AGENDA

PUBLIC HEALTH ADVISORY BOARD

May 20, 2021, 2:00-4:30 pm

Join ZoomGov Meeting
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Meeting objectives:
- Approve April meeting minutes
- Discuss Public Health Advisory Board subcommittees
- Review FY22 Preventive Health and Health Services Block Grant proposed activities
- Hold a public hearing on the Preventive Health and Health Services Block Grant
- Discuss public health survey modernization

Time	Topic	Presenter
2:00-2:10 pm	**Welcome, updates and agenda review** • ACTION: Approve April meeting minutes • Discuss recording and posting PHAB meetings • Review American Rescue Plan Act investments in public health • Update on Curry County public health services	Veronica Irvin, PHAB Chair
2:10-2:20 pm	**Discuss PHAB subcommittees** • Provide update on subcommittee work ahead	Jeanne Savage, PHAB Accountability Metrics

		Alejandro Queral, PHAB Strategic Data Plan
2:20-2:30 pm	**PHAB member discussion** Discuss key issues that PHAB members should be aware of or should help problem solve on behalf of the public health system	Veronica Irvin, PHAB Chair
2:30-2:45 pm	**Preventive Health and Health Services Block Grant review** • Provide information on FY22 Block Grant work plan activities	Wendy Polulech, Oregon Health Authority
2:45-2:50 pm	**Break**	
2:50-3:00 pm	**Public comment and Preventive Health and Health Services Block Grant public hearing**	Wendy Polulech, Oregon Health Authority
3:00-4:30 pm	**Public Health Survey Modernization** • Provide updates on community-specific research projects and findings • Recommend next steps for the 2021-23 biennium and beyond	Andres Lopez, Coalition of Communities of Color Alyshia Macaysa, Macaysa Consulting Bridget Caniff, Northwest Portland Area Indian Health Board Margaret Braun and Kusuma Madamala, Program Design and Evaluation Services

| 4:30 pm | **Next meeting agenda items and adjourn** | Veronica Irvin, PHAB Chair |

PUBLIC HEALTH ADVISORY BOARD (PHAB) MEETING MINUTES
April 15, 2021, 2:00-4:00 pm

Attendance

Board members present: Dr. Eli Schwarz, Kelle Little, Dr. Bob Dannenhoffer, Dr. Sarah Present,
Dr. Veronica Irvin, Muriel DeLaVergne-Brown, Carrie Brogoitti, Alejandro Queral, Dr. Jeanne Savage, Dr. David Bangsberg, Rebecca Tiel, Carrie Brogoitti, Eve Rippeteau, Sarah Poe

Board members absent: Rachael Banks, Dr. Dean Sidelinger, Dr. Jeanne Savage

Oregon Health Authority (OHA) staff: Cara Biddlecom, Sara Beaudrault, Wendy Polulech, Julie Johnson, Lisa Rau

Members of the public: None

Meeting Objectives

- Approve March Meeting Minutes
- Discuss Public Health Advisory Board Subcommittees
- Preventive Health and Health Services Block Grant Update
- COVID-19 Response and Vaccine Equity Presentation
- PHAB Member Discussion for Future Meeting Topics

Welcome and Agenda Review
Veronica Irvin, *PHAB Chair*

Dr. Irvin welcomed everyone to the meeting. She stated that this meeting was running two hours, as compared to last month's 90 minutes, in order to allow time for guest presentations and questions afterwards.

Cara Biddlecom took roll. A quorum was present. Dr. Eli Schwarz requested that the spelling of his name be corrected in the March minutes. The PHAB approved the meeting minutes unanimously (to include the corrected spelling of Dr. Schwarz's name.)

Dr. Irvin pointed out that there were two Oregon Health Policy Board handouts in the packet this month. One was a Committee Summary, and the other was a handout on the Medicare 1115 Waiver Process. There will be more information about the Medicare Waiver in upcoming months.

Discuss PHAB Subcommittees
Sara Beaudrault, *Oregon Health Authority*

Sara provided an update on the three PHAB subcommittees:
- Accountability Metrics
- Incentive and Funding
- Strategic Data Plan

She said that the subcommittees have not met yet, but the Accountability Metrics group was scheduled to meet next week, and the Strategic Data Plan meeting was meeting the following week.

If you are a member of the Incentive and Funding subcommittee, we will be getting together in May to discuss components of the Public Health Modernization formula, should we get additional funding.

The members of the two scheduled subcommittees received an orientation meeting on Monday, April 5, to talk about the responsibilities of being a committee member. However, the main purpose of the meeting was to provide

time for community partners and OHA staff to connect and get to know one another.

An overview of PHAB and Oregon Public Meeting Law was discussed, and members were asked what OHA can do to make this a successful partnership going forward. Committee members were also reminded that these meetings take place in a public forum, where public feedback and testimony is allowed, and the public can also make public record requests of the meetings.

Next month, the PHAB will hearing from the subcommittees themselves and the direction they will be heading.

Dr. Irvin invited any of the community members of the subcommittees who were attending this meeting to introduce themselves, but there was no response. She asked if any PHAB members had questions about subcommittees, but no one had a comment.

Preventive Health and Health Services Block Grant Update
Wendy Polulech, *Oregon Health Authority*

Dr. Irvin reminded everyone that PHAB is the Public Advisory Board for this grant, and OHA typically provides an update on the current year's funding for the grant. Next month, OHA will be proposing the fiscal 2022 workplan and budget and hold the block grant public hearing. She introduced Wendy Polulech, who is an Operations Analyst and the Block Grant Coordinator. She will be giving today's update and presenting next month's proposed 2022 budget and workplan.

Wendy announced that the grant was approximately $1.1 million for the fiscal year 2021, which ran from October 2020 to September 2021. She mentioned that this was a typical grant size for Oregon. About $85,000 of the grant money went to Oregon Coalition Against Domestic and Sexual Violence (OCADSV) as the required set-aside for sexual violence prevention. The remainder of the budget went towards improving public health infrastructure, such as development and implementation of Healthier Together Oregon and Public Health Modernization.

Dr. Schwarz commented that cases of domestic violence seem to be rising, yet the grant money amount stays the same. He was wondering why the grant amount could not be increased to help deal with this crisis. Cara Biddlecom responded that the pass-through money sent to the OCADSV is a pre-determined amount by the Federal Government as part of the conditions of the grant.

Dr. Schwarz shared that he attended a recent session of the house legislature and noticed the increased focus and positive attitudes towards Public Health Modernization and the need to infuse more funds into this. He wondered if the PHAB has asked the legislature for more money towards modernization, or are any of the federal relief funds going towards this?

Cara replied that last summer, OHA requested a $68.9 investment in Public Health Modernization as a request for its biannual budget. In the Governor's recommended budget released in December, Governor Brown allocated $30 million for this. Currently, this is an ongoing conversation in the Joint Committee on Ways and Means regarding OHA's budget and how much of it will be invested in Public Health Modernization.

Regarding the America Rescue Plan Act Funds, Cara said that we have not received any news about this topic, but there is still more funding to come. Currently, the relief funds we have received have been earmarked for supporting immunizations for COVID-19 (about $38 million) and will be distributed to LPHAs, Tribes and CBOs to serve their communities and help reduce health inequities. OHA has received money to go towards the safe re-opening of schools.

Dr. Present asked if it was possible to funnel more funding from the block grant into the OCADSV, if Oregon chose to. Cara explained as a condition of the funding, states needed to choose one or more "Healthy People 2030" objectives to work towards. In Oregon we chose Public Health Infrastructure and Public Health Agency Quality Improvement Program as our objectives, and we must track the budgets for both of those objectives.

Wendy continued to review how the funding was spent and invited anyone who would like additional details to contact her. She ended by stating that the money given to OCADSV was used for staffing, subgrantees, and assessment of program efficiency and equity. There were no further questions for Wendy.

A handout about the specifics of the grant is in today's meeting packet.

PHAB Member Discussion of Upcoming Issues and Topics
Veronica Irvin, *PHAB Chair*

Dr. Irvin asked if the discussion section of the agenda could be moved up since the meeting was ahead of schedule. This would allow the speakers to present at their scheduled times. She invited everyone to share any issues or topics that PHAB members would like to see at future board meetings, adding that she would like to have an update on OCADSV programs, funding, and initiatives at a future meeting. There were no additional comments.

Since the presenters were not on the call yet, Cara asked Dr. David Bangsberg if there were any updates from the Oregon Health Policy Board (OHPB) on the engagement of the 1115 Waiver process since the last PHAB meeting. Dr. Bangsberg mentioned the OHPB continued to work on the Governor's requests regarding the Medicaid Waiver and healthcare cost containment, and the alignment of the two. He feels an important role that PHAB can play is figuring out how equity plays into these two topics and how to apply lessons learned so far.

Dr. Schwarz asked Dr. Bangsberg whether or not the OHPB discusses and addresses topics like health biases, as exhibited in a recent article in Health Affairs. Dr. Bangsberg replied that they are looking at measures of health equity in populations and where the gaps are.

Cara suggested a short break and the group dispersed until 2:50 p.m.

Discuss COVID-19 Response and Vaccine Equity
Julie Johnson*, Oregon Health Authority Tribal Affairs*

Sharon Stanphill, DrPH, RD, Chief Health Officer
Cow Creek Band of Umpqua Tribe of Indians

Lisa Guzman
Yellowhawk Tribal Health Center

Dr. Irvin welcomed everyone back from the break and introduced the guest speakers: Julie Johnson, Sharon Stanphill, and Lisa Guzman. She mentioned that many Oregon Tribes have been engaged in Public Health Modernization since 2017. She also thanked Kelle Little for her service in representing Oregon Tribes on the PHAB committee.

Julie Johnson began by introducing herself as a Paiute woman and mother. Her role as the Tribal Affairs Director over the past year has been to uphold the government-to-government relationships with the nine federally-recognized Tribes in Oregon. Each Tribe is an individual sovereign nation with the authority to govern over its own lands and people. She stressed that it's important to understand that the relationship begins at the federal level and is upheld by the state.

Julie Johnson then presented a slide show documenting the work of OHA with the Tribes and their response to COVID-19. She stressed the importance of maintaining the supportive relationships between all partners.

The question was asked if Julie had any advice to give counties and agencies serving indigenous populations to better help them promote COVID-19 vaccinations, recognizing that messaging will look different from community to community. Julie said that the other presenters will provide more information about this. However, many of the tribes have great communication teams with websites using videos, flyers, story-telling, and other methods to encourage vaccinations. All partners have worked hard in developing culturally responsible and specific media campaigns. About 30,000 vaccines have been allocated to the tribes; six tribes went with OHA and three with IHS. She then introduced Dr. Sharon Stanphill.

Dr. Stanphill began by thanking Kelle Little and Julie Johnson, and was especially grateful to Dr. Bob Dannenhoffer for his tireless work in Douglas County. She continued by presenting a slide show documenting the progress her organization made using the Public Health Modernization funds they received in preparing for and responding to the pandemic.

As a follow-up question, Dr. Stanphill was asked about the statistics of disease rate and mortality of Oregon Tribes. She mentioned that Cow Creek had been extremely fortunate with only twelve positive cases and no deaths, but many of her sister Tribes here in Oregon and Washington were hit extremely hard.

Dr. Present was wondering about two things: where is your Tribe headed after the vaccine is over based on what you learned this year, and what are the vaccine hesitancy rates in your community? Dr. Stanphill is anticipating that the funding will go away at some point and they are preparing for that, but they also are writing grants and looking for other funding sources to continue building infrastructure. She said there was a tremendous amount of vaccine hesitancy due to the historical trauma of their people and the general reluctance to take an unknown medication.

Lisa Guzman went next. She showed a video from Elkhorn Media created for tribal communities to address vaccine hesitancy.

She then presented a slide show showing how the Yellowhawk Tribal Health Center developed the infrastructure to handle the pandemic while providing regular health care at the same time. She also shared a "Community Vaccination Centers Playbook" through FEMA. Their group found this playbook very helpful in providing a step-by-step process in creating a vaccination event.

Public Comments
Cara Biddlecom, *Oregon Health Authority*

There were no public comments.

Next Meeting Agenda Items
Veronica Irvin, *PHAB Chair*

- Update on Federal funding
- Update on State Public Health Modernization funding

The meeting adjourned at 3:50 p.m.

The next meeting will be held on Thursday, May 20, from 2-4:30 p.m.

White Supremacy and the Core Functions of Public Health

Sirry Alang, PhD, Rachel Hardeman, PhD, MPH, J'Mag Karbeah, MPH, Odichinma Akosionu, MPH, Cydney McGuire, MPH, Hamdi Abdi, MPH, and Donna McAlpine, PhD

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Global outrage followed the murder of George Floyd by now former Minneapolis, Minnesota, police officers. The outrage was targeted at police brutality—police conduct that dehumanizes through the use of physical, emotional, or sexual violence as well as verbal and psychological intimidation, regardless of conscious intent—one of the oldest forms of structural racism.[1] In decrying police brutality, many public health organizations issued statements declaring racism a public health crisis, with promises of change. However, change is stymied if we do not critically evaluate how the discipline (scholarship, conceptual frameworks, methodologies), organizations (governmental, nonprofit, and private institutions that seek to promote population health), and public health professionals (in academia or practice) contribute to structural racism that is manifested in police brutality, among many other outcomes.

"Structural racism" here refers to policies and practices, in a constellation of institutions, that confer advantages on people considered White and ideologies that maintain and defend these advantages, while simultaneously oppressing other racialized groups.[2] Structural racism is sustained through White supremacy: the glossary of conditions, practices, and ideologies that underscore the hegemony of whiteness and White political, social, cultural, and economic domination.[3,4] White supremacy makes it possible for structural racism to reproduce over time, albeit with different mechanisms, from the enslavement of Black people to mass incarceration. Consideration of White supremacy makes visible that structural racism is "White controlled,"[4] and without examining the former, we will not dismantle the latter in public health.

Public health is organized in a framework of three core functions—assessment, policy development, and assurance—and 10 essential public health services (EPHSs). The framework is meant to help public health "speak with one voice" about what public health is and what it aspires to do.[5] This framework has been immensely influential. Accreditation of public health

departments and educational programs partially relies on EPHSs and is included in some state statutes. The EPHSs are taught in our classrooms, are used for performance measurement and evaluation, and have helped to communicate to the public and policymakers what public health is about.[5]

The revised EPHSs were recently released, 25 years after the original framework was developed. The most important change is that the framework now centers equity, defined as a "fair and just opportunity for all to achieve good health and well-being."[6] In the equity statement, racism is mentioned as one of the "forms of oppression" that the EPHSs should address. Living up to the potential of equity requires directly addressing structural racism and White supremacy. We provide examples of strategies in the core functions and EPHSs to do so (Table 1 presents a summary of these).

