

Executive Summary

Process Overview

In the first phase of the Prevention Partner Outreach, Coraggio Group gathered input through stakeholder listening sessions conducted in Portland, Roseburg, Coos Bay, Pendleton, Bend, and Milwaukie, as well as via an online survey. Participants included substance abuse prevention coordinators, tribal prevention staff, community coalition representatives, and other local public health staff. In all, we heard from 109 individuals. Findings from that outreach process was summarized in the Interim Report, attached to this report in the Appendix.

A second round of outreach followed that included 23 individual stakeholder interviews, in-person workshops in Eugene and Newport, and three online workshops. In all, we received feedback from 48 participants in the second round of outreach. In total, 157 individuals have participated in the outreach process.

Participants in the second round of workshops helped to refine some of what was learned in the first round of outreach, and identified areas of opportunity for HPCDP to consider in moving forward. What was learned in this second phase of the outreach is the basis for this report.

Coraggio has worked in good faith to build understanding of the alcohol, opioid, and other drug prevention community and the outcomes of the transfer of these functions from AMH to HPCDP. However, if there are areas where our understanding is incomplete, we hope they provide opportunities for greater discussion between HPCDP and their prevention partners.

Key Areas of Opportunity

We have identified the following six key areas of opportunity for HPCDP and the prevention community at large in Oregon. They are detailed on the pages that follow.

1. Define, Align and Integrate the Approaches of the Public Health Profession and the Prevention Profession (to foster a more holistic approach)
 - › Crosswalk the language and frameworks of public health and prevention
 - › Create opportunities for collaborative and cross-functional work teams
 - › Communicate about and promote a wide-range of prevention approaches

2. Reinvent Approaches to Professional Development and Knowledge Sharing for Prevention Professionals
 - › Consider continuation or replacement of CPS designation
 - › Consider establishing regional cross-functional prevention cohorts
 - › Consider developing an online community for sharing of information and best practices between prevention partners

3. Leverage Local Prevention Expertise and Evidence-Based Practices in Ways That are Complementary to One Another
 - › Consider collaborating with prevention partners to redesign how prevention happens in Oregon
 - › Consider taking steps to foster a stronger culture of evidence-based prevention
 - › Consider establishing regional cross-functional prevention cohorts (Repeated from Theme 2)

4. Develop Stronger Relationships With the Tribal Health Community
 - › Consider building a communications protocol that encourages peer-to-peer communications between HPCDP and tribes
 - › Consider establishing a cadence of in-person visits to all tribes on a regular basis, including individual tribal visits and Nine Tribes meetings
 - › Consider continuing or expanding options for culturally-specific prevention approaches

5. Lead with Clarity & Transparency
 - › Establish and clearly communicate state-wide strategies, goals and priorities
 - › Provide evidence-backed guidance on options to choose from at the local level
 - › Communicate the “why” and “how” of decisions and strategies

6. Cultivate Trusting Relationships
 - › Express humility and acknowledge impact
 - › Establish clear points of contact and individualized relationships
 - › Communicate a clear response to the outreach process and any related changes

Suggested Next Steps

- › HPCDP should work internally to make meaning of these findings, and to build deeper understanding of what prevention partners are asking for.
- › HPCDP leaders might engage personally in work sessions with the prevention community to acknowledge their experience and work together to begin to describe solutions, based on the findings of this report.
- › HPCDP might pilot selected efforts to test and demonstrate approaches rooted in collaboration and innovation.

1. Define, Align and Integrate the Approaches of the Public Health Profession and the Prevention Profession (to foster a more holistic approach)

Overview/Context:

There is significant interest in defining the overlap and intersection inherent in the foundational frameworks, language, and approaches most commonly utilized within the public health and prevention professions. Without a clear effort to identify the overlap and alignment between the two fields, the differences can be positioned as oppositional or competing, when in fact they are likely aligned. This extends to the professionals themselves working in these two fields, feeling at odds with one another or as though their work isn't understood or valued. An effort to more clearly define and integrate these approaches would serve to foster greater understanding across the fields, demonstrate the legitimacy of the fields themselves, and begin to build a sense of shared values, expertise, and objectives. Several of the interviewees also spoke to the power of getting to work together on collaborative projects as a means of quickly dissolving differences and to build a sense of alignment, understanding and respect across the fields. Many people commented that communications from HPCDP seem to center primarily around using policy to drive prevention work. They would like to see the other capability areas within the public health modernization model also represented, including community partnership development.

What We Heard:

- › “When we saw what OHA was doing we were really worried because it looked like they were just moving people over and expecting this new structure to just work. We shared that feedback and it didn't seem like it was heard. If it was as hard as it was for us at the county level, just think how hard it will be at the state level given the complexities.”
- › “It makes sense to put A&D with other disease prevention. HPCDP has a good record of prevention efforts that haven't involved creating expensive state-wide infrastructure of staff- doing their work through established public health agencies. Those agencies and HPCDP are medically oriented, which means scientific and evidence-based and that is exciting.”
- › “It would be of value for them to be connected closely with public health nurses or other treatment providers. In some counties CPS are operating in isolation, they should definitely be connected to the public health system. Or even employed by the school district.”
- › “Prevention people think about the public health approach with policy as a negative- they think of it as punishment or coercion to change (taxing, etc.). Instead of a prevention approach which is more about finding ways to promote positive choices. We need to broaden the policy approach. Public health is the ‘no’ people and we are the ‘yes’ people- we want to build assets.”
- › “Public health needs to communicate and genuinely show an interest in their commitment to broadening their definition for prevention and that there is a common

language established. Even at the level of: what is a policy/what are the different kinds- that it isn't just about restrictions, it can also be guidelines for how we do business."

- › "Local public health should be brought in with the CCOs to do more upstream work. This approach would give prevention professionals more of a role in that public health work. Looking at the community and whole-person health instead of the siloed approach we've had by issue. Instead, we need to all be working together towards the health of communities and families."
- › "I think the meetings need to be pretty heavily facilitated and folks need to be working on tasks together- things like developing logic models, or story boards to actually work together. I think that healthy debate can also be really helpful for folks."
- › "You can't just make things illegal and not have any resources to support people to quit. We haven't figured out a way in public health of also supporting and activating individuals to own their own health."
- › "I'm not sure how the state decides what strategies are allowed. We need to have mechanism in the grants to support them to work together now that public health and prevention are integrated."
- › "I would say that it [effective integration] would be more upstream, and a good integration of different levels of prevention... especially making the connections between physical health and behavioural health. Any research around physical chronic conditions and behavioural chronic conditions. That's what it should look like in HPCDP. Social determinants of health connection."
- › "Maybe it's better if we train people on the pros and cons of different programs and practices, rather than doing a certification."

Opportunities:

- › Crosswalk the language and frameworks of public health and prevention

Consider the development of a crosswalk of public health and prevention fields that identifies the overlap and intersections of the language and approaches as well as developing shared definitions for key terms, such as prevention and promotion. It will be beneficial to acknowledge both the strengths and limitations of the various approaches in both fields and helpful to also point to the research behind the approaches and outline where each approach is most relevant.

To integrate prevention and public health approaches, HPCDP may consider funding or piloting initiatives that actively leverage the strengths and approaches of both fields concurrently, to develop new and innovative approaches to the work.

Consider the development of learning opportunities and resources to support cross-functional development, where public health professionals can learn about the tools of prevention and vice versa.

- › Create opportunities for collaborative and cross-functional work teams

Consider opportunities for cross-functional teams of professionals to “roll up their sleeves” and get to work together on the challenges and opportunities facing the state. This presents the venue for bringing the best thinking and approaches from a variety of fields together in service to collaborative problem solving and will also serve to build understanding of these approaches through their application to existing challenges. These cross-field teams could serve to build bridges between prevention and public health, and foster broader linkages with CCOs, schools and public health nurses, for example. These cross-field teams have a high likelihood of pushing the interventions further upstream, as together they identify root causes and key leverage points. One way to clearly demonstrate support for and encourage the development these cross-functional teams would be to offer funding specifically for collaborative efforts; shifting away from a more “siloesd” approach that focuses on individual areas on prevention.

- › Communicate about and promote a wide-range of prevention approaches

In alignment with the model for public health modernization, there is opportunity for HPCDP to communicate about and provide best practice resources and tools related to the full breadth of foundational capabilities- from policy and planning to community partnership development, to cultural responsiveness. This would demonstrate a more integrated approach to prevention at the state level, and encourage the use of all available resources and capabilities.

2. Reinvent Approaches to Professional Development and Knowledge Sharing for Prevention Professionals

Overview/Context:

Historically, the Summits provided an opportunity for prevention professionals to accomplish two things: spend face-to-face time with peers and gain continuing education credits to maintain CPS certification. Recognizing that replacing the Summits may not be desirable or feasible, it nevertheless seems important to somehow replace the two main functions of continuing professional development and community-building. New technologies and regionally-focused approaches may be opportunities to achieve these goals at a lower investment of time and resources.

What We Heard:

- › “I think that having a professional certification—the CPS—is pretty critical, and that professionalization, that requirement to get continued education is pretty important. The CPS is imperfect. Like anything, it needs to be checked-in on and updated. Some of the content could evolve and grow, but I think something like that, especially with required CEU-type things, could really go far to achieve that. [It] does a lot to get everybody on the same page, and to get best practices to the people.”
- › “I think the summits were sometimes good, sometimes not. But they provided an opportunity to connect with one another twice a year. They could network and learn from each other... Maybe using [the Regional Support Network] model, but having everybody—not separate. All areas of prevention, but regional.”
- › “I 100% believe that we need to provide those ongoing trainings and that we need to keep the CPS designation. We have a requirement here that you either need to have a MPH or CPS. You need some specific training in prevention, and that’s what the CPS does. The state should take responsibility for it one way or the other: provide it or contract it out.”
- › “HPCDP has developed regional support networks, and in some cases those have been really effective in getting people from a region get together. That’s a great opportunity to get the coordinators sharing together in a region. Regionally, that’s the way to go.”
- › “In general, it would be great to think about how the health communities, tobacco, and other prevention professionals come together. Maybe it’s in conjunction with those larger meetings like Place matters to bring those folks together. But I think we need to get them out of their silos.”
- › “I think it ought to be more than annual. It would be interesting to put public health folks with prevention folks in a room together a couple of times a year.”
- › “The Oregon Pain Guidance website is a great example of a place to share resources and as a communication tool for what’s going on across the state.”
- › “The Transformation Center just did an integrated health summit a few weeks ago and it was a great opportunity to bring people together across fields and settings. They did a

world café table topic approach that gave folks a venue to bring their expertise. Maybe something like that would be helpful for prevention. I think it would be good for them to see one another leading those groups.”

