
Multnomah County's
Reopening Framework
June 5, 2020
Multnomah
County

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Deborah Kafoury
Multnomah County Chair

June 5, 2020

The Honorable Governor Kate Brown
Office of the Governor
900 Court Street NE, Suite 254
Salem, OR 97301-4047

Dear Governor Brown,

I am writing this letter on behalf of the Board of County Commissioners to request your approval for Multnomah County to enter Phase 1 reopening on June 12 against the backdrop of a profound and potentially transformative tipping point in our country. Since March, in response to the COVID-19 pandemic, the residents of Multnomah County have shown a deep commitment to each other's health and wellness by staying home as much as possible. But over the last week, our residents have been compelled to leave their homes and flood into the streets despite the risk, in order to confront an even-deeper sickness: the systemic racism that enables the tragic and unwarranted killing of Black people at the hands of police brutality.

Police violence, however, remains only one of countless manifestations of structural white supremacy. Our systems have built higher and wider barriers to health for communities of color, and particularly Black communities: from higher rates of untreated chronic diseases to a lack of healthcare access and education, fewer economic opportunities to educational inequities. During this COVID-19 pandemic, these existing inequities translate into a set of underlying conditions exacerbating the risk and vulnerability of Black, Indigenous and other communities of color to the impacts of the virus. Simply put, those who are most vulnerable to the COVID-19 pandemic are those whose health is harmed most by the ongoing pandemic of structural racism.

We are facing one public health crisis within another. The County recognizes that an effective, equitable response to the pandemic that first touched our community four months ago requires us to actively address the disease that has been endemic to this country for 400 years. As both the local public health authority and the largest provider of safety net services in the state, Multnomah County is committed to putting that acknowledgement into action by inclusively leading with race.

Since the beginning of our pandemic response, we have worked to listen to voices of color, institute practices and bolster resources to ensure that Black, Indigenous and other communities of color are served equitably. This commitment — to specific measures that prioritize the needs of communities disproportionately impacted by COVID-19 and ensure this

emergency does not widen existing racial inequities — is further reflected in our reopening strategies.

Leading our community through this public health crisis and toward a plan for reopening has required countless decisions that impact our internal operations and the community. In response, the County developed a framework built upon Multnomah County's overarching values, and established it as the foundation for our public health response, our organizational practices and our approach to reopening. In summary, the principles of this framework are:

1. Save lives, limit the spread of the virus and respond effectively.
2. Recognize and care for the emotional, physical and economic toll of COVID-19-related restrictions on all community members.
3. Value collaborative, responsible and creative relationships with the community and businesses.
4. Provide excellent service and support people in the community; offer Multnomah County employees that same level of care and concern.
5. Center the voices of those who will be most impacted by decisions to facilitate equitable decision making.
6. Inclusively lead with race: make decisions in a way that incorporates an understanding of the ways race is connected to risk and vulnerability.
7. Keep our approach gradual, adaptive, and informed by our community, science and public health experts as we move into reopening,

This framework was instrumental in bridging the work required to meet Phase 1 prerequisites and our own jurisdiction-specific standards for health equity to develop an approach for reopening that remains faithful to Multnomah County's values.

Accordingly, the County supplemented the State-established prerequisites for reopening with two additional thresholds: a 14-day decline in hospital admissions among people of color and a sufficient stock of PPE for health and social service agencies essential to community health and safety. These metrics are intended to ensure that Multnomah County can reopen in a manner that advances every segment of our community forward in regard to their health, economic stability and ongoing access to support and opportunities.

I hope this letter has made it abundantly clear that Multnomah County has undertaken thoughtful, extensive and thorough work to be as prepared as possible to enter into Phase 1 of reopening. However, we must continue our efforts to work together with you and our partners at the City of Portland to help provide the financial support that will ensure we can protect health and support our community. And, as the state's most populous, dense and diverse county, Multnomah County understands that we face unique challenges in how we manage COVID-19, especially with regard to how quickly transmission hotspots can appear. We are prepared to take great caution as we approach reopening. Even with your approval, Multnomah County will

evaluate our most recent developments on June 10 to confirm that all trends continue to move in a positive direction. Only then will we move into Phase 1 reopening on June 12.

Our attached application shows that Multnomah County has completely met five of the State's seven prerequisites for reopening. As of this writing, the County has employed 63 contact tracing staff members, or 52 percent of the 122 total required; we continue to make progress toward a fully staffed contact tracing operation, utilizing a hiring plan that ensures our contact tracing workforce reflects the diversity and needs of our community. The County also continues to strengthen and broaden the network of community service partners that our contact tracing teams can refer affected individuals and families to for support during a deeply vulnerable, challenging time.

While we have met the State's regional metric for having sufficient testing sites accessible to underserved communities, the County will continue to assess emerging community needs, identify cultural or geographic gaps, and expand testing capacity to provide even greater access.

The County has worked tirelessly to open with care, and we are now poised to imminently meet the prerequisites identified in your framework for rebuilding a safe and strong Oregon. I am committed to leading the County's collaborative work with the State, neighboring jurisdictions and community-based organizations in a way that ensures all Multnomah County residents, especially our most vulnerable neighbors, can safely experience and equally benefit from our community's reopening.

On Thursday, June 4th, the Multnomah County Board of Commissioners unanimously approved this step to apply. Our community looks forward to your approval for Multnomah County's Phase 1 reopening on June 12. We welcome the opportunity to answer any questions you may have about our application.

Sincerely,

Deborah Kafoury
Chair, Multnomah County Board of Commissioners

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June 4, 2020

Honorable Governor Kate Brown
Office of the Governor
900 Court Street NE, Suite 254
Salem, OR 97301

Honorable Governor Brown and State colleagues:

It is with cautious optimism that Multnomah County submits the enclosed application for Phase 1 reopening.

As the most densely populated county in Oregon and home to the majority of health systems, Multnomah County has either met or exceeded State criteria in an effort to publicly hold ourselves accountable to the wellbeing of everyone in our county.

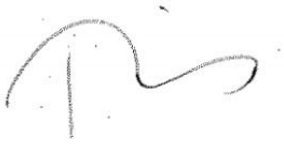
And while the City of Portland seethes with appropriate shock, anger and grief at the senseless death of George Floyd, Multnomah County has doubled down on our commitment to Black, Indigenous and Communities of Color in our response plans.

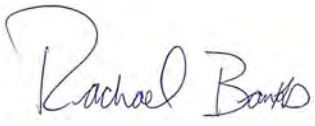
Multnomah County will continue to work with you to address the broad and deep underlying social conditions that the COVID-19 pandemic has brought into sharp relief: racism, lack of housing, gaps in behavioral health services, inequities in employment, education, income, and access to health care.

Finally, it is with sincere gratitude and humility that we acknowledge the many sacrifices of Multnomah County residents, whose collective efforts under the Stay Home Say Safe executive order saved lives and bought us time to plan a thoughtful reopening designed to prevent the virus's most devastating effects.

We look forward to your comments and approval.

Sincerely,





Jennifer Vines, MD, MPH
Multnomah County Health Officer

Rachael Banks, MPA
Multnomah County Public Health Director

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Executive Summary

Multnomah County was quick to recognize the potential severity of the COVID-19 pandemic. In December 2019, Multnomah County Health stood up a team to develop a novel coronavirus response plan. The County elevated efforts when it opened its Emergency Operations Center (EOC) in January 2020, nearly a month before the first case of COVID-19 was reported in Oregon. The County has been working actively since January to minimize the spread of COVID-19, reduce severe illness and prioritize the needs of those most vulnerable to the impacts of a pandemic.

Despite our best efforts, 63 Multnomah County residents have tragically lost their lives. The burden of illness has also fallen disproportionately on those who work in public-facing jobs, on residents with underlying health conditions and people in long-term care, and due to current and historic health inequities, on people in Black, Indigenous and other communities of color.

The pandemic is not over, and we may still be more than a year from a widely available vaccine that could end it. The County recognizes the emotional, physical and economic impact the current restrictions related to the COVID-19 virus have had on our community members. And returning to the community life we had before is unlikely. To thoughtfully and safely approach the first phase of reopening, the County developed a COVID-19 response framework that was built upon Multnomah County's overarching values.

Multnomah County Values

The Multnomah County Board of Commissioners has formally adopted values to provide a framework for making decisions that impact the Multnomah County government and the community. These values include:

Social Justice: Promote equity in the community, include people who have not been included in the past and help those who need help.

Health: Support a healthy community from birth through adulthood.

Public Safety: Maintain safe neighborhoods through prevention, intervention and enforcement.

Integrity: Be honest and trustworthy, creating transparency and harmony between what we think, say and do. Put the County's mission above personal goals.

Stewardship: Demonstrate tangible, cost-effective results from our work; decisions are clear, evidence-based and fair.

Creativity and Innovation: Think in new ways, value new opinions, and recognize ingenuity and resourcefulness.

Sustainability: Focus on the long-term environmental and economic well-being of the community.

In response to the COVID-19 pandemic, the County developed a specific ***Guiding Framework.*** This framework was developed by Multnomah County leadership, Public Health and EOC staff in order to support compliance with the Governor's Phase 1 prerequisites, and with the County's own standards for health equity. It is also intended to describe how the County will approach Phase 1 reopening in a way that is in accordance with emerging best practices for managing the pandemic, and with the values of the County.

Framework Principles

1. Multnomah County seeks to save lives, limit the spread of COVID-19, and respond effectively to the complex public health, physical and behavioral health challenges the virus poses for our community.
2. Multnomah County recognizes and cares about the emotional, physical and economic impact the current restrictions related to the COVID-19 virus are having on all our community members.
3. We value collaborative, responsible and creative relationships with the community and businesses. Government, public health and healthcare organizations, community-based organizations, and businesses must work together to support reopening our community.
4. Providing excellent service and supporting people in the community is a hallmark of what we do. This work is strengthened when Multnomah County employees receive that same level of care and concern from our leadership and from one another.
5. Centering the voices of those who will be most impacted by decisions is important for equitable decision-making. Executive leadership, managers, front-line employees, clients, customers and community stakeholders must inform final decisions.
6. We are committed to inclusively leading with race. We are explicit about understanding the ways that race can be connected to risk factors and vulnerability, and committed to analyzing and incorporating those considerations in our decisions.
7. As we move into reopening, County efforts will continue to evolve and be informed by the communities we serve. Our approach will be gradual and adaptive as we are informed by our community, science and the best thinking of public health experts.

Framework Objectives

1. Minimize the spread of COVID-19.
2. Minimize severe illness in the county.
3. Mitigate the unintended negative consequences of policies that aim to reduce COVID-19 transmission.
4. Minimize risk to, and prioritize the needs of, communities at greatest risk, including:
    a. Black, indigenous, and people of color (BIPOC)
    b. People over 65
    c. People living in a congregate setting

    d. People with underlying health conditions
5. Adhere to all relevant state and federal guidance, and work collaboratively with government partners in response.
6. Promote economic recovery.
7. Support opportunities for small groups and teams to preserve cohesion, community and cultural practices.
8. Foster safety, trust and belonging among employees and community members through consistent and transparent communication and engagement.
9. Evaluate implementation and allow adjustments to achieve the objectives above.

Assumptions

This Framework is intended to support Multnomah County's efforts to safely reopen business and services in the community. It assumes that:

1. We will be living with the COVID-19 pandemic until there is a treatment or cure, which could be more than a year away.
2. Thousands of people in the community are vulnerable to COVID-19.
3. Many people in the community are unaware if they have the virus and could unknowingly be carriers.
4. Public health and community support and intervention strategies will reflect the unique needs of our communities that have been disproportionately affected by COVID-19, including those in congregate settings, communities of color and older adults.
5. Testing and contact tracing will be used as tools to understand, manage and contain viral spread.
6. Indications of a large increase in positive case counts, hospitalizations and/or fatalities may require increased disease control measures or returning to previous levels of restrictions.
7. The strategies and structures we use to conduct business will continue to evolve as we have more information.

Prerequisite Criteria

Multnomah County's Guiding Framework prompted the County to develop two additional reopening prerequisites in addition to the standards outlined by the State of Oregon.

In total, this document addresses *seven* prerequisites identified by the State for the County to meet for Phase 1 reopening, the *five* Region 1 health prerequisites, *one* state prerequisite and *two* additional criteria identified by the County.