ASSESSMENT

The core function of assessment is a focus on surveillance. The first EPHS is to "assess and monitor population health status, factors that influence health, and community needs and assets." The revision to this EPHS emphasizes "root causes of inequities." If police brutality and structural racism are root causes, then our health surveillance systems and surveys, such as the National Health Interview Survey and the Behavioral Risk Factor Surveillance System (BRFSS), should routinely track experiences of police brutality, as well as exposure to structural racism. Embedding geocoded information on racial inequities in socioeconomic status in the National Longitudinal Study of Adolescent Health is a good example of this approach.[7] We should assess indicators of structural racism, such as racial inequities in

> TABLE 1— Public Health's Core Functions and Essential Services as an Organizing Framework for Dismantling White Supremacy

Core Functions	Essential Services	Example Strategies for Dismantling White Supremacy
1. Assessment	1. Assess and monitor population health status, factors that influence health, and community needs and assets	Routinely track and report respondents' exposures to and experiences of police brutality and other indicators of structural racism and White supremacy
	2. Investigate, diagnose, and address health problems and hazards affecting the population	Investigate the complex mechanisms through which White supremacy shapes health outcomes
2. Policy development	3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it	Educate the public and policymakers on indicators of White supremacy and how these might shape the social determinants of health
	4. Strengthen, support, and mobilize communities and partnerships to improve health	Ensure equitable allocation of resources and redistribution of power in community partnerships
	5. Create, champion, and implement policies, plans, and laws that affect health	Policies must center the experiences of those most affected by structural racism and White supremacy
	6. Utilize legal and regulatory actions designed to improve and protect the public's health	Develop and enforce regulations and policies to dismantle practices that maintain structural racism and White supremacy
3. Assurance	7. Ensure an effective system that enables equitable access to the individual services and care needed to be healthy	Acknowledge racist systems, advocate antiracist policies, and link Black people, Latinx people, Indigenous people, and other people of color with a range of resources
	8. Build and support a diverse and skilled public health workforce	Set clear expectations for education on equity. Schools of public health and public health institutions should set measurable goals on racial equity competency for students and practitioners
	9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement	Focus on critical race conceptual frameworks and antiracist methodologies. Mandate measuring and reporting diversity, equity, and inclusion efforts
	10. Build and maintain a strong organizational infrastructure for public health	The infrastructure for teaching, research, and practice should be grounded in critical race theory so that the implications of historical and contemporary manifestations of White supremacy are addressed

opportunities, legislation, and policy outcomes; criminalization and incarceration; and neighborhood- or zip code–level inequities in assets, debts, political participation, housing, and employment patterns.[8,9]

In 2002, BRFSS added an optional module, Reactions to Race, but few states administered it. That our surveillance systems do not routinely collect data on racism is one indication of how White supremacy plays out in public health: ignoring everyday experiences of, and exposures to, salient stressors among Black people, Indigenous people, and other people of color (BIPOC). Expanding analyses of the impact of structural racism and White supremacy on the distribution of needs and assets

in communities should be a critical aspect of assessment.

The second EPHS is to "investigate, diagnose, and address health problems and hazards." Using the example of police brutality, scholars need to continue to identify mechanisms such as mass incarceration, stress proliferation, institutional mistrust, and economic and financial strain that link health with exposure to and experiences of police brutality.[1] We must also investigate the mechanisms through which other indicators of structural racism and White supremacy shape health outcomes. Hitherto, public health has accounted for race in health disparities research but has rarely examined the role of structural racism.[10]

POLICY DEVELOPMENT

Public health's third essential service is to "communicate effectively to inform and educate people about health, factors that influence it, and how to improve it." Global protests against racism and the attention to racial inequities in the impact of COVID-19 present no better time to confront White supremacy in communication. However, public health institutions such as the Centers for Disease Control and Prevention did not issue any specific official statements on structural racism. Statements that some other public health organizations have released fall short. For example, the American Public Health Association stated:

[The organization] denounces the use of violent methods by law enforcement against peaceful protesters. The current protests are the result of the American people rightfully demanding an end to the racial profiling by some police officers and a system of structured racism resulting in disproportionate harm to the health of individuals and communities of color.[11]

Although the full statement acknowledges racism as a public health crisis, it neither educates readers on the meaning and manifestations of racism nor implicates White supremacy. Public health has largely failed to take advantage of this opportunity to educate the public about racism and White supremacy, beyond well-intentioned statements that can often be distilled to "racism is bad" and "'they' [the police, other institutions, and people who are racist] need to do better." Public health organizations, institutions, and practitioners must actively educate the public about the role of racism in producing health inequities. For example, speaking up against the recent surgeon general's report on maternal mortality,[12] which does not mention racism as a fundamental cause of racial inequities in maternal health outcomes, and against policies such as former president Trump's Executive Order 13950, which banned training in critical race theory, are necessary actions for educating the public about factors that influence health.

The fourth EPHS is "strengthen, support, and mobilize communities and partnerships to improve health." The revised version focuses on authentic relationships to promote equity. Authenticity is difficult to achieve given inherent power differentials. Public health leaders, most of whom are White,

primarily make decisions about the allocation of resources for research and practice, shape engagement of stakeholders, and determine whether and how the perspectives of community members are used.[13] Redistributing power in community partnerships can help challenge White supremacy. Our community partnerships should be characterized by frequent open conversations about power dynamics that are at play. We also think it is time for our funding agencies to not fund community-based research unless researchers demonstrate that the allocation of resources is fair and there is equitable compensation for community partners.

Public health's fifth EPHS is to "create, champion, and implement policies, plans, and laws that affect health." The knowledge that informs policy should be grounded in the experiences of those most affected. But policymakers and academic researchers are predominantly White.[14,15] As a result, White intellectual dominance characterizes the production of knowledge, its translation into practice, and the formulation of policy. As a profession, we need to address the reality that research led by Black scholars who have the experiential knowledge of how racism and White supremacy affect health is less likely to be funded than research led by their White counterparts.[16] We must also prioritize work that centers the experiences of historically excluded populations most affected by White supremacy. One way forward is to engage more meaningfully with grassroots organizations such as Black Lives Matter and to extend our professional responsibilities to include community-engaged advocacy for the policy priorities these organizations have articulated. Public health must be intentional about finding ways to create space for those

without formal power to influence decision-making through the expertise of their lived experiences, especially experiences of racism.[13]

The sixth EPHS is "utilize legal and regulatory actions designed to improve and protect the public's health." Public health performs this service well when it comes to enforcement in areas such as immunization, tobacco, and alcohol regulations. However, the field is yet to develop regulations to dismantle practices that specifically uphold structural racism and White supremacy. For example, public health should be at the forefront of enforcing regulations to prevent disposal of toxic waste in Black and Indigenous communities. Mandating restorative justice practices that prevent the disproportionate incarceration of BIPOC is necessary.

ASSURANCE

Under the core function of assurance, the seventh EPHS is ensuring "an effective system that enables equitable access to the individual services and care needed to be healthy." We must first recognize areas of significant need and acknowledge how historical and contemporary forms of racism act as barriers to accessing services that meet these needs. For example, public health institutions and organizations should address the ongoing mistrust in medical institutions and the COVID-19 vaccine hesitancy by first acknowledging the harm science and medicine have inflicted on Black, Latinx, and Indigenous communities. Promoting vaccine uptake must be done simultaneously with advocating policies to ensure access to testing, treatment, and other resources needed to survive the pandemic. For communities to trust in public health and utilize the services and systems we

provide, public health must first be trustworthy.[17]

The eighth EPHS is "build and support a diverse and skilled public health workforce." We know that the public health workforce is disproportionately White, especially at the supervisory and managerial levels.[14] Schools of public health are also disproportionately White. In 2017, only 0.2% of tenured faculty were Native American, 3.8% were Black, and 7.4% were Latinx/Hispanic, and those numbers have barely budged in years.[15] That a predominantly White profession and discipline is charged with educating and addressing the needs of communities that are disproportionately Black, Indigenous, and Latinx sustains White supremacy within public health. White frames dominate the information we convey, the interventions we develop, and the policies we implement, all of which are often completely disconnected from the experiences of the people most likely to experience health inequities.

The training that public health practitioners often receive is partially responsible for our inability to address structural racism and White supremacy. Leading textbooks intended for undergraduate education often fail to critically analyze the concept of race and barely touch on racism. Moreover, a recent review of 59 accredited schools of public health found that only 33% mentioned diversity, inclusion, or equity in their public mission, vision, or values statements, and 20% made no mention of any of these terms in their goals, objectives, or strategic plans.[18] It is encouraging that the revised EPHS now mentions building a workforce that "practices cultural humility." But cultural humility in place of discussions of structural racism and White supremacy will not change much and echoes hanging our hats on the term "implicit bias,"

rather than talking about forms of racism. To begin to make antiracist training real, it is imperative that the Council on Education for Public Health set clear expectations for education on equity and racism and that schools and organizations set goals for racial equity competency for students and practitioners that are measurable and for which someone is accountable. Metzl and Hansen[19] have made the case for structural competency to be integrated into medical education, and the same should be promoted in public health.

The ninth EPHS is "improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement." It has been 10 years since Ford and Airhihenbuwa[20] laid the foundation of how critical race theory could help examine and address health inequities, but much of public health research still documents how health risks, behaviors, and outcomes vary by race, rarely naming racism[10] and with the concept of White supremacy almost invisible. We fully support the recommendations of Boyd et al.[21] for standards that include rejecting the publication of articles that use race but do not examine racism. Dismantling White supremacy through quality improvement also requires us to make diversity, equity, and inclusion a meaningful part of the Public Health Accreditation Board and Council on Education for Public Health accreditation standards by requiring institutions and organizations to publicly report student, faculty, and workforce statistics by racial group.

The 10th EPHS is to "build and maintain a strong organizational infrastructure for public health." This service emphasizes ethical leadership, transparency, inclusivity, accountability, and equitable distribution of resources.

Yet, many public health teaching institutions reside on land and have built endowments by selling land taken from Indigenous people through displacement and genocide.[22] The wealth of other institutions is grounded in the selling of Black persons who were enslaved.[23] Public health institutions have to thoughtfully engage with the reparations movement within their own institutions and nationally. And the infrastructure for teaching, research, and practice should be grounded in critical race theory so that the implications of historical and contemporary manifestations of White supremacy are addressed.

CONCLUSIONS

The core functions and EPHSs have alternatively been called "guidelines," "vocabulary standards," a "framework," and "principles." They provide a way of making sense of what public health is to us and to others. It is encouraging that the most recent revision centers the concept of equity. But to live up to equity in our EPHSs, they must also tackle structural racism and its roots: White supremacy. In the tradition of public health, we advocate going upstream to deliver the EPHSs, but fully going upstream requires naming and dismantling White supremacy. Success requires building alliances across systems to address the range of social determinants of health caused by White supremacy.

Assessment must include data collection, monitoring, and reporting racism pertinent to the health of BIPOC. Policy development must center on communication about White supremacy, building authentic community partnerships, eliminating regulations that sustain White supremacy, and centering the experiences of people most affected by White supremacy. Assurance requires us to

analyze the impact of White supremacy on training curricula, scholarship, the racial composition of the public health workforce, and the public health infrastructure.

Sustained underinvestment in public health is a considerable barrier to achieving equity in the EPHSs, but this barrier fades in comparison with the disproportionately greater underinvestment in people who are more likely to experience early mortality because of White supremacy. We believe that addressing White supremacy does not require more money; it requires the reallocation of resources.

Although the strategies presented here are based on deeply and honestly examining the field and profession of public health, we echo an earlier call for self-reflection by individual scholars and practitioners: "We must ask ourselves if our own research, teaching, and service are fundamentally and unapologetically antiracist."[1(p664)] *AJPH*

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PUBLICATION INFORMATION

CONTRIBUTORS

S. Alang and D. McAlpine conceptualized the article and wrote the initial draft. R. Hardeman, J. Karbeah, O. Akosionu, C. McGuire, and H. Abdi edited subsequent versions. All authors contributed to the final revised version.

ACKNOWLEDGMENTS

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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Preventive Health & Health Services Block Grant (Block Grant)
October 2021 – September 2022 Work Plan Proposal

<u>Background</u>

- Non-competitive grant issued to all states and territories to address state/territory determined public health priorities.
- The Public Health Advisory Board (PHAB) is designated as the Block Grant Advisory Committee which makes recommendations regarding the development and implementation of the work plan.
- Federal code states that a portion of the allocation (pre-determined) be used for rape prevention and victim services. This funding currently goes to the Oregon Coalition Against Domestic and Sexual Violence.
- Work plan must be tied to Healthy People 2030 objectives. Oregon has historically used the block grant to support infrastructure, including public health modernization. Healthy People 2030 objectives in the 2021-22 work plan:
  - Public health infrastructure (PHI-R07 Explore the use and impact of quality improvement as a means for increasing efficiency and/or effectiveness outcomes in health departments)
  - Sexual Violence (Reduce sexual violence)

Proposed October 2021-September 2022 Work Plan

- Support SHIP implementation – Healthier Together Oregon
  - Support reformed PartnerSHIP for implementation
  - Prioritized strategies list will inform OHA's policy and partnership development and investments
  - PartnerSHIP will make decisions about budget allocations moving forward
- Implement statewide public health modernization plan
  - Align OHA-PHD's processes, structures and systems with foundational programs and capabilities
  - Local public health investment and accountability metrics data collection and reporting
  - Workforce development to support impact objective
  - Tribal public health modernization assessment, planning and implementation
- Public Health Partnership Coordination, Training, Technical Assistance and Performance Management
  - Compliance Reviews
  - Contract administration and coordination for LPHAs and Tribes
  - Coordinate and support OHA-PHD work with Conference of Local Health Officials and Tribes
  - Technical assistance and training for LPHAs and Tribes
  - Tribal Consultation Policy Implementation

- The Oregon Coalition Against Domestic and Sexual Violence (OCADSV) proposes to use Block Grant funds to:
  - Fund one to three local, culturally specific organizations and/or Tribal sexual/domestic violence programs to build capacity for sexual violence primary prevention, implement sexual violence primary prevention programming.
  - Fund 0.8 FTE position to provide to funded and non-funded organizations online and in person (as able) sexual violence primary prevention technical assistance and training.

