MEETING MINUTES
Tulsa City-County Board of Health
June 29, 2022 at 6:00pm
James Goodwin Health Center
5051 S. 129 East Ave.
Tulsa, OK 74134

Board Members Present:

Mike Stout, PhD; Chair
Regina Lewis, D.O; Vice-Chair
Aimee Boyer, J.D., CFP; Treasurer
Krystal Reyes, MPA
Jeffrey Galles, D.O.
Mousumi Som, D.O
Ann Paul, DrPH

Staff Present:

Bruce Dart, PhD, Executive Director
Chanteau Orr, Legal Counsel
Scott Buffington, Employee Resources & Development
Monica Rogers, PhD, Data & Technology
Priscilla Haynes, Preventative Health
Lori Just, Marketing & Communication
Kelly VanBuskirk, Prevention, Preparedness and Response
Jumao Wang, Finance Department
Adam Austin, Environmental Health
Marcus Anderson, Adolescent and Child Health Services

I. Call to Order and Welcome

Dr. Mike Stout called the meeting to order at 6:05 pm.

The meeting notice and agenda were posted at the James Goodwin Health Center, the North Regional Health and Wellness Center, and the Tulsa City-County Health Department (THD) website, and emailed to the Tulsa County Clerk, the Tulsa City Clerk, and the Tulsa City-County Library on June 17, 2022.

Approval of the Meeting Minutes

Dr. Mike Stout entertained a motion to approve the May 18, 2022 minutes. **The May 18, 2022 minutes were approved:**

Dr. Stout	aye
Dr. Lewis	aye
Dr. Schumann	not present
Ms. Boyer	aye
Dr. Jones	not present
Dr. Paul	aye
Ms. Reyes	aye
Dr. Som	aye
Dr. Galles	aye

II. Chair's Report: Dr. Mike Stout

Dr. Mike Stout talked about the two recent Supreme Court decisions, Dobbs v Jackson Women's Health Organization and New York State Rifle & Pistol Assn., INC. v. BRUEN, will have significant implications for public health in Tulsa and in communities across the country. As you have all heard, the SCOTUS decision in Dobbs overturned their prior decision in Roe v Wade that granted Americans a constitutional right to an abortion. In Bruen, SCOTUS expanded on their Heller decision, which granted individuals the constitutional right to gun ownership to protect their homes, to grant constitutional rights for individuals to carry guns in public spaces for personal protection, which significantly reduces state's abilities to regulate the carrying of firearms outside of the home.

The politically charged issues of guns and abortion have been at the center of public policy debates in the US for decades and have established themselves as the focal points of our nation's "culture wars." People have very strong personal and religious beliefs on these issues, making it difficult to have rational policy discussions based on the best available scientific research and evidence about the impact of various policy preferences and proposals that arise from these beliefs. However, as a Board of Health tasked with protecting and improving public health in our community, we must be

aware of what the science and evidence reveal about the potential implications these decisions will have on our community, regardless of our personal and religious views on abortion and guns.

Regarding Bruen, the best available research very clearly shows that states with fewer regulations and restrictions around the purchase and ownership of firearms have higher rates of gun deaths, including homicide and suicide (nationally, 53% of all gun deaths are suicides). Recent reporting revealed a spike in gun deaths across the state of Oklahoma following Governor Stitt's signature on legislation permitting permit less carry in the state. As reported recently in The Oklahoman: "In all, the average number of gun deaths per month increased nearly 20% compared to the 10 years before the new law went into effect, a period in which the population grew just over 6%." Taken together, long standing social and economic inequities, the lingering effects of the COVID-19 pandemic and the recent and rapid rise in inflation, all mean that the widespread availability of firearms has significantly increased the prevalence of gun violence in our community and in communities across the state.

Regarding Dobbs, the best available research suggests that Oklahoma's new forced birth policy, characterized with some pride among supporters as the most restrictive anti-abortion policy in the country, will have a significant impact on the health and well-being of Oklahoma's children and families. The best summary of the evidence that I've seen comes from an *amicus* brief, submitted on behalf of 547 DEANS, CHAIRS, SCHOLARS AND PUBLIC HEALTH PROFESSIONALS, THE AMERICAN PUBLIC HEALTH ASSOCIATION, THE GUTTMACHER INSTITUTE, AND THE CENTER FOR U.S. POLICY, in support of the respondents (Jackson Women's Health Organization) in the case. The brief lays out, in detail and with citations to reputable academic research, the public health implications of forced birth policies in states that ban abortions in most or all circumstances.

According to the brief: "Any ban on pre-viability abortion—such as Mississippi's, which bans nearly all abortions greater than fifteen weeks into pregnancy and provides no exceptions for rape or incest—carries major public health implications because it forces women to carry pregnancies to term under adverse circumstances marked by substantially greater risks to their health and that of their families. Of particular concern to Amici, any ban will disproportionately affect young women, women of color, and low-income women who live in families and communities already vulnerable to elevated health and social risks and reduced access to necessary health care."

