

AGENDA

PUBLIC HEALTH ADVISORY BOARD

January 16, 2020, 2:00-5:00 pm

Portland State Office Building

800 NE Oregon St.

Conference Room 177

Portland, OR 97232

Zoom meeting: <https://zoom.us/j/730818593>

Meeting ID: 730 818 593

Conference call: +16699006833,,730818593#

Meeting objectives:

- Learn about Oregon's history of racism and policies that have adversely affected health and discuss how PHAB can ground its work in equity.
- Review PHAB funding principles and propose revisions for 2020.
- Discuss outcomes of the December 19 Accountability Metrics subcommittee meeting.
- Approve priorities for 2021-23 investment in public health modernization.

2:00-2:20 pm

Welcome and agenda review

- **ACTION:** Approve November meeting minutes
- Update on PHAB mini-retreat
- Confirm member participation in PHAB Incentives and Funding subcommittee
- Discuss opportunity to provide testimony to Health Plan Quality Metrics and Metrics and Scoring committees related to obesity and health equity measures

Rebecca Tiel,
PHAB Chair

2:20-2:55 pm

History of racism in Oregon

- Learn about how Oregon's history and policy have affected health equity in Oregon
- Discuss how to incorporate PHAB's reflections and learning into the board retreat in February

Wendy Morgan,
OHA staff

2:55-3:15 pm

PHAB funding principles

- Review PHAB funding principles adopted in 2018
- Discuss potential areas for revision or updates

Rebecca Tiel,
PHAB Chair

3:15-3:30 pm

Break

3:30-3:45 pm	Subcommittee updates <ul style="list-style-type: none"> Hear update from the Accountability Metrics subcommittee 	Teri Thalhofer, PHAB member
3:45-4:20 pm	2021-23 public health modernization funding priorities <ul style="list-style-type: none"> Discuss recommendations for funding priorities with additional investments in 2021-23. PHAB's recommendations will be used to develop the OHA Policy Option Package budget request for public health modernization ACTION: Vote to approve recommendations 	Rebecca Tiel, PHAB member Cara Biddlecom, OHA staff
4:20-4:35 pm	Public comment	Rebecca Tiel, PHAB Chair
4:35 pm	Adjourn	Rebecca Tiel, PHAB Chair

Public Health Advisory Board (PHAB)

DRAFT November 21, 2019

Meeting Minutes

Attendance:

Board members present: Dr. David Bangsberg, Akiko Saito, Dr. Jeanne Savage, Rebecca Tiel, Dr. Eli Schwarz, Kelle Little, Dr. Bob Dannenhoffer, Eva Rippeteau (by phone), Lillian Shirley (ex-officio), Teri Thalhofer (by phone), Tricia Mortell (by phone), Alejandro Queral, Muriel DeLaVergne-Brown (by phone), Carrie Brogoitti (by phone)

Board members absent: Dr. Jeff Luck, Dr. Paul Lewis, Dr. Dean Sidelinger

Oregon Health Authority (OHA) staff: Cara Biddlecom, Krasimir Karamfilov, Sara Beaudrault, Dr. Emilio DeBess, Jude Leahy, Samantha Byers, Dr. Ann Thomas

Members of the public: None.

Welcome and Agenda Review

Rebecca Tiel, PHAB Chair

Ms. Tiel welcomed the PHAB to the meeting. She introduced herself. The PHAB members introduced themselves.

- Approval of October 2019 Minutes

A quorum was present. Dr. Schwartz proposed a correction to the minutes on page 28 related to a statement he had made. Dr. Dannenhoffer moved for approval of the October 17, 2019, meeting minutes. Dr. Schwarz seconded the move. The PHAB approved the meeting minutes unanimously.

- Update on PHAB Mini-Retreat

Ms. Tiel informed the PHAB that the PHAB mini-retreat has been scheduled on February 19, 2019. It will take place between 12:00 p.m. and 4:00 p.m. in Portland. The standing PHAB meeting on February 20, 2020, will be cancelled.

Dr. Schwarz asked if he could leave the retreat early, due to engagements in the afternoon of February 19, 2019. Ms. Tiel answered that it was fine. Ms. Biddlecom added that as soon as Dr. Schwarz knew his time of departure, he should inform the PHAB, so that the agenda for the retreat was adjusted.



Public Health Advisory Board
Meeting Minutes – November 21, 2019

- December Meeting Schedule

Ms. Tiel stated that the PHAB meeting on December 19, 2019, would be held as a phone meeting, if the PHAB had to deal with committee business. If there is no committee business to attend to, the board meeting in December will be canceled.

Ms. Tiel acknowledged two PHAB members, Dr. Luck and Ms. Mortell, who would be coming off the board at the end of 2019. Commemorative plaques will be presented to Dr. Luck and Ms. Mortell. Dr. Luck was the first chair of the board's current version, taking the PHAB through many time-sensitive and important issues and legislative deliverables. Ms. Mortell represented the largest counties, which are a huge part of the state's public health system. Their service to the PHAB is appreciated.

Dr. Bangsberg remarked that the departure of Dr. Luck and Ms. Mortell was sad and that they would be missed.

- Volunteers for 2020 Public Health Accountability Metrics Report

Ms. Tiel explained that the Public Health Division (PHD) has been working on the 2020 Public Health Metrics Accountability Report. PHAB members are needed to work on the development of the report. The work could be done through the Accountability Metrics Subcommittee. Its current members are Dr. Schwarz, Dr. Savage, Ms. Thalhofer, Ms. DeLaVergne-Brown, and Ms. Rippeteau. The work could also be done through a small workgroup. Involved PHAB members will be committed from December 2019 through March 2020 and will work on the purpose, use, and relevance of the report, laying out the recommendations, reviewing 2020 data, identifying findings, and advising on the look and feel of the report.

Dr. Schwarz asked Ms. Beaudrault if she would be running those meetings as planned telephone meetings, as she had done so in the past. He was fine with continuing to be involved, if she still wanted him to be. The board erupted in laughter.

Ms. Tiel asked Ms. Beaudrault if she wanted new people to work on the report. Ms. Beaudrault answered that some PHAB members had a hard time making the meetings and it was difficult for the subcommittee to do their work last year. The request for volunteers is to make sure that people who are interested can be involved and the subcommittee can get the work done.