Multnomah County has created a dashboard that shows the County's status on key metrics. It has been updated weekly to keep both partners and the community aware of our progress. Figure 1 lists each of the 15 identified prerequisites and their current status as met.

Based on our approach, our values, the status of metrics reflected on our dashboard, and our overarching focus on safety for our community and our employees, we are well-positioned to reopen Multnomah County for Phase 1 on June 12, 2020.

Figure 1. Multnomah County's Status of Phase 1 Prerequisite Criteria

	Criteria	Unit of Assessment	Comment
	Declining Prevalence of COVID-19		
✔	The percentage of emergency department visits for COVID-19-like illnesses (CLI) are less than the historic average for flu at the same time of year, measured statewide.	State	State Prerequisite. Oregon Health Authority (OHA) has confirmed this is met. See Appendix B: Hospital Attestation Letters.
✔	A 14-day decline in COVID-19 hospital admissions.	County	COVID-19 admissions have declined from 16 to 9 for the last two weeks data is available. More information on page 11.
✔	A 14-day decline in COVID-19 hospital admissions among Black, Indigenous and other people of color (BIPOC).	County	The county has declined from 7 admissions to 4 admissions for the last two weeks data is available. More information on page 12. Strategies to support BIPOC communities are found in Appendix C: BIPOC Reopening Framework.
	Minimum Testing Regimen		
✔	Region able to administer testing at a rate of 30 per 10k per week.	Region	The regional requirement for testing capability is 5,865 and the Region 1 weekly capacity is 12,695. More information on page 12.

✔	Sufficient testing sites accessible to underserved communities.	Region	Low-barrier testing is now available. Multnomah County is expanding access to testing in Mid County and East County, as well as partnering with community-based organizations to offer testing at culturally specific sites. More information starting on page 13.
	Contact Tracing System		
✔	County has 15 contact tracers per 100k people.	County	63 trained contract tracers are on staff as of 6/3. 70 will be on staff by 6/8. Plan to reach 122 in June, growing as need grows. More information on page 14.
✔	County contact tracing workforce is reflective of the county and able to work in needed languages.	County	40% of planned case investigation/contract tracing positions with bilingual skills are currently filled. More information on page 15.
✔	County is prepared to trace 95% of all new cases within 24 hours.	County	County continues to meet this goal at 95% or above. More information starting on page 15.
	Isolation Facilities		
✔	Counties have hotel rooms available for those who cannot self-isolate.	County	120 motel rooms currently identified to support persons who cannot self-isolate. More information on page 16.
✔	Provide a narrative of how they will respond to three different outbreak situations.	County	Four outbreak narratives provided, including homeless shelter, food processing plant, long-term care facility and corrections. Narratives starting on page 16.

	Finalized Statewide Sector Guidelines		
	Sufficient Health Care Capacity		
✔	Region must be able to accommodate a 20% increase in hospitalizations.	Region	Region 1 Health Preparedness Office (HPO) indicates this is met. OHA will confirm.
	Sufficient PPE Supply		
✔	Hospitals in the region are reporting PPE supply daily through HOSCAP.	Region	HPO indicates this is met, and they will prompt hospitals if tardy. OHA will confirm.
✔	Hospitals in the region must have a 14 or 30 day supply of PPE depending on their size and whether they are a rural hospital.	Region	OHA has received affirmations and can confirm.
✔	Counties must have sufficient PPE for first responders.	County	County first responders have indicated a PPE supply of 30 days or greater. More information starting on page 22.
✔	Health and social service workers essential to community health must have access to adequate PPE.	County	Based on the current PPE request rate from community organizations, a 30-days-or-greater supply of procedural masks is available. More information starting on page 23

Multnomah County Profile

Multnomah County has 812,855 residents and covers about 466 square miles. It is the most densely populated county in Oregon. Multnomah County is also one of Oregon's most diverse places, where 30.7 percent of residents identify as Black, Indigenous, or person of color (BIPOC), where 14 percent of residents are foreign born, and 20 percent of residents speak a language other than English at home. Thirteen percent of residents are over 65 years of age.[i]

Its size and diversity make Multnomah County a cultural center and an economic engine for the state of Oregon. It includes the state's only international airport, a vital west coast seaport, and Oregon's largest center for employment and the arts.

The healthcare industry is the largest employer in Multnomah County. Adventist Health Portland, Legacy Emanuel, Legacy Good Samaritan, Legacy Mount Hood, Oregon Health & Science University (OHSU), Providence Portland, and Shriners Hospital for Children are all located in Multnomah County, representing the most hospitals and the most hospital beds of all Oregon counties.

Despite the county's strengths, it is especially vulnerable to the effects of a pandemic. The high population density puts it at increased risk compared to rural counties. Healthcare workers face special risks. Additionally:

- Multnomah County has the largest houseless population in the state. About 2,000 people are unsheltered, and another 2,000 stay in emergency shelters or transitional housing.[ii] These congregate facilities have elevated risks.
- Multnomah County residents are much more transit-dependent than the state as a whole. Consider: 12.7 percent of households do not have access to an automobile[iii], and transit use is challenging in a pandemic.
- About 34 percent of Multnomah County households fell below the Self-Sufficiency Standard *before* the 2020 pandemic, meaning they were already unable to meet their basic economic needs.[iv] The economic effects of business closures severely impact many of these households.

Multnomah County is governed by a County Chair and four Commissioners elected by district. The County has a full-service health department and a comprehensive human services department. These departments operate public health programs, clinics, pharmacies, dental services and behavioral health programs, and provide essential safety net services such as nutrition assistance, domestic violence support, intellectual and developmental disability services, older adult services, protective services, and veterans' services to many residents.

The County partners with the City of Portland to provide services to houseless residents through the Joint Office of Homeless Services. Further, the County provides many other essential services such as libraries, courts, elections, public safety, community justice and animal services. County workers are participating in the pandemic response in a variety of ways.

Multnomah County Pandemic Response

Incident Overview

In December 2019, nurses and epidemiologists from Multnomah County Public Health established a team and began developing a response plan for what was then called novel coronavirus, a respiratory illness that was beginning to spread from Wuhan, China to other parts

of the world. On January 21, the first case of novel coronavirus was reported in the United States, in Washington state.

On January 30, the Multnomah County Emergency Operations Center (EOC) was activated to coordinate planning efforts for coronavirus impacts, and on February 28, the Oregon Health Authority confirmed Oregon's first presumptive case of the novel coronavirus, in Washington County.

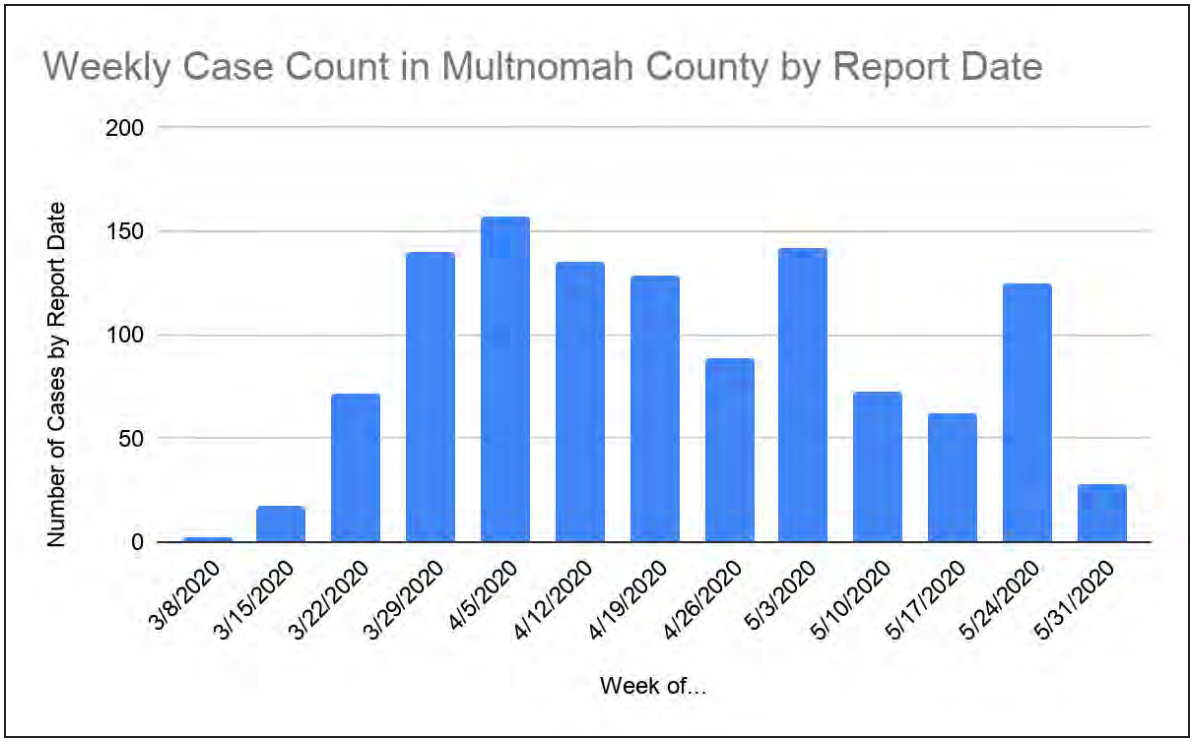
On March 8, Oregon Governor Kate Brown declared a state of emergency related to the novel coronavirus, now officially named COVID-19 by the World Health Organization. On March 23, the governor strengthened protections statewide by issuing the "Stay Home, Save Lives" executive order, directing Oregonians to stay at home, closing non-essential businesses and requiring physical distancing measures at other facilities.

On March 24, the first outbreak at a congregate living facility in Multnomah County was reported and resulted in over 100 positive cases in staff and residents. Due to the vulnerability of residents living in long-term care facilities, they are a priority setting for outbreak prevention and response. Multnomah County has continued to respond to outbreaks as they have occurred in long-term care facilities, other healthcare facilities and worksites by providing infection control recommendations and personal protective equipment, and ensuring access to testing.

To date, COVID-19 has infected 1,240 people in Multnomah County, and 63 have died. The peak case count in Multnomah County by the date of this report was on April 5, 2020, when 157 cases were reported. Weekly case counts from March 2020 to date are shown in Figure 2.

The human suffering and loss of life has been profound. The closures associated with the pandemic have also had an acute effect on residents. A record number of Oregonians are unemployed, and the number of people seeking food and financial assistance has grown steadily since March. Many local businesses are closed with no certainty of reopening.

Figure 2. Cases of COVID-19 for Multnomah County reported weekly*



**Data for most recent dates are not complete due to a delay from when a person gets sick, goes to the doctor, is tested and then reported to Public Health.*

Current Efforts

The Multnomah County EOC is fully activated as of June 5, with over 150 staff working seven days per week in support of the COVID-19 response. Operations at the EOC include managing:

- A growing COVID-19 contact tracing team
- The creation of a community testing team
- Four physical-distancing shelters with a capacity of 390 guests
- Two Isolation Support shelters with a capacity of 120 guests
- A volunteer center
- A community donation center
- A warehouse for donated, purchased and state-provided personal protective equipment and other supplies
- A team to accept, process and distribute requests for supplies from the warehouse
- A team of community liaisons to ensure information exchange with a multitude of sectors, from hospitality and pharmacies to schools, law enforcement and affordable housing operators.
- A team of culturally specific liaisons to ensure information exchange with Black, Indegenious and other communities of color in varying languages.
- Multilingual communication with residents and with many sectors — including healthcare, schools, manufacturing, agriculture, other employers and public agencies —

to provide specific and actionable guidance on appropriate protective measures through the County's COVID-19 website, social media and call center

County staff from many departments are contributing to the work of the EOC and in the shelters, as are volunteers and temporary staff hired to support the effort.

Community Impacts and Equity

COVID-19 affects people of all ages and walks of life. However, people over 65 and people with underlying medical conditions have a greater risk of hospitalization and death from COVID-19. Additionally, people who live in congregate settings are at greater risk of contracting the illness because of the challenges of controlling infection.

For a number of reasons, BIPOC community members are disproportionately impacted by COVID-19. This is true nationwide, and is also observed specifically in Multnomah County:

- Black, Indigenous and other people of color represent 40 percent of COVID-19 cases, despite comprising only 30 percent of residents.
- Latinx and Asian American residents appear more likely to be hospitalized from the virus, and many of those residents reported underlying health conditions.
- Most residents who have died of COVID-19 lived with chronic health conditions — conditions that occur at far higher rates among Black and African American residents due to systemic racism and resulting inequitable social determinants of health.
- On April 29, Multnomah County's Public Health division convened an online panel discussion regarding health disparities among communities of color, and then published data demonstrating a disproportionate burden of illness and death from COVID-19, as well as a call to action.