They go on to write: "The public health risks of forcing women to carry unintended, and especially unwanted, pregnancies to term, wash over families. Elevated risks to life, health, and well-being include maternal mortality, prematurity, infant mortality, developmental difficulties, and increased

likelihood of exposure to significant traumas, whose lifelong, adverse physical and mental health effects trigger intergenerational harm…Compared to those able to obtain abortions, women who are denied abortions are also subsequently more likely to live in poverty, more likely to lack financial supports critical to better health outcomes, such as housing and nutrition, and more likely to raise their children alone."

A lack of access to abortion services has also been shown to increase maternal death rates. As stated in the brief: "Put simply, women living in states with the most restrictive abortion policies—and thus the least abortion access—were found to be more likely to die while pregnant or shortly thereafter than women living in states with less restrictive abortion policies, regardless of state-to-state differences in poverty, race/ethnicity, and education."

Forced birth policy will also have an impact on childhood trauma and adversity and on rates of domestic violence: "Children born of unintended pregnancies, and their siblings, are more likely to be exposed to adverse child experiences ("ACEs"), i.e. "potentially traumatic events that occur in childhood (0–17 years)...Between 5.6 and 10.7 percent of women whose pregnancies were unintended reported physical abuse; the rate for women who had planned their pregnancies was between 3.8 and 6.9 percent."

Finally, forced birth policy has detrimental impacts on maternal mental health: "The mental health of parents is critical to the health of their children. Compared to women with planned pregnancies, mothers experiencing unintended pregnancy and birth were more likely to report postpartum depression, as well as poorer mental health later in life…Overall, denying women the ability to plan their pregnancies negatively impacts their children, who are more likely to live in poverty and have a parent in emotional distress as result of the denial of the abortion."

Oklahoma already ranked poorly on indicators of reproductive health prior to the Dobbs decision, and with the outright ban on abortion access in the state protecting and improving reproductive health will become even more of a challenge. I hope that, as a Board, we are able to work together to find common ground on meeting that challenge, regardless of our own personal and religious views on these highly charged issues.

State	Early Entry Into Prenatal Care Ranking‡[1]	Infant Mortality Rate RankingV[2]	Low Birthweight Ranking‡[3]	Young Child Poverty (Ages 0-5) Ranking^[4]	Children with 2+ Adverse Childhood Experiences (ACEs) Ranking[5]
Maryland	46	30	33	9	9
Massachusetts	6	2	16	8	2
Michigan	16	35	35	35	33
Minnesota	11	9	9	4	10
Mississippi	**21**	**49**	**51**	**51**	**41**
Missouri	25	32	37	32	11
Montana	34	10	12	16	48
Nebraska	23	14	17	12	21
Nevada	43	24	36	31	26
New Hampshire	3	1	2	1	12
New Jersey	31	6	22	13	1
New Mexico	18	23	10	49	49
New York	14	5	23	34	3
North Carolina	36	38	41	43	6
North Dakota	22	46	7	2	34
Ohio	33	41	31	40	42
Oklahoma	44	45	25	41	45
Oregon	12	11	5	11	35
Pennsylvania	29	28	30	27	18
Rhode Island	5	26	21	22	19
South Carolina	45	40	45	45	36
South Dakota	30	37	10	24	37
Tennessee	40	44	39	42	27
Texas	51	21	27	39	22
Utah	10	18	13	5	15

I'd like to conclude my Chair remarks on a positive note and offer up a hearty congratulations to THD's fearless leader, Dr. Bruce Dart, for recently being notified that he has been nominated for and received the 2022 Mo Mullett Lifetime of Service Award. The National Association of City and County Health Official's (NACCHO's) Mo Mullet Lifetime of Service Award honors local health officials for noteworthy service that reflects Mullet's commitment, vigor, and leadership. It's the highest honor NACCHO awards to its members, and I can think of nobody more deserving. Please join me in congratulating Dr. Dart!

III. THD Reports/Action Items

A. Public Health Threat: COVID-19 Vaccinations & Testing Update

Priscilla Haynes talked about giving an update on the COVID-19 vaccine update for moderately/severely immunocompromised, and then there are a couple of updates. She showed a chart that talked about children ages 5-11 years old having no recommendations for boosters for

those who are moderately/severely immunocompromised. Those individuals still need to receive three doses to be fully vaccinated. They receive their second dose 21 days after the first dose and their third dose four weeks after their second dose. Then there are no additional boosters for that age group. The change is for ages 12 and older; an additional second booster can be received for those twelve and older. Pfizer is the only vaccine approved for those under eighteen years old. Those twelve to eighteen years old can receive a Pfizer second dose four months after receiving their first dose.