<u>Funding</u>
- Total PHHS Block Grant funding for October 2020 through September 2021 is $1,101,927 with $85,660 designated for sexual assault prevention and services.

- Funding by Health Objective:
  - Quality improvement – $1,016,267
  - Reduce sexual violence -- $85,660
  - Indirect costs (capped at 10%) -- $101,627
- OHA-PHD Staff:
  - 1.0 FTE Strategic Partnerships Lead
  - 2.0 FTE Public Health Systems Consultant
  - 1.0 FTE Strategic Initiatives Coordinator

Engaging Communities in the Modernization of a Public Health Survey System

Public Health Advisory Board
May 20, 2021

Reminder:
What is the survey modernization project?

Reliance on Behavioral Risk Factor Surveillance System (BRFSS)

- Telephone survey of adults in Oregon

- Part of national survey

- Range of topics: risk and protective factors, prevention/screening, health outcomes, demographics

- Every few years, racial and ethnic oversample conducted

Current Challenges with BRFSS

- Expensive
- Lack estimates for smaller geographic areas
- Survey is long
- Concerns about representativeness and validity of data
- Lack of community engagement
- Lack data for Pacific Islander communities

Collaborate with communities

With Latinx, Black/African American communities:
- Analyze BRFSS/OHT data
- Community led data collection
- Create data briefs

With AI/AN communities:
- Analyze BRFSS/OHT data
- Create data brief

With Pacific Islander communities:
- Design & implement data collection methods
- Create data briefs

Identify innovative statistical & survey methods

Explore science to identify/pilot methods to modify adult survey system overall

Solutions

Updated plan for adult survey system by June 2021

Collaborators

Coalition of Communities of Color:

      Dr. Andres Lopez, Research Director

      Dr. Mira Mohsini, Senior Researcher

Latinx Project Team:

      Dr. Lorraine Escribano, Director of Evaluation, Latino Network

      Roberto Gamboa, Operations Manager, Euvalcree

      Dr. Daniel Lopez-Cevallos, Associate Professor, Oregon State University

      Claudia Montano, Projects Manager, The Next Door, Inc

      Karla Rodriquez, Community Health Worker, Oregon Latino Health Coalition

Black/African American Project Team:

      Dr. Roberta Hunte, Assistant Professor, Portland State University

      Oluchi Onyima, formerly of Urban League, now independent consultant
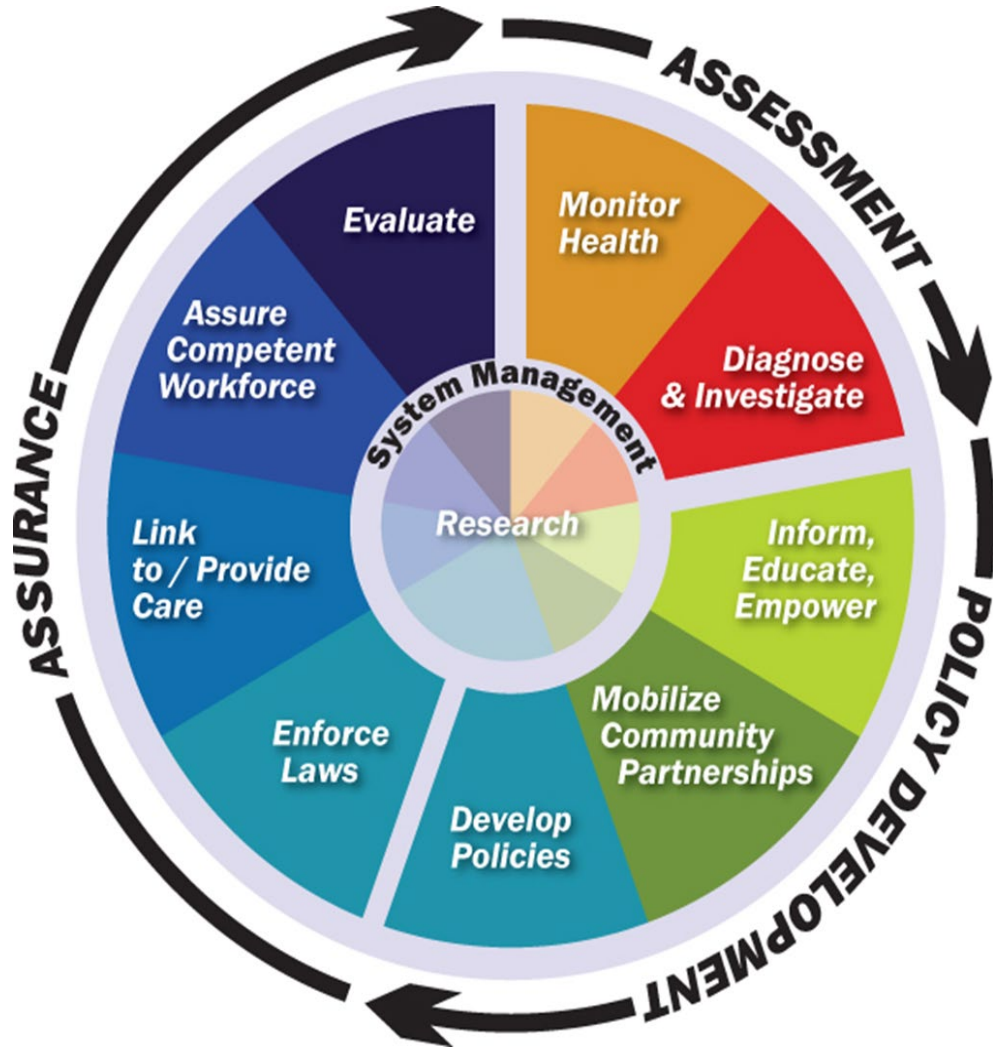
      Sherly Paul, Community Health Nurse, Multnomah County Healthy Birth Initiative

      Dr. Ryan Petteway, Assistant Professor, OHSU-PSU School of Public Health

Thoughts as Public Health Scientist

- Background is not in data justice
- Started working in community health assessment in late 90s
- Working in and examining governmental public health systems for over 20 years & serving on variety of national public health systems improvement efforts
- Survey modernization work has had me question my public health education & training
- Process – challenging and uncomfortable with a need to recognize the unintentional harm done
- Deeply grateful to our partners and project team members

THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems, and services that enable good health and seek to remove obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression, that have resulted in health inequities. Everyone should have a fair and just opportunity to achieve good health and well-being.

Assessment
- Assess and monitor population health
- Investigate, diagnose, and address health hazards and root causes

Policy Development
- Communicate effectively to inform and educate
- Strengthen, support, and mobilize communities and partnerships
- Create, champion, and implement policies, plans, and laws

Assurance
- Utilize legal and regulatory actions
- Enable equitable access
- Build a diverse and skilled workforce
- Improve and innovate through evaluation, research, and quality improvement
- Build and maintain a strong organizational infrastructure for public health
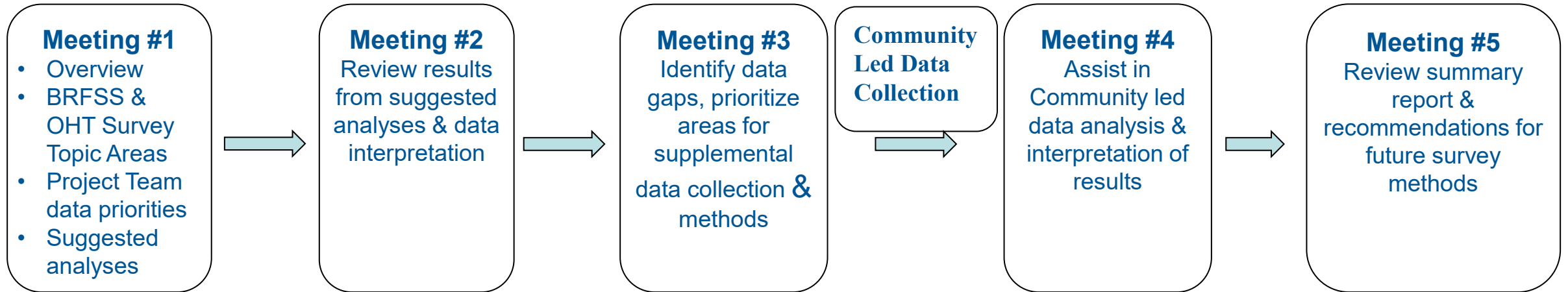
Equity

Created 2020

Early Lessons Shared in September 2020

- Scientific integrity is compromised without community engagement

  - Validity, relevancy and generalizability
  - Behavior questions presented without context shift entire responsibility to the individual and let institutions off the hook for their part in creating, perpetuating and exacerbating disparities

- Design questions so that they result in data that is actionable and can drive community program & policy change

- Equity as a starting point for survey design rather than being driven by siloed programmatic needs than community centered

- Community engagement at every step of the process from question design, data analysis and reporting

- Data justice – fairness in the way people are made visible, represented and treated as a result of their production of digital data (Taylor, 2017)

Methods

- Created a four-year BRFSS file, weighted for analyses by race/ethnicity
- Extensive partnership infrastructure building took place between October 2019 - March 2020
- Internal team project team - Partnership between Coalition of Communities of Color (CCC) & PDES
- Latinx and Black/African American project teams of 4-5 individuals consisting of both representatives from community-based organizations (CBOs) and researchers who are community members and have conducted community specific health related research
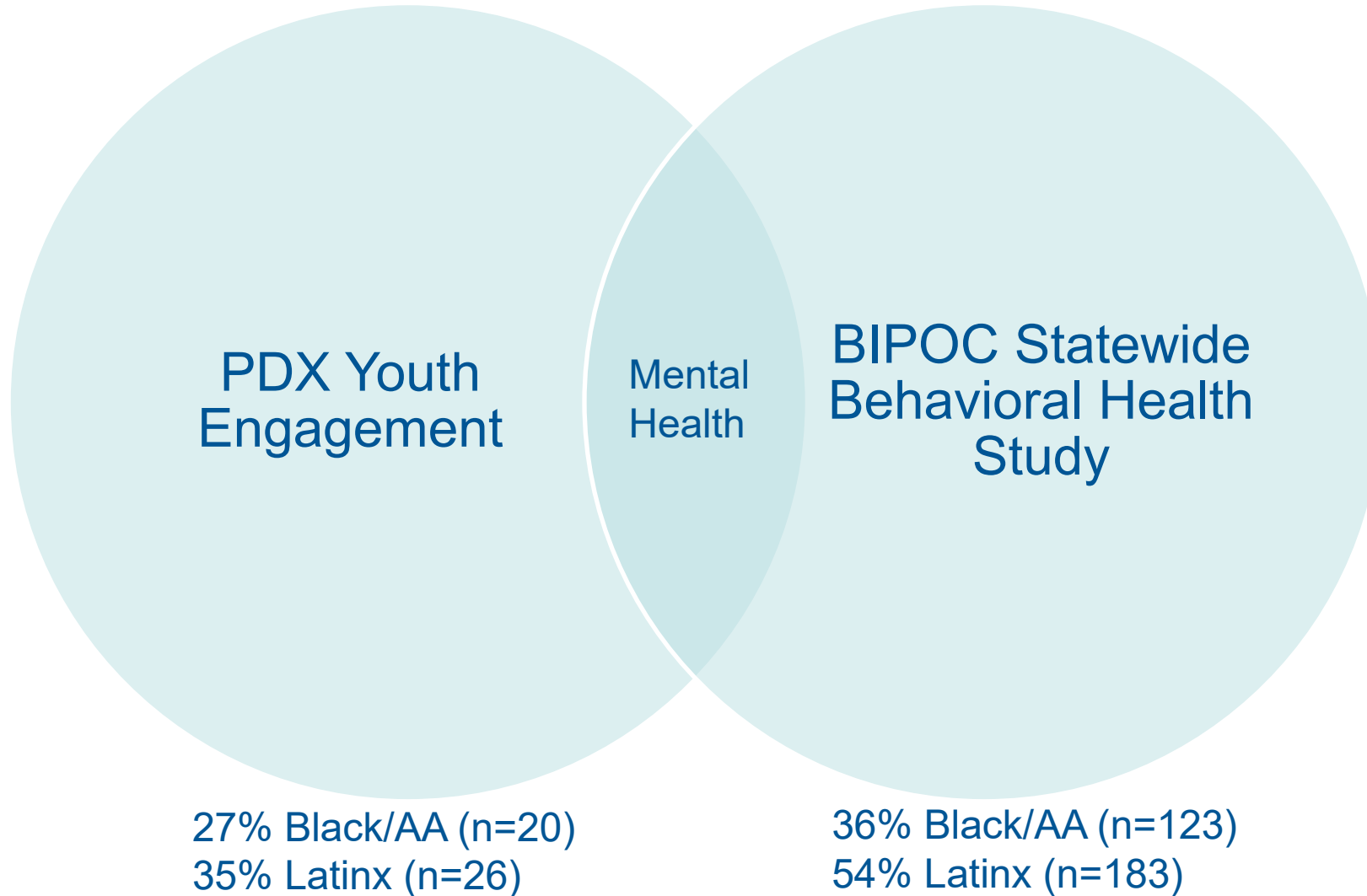
Data Project Team Process

Meeting #1
- Overview
- BRFSS & OHT Survey Topic Areas
- Project Team data priorities
- Suggested analyses

Meeting #2
Review results from suggested analyses & data interpretation

Meeting #3
Identify data gaps, prioritize areas for supplemental data collection & methods

Community Led Data Collection

Meeting #4
Assist in Community led data analysis & interpretation of results

Meeting #5
Review summary report & recommendations for future survey methods

Community Led Data Collection Topics & Methods

Positive Youth Development, ACES, & State Survey taking experience

Connecting empathy with data justice; discussing how state surveys (de)center students in question creation & uses; online survey

Access to culturally & linguistically specific mental & behavioral health services and providers, experiences of discrimination & medical mistrust

CBO & working group constructed and disseminated online survey

PDX Youth Engagement

Mental Health

BIPOC Statewide Behavioral Health Study

27% Black/AA (n=20)
35% Latinx (n=26)

36% Black/AA (n=123)
54% Latinx (n=183)

Findings

Six key themes - highly interrelated, each deserves to be highlighted in its own right as a lens through which we view the work of survey modernization and community engagement

1. Sample size
2. Survey translation and health literacy
3. Lack of meaningful context
4. Questions need to be actionable
5. Integration of other data sources
6. Intersectionality

Key Themes

1. Sample size
2. Survey translation and health literacy
3. Lack of meaningful context
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Sample size

