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Report 1 of 3

EXECUTIVE SUMMARY:
PUBLIC HEALTH RESPONSE
TO THE COVID-19 PANDEMIC IN OREGON

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Oregon Health Authority

Executive summary

Study of Oregon's public health system response to the COVID-19 pandemic

This summary includes high-level key findings and recommendations.

The purpose of this study is to fulfill the requirements of Senate Bill 1554 (2022), which calls for a comprehensive study of Oregon's public health systems COVID-19 pandemic response. This is the first of three legislatively mandated reports. Primarily focused on the government-led and government-funded public health systems response to the COVID-19 pandemic, this report is based on a narrow definition of the term "public health systems response" to mean activities undertaken to equitably control the spread of a deadly, infectious disease.

Design and limitations: The study team used an exploratory sequential design for this study, a robust mixed-methods study design that integrates qualitative data to provide an enhanced understanding and interpretation of quantitative findings. Study findings, however, should be interpreted in the context of the limitations of this study. The most significant limitation in this phase of the study was the time constraint (four months). Another limitation was the retrospective nature of this study, which covers over two years, introducing recall bias in which participants may not accurately recall past events. Public health workforce turnover, limited incentive availability for specific informant groups, documents lacking dates and other context, and reliance on self-reported data for online surveys were also limitations.

Resources

Key findings: Prior to 2020, Oregon's public health system was critically underfunded. Efforts to modernize the system by increasing state resources to rebuild the public health system from 2017-2020 were laudable but inadequate. Sustained state funding is necessary to rebuild the public health system and recover from the strains on the system caused by the COVID-19 pandemic.

Recommendations:

1. As the COVID-pandemic is ongoing and additional population-level health emergencies have surfaced, the Oregon State Legislature must fund the public health system at the level requested in 2023-2025 OHA budget request for $286,000,000 devoted to public health modernization and $32,000,000 to develop a pandemic response information system.

COVID-19 health outcomes

Key findings: As of the week of July 31, 2022, OHA recorded 860,300 COVID-19 cases in Oregon. There were 34,376 hospitalizations (4%), and 8,291 people died. The COVID-19 case rate peaked at 1,332.3 during the week of January 10, 2022. It is evident that COVID-19 exacerbated already existing health inequities in the state of Oregon. In particular, Tribal Nations and communities of color were impacted by the COVID-19 pandemic disproportionately in comparison to White communities.

Health equity

Key findings: Health equity was a central focus in Oregon's public health system response to the COVID-19 pandemic. Study participants noted they were highly motivated to center equity in pandemic response efforts and were aligned in naming that the central elements of an equitable pandemic response are equitable access to information and equitable access to resources. LPHAs and CBOs were seen as invaluable resources in the response.

The greatest health equity challenges Oregon faced in its public health pandemic response were an emergency management infrastructure that did not include equity practitioners and communities impacted by health inequities in decision-making; limited equity capacity across the state, including significant delays and challenges producing accessible and culturally-tailored public messaging; and inconsistent buy-in for equity work. A few factors that facilitated and enhanced an equitable pandemic response included strong partnership networks with role clarity; and adequate, timely, and flexible funding.

Recommendations:

1. Improve equitable communication by ensuring information is timely and accessible for all Oregonians. OHA should do everything possible, including conducting translation in-house, to eliminate the lag in the translation of critical health information into non-English languages. OHA should be hiring, recruiting, and retaining bilingual, and preferably bicultural, staff into various departments- as opposed to hiring that is done solely in response to a critical need.
2. Ensure that timely and accurate morbidity, hospitalization, and mortality data about historically marginalized communities (those most likely to experience health inequity) are collected and available to those communities and partnering organizations serving them as well as government public health.
3. Continue to fund public health-focused community-based organizations serving historically marginalized communities.

Emergency management + coordination

Key findings: Throughout the pandemic, some state-level primary response agencies in Oregon struggled to collaborate in coordinating the response and defining leadership roles and authorities. The lack of role clarity between the Oregon Health Authority and the Oregon Department of Emergency Management likely led to confusion early on in the pandemic. Issues arising from this confusion affected the overall response but directly impacted Local Public Health Authorities and City and County Emergency Management.

Recommendations:

1. Explore the concept of a fully resourced, flexible, and scalable unified command structure between the Department of Emergency Management (OEM) and Oregon Health Authority (OHA) in support of future public health emergencies. This would allow the full weight and power of the authorities outlined in the Oregon Revised Statutes (ORS) §401 et seq to be utilized. Additionally, OEM and OHA should commit resources to develop and participate in an integrated Multi-Year Training and Exercise

Program (MYTEP) with a specific focus on executive leadership training. MYTEP goals may include achieving a thorough understanding of the agencies' roles and responsibilities and updating the state's Emergency Operations Plan and its associated annexes.

2. OEM and OHA should work together to establish an equity-specialists team that is formally adopted into the response structure, including roles and responsibilities, job action sheets, inclusion into the MYTEP training and exercises, and integration into the state's emergency plans and procedures.

Enforcement of public health mandates

Key findings: Enforcement of public health mandates was inconsistent across Oregon, especially after Stage 1 of the pandemic when the politicization of the response effort took root, and a widespread misinformation campaign marred the compliance landscape. Interviews with State Agencies, Health Care Associations, LPHAs, and City, County, and Tribal Emergency Management highlight pandemic-response inconsistencies across Oregon, not only in enforcing public health mandates but also in other areas of the pandemic. They raised concerns that the localized decision-making of LPHAs created responses that put politics over health. Multiple State Agencies worked together to enforce public health mandates. While laudable, this structure led to confusion and gaps in enforcement.

Recommendation:

1. Local and state agency partners should be convened in a formal committee to determine if the enforcement mechanisms used to protect the public's health from COVID-19 in 2020-2022 are the best fit for Oregon, given all the factors described in this report. If changes to the enforcement structure for public health mandates are deemed necessary by OHA, partners and the Oregon State Legislature should work to enact necessary statutory or regulatory changes. Finally, enforcement of public health mandates and various roles and responsibilities should be clearly articulated, and all parties in the public health system should educate themselves accordingly. Minimally, this committee should include OHA, Department of Justice (DOJ), LPHAs, CBOs, OR-OSHA, and OLCC.