The disparate impacts of COVID-19 on BIPOC residents were predictable and caused in large part by historic and current systems of oppression. For this reason, the EOC has made equity a key element of their response efforts. This focus squares with the values of Multnomah County government.

This framework includes reopening criteria related to racial equity, in addition to the baseline requirements provided by the State of Oregon. These criteria reflect the County's commitment to tangible actions that prioritize the needs of communities most impacted by COVID-19, and ensure that the pandemic does not increase existing racial inequities in our community.

How Multnomah County Complies with Phase I Prerequisites

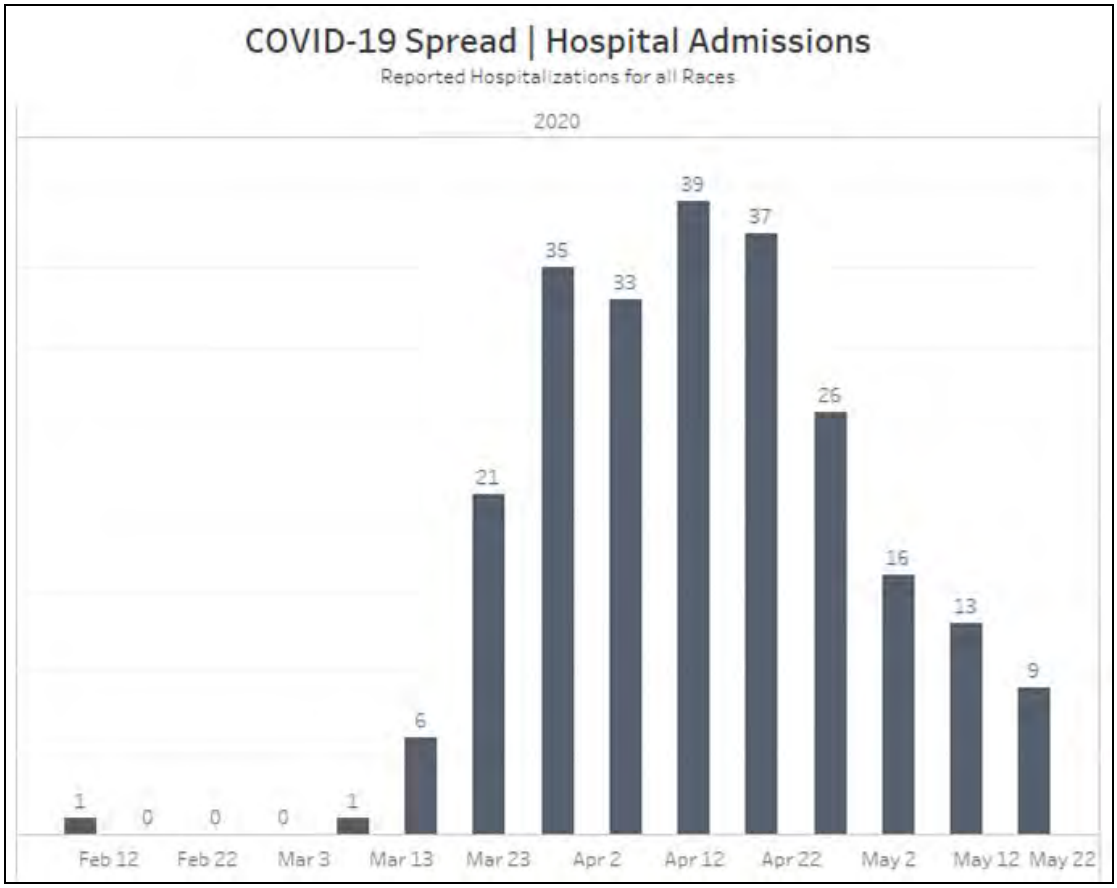
The following responds to the Governor's prerequisites to qualify for Phase 1 reopening.

Declining Prevalence of COVID-19

The percentage of emergency department visits for COVID-19-like illnesses (CLI) are less than the historic average for flu at the same time of year. The Oregon Health Authority has affirmed this in their communications around reopening.

A 14-day decline in COVID-19 hospital admissions. Based on situation status reports from our Health Preparedness Organization (HPO), Multnomah County believes this prerequisite is met. Our HPO indicates that hospital admissions have continued to decrease in HOSCAP. Figure 3 shows a total of nine hospital admissions for the last week information is provided, compared to 16 admissions two weeks earlier.

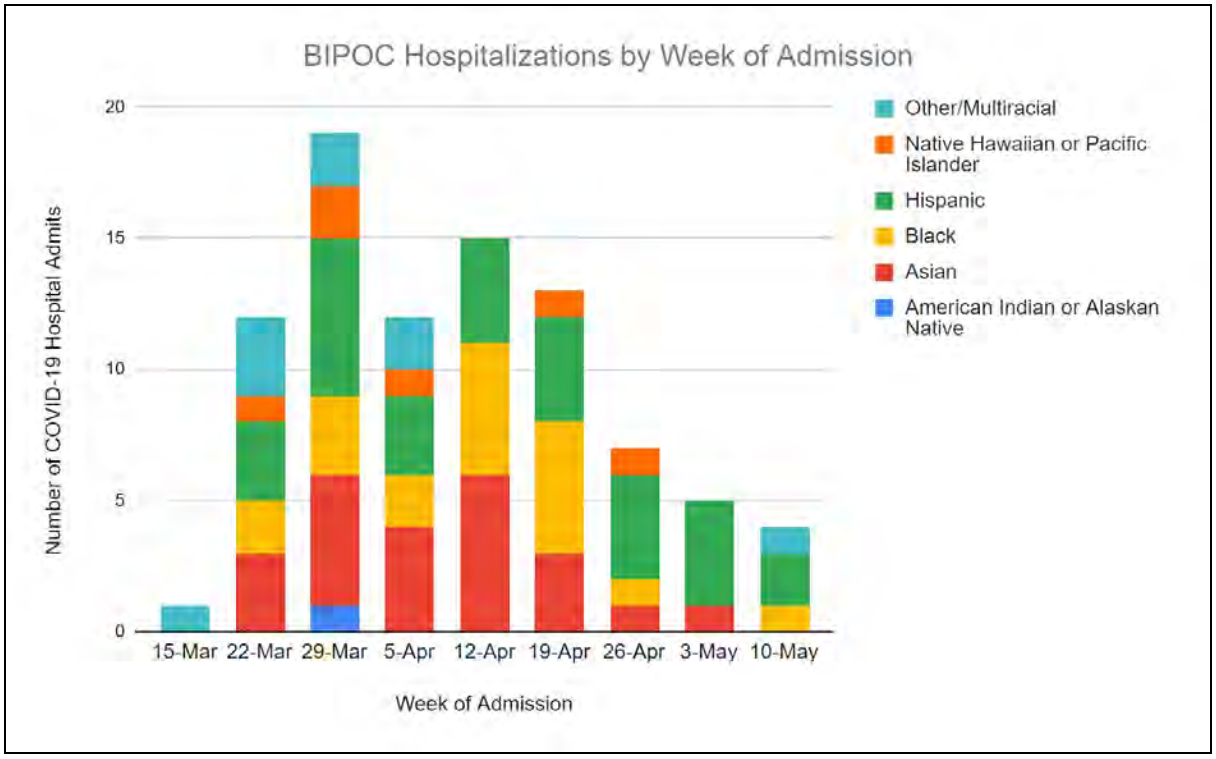
Figure 3. Reported COVID-19 hospitalizations for Multnomah County



The Oregon Health Authority must affirm compliance with these prerequisites.

A 14-day decline in COVID-19 hospital admissions among BIPOC residents. Based on the race and ethnicity data available, this criteria is also met. The county has gone from seven admissions to four admissions over the last two weeks which data is available. Figure 4 shows the hospitalizations starting the week of March 15.

Figure 4. BIPOC Hospitalizations by Week of Admission



Multnomah County will continue to monitor hospitalization rates and deaths for the county as a whole, and for BIPOC communities. If hospitalization rates or deaths rise, or if they rise disproportionately for BIPOC communities, interventions will be put in place before moving forward with reopening. Effective case investigation will help to determine what interventions are necessary.

Minimum Testing Regimen

Region is able to administer testing at a rate of 30 tests per 10,000 residents per week. Our region has about 1,955,00 residents, therefore requiring about 5,865 tests per week to meet this benchmark. Table 1 summarizes the current weekly testing capacity in our region**.**

Table 1. COVID-19 testing capacity for Region 1

Facility	Weekly Capacity
Adventist:	420 tests
Legacy:	8,525 tests
OHSU:	3,750 tests
TOTAL	12,695

Total testing capacity is more than 200 percent of what is required. OHA must confirm this.

Sufficient testing sites accessible to underserved communities. The majority of residents, including low-income residents, will access COVID-19 testing through referrals from their regular care providers. 211 Info provides information about testing for people who have no regular care provider. 211 Info is able to answer calls in over 150 languages.

Testing sites have been established at 14 Federally Qualified Health Centers (FQHCs). Other community health clinics have also increased their capacity to serve their low-income symptomatic patients with COVID-19 testing, either by providing testing directly or partnering with a hospital. ZoomCare, Legacy GoHealth, Providence Express Visits and other urgent care clinics provide testing to symptomatic individuals for an out-of-pocket fee. Thirty-two of these urgent care sites provide testing in Multnomah County currently; patients can usually be seen same-day.

OHSU provides testing at the Portland Expo Center to symptomatic individuals, regardless of medical home or insurance status. No appointment or referral is necessary. They will bill the individual's insurance or Oregon Health Plan. No co-pay is required and there is no cost to uninsured patients.

Multnomah County piloted a pop-up, no-fee, walk-in testing site near an outbreak facility on May 8, 11 and 12 as part of an outbreak response plan. On June 8, the County, in partnership with other agencies and organizations, will stand up twice-weekly low-barrier drive-thru and walk-up testing sites for symptomatic individuals in the East County Clinic parking lot. By early July, the County intends to identify a location and implement a twice-weekly low-barrier drive through testing site in Mid County as well. No one is turned away based on insurance or immigration status. They are designed specifically for individuals without a regular healthcare provider.

The County is also partnering with community leaders and trusted organizations to offer testing at culturally specific community sites. The County is hiring a diverse set of community health nurses and medical assistants, and partnering with community health workers through contracts

with culturally specific community-based organizations, to form core teams that will work with to further develop and implement these testing programs.

Conversations are underway with community leadership to identify the most effective models of testing, sites, pre-testing education and wraparound services that will be required to best serve individuals and communities. Potential models include home-delivered self-collection tests for sick individuals and exposed large households, and rotating sites for countywide coverage hosted at various houses of worship, community-based organizations, and school parking lots. Communities include African American/African, Immigrant and Refugee, Asian, Latinx, Native American and Pacific Islander communities. County community drive-through sites can be promoted to and accessed by culturally specific communities as well. The culturally specific testing described here will be targeted in focus, but inclusive in practice. No one will be turned away.

The first culturally-specific testing event will be June 6, 2020. Another is scheduled for June 20. The goal is to have culturally specific testing available multiple times weekly. The County will continue to assess developing community needs and seek to identify and address cultural or geographic gaps.

As the County continues to expand testing options we are also developing a community information campaign that includes:

- A public map of testing sites by provider type and location.
- Information materials to distribute in the community, describing current testing resources.
- Partnerships with trusted community organizations to promote these testing resources.

Additionally, Multnomah County will continue to work to improve the collection of race and ethnicity data for all tests, including negative tests, to ensure that BIPOC communities have adequate access to testing. The County will continue to share race and ethnicity data as part of the COVID-19 data it provides to the public on its website.

We will also continue to advocate for FQHCs and safety net clinics to have access to the supplies and resources required to provide testing that meets community needs, and to ensure that public-facing professions with large numbers of BIPOC workers are recognized as front-line workers who should be prioritized for testing.