- › “I would not want to replicate the prevention summit. Historically the content of those has not met the need of prevention coordinators. It gave them time to talk, but the summits themselves have not been structured in the best way.”
- › “Initially, since we don’t know each other well, in-person meetings are going to be important. I think that goes over better and there is some trust and relationship building that’s needed, so I would emphasize in-person, but... no one entity should have hierarchy over one another. I caution a little bit, because I think HPCDP has a tendency to come in and be dominant. They need to be careful not to be dominant when they are relationship-building. Clearly, they are our funder, and they have some authority, but they need to find ways to listen and learn in a way that comes away as, ‘We’re here to hear your thoughts and do some brainstorming together.’”
- › “The cohort model worked really well with the newer staff. Maybe you could do regional cohorts that include CPS and other public health roles as well.”
- › “Professional development can occur in an exciting way when you bring people together to challenge your thinking.”
- › “They (HPCDP) might even require regions to work together. That’s required of them, directed by HPCDP and in those meetings they are sharing. That will ensure that it happens.”
- › “I don’t think it always has to be face-to-face training. We had this cool program where I came from where if I was interested in anything related to behavioral health, they had access to like 5,000 classes. I was able to do everything I needed to do to get certified online.”
- › “Maybe there could be summits that are happening at the regional level. I learn best from connecting with others and having a face to face experience.”
- › “Things that I like, and even what Jackson and Josephine County did... it kind of went away, but at that time we created our own region of prevention coordinators—all the neighboring counties, and we created our own group. The tobacco folks do this every month or every other month. That is one good strategy—having your region of prevention specialists.”
- › “Looking at the [Coraggio interim] report, and knowing what my staff had to say about the Place Matters conference, it’s important to have tracks for each specialty—that’s part of the integration. What they would do at the summit, have that track at Place Matters.”
- › “That is where the CPS training comes in. In southern Oregon, Josephine County has been putting them on. They have hosted three cohorts. We have counties meeting that need, but in our opinion the state should be doing it.”
- › “We do need some kind of summits to bring people together in person to have the basis of relationship for those tougher conversations. HPCDP staff are great people. We had some tough feedback for them early on.”
- › “Could the summits be integrated into Place Matters? Could it occur in another manner? Online, webinar, integration into the nine tribes meetings?”

Opportunities:

- › Consider continuation or replacement of CPS designation

State requirements for certification demonstrate the state's interest in and recognition of the importance of prevention work. Certification brings many benefits to prevention professionals, including career development, skill building, and assurance of being up-to-date with best practices. Additionally, CPS certification has the benefit of reciprocity in other states.

From the state's perspective, certification ensures that all prevention professionals are working from the same playbook, resulting in a high-quality workforce with evidence-based prevention knowledge.

Although trainings will need to meet certification requirements as set by the National Association of Alcoholism and Drug Abuse Counselors, if the state elected to offer in-person trainings and/or draft curriculum, it would provide an opportunity for HPCDP to begin to shape common understanding on high-priority topics, such as the application of evidence-based approaches. Additionally, the use of local experts as trainers could bolster the relationships between HPCDP and local prevention professionals.

- › Consider establishing regional cross-functional prevention cohorts

Many participants in our listening sessions recommended that any reinvention of the Summits be done on a regional basis, both because of the commonalities of need within regions, and because it would simplify logistics. At the same time, we heard a strong call for these gatherings to be cross-functional—all areas of prevention would join together to ensure parallel efforts relate to one another and are informed by data and best practices.

These regional meetings would be a forum for sharing new approaches, and establishing procedures to test for effectiveness. They should include a mechanism for cross-pollination between regions, which might mean HPCDP attendees gathering evidence-backed best practices from the regions and taking that information to other regional meetings. Programming might also include a process for highlighting best practices being applied in other states or countries.

These regional gatherings should include both prevention professionals and HPCDP staff.

- › Consider developing an online community for sharing of information and best practices between prevention partners

An online marketplace of ideas would be complementary to regional face-to-face meetings, allowing prevention professionals and HPCDP staff to stay in contact. This tool would also allow for the "crowdsourcing" of answers to questions, allowing liaisons to focus more on relationship-building and less on technical assistance.

Off-the-shelf tools exist that HPCDP could use to form an online community at minimal or no cost.

3. Leverage Local Prevention Expertise and Evidence-Based Practices in Ways That are Complementary to One Another.

Overview/Context:

In many of our conversations, we heard the local expertise of prevention professionals contrasted with evidence-based approaches. This seems to be a bias that is held on both sides—that these ideas are somehow opposite of one another. If HPCDP can find a way to identify and develop understandings and approaches that are in the overlap—especially those that move “upstream” to address root causes of addiction—it could have a significant positive impact on outcomes.

There is a related opportunity to align HPCDP staff and community partners on what is meant by “evidence-based” and/or “research-based” prevention. ORS 182.525 requires that “An agency shall spend at least 75 percent of state moneys that the agency receives for programs on evidence-based programs.” For some, working in an “evidence-based” way implies a major restructuring of the approach to prevention, and a focus on early interventions that have been shown to be effective in preventing many of the negative health outcomes that OHA wishes to prevent. This may contrast with approaches and funding models that are more focused on a single area of prevention, where activities are sometimes developed then tied back to research as a way to legitimize or verify the probable efficacy of the activity (or to comply with ORS 182.525). These very different approaches both use research to inform decision-making, but may be at opposite ends of the spectrum in terms of the breadth of impact and overall cost-effectiveness.

Anthony Biglan sums up the situation well in his book [The Nurture Effect](#):

“The proliferation of randomized controlled trials of interventions in schools has proved threatening to people who have unevaluated programs. I often hear comments like, ‘I know our program works. We don’t have the money to do the research on it, but I’m sure it works.’ Many researchers, including me, have been sceptical. After all, we are committed to the proposition that science is essential to improving human well-being. The feeling among many researchers is that much of what is being done in the way of school or family interventions hasn’t been evaluated, and that some of what has been evaluated has turned out to be useless or even harmful. Meanwhile, over the last thirty years or so researchers have been conducting randomized controlled trials that have identified more effective interventions. Researchers have often seethed at practitioners’ resistance to adopting evidence-based interventions, and frequently haven’t been very sympathetic or polite toward those who aren’t researchers but are sincerely trying to make a difference in people’s lives.”

What We Heard:

- › “A public health approach should take victories wherever it can get them. There are interventions that work at the behavior change level and we should be doing those, in addition to policy.”
- › “I would be interested the degree to which social media can be used to bring people together. If you look at the tobacco control movement and the success they’ve had, the

decline has occurred because individuals are motivated to quit smoking. Policies are important in building awareness, but you take all the problems that we have and the main driver is the stress that people experience in their day to day lives, like discrimination. Stressful environments in children are hugely influential, but you don't change that with media campaigns.”

- › “We have the Oregon Healthy Teen survey data and when you look at relative risk of any one problem they are all interrelated with one another. They all stem from the same conditions. More likely in high conflict and stress environments, including poverty and discrimination.”
- › “What do we mean by best practices? Evidence-based best practices, or just ‘I tried this and it worked well and people liked it.’?”
- › “The state needs to bring people together around a shared view of what human beings need to thrive and what we can do to ensure that outcomes are better. There needs to be a shared vision of that we want to do and all the ways we can make people’s environments more nurturing. Nurturing environments limit toxic environmental and social [environments], richly support pro-social behaviors, limit opportunities for risky behaviors and promote a flexible approach to one’s own values.”
- › “I really hope that the state identifies the SMEs in the field and the county level, and brings those people close to them and not push them away.”
- › “The counties are dependent on OHA for expertise, because they have such limited resources. If OHA is more proactive in reaching out to them, it’s better to get that integration. Being proactive has helped the state with local prevention professionals in the past a lot.”
- › “Data is great, but it still comes back to [the] individual. Listening, being responsive, developing those relationships. It’s key in Oregon—it’s especially important for people to feel that their voice is heard and that there’s a response to it. And that it’s transparent.”
- › “It’s a cultural shift in attitudes from us as professionals... [and] it’s a cultural shift from the public who has any knowledge about how the systems run in this state. HPCDP is focusing on itself to create a culture of change, but it has to be greater than that— a whole shift on everybody’s part. Looking way, way outside the box.”
- › “We are guided by ethics, we need to learn to organize around data... there are things [that are] important for prevention professionals to be aware of.”
- › “It would create an environment where we were supporting work that has a research, data—a public health approach (community-wide impact), but also supporting local initiatives or targeted efforts related to specific challenges.”
- › “For example, in [my community], we brought some of the key partners back to the table after the summit to talk about data collection. We were asking what data they needed, and where they were trying to go with that. They told us about problems in their community, where if we could identify data on it, they might be able to get funding for [prevention efforts related to] that problem. If data is being collected that’s informed by the community, and if they own the process, then that can direct the way the data is collected and reported. We had a really successful meeting in that way. Healthcare was at the core of those conversations.”

- › “I think consistent messaging. In the end, our communities should be a united approach and a united team. There should be consistent messaging—not only messages we are putting out there, but also what’s coming off the tongues of the prevention professionals. What we’re addressing, why, how, what the key data points are. That’s the only way we’re going to change community perceptions and behaviour.”
- › “There are cheap and proven prevention efforts that have been used little in the past and the state would benefit from implementing those quickly and widely. Prevention work had been centered on creating prevention coordinator people in each county, but they didn’t understand or value evidence-based practices. They spent money on things that there is no research to support.”
- › “If we use the good science on prevention it matters a lot less what individuals ‘think’ the best approach to prevention is. We need to redirect funding to the right places. I hope HPCDP can use the science available to make decisions.”

Opportunities:

- › Consider collaborating with prevention partners to redesign how prevention happens in Oregon

It may be that the current approach of prevention partners aimed at specific areas of prevention will not serve the long-term goals of the state, understanding that some of the same risk factors may lead an individual to addiction to tobacco as well as opiates. However, current structures are built around funding mechanisms that may not change so readily.

A future-focused design team consisting of prevention professionals and HPCDP staff could use an iterative design process, with data collection and testing, to identify steps that prevention in Oregon will need to take over the coming years to become more integrated and focused on root causes, risk factors, and protective factors.

- › Consider taking steps to foster a stronger culture of evidence-based prevention

The July 2016 Public Health Modernization Manual recommends that prevention and health promotion functions “Demonstrate the connection between early prevention and educational achievement, health outcomes, intergenerational outcomes and other outcomes (i.e., social determinants of health) to communities, partners and stakeholders, policy makers and others.” Meanwhile, the Roadmap for Modernizing Oregon’s Public Health System has Strategy 11, which states: “Adopt shared metrics and incentives with the early learning and health care delivery systems for collective impact.”