This one is even more complicated for individuals that have received the J&J/ Janssen Vaccine. Still, those eighteen years old or older who are moderately/severely immunocompromised receive their first dose of J&J; their second dose can be an mRNA vaccine, and that's given 28 days after the first dose. Then they can get their booster two months after they receive their second dose. Individuals who are fifty years old and older can also receive that second booster, given four months after receiving their first booster dose. And they don't have to be moderately/severely immunocompromised. The individuals who are eighteen to forty-nine years old that are not moderately or severely immunocompromised received as their primary dose J&J. And chose J&J as their booster; that group is also approved for a second booster. Four months after receiving their J&J booster, it has to be an mRNA.

Priscilla talked about the COVID-19 Vaccination Incentive update. She showed a chart that listed Team Bruce at 70.0%; his team included the Director's office, Prevention, Preparedness & Response, Adolescent & Child Health, and team Reggie was over 70%, including Environmental, Preventive Health Services & Data, and Technology. The Tulsa Health Department is not testing the community for COVID-19, but THD is still testing our employees if the need is there. Employee rapid tests are available for employees with symptoms, household contacts with symptoms, and asymptomatic employees. She showed a chart of how many individuals had tested positive in the agency. In January, there were seventy; in February, there were nineteen; in March, there were six individuals. And so far in April, only two individuals have tested positive.

B. **Public Health Threat:** MonkeyPox Virus

Jessica Rice talked about Monkeypox as a zoonotic illness from the same orthopoxvirus genus as smallpox and cowpox. Monkeypox can be broken into two different clades, the Central African and West African clades. The current outbreak is related to the West African clade that is generally associated with less severe illness. Transmission is generally self-limiting, but human-to-human spread occurs from contact with skin lesions, contaminated objects, and respiratory droplets. Two phases of symptoms are associated with Monkeypox, including a prodromal phase followed by a rash that occurs in five different phases. A person is considered infectious until all their lesions have crusted over and a new layer of skin has formed. Contact tracing can be conducted based on the infectious period and type of contact type and the appropriate recommendations provided. Contacts are monitored for 21 days from their last known exposure to a confirmed case of Monkeypox. The current outbreak was first identified in the UK by an individual who reported a travel history. Other cases were soon identified within and outside the UK that did not have travel history or geographical linkage to other confirmed cases, indicating community spread. The first case in the

United States was identified as an individual who reported traveling to Canada. Oklahoma announced our first case on June 10th, with the second on June 17th. The current outbreak is the largest outside of countries where it is endemic.

C. **Community/Health Improvement**: CDC COVID-19 Health Disparities Grant

Shauna Meador provided an overview of the CDC National Initiative to Address COVID-19 Health Disparities Grant. The presentation covered an overview of the grant, including the timeline, $5,975,146 in award funding direct from CDC, and $1,509,600 in passthrough funding from OSDH. The presentation provided an overview of internal THD programmatic expenses and operations covered by this funding, as well as initiatives being funded by external partners. Grant activities internal to THD were shared. Including IT upgrades, JGHC clinic remodels, culturally relevant marketing, strategic planning consultants, and a detailed explanation of the new Health Equity Office and Mobile Health Clinic, including staffing and operations details for both projects.

IV. **Community Engagement/Partnerships:** Food Advisory Council

Jeffery Townes was appointed to the Tulsa Food Advisory Council. Dr. Mike Stout entertained a motion to approve the appointment of Jeffery Townes. A motion was made by Dr. Regina Lewis and seconded by Aimee Boyer.

Dr. Stout	aye
Dr. Lewis	aye
Ms. Boyer	aye
Dr. Paul	aye
Ms. Reyes	aye
Dr. Som	aye
Dr. Galles	aye

V. **Board of Health Bylaws Revision**

The board of health revised bylaws edits was approved.

Dr. Stout	aye
Dr. Lewis	aye
Ms. Boyer	aye
Dr. Paul	aye
Ms. Reyes	aye
Dr. Som	aye
Dr. Galles	aye

VI. THD Executive Director's Annual Contract

The THD Executive Director's Contract was renewed. Dr. Mike Stout thanked Bruce Dart for his service to the community. He entertained a motion to approve the contract of the Executive Director Bruce Dart.

Dr. Stout	aye
Dr. Lewis	aye
Ms. Boyer	aye
Dr. Paul	aye
Ms. Reyes	aye
Dr. Som	aye
Dr. Galles	aye

Announcements

Next Board Meeting Wednesday, August 17, 2022 at 6:00pm I NRHC Room 208

VII. Adjournment

The meeting adjourned at 7:50pm.

APPROVED:

Dr. Mike Stout, Board of Health Chair

ATTESTED:

Makeda Thompson, Tulsa Health Department Assistant