County has 15 contact tracers per 100,000 people. Multnomah County has about 812,000 residents and, to meet the state's threshold, will eventually require 122 contact tracers available to work. The County currently has 63 trained contract tracers on staff. In the initial buildout of our response, the County was able to utilize local medical students to aid in contact tracing efforts. The Health Department and County Human Resources have identified approximately 60 existing County staff that have the knowledge, skills and abilities to serve as contract tracers, and they have been reassigned to this work. The County is also recruiting externally for contract tracers and case investigators. These jobs were posted on Thursday, May 28 and closed on

Saturday, May 30 due to overwhelming interest in these positions. The County is currently interviewing these candidates, and does not anticipate any difficulty in filling the positions with qualified candidates.

The County's approach is providing the opportunity to recruit a diverse workforce, and to provide adequate training and onboarding of new staff. The current workforce is more than adequate for the number of positive test results received to date, and it is growing.

County contact tracing workforce is reflective of the county and able to work in needed languages. 33 case investigation/contract tracing positions with bilingual skills are planned. Of these, 40% are currently filled. The complete workforce is expected to include workers with language ability in Spanish, Russian, Vietnamese, Somali, or Arabic, among others. Interpretation via phone is also available.

The County will increase language-specific staffing if the need for other languages appears, as well as a cultural competency for Latinx (32%), African American (21%), Asian (7%), Slavic (4%), Pacific Islander (5%), Native American/Alaska Native (4%), Middle Eastern, and other immigrant (5%), and LGBTQ (4%) communities. These identified skills are based on the current COVID-19 health data as well as past health inequities. See Appendix E: Contact Tracing Model.

Additionally, Multnomah County is currently subcontracting with numerous culturally specific community partners for wraparound support services for people and families who must isolate for 14 days. These culturally specific community-based staff are an integral part of the contact tracing team who will support successful isolation and quarantine efforts, and help identify other possible contacts, transmission pathways and more effective prevention measures. If COVID-19 continues to disproportionately impact BIPOC communities, contract tracing will help the County identify more effective supports or additional interventions.

County is prepared to trace 95% of all new cases within 24 hours. The schedule of case investigators and contact tracers ensures there is a full contact tracing team on staff daily, including weekends. The County employs on-call-staff as needed to fill any gaps.

Workflows are designed to ensure efficiency in case follow-up, including prompt notification of positive lab results by the investigator if needed, as well as prompt medical record review to initiate case investigation outreach as soon as possible after receipt of the positive lab result.

New contact tracers are provided self-study materials to review, including investigative guidelines, interview scripts and general Orpheus training videos. New contact tracers also participate in a live webinar training that outlines disease knowledge, contact tracing roles and structure, investigation protocols and expectations, and Orpheus system COVID-19 case entry. This training also includes an overview of priority data elements to be entered in Orpheus during investigations.

New contact tracers are designated a Team Lead experienced in COVID-19 investigations to oversee their activities and review their work in Orpheus. The Team Leads ensure timely follow-up on all reported cases and ensure that data entry in the Orpheus system is accurate and complete. Investigators and contact tracers utilize a shared chat room while working in order to communicate when questions arise regarding investigations and the Orpheus system.

As of the week of June 1, at least 95% of all new COVID-19 cases in Multnomah County had the first tracing call placed within 24 hours. This criteria is met.

Isolation Facilities

Counties have hotel rooms available for those who cannot self-isolate. There are currently 120 motel rooms available at two Multnomah County EOC-managed sites that serve as Isolation Support shelters. These shelter spaces were opened to serve people experiencing homelessness, but the census has not exceeded 20. Rooms can be made available to others who need them.

The County is developing a mechanism for community-based organizations to refer people who are experiencing symptoms of COVID-19 to Isolation Support shelters if they are unable to isolate at home. In addition, the County is exploring alternate isolation strategies, such as house rentals or recreational vehicle rentals, that can be activated on short notice to accommodate the needs of families and individuals residing across the county, including in rural areas.

Furthermore, Multnomah County continues to add motel capacity in anticipation of moving vulnerable houseless people out of congregate shelters and into non-congregate settings. These facilities are expected to remain available for a year or more, even after the EOC is demobilized, because some at-risk houseless people will require support until the pandemic abates. These rooms could also be made available to others if need ramps up suddenly. More information about physical distance congregate shelters in Scenario 1: Homeless Shelter.

This is another benchmark that Multnomah County will continue to work to exceed, but the criteria is currently met.

Counties provide a narrative of how they will respond to three different outbreak situations in the county. Multnomah County follows the OHA COVID-19 Investigative Guidelines requirements and recommendations for outbreak response. In addition, site-specific prevention, identification and response strategies for four unique, high-risk settings are described below.

Scenario 1: Homeless Shelter
Prevention: We acknowledge that the best situation to prevent transmission of COVID-19 and promote general health is to ensure that all people have safe, permanent housing available. People who are experiencing homelessness have a high risk of hospitalization and death from COVID-19, if infected. Untreated chronic disease is more prevalent in the houseless community, and most houseless people also experience barriers to timely access to healthcare. People

without stable homes often lack consistent access to facilities or resources for handwashing or general hygiene, resulting in a higher risk of spreading illness in their community if they are infected.

To reduce risk in unsanctioned camps, a large, trained team of outreach workers has provided hand hygiene supplies and COVID-19 prevention information to campers throughout the county, logging over 1,500 individual interactions. The City of Portland also installed portable handwashing stations in areas commonly used for unsanctioned camping and established three temporary outdoor emergency shelters to facilitate hygiene and physical distancing needs. Additionally, Portland Parks and Recreation opened 50+ restrooms in parks.

The County has also worked to reduce risk in indoor shelters. Indoor shelters offer substantial benefits to vulnerable populations. However, the risk of illness spread is heightened at shelters due to physical closeness in sleeping, eating and socializing spaces. To reduce these risks:

- Working together, the EOC and the Joint Office of Homeless Services set up four new temporary physical distancing shelters. This allowed existing shelters to decrease their census and reorganize their spaces to comply with six-foot physical distancing and other considerations. Adequate capacity to maintain physical distancing will be sustained.
- Daily symptom screening with temperature checks are performed at all County-supported shelters and recommended for others. No-touch thermometers and PPE have been provided.
- Symptomatic guests are transported to one of two Isolation Support shelters where they reside until they are tested and medically cleared to re-enter other shelters.
- Infectious individuals discharged from hospitals can convalesce at the Isolation Support shelter if they do not have safe, permanent housing.
- The Joint Office and Public Health, along with shelter operators and advocates, have created and continue to update guidance on the most practical ways to apply public health best practices in shelters.

Individuals at highest risk of severe illness and their household members in County-funded congregate and semi-congregate shelters are also relocating to apartments or to hotel rooms. Highest risk is defined as meeting multiple of the following criteria:

- Age 65 or older
- Serious heart, kidney, liver, or immune system condition, diabetes, obesity
- Being a member of a community at higher risk for COVID-19 and associated complications due to longstanding social and health inequities, including BIPOC and linguistically diverse populations.

Identification: Shelter operators and advocates hold weekly phone meetings with Public Health and related agencies to foster dialogue and partnerships in support of early identification and response to outbreaks.

Public Health has attempted investigation of every case of COVID-19 since the pandemic's beginning. It will maintain adequate capacity to continue to do so.

Response: In the event of one or more confirmed positive cases in a congregate or semi-congregate setting the following procedures will generally apply:

- On-site managers will be notified of a confirmed positive case so that they may assist with relocation of the individual and facilitate contact investigation.
- Guests with COVID-19 will be required to relocate to an isolation room in one of the Isolation Support shelters until medically cleared.
- Individual staff members with symptoms of COVID-19 will be required to cease working at the shelter until medically cleared to return.
- Communicable Disease Services will conduct a contact investigation with the COVID-19 positive individual.
- All identified close contacts will be notified, tested, and supported to quarantine. In a shelter setting that may include all residents and staff.

Shelter providers are strongly encouraged to develop plans for staff testing in the event of an outbreak as part of routine occupational health. If needed, County Public Health will assist in securing testing for employees.

If the process outlined above leads to enough staff having to self-isolate that shelter operations are jeopardized, Multnomah County will assist in providing temporary staffing to allow for continuity of services.

Staff and guests continuing to work and live in the shelter will receive education and resource supports to continue physical distancing practices and monitor symptoms.

At the threshold of one case among staff or guests, the County Chair and Joint Office leadership will be notified. Two cases among staff or guests will be defined as an outbreak, an outbreak number will be requested and OHA will be engaged for coordination.

Note: response protocols require COVID-19 positive residents to relocate. However, if the setting is an individual's home (e.g. Single Room Occupancy (SRO) housing unit), they cannot be required to leave. If an individual is unwilling to leave, wrap-around services will be provided to allow the individual to maximally self-isolate in their unit. Enhanced protocols will be implemented if there are shared facilities that the individual must access (e.g. a shared restroom).

Scenario 2: Food Processing Plant

Prevention: Multnomah County is developing an outreach program for farms, nurseries, and related food-processing employers. It is assessing what assistance may be needed with PPE, hand hygiene products for employees at home, and employee prevention and testing information. The County's goal is to support local employers in higher-risk industries and facilities and promote compliance with quarantine, isolation, and infection-control procedures.

The County is also developing multilingual prevention and education materials to support workers in higher-risk industries with information and resources necessary to keep themselves and their families safe. Efforts include:

- Latinx-specific media campaigns (print, radio, TV)
- Partnerships with Latinx advocacy groups and community organizations
- Bilingual community health workers for education and wrap-around services that help workers who need to self-isolate.

Identification: In this situation, Multnomah County will again follow Oregon Health Authority Investigative Guidelines. Two positive cases of COVID-19 at the same worksite will initiate an outbreak investigation by Multnomah County in conjunction with the Oregon Health Authority.

Response: In an outbreak, the County will work promptly to:
- Gather information about the facility, including products made, sanitation infrastructures, worker roles, and frequency of position change/team mixing.
- Interview management to characterize the practices of the facility, including employee prevention education, temperature and symptom screening, and messaging about sick leave policies.
- Observe the facility in a site visit.

With this information, the County will:
- Provide clear recommendations to the employer about the need to support sick employees to leave the work site immediately, the necessary length of isolation and quarantine, and appropriate criteria for returning to work.
- Confirm testing has been initiated and discuss the testing plan, or recommend/support employer-paid testing be implemented.
- Assure prompt reporting and two-way communication with public health
- Ensure roles and expectations are clear between the employer and public health
- Remind the employer of public health standards for information release to the public or media.

The County will also work with the partners identified as part of prevention efforts to support affected households and prevent further spread, and perform case investigation and contact tracing to identify possible exposure interactions outside of work.

The County will also seek to identify regionally linked cases. In this effort, they may contact state partners such as Oregon Health Authority, the Department of Agriculture, and the Occupational Safety and Health Administration.

If seasonal workers are present or expected to arrive, the County may also:
- Identify and inspect any on-site housing for sanitation infrastructure, cleaning practices, and physical distancing assurance for sleeping, eating, bathroom, and other common spaces.
- Assess visitation policies, carpooling and other shared modes of transportation to and from work sites.
- Assess presence of plan for testing and subsequent isolation or cohorting of sick or COVID-19 positive individuals.

- Assess awareness of incoming workers of on-site outbreak, and consult with consulates and other jurisdictional authorities about how the employer or the County may inform and assure safety of traveling workers.

Scenario 3: Long Term Care Facility
Prevention: Oregon Health Authority, Oregon Department of Human Services, Multnomah County Public Health and Multnomah County Aging, Disability and Veteran's Services Division have already shared prevention guidance, technical assistance, and PPE. Multnomah County is now engaging in regional prevention activities for long term care facilities with Clackamas and Washington Counties. We anticipate this will take the form of regular webinars and training sessions for facilities to ensure they are prepared for cases of COVID-19 in their facilities.

Identification: Multnomah County Health Department Communicable Disease Services (CDS) has a case investigation and support team specifically dedicated to congregate setting outbreaks. When one case is identified among employees or residents of a long term care facility, Communicable Disease Services initiates priority case investigation, and communicates with the facility to quickly identify other sick staff or residents, or suspected or presumptive cases.

Response: With one case, Communicable Disease staff do a virtual assessment with the facility utilizing guidance in the Long Term Care Facility (LTCF) COVID-19 Response Toolkit. This review ensures measures are in place to prevent the spread of COVID-19 in the facility such as:

- Visitor and communal activity restrictions
- Routine employee and resident screening
- Proper use of personal protective equipment (PPE)
- Adherence to infection-control practices such as hand hygiene and disinfection of environmental surfaces

Communicable Disease staff also inquire about adequate PPE supplies and link the facility to resources if needed.