Beginning with a well-articulated vision for the future of prevention work in Oregon, HPCDP can begin a process of shifting the culture of prevention in Oregon to one that recognizes the overlap between some community-based approaches and what research has shown to be effective. This will be a long-term shift, and not a quick win, but would serve the state’s interest, support

modernization efforts, and would also support the need for prevention professionals to know that they are making a difference.

Strategically, HPCDP could target high-gain opportunities for early wins, build support by consistent messaging focused on the benefits to prevention professionals, gain the support of influential members of the community, and leverage changes to professional certification requirements to create support over time.

- › Consider establishing regional cross-functional prevention cohorts (Repeated from Theme 2)

Many participants in our listening sessions recommended that any reinvention of the Summits be done on a regional basis, both because of the commonalities of need within regions, and because it would simplify logistics. At the same time, we heard a strong call for these gatherings to be cross-functional—all areas of prevention would join together to ensure parallel efforts relate to one another and are informed by data and best practices.

These regional meetings would be a forum for sharing new approaches, and establishing procedures to test for effectiveness. They should include a mechanism for cross-pollination between regions, which might mean HPCDP attendees gathering evidence-backed best practices from the regions and taking that information to other regional meetings. Programming might also include a process for highlighting best practices being applied in other states or countries.

These regional gatherings should include both prevention professionals and HPCDP staff.

4. Develop Stronger Relationships With the Tribal Health Community

Overview/Context:

There is considerable frustration among tribal communities in Oregon related to the interaction of HPCDP with their tribal health and prevention staff. The path forward likely requires a deliberate re-building of those relationships, rooted in mutual respect and a recognition of the sovereign status of the tribes.

What We Heard:

- › “Have a presence at the meetings that the tribes already have. Be in-person at tribal meetings that already occur with the state. The SB770 agenda. Provide an opportunity for meaningful discussions, not just consultation. By meaningful, it means we have the full material in advance of the meeting, there’s enough time on the agenda, the appropriate players are in the room, and they receive enough advance notice so they can be sure to be there. Those are some of the things that need to happen to ensure that the information flow is bi-directional and meaningful. Having HPCDP participating written and orally, and information available at least two weeks in advance to provide the opportunity for the appropriate staff to be at the table.”
- › “The Tobacco program is solely about policy work and no real outreach to help with stopping except calling the Quit line. When the Tribe submits work plans to the State, they make numerous recommended changes until it is how they want it and not what is best for our Tribal people. If alcohol/drug is going more towards a public health model our program will lose engagement with the tribal community—people will not come to prevention coalition meetings to work on policy work.”
- › “I think there’s got to be more face-to-face between HPCDP and the tribes, because to build the relationship, they are going to get paid attention to more. Ultimately, they have got to genuinely listen, hear what’s being said, and then respond to it concretely.”
- › “Some in HPCDP are not really genuinely hearing and acting upon what’s being shared by the stakeholders, and until we get past that, we’re dead in the water. I am concerned about the sense from the tribes that their sovereignty is not being considered. It’s not just about the prevention work. What we are hearing is a lot of angst and dissatisfaction around working with HPCDP in general. The movement of prevention into HPCDP has been the catalyst to bring that frustration forward, but it goes beyond this body of work... The stakeholders feel that the decisions were made before there were any genuine questions asked.”
- › “They really need to focus on the connection and partnership with the tribes. [There are] legitimate complaints that OHA often treats them as an afterthought. There has been a whole lot of work done to get over ruffled feathers in regards to a federal grant prevention was working on, and I would hate to see the gains and trust built in that effort lost.”
- › “The Oregon tribes have developed tribal best practices. And I believe one of those concerns is that those best practices will be diluted. It’s work to be extremely proud of,

and it's occurred for 15-16 years. They follow a standard format and standard process, such as smudging, dance, gathering— as prevention activities that can be used with the state funding. This law provided a vetting format and baseline as to what to do for tribal best practices, and there are mechanisms for adding best practices.”

- › “The constant issue and irritation of the tribes is that consultation regarding changes to government programs does not occur on a government-to-government basis, and that changes occur before the tribes have an opportunity to engage in meaningful conversation. What we are doing now is after the fact. This situation occurs time and again. The tribes become frustrated and angry that there is not the recognition that we are sovereign governments... essentially we are another state, and any changes that can affect our funding needs to occur at the highest level—OHA Director to Tribal Health Director, or the Governor to the Tribal Council.”
- › “I would also say in-person visits to counties and tribes is hugely important. I don't think the leadership of HPCDP has visited [my] County.”

Opportunities:

- › Consider building a communications protocol that encourages peer-to-peer communications between HPCDP and tribes

Because tribes have status as sovereign entities, communication protocols will need to be different than they are for county health departments or other agencies. This means that communication to the tribes should be undertaken with an eye to the status of the individuals. For example, the Tribal Health Director should hear directly from the OHA Public Health Director, and the Tribal Council should hear directly from the Oregon Governor.

Establishing such a protocol and building additional time into communication processes to enable those connections would make an important contribution to rebuilding the trust of the tribes.

- › Consider establishing a cadence of in-person visits to all tribes on a regular basis, including individual tribal visits and Nine Tribes meetings

In order to ensure that communications are predictable, don't come at the last minute, and to serve the relationship-building need of face-to-face communication, it may make sense for HPCDP and the tribes to agree upon a regular cadence of in-person meetings. Ideally, these meetings would take place at tribal locations, and would reflect the kind of peer-to-peer communication that recognizes the sovereign status of tribes.

- › Consider continuing or expanding options for culturally-specific prevention approaches

Historically, OHA has had a process for the approval of culturally-specific prevention practices that tribes submitted, as well as a webpage offering a detailed list of these practices. It appears that this webpage has been removed from the internet within the past couple of months. This may not indicate a policy

shift on the part of OHA, but HPCDP may consider clear communication on this question to the tribes.

Without sacrificing the goal of using scientific evidence to choose approaches that drive the greatest results, HPCDP should consider working with tribes to maintain a current list of EBPs that are culturally specific. A multi-tribe working group may be indicated for setting a good foundation for future work on this topic.

5. Lead with Clarity & Transparency

Overview/Context:

There is an opportunity for HPCDP to lead the prevention field with greater clarity and transparency. Prevention professionals expressed a need for greater clarity both in regard to the overall prevention strategy and goals for the state, as well as clearer guidance on priorities and recommended approaches, and a clearer understanding of how and why HPCDP's decisions. Within the strategy and guidance, there is an interest in flexibility and the ability to customize the specific approach based on community context and readiness wherever possible, but the desire to know where HPCDP stands remains. Prevention professionals are eager to align, mobilize together, and to play a role in making an impact. To clearly communicate and reinforce HPCDP's stance, any messaging in regard to strategy, goals and approaches needs to be frequent, consistent and wide-ranging in terms of medium. Increasing the transparency of HPCDP's leadership by sharing more information about how decisions are made or why particular strategies, goals or priorities are chosen would bring greater understanding, meaning, investment and support from prevention professionals.

What We Heard:

- › “There are many things that are reasonable for the state to spend money on related to alcohol and drug prevention. Their job is to set the goals and objectives and move toward them.”
- › “Give options that work for people to choose from. State guidance, but local control.”
- › “In the past the prevention affiliation with AMH was good, but there wasn't really any strategy from the state. They were more focused on treatment and just let prevention do their thing as long as they weren't making waves.”
- › “When you know how to solve a problem and you have public funds to work on solving it, you have to do what works.”
- › “The first step is finding a shared goal, and then agreeing on how to get there... Need to look at the theory of change and then roles within that.”

Opportunities:

- › Establish and clearly communicate state-wide strategies, goals and priorities
Leading with clarity requires clear, consistent and frequent communication, to ensure the message is both heard and reinforced. There is opportunity for HPCDP to clearly establish and outline the state-wide prevention strategies, goals and priorities. This could then be tested via an advisory group to ensure a clear and direct, yet comprehensive message that delivers what prevention professionals need to know. Using a variety of channels (broad communications, the HPCDP website, 1:1 relationships, established workgroups, etc.) HPCDP

could then clearly and consistently state and reinforce the priorities and objectives state-wide.

- › Provide evidence-backed guidance on options to choose from at the local level

In support of the established strategies, goals and priorities, there is also the opportunity to clearly communicate the evidence-based recommended approaches to prevention. Acknowledging the varying levels of readiness as well as the influence of the unique needs and cultures across communities, wherever possible it is helpful to outline the various options that align with each priority area, allowing flexibility and choice within proven approaches at the local level. HPCDP could share examples or case studies of different approaches being utilized to address the same goals, and where willing, offer points of contact around the state utilizing various approaches.

- › Communicate the “why” and “how” of decisions and strategies

There is opportunity to provide more information, so that HPCDP’s leadership is not only clear, but also more transparent. HPCDP could include information in communications such as the process by which decisions were made, who was included, what data, research or other information influenced the decision, etc. Knowing that different situations require different decision-making approaches, HPCDP could transparently communicate what approach is being utilized for a given situation. At times when an approach is shifted, a program is stopped, or any significant change is made, HPCDP can acknowledge the change and provide some information as to the basis of the decision, ideally before the change takes effect. Drawing on an advisory group and individual relationships HPCDP could test out communications to test for a clear and resonant “why” or “how,” in order to reinforce the strategies and decisions with personalized application.

6. Cultivate Trusting Relationships

Overview/Context:

There is significant opportunity for HPCDP and prevention professionals to cultivate strong working relationships with one another. In many cases, prevention professionals lost a sense of trust in HPCDP as a result of the way the integration process has happened. HPCDP demonstrating a genuine interest in rebuilding that trust is an important first step in re-establishing strong relationships where connections have been damaged. Similarly, prevention professionals have an interest in knowing what HPCDP has gained from the outreach and listening process as well as what they plan to do in response. To begin to (re)build these relationships and also to communicate a clear and authentic response to the outreach process, it is recommended that HPCDP find opportunities for face-to-face interactions with prevention professionals. There is also the opportunity for some prevention professionals to approach the relationship with HPCDP with greater openness to the potential for change.

What We Heard:

- › “There will be professional jealousies and deep cultural differences between prevention specialists and MPH’s. We treated that as a cultural competency issue. That’s how I think you have to approach it. That’s also how we work with law enforcement, medical community, etc. It is like working across cultures.”
- › “Looking ahead, engagement and communication are critical for regaining trust and credibility.”
- › “What will HPCDP do with what they learn from this process? I’ve seen OHA do listening sessions and surveys in the past and then they don’t take any action. It seems to just buy them some freedom for a couple of years so they can say that they are “working the process” and not really do anything. I’m pretty cynical about OHA and a number of other state departments and how they conduct change processes. They have a goal, but construct and elaborate process around it in order to just get to the place they intended to get in the first place. I do get that it creates some political cover while they make tough decisions, but how long does this need to go on? Just pull the parachute and do what needs to be done.”
- › “The information that comes from the state feels like one size fits all pronouncements. When you’ve been doing this work for a really long time and you’re on the receiving end of it and they’re acting like they’re sharing something new it comes across as top down and disconnected or tone deaf- like they don’t know who we are, or don’t get that we’re not all new to this work.”
- › “There still seems to be a lot of defensiveness that I’m hearing from prevention specialists. To a certain extent that has made me more aware that as a group of like-minded professionals, we are not nearly as connected as we think we are.”
- › “There is so much emotion and it is not very factual. I went through the emotion and then I decided to ask questions to understand why the state did this and I developed a working relationship and trust with HPCDP and they seem them be very genuine and

want to make it work. Others haven't had that and so there is still distrust, instead of seeing them as an advocate."