Survey translation and health literacy

Key Themes

1. Sample size
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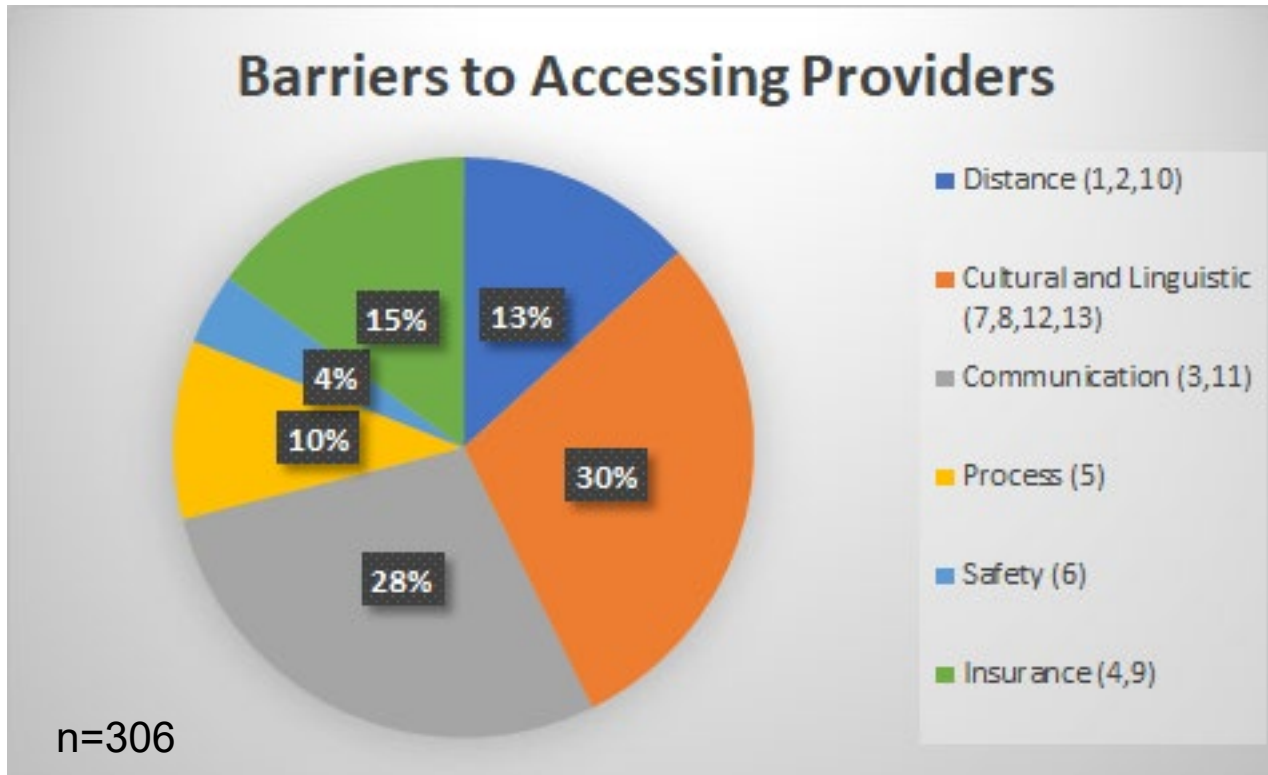6. Intersectionality

Lack of Meaningful Context

Examples

- Health care access
- Experiences of discrimination and harassment
- Experiences of medical mistrust

BRFSS	Community led Data Collection – example access question
1.Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, government plans such as Medicare or Indian Health Services? 2. Are you currently enrolled in the Oregon Health Plan (OHP), which is the State's Medicaid program? 3. Do you have one person who you think of as your personal doctor or health care provider? 4. Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost? 5. About how long has it been since you last visited a doctor for a routine checkup?	Do any of the following **prevent** you or members of your family from seeking support from your Coordinated Care Organization (CCO) or other health provider with issues around stress, frustration, worry, anger, addiction, violence, and/or abuse? Please select all that apply. • CCO/health provider is too far away • Don't have access to transportation • Don't have access to childcare • Don't have consistent access to internet for virtual appointments • Don't have health insurance • Process for making an appointment with a provider is difficult • Don't feel safe visiting my provider • Provider cannot communicate in a language that I'm comfortable using • Provider doesn't have the same cultural background as me • The service(s) I/we need is not covered by my insurance • The service(s) I/we need is not available near me • Not aware of what services are available near me • Information about services is not provided in a language that I'm comfortable using • Don't trust that my CCO/health provider will be respectful of my cultural values • Other (please specify)

Lack of Meaningful Context: Healthcare Access

What's keeping individuals from going to the doctor apart from cost and coverage?

Barriers to Accessing Providers

- Distance (1,2,10)
- Cultural and Linguistic (7,8,12,13)
- Communication (3,11)
- Process (5)
- Safety (6)
- Insurance (4,9)

13% | 15% | 4% | 10% | 30% | 28%

n=306

Key:
Distance - provider is too far away, services are far away, lack transportation
Cultural and Linguistic - information and services are not culturally and linguistically specific/responsive
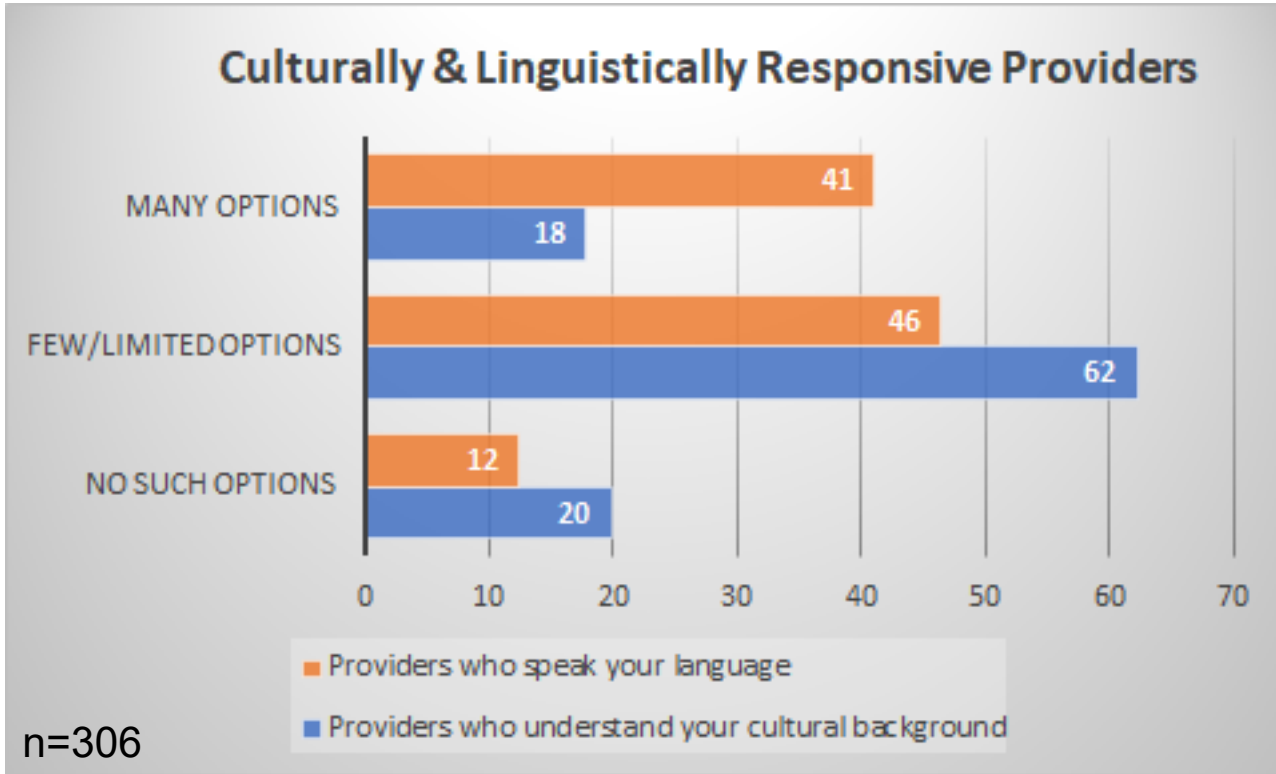**Communication** - not aware of services, lack internet
Process - making an appointment is difficult
Safety - feel unsafe visiting provider
Insurance - no insurance or services not covered

Communication	Insurance
Culture/Language	Process

Top 3 Most Frequently Chosen Options	
Black/African American	**Latinx**
Not aware of what services are available near me	Not aware of what services are available near me
Provider doesn't have the same cultural background as me	The service(s) I/we need is not covered by my insurance
Don't trust that my CCO/health provider will be respectful of my cultural values	Process for making an appointment with a provider is difficult

Lack of Meaningful Context: Healthcare Access

Culturally & Linguistically Responsive Providers

MANY OPTIONS: 41 / 18
FEW/LIMITED OPTIONS: 46 / 62
NO SUCH OPTIONS: 12 / 20

- Providers who speak your language
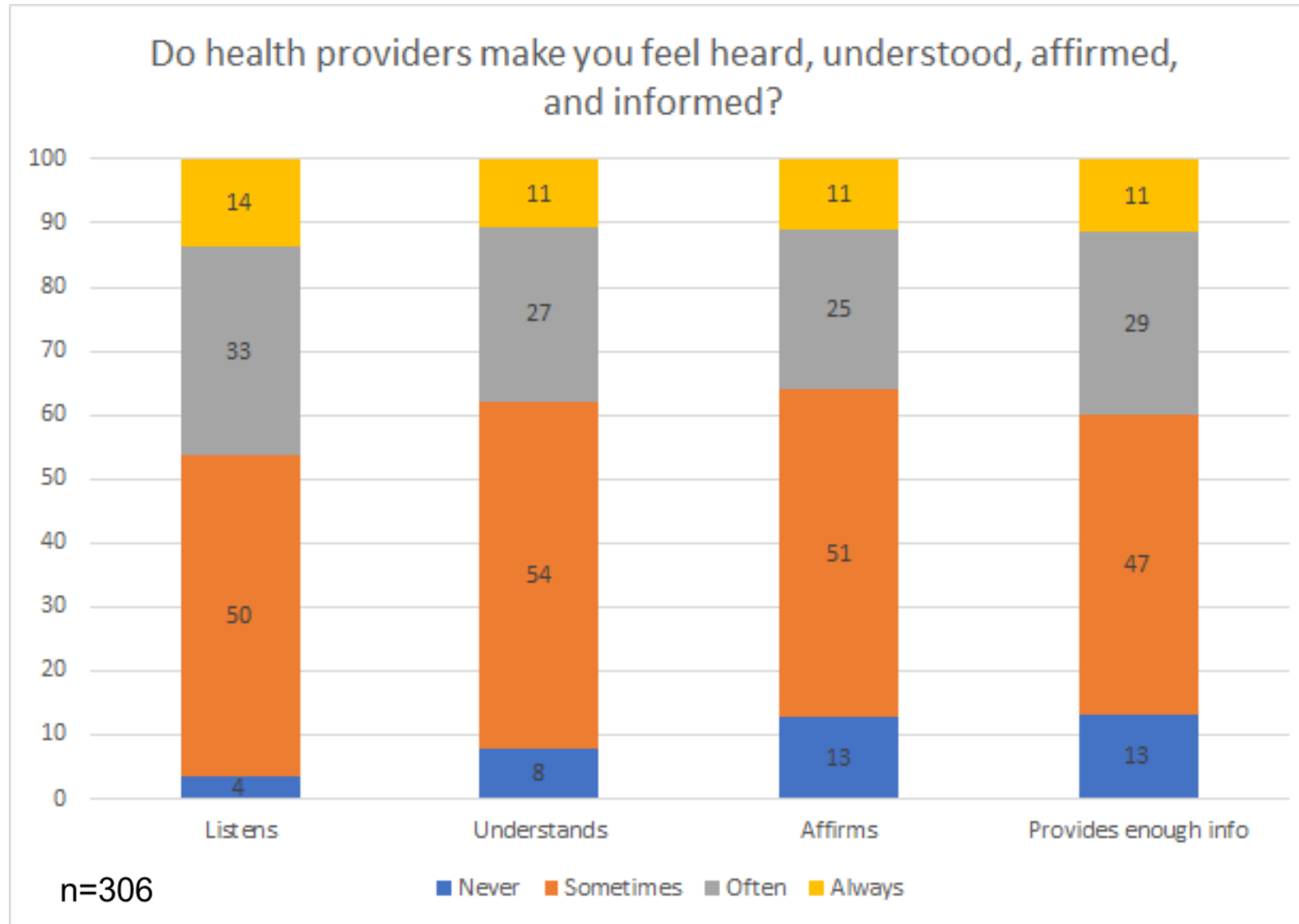- Providers who understand your cultural background

n=306

Narrative: 58% of respondents said they have *few or no options* for accessing <u>linguistically</u> responsive providers, and 82% said *few or no options* for accessing providers who understand their <u>cultural background</u>.

Understands your culture	Black/African American	Latinx
No such options	23	10
Few/limited options	74	51
Many options	22	11
Speaks your language	**Black/African American**	**Latinx**
No such options	13	6
Few/limited options	46	47
Many options	60	19

Lack of Meaningful Context: Experiences of Medical Mistrust

Do health providers make you feel heard, understood, affirmed, and informed?

n=306

Lack of Meaningful Context: Experiences of Medical Mistrust

Top 3 Themes	Examples
Providers lack empathy	- Dismissive - Patient feels unheard - Disrespectful - Rushed appointments
Experiences of harmful care practices	- Denied care - Misdiagnosis - Unnecessary treatment - Need to self-advocate
Stereotyping by providers n=220	- Presumed incompetent - Assumed drug addiction

Key Themes

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Questions Need to be Actionable

Examples

- School Absenteeism
- Physical Activity

Questions Need to be Actionable: School Absenteeism

- For OHT, both teams noted the questions only focus on school and not the everyday lives that impact how, when, and why students show up at school.

- Teams questioned why students are missing school beyond physical and emotional & mental health reasons.

- Are they working a job? Are they caring for a family member? Is there a hostile school climate? How is food insecurity affecting attendance?