Ms. Rippeteau admitted that her schedule last year had been difficult. If others were interested, she would be happy to step aside and let somebody else take her spot, or she could continue and work to make the meetings.

Ms. Tiel volunteered to be a part of the subcommittee. She asked if the current Accountability Metrics Subcommittee members wanted to remain involved. All members agreed to stay involved.

Dr. Savage noted that it was nice not to add another meeting or another small group. She would like to participate and keep the work within the Accountability Metrics Subcommittee instead of having a subgroup of a subgroup.

Public Health Modernization Initiatives

Heather Kaisner (Deschutes County Public Health), Teri Thalhofer (North Central Public Health District), Dr. Emilio DeBess (OHA Staff)

Ms. Tiel pointed out that now that public health modernization funds have been allocated to LPHAs, the PHAB will be hearing more in-depth about these projects. These presentations should be grounded in the Public Health Modernization Manual (PHMM). The state, local, and state/local joint roles for assessment and epidemiology and communicable disease control have been described in the PHMM. She introduced the first presentation and invited the presenters to introduce themselves.

Ms. Kaisner gave credit to Tri-County epidemiologist Dr. Jennifer Faith, who created the presentation, but could not be present today. She provided some background on the needs of the Tri-County partnership (i.e., Jefferson, Crook, and Deschutes counties). A key focus of the partnership is communicable disease epidemiology. Deschutes County has had an epidemiologist for a few years, with the position focusing on behavioral health and public health. A need was felt all around Central Oregon to develop a position that would be focused on communicable disease epidemiology, as well as on environmental health and emerging public health threats. The partnership made that a priority when going after the original funding for modernization.

Ms. Kaisner showed the primary roles of the partnership's communicable disease epidemiologist. Dr. Faith has expanded her role to include enhanced surveillance and risk communication to providers, partners, and the public, as well as a focus on internal data quality and using the ORPHEUS reports to drive quality improvement with CD staff in each of the three counties. Dr. Faith provides ad hoc data presentations, creates content for the 2019 Central Oregon Regional Health Assessment, and provides surge capacity for outbreak response and emerging threats.

Ms. Kaisner showed an example of a flu surveillance report created by Dr. Faith. The data in the colorful report was presented in both tabular and graphic forms. The flu report aggregates Central Oregon data to help healthcare providers in the tri-county area. Although the reports initially targeted healthcare providers, they are now posted online for public viewing and media use. Another report Dr. Faith creates is a quarterly communicable disease (CD) report with

topics that change every quarter. An annual summary of CD cases/rates is prepared during the first quarter of every year.

Ms. Kaisner shared that Dr. Faith supports CD staff with local data and cross-jurisdictional communication. Dr. Faith creates and disseminates an internal QI (Quality Improvement) data report, using the Orpheus system, which is used for reporting and tracking CD cases. These reports are created on a monthly basis for Deschutes County and on a quarterly basis for Crook County and Jefferson County. The CD staff from the three county health departments and the Confederated Tribes of Warm Springs convene weekly for a surveillance check-in call to share information and discuss cases and emerging threats.

Ms. Tiel asked whether the counties were asking the state for the data to compile these reports or the counties shared the data with each other.

Ms. Kaisner answered that the counties are sharing data among each other and Dr. Faith could view the data for the three counties in Orpheus.

Ms. DeLaVergne-Brown clarified that the public health administrator from each county signs the security documents with Orpheus once a year, which allows the addition of other counties. The counties also sign Memoranda of Understanding (MOUs) among each other. It is truly a tri-county partnership.

Ms. Kaisner added that Dr. Faith also provided local data to an Infection Prevention Nurse for use in infection prevention trainings. In addition, Dr. Faith created the demographic, immunizations, CD, and STD sections in the 2019 Central Oregon Regional Health Assessment. She also participated in the Regional Health Assessment (RHA) Steering Committee. Dr. Faith's ad hoc activities include ad hoc reports and presentations, after-action outbreak reports and meetings with facilities for each outbreak in the tri-county area, and surge capacity when needed (e.g., measles exposure).

Dr. Schwarz asked how the data was transmitted between providers and the LPHAs.

Ms. Kaisner explained that Orpheus was a statewide database used by state labs and healthcare providers to report information. The county health departments have access to the database. Every disease that is reportable is entered into Orpheus. The LPHAs respond locally based on those data. All data are in the statewide system.

Ms. DeLaVergne-Brown added that once a county got a case, it was the LPHA's responsibility at the local level to interview the case, or talk with the physician, and put that information into Orpheus. That's how it happens in real time.

Ms. Thalsofer introduced herself as the director of the North Central Public Health District (NCPHD), which is the fiscal agent for the Eastern Oregon Modernization Collaborative (EOMC). The EOMC partnership includes 11 LPHAs, 13 counties, the Eastern Oregon Coordinated Care Organization, and Mid-Columbia Health Equity Advocates. The partnership serves 240,850 Oregon residents. The partnership covers one third of the state, but nowhere near that portion of the residents in the state.

Ms. Thalsofer noted that the staff working at the EOMC included a regional epidemiologist (Ms. Lamendola-Gilliam) and a regional systems liaison (Ms. Zimmerman). These two staff were trained to be able to add capacity for communicable disease reporting, response, analysis, and prevention. Many of the LPHAs in the EOMC don't have anyone who is dedicated to do communicable disease work. For many EOMC members, CD work is assigned in addition to their full-time work. For example, a home visiting nurse could do the reproductive health program. Oftentimes, the administrator could do the CD work as it comes in. In the past, whenever there was an outbreak or an unusual disease in a jurisdiction, all work stopped. The collaborative staff provides Orpheus backup and surge capacity, has recorded over 150 hours of case management activities, provides one-on-one training to local staff in use of DUDE, a system the partnership uses for outbreak work, and Orpheus data entry and case management, and provides opportunity for regional partners to be "off the grid" to enhance wellness.

Ms. Thalsofer stated that the regional epidemiologist, Ms. Lamendola-Gilliam, developed policy for use of email, texting and social networking sites as a means to contact CD/STI cases and improve partner notification. She increased capacity to respond to West Nile virus in the region and facilitated testing to confirmation for a case. She facilitated and participated in Passport-to-Partner services training which enhanced STI response. Because this training is offered once a year by state partners in the metro area, it proved very difficult for Eastern Oregon partners to participate due to limited number of participants. Providing this training in the region allowed all Eastern Oregon partners to send at least one staff member, which increased comfort for partner interviews when talking to people about STI contact.

