter improves communication for full understanding, removes any emotional bias or additional family trauma to ensure the correct information is shared, improves comprehension, and we comply with laws and regulations which can maximize reimbursement and minimize penalties.

Environmental Health (EH)

This month the Environmental Health team attended the 2023 FDA Portland Retail Seminar. This 3-day conference provided the latest food safety information, rules and regulations, and investigative techniques to improve local public health outcomes. This conference also provided an opportunity to network and collaborate with other federal, state, local, tribal, and territorial food safety professionals.

EH Administrative Support, Jessie Elias completed and passed (with flying colors) his interpreter training. Jessie is now a qualified interpreter! Congratulations, Jessie.

Administrative – Front Office

Cynthia Rojas attended a Reproductive Health CVR refresher webinar at the end of September & it was very informative. Chelsea Downey will be attending the same webinar in October. Both Cynthia & Chelsea assisted in organizing NCPHD's "purge" day. Received many phone calls from the public regarding Flu/COVD/RSV vaccines & directed them to the proper resources. Along with her regular duties, Cynthia Rojas has stepped in to keep the billing current until our billing is outsourced; which should happen sometime in October.