Questions Need to be Actionable: School Absenteeism

Oregon Healthy Teens Survey	Community Led Data Collection - What would youth ask?
During the past 12 months, ○ <u>how many days</u> of school did you miss for any reasons? ○ how many days of school did you miss because of <u>physical health reasons</u>? ○ how many days of school did you miss because of <u>emotional or mental health reasons</u>? ○ how many days of school did you have <u>unexcused absences</u> (meaning you skipped or cut school? ○ did you miss one or more hours of school due to any of the following reasons? I had a toothache or painful tooth; My mouth was hurting; I had to go to the dentist because of tooth or mouth pain; I had to go to the hospital emergency room because of tooth or mouth pain; I had a mouth injury from playing sports.	• Just ask them "What's causing you to miss school?" • Do you have problems at home/outside of school? • Are you doing ok? • After each question just add a "why section" • What is elevated above school? Why does it come up? • Do you have other things to do other than school? • What are things affecting you outside of school that keep you from being successful? • In what ways does school feel unsafe to you? • Is someone making fun of you or are there stressful conditions you want to avoid at school like students or teachers? • What would make school a safer environment? • What at schools feels welcoming/accepting? What does not?

Questions Need to be Actionable: Physical Activity

BRFSS	What is needed to be actionable
During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?	Understanding of what's preventing them from being physically active Mapped in relation to policy-related PA contexts. Examples: • Joint use agreements between schools and public • Amount of greenspace • % of jurisdiction zoned for public recreation use • Density of free gym facilities as ratio of non-free ones • Traffic/pedestrian injury rates • Sidewalk existence & quality • % of tax revenue invested in parks This then renders PA responses open to deep examination and action, e.g., what is relationship between joint use agreements and PA rates for xyz county/neighborhood? Is there a demographically comparable area w/ similar level of agreements that has lower PA rates? Why?

"Behaviors evolve/match contexts. Policy creates/shapes/maintains contexts. This is not news to any of us. How come our surveys appear impervious?"

"We don't need more detailed data about how black folks experience even worse ACEs - more toxic environments -- we already know that. We need data that can help drive policy."

Key Themes

1. Sample size
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Integration of Other Data Sources

- Latinx team requested to see the OHA immunization registry data to provide better understanding of the self-report influenza vaccination data in BRFSS back in May 2020. Also shared with Black/African American team.

- Latinx team wanted to compare Oregon Department of Education (ODE) data and OHT. ODE Free and Reduced lunch data by ethnicity was found and shared. Also shared with Black/African American team.

- Policy related contexts – integration of legal epidemiology

Key Themes

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Intersectionality

- Racialization & Generational Groups
- Age, Country of Birth, and Language
- U.S. Born versus Foreign Born
- Collecting REaLD & SOGI for better disaggregation

Dominant Culture Perspective
Reflected in each of the themes presented

**EXAMPLE OHT Bullying
Question Response Options**

- Bullying about your race or ethnic origin
- Unwanted sexual comments or attention
- Bullying because someone thought you were gay, lesbian, bisexual, or transgender
- Bullying about your weight, clothes, acne, or other physical characteristics
- Bullying about your group of friends
- Other reasons

Team member comments

- Inclusion of racial discrimination as simply a form of "bullying" is problematic
- Minimizes the extent/depth of interpersonal racism as connected to/enabled by institutional racism
- Should not lump forms of systemic devaluation, exclusion, and oppression in with getting bullied b/c of clothes, etc.
- Actions that are biased, hostile, or violent toward others based on race are racist, and appropriately viewed as hate speech/actions
- Subsuming them under the concept of "bullying" clouds the dynamics of power that are at play
- Serve as a reminder of the need for systemic/ institutional/organizational change. It is not the responsibility of the person/community to "cope", but for the environment (policies, practices, providers) to become welcoming, inclusive, and less discriminatory

Thoughts from a Community Based Researcher

- Communities of Color are hit the hardest – health, economics, education, hate, housing, etc.

- Mainstream data bolsters research oppression

- Communities of color are fed up with the same responses and lack of accountability

- Demands for systems change is the new normal

What we can do...

- Center community data & strategies for self-determination
    - Let communities of color frame how mainstream data fails to represent them
    - Help local and regional entities with community led question development, data collection strategies, data analysis, and data uses
    - Connect available mainstream data to community data. This process should be led by the community.
    - Establish decision making processes that defer to community

Early Lessons Shared in September 2020
Updates May 2021

- Scientific integrity is compromised without community engagement
  - Validity, relevancy and generalizability
  - Behavior questions presented without context shift entire responsibility to the individual and let institutions off the hook for their part in creating, perpetuating and exacerbating disparities
- **As a result – misrepresents people's experiences, further blames and causes them harm "This approach (BRFSS and OHT) damages people to be misrepresented"**

- **If the data are not actionable, then we can't hold ourselves accountable**

- **We're accountable to the communities we serve and data from BRFSS and OHT prevent our ability to be accountable**

- Equity as a starting point for survey design rather than being driven by siloed programmatic needs than community centered

- Design questions so that they result in data that is actionable and can drive community program & policy change

- Community engagement at every step of the process from question design, data analysis and reporting

- Data justice – fairness in the way people are made visible, represented and treated as a result of their production of digital data (Taylor, 2017)

Project Team Recommendations
Next steps

- Build in **time and resources necessary for relationship development** between govt public health and community partners in data
- Continue **long term, sustained compensated Community led Data Collection**
- Conduct a **minimal BRFSS** – explore lessons from the **CA Health Interview Survey**
- Integrate **Community Leadership** in survey development, administration, analysis & use
- Establish a Survey **Translation Advisory Committee**
- Continue **data project teams** and ensure team members are made up of folks who share experiences of those who are being "researched"
- Engage **Community Based Organizations and/or Regional Health Equity Coalitions** in survey administration
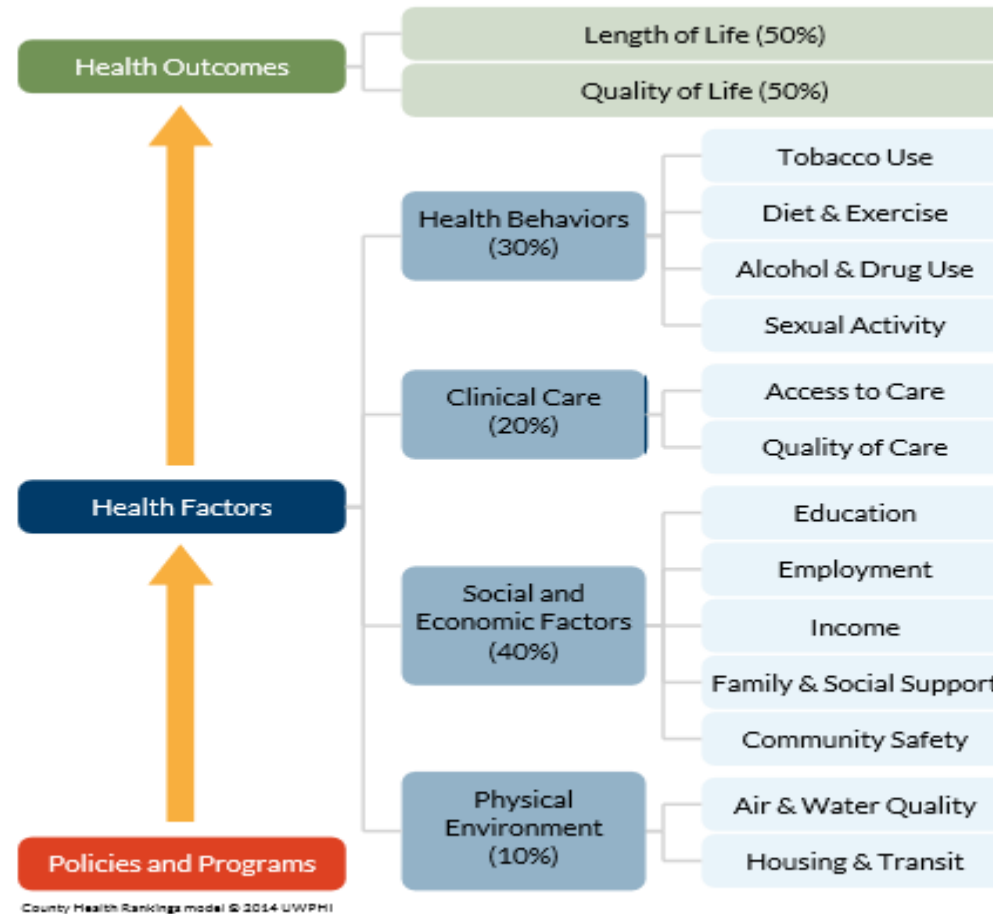- Reengage the Health Equity Researchers of Oregon (HERO) group

Call to action & funding of strategy development of what the work can look like and who should be engaged

Project Team Recommendations

Need for clear conceptual framework guiding OHA in general, and BRFSS/OHT more specifically, that spells out the multilevel, multilayered understanding of the issues

County Health Rankings Model

Key Lessons for Equitable Data Practices

- Recognition of **skill sets, background and respect** of each community & govt partner are valued
- Show respect to community members by **paying them for their time and expertise**
- See **community members as experts** in their areas – center & value community knowledge
- **Share data** and TA as needed – in this case BRFSS & OHT Datasets, requested contextual data (i.e. ALERT IIS & ODE) & BRFSS pilot results
- Resist letting the "small numbers" argument get in the way of sharing data with communities. Sometimes communities see this as intentional and can further distrust
- **Share project/survey budgets** with community partners
- **Share translated surveys** for review
- **Defer human subjects protections** to community research partners
- Increase collection of **contextual/environmental & actionable measures** collected by both Community led data collection and State BRFSS and SHS
- Improve **integration** and reporting population health outcome measures with collected contextual information
- Those measures should be considered for inclusion in the Healthier Together Oregon **SHIP** metrics

Thank you!

Oregon Survey Modernization AI/AN Project Team Update

Northwest Portland Area Indian Health Board

Northwest Tribal Epidemiology Center

Bridget Canniff, MALD, CPH

Project Director, Public Health Improvement & Training

**NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD**
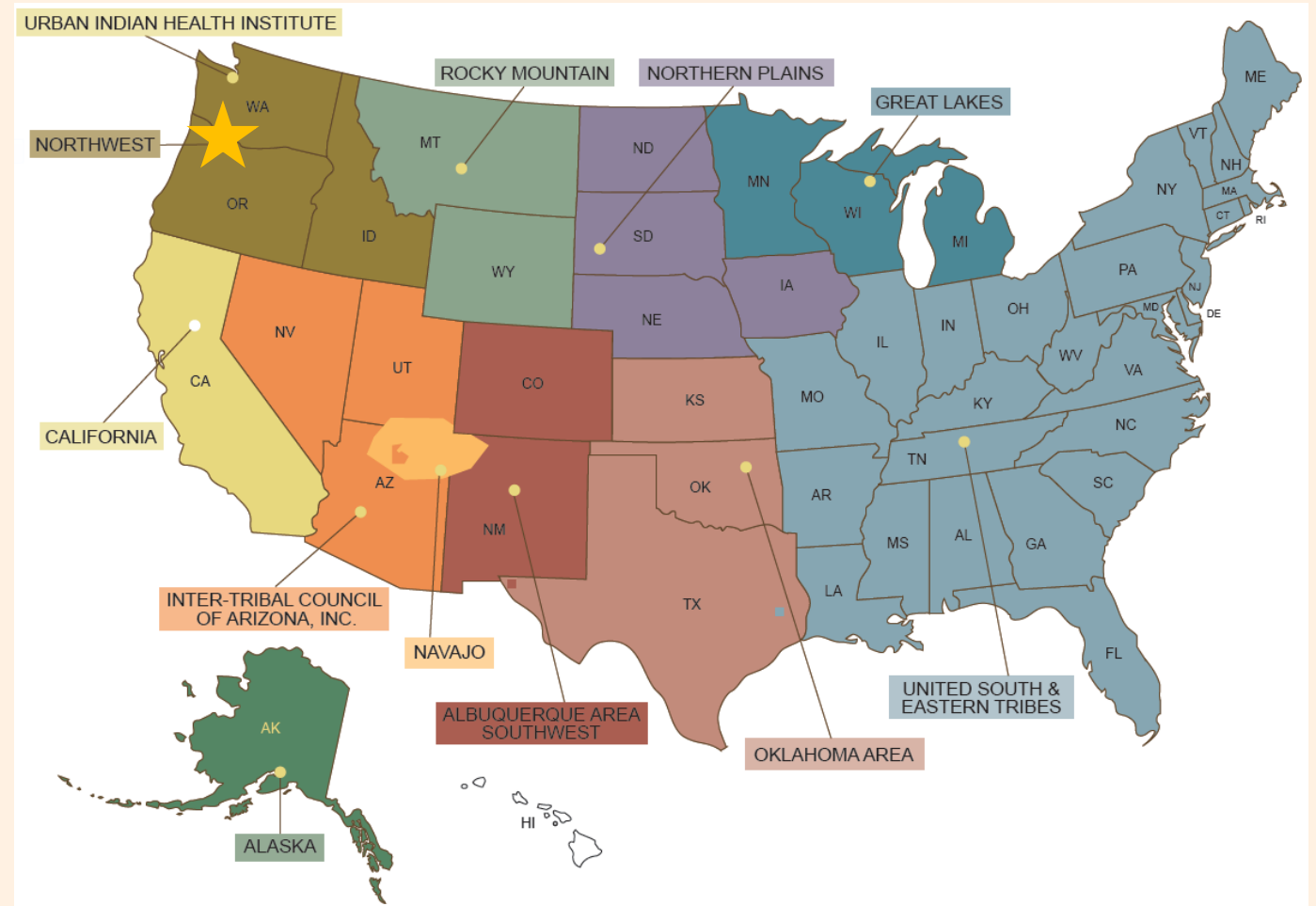*Indian Leadership for Indian Health*

NPAIHB and NWTEC

- Northwest Portland Area Indian Health Board (NPAIHB)
    - Tribal organization formed in 1972
    - Serves 43 federally-recognized tribes in ID, OR, WA

- Northwest Tribal Epidemiology Center (NWTEC)
    - Formed in 1996 as a department of the NPAIHB
    - Guided by the Public Health Committee of the NPAIHB
    - Reports to the NPAIHB Tribal Delegates

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Indian Leadership for Indian Health

Tribal Epidemiology Centers (TECs)

- Established as public health authorities through permanent reauthorization of the Indian Health Care improvement Act (IHCIA) in 2010

- Function independently, but also as part of a national group called TEC-Consortium

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NWTEC as a Public Health Authority

> Does not alter Tribes' Public Health Authority as sovereign nations, but is supportive to it.