Ms. Thalsofer noted that in terms of analysis capacity, Ms. Lamendola-Gilliam produced monthly CD/STI reporting by county and by region. This has been very helpful because, for most staff, part of the data has been suppressed. She provided annual reports describing the burden of disease by county with historical comparisons and provided data analysis as requested by LPHAs and tribal partners. She worked hard to develop a good relationship with Yellow Hawk tribal clinic on the Confederated Tribes of Umatilla reservation. She also provided data to inform the Columbia Gorge CCO Community Health Assessment that serves Wasco County and Hood River County.

Ms. Thalsofer added that the staff has added outreach capacity by developing a fact sheet regarding the increase of gonorrhea/chlamydia/syphilis infections in Eastern Oregon that included treatment recommendations and the link to increased risk for HIV infection and burden of disease based on race and ethnicity. The fact sheet was mailed to every provider in the region during the STI awareness month. Feedback from residents showed that they didn't know how high the rates had climbed. Ms. Lamendola-Gilliam distributed toolkits for use by long-term care facilities that provided guidelines for outbreak response to influenza and norovirus. She provided capacity to either visit those facilities, if jurisdictions would prefer, or she would coach them in sharing the toolkit with their partners. She also provided data analysis to LPHAs and partners for use in PSAs (Public Service Announcements) and outreach efforts.

Ms. Thalsofer pointed out that neither Ms. Lamendola-Gilliam nor Ms. Zimmerman worked out of the North Central Public Health's office in The Dalles. Ms. Zimmerman works out of Pendleton and drives around the region as needed. Ms. Lamendola-Gilliam works out of Portland and drives to the region as necessary. It's interesting how the North Central Public Health District has gained capacity through the use of technology.

Dr. Savage asked if the epidemiologist of the Tri-County Central Oregon partnership was the same epidemiologist for the NCPHD.

Ms. Thalsofer answered that each partnership has hired its own epidemiologist. There is a little crossover work between the partnerships because the majority of the Warm Spring Reservation is in Wasco County, but the majority of the tribe population is in Jefferson County.

Dr. Savage asked if the modernization funding used for this work was from the last biennium or from the new biennium.

Ms. Thalsofer answered that it was both for the NCPHD. This project was created during the last biennium. The funding for the regional project in the 2019-2021 biennium is less than the funding in the last biennium, but each county in the district used part of their local funding to continue to support the regional effort.

Ms. Kaisner added that it was similar for the Tri-County Central Oregon partnership. The funding was from the last biennium, but the work continued into this biennium with the regional funding, which was less for infection prevention.

Mr. Queral asked Ms. Thalsofer about the increased capacity to response to the norovirus in the region and whether that was by virtue of having an epidemiologist who could focus on that disease or whether it was a process that was set. He asked why she highlighted the West Nile virus as increased response capacity and if each communicable disease required the development of capacity specific to that disease response.

Ms. Thalhoffer answered that when the presumptive case happened, it was new to the country it was happening in and it took all their time. Ms. Lamendola-Gilliam was able to step in, take over the work, and allow the communicable disease staff in that county to pay attention to everything, so she could focus on the West Nile. She helped get the testing done and transported for confirmation and worked with the state. That was the focus of her work at that point in time without the distraction of the regular CD workload that was coming in.

Dr. DeBess explained that when there was a West Nile case, there were many implications. One was the human case, but also there was the veterinary component and the mosquito component. These components create a ton of work. The counties have done an amazing job in putting out press releases, so the public and the veterinary community could be informed. He praised the staff for stepping up and doing the work.

Ms. Thalhoffer added that the NCPHD was putting some money aside in the new biennium from a local project to think about how to continue these efforts if regional funding didn't happen in the next biennium and all the money comes out in the LPHA funding formula. It's one thing when there is money to be shared among groups; it's different when the money comes to each county.

Ms. Tiel invited Dr. DeBess to introduce himself to the PHAB. Dr. DeBess introduced himself as the state veterinarian for Oregon. He is a veterinarian by training and holds a Master's in Public Health degree. His job involves working on communicable diseases, food-borne illnesses, and diseases borne by ticks, mosquitoes, and other animals. Although his job is wide in scope, he gets a lot of support from the local health departments. He praised Ms. Kaisner and Ms. Thalhoffer for the great work they have been doing in their partnerships.

Dr. DeBess explained that the job of OHA's Public Health Division was to promote and encourage healthy behaviors for Oregonians to protect themselves against diseases and potential injury. Beyond that, it is about working with communities to educate them and provide them with the base that they need so that they can be a healthier population.

Dr. DeBess stated that communicable disease prevention and control was a cooperative effort of the larger community and the local health departments. The effort includes communicating information that has been obtained and analyzed to understand what populations have been affected and how to prevent disease. The focus of the work in communicable disease is not only on surveillance, but also on prevention. Communicable disease prevention is the key and is a foundational program of modernization.

Dr. DeBess clarified that modernized disease response included two components: community partnership and assessment and epidemiology. The work is viewed through a health equity lens. The community partnership work involves supporting LPHAs, medical providers, and

infection control nurses to identify and stop disease transmission. It involves creating partnerships to develop new systems to track patient clinical and risk information, as well as educating and providing training to protect patients and communities. The assessment and epidemiology work entails maintaining informatics systems to track cases and identify outbreaks. It also involves identifying risk factors for disease transmission.

Dr. DeBess remarked that developing state and local public health capacity to respond to emerging threats depends on information. It all starts with a sick patient. For example, a case of E.coli connected to a particular supermarket selling ground beef means that there is a group of individuals who became ill, and had similar symptoms to the one case, but didn't go to the doctor. This is important because it informs what needs to be targeted and dealt with. Once a patient visits a medical provider, the provider collects a sample and performs a test. That information goes to the county health department. The county health departments receive the information electronically and do an investigation. There is an electronic system that connects the local labs with the Orpheus database. The information is in the form of a laboratory report that says that an individual has been diagnosed with E.coli, or Hepatitis A, or the measles. This information is transmitted daily and in real time to the county health departments.