Upon identification of two sick individuals, Communicable Disease staff open an outbreak case and review infection control practices using the Outbreak Response Tool checklist in the Long Term Care Facilities Toolkit. Recommendations are made based on this assessment for infection control, cohorting, testing, and other outbreak interruption measures. Additional infection control support may be provided by the OHA's Healthcare Acquired Infections team, through consultation or through virtual or onsite assessments at the facility in coordination with Multnomah County. Multnomah County communicates routinely with the OHA, Oregon Department of Human Services, and Multnomah County Aging,Disability, and Veteran's Services to ensure continuity of services and response for long term care facilities with COVID-19.

CD staff communicate with the facility administration on a daily basis for the duration of the outbreak. This daily communication includes updates on newly symptomatic residents or staff through a shared electronic line list, discussion of infection control practices, update on PPE needs for supply assistance from the County, and updates on pending staffing shortages.

Multnomah County may support the facility with resident testing if needed. It is generally the expectation that employers will provide testing for their employees, but Multnomah County will work with facilities to ensure staff have access to testing. Any symptomatic resident or staff should be tested. Asymptomatic testing may be done on a case by case basis to support actions such as cohorting sick residents away from well residents.

Multnomah County follows outbreaks until illness has resolved for two full incubation periods of COVID-19, which is 28 days. After 28 days with no illness in the facility, the outbreak is closed. All outbreak documentation occurs in the state ORPHEUS database.

Scenario 4: Corrections

Prevention: Multnomah County Adult Corrections prioritizes the health of staff and detained individuals. It has put in place symptom screening and temperature checks upon entry at booking. Detained individuals receive a face covering for use in the booking setting. Symptom screening and a temperature check occur again during intake screening before housing, followed by daily symptom screening and temperature checks for the first 14 days of incarceration for all detained individuals. Detainees are assigned a stable group in single cell housing for the first 14 days of incarceration before mixing into the general population.

Enhanced infection control is continuously in place including: restricting ill staff, frequent cleaning of high touch surfaces, appropriate PPE use, and good hand hygiene.

Identification: Any individual found to have symptoms of COVID-19 are moved to a pre-identified isolation room with negative airflow. They are tested for COVID-19 and otherwise evaluated and treated as appropriate by a licensed medical provider. Any individual testing positive remains in the medical unit in negative airflow with droplet precautions. Close contacts among staff and other detainees will be identified based on a detailed review of the individual's movements while in custody during the infectious period.

Dorms will be assessed for risk of exposure. If needed they will be closed to new admissions and all non-mandatory communal and social activities stopped. Detainees in those dorms will be watched closely for symptoms of COVID-19. They will not be allowed to mix with detainees from other housing units.

Response: Once two individuals are identified as having COVID-19, Corrections Health will notify Multnomah County Health Department's Communicable Disease Services, their assigned Infection Preventionist, and the Corrections Facility Chief Deputy.

Corrections Health staff will track daily counts of ill individuals and report to Communicable Disease and Infection Prevention. Depending on the situation, Corrections Health leadership may decide to test all individuals in a dorm or cohorted housing using the Oregon State Public Health Laboratory. Staff will be advised to seek testing through their personal health care provider or through Multnomah County Communicable Disease Services.

All staff, deputies and adults in custody will be notified of the outbreak and provided appropriate health education. Corrections will remain in close contact with Communicable Disease Services

until the outbreak is considered over. After 28 days with no illness in the facility, the outbreak will be closed.

Statewide Sector Guidelines

Multnomah County affirms that it will apply the statewide sector guidelines. In addition, the County will provide communications to residents, specifically including BIPOC communities, about the reopening guidance. The County will also prioritize PPE resources for frontline workers in public-facing jobs that employ large numbers of BIPOC residents.

Sufficient Health Care Capacity

Region must be able to accommodate a 20% increase in hospitalizations. Based on situation status reports from our Health Preparedness Organization (HPO), Multnomah County believes this prerequisite is met. There is a low census in hospitals currently per our HPO and HOSCAP. Other counties in our region have also been approved to reopen. OHA must affirm this criteria is met.

This criteria is in place because of the risk that hospitals could become overwhelmed. Recognizing this, Multnomah County is also advocating that hospitals provide their critical care guidance for the community to see and understand. Critical care guidance determines who gets hospital beds and ventilators if there are not enough for every patient. Critical care guidance must not penalize BIPOC communities for past health inequities in chronic disease.

Sufficient PPE Supply

Hospitals in the region are reporting PPE supply daily through HOSCAP. Hospitals in our region are in compliance. Our HPO staff have also committed to monitor data entry and conduct direct outreach to any hospital that falls behind. We believe this criteria is met, and other counties in our region have been approved to reopen. OHA will affirm.

Hospitals in the region must have a 14 or 30 day supply of PPE depending on their size and whether they are a rural hospital. Our HPO staff has confirmed that attestation letters have been received by OHA, and we believe this criteria is met, as other counties in our region have been approved to reopen. OHA will confirm.

Counties must have sufficient PPE for first responders. We have received confirmation from each first responder agency that is dispatched from the Portland Bureau of Communications, which supports Multnomah County. Fire and EMS agencies have provided a coordinated inventory that shows sufficient PPE. Individual law enforcement agencies have provided letters indicating that their PPE is sufficient. See Table 2.

Table 2. First responder agencies in Multnomah County and PPE sufficiency information

Agency Name	# of First Responders	Date letter submitted	"Sufficient" PPE until
Portland Airport Fire & Rescue	40	May 12, 2020	31-Aug-20
American Medical Response (AMR)	246	May 12, 2020	31-Dec-20
Corbett Fire District No. 14	25	May 12, 2020	30-Sep-20
City of Gresham Fire and Emergency Services	106	May 11, 2020	31-Aug-20
Portland Fire & Rescue	707	May 12, 2020	31-Aug-20
Sauvie Island Fire District	25	May 12, 2020	1-Sep-20
Portland Police	917	May 13, 2020	Mid August
Sheriff's Office	626	May 13, 2020	30-Jun-20
Gresham Police	130	May 13, 2020	30-Jun-20
Port of Portland Police Department	53	May 14, 2020	30-Jun-20
Portland State University Campus Public Safety	6	May 13, 2020	15-July-20

The County also has PPE inventory to accommodate requests from first responders, and there are none pending.

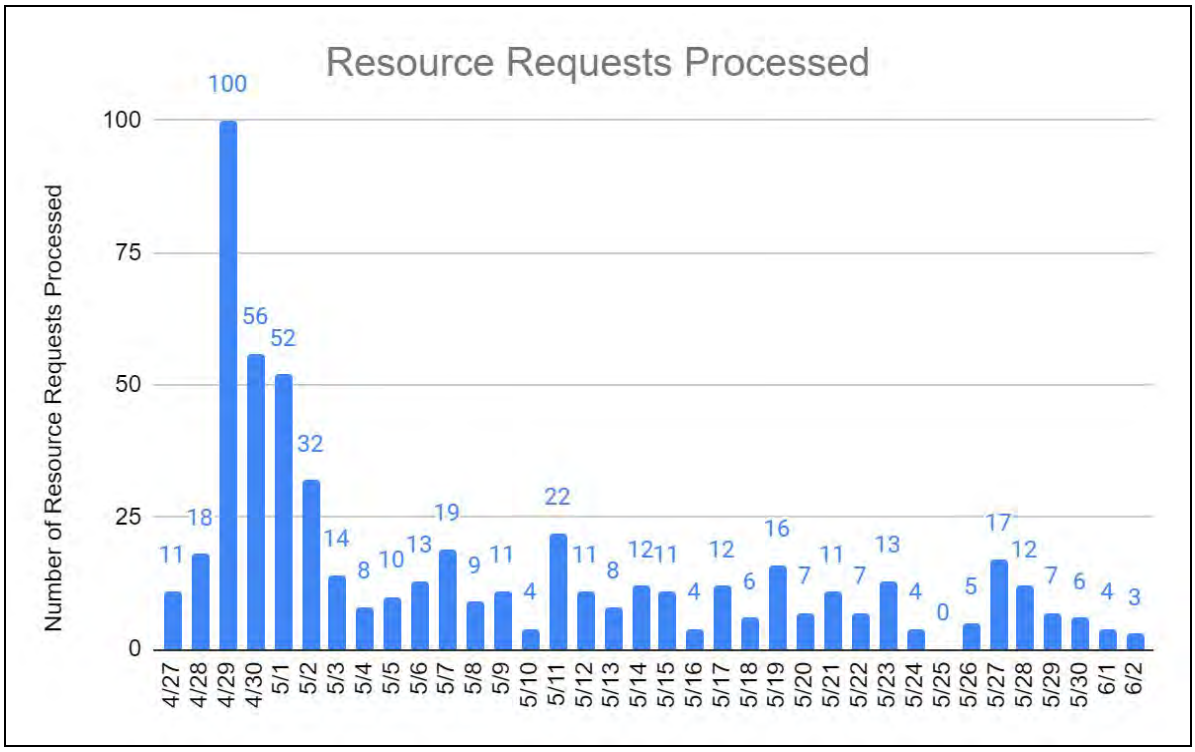
This criteria is met. This document serves as Multnomah County's attestation to this criteria.

PPE Monitoring for Key Constituents. Health and social service workers essential to community health must have access to adequate PPE. Healthcare providers and other service organizations normally purchase PPE, but when supply chains are disrupted and they are unable to acquire necessary PPE, they can request it from the County. The County prioritizes healthcare providers in distributing PPE, and seeks to assure that all County-funded programs provide the basic, necessary PPE to contractors and clients.

The County also works with community-based organizations, churches, and nonprofits, to assist with PPE distribution. The most requested item is procedural masks. Based on the number of requests the County has received and the quantity of masks on hand, the County has greater than a 30 day supply to continue support for key county organizations; this criteria is met. Figure

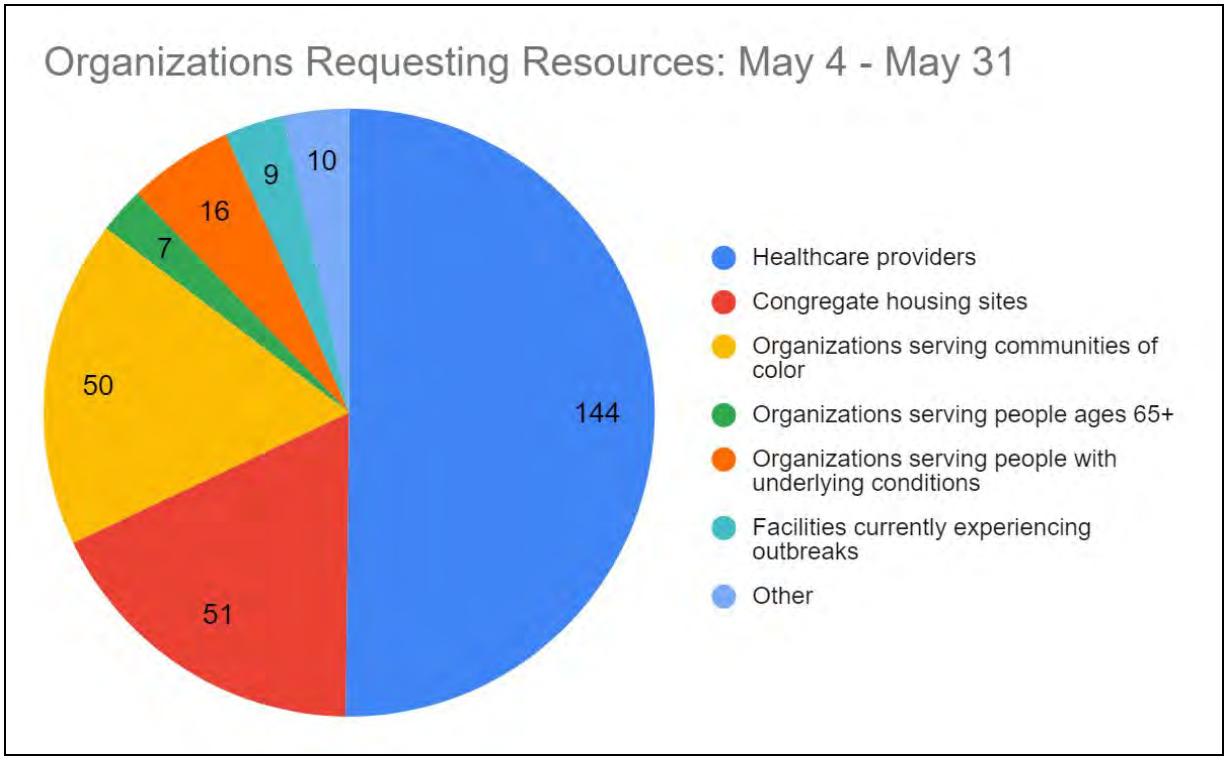
5 shows the number of requests the County received daily from April 27 - June 2. The number of requests has remained relatively flat for over the last 3 weeks.