- US Health and Human Services (HHS) directive gives TECs access to HHS data systems and protected health information

- CDC must provide technical assistance to TECs

- Each Indian Health Service (IHS) Area must have TEC access

- Role as Public Health Authority at the request of tribes for data and provision of technical assistance

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Tribal Data Sovereignty

As sovereign nations, tribes are the owners of data for their citizens and should have primary control and voice in the use, interpretation, and disposition of data related to their citizens.

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NPAIHB Project Team

NPAIHB/NWTEC

- Bridget Canniff
  Project Director, Public Health Improvement & Training (PHIT)

- Kimberly Calloway
  Project Specialist, PHIT

- Kerri Lopez
  Project Director, Western Tribal Diabetes and NW Tribal Comprehensive Cancer Projects

- Natalie Roese
  Contractor

Tribal Workgroup

- Nicole Barney
  University of Oregon/Klamath Tribes

- Pamela Gutman
  Cow Creek Tribe

- Jessica Hamner
  Coquille Tribe

- Obinna Oleribe
  Klamath Tribes

- Richie Thomas
  University of Oregon

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PROJECT WORKPLAN

Meeting #1
- Introduce project
- Identify areas of concern
- Discussion

Meeting #2
- Discussion with OHA
- Finalize project team data priorities
- Identify areas for additional analyses
- Suggestions for supplemental data review

Meeting #3
- Review additional results from suggested analyses
- Finalize areas for supplemental data review

Meeting #4
- Assist in interpretation of supplemental data review and presentation of results
- Draft report due to OHA **May 21**

Meeting #5
- Review summary report & recommendations for future survey methods
- Final report due to OHA **July 31**

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Project Team Topics of Interest

- **Adverse Childhood Events (ACEs)**

- **Chronic health conditions**

- **Suicide**

- **Behavioral health**

- Substance use disorder

- Physical activity and nutrition

- Healthcare access

- School attendance

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Key Findings

- AI/AN definition
- Strengths of Tribal BRFSS model
- Lack of meaningful context
- Need for actionable data

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NPAIHB/NWTEC Approach: AI/AN Definition

- Include American Indian or Alaska Native (AI/AN) data, whether alone or in combination with other race/ethnicity

- Linkages of state datasets with NWTEC tribal registry to provide more complete data reporting to tribes
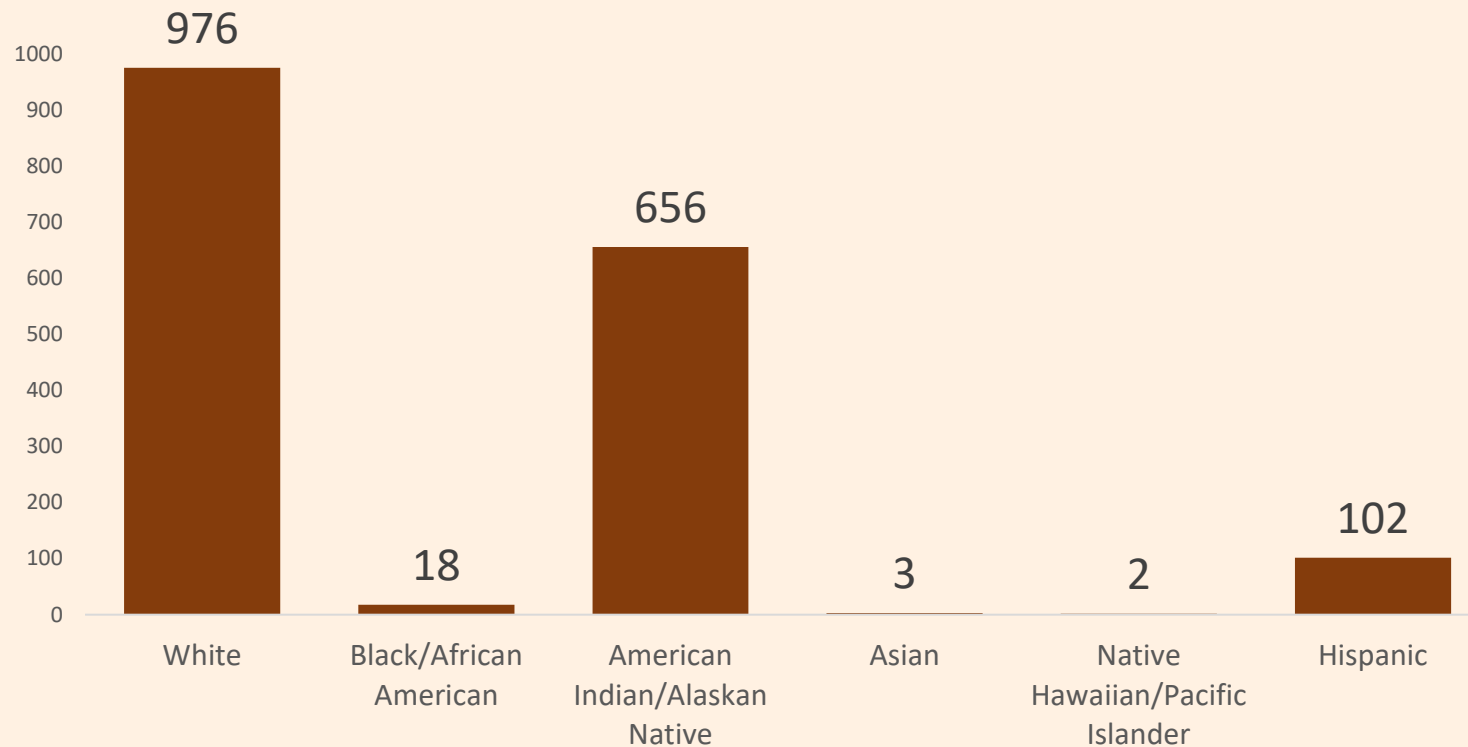
- Focus on our population of interest

"American Indians and Alaska Natives are often incorrectly classified as another race (usually White) in vital statistics, cancer registries, and other public health datasets. In the Northwest, AI/AN misclassification in health datasets can range from 10-60%... Without accurate data, tribes are limited in their ability to identify and allocate resources to the areas of greatest need."

- IDEA-NW Project, NPAIHB/NWTEC

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AI/AN Identification by Race/Ethnicity Classification

Bar chart showing AI/AN Identification by Race/Ethnicity Classification:
- White: 976
- Black/African American: 18
- American Indian/Alaskan Native: 656
- Asian: 3
- Native Hawaiian/Pacific Islander: 2
- Hispanic: 102

Tribal BRFSS

- NWTEC supports tribes, upon request, in conducting tribal-specific surveys

- Questions can be tailored to the health priorities and services of each tribe, such as:
  - Point of access for healthcare (tribal clinic vs. other)
  - Use of or need for specific services, such as Elders programs
  - Cultural activities that support health and wellness

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Strengths of Tribal BRFSS Models

- Community trust
- Customized approach to recruitment of participants
- Actionable data and informed program planning
- Tribal ownership of data

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Context: Question Wording

CDC BRFSS

Section 4: Hypertension Awareness

4.1 Have you EVER been told by a doctor, nurse, or other health professional that you have high blood pressure?

(101)

Read only if necessary: By "other health professional" we mean a nurse practitioner, a physician's assistant, or some other licensed health professional.

4.2 Are you currently taking medicine for your high blood pressure?

(102)

1 Yes
2 No
7 Don't know / Not sure
9 Refused

CDC BRFSS

Section 8: HYPERTENSION AWARENESS

SAMPLE TRIBAL BRFSS

8.1. Have you had your blood pressure taken in the past 12 months?

1 YES
2 NO
7 DON'T KNOW/NOT SURE
9 REFUSED

8.2. Have you ever been told by a health provider that you had high blood pressure? [**read only if necessary**]: not including high blood pressure while pregnant.

1 YES
2 NO ➔**GO TO NEXT SECTION**
7 DON'T KNOW/NOT SURE ➔**GO TO NEXT SECTION**
9 REFUSED ➔**GO TO NEXT SECTION**

NOW, I AM GOING TO READ A LIST OF REMEDIES YOU MAY BE USING TO TREAT YOUR HIGH BLOOD PRESSURE.

8.3. Are you using…

	READ CHOICES	YES	NO
A.	ORAL MEDICINE (MEDICINE YOU TAKE BY MOUTH)	1	2
B.	TRADITIONAL MEDICINE (PLEASE DESCRIBE) _____	1	2
C.	ACUPUNCTURE	1	2
D.	MASSAGE THERAPY	1	2
E.	DIET	1	2
F.	EXERCISE	1	2
G.	YOGA	1	2
H.	LIFESTYLE & WELLNESS COACH	1	2
I.	NO LONGER HAVE HIGH BLOOD PRESSURE	1	2
J.	OTHER (SPECIFY): _____	1	2

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Lack of Meaningful Context

Oregon Healthy Teens (OHT) Survey

"During the past 30 days, did you ever sleep away from your parents or guardians because you were kicked out, ran away, or were abandoned?"

"During the past 12 months, did you have any physical health care needs that were not met? (Count any situation where you thought you should see a doctor, nurse, or other health professional.)"

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Actionable Data

- For tribes, the BRFSS is not as useful for looking at AI/AN data across multiple counties within a tribe. Data require complicated cross-tabulations and often lacks necessary context.

There is a need for more funding to meet the needs that have already been determined, and not simply more surveys to further assess needs.

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Next Steps

- Draft report
- Review draft at Meeting 5 in June with Project Team
- Submit final report to OHA in July
- Share and discuss report recommendations with NPAIHB delegates and tribes

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Thank You

For more information about NPAIHB and the work of the Northwest Tribal Epidemiology Center, please visit www.npaihb.org

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OPHD Survey Modernization with Pacific Islander Communities

PACIFIC ISLANDER DATA MODERNIZATION (PIDM)

Pacific Islander Data Modernization (PIDM)

- PIDM's aim was to utilize Pacific Islander leadership to study *Community Determinants of Health* for Oregon's Pacific Islander communities

- PIDM builds off Multnomah County's PIDP:
  - Community-based participatory research (CBPR) model
  - Put Pacific Islander wisdom at the center of this work

- Goal: Collect relevant data through a community-based and action-oriented approach to tell the story of what it means to be a Pacific Islander in Oregon

Community Engagement

High-level Advisory
Outreach network
Holds DSA

CBOs
Cultural advisors
Hosted workshops

CRWs
Support facilitation and data analysis

Natlie Dutro - Native Hawaiian
Siiri Visto - Native Hawaiian
Sisilia Afemui - Tongan
Adri Jones - Filipinx
Kianna Angelo - Marshallese
Jonathan Cruz - Native Hawaiian
Jasmine Kahananui - Native Hawaiian
Bella Borja - CHamoru
Dr. Jacinta Galeai - Samoan
Elizabeth Paulson - Samoan

Core Team
Research and Engagement Leads

Maria Dizon - Filipinx / lived in Saipan

Virginia Luka - Palauan / lived in Guahan

Alyshia Macaysa - Native Hawaiian and Filipinx

PI HEAL Workshops & Assessment

- Each CBO sponsored a 3-hour Pacific Islander **H**ealth, **E**quity, **a**nd **L**iberation (PI HEAL) virtual community workshop

- CBOs led recruitment of community member participants and compensated them directly

- CRWs and Core Team members worked with each CBO to plan and develop content for their workshop, generally:
  - Welcome, Blessing, and Land Acknowledgement
  - Who is a scientist? What is data? What is research?
  - What is Pacific Islander Data Modernization?
  - Consent
  - Independent completion of PI HEAL Assessment (online)
  - Small group breakout
  - Large group share out

KA ʻAHA LĀHUI O ʻOLEKONA
HAWAIIAN CIVIC CLUB OF OREGON & SW WASHINGTON

Pacific Islander Data Modernization Project
Funded By The Oregon Health Authority

Hosted By Ka ʻAha Lāhui O ʻOlekona Hawaiian Civic Club

Pacific Islander

HEAL
Health, Equity, And Liberation

Workshop will focus on the PI HEAL Assessment. Participants will share their stories and experiences about what it means to be Pacific Islander, and what challenges and opportunities there are to achieve health and healing.

Participants must:
*Self-identify as Pacific Islanders
*Live, work, organize or access services in Oregon
***Be at least 18 years of age**

Saturday
February 13 2021
10 am to 1 pm

*Registered participants will receive a $75.00 gift card.
If you have any questions, please contact info@kalohcc.org*

REGISTER TODAY!
HTTPS://TINYURL.COM/PIHEALKALOHCC

PI HEAL Assessment

- Core team co-developed the Pacific Islander **H**ealth, **E**quity, and **L**iberation (PI HEAL) Assessment
  - Adapted from Prevention Institute's THRIVE assessment, informed by PIDP, previous work on PI-specific SDOH, and Community Counts
  - Consulted with CBOs, CRWs, and broader PI community

- Four priority areas with 16 community health factors **specific to Pacific Islander community health:**
  - **People:** Community Connections, Care for Community, Community Values
  - **Place:** Housing, Food, Access to Land, Getting Around, Cultural Centers
  - **Opportunity:** Living Wages, Local Wealth, Education, Information
  - **Healing:** Self Determination, Decolonization, Spiritual Health, Healthcare

- REAL-D and SOGI questions

- Translated into Tongan, Pohnpeian, Marshallese, ʻŌlelo Hawaiʻi, and CHamoru/Chamorro*, which were centralized and accessible through the project website https://www.pacificislanderheal.com/

PI HEAL Assessment, cont.