Dr. DeBess explained that the investigation involves talking to the individual with E.coli and recording their experience. The Orpheus database, which can be accessed from every computer at every county health department, has a set of clinical questions and a set of risk questions that are asked of the patient. The questions could cover multiple pathogens, such as E.coli and salmonella. When all answers have been collected and entered by the county health departments into the system, the information shows up in the OHA system in real time. There is a communication system within Orpheus that allows OHA staff to send a note to the county that says, for example, "Could you ask the patient when they went to the supermarket?" That message pops up on the screen, and if a local public health staff member happens to be with the patient, they ask that question.

Dr. DeBess noted that the electronic communication system had been modernized to the point where real-time interactions were possible, which was above and beyond anything anybody could have thought. In addition, OHA works with LPHAs to improve education and outreach, with the education component being done on the local level. The modernization work also includes modernizing laboratory identification to detect outbreaks. For example, instead of talking in general terms about salmonella, it is now possible to do whole genome sequencing (WGS) to identify which type of salmonella it is. WGS involves looking at the genes in the salmonella bacteria. As most states in the U.S. can do this type of work, salmonella bacteria can be compared across states. As a result, a patient in California could be linked to a patient in Portland, only to discover that they ate at the same restaurant in Portland in recent past. Such connections explain why people are getting sick and what were the risk factors involved.

Ms. Shirley shared that, a few years ago, whole genome sequencing equipment was not known to public health laboratories across the nation, but the PHD administrators decided to invest in it. Some of the changes in the healthcare industry made it difficult on the public health side, because people were sending things to commercial labs. The health insurance was no longer paying for these tests and the hospitals and labs were not doing the type of public health analysis OHA needed to look at the protection factor for large scale outbreaks.

Dr. DeBess stated that one of the tools used to link laboratory and epidemiology data was the DUDE system which housed the Orpheus database and an outbreak database. When two or more cases of a particular illness have been reported, an outbreak number is created. The outbreak report contains information such as what caused the outbreak, how many people have been affected by it, what carried the pathogen (e.g., ground beef), and the factors involved in the investigation. In this way, the CDC gets all the information needed to understand why outbreaks happen.

Dr. DeBess pointed out that OHA supported LPHAs with real-time training and surge capacity. It's a necessary activity within the process of modernizing our view of public health and communicable disease. For example, if a county employee left a position in communicable disease and a new employee started the job without a lot of knowledge of what was going on, OHA provides real-time distance training through a surge capacity epidemiologist. It is active training that happens on all levels, not only on the level of the county health department.

Dr. DeBess explained the importance of increasing surge capacity, both for OHA and LPHAs, not only to get their work done, but also help with any other conditions that may take a lot of time, such as the West Nile virus, or measles, or a food-borne illness. OHA ensures that LPHAs have everything they need to move forward. There are a few counties, however, that have had ongoing difficulties in meeting their needs for case investigations. The surge capacity, as well as the teams led by Ms. Kaisner and Ms. Thalsofer, have improved the ability to do case investigations. By providing assistance, OHA learns what is going on in areas of the state that don't have the ability to do their investigation. For example, when Lyme disease is discussed, the typical affected areas are west of the Cascades. Now cases have been identified east of the Cascades. This shows OHA staff that there is an expansion of vector-borne disease due to climate change that could potentially be leading to an expansion of illnesses in different areas in the state of Oregon. He presented examples with Colorado tick fever, with Oregon reporting four cases in one month to CDC, and with measles, with Oregon reporting four cases in 2019.

Dr. Dannenhoffer remarked that he was impressed by the presented work. He thought it interesting that the three presentations talked about surge capacity. The Douglas County region is doing surge capacity work as well. The counties work together, but there is much overlap between the regional players.

Dr. Schwarz echoed Dr. Dannenhoffer's praise about the presented work. He noted that while Dr. DeBess talked about food-borne diseases and other infections, the first two presentations indicated the sharp increase in STDs. He asked if the improved surveillance capacities can also be used for epidemiological evaluation of preventive activities, and if this improved knowledge of things in real time can be used for interventions and the surveillance system can then show the effect of the interventions.

Dr. DeBess answered that it all started in the laboratory, with the cases being diagnosed in real time and the information being given to the county health departments. Beyond that, there are multiple levels: contacting the patients, performing antibiotic susceptibility, ensuring that the individual is treated correctly based on the available information, so that more prevention can be done. The idea is to include all those layers and then provide information about prevention. Prevention could be as simple as indicating that a particular antibiotic doesn't work anymore. When a patient has resistance to an antibiotic, he/she is switched over to another antibiotic to protect the individual and all the contacts around the individual.

Ms. Kaisner added that with STD cases, the LPHA not only collects the lab reports, but a communicable disease nurse conducts an intensive interview with each case. Then an epidemiologist combs through the data in Orpheus ask questions, such as "Are there connections here based on demographic or geographic information? Do we need to be targeting the reach-out efforts and doing very targeted approaches in different regions, or different areas, or with different populations, or age groups?" All that data is collected when a case investigation is done. Having a dedicated epidemiologist to look at those data has helped the partnership create more targeted interventions.

Dr. Savage asked Ms. Kaisner if she could correlate the rise in STIs with the use of the LARC (long-acting reversible contraception), which has become popular. Although chlamydia infections are on the decline, if people are using more LARCs and not the barrier method, are they increasing their infection risk?

Ms. Kaisner answered that the CDC recently put out a [report](#) on the rise of STDs in the county and indicated a few reasons for that, including the use of LARCs.

Ms. Thalsofer remarked NCPHC distributed condom boxes across Umatilla County to help prevent the spreading of STDs. The staff at the Yellow Hawk tribal clinic reported that many of the women on the reservation preferred condoms as their birth control method. The women were very happy to be able to access condoms in the community.

Ms. Saito praised the positive approach of the modernized system. With issues such as Ebola, Zika virus, and vaping, it makes a difference to have a flexible modernized system that could take on new surveillance systems. Both Ebola and vaping were huge lifts. The outcomes

wouldn't have been so positive, if effort was not put into modernizing at the local, tribal, and state levels for epidemiological systems.

Dr. Bangsberg asked if the LPHAs did contact tracing and partner notifications for HIV.

Ms. Kaisner answered that they did.

Ms. Tiel thanked the presenters. She echoed Ms. Saito's comments and introduced the next presentation.

Tribal Public Health Modernization

Kelle Little

Ms. Little thanked Ms. Danna Drum on OHA's Policy and Partnership team for putting together the presentation slides, spearheading the tribal work at the OHA level, being an advocate for tribes, and ensuring that tribal nations had access to modernization funding to improve their public health systems and integrate them with LPHAs. She also thanked the partners involved in the tribal public health modernization work.