Figure 5. Resource requests processed by the County 4/27- 6/2



In addition to tracking the number of requests, the County also tracks different categories of businesses requesting PPE to better understand the community's needs. Figure 6 illustrates the key groups the County is supporting and the number of requests over a 4 week period.

Figure 6. Resource requests categorized by type of business or organization



Conclusion

The County will continue to work actively to minimize the spread of COVID-19, reduce severe illness, and prioritize the needs of those most vulnerable to the impacts of a pandemic. We will focus our efforts on the community which has disproportionately felt the impact of the pandemic including those in public-facing jobs, residents with underlying health conditions, people in long-term care and, due to current and historic health inequities, on Black and Indigenous people, and other communities of color.

Based on the County's status of the Governor's Phase one opening prerequisites and our overarching focus on safety for our community and our employees, we are requesting an approval of this plan and a Phase 1 opening for Multnomah County on June 12, 2020.

Appendix

A. References

B. Hospital Attestation Letters

C. BIPOC Reopening Framework

D. Comprehensive COVID-19 Testing Strategies

E. Contact Tracing Model

Appendix A: References

[i] From US Census* *Quickfacts*:
https://www.census.gov/quickfacts/fact/table/OR,multnomahcountyoregon/PST045219.
*The US Census undercounts people of color, houseless people, and undocumented residents.

[ii] *2019 Point in Time Count of Homeless in Multnomah County Oregon.*
https://multco.us/file/82568/download.

[iii] From US Census, *American Community Survey 2019*:
https://www.census.gov/acs/www/about/why-we-ask-each-question/vehicles/.

[iv] *Poverty in Multnomah County.* 2019.
https://drive.google.com/file/d/1Bx48_RZJejqR9dIZJCby5Kkk--FgWuAW/view

Appendix B: Hospital Attestation Letters

1. Kaiser Medical Centers
2. Providence Health and Services
3. Shriners Hospitals for Children
4. Legacy Health Medical Centers
5. Adventist Health Portland
6. OHSU Hospitals and Clinics

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Kate Brown, Governor

Oregon Health Authority

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Hospital Attestation to Resume Non-Emergent or Elective Procedures

On April 27, 2020, the Governor issued Executive Order 20-22, that allowed hospitals to resume non-emergent or elective procedures, by May 1, 2020 at the earliest, if a hospital is in compliance with Oregon Health Authority (OHA) guidance. The guidance issued by OHA on April 29, 2020, requires hospitals to have adequate personal protective equipment (PPE) on hand and to attest to OHA prior to resuming non-emergent or elective procedures, that the hospital meets OHA standards.[1]

This attestation form must be signed by an individual with legal authority to act on behalf of the hospital or health system.

I, James L. Robinson III (printed name), on behalf of Kaiser Sunnyside + Westside (name of hospital or health system), attest to the following (please check any of the boxes that apply and supply any additional information):

- [X] The hospital or health system intends to resume non-emergent or elective procedures by (insert date) 5/11/20
- [X] The hospital or hospitals within the health system have adequate medical grade PPE supplies that meet applicable National Institute for Occupational Safety and Health and U.S. Food and Drug Administration regulations for performing non-emergent or elective procedures.
- [X] As a large hospital (as defined in OHA guidance) the hospital has an adequate 30-day supply of PPE on hand that is appropriate to the number and type of procedures to be performed or an open supply chain, as that is defined in OHA's guidance.
- [ ] As a small hospital (as that is defined in OHA guidance), the hospital has an adequate 14-day supply of PPE that is appropriate to the number and type of procedures to be performed on hand or an open supply chain, as that is defined in OHA's guidance.

---

[1] The guidance can be found at X.

☒ As a health system, PPE supplies on hand were calculated at a health system level and the PPE requirements can be met for each of the hospitals within the health system listed below.

If a health system is submitting this attestation, please list all of the hospitals in the system for which this attestation applies:

Kaiser Sunnyside Medical Center
Kaiser Westside Medical Center

I certify that the responses in this attestation are accurate and complete. I understand that if OHA determines that a hospital is not in compliance with the PPE requirements, OHA may require the hospital to cease performing non-emergent or elective procedures for a specified period of time.

James L. Robinson III, PsyD
Printed name and title

5/8/20
Date

Signature

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This attestation form must be signed by an individual with legal authority to act on behalf of the hospital or health system.

I, William Olson (printed name), on behalf of Providence Health & Services (name of hospital or health system), attest to the following (please check any of the boxes that apply and supply any additional information):

- ☒ The hospital or health system intends to resume non-emergent or elective procedures by (insert date) May 4, 2020
- ☒ The hospital or hospitals within the health system have adequate medical grade PPE supplies that meet applicable National Institute for Occupational Safety and Health and U.S. Food and Drug Administration regulations for performing non-emergent or elective procedures.
- ☐ As a large hospital (as defined in OHA guidance) the hospital has an adequate 30-day supply of PPE on hand that is appropriate to the number and type of procedures to be performed or an open supply chain, as that is defined in OHA's guidance.
- ☐ As a small hospital (as that is defined in OHA guidance), the hospital has an adequate 14-day supply of PPE that is appropriate to the number and type of procedures to be performed on hand or an open supply chain, as that is defined in OHA's guidance.

---

[1] The guidance can be found at X.

☒ As a health system, PPE supplies on hand were calculated at a health system level and the PPE requirements can be met for each of the hospitals within the health system listed below.

If a health system is submitting this attestation, please list all of the hospitals in the system for which this attestation applies:

Providence St. Vincent Medical Center
Providence Portland Medical Center
Providence Seaside Hospital, Providence Milwaukie Hospital
Providence Hood River, Providence Willamette Falls Medical Center
Providence Newberg Medical Center
Providence Medford Medical Center

I certify that the responses in this attestation are accurate and complete. I understand that if OHA determines that a hospital is not in compliance with the PPE requirements, OHA may require the hospital to cease performing non-emergent or elective procedures for a specified period of time.

William Olson, COO
Printed name and title

4/30/2020
Date

William Olson
Signature

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This attestation form must be signed by an individual with legal authority to act on behalf of the hospital or health system.

I, Dereesa Reid (printed name), on behalf of Shriners Hospitals for Children (name of hospital or health system), attest to the following (please check any of the boxes that apply and supply any additional information):

- ☑ The hospital or health system intends to resume non-emergent or elective procedures by (insert date) 5/5/2020
- ☑ The hospital or hospitals within the health system have adequate medical grade PPE supplies that meet applicable National Institute for Occupational Safety and Health and U.S. Food and Drug Administration regulations for performing non-emergent or elective procedures.
- ☐ As a large hospital (as defined in OHA guidance) the hospital has an adequate 30-day supply of PPE on hand that is appropriate to the number and type of procedures to be performed or an open supply chain, as that is defined in OHA's guidance.
- ☑ As a small hospital (as that is defined in OHA guidance), the hospital has an adequate 14-day supply of PPE that is appropriate to the number and type of procedures to be performed on hand or an open supply chain, as that is defined in OHA's guidance.

[1] The guidance can be found at https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2322u.pdf.

☐ As a health system, PPE supplies on hand were calculated at a health system level and the PPE requirements can be met for each of the hospitals within the health system listed below.

If a health system is submitting this attestation, please list all of the hospitals in the system for which this attestation applies:

_____

_____

_____

_____

I certify that the responses in this attestation are accurate and complete. I understand that if OHA determines that a hospital is not in compliance with the PPE requirements, OHA may require the hospital to cease performing non-emergent or elective procedures for a specified period of time.

Dereesa Reid, MBA Hospital Administrator
Printed name and title

May 5, 2020
Date

Signature

OFFICE OF THE DIRECTOR
Kate Brown, Governor

Oregon Health Authority

500 Summer St. NE E20
Salem, OR 97301
Voice: 503-947-2340
Fax: 503-947-2341

Hospital Attestation to Resume Non-Emergent or Elective Procedures

On April 27, 2020, the Governor issued Executive Order 20-22, that allowed hospitals to resume non-emergent or elective procedures, by May 1, 2020 at the earliest, if a hospital is in compliance with Oregon Health Authority (OHA) guidance. The guidance issued by OHA on April 29, 2020, requires hospitals to have adequate personal protective equipment (PPE) on hand and to attest to OHA prior to resuming non-emergent or elective procedures, that the hospital meets OHA standards.[1]

This attestation form must be signed by an individual with legal authority to act on behalf of the hospital or health system.

I, Trent Green (printed name), on behalf of Legacy Health (name of hospital or health system), attest to the following (please check any of the boxes that apply and supply any additional information):

- ☑ The hospital or health system intends to resume non-emergent or elective procedures by (insert date) May 1, 2020
- ☑ The hospital or hospitals within the health system have adequate medical grade PPE supplies that meet applicable National Institute for Occupational Safety and Health and U.S. Food and Drug Administration regulations for performing non-emergent or elective procedures.
- ☐ As a large hospital (as defined in OHA guidance) the hospital has an adequate 30-day supply of PPE on hand that is appropriate to the number and type of procedures to be performed or an open supply chain, as that is defined in OHA's guidance.
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[1] The guidance can be found at https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2322u.pdf.

☑ As a health system, PPE supplies on hand were calculated at a health system level and the PPE requirements can be met for each of the hospitals within the health system listed below.

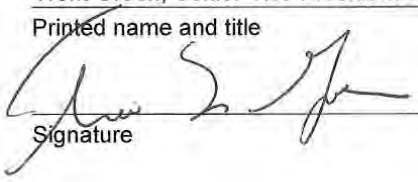
If a health system is submitting this attestation, please list all of the hospitals in the system for which this attestation applies:

Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center,
Legacy Meridian Park Medical Center, Legacy Mount Hood Medical Center,
Legacy Silverton Medical Center

I certify that the responses in this attestation are accurate and complete. I understand that if OHA determines that a hospital is not in compliance with the PPE requirements, OHA may require the hospital to cease performing non-emergent or elective procedures for a specified period of time.

Trent Green, Senior Vice President & COO
Printed name and title

4/30/2020
Date



Signature

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This attestation form must be signed by an individual with legal authority to act on behalf of the hospital or health system.

I, Donald E Welch (printed name), on behalf of Adventist Health Portland (name of hospital or health system), attest to the following (please check any of the boxes that apply and supply any additional information):

- ☑ The hospital or health system intends to resume non-emergent or elective procedures by (insert date) May 1, 2020
- ☑ The hospital or hospitals within the health system have adequate medical grade PPE supplies that meet applicable National Institute for Occupational Safety and Health and U.S. Food and Drug Administration regulations for performing non-emergent or elective procedures.
- ☑ As a large hospital (as defined in OHA guidance) the hospital has an adequate 30-day supply of PPE on hand that is appropriate to the number and type of procedures to be performed or an open supply chain, as that is defined in OHA's guidance.
- ☐ As a small hospital (as that is defined in OHA guidance), the hospital has an adequate 14-day supply of PPE that is appropriate to the number and type of procedures to be performed on hand or an open supply chain, as that is defined in OHA's guidance.

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If a health system is submitting this attestation, please list all of the hospitals in the system for which this attestation applies:

_____

_____

_____

_____

I certify that the responses in this attestation are accurate and complete. I understand that if OHA determines that a hospital is not in compliance with the PPE requirements, OHA may require the hospital to cease performing non-emergent or elective procedures for a specified period of time.