- PI HEAL respondents rated each community health factor based on **how accessible and abundant** they believe the factor is to Pacific Islanders in Oregon

- Ratings are based on a "fish" scale:

    Bonefish: Myself, my family, and my community do not have this

    One little fish: This is something I have personally, but is not something that my family or community have

    One large fish: This is something I have and my family have, but not my community

    Two fish: This is something I have, my family have, and some of my community have

    Three fish: This is something I have, my family have, and my community have

- Respondents then ranked each factor as low, medium, or high priority for future health improvement efforts and chose their top 3
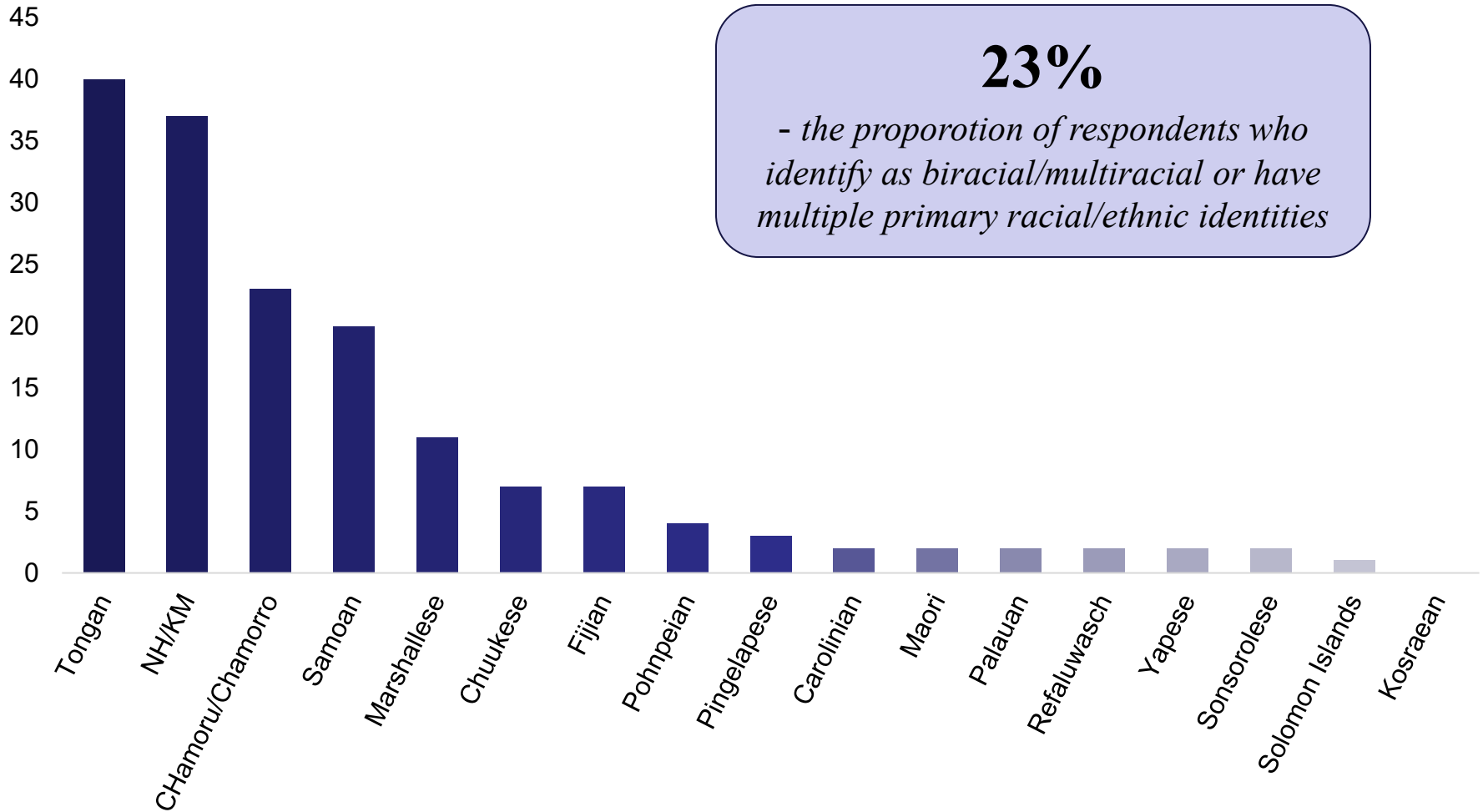
PI HEAL ASSESSMENT RESULTS

Whose voices are present?

Age, Gender, SO, Language, and Disability

- 136 respondents

- Average age = 39 (SD=12), range = 18-74

- Most identified as a woman (n=90) or man (n=33)

- Most identified as straight/heterosexual (n=96), and others listed LGB, Queer, Pansexual, Asexual, Questioning, etc.

- Most reported speaking English "very well" or "well"
  - Other language abilities included CHamoru, Chuukese, Marshallese, Samoan, Tongan, and 'Ōlelo Hawai'i

- About 18% reported experiencing one or more disabilities

- Multiple Pacific Islander ethnic identities
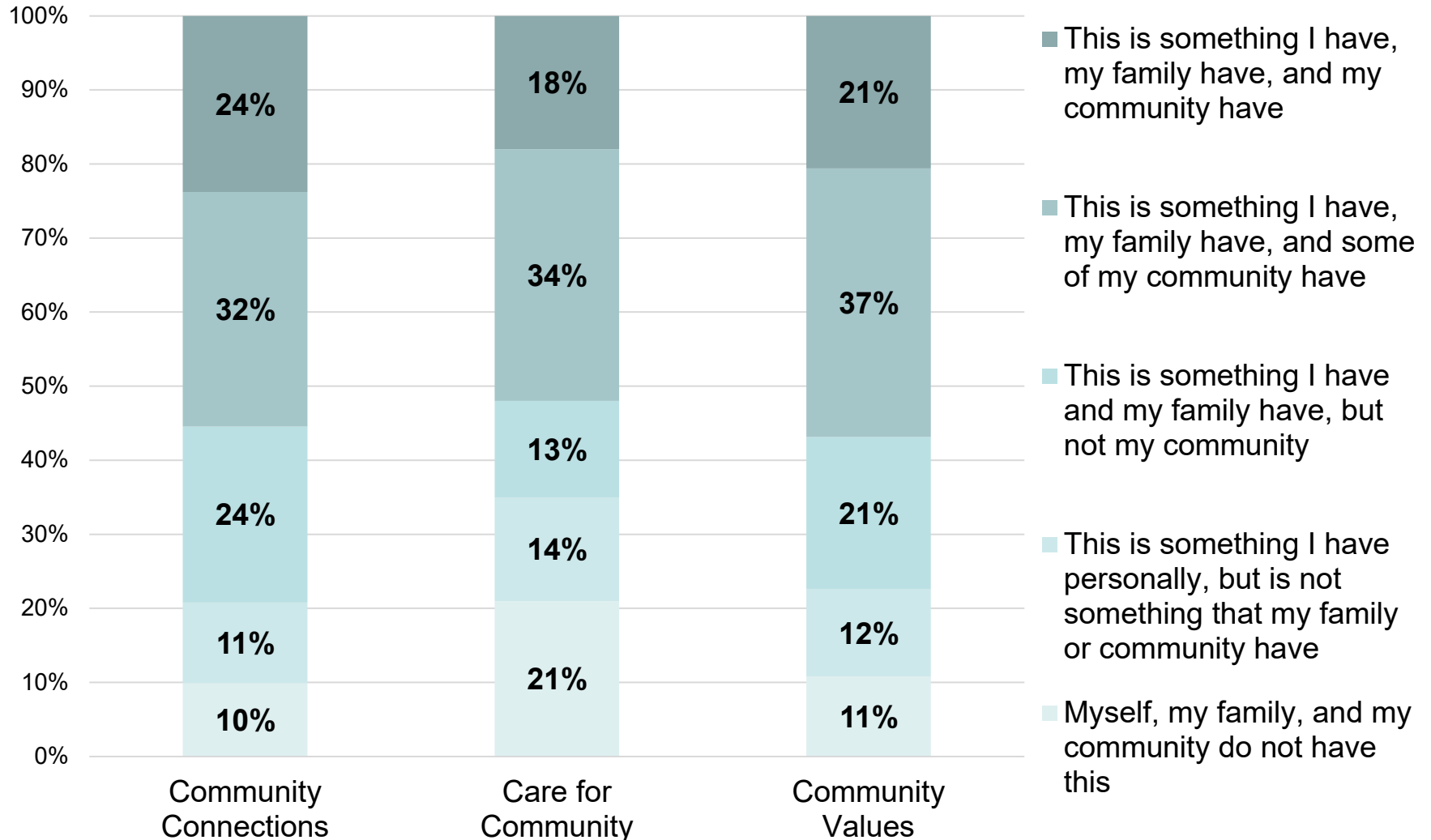
Pacific Islander Ethnic Identities

23%

- the proporotion of respondents who identify as biracial/multiracial or have multiple primary racial/ethnic identities
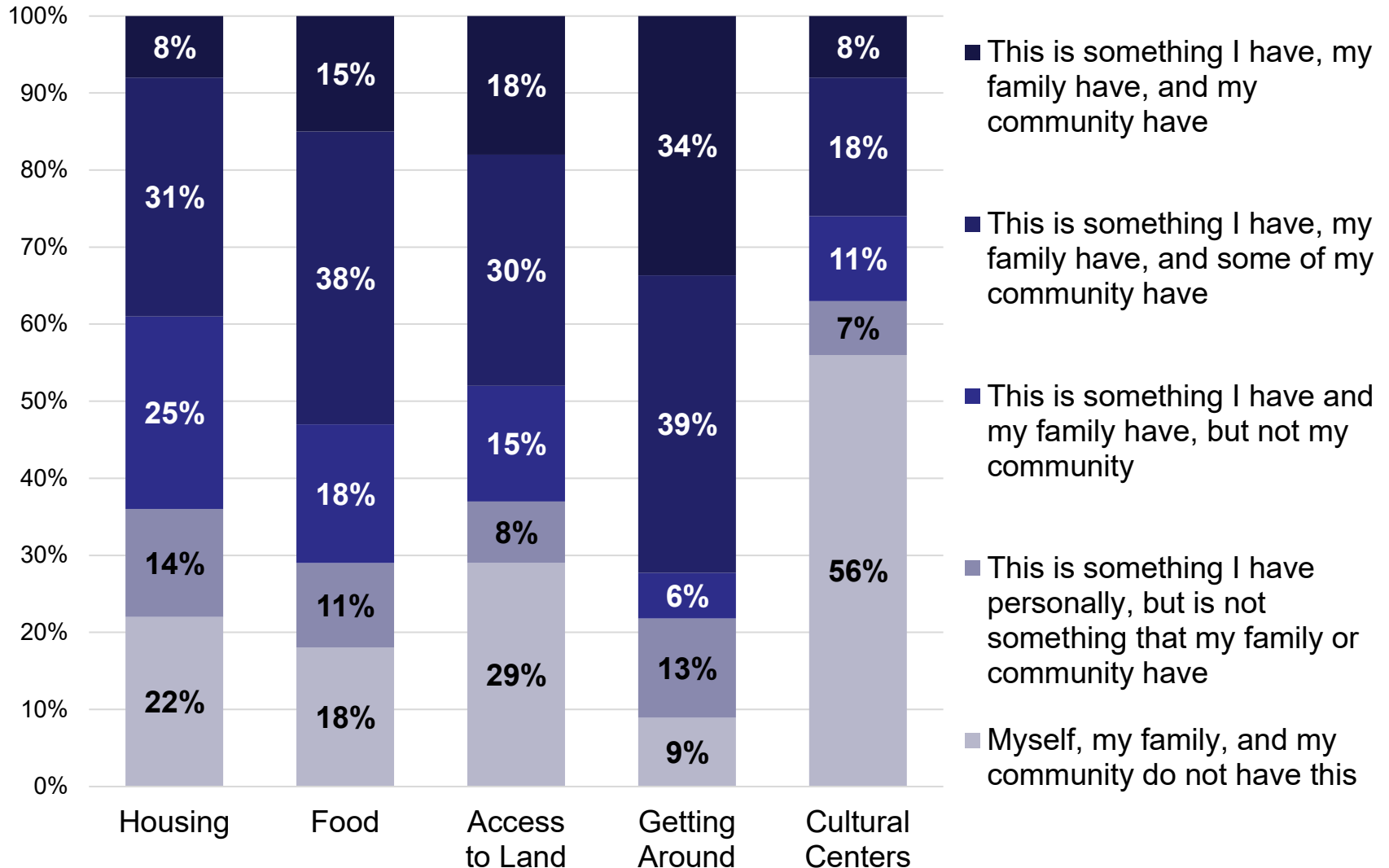
PI HEAL ASSESSMENT RESULTS

How abundant or accessible are the Community Health Factors?