Ms. Little stated that funding was legislated in 2017 for LPHAs to begin public health modernization, while tribes were excluded. There was no mandate to participate in assessment, planning, and implementation of PHM (Public Health Modernization) due to respect for tribal sovereignty. There were also no funds designated to support tribal PHM assessment. In 2016, Ms. Drum had several conversations with tribal representatives who had expressed interest in PHM and improving and implementing the tribal systems. One of the most important things is that tribal culture is different when it comes to public health. There's no funding for public health within tribal organizations, and if there is, it is very small. It all depends on the tribe's priorities and ability to raise additional funding and partner with local public health partners.

Ms. Little noted that three tribes expressed interest in pursuing PHM efforts and work. The tribes worked with Dr. Victoria Warren-Mears at the Northwest Tribal Epidemiology Center and Ms. Drum on the development of a PHM assessment that was tribal-specific. It was based on an assessment that was done by Washington State and Berk Consulting for tribes in Washington state. Because there was not financial support from OHA, the tribes took it upon themselves to do the work. The Northwest Portland Area Indian Health Board supported the work and did the data analysis. The work took place from August 2016 through July 2017.

Ms. Little remarked that while there was no PHM funding for tribes in the 2017-2019 biennium, conversations began in 2019 with Ms. Drum to develop different funding models as to what it would look like if there were funding for tribes at different levels. The funding models were forwarded to various tribal partners. It's not that other tribes or urban Indian organizations are

not interested in this work – it's about priorities and capacity and being able to get the work done. In 2019, the legislative allocation for PHM included funding to support tribal PHM work. Because there was funding now, more intensive work began in summer 2019. A tribal workgroup with representatives from tribal health directors and NPAIHB developed scope of work and funding proposal with OHA in fall of 2019. The proposals were presented to the tribes and, at the end of October, the tribes and tribal organizations approved the tribal PHM.

Ms. Little explained that six tribes have not completed the PHM assessment and they would be doing that. The tribes that have completed the assessment, which is now two years old, will update it and begin work on developing an implementation workplan. Tribes and NARA (Native American Rehabilitation Association) will determine how they want to engage in Oregon's modernized public health system and whether they will participate in regional partnerships with LPHAs in their service areas.

Ms. Little reviewed the scope of work for the tribes, NARA, and NPAIHB. The Northwest Tribal Epidemiology Center will be doing the learning collaborative for the tribes.

Dr. Savage asked Ms. Little if she could provide more information about the Northwest Tribal Epidemiology Center.

Ms. Little responded that the Northwest Tribal Epidemiology Center was housed within the Northwest Portland Area Indian Health Board. Tribal epidemiology centers are funded through the Indian Health Service (HIS) across the various regions. The Northwest was the first to have a tribal epidemiology center and it is one of the most robust centers in the country.

Ms. Little highlighted the deliverables in the 2019-2021 biennium. Each participating tribe/NARA will complete PHM assessment by September 1, 2020, and an action plan by February 1, 2021. The tribes/NARA that are implementing one or more action plan priorities will submit a tribal program plan to OHA, describing activities to be completed by June 30, 2021.

Ms. Little pointed out that the reporting requirements included aggregated and deidentified assessment and action plan report across all participating tribes/NARA. The assessment will describe Indian country in Oregon, as well as urban Indian challenges. The requirements also include aggregated progress reports in June 2020, December 2020, and June 2021, describing accomplishments, challenges, lessons learned, and recommendations for future work. Individual tribe/NARA quarterly progress reports on accomplishments, challenges, and deliverables will also be submitted.

Ms. Little stated that the direct funding to the nine tribes/NARA was \$833,000 for the biennium, split evenly across participating tribes/NARA. There's no guarantee that all tribes will participate. The average funding per tribe per year is \$41,500. It would be challenging for many

tribes to recruit, train, and hire staff for this type of work. If the funding is discontinued, the tribes will have to figure out how to continue the work, which would be challenging, especially for remote tribes. Tribes could partner with other tribes or combine the PHM funding with other similar types of funding to create positions such as public health nurse, public health manager, and public health emergency preparedness, among others. There will be a contract with NPAIHB, totaling to \$443,982, to provide technical assistance and training. The funding sources include PHM 2019-2021 legislative approved budget and Preventive Health & Health Services Block Grant (federal).

Ms. Little remarked that the tribes/NARA were reviewing the program element and would notify OHA if they were opting in by November 27, 2019. The program element and funding will be included in the December 2019 Tribal Public Health Intergovernmental Agreement Amendment. OHA's public health division is developing agreements for training and technical assistance with NPAIHB and each individual tribe. Each tribe has unique contracting requirements as a sovereign nation.

Dr. Bangsberg shared that the Oregon Health Policy Board (OHPB) was required to do one meeting outside of Portland every year. This year, OHPB had four out-of-town meetings. One of the visits was with the Federated Tribes of Umatilla, where OHPB did a deep dive. The visit was impressive as it showcased the integration with CCOs and public health. It was one of the stellar examples in Oregon. The OHPB also visited a tribe in Coos Bay that had also done some great work. It is worth for PHAB to consider making a field trip for one of its meetings, because one gets a different perspective as to what the challenges and the resources are and also appreciation for the great work that has been done.

Dr. Schwarz asked if Ms. Little used the model from the Public Health Needs Assessment, which was the basis for the modernization report. He asked if the language was the same as with the bigger systems.

Ms. Little answered that the assessment that was developed for Oregon was based upon the PHM model. It was first developed to be used with tribes in Washington state by the Department of Health in consultation with tribes in Washington. It was adapted. It is based upon the PHM model and foundational capabilities. It is very similar to the LPHA document, but it is specific for tribes in recognition of sovereignty.

Dr. Schwarz asked whether the tribes were as bad off as the counties in the assessment.

Ms. Little answered that the tribes were much worse off. Most tribes, in general, rely on counties to do the heavy lifting for public health work. No tribes have communicable disease or environmental health investigative capabilities. The NPAIHB is assuming environmental health responsibilities from the Indian Health Service and will be working with tribes. Tribes have different sizes and most tribes invest significant amount of their funding that is

discretionary in some capacity into doing direct health care, because of the significant health disparity. Public health is often at the lower end of the tier.