Donald E Welch , CFO
Printed name and title

April 30, 2020
Date

Donald E Welch
Signature

Click here to submit form

Print Reset

OFFICE OF THE DIRECTOR
Kate Brown, Governor

Oregon Health Authority

500 Summer St. NE E20
Salem, OR 97301
Voice: 503-947-2340
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Hospital Attestation to Resume Non-Emergent or Elective Procedures

On April 27, 2020, the Governor issued Executive Order 20-22, that allowed hospitals to resume non-emergent or elective procedures, by May 1, 2020 at the earliest, if a hospital is in compliance with Oregon Health Authority (OHA) guidance. The guidance issued by OHA on April 29, 2020, requires hospitals to have adequate personal protective equipment (PPE) on hand and to attest to OHA prior to resuming non-emergent or elective procedures, that the hospital meets OHA standards.[1]

This attestation form must be signed by an individual with legal authority to act on behalf of the hospital or health system.

I, Joe Ness, COO (printed name), on behalf of OHSU Hospitals and Clinics (name of hospital or health system), attest to the following (please check any of the boxes that apply and supply any additional information):

- ☑ The hospital or health system intends to resume non-emergent or elective procedures by (insert date) May 1, 2020
- ☑ The hospital or hospitals within the health system have adequate medical grade PPE supplies that meet applicable National Institute for Occupational Safety and Health and U.S. Food and Drug Administration regulations for performing non-emergent or elective procedures.
- ☑ As a large hospital (as defined in OHA guidance) the hospital has an adequate 30-day supply of PPE on hand that is appropriate to the number and type of procedures to be performed or an open supply chain, as that is defined in OHA's guidance.
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[1] The guidance can be found at https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2322u.pdf.

☐ As a health system, PPE supplies on hand were calculated at a health system level and the PPE requirements can be met for each of the hospitals within the health system listed below.

If a health system is submitting this attestation, please list all of the hospitals in the system for which this attestation applies:

_____

_____

_____

_____

I certify that the responses in this attestation are accurate and complete. I understand that if OHA determines that a hospital is not in compliance with the PPE requirements, OHA may require the hospital to cease performing non-emergent or elective procedures for a specified period of time.

Joe Ness, COO
Printed name and title

04/30/2020
Date

Joe Ness
Digitally signed by Joe Ness
DN: cn=Joe Ness, o=OHSU, ou=COO, email=nessjo@ohsu.edu, c=US
Date: 2020.04.30 13:37:52 -07'00'
Signature

Print Reset

Appendix C: BIPOC Reopening Framework

BIPOC Reopening Priorities and Strategies for Support

06.01.2020

STATE REOPENING CRITERIA	BIPOC REOPENING STRATEGIES
Declining prevalence of COVID-19 • The percentage of emergency department visits for COVID-19-like illnesses (CLI) are less than the historic average for flu at the same time of year. • A 14-day decline in COVID-19 hospital admissions.	**Ensure health inequities don't worsen for BIPOC hospitalizations and deaths** • Regularly monitor trends for BIPOC cases, hospitalizations and deaths and report out as part of regional data and reopening dashboard. • Add decreasing BIPOC hospitalizations as a re-opening criteria. • If BIPOC hospitalizations are rising while overall hospitalizations are down within the 14-day period, interventions must be in place before moving forward with reopening. • Analyze decreasing hospitalizations for each race/ethnicity and/or have targeted remediation for categories not being met. • Through direct support, collaboration with partners and advocacy, increase access to basic needs and wraparound social services especially for BIPOC with underlying conditions. These efforts represent an important upstream approach in preventing and decreasing severe illness and hospitalizations.
Minimum testing regimen: measured regionally • Testing at a rate of 30 per 10,000 people per week. (Prioritize symptomatic persons, contacts of known cases, all people in congregant settings when someone tests positive, frequent tests of frontline workers). • Maintain an appropriate number of testing sites to accommodate its population and must fully advertise where and how people can get tested. • Testing must be accessible to low-income and underserved communities.	**Work with trusted organizations to ensure BIPOC have access to testing throughout the county** • Regularly monitor and report out disaggregated race and ethnicity of positive and negative tests to help determine if testing for BIPOC is adequate. • To improve collection of disaggregated race and ethnicity data for negative tests, work with the state to encourage providers to collect, and labs to report race and ethnicity data for negative tests. • Map existing testing sites by provider type and location. • Identify community organizations to promote existing testing. • Create informational materials to distribute to the community for current testing resources. • Develop proposal and budget to expand community and culturally appropriate testing in the county. • Advocate to ensure Federally Qualified Health Centers and safety net clinics have access to the supplies and resources necessary to provide expanded access to

	resources necessary to provide expanded access to testing. • Pilot community testing model in areas of increased risk or need. • Identify community organizations to recruit, assist or host community testing sites as needed. • Provide equity and other relevant training for healthcare workers/volunteers administering BIPOC community testing. • Ensure the local definition of frontline workers also includes professions with large numbers of BIPOC folks so they can be prioritized for testing.
Contact tracing system: **County level** • Minimum of 15 contact tracers for every 100,000 people. Multnomah County (122). • Every county must be prepared to contact trace 95% of all new cases within 24 hours • Contract tracing workforce must be reflective of the region and be able to conduct tracing activities in a culturally appropriate way and in multiple languages as appropriate for the population.	**Implement a multi-layered culturally specific contact tracing system** • Recruit the majority of expanded contact tracing capacity within county positions as *culturally specific* and/or *diverse language capacity* - ensuring employees have the knowledge, skills and abilities to work with BIPOC communities. • Work with existing culturally specific Community Health Workers (CHWs) and Community Based Organizations as contact tracers, navigators, etc. • Contract with trusted community based organizations (CBO's) to provide wrap-around support for people and families isolating for 14 days (food, rent assistance, etc.). • Advocate that federal, state or other CARES funding goes to the county to support culturally specific strategies and CBO's.
Isolation/Quarantine facilities ● Counties must have hotel rooms or other shelter locations available for people who cannot self-quarantine if required, or who test positive for COVID-19 and cannot self-isolate. The Department of Public Health at the Oregon Health Authority will provide support to local public health to identify needs and help with resources.	**Ensure facility capacity is adequate to support BIPOC communities or find alternate strategies.** • Prioritize people with underlying health conditions for isolation in hotels. • Provide community based organizations the ability to refer sick people unable to isolate at home to hotels. • Determine if alternate isolation strategies are needed for large intergenerational families (renting large houses, airbnb, etc.).

Finalized Statewide Sector Guidelines • Each sector must adhere to Oregon Health Authority statewide guidelines to protect employees and consumers, make the physical work space safer and implement processes that lower risk of infection in the business.	**Support BIPOC businesses and employees to implement State guidance** • Provide technical assistance, webinars and communications to BIPOC communities on reopening, including translation and interpretation of materials. • Support BIPOC businesses and BIPOC employees working in sectors unable to maintain 6 feet of distance from customers or clients to get access to personal protective equipment (PPE) resources.
Sufficient Health Care Capacity: measured regionally • Be able to accommodate a 20% increase in suspected or confirmed COVID-19 hospitalizations compared to the number of suspected or confirmed COVID-19 hospitalizations in the region at the time Executive Order No. 20-22 was issued.	**Advocate for equitable hospital access, and equitable treatment for BIPOC Oregonians** • Request hospitals modify their critical care guidance to ensure it won't make inequities worse and won't penalize BIPOC people for past health inequities in chronic disease. The critical care guidance determines who gets ventilators and beds if there's not enough. • Request hospitals provide critical care guidance for the community to see and understand.
Sufficient PPE Supply • All hospitals in the health region must report PPE supply daily to OHA's Hospital Capacity system. Large hospitals and health systems in the region must attest to a 30-day supply of PPE, • Counties must attest to sufficient PPE supply for first responders in the county.	**Ensure Personal Protective Equipment (PPE) priorities include essential BIPOC businesses and community organizations who are specifically serving BIPOC communities (in alignment with public health guidance on priority populations)** • Support childcare providers and others working with young children in getting adequate PPE. • Support businesses and organizations serving BIPOC communities in accessing personal protective equipment, specifically in sectors that are unable to maintain 6-feet of distance from clients or customers. • Work with culturally specific community based organizations to determine the best way to disseminate and distribute PPE (e.g., hubs, delivery, etc.) • Add to dashboard a prerequisite that ensures PPE needs for BIPOC communities are being assessed, tracked and resourced to the greatest extent possible • County-funded programs provide a basic threshold of PPE to contractors and clients.
	Communications and Innovation • Support the creation of multiple modes of communication to share information on reopening and navigating resources including videos, oral recording and mobile platforms.

	• Where possible, also provide the above information on atypical local platforms such as community radio, cable access channels (particularly foreign language channels). • To the greatest extent possible, ensure that translated information is released at the same time as English version of information so there is no delay of information to non-English speaking communities. • Equip trusted community leaders and spokespeople with COVID-19 information. • Support creation of a community panel of BIPOC people with communications expertise to advise on communications strategy and supports for multilingual and multicultural communities. • Utilize communication channels to combat myths and fears (e.g. that inequities are because of exposure, not 'bad' behavior).

Appendix D: Comprehensive COVID-19 Testing Strategies

Contents:

1. Testing Goals
2. Testing responsibility
3. Assessment of current state of testing
4. Gaps
5. County current and new activities for assurance, coordination, and direct service
6. Process and output evaluation metrics

Purpose: This document describes information and proposals to fulfill County public health roles related to COVID-19 testing: identifying current testing goals, assessing gaps, convening and coordinating with multiple partners to ensure equitable access, prioritizing, planning, implementing, and evaluating County provision of direct service testing strategies in partnership.

Information and testing guidelines are current as of 6/03/2020, and may change frequently.

Testing goals

- Meet Governor's gating criteria for entering Phase 1 of reopening include:
    - Regions able to administer testing at a rate of 30 per 10k per week
    - Sufficient testing sites accessible to underserved communities
- Assure testing strategies are implemented equitably, leading with racial equity lens, due to national and regional disparities in case count and hospitalization for communities of color. See Regional COVID-19 data dashboard
- Identify infectious people (cases) to support their self-isolation and to identify their close contacts to support their quarantine until we are sure they are not also infectious
- Quickly identify and stop outbreaks in high risk settings with most vulnerable populations (test then separate)
- Identify asymptomatic employees who have high close contact with vulnerable populations in vulnerable settings such as health care sites, remove from workplace while infectious (this accompanies symptom screening/temperature checks)
- More accurate epidemiology of disease incidence informs decreasing physical distancing policies and ability to monitor changes in disease incidence after policy change, including identifying and responding to disparities in communities of color (Public Health also uses trends in COVID-related deaths, hospitalization rates, ED visits, etc).
- Community needs equitable testing for all above reasons, to trust epidemiology, and to trust government policy decisions are not biased toward or against subpopulations with more or less test access
- References: CDC testing guidelines OHA testing guidelines

Testing responsibility

- Health care system including hospital systems and safety net clinics: test patients and share in testing of people with no medical home
- Employers: test employees if a worksite outbreak occurs, screen employees in high risk setting (more and more pressure to screen regularly) and share in screening residents in congregate settings as possible.
- Public health/health department: Assure equitable testing access to vulnerable populations, particularly communities of color. Assure timely testing of contacts where warranted. Assure timely testing in congregate or high risk workplace settings with outbreaks. Coordinate testing for epidemiology.

Local assessment of current testing capacity, access, and plans:

MCHD and region exceed the Governor's criteria of capacity to administer 30 tests per 10,000 residents per week, demonstrated by actual testing numbers and hospital/healthcare system reports of total current test capacity available per week. This means access to lab supplies, test collection supplies, PPE have all become more steadily available in the past weeks.

Patient and community testing

- Kaiser, Providence, Legacy, OHSU all have convenient (weekend, evening) drive through testing for patients of their affiliated clinics
- Many Fee for Service Urgent Care Clinics like Providence Express visit and Legacy Go Health Provide testing for about $100 out of pocket
- FQHCs and other safety net clinics have recently increased access to testing their own patients through partnership with hospital drive through test collection sites or ability to obtain supplies and staffing to perform own test collection
- OHSU additionally provides low barrier community drive through testing at Expo Center
- MCHD testing:
    - Integrated Clinical Services currently provides COVID19 testing to existing patients as part of the Community Health Center program. New patients are being accepted.
- CBO interest/offers: culturally specific community based organizations are interested is coordinating to assure testing is culturally appropriate and accessible to communities of color

Outbreak Testing:

Public Health

- contract with AMR for specimen collection
- IGA in development with Portland Fire and Rescue for specimen collection
- preparing Communicable Disease nurses for testing (fitting for PPE, etc)
- Oregon Public Health State Lab will process tests for outbreaks
- developing access to self-collected specimen lab options as well
- Site-specific testing plans for Corrections, Long Term Care Facilities, shelters, etc

Healthcare Settings: hospital systems have their own outbreak plans

Other employers: Employers will be requested to provide testing of employees, if recommended.