- › "It's been approached as a structural change, and the personal and emotional aspects of the change were never acknowledged. We never had a connection with the state before except for the individuals that we used to work with, so now they aren't there and people don't feel any sense of a personal relationship with the state."
- › "Prevention people are so much about the relationship and they want to be communicated with more thoughtfully. We don't do well with emergency room-triage approach to communications that seems characteristic of public health. Maybe have some random prevention people vet those communications for tone and impact."
- › "Err on the side of oversharing. Get out and visit and see what the prevention professionals are actually doing in the community. Really get a sense of their work and focus on relationship building. Engage people more in decision making."
- › "The Transformation Center has done a really good job with the CCOs... they have also done a great job of relationship building and including stakeholders in the process."
- › "I think there is still opportunity to swing the pendulum to the other side in terms of relationship building and bringing local folks in so they can see how they are included and important in the modernization. Karen and Luci have been very collaborative and positive in my work with them, so they need to share that with others."
- › "It seems like it has been a deeply divisive issue. I get that transitions are hard, but it is frustrating that important work had to be put on hold. It just seems so emotional. There is a lot of work to get done in our state and there are some crises. It seems like a waste to stop the work because people are upset."
- › "People need a job to do together. Let's just get to work. How to integrate is a never-ending discussion. More progress could be made by just selecting some things and getting to work together."
- › "I really think it is important that the work gets put first here... We have a lot of work to do and I feel frustrated that because people are bent out of shape that we have had to stop and do all of this. I hope we can get this all patched up quickly and get back to work."
- › "We had a rocky time doing it and those whose work was outside of public health felt belittled. I know folks are already feeling that from HPCDP- things like when they say they're going to "train up" prevention specialists."
- › "We have some responsibility for that [ensuring an inclusive and broad reach]. We need to learn how to address issues that are uncomfortable."
- › "There are a lot of professionals who are leaders in the field, especially within the OCPP leadership. They have influence in the field and I would advise staying connected with those folks, to let them know where the process is at, and asking for feedback, etc. I think that would help radiate information back to the field, with us as the messengers. Prevention professionals in the field might trust it more coming from us. I've offered that before but no one has followed up for me to help. Use us; we want to help."
- › "Encourage local level prevention professionals to call us at any point asking for suggestions. Keeping that kind of access, even if you aren't doing face-to-face connection every time. That is really helpful."

Opportunities:

- › Express humility and acknowledge impact

There is an opportunity for HPCDP to bring greater authenticity, vulnerability and humanness to their relationships with prevention professionals. The impact of the integration process has been personally significant for many and an acknowledgement of that from HPCDP which feels authentically humble and responsive would go a long way to foster trust and move relationships forward.

- › Establish clear points of contact and individualized relationships

Many of the prevention professionals expressed an interest in having a clear point of contact within the HPCDP team. There is opportunity for these individuals to visit the prevention professionals and their communities, both to learn about the unique realities, needs, and cultures of the community as well as to gain a greater understanding of the day-to-day realities, work, tools and approaches of prevention professionals. This would create more personal connections and relationships and stronger two-way communication channels. More individualized relationships could also be built through the regional cohorts (theme 2) as a venue for testing and vetting efforts and communications.

- › Communicate a clear response to the outreach process and any related changes

HPCDP has the opportunity to consider the feedback generated from the outreach process and to clearly communicate the meaning they make of it. It is recommended that the response be honest and transparent- acknowledging feedback they intend to act on, as well as feedback they do not intend to act on, and in those cases why not. The Insight Report Tour could be utilized to clearly communicate the implications of what they've learned and to collaboratively define the shifts they are will make as a result. In order to establish and maintain trust, it is important that visible changes then be made in those areas. Where possible it is recommended that related roles, goals, and timelines connected to these changes be communicated. As has been shared in other areas of this report we recommend HPCDP err on the side of oversharing and tailor communication messages and mediums to various stakeholder groups.

APPENDIX

Interim Report



Oregon Health Authority, Public Health Division
Health Promotion and Chronic Disease Prevention (HPCDP)

Prevention Partner Conversations: Interim Report

March 10, 2017

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Overview

About the Process

In the first phase of the Prevention Partner Outreach, Coraggio Group gathered input through stakeholder listening sessions conducted in Portland, Roseburg, Coos Bay, Pendleton, Bend, and Milwaukie, as well as via an online survey. Participants included substance abuse prevention coordinators, tribal prevention staff, community coalition representatives, and other local public health staff. In all, we heard from 109 individuals.

Key Themes

Our survey and conversations with stakeholders surfaced themes in regards to the experiences and ideas shared by many of the participants. These themes are collected in this report in the interest of capturing progress on the project, and to mirror back to the stakeholder community what we heard. These themes will inform the questions that we will seek to answer in the next phases of the project, which will include additional listening sessions and interviews with individual stakeholders.

Themes that emerged from the outreach in phase one of the project include:

Professional Standards and Best Practices

1. Prevention professionals need a venue for connecting with one another and sharing best practices.
2. Prevention professionals are questioning how committed HPCDP is to the CPS (Certified Prevention Specialist) designation going forward.

HPCDP Leadership and Flexibility

3. Community prevention and public health professionals want HPCDP to lead in terms of priorities and policies, but not approaches.
4. HPCDP's approach and funding mechanisms don't appear to have the flexibility to incorporate community-level realities.
5. Prevention professionals are eager to bring their expertise to the integration process, and doing so would help to foster a sense of respect.
6. Tobacco prevention is ahead of the curve, and it's unclear whether HPCDP recognizes the need for different approaches for other areas of prevention.
7. HPCDP has an opportunity to lead a more cohesive approach to data gathering and use.

Integration Opportunities

8. The word “integration” has been used to describe OHA’s action, but it doesn’t feel like integration to those in the field.
9. The integration has diminished the ability to apply holistic approaches.
10. There’s a need to crosswalk the language, frameworks and goals of public health and prevention and define the alignment.

Communication and Relationships

11. While encouraged by the listening sessions, prevention partners are hesitant to expect change based on past experiences with OHA.
12. Proactive, relevant, and direct communication would help to build trust.
13. Stakeholders desire more clarity from HPCDP about key HPCDP functions, and what the future of programs and funding looks like.
14. Stakeholders expect more transparency and humility in communications from HPCDP.
15. Prevention professionals want key contacts at HPCDP who understand their local and specialty history, and to whom they can turn with questions.

Tribal Relationships

16. Tribal partners feel that their status as sovereign nations isn’t fully honored by HPCDP.
17. Tribes fear that their best practices and cultural approaches will not be honored.

In the pages that follow, we have detailed each of these seventeen themes with survey data and quotes from participants.

1. Prevention professionals need a venue for connecting with one another and sharing best practices.

Stakeholders value building connections with other prevention professionals and hearing about best practices and new approaches directly from one another. The bi-annual summits were popular with prevention professionals in the field, and were an important resource in this regard. Whether or not future efforts take the same form, stakeholders voiced a preference that an opportunity to connect and share best practices be restored in some manner.

What we heard:

- › “At Place Matters or the biannual tobacco conference, there wasn’t any opportunity for us to speak. It isn’t inclusive and they aren’t asking for our expertise. There are so many invested and passionate people who want to help change the outcomes... people are really interested in sharing what works. The state staff with AMH were the leaders in that they were inclusive and never acted like they knew more than us.”
- › “The summits we used to have were a great connecting point for getting information out across the state and a great opportunity to cross-train across disciplines.”
- › “The CPS cohort was very important... [a place to learn] prevention-specific strategies.”
- › “I was surprised at Place Matters. The attitude was: ‘We know this information and it so fortunate you get to be here to be the recipients of what we get to say.’ That was a missed opportunity to have people from across the state share what they know with one another.”
- › “We used to have spring and fall summits. They were very valuable. [We had the] opportunity to meet with people around the state doing the same work we are, rather than being [at] a general mental health conference.”
- › “Place Matters—it’s a waste of money. Very urban-centric.”

2. Prevention professionals are questioning how committed HPCDP is to the CPS (Certified Prevention Specialist) designation going forward.

In the absence of clear communication from HPCDP on the matter, participants in our conversations expressed concern that the CPS designation would be de-emphasized in the future. Stakeholders said that CPS certification is important to the sense of professional identity, establishes standards for professionals working in the field, creates a sense of cohesion and community across the field, defines a path for professional development, and is required by some job descriptions.

What we heard:

- › “OHA Public Health staff treat us as if we know less about public health than they do and as though our knowledge of our communities is irrelevant. The role of state public health should be to provide the bigger picture and resources to support local public health work—not tell us what to do and how to do it. Most of us have the same academic credentials as state employees, plus we have the experience of working in our communities. We know how to do the work on the ground and deserve to be treated with respect for our expertise.”
- › “It feels at times like our credentialing (CPS) is not valued as much as an MPH. Both are important, and complement each other, and provide important skill sets upon which to build this work.”
- › “There is a very clear disdain and little respect for the Certified Prevention Specialist credential.”
- › “We wrote in CPS as a requirement in our job descriptions, and now we have no way to get trained on it. It was great to have a low-expense, organized way for people to move through that training. The cohort and peer model was really valuable, to be able to reflect, and discuss and ask questions of others who are going through the same learning experience. Very different if you’re just trying to do it on your own.”
- › “There haven’t been enough trainings this year to keep CPS training and credentials up to date. I’m seeing prevention coordinators hired without any CPS stipulation now. Where is that requirement going? If it’s going away, it would be nice to know.”
- › “They have no appreciation for what we [do]. No appreciation of CPS training, their model of prevention is public health, not ours.”
- › “[Regarding] CPS, what I got out of the summit is that HPCDP didn’t care about that. The certification is a hard one to get, with thousands of hours and—speaking for those who came before me—it took a lot of work to put in place to raise the profession of prevention, and I wouldn’t want that to go away.”
- › “I don’t know if they are aware of what the CPS entails. They need to learn about [that] if they aren’t.”
- › “I’d like some clarification [around] if prevention is going to continue.”
- › “[I’d like to see better] information dissemination to us—are they going to do away with CPS and make us health educators? Rumors are not good.”