"People" Community Health Factors
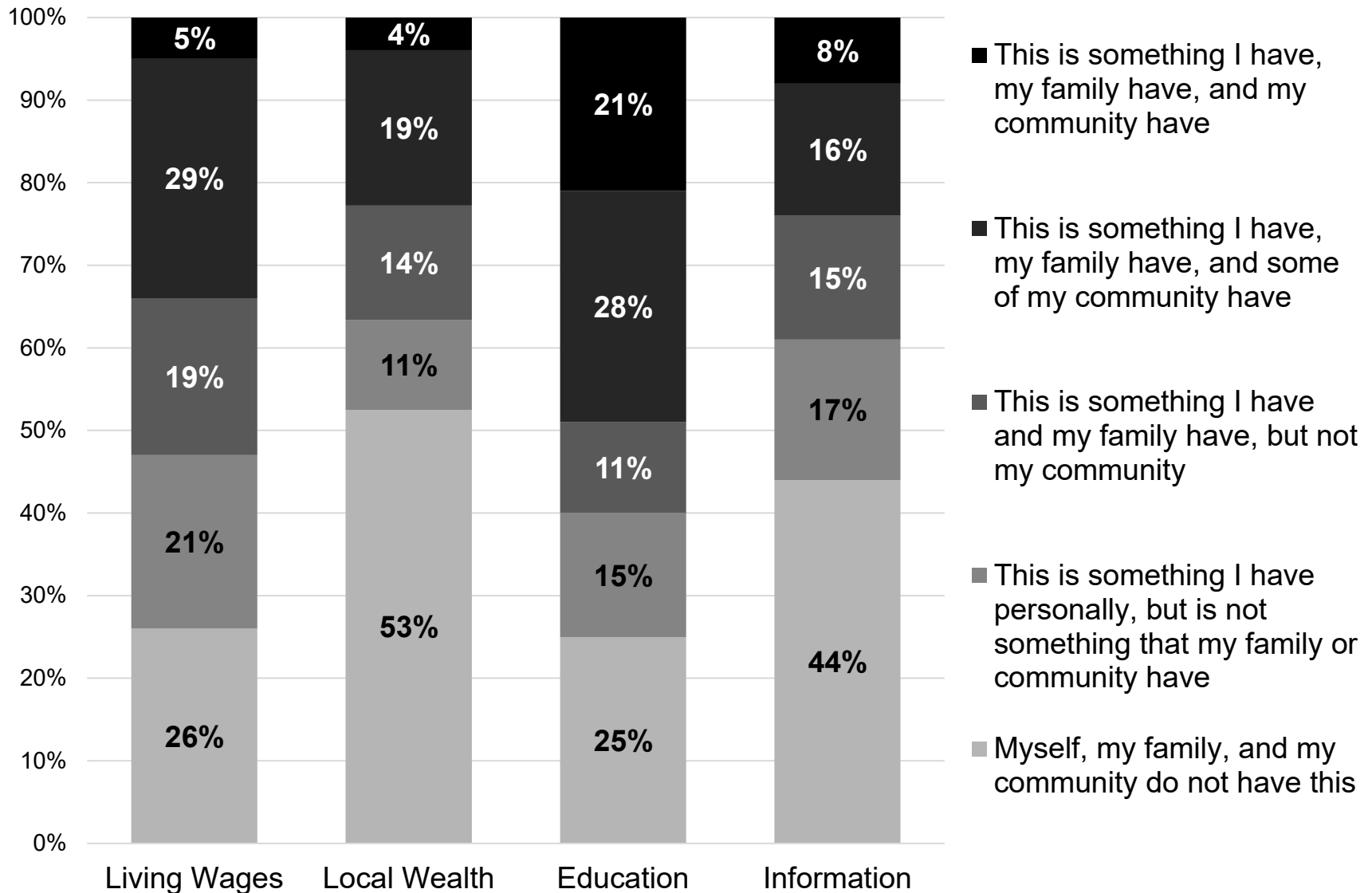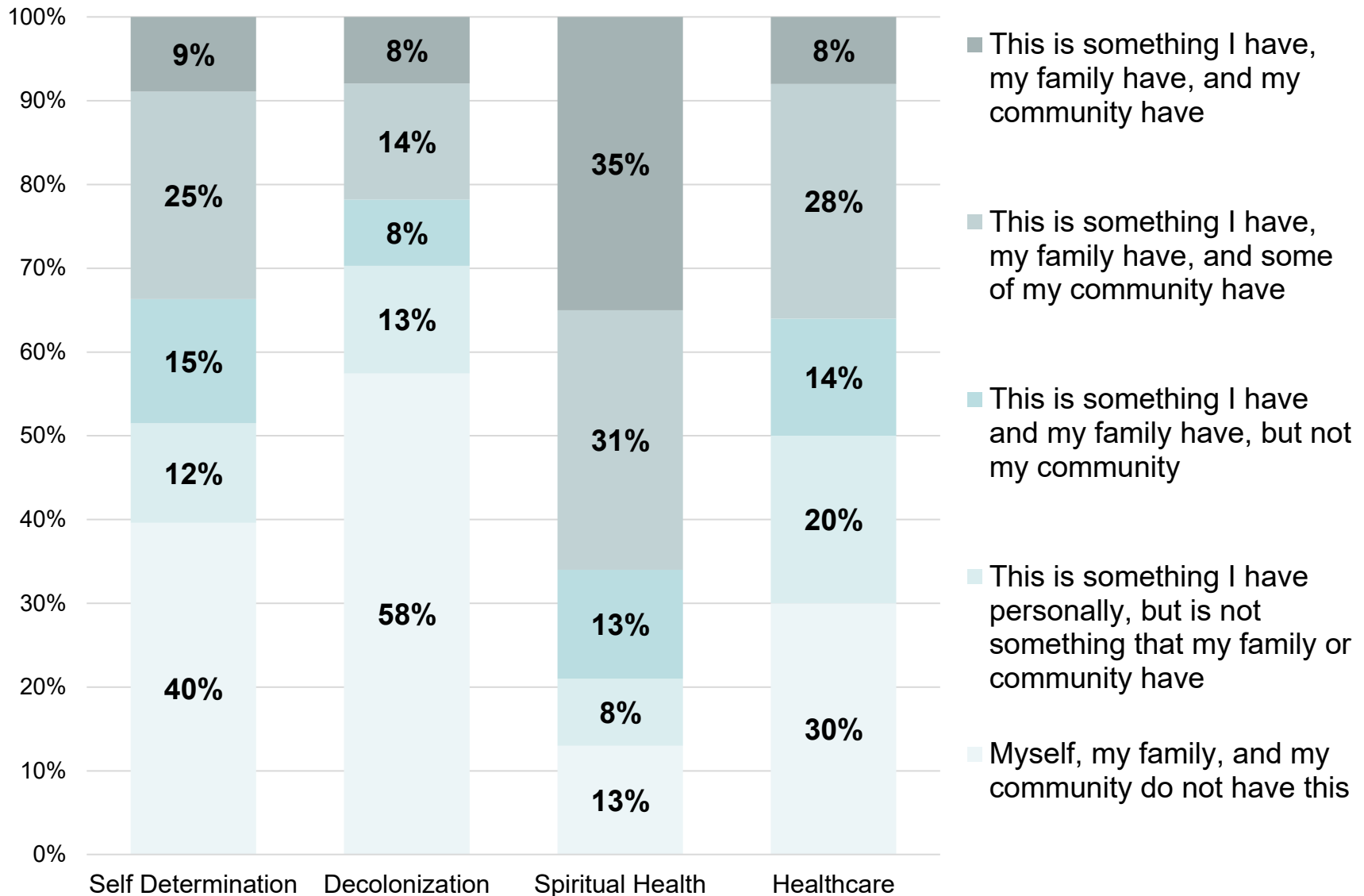
"Place" Community Health Factors

"Opportunity" Community Health Factors

Legend:
- ■ This is something I have, my family have, and my community have
- ■ This is something I have, my family have, and some of my community have
- ■ This is something I have and my family have, but not my community
- ■ This is something I have personally, but is not something that my family or community have
- ■ Myself, my family, and my community do not have this

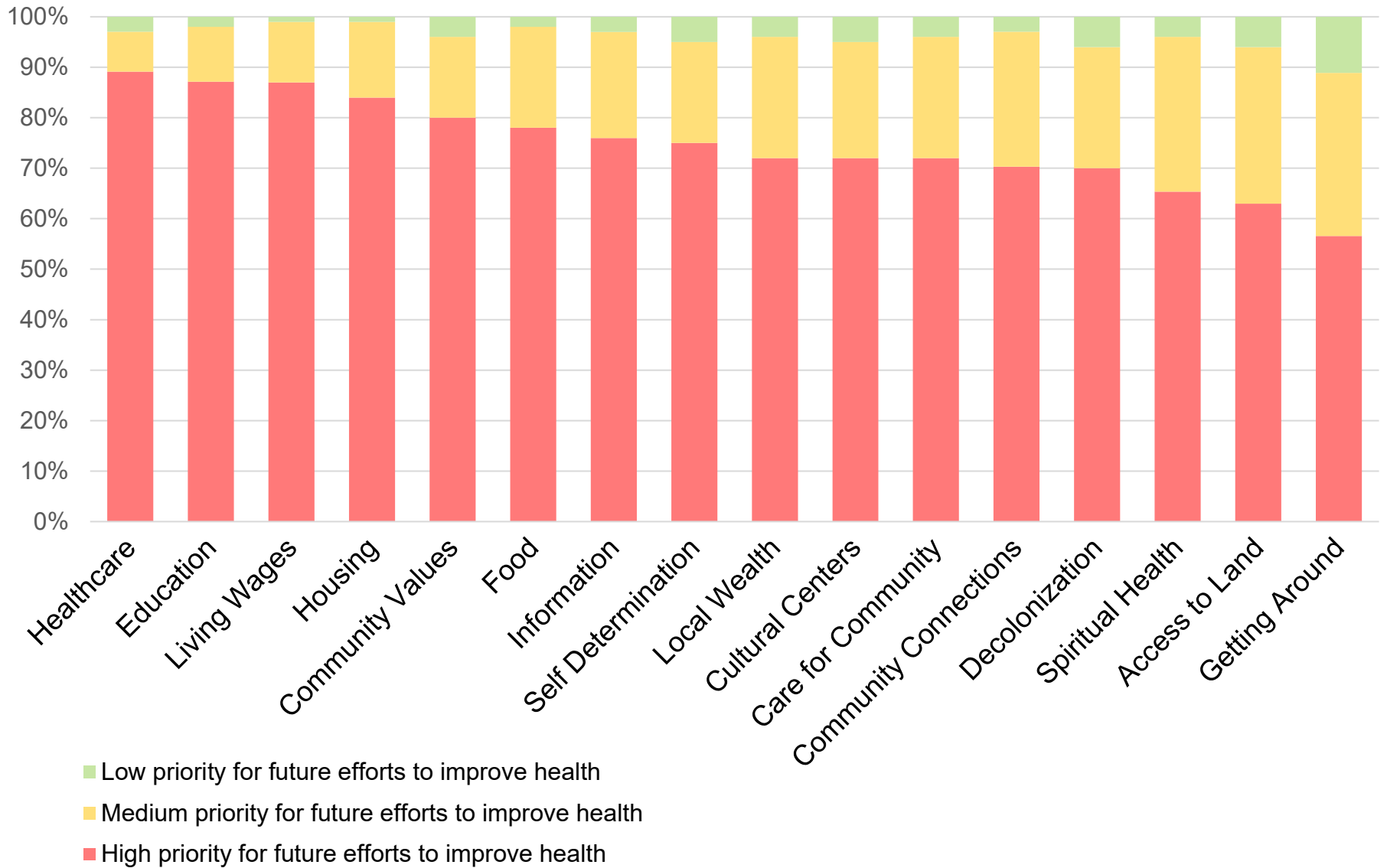|	Living Wages	Local Wealth	Education	Information
This is something I have, my family have, and my community have	5%	4%	21%	8%
This is something I have, my family have, and some of my community have	29%	19%	28%	16%
This is something I have and my family have, but not my community	19%	14%	11%	15%
This is something I have personally, but is not something that my family or community have	21%	11%	15%	17%
Myself, my family, and my community do not have this	26%	53%	25%	44%

"Healing" Community Health Factors

PI HEAL ASSESSMENT RESULTS

How important is each factor for future efforts to improve community health?

	Low priority for future efforts to improve health	Medium priority for future efforts to improve health	High priority for future efforts to improve health

Top 3 Priorities

⭐ **HEALTHCARE**

⭐ **HOUSING**

⭐ **EDUCATION**

PIDM LESSONS LEARNED & RECOMMENDATIONS

A larger budget is needed for equitable implementation and engagement

- Need enough technical skills and capacity to ensure there is robust project coordination, research/data expertise, and cultural advising

- Particularly with language support to take the survey, and technology to participate in workshops.

- Funding a review board or validation process for translated work

- Being able to engage multiple organizations that serve the same community. Even within a specific identity, the community is not a monolith.
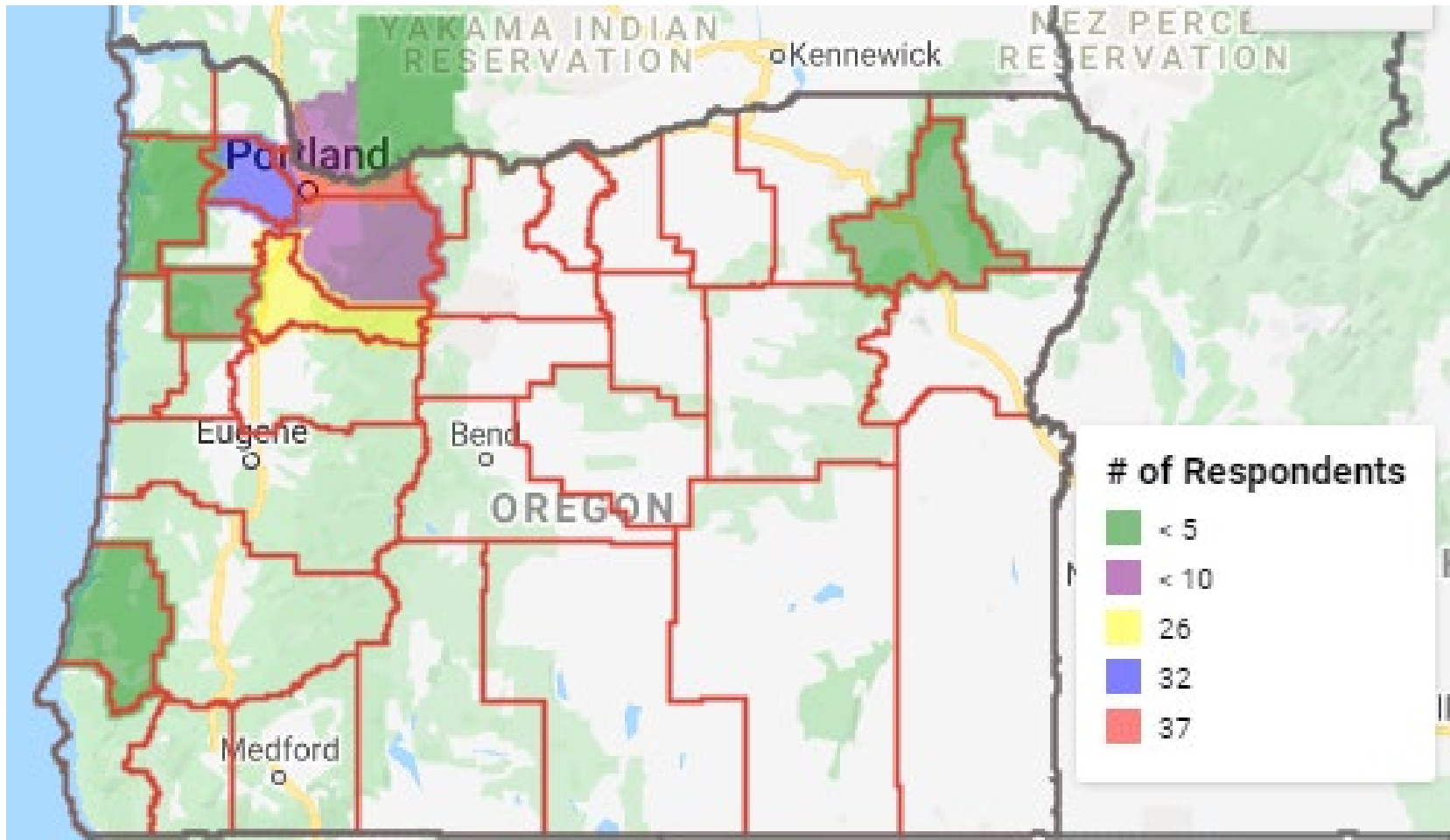
Improve upon the assessment so that it is digestible and accessible

- Host community<>community conversations on SOGI

- Hone in on writing the assessment in plain language

- Potentially add in a category on safety to measure experiences of discrimination and racism across each factor

- Provide more succint definitions or break up a community health factor into multiple factors

Pacific Islanders are ready to engage in research and do a deeper dive

- Consider having reports specific to particular Pacific Islander identities or by specific community health factors

- Need to integrate multi generational values of community and ensure there is a youth specific component to future research

- Still need to engage a larger number of Pacific Islanders across Oregon (see next slide)

PI HEAL Reach

THANK YOU!