Identified Gaps

Gap analysis:

- Test Site Map shows lack of access to testing sites in both the East and Mid County areas , especially those who are not established patients of a clinic https://www.google.com/maps/d/viewer?mid=1RXVVSVvZ-eV7UJM3P4DlMtHmxS2ok9xV&ll=45.54082654280079%2C-122.49072518519864&z=12
- Reports about lack of access regularly come from community of color liaisons and partner organizations.
- Race/ethnicity data for all tests has been improving - currently about 25% missing.
- Infrastructure planning now for possible future change in testing guidance to include contacts
- From culturally specific liaisons and BIPOC leadership: the disenfranchisement of communities of color from mainstream health system historically, and the concern about reports of test results to the government have been barriers to willingness to test. BIPOC leaders from most communities have identified a need not only for CHWs to educate and assist with testing access, but also request some type of non-clinical testing in familiar locations with trusted CBO partners (CBO sites, schools, churches or mosques have been identified, for example).

  Gap Identified: At this time data does not assure equitable low barrier community testing exists, particularly for communities of color, across the county geography to meet multiple testing goals. If testing of contacts expands, the need will increase for infrastructure that can assure rapid, reliable, and accurate test provision and contact tracing as needed.

Ongoing Testing Efforts and Explorations

- PH continues to advocate for and problem solve for better test data to assess ongoing gaps in access to testing for communities of color.
- PH continues to leverage hospital system low barrier outdoor or drive through test sites to provide test access to low income communities and to communities of color: continue new promotion of OHSU site, encourage Providence/Legacy sites to provide pathway to comparable access for low-income individuals without current medical home. Encourage HealthShare/CareOregon to continue to partner to sustain access for safety net clinics and help improve access for vulnerable populations without a medical home.
- ICS continues to outreach to communities of color and low income communities to enroll in FQHC for ongoing care including testing when needed.
- EOC continues outreach through website/liaisons/comms/CHWs/CBO partners: promote messaging to communities of color that providers now can offer testing who could not

previously, encourage enrollment in medical homes/OHP, provide updated information about testing access and testing recommendations.

New Testing Services to Fill Gaps

- Implement two low barrier outdoor or drive through testing sites 2 times weekly each for symptomatic individuals
- East County Clinic site starts June 8, 2020
- Mid County site TBD, start date by early July 2020
- Promote extensively to communities of color, no one turned away based on demographics, insurance status, or immigration status. Available to individuals without a regular health care provider.

CBO/PH culturally specific community testing and contact testing:

- Hiring a diverse set of Community Health Nurses and Medical Assistants and partnering with Community Health Workers through contracts with culturally-specific CBOs to form core teams. Conversations under way with community leadership to identify most effective models of testing, sites, community partners, and the pre-testing education and wrap around services that will be required for individuals, and communities. Possible models may include home-delivered self-collection tests for sick individuals and exposed large households, rotating site for county-wide coverage at various hosting faith houses, CBOs, and neighborhood school parking lots.
- Communities identified: African American/African Immigrant, Asian, Latinx, Native American, Pacific Islander communities. Both ICS/PH community drive through sites can be promoted to and accessed by other culturally specific communities as well. Additionally, expect subcontracting will include Arabic speaking/Middle eastern community, Slavic community and other CHWs to promote testing and support households with COVID-19.
- The culturally specific testing described here will be targeted in focus, but inclusive in practice. No one will be turned away.

Process and outcome evaluation

- Client satisfaction: high quality, culturally welcoming, safe, understandable and relevant information
- Increases equity of testing access for BIPOC communities as demonstrated by reported testing data overall
- Efficiency, adequate volume and capacity
- Multilingual language needs met
- Physical ability/ADA access need met
- Test positivity rate demonstrates PH testing goals are being met and eligibility is appropriately focused
- Successful linkage to case investigation, contact tracing, and support to isolate after positive test

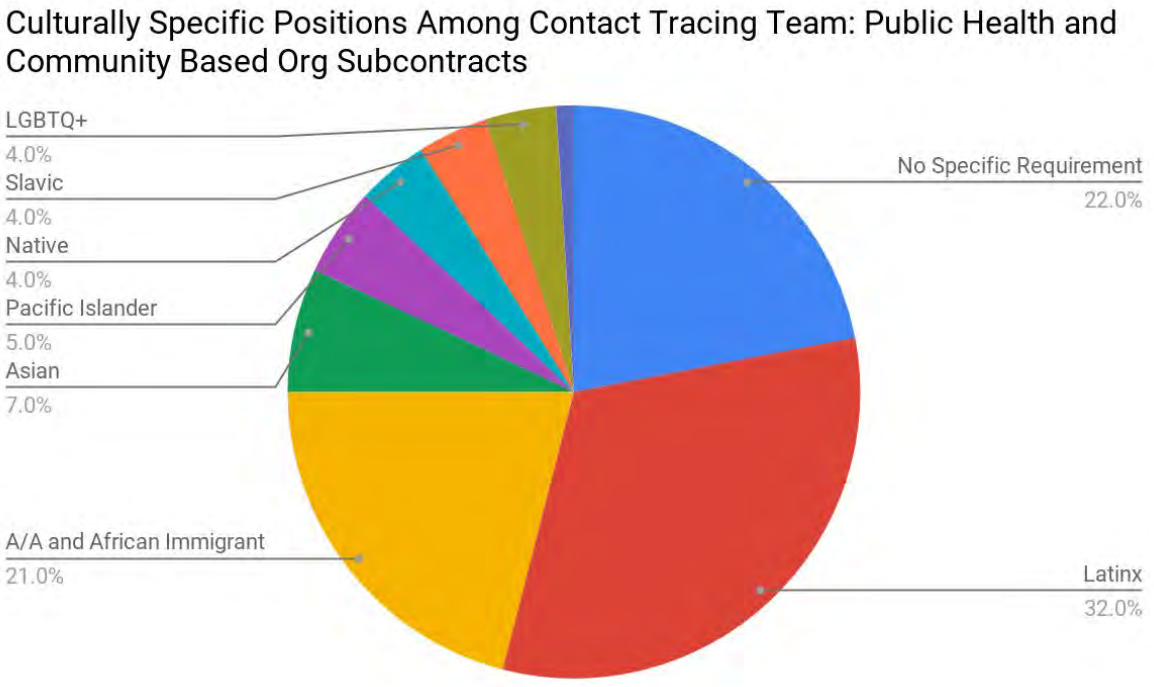
- Strengthens community partnerships with culturally specific CBOs
- Maximizes reimbursement by private health insurance/Medicaid/Medicare while remaining financially low barrier to individuals

Appendix E: Contact Tracing Model

Contact Tracing Model

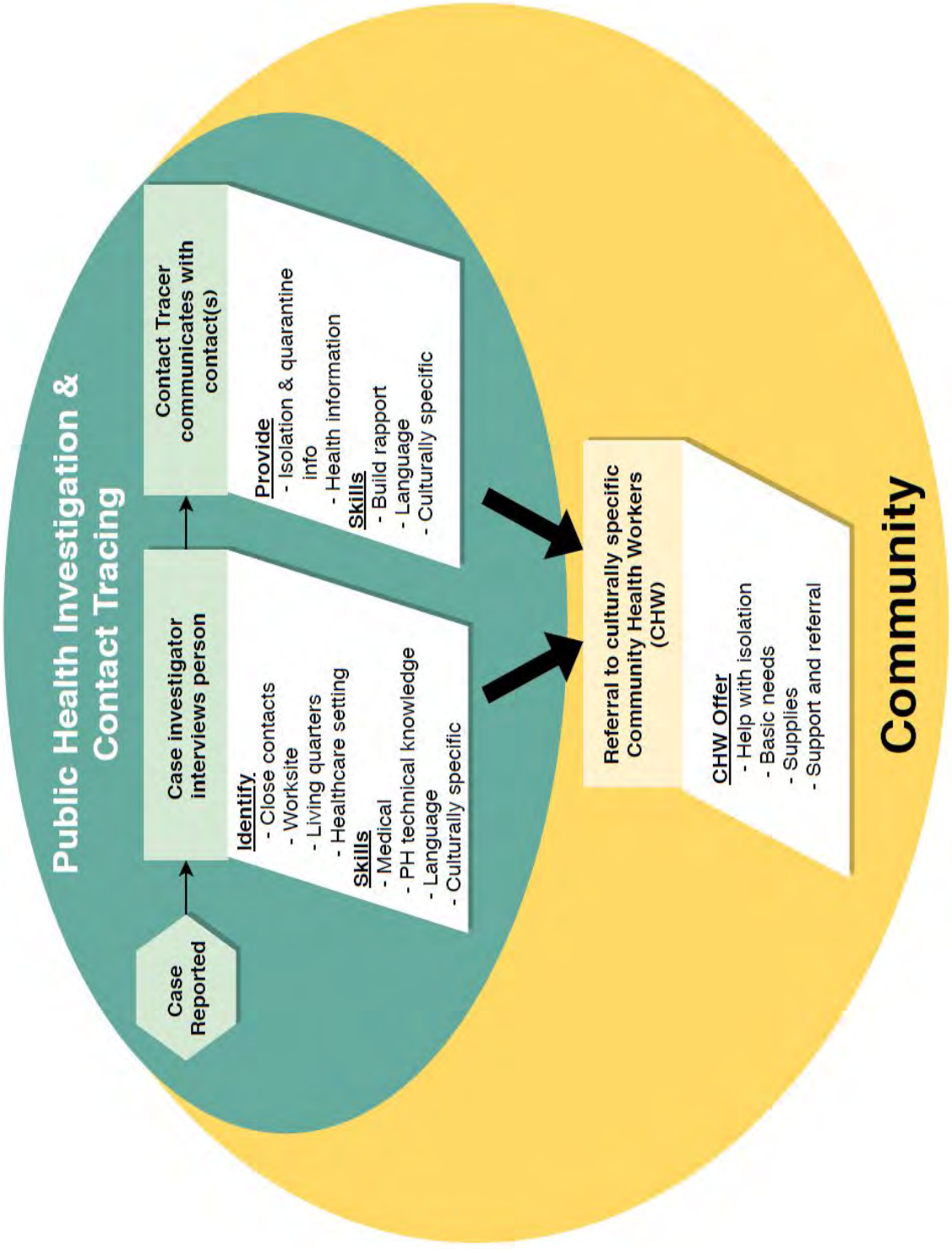
- 9 diverse teams of case investigators / contact tracers
  - Interview cases and close contacts
  - Provide isolation and quarantine information
- 1-2 teams devoted to outbreaks and congregate settings
  - Specialized epi, medical, and infection prevention skills
- Teams hired have the necessary skills and talents including:
  - Staff with language KSAs (Spanish, Russian, Vietnamese)
  - Staff with cultural KSAs (African American, Latinx, Pacific Islander, Native, LGBTQ)
  - Technical knowledge
  - Medical knowledge
- Community health worker isolation/quarantine support
  - Contract with culturally specific community based organizations
  - Provide wrap-around support for successful isolation, identifying other contacts/networks/sites

Culturally Specific Positions



Organizational Chart
95 staff
Manager
Scheduler
Congregate Setting Team Lead
Admin
3 Investigators
1 Infection Control
1 Med. Records Reviewer
1 MD/NP Chart Review
Supervisor
Admin
Team Lead
5 Case Investigators
2 Contact Tracers
1 Med. Records Reviewer
35 contracted culturally specific Community Health Workers

Process


Public Health Investigation & Contact Tracing
Case Reported
Case investigator interviews person
Identify
- Close contacts
- Worksite
- Living quarters
- Healthcare setting
Skills
- Medical
- PH technical knowledge
- Language
- Culturally specific
Contact Tracer communicates with contact(s)
Provide
- Isolation & quarantine info
- Health information
Skills
- Build rapport
- Language
- Culturally specific
Referral to culturally specific Community Health Workers (CHW)
CHW Offer
- Help with isolation
- Basic needs
- Supplies
- Support and referral
Community