Professional Standards and Best Practices

- › “HPCDP seems to think they know what kind of training is needed, but it is often too basic. We need a tiered level of training for people who have a wide range of knowledge and expertise and prior training.”

3. Community prevention and public health professionals want HPCDP to lead in terms of priorities and policies, but not approach.

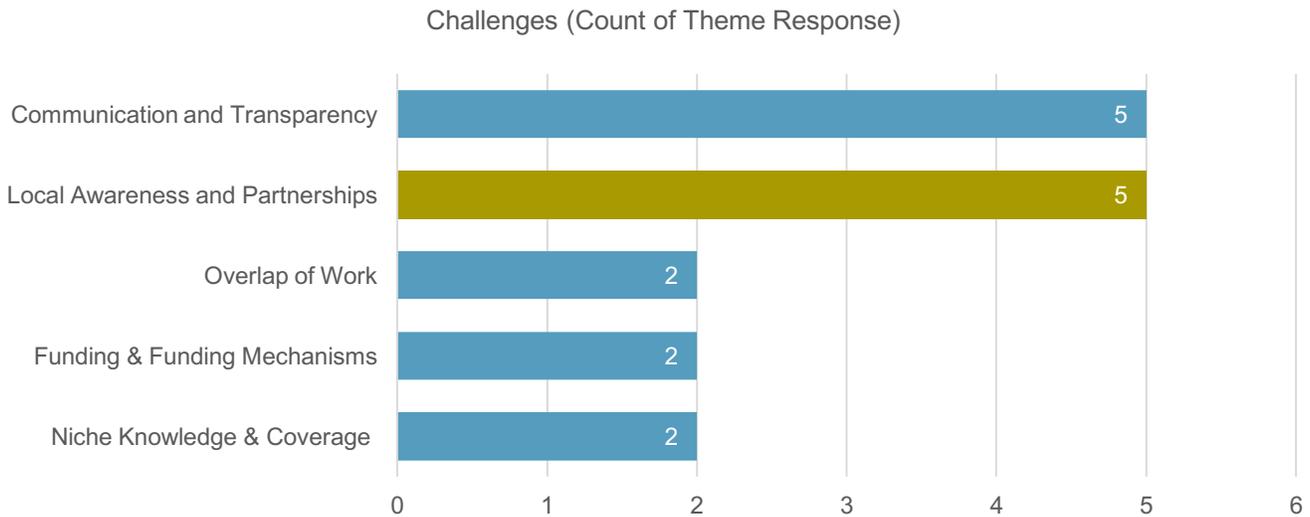
Members of the prevention community look to HPCDP for a clear vision of the future and a sense of shared priorities and direction at the state level. However, they wish for more autonomy in how prevention strategies are deployed at the local level, in order to address the identified priorities.

What we heard:

- › “We need HPCDP to determine the full complement of strategies at each level to really be effective in our prevention work. We’re out there saving kids’ lives and it takes day-to-day work with families and kids.”
- › “I’m out in the community and working with people and I can share what works. [It’s] amazing at the summits to hear from folks in rural areas what they have make work. We know how to borrow strategies from one field (tobacco for example) and apply it to other areas.”
- › “You have people on the ground who know the history at the local level and how to influence in those communities. We could all spend hours talking about what we’ve learned about from people in the field. ‘One size fits all’ doesn’t work.”
- › “Even if we’re mustering policy at local level—we need the support and championing from the state level. That is attractive to think we’ll be partnering with the state who can navigate that. Especially related to alcohol.”
- › “HPCDP micromanages the work at the local level. They have an ideal expectation and have strong hold on what we do locally. [That] stifles the community partnership and grassroots. We don’t want to lose local control and decision making.”
- › “We need a strategic plan at the state level; for HPCDP to do what it’s done for tobacco for alcohol and other drugs: legislation and state- level support. A plan that honors the local level to look at capacity and readiness. Some flexibility and options within the plan to select what best fits your community.”
- › “We’re trying to figure out how to work together at a grassroots level without clear direction from the top down at the state level. So, we might be wasting our time because once we get direction, they might want us to be doing it differently.”
- › “A great outcome would be one vision and a framework for how to unite the different areas of prevention. Draw the tent. How do we all fit?”
- › “My expectation about people at the state is that they have some kind of clear vision. I might still have ideas about it and I want them to have openness to influence, but I expect them to have a vision.”
- › “We’re going to have pizza sometimes, and it’s OK. We’re going to do it how we do it, and don’t be negative about it. We’re not living in downtown Portland, riding our bikes every day, and drinking carrot juice.”

4. HPCDP’s approach and funding mechanisms don’t appear to have the flexibility to incorporate community-level realities.

Many participants expressed frustration at what they see as a “one size fits all” approach optimized for urban areas that doesn’t recognize community readiness and other factors that may require custom localized solutions.



What we heard:

- › “Events/meetings are planned in local settings without local stakeholder knowledge; assumptions that local expertise is lacking.”
- › “OHA coming into the county to do work without coordinating with the local department... funding with so many strings it removes local autonomy to truly do work driven by local data.”
- › “We are in a rural area. There is a HUGE difference between the cultures in rural Oregon and urban Oregon. If you don't live in that culture, again, it's easy to overlook the differences.”
- › “HPCDP has these things that they say: ‘These are the things we’re going to tell you to do in your community.’ But our communities aren’t necessarily ready for these things... I get that they are environmental and trying to move the needle statewide, but how can we honor unique local conditions without alienating local coordinators, and keeping them from feeling punished because their community is in a different place, like they aren’t as good as other counties?”
- › “Seems like the policies they write are what they see outside their window—Portland.”
- › “Send Lynne Saxton down to talk to us.”
- › “Every county is different. Not every county coordinator sits in a public health department.”
- › “[I would like to see] perhaps a little more freedom in some of the tobacco areas. The ability to flex some of the work to meet the needs of the community.”

HPCDP Leadership and Flexibility

- › “[The] Place Matters language seemed very metro-focused and didn’t match my community and eastern Oregon.”
- › “Strategies don’t line up with our community readiness. Across Oregon, we have different levels of readiness. Community readiness is a huge issue—whether alcohol, suicide, etc.”
- › “Policy change is one piece, [and is] maybe an end result of years of work, but you’ve got to allow... the community to do the ground work first.”
- › “[You can craft] policy all you want, but with no enforcement... we had a policy before [our local government] last week, and they wouldn’t pass it because there was no enforcement.”
- › “You have all these different entities with different plans thinking they are going to drive the work, because the state, where all the money is flowing through, is siloed.”
- › “But still, we don’t have the ability to compete with the counties and we can’t match those funds. We don’t have funds to match. So every time the state imposes a match requirement, we’re already out of the game.”
- › “We use SAMHSA and CADCA. CSAP is what the state tends to use because of federal funding, but I like CADCA better.”

5. Prevention professionals are eager to bring their expertise to the integration process, and doing so would help to foster a sense of respect.

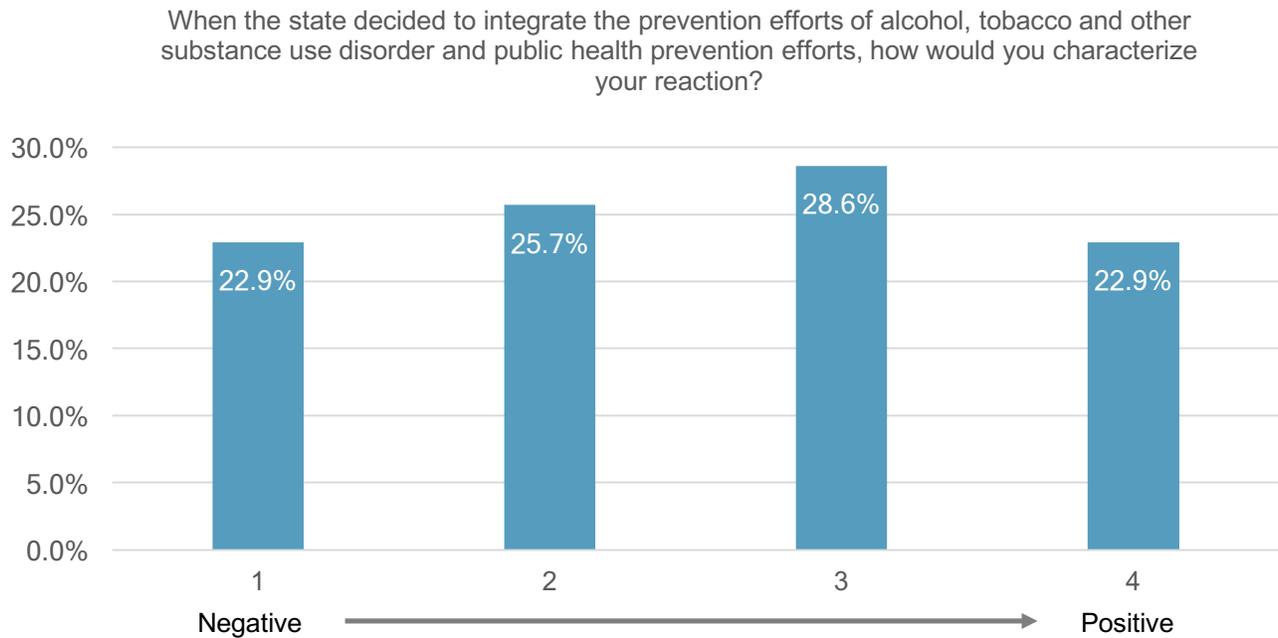
Prevention professionals are passionate about their work, invested in the success of this integration, and eager to bring their knowledge and ideas to the process. Participants expressed a desire for more two-way sharing of approaches and best practices. In the absence of this, it can feel like their input is not valued and they are concerned that HPCDP may miss opportunities to gather and highlight important learnings from the field.

What we heard:

- › “While things are still being designed, it would be important to utilize an advisory group of prevention coordinators. This would go a long way to establish trust and show commitment to valuing our input.”
- › “We have personal and professional investment in these issues. We’re being underutilized and it feels disrespectful. Not asking people who’ve been doing this work a long time for guidance or to be included to take on pieces of the work.”
- › “Build an infrastructure made up of prevention specialists. They could bring us together and bring learning from the field. Maybe an advisory committee of prevention coordinators.”
- › “As long as Luci and others are willing to keep the conversation going, she could build a massive army of people who are really passionate about prevention.”
- › “Public health is so policy-driven. That’s not true prevention... not how people change. Prevention is about helping people learn skills.”
- › “I want to make sure the state realizes how important it is to respect all of us, and understand that we are all experts in our field. To remember that.”
- › “HPCDP has several county examples of where similar integration has happened. I thought there was going to be an integration group to learn from the counties... as far as we’ve heard, there has been no follow-up on that. Ask us. We are willing to get together. They may have done it among themselves because they couldn’t get HPCDP to do it.”
- › “Every change that is being made has a trickle-down effect, so try to keep in mind all the communities that it is affecting—the young people. Decisions aren’t just funding and administrative, but it really impacts what is happening at the community level, so it is important to have those voices at the table.”
- › “I do really think this could be a great relationship with a common goal.”