Ms. Shirley noted that OHA staff were very excited about the PHM funding to tribes. The tribes were not factored in in the first round of funding. The new funding is important for the ongoing work and for the future. As per the capacity issue, which was also discussed by Ms. Thalhoffer, she asked if Ms. Little had thought about academic partnerships for some of the assessment work. If Ms. Little wrote a proposal in which she described what kind of academic partnerships could be helpful, the PHAB or OHA could make that happen.

Ms. Little answered that academic partnerships had been discussed as opportunities, as now tribes relied heavily on the Northwest Tribal Epidemiology Center to support the assessments because that has been its business historically with tribes and the center has standing relationships. If there are opportunities to recruit academia to support some of this work, the tribal representatives will have to explore what that would look like. She represents the Coquille Indian Tribe and tribal interests in Oregon and can't speak for other tribes.

Dr. Schwarz mentioned that, two weeks ago, he gave a class to one of OHSU's programs that recruited Native Americans into OHSU's medical school. The dental school at OHSU has the same shortage of Native American students. It would be smart to build on the existing program than try to make something else. It probably has to start at a very early stage. Some of the students might end up in the OHSU-PSU School of Public Health and come out with an epidemiology degree. It's a long-term prospect. The class he taught had 10 students who were very interested in health and had great backgrounds.

Ms. Saito remarked that this last year OHA's Emergency Preparedness program worked with two tribes in Oregon and Barbara Hershey, a tribal law expert at the University of Pittsburgh. The program did a tabletop exercise with OHA's general council around isolation and quarantine. Those are good project and there are some national projects that are going around. It would be great for the tribes and OHA to think about how they might engage them with the modernization work.

Dr. Schwarz asked if the tribal PHM updates could be added to the updates of other modernization activities, instead of having separate update for tribal PHM.

Ms. Tiel answered that it could be done. She asked Ms. Little if her partners would be willing to come to a PHAB meeting and present.

Ms. Little answered that her partners would love to come and present to the PHAB. The NPAIHB will be assisting with gathering of information. The NPAIHB will be hiring two public health positions to support some of this work and some of the public health activities.

Ms. Biddlecom thanked Ms. Little for her presentation. She noted that the last two presentations were about how the \$15 million for PHM was being utilized. Based on some feedback that Ms. Tricia Mortell had provided to OHA after the last round of funding in the last biennium, today's presentations tried to tie the topic together. She asked the PHAB members for their feedback on focusing future conversations on specific bodies of work that were shared across the governmental public health system.

Ms. Mortell stated that she appreciated the PHAB's consideration of her feedback. One of the goals of public health modernization is the systems approach, not the local, state, or tribal singular approach.

Dr. Bangsberg remarked that this gave him a much better understanding of what public health modernization was. It is practice, implemented. It's not reading OHA's beautiful report, which is top-notch, but it's theory. The presentations were about practice. It is nice to see PHM happening.

Ms. Little noted that she would like to see the themes for the various topics. It helps articulate how the work occurs and how it works in the communities, and that becomes translatable.

Dr. Bangsberg added that what the PHAB saw in the presentations were investments that led to best practices. It's not identifying gaps in the state. It's important for the PHAB to figure out a way to find the holes. OHA is funding the best programs that do the best work through a competitive process, but it's not homogeneous across the state. There must be holes. What is the mechanism for the PHAB to detect those holes?

Ms. Thalsofer commented that as the NCPHD staff develop the funding workplans, both for the regional and the local work, they are using the knowledge they have from where their gaps were in their assessment. It should be noted that Deschutes, Crook, and Jefferson counties didn't do exactly the same things as some modernization collaboratives did. When the NCPHD staff are filling out the workplans, they are using the assessment data NCPHD has. She shared that, unlike Ms. Tiel, she had the modernization manual opened all the time, looking at what the local roles are and where NCPHD is doing that work. It may be a way to tie that back in, but that's how NCPHD is proposing the work it does to the state.

Ms. DeLaVergne-Brown agreed with Ms. Thalsofer. Crook County used that assessment and is in the process now of taking a look at it again, looking for gaps. When the LPHA developed the workplan, they looked at it, but now they will do an assessment of the whole thing.

Ms. Mortell appreciated Dr. Bangsberg's reminder that this was a very small sliver of the gap LPHAs have identified. Although everybody is doing good work, LPHAs need to track all the places where they are not able to build new systems and move forward.

Dr. Savage shared that in terms of collaborations between OHA, LPHAs, and tribes, it would be nice to have similar metrics across jurisdictions, and each entity to put in prevention and treatment strategies that might be similar, and measure them in a similar way to find out how they work across populations. Applying this model to tribal areas and LPHA areas would be fascinating, rather than having different metrics across jurisdictions, with one working here and one working there. Having consistency across jurisdictions would be great.

Dr. Schwarz stated that in a month a half, CCO 2.0 would begin. One of the features of CCO 2.0 is a higher focus on social determinants of health and collaboration between public health organizations and CCOs. The PHAB should continue to be interested in this collaboration because it is about the leveraging of resources. While public health didn't have resources in the past, CCOs now have resources of their own and we are seeing how these resources are being utilized. On the other side, there are CCOs that can use flexible health dollars for public health work. The PHAB needs to figure out how to monitor what is happening and how these collaborations continue to develop.

Dr. Bangsberg remarked that one thing he had been advocating for at the OHPB was a CCO-wide summit to see how the CCOs were investing in social determinants of health and compare notes across CCOs to determine best practices. Right now, the policy is written a little ambiguously. It says that a CCO has to invest something in social determinants of health – *something* – and involve its community advisory council, its community health assessment, its community health improvement plan, and its LPHA in some unspecified way. Freedom is good, but we want more specificity about the local public health. Let's create a sense of accountability and best practices through the CCO-wide summit. There is some enthusiasm for that. It would be great to have the PHAB at that CCO summit to ask the public health questions, such as "Is that really a social determinant of health?"

Ms. Tiel thanked the PHAB members for their feedback. In the coming year, the PHAB will think about how to structure this type of information sharing – maybe similar to today's presentations, maybe through looking at the PHM manual, or looking at other ways to have these presentations be in partnership, rather than presentations on individual workplans.

Ms. Rippeteau clarified that she would like to stay on the metrics subcommittee. She is also staying on the PHAB.

