



# Advisory Council

## October 21, 2014

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**Council:** Remy Eussen, Trevor Evers, Bob Richardson, Aaron Fredriksen, Greg Noelck, Mark Collier, Karen Evans, Joan Caley, Bryce Hackett, and Dave Scott  
**Staff:** Alan Melnick, Julie Grimm, Janis Koch, Jeff Harbison, Cyndie Meyer, and Julie Grimm  
**Guests:** Christine Kragnes

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### 1. WELCOME/INTRODUCTIONS/APPROVAL OF MEETING NOTES (*Trevor*)

Trevor opened the meeting, and introductions were made. The council reviewed the meeting notes from the ACES retreat.

Joan received a call from Dave Seabrook regarding a meeting on October 28 and the proposed oil terminal at the Port of Vancouver. Dave thought it would be important to have a letter from the council about the public health impacts of the oil terminal (to be addressed later on the agenda).

Trevor introduced three new members to the council: Tracy Rude (representing consumers of public health services), Dr. Remy Eussen (representing the Clark County Dental Society), and Bryce Hackett (representing Clark County youth).

### 2. DEPARTMENT UPDATE (*Alan*)

(a) Update on COO Position: Tricia Mortell's last day in this position was October 1. This position oversees all public health programs, and it was advertised nationally. There were originally 14 applicants, whittled down to 8, and then to 4 finalists. The interview process will include a community partner panel, which is scheduled for November 4-5.

(b) Communicable Disease Update:

- *Influenza*: The season is here. It is circulating at low levels right now. People should be much more concerned about getting their flu immunizations compared to the extremely remote risk of contracting Ebola.
- *Enterovirus D68*: This virus is particularly severe and is especially problematic for kids who have asthma. Some limb paralysis may be associated with this virus.
- *Ebola*: If you turn on the news, you can be terrified by Ebola. The CDC has made recommendations on protective equipment for health care workers, wherein no skin would be visible. Hoods are used to protect the head and neck; complete body coverage. Training is given on how to put the equipment on and off. In West Africa, the ratio of physicians is

about 1 for 100,000 people. Given this statistic, it is not surprising that the epidemic is still spreading in Africa.

Here in Clark County, we are on regular calls with the State Department of Health. Our Infectious Disease Advisory Committee recommended a meeting be called for planning for how to respond to different Ebola scenarios. We are putting together distinct algorithms to put in place for response. However, the risk to the population is incredibly low.

*Discussion:*

- Would public health be involved in terms of Incident Command? (*Joan*)
  - Yes, that would be part of the algorithm. If there was a serious risk, we would be able to go into Incident Command. We also have experience in Joint Incident Command. If we had even one case of Ebola here, we would not only be going into Incident Command, we would be calling in the CDC for assistance. (*Alan*)

(c) Budget: Due to the loss of one federal grant and the potential loss of another, we held off on filling three positions. Once we know the collective reduction on the current grants and the state budget, we will decide on those positions. There are uncertainties around the federal budget as well.

Public Health receives about 27% of its budget from state-shared revenues and about \$2.25 million of county general fund. The breakdown of public health funding is about one-fourth state, one-fourth federal, and one-half local. Public Health is on-call 24/7. The public wants that protection (just like law enforcement); however, resources continue to dwindle. Local public health jurisdictions across the state are tracking costs of Ebola response. We will use the results to work with legislators to support adequate funding for core public health services.

### **3. EXECUTIVE COMMITTEE**

- Volunteers for Nominating Committee:

Joan Caley, Karen Evans, and Sandy Mathewson will serve as the Nominating Committee for PHAC's 2015 Executive Committee slate of officers. (Julie will contact the committee members to schedule a meeting prior to the November PHAC meeting.)

### **4. WHAT CAN PHAC DO TO MAKE A DIFFERENCE IN OUR COMMUNITY?**

(a) Reflections on the ACES retreat

- Incorporating ACES in systems
  - Ultimately, develop a program to train officers in ACES is important, especially for younger officers; more tools in their toolbox.
  - There are a lot of opportunities to incorporate ACES screening in the health care system. (example: pediatricians)
  - There are challenges with EHRs (electronic health records). They don't communicate well with each other. Hopefully, the RHA will deal with this.

- Start looking at family charts. Example: If dealing with an adult with chemical dependency, how to work with other family members (especially children) who might be affected.
  - Community health worker training in ACES. (example: a coalition could recommend that all community health worker training include a module on ACES.)
  - It is important to capture the business community; make sure they understand the impact of ACES.
- There's a lot of talk in the community about ACES (ESD, SELF, and Children Can't Wait campaign). There are very good ideas, such as a facilitated ACES coalition.
    - How can the council best facilitate the establishment of a coalition?
    - Consider a coalition for ACES similar to the plan to end homelessness.
    - What councils or coalitions currently exist that are working on ACES?
    - Convene a summit of organizations currently working on ACES, such as SELF. (PHAC has done this in the past. Example: Meth Town Hall).
  - Awareness – education:
    - A challenge with ACES is how to get buy-in when it takes so long to fully understand it.
- (b) Process/tools to identify goals and prioritize short, medium, and long-term strategies (at November meeting)

- Where do you get traction?
  - Goals should come out of a coalition
  - Possible process – divide into subgroups with specific assignments (similar to the PHAC worked on a community-wide plan for the health element.)
  - Is our goal to establish a coalition? (coalition is really a strategy to meet the goals)

Overall Goals:

(1) Community Alignment

- Evaluate plan – efforts to address ACES

(2) Community Plan to address ACES

- Components:
  - Law enforcement
  - Schools
  - Health care
  - Housing and homeless providers
  - Businesses
  - Faith communities
  - Non-profits
  - Behavioral health
  - First responders
  - Foster parents
  - CPS
  - Corrections
  - Courts/justice

- Early childhood centers
- NA
- Resource centers
- Boys & girls' clubs
- YMCA

(3) Strategies:

- Summit
- Coalition
- Task force
- Identify PHAC champions (liaison to represent sectors)
- Pilot program/work
- Grant funding

Develop metrics – some will be short, medium, and long-term

In terms of the November meeting, we talked about what the proposals might be like in November. How do we want to take these goals and move them into strategies, actual planning, and how the council will move this forward?

Partners to join meeting -

- Debbie Ham, SELF (what are they doing now?)
- VHA, ESD
- Kim (Portland Policy Academy) teaches officers – juvenile justice

If council members have ideas, please send them to Julie.

**(5) PUBLIC COMMENT:**

Joan Caley brought a letter to the Council for review and discussion. The letter was from the Secretary of the Department of Health to Stephen Posner of the Energy Facility Site Evaluation Council regarding the proposed Tesoro Savage Vancouver Energy Distribution Terminal. The letter provides the DOH's concerns for public health for the construction and operation of a crude oil-by-rail storage and loading facility at the Port of Vancouver.

After discussion, it was proposed that Public Health contact the DOH to get a status update and bring that information back to November meeting; council to consider any further action based on the information.

**(6) ADJOURNMENT**

The meeting adjourned at 8:00 p.m.