6. Tobacco prevention is ahead of the curve, and it's unclear whether HPCDP recognizes the need for different approaches for other areas of prevention.

Participants cited the success that tobacco prevention has had with public health, but point out that prevention work in other areas face striking differences in terms of community readiness and support for prevention efforts. Participants are concerned that in trying to replicate successful tobacco prevention efforts in other prevention areas, HPCDP may deploy strategies that communities are not ready for.

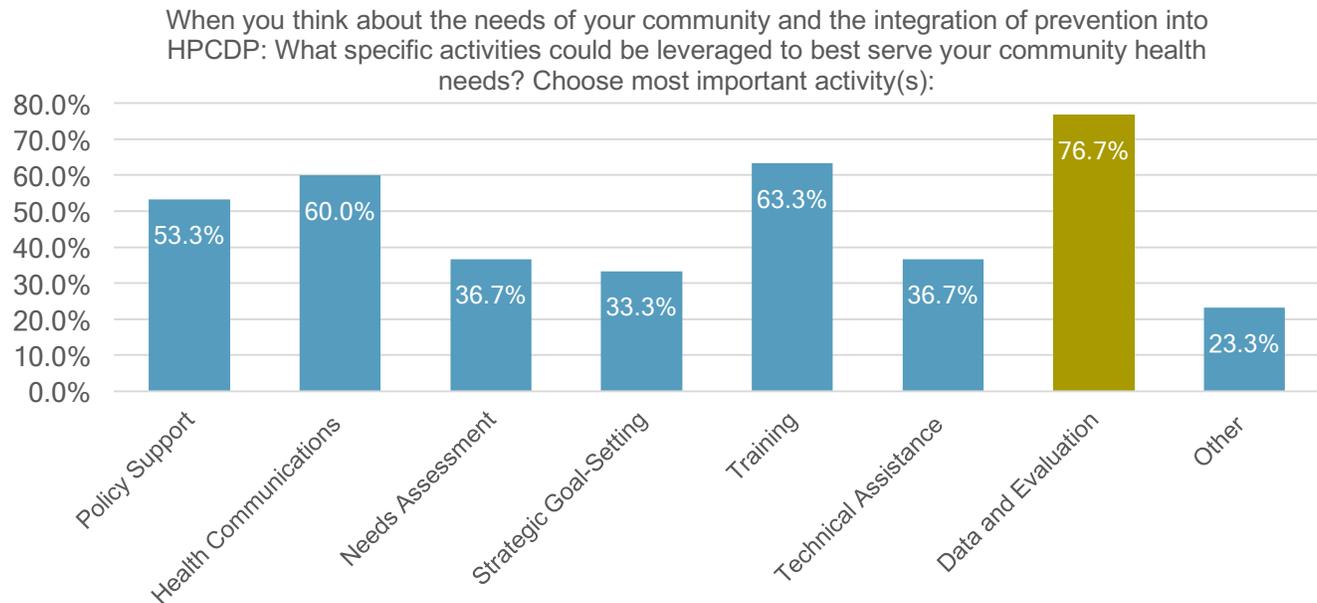


What we heard:

- › “[There are] some risky behaviors we are still trying to get recognized as a risky behavior to get community buy-in. Like gambling. Marijuana is another example. There is a lot of research out there, but you still have to convince the community of the risks... It is about where we are on the continuum of awareness, as opposed to something like tobacco. That isn’t to say we won’t get to the environmental strategies, but you can’t put a new policy in place until the community has the awareness.”
- › I feel like tobacco is policy-driven. Gambling and substance abuse are CSAP—community-based. Tobacco used to be more aligned with where substance abuse is [today].”
- › “[The tobacco approach is] very directive, not as reflective of county qualities.”
- › “Content matter [for other areas of prevention] is really different than tobacco. Tobacco evidence is clear that is unhealthy. It is less definitive with alcohol, marijuana and prescription drugs. It requires a very different approach.”
- › “In our work, we look at the needs of the community before we provide any kind of service, and I would like HPCDP to take the same kind of approach.”

7. HPCDP has an opportunity to lead a more cohesive approach to data gathering and use.

Respondents to the survey indicated data and evaluation as the most important activity that HPCDP could leverage to best serve their communities' health needs. Participants in our focus groups also expressed their need for this service, and discussed the inconsistency with which data currently is gathered and used in prevention.



What we heard:

- › “There are two surveys and it creates the perception at the local level that they must not be aligned or have it together, they must be siloed if we have two surveys. We also can’t use the data as well in terms of trending because there are gaps in years in between.”
- › “It would be great to streamline and have one survey that we can get year to year data from so that we know what is happening and what is current. We need to be able to get this data and also share it statewide.”
- › “If prevention works, there is nothing to report.”
- › “We have two student surveys. Very cumbersome at [the] local [level]. We need to analyze what’s needed across the state and federal requirements and create a survey that hits all needs. There has to be planning to navigate this—we will jeopardize federal funding if we don’t.”
- › “Are there other opportunities other than the schools to conduct the survey? They don’t see the benefit.”
- › “[Something that is working well is] data support, and analysis. The snapshots are phenomenal; empowers us to be accurate and consistent across the state.”

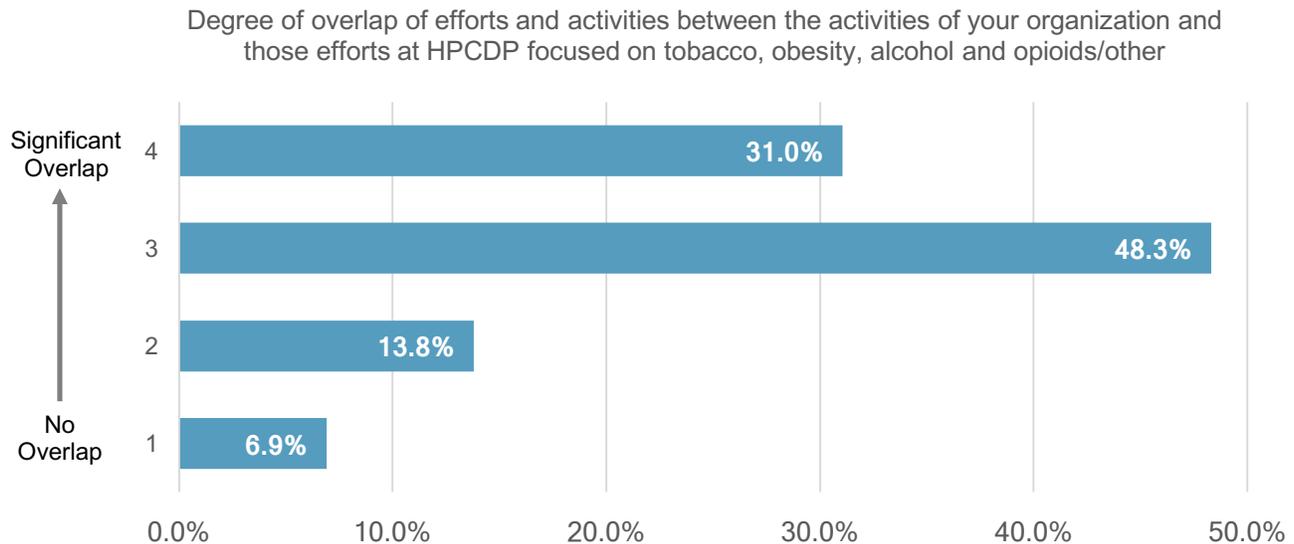
HPCDP Leadership and Flexibility

- › “[A focus area we need from HPCDP] should be around the data on alcohol, marijuana, prescription drugs, opioids. [We need] coordinated efforts to be more accurate with data and talking points. It is happening with tobacco now, but need to do this with other areas.”
- › “I don’t think we were capturing everything we did, so the data was incomplete.”

Integration Opportunities

8. The word “integration” has been used to describe OHA’s action, but it doesn’t feel like integration to those in the field.

Many participants feel that, although prevention activities have been relocated to HPCDP, this is not an integration of prevention and public health, because a true alignment of mission and approaches has not yet occurred.



What we heard:

- › “Define ‘integration’. We use the word integration in our county, but it’s just that we’re just on the same floor.”
- › “The change did not come after consultation with partners, and appears to be motivated by administrative cost-saving rather than improving program effectiveness.”
- › “There hasn’t been any integration. It was just picking up the programs and funds and moving them over somewhere else... It was up to those of us in substance abuse prevention to integrate into their system. Not about integrating together. No integration of frameworks either. [The] expectation is that we just use the public health frameworks now.”
- › “If one of their key outcomes is integration—then get on the ground and look locally. An example is opioids—you can see all of us at the table working on these issues and understanding how we’re working to address the real issues that are impacting folks every day.”
- › “It feels like a hostile takeover right now, not a partnership. [HPCDP is] creating enemies, not friends. I was really excited about it and stood up to my colleagues with excitement, but I can’t hold the torch anymore.”
- › “Since the merge of the funding into HPCDP there has been a vacuum of guidance and leadership from OHA in terms of communication to the counties. So, the alignment remains to be seen. The direction is unclear.”

Integration Opportunities

- › “There was a reorganization, but the word integration keeps being used. Is that really what happened? What does integration mean? Collocating or something more strategic?”
- › “Will the state’s perspective see that physical health prevention or treatment must include a mental health perspective? For example, will you see that a person who is overweight and/or has diabetes may need support for not only those physical ailments but also support for potential thinking errors about self-image that hold them back from successfully managing their symptoms?”

9. The integration has diminished the ability to apply holistic approaches.

Participants described a conflict between the frameworks they utilize in their work, which emphasize a whole-person approach to prevention, and what appears to be a more siloed approach to prevention within the public health model.