Ms. Tiel thanked Ms. Rippeteau for her clarification.

Ms. Mortell thanked the PHAB members and stated that it had been an honor and a pleasure to work with them as the large county representative to the PHAB. It's always important to look for opportunities for others to provide input and leadership. The large county community group and CLHO (Coalition of Local Health Officials) have endorsed Rachael Banks, Multnomah County's Director of Public Health, to move forward her application as the representative for

the large county local public health jurisdictions in Oregon. She will remain in her role as the public health administrator in Washington County.

Eastern Oregon Hepatitis C Prevention Initiative

Jude Leahy (OHA Staff), Samantha Byers (OHA Staff), Dr. Ann Thomas (OHA Staff)

Ms. Leahy introduced herself as the adult bio-Hepatitis prevention coordinator for OHA in the acute and communicable disease prevention program.

Ms. Byers introduced herself as the opioid rapid response project coordinator for the Health Systems Division.

Dr. Thomas introduced herself as a public health physician in the acute and communicable disease prevention program.

Ms. Leahy noted that the presentation would be about a project her team was doing in Eastern Oregon, in Klamath County, using a syndemic approach for Hepatitis C prevention. She read a quote by Alan Muskat that appeared in an [article](#) on The Fix blog: “If we only look at addiction on an individual level, we are missing the forest for the trees. If you don’t heal the forest, it gets harder and harder to heal each tree.” She added that her team is working on both the forest and the trees. The work aligns with the public health advisory’s guiding principles, values, and strategies. The interventions are multi-level and cross-sectorial and they involve academic researchers, hospitals, public health organizations, and community-based organizations. The team is leveraging existing opportunities to plan, implement, and share their learnings and, hopefully, improve systems, communities, and the lives of individuals affected by substance use disorder. The team hopes that the presented interventions build evidence for no-barrier, harm reduction, peer-intervention that would get people who are currently using drugs into medical care, MAT (medication-assisted treatment), and Hepatitis C treatment in Oregon.

Ms. Leahy presented a conceptual model that described the relationships between substance abuse, overdose, STIs, and associated conditions and IDU-related infections. When combined, these epidemics make a syndemic (from Greek *syn* “together”). Syndemics are two or more interacting and synergistic epidemics that share a common cause, consequence, and needed response. They arise from conditions of health inequity and harmful social conditions. The base of the syndemic in Oregon is substance use, substance misuse, and disordered use. The inputs are substances that have misuse potential (i.e., they are legal), as well as those that are not legal. Some of the outcomes that happen are neonatal abstinence syndrome and fetal alcohol spectrum disorder. Other outcomes include morbidity and mortality and suicidality. Suicide is the leading cause of death for people with substance use disorder. Substance use, misuse, and disordered use lead to sexually transmitted infections (STIs). Injection drug use leads to infections in skin and soft tissue.

Ms. Leahy explained that underpinning this model were root social and economic issues that created health inequities and the harmful social conditions, such as adverse childhood experiences and toxic stress that affect access to and availability of resources to prevent recovering respond. The issues influence the existence of protective factors that shape individual resilience and health.

Dr. Thomas presented visual representations of the geographical distribution of disease in Oregon in the last few years. For years, OHA would look at frequencies of hepatitis C in Oregon and Multnomah County had the highest number of cases. It wasn't until OHA started looking at the data and calculating rates that it became clear that substance abuse was a big problem in rural areas. For opioid overdose hospitalizations, there are many cases in Multnomah County, but the rest of the counties in the metro area are not in the top 10. The results are similarly overwhelming for methamphetamine/psychostimulant hospitalizations in rural areas.

Dr. Thomas stated that injection drug use related hospitalizations by infection have also risen over the last ten years, especially *bacteremia sepsis* and *skin/soft tissue infections*. The distribution of new cases of HIV and Hepatitis C in Oregon between 2012 and 2016 is concentrated in the metro counties and down the I-5 corridor. For chronic hepatitis C cases, the data reflects only cases in people below 30 years of age. Due to lack of resources, LPHAs cannot interview all new 5000-6000 cases every year. The rates for people under 30 are a marker for recent infections that are most likely acquired through injection drug use. The increase in hepatitis C has gone up 30% over the last five years. In the same time period, the rate of HIV diagnoses has gone down, but when broken up to Portland area versus the rest of the state, the HIV rate is increasing in the rest of the state.

Dr. Thomas provided an overview of the HOPE study. The goal of the study was to increase outreach to people who inject in rural settings and offer them a rapid test for HIV, Hepatitis C, and syphilis. A peer-based model was used. Individuals were accessed through HIV Alliance and needle exchanges in Roseburg, Cottage Grove, and southern Lane County. Personal data were collected quantitatively via a survey and a small group of individuals participated in in-depth qualitative interviews. Study participants worked with their peers to drive them to the local food pantry, or help them get on the Oregon Health Plan, among other activities.

Dr. Thomas pointed out that this was a multi-level intervention. At the individual level, OHA worked with clients. At the provider level, OHA worked with the AIDS Education Training Center, trying to provide training on both addiction medicine and Hepatitis C care to primary care providers in those areas. At the community level, OHA distributed community-level factsheets that showed drug overdose hospitalizations and deaths in cases of hepatitis C, HIV, and neonatal abstinence syndrome in every county, so that individuals can use the sheets locally to inform the local advisory committees that have been set up with the opioid funds. The sheets are also useful for advocacy purposes. The HOPE study was done as a pilot in Douglas

and Lane counties, with the goal to expand to seven counties. In the next three years, without funding, the pilot will expand to Coos, Curry, and Josephine counties.

Dr. Thomas remarked that in Douglas and Lane counties, OHA would pilot an ATILA (Assistive Technology and Telecare to maintain Independent Living At home) health intervention, where people who tested positive for hepatitis C would be recruited through a rapid Hepatitis C test in an outpatient setting. OHA will work with them to get on the Oregon Health Plan and take them to a local hospital lab for an initial evaluation prior to treatment. Then the individuals will be referred to a community provider or a telehealth provider at OHSU. The peers will sit down with the individuals and load up an iPad and have them meet with a doctor from OHSU, who will fax a prescription to a local pharmacy for them.

Dr. Savage asked if any of the presented data overlapped with the data in the PDMP (Prescription Drug Monitoring Program). She asked if Dr. Thomas's team worked with that program.

Dr. Thomas answered that recently OHA received funds from the State Opioid Response funding to do a vulnerability assessment. The team did a lot of modeling and looked at data from PDMP, as well as social determinants of health data, such as availability of transportation, income, and education, among others, to find out the best predictors of a Hepatitis C outbreak at a county level. The determinants had to do with the county's rate of risky prescribing, or the rate of people with more than 90 MME (morphine minimum equivalent) dose, and years of potential life loss, which is more of a sequelae of injection drug use. If a lot of people are dying of overdoses and acquiring hepatitis C, more deaths will occur among people in their 40s and 50s. That is a good predictor, along with lack of transportation. These are people who are not accessing health care and not accessing needle exchange.

Ms. Leahy added that, in relation to the syndemic model, as the PDMP reworked the opioid dashboard, they would be including more programmatic data. The PDMP is operating in a somewhat syndemic way, both with OHA's Health Systems Division's partners and the injury violence prevention program to incorporate Hepatitis C, because it affects so many people, who are also affected by overdose.

Ms. Leahy noted that the peers who worked on the HOPE site were Larry and Joanna. Both have lived experience with substance use disorder and both are peer recovery mentors. They are certified by the state in one of the five types of care. They are both supported and employed by HIV Alliance. They go into the community, they go to trailer parks, they knock on doors, they hang out in parks, they build relationships with people who are currently using drugs who are completely disengaged from the health system (they are not people showing up at HIV Alliance's door), they bring them harm reduction "gift bags" that include syringes, safe injection equipment, and information. They bring these things to people and they keep going back and around and meet people. After a while, people trust them. They also can conduct

rapid Hepatitis C/HIV/syphilis testing in the field. They help people register for CCOs. They are a link to treatment, transportation, and housing assistance. They say to people, “What do you need to make your life better? How can I help you reduce the risk of substance use?” They clear the deck for someone to be able to have the stuff that are really important to them taken care of, so then they have the space to say, “What can I do next about my health?”

Dr. Thomas stated that over the last two years, OHA has recruited 177 participants into the Oregon HOPE study in Lane and Douglas counties. The first step is getting them the very basic things. These people have a lot of overwhelming needs. The data showed that 68% were homeless in the past 6 months, 51% were incarcerated in the past 6 months, 50% were Hepatitis C positive, and 45% shared syringes/equipment in the last 30 days. Although the funding is for opioids, there is still a lot of methamphetamine use in the state. In terms of drug of choice, 44% used heroin, 49% used meth, and 7% used another drug. Over the past 30 days, 78% had used an opioid, with 96% of them using meth in the past 30 days. In terms of getting naloxone, 73% even witnessed an overdose, 42% ever overdosed, and 28% currently have naloxone. The top two reasons for not accessing medical care were: 50% did not have transportation, 49% were afraid they would be treated with disrespect because of their drug use. Of the people who hadn’t engaged in some kind of substance use disorder treatment in the past, 18% of the peer-outreach clients engaged in substance use within the next 3 months.

Dr. Thomas pointed out that some of the lessons learned from this model included barriers, such as stigma, transportation, access, and housing instability – all things needed to develop a successful intervention. The peer-led interventions are a way to make inroads with this hard-to-reach group. A lot of the peer-led research has not been done in rural settings. Oregon is in the forefront in this. The syndemic approach is the way to go.

Dr. Savage asked if the HOPE study was over or it was still going.

Dr. Thomas answered that it has been more of a data collection effort and piloting the use of peers for two years in two counties. The next stage in Douglas and Lane counties is a push to get them into care both for Hepatitis C. It’s the telehealth intervention, trying to get them to substance use disorder treatment. In the three new counties, OHA will be doing the work that has been done in the first two counties, with a lot more of the initial recruitment and in-depth data collection that will inform community efforts in Coos, Curry, and Josephine counties.

Dr. Savage asked if the study was still funding the peers.

Dr. Thomas answered that the study would continue for three more years.

Ms. Leahy reiterated that the first two years were a pilot to show that OHA could find people and get them in and the peers could provide service. The CDC released some funding with the prompt “How can you reach people who are using drugs in rural areas and get them tested and

treated for Hepatitis C?” Taking the syndemic approach and wanting to leverage what exists, the team approached all partners to figure out how to make it better. The OHA team used the vulnerability data and identified counties that had high vulnerability and didn’t have HIV prevention funding from the state or have access to at least using the money they had to screen for hepatitis C.

Ms. Byers pointed out that the work wrapped around House Bill 4143 that was geared toward reducing overdoses by placing recovery peers in emergency departments. Ms. Samantha Byers leads that project, as well as the 2019 State Opioid Response Expansion, which expanded recovery peer work to 14 counties. A lesson from the HB 4143 pilot was that the peers needed flexibility to work in emergency departments, primary care, urgent care, and county health department clinics. Because of the peer expansion, the OHA team decided to wrap the hepatitis C screening and linkage to care around the overdose work. The OHA team approached people at the health system level and they wrote the grant together and were successful in obtaining it. The funding is for one year, and it is called Peer Recover Initiated in Medical Establishments (PRIME). The place where peer work could be wrapped around hepatitis C work is called PRIME Plus for testing and linkage to care. The rural counties were approached based on their high vulnerability to complications of injection drug use, they are not OR-HOPE counties, and they don’t have other funding that could be used for HIV/hepatitis C testing.

Ms. Saito asked how the peers got paid for their work.

Ms. Byers answered that the grant from the CDC was for half a million dollars per year. Most of the money was disbursed to the counties. It takes about 90K to support the peer and the peer work. The OHA team went through CLHO to help identify what the team would do. During the writing of the grant, instead of telling the counties how to use the funding, the OHA team approached the counties as the grant was being written and asked them how they would use the money. In the three different counties, the money is going in three different ways. In Klamath County, the money is going to a community-based agency. In Malheur County, the money is going to the public health department. In Umatilla County, the money is going to the county’s behavioral health addiction program.

Ms. Saito asked if the peers got paid per person they were working with.

Ms. Byers answered that the peers were full-time, salaried, and hopefully with benefits. The project has primary and secondary aims. The primary aims are to conduct the Hepatitis C and B testing and provide peer support. The secondary aims are linked to other types of syndemics through support of participants to access preventive care and substance use treatment and provide harm reduction counseling and support. The peers will engage