What we heard:

- › “With so many departments, and so much overlap in the work they do, it can be hard to know who is doing what. Example: both HPCDP and Injury and Violence Prevention are working on opioids.”
- › “It seems challenging that the different chemicals are so separated. It would be good to blend Marijuana and Tobacco, as some of the issues are the same.”
- › “We kind of left behavioral health behind. If someone is smoking because of depression, we’re not looking at that as much now. Those are important causal factors and we’re creating these worrisome divides that don’t match up with how humans function. [It] means that, again, we’re not looking at this holistically.”
- › “I don't care what the state does. They can plug it wherever they want. We're not moving prevention. It is absolutely a part of our behavioral health program.”
- › “Substance abuse is, to me, a secondary condition. There's something out there that could cause this, and they're [not] resourced to manage it.”
- › “We're trying to prevent our kids from smoking, drinking, [doing] drugs, [engaging in risky] sexual [behaviors]. We have a huge range of stuff that we deal with. And I realize that some of those are diseases, but at the same time the whole point is to prevent them, not throw us into public health. And you know it just doesn't fit.”
- › “We do holistic work, not segmented work like they ask us to do.”
- › “Those who do the work were not consulted. They [HPCDP] were hearing, but not listening. [There] wasn't trust in the leadership we had to honor what has been done, and plan the best strategies to move forward. Has been disrespectful.”
- › “Needs to have a holistic approach. Healthy Communities is siloed, tobacco is siloed, etc.”
- › “[We] need to blend the concrete data decision-making of HPCDP with community mobilization of substance abuse prevention.”

10. There's a need to crosswalk the language, frameworks and goals of public health and prevention and define the alignment.

Stakeholders see an opportunity for greater alignment between public health and community-based prevention approaches. They would like to see an effort to clarify the commonalities in regards to language, frameworks, practices and goals, as well as the unique strengths that public health and prevention approaches each bring.

What we heard:

- › “It seems like it should all be the same whether it’s obesity or smoking or drug use, prevention efforts are really all the same kinds of approaches that work; a lot of things we can share. Risk factors and best practices are the same.”
- › “We’re often talking about the same thing, but speaking different languages. That’s a lot of the rub. We need to crosswalk the language and integrate the models, instead of thinking one is better than another. We have to communicate.”
- › “Moving to just environmental seems really drastic. We need the foundational approach of prevention that is focused on building relationships and spaces for healthy communities to come together. I worry we’ll lose this with the public health approach.”
- › “In prevention, we talk about the use of the drug as being the bad thing, whereas in public health, they’re looking at overall health outcomes and disease so that means that our goals end up being different and that we’re talking different languages. We haven’t slowed down enough to find out how we line up and to develop a common language. Like, what is the difference between prevention and promotion? Social determinants of health—that is what we need to be talking about. You have the right people and the base of knowledge, but need to get the shared language.”
- › “Community mobilization and risk and protective factor models are how I grew up in prevention. We need to clarify how these CPS folks across the state transition into this IOM model, and what cross-pollination and cross-training can happen. Prevention can learn from tobacco.”
- › “We’ve been siloed, and the language from different fields silos us.”
- › “HPCDP is a better fit than under behavioral health. Leaders in AMH didn’t have the background to support community change efforts, they were more focused on individual change. There’s a lot of potential for strength. The strategic efforts we do are the same—the difference is how we talk about them and the philosophical difference of top down vs. grassroots.”
- › “It is a different kind of world—public health and substance abuse prevention. Pieces are alike, but different ways of doing business... [you] will lose the effectiveness at the local level if you try to change them to be like public health. That would be a huge mistake. Substance abuse doesn’t fit perfectly in public health... there needs to be an effort to understand that.”

Integration Opportunities

- › “Will there be an effort to understand how best to merge these two professions (public health and mental health) so they have mutual understanding and respect? It almost seems like we have to do some major work within the professions before we can start communicating a cohesive message to the community.”
- › “The language can be different. It seems like HPCDP is more technical and cold, and prevention efforts have been more in the community.”

11. While encouraged by the listening sessions, prevention partners are hesitant to expect change based on past experiences with OHA.

Prevention professionals in the field have experienced disappointment in HPCDP's responsiveness, level of inclusiveness in processes, and willingness to change in the past. This has resulted in cynicism regarding the integration efforts.

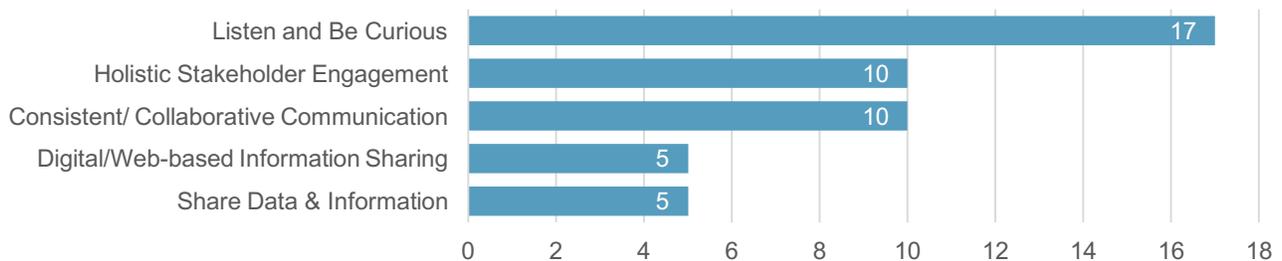
What we heard:

- › “The relationship is suspicious and tenuous. I want to believe in good intent, but to see staff who had been there for ever have to give up...”
- › “It's frustrating because we don't know what the changes are. Nobody's talked to us. Nobody has asked us. Nobody said, ‘Come to the table—we're going to at least give you some information and then we can argue from there.’ They're getting a blank wall.”
- › “Communication has been a one-way street, and minimal. Dictate, dictate, do not listen.”
- › “Public health hears, but doesn't listen to a community, and there's a pretty bad track record... a structure and a more unified approach, but let communities breathe and be respectful of communities.”
- › “People seem to listen to me, but only to appease. There's no action or follow up or change in behavior.”
- › “There were very abrupt changes and then this pause and HPCDP realized that they needed to back-track and look at the big picture and get input, when really that should have happened up front. So, going forward, be more strategic and gather information before making dramatic changes that affect lots of people.”
- › “[The] TPEP application is a good start, but lacking any real pre-work to frame up the conversation, locals are not fully seeing a win-win as it relates to access to resources.”

12. Proactive, relevant, and direct communication would help to build trust.

There is desire for more predictable and targeted communication from HPCDP. In the absence of consistent communications and an effort to ensure all stakeholders are reached, misinformation has circulated, rumors have developed, and not all interested parties have been included.

If you were to design the way HPCDP shares information and hears from stakeholders, what would you identify as three key principles you would adhere to? (Count of Theme Response)



What we heard:

- › “Communication messages are staggered (some getting information before others) and inconsistent (some things I hear about from other prevention staff and not OHA staff). Also, messages should more frequently come from program managers to help us better develop relationships with those people.”
- › “Be consistent in communication. Have one person who sends out and responds to communication.”
- › “Substance abuse folks sit in a lot of different venues within their communities and only about 1/3 of prevention coordinators were located in public health, and that doesn’t even include the tribes. The idea was that if we get communications to public health it will reach them. No acknowledgement of where most people even sit and operate from. There was no understanding of how people actually worked.”
- › “CHLO is a great model. We get more information from those calls than we do from the state. It’s also a way to funnel information up. But this is something that only prevention coordinators who sit in public health know what it is. HPCDP thinks if they tell CHLO, they’ve communicated, but it only reaches about 1/3 of people. [They] could promote that call with others though.”
- › “If they knew they were going to be shifting, they could have been more forthcoming. They are never proactive.”
- › “[We need] consistent communication. I could probably count official communications on one hand in the last year from the agency that oversees me. Tell us what it is: monthly? Bi-annual meeting? So we know what to expect and when. Even if you don’t have anything to tell us, let us know.”
- › “Past RFP is an example. There was not a lot of forethought before release. That’s the issue. We need more forethought, collaboration and communication.”

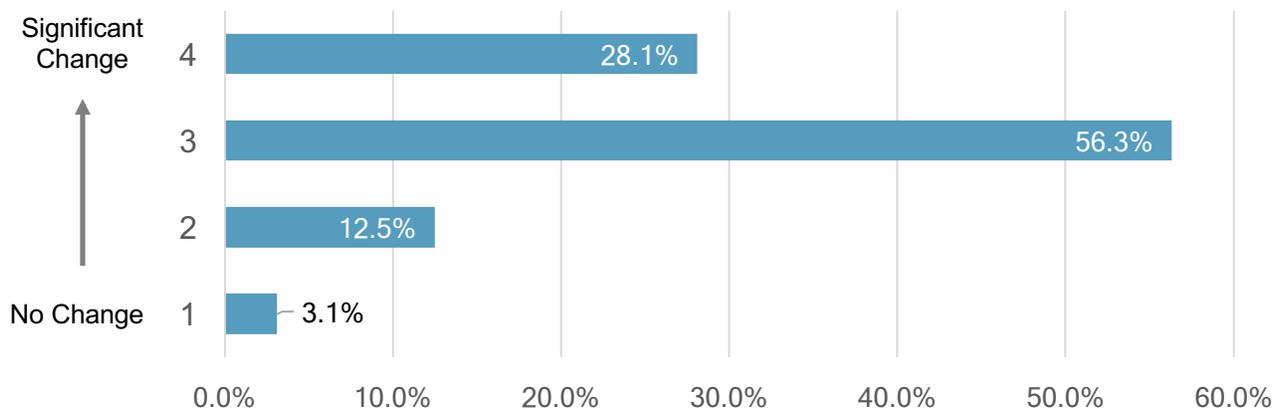
Communication and Relationships

- › “I don’t know how the integration decision was made. Had there been a collection of prevention coordinators across the state, planning the transition process—it would have been more methodical and communicative”
- › “[It] would behoove them to communicate regularly and to include. So far, their communication is only through public health and most of substance abuse prevention across the state isn’t in public health, so most people aren’t receiving information.”
- › “There is a lot of talking but not much is being said. There isn’t much direct communication. [I’ve] heard a lot of frustration from prevention folks. The relationship is suffering because it doesn’t seem like people within HPCDP are on the same page or up to speed. No clear answers to all the questions we have.”
- › “If we don’t seek out the information, it never gets to us or we get fragmented communication [such as]: ‘we’re having conversations, we’re not sure yet.’ It leaves us wondering.”
- › “My frustration was with the reporting system. We got the training, but they should have foreseen some of the glitches. Instead, we end up doing a webinar on how to correct those. I still feel like I need to be walked through it.”
- › “We just need to know what’s going on. Plain & simple. We’re busy and it gets pushed to the back burner.”

13. Stakeholders desire more clarity from HPCDP about key HPCDP functions, and what the future of programs and funding looks like.

While stakeholders expect there to be changes in the area of prevention, the structure and goals of HPCDP are a mystery to many stakeholders. Participants were especially concerned about what changes might be planned for the future, and whether they would be kept abreast of those changes.

Do you think the integration into HPCDP will change the scope of prevention in any way?



What we heard:

- › “We don't know what the financing is going to be. We can't seem to get answers.”
- › “At the systemic level I don't know [what HPCDP does]—it seems siloed, though.”
- › “Since the shift has already happened, how do they see prevention fitting in? How do they see what we do fitting into their program?”
- › “What is the plan to re-hire positions that are gone?”
- › “Funding—traditionally, we knew what funding would be... How might that change? When will those discussions take place?”
- › “If there are changes, those are things we really need to know now. You can't change your county strategy in a week. And if we don't have to change, [that would be] nice to know too.”
- › “[I would like to see] an org chart, across the state. Who at the state, and who at the counties, and for that to be kept up-to-date with contact information.”
- › “We don't have a logon to the HPCDP resources site.”
- › “I didn't know HPCDP existed until recently. I feel uninformed in that way. It would have been a really helpful way to launch the integration: ‘Here's what we do.’”

Communication and Relationships

- › “No vision and no process was described... I don’t know what HPCDP does. There’s no map of how we’ll function. What’s the vision of where we’re headed and how we’ll do it together? [We] just hear: ‘Hey, we’re working on it’, and that’s not sufficient.”
- › “A HPCDP organizational chart would be really helpful to see. Even to see the structure without vacancies. A live one online that gets updated would be great. It’s one thing to know titles, [but it] would be great to also have a paragraph describing what that person is responsible for.”
- › “What’s the process for drawing down state resources—like media, policy, training and other specialty areas of support within HPCDP? I don’t know what the process is. What’s the protocol and what steps do I need to take?”
- › “When will the new applications be out? Where will cuts in funding be?”
- › “[They’re] usually working on new plans in February, and we’ve heard nothing.”

14. Stakeholders expect more transparency and humility in communications from HPCDP.

Members of the prevention community sense a defensiveness in communications from HPCDP, and would welcome a more vulnerable and transparent approach, even if that means acknowledging that things are still developing, or admitting that HPCDP doesn't have all the answers.

What we heard:

- › “[We] need an apology; acknowledgement that for a long time that things could have been done better. Maybe: ‘We’re sorry, how can we reset and bring people together?’”
- › “[We need] transparency about what’s happening. Where we are at. If you don’t know, tell us you don’t know.”
- › “They were probably told—not asked—to do this, so their communication was probably as lacking as ours is. Luci has been wonderful every time I have called her.”
- › Decisions have been communicated through a colleague network, nothing official—so there is misinformation and personal bias that colors it. There’s a lot of speculation that isn’t grounded in reality.”
- › “Seems like HPCDP thinks they’re expected to have the answers so fill the space with talking, instead of being willing to say: ‘We don’t know.’”
- › “It’s okay to say: ‘We screwed up.’ It would actually bring a sigh of relief to hear that. Because instead, people have a lot of worry because they wonder if they were intentionally left out. Own it.”
- › “We need them to share back the good, the bad and the ugly from this process. It’s a learning opportunity and we can use it to be better in the future. There is value in all of it. We can work with it and take something from it.”
- › “[Our reaction to learning about the integration move was] pure anger, frustration, and fear. Our prevention program is the heart of our tribe. Now it’s four people. We know the system at AMH, and I know what HPCDP has been because of tobacco. HPCDP feels like a mess all the time.”

15. Prevention professionals want key contacts at HPCDP who understand their local and specialty history, and to whom they can turn with questions.

The transition from AMH to HPCDP and the turnover in the liaison positions has left many prevention professionals feeling adrift, and without a reliable connection to HPCDP for information or technical assistance. Participants expressed a desire for a point of contact who is genuinely interested in understanding their community and needs and who can serve as a resource with related knowledge to share.

What we heard:

- › “I haven’t had any communication from anyone at the state directly in a year and a half. Hard to feel like they care when they don’t know me. Very noticeable difference. New model is: ‘We’ll tell you what to do, and you better do it.’ It used to be with AMH: ‘How can we help you do what you know your community needs?’ And they were friendly and I knew them. Now it feels like they don’t even want us to call them, or they tried to send us up the chain, but I don’t even know what the chain is.”
- › “In enforcement, I’ve asked them to ride along with me to see what I see, but they never come. I think they would be more supportive if they just did one ride-along with me. AMH had staff who had been in the field and so they could better relate to what we experience.”
- › “I don’t even know when reports are due for our funding. I don’t even know who to submit it to, or if they want the same format as before. No guidance on deadlines or what is expected for future funding requests. That makes me really nervous. I like to have enough time to assess and plan.”
- › “On [the] tobacco side, it is very good—there is a deep well of knowledge about tobacco, good policy information and saying abreast of best practices around tobacco policy work at state, local, and federal level and they pass that knowledge along pretty well. We have liaisons and know who to call, but there is high turnover with them.”
- › “But the fact is, everybody else in the whole department no longer is there. Why? Because they did not want to work in Portland. Somebody made a decision and edged out our best people... a couple hundred years of experience, combined, are all gone. Somebody made a decision at the top but didn’t think about repercussion... didn’t care about the repercussion.”
- › “Phone calls among TPAP and CLHO Healthy Communities calls work well now. Our tobacco coordinator seems in good contact with the state. Regional support networks are working well.”
- › “They should do a road trip and physically take the time to talk not just with the managers, but with the breadth of staff to take the time to get to know people. Face-to-face communicating and observing the day-to-day and how we’re already integrated. There isn’t the same chasm at the local level that there is at the state level.”
- › “There doesn’t seem to be a lot of experience with county-level work. When providing technical assistance to counties, it would be helpful to have some background with that to understand how counties work and what the challenges are.”

Communication and Relationships

- › “... from my experience, it’s been a struggle. There’s been a lot of turnover. You give up on figuring out who to talk to.”
- › “When I think about DHS, I can think about people I can contact. In OHA, I wouldn’t know who’s above that coordinator... I don’t get their org chart, and how we are going to fit in it.”

16. Tribal partners feel that their status as sovereign nations isn't fully honored by HPCDP.

Many tribal members expressed frustration around the lack of consultation efforts and at being told how to do their daily prevention work. This directive approach is out of alignment with how the State should approach working with sovereign nations.

What we heard:

- › “They [HPCDP] haven't taken into account the sovereignty of our nations.”
- › “The relationship with the state has been much worse with tribes. And that's because of lack of acknowledgement of the tribes as sovereign nations and also the lack of communication.”
- › “There is a requirement for the state to consult with tribes under HB 770. And as far as I know, that didn't occur unless somebody else knows about it. It was just a dictation.”
- › “As a staff person, I don't have as much push as our tribal councils do.”
- › “We're back in the arena of the states dictating to us what we do—how much we have—they've given all of the control to the state, versus a tribe having self-governance and being able to decide for themselves.”
- › “But still, we don't have the ability to compete with the counties and we can't match those funds. We don't have funds to match. So every time the state imposes a match requirement, we're already out of the game.”
- › “The relationship with the state has been tumultuous with the tribes. [There has been a] lack of communication—not seeing us as equals.”
- › “We tell them they have no authority here—we tell them all the time.”

17. Tribes fear that their best practices and cultural approaches will not be honored.

Tribal members have concerns that a lack of cultural competence and a lack of awareness of and respect for tribal cultural norms will result in the elimination of important prevention approaches and programs.

What we heard:

- › “They’re just so far from each other, and that’s what I’m fearful of—this convention will go that direction... we don’t know, but if it does it’s really going to limit the ability for the tribes to use their best practices and to do the things that we already know are working.”
- › “It’s really hard to tell whether the impact is from the family, from the program, from the activities... and yet the state is completely driven by data that’s irrelevant.”
- › “Culture is prevention. That’s what we’ve been saying for a long time—culture *is* prevention.”
- › “As tribes, we wonder: are there programs that are Christian-based, or whatever faith-based programs in this world, that are sort of given more leeway than yours?”
- › “Our nine tribes meetings have been going on for a long time—[we share] tribal best practices.”
- › “Jeff retired. Jill took a county job. Now you have no prevention unit other than Julie. [It] went from 5 to 1. Those people took the time to get to know the tribes.”
- › “Now our tribal best practices [we developed] have moved to Arizona and Alaska.”
- › “If a couple of them even visited one tribe and spent one day—we could make it a special day—come to our after-school program. Look at how we have been cultivating and raising these kids.”
- › “Not a lot of overlap. Tobacco overlaps, but when it comes to tribal best practices, HPCDP doesn’t recognize or support that.”
- › “I see where health disparities go along with alcohol and drug prevention, but it’s throwing a blanket on the whole problem. Before, we could be more specific to tribal best practices and evidence-based practices.”
- › “Make sure our tribal partners are supported are being able to use tribal best practices in prevention. They have been demonstrated to be effective. Be sure to continue to honor and support those approaches. That needs to be preserved. They have done a good job of this through TPAP.”
- › “Our history—the way we have worked—doesn’t fit in the HPCDP stuff.”
- › “Tribal best practices need to get incorporated into their value set.”
- › “Our focus is on integrating culture with everything we do. We need to be able to do that in prevention. It’s not about policies.”

Appendix

The following information was shared in the January 2017 Oregon Coalition of Prevention Professionals newsletter:

- › The OCPP Learning Committee and Board offer these items as Substance Abuse Prevention priorities to share with the Corragio Group regarding beneficial prevention infrastructure which were formerly provided by the State AMH Prevention Office:
- › Maintain Oregon Administrative Rules which require Prevention Coordinators to have their Prevention Specialist Certification (CPS).
- › Support the Behavioral Health Promotion and Prevention subcommittee as an advisory to the oversight and expenditures of the Substance Abuse Prevention Block Grant.
- › Maintain open communication regarding the 21 Tribal Best Practices in the State of Oregon with the 9 federally recognized tribes (CTCLUSI, Siletz, Burns Paiute, Warm Springs, Umatilla, Klamath, Grand Ronde, Cow Creek & Coquille), inclusive of Native American Rehabilitation Association Northwest & Northwest Portland Area Indian Health Board, and maintain open communication regarding government-to-government relationships, generally discussed at meetings like the 777 cluster meetings and consistent with established governmental agreements with said tribes and entities.
- › Proactively facilitate supportive and open communication paths which include the DFC coalition coordinators regardless of how their funding streams relate to the State Block Grant or other state offered substance abuse prevention grants.
- › Maintain opportunities for grassroots input which reflect local conditions. Recognize local input and local problem solving as a best substance abuse prevention best practice. Use alcohol and drug prevention research about community engagement/mobilization and readiness, for example.
- › Include substance abuse prevention specialists in any workforce development planning conducted by or contracted by HPCDP.
- › Include DFC coordinators in any CPS training cohorts.
- › Support the implementation of the new SAP Specialist Training for any who need it or want it.
- › Maintain OHA data collection efforts which provide youth behavior data required by the Drug Free Communities Grant.
- › Use professional prevention resources, language and best practices that have already been created and established through years of research by professional agencies such as SAMHSA and CADCA (i.e.: strategic prevention framework, positive community norms, and various other evidence based programs and practices available on these and other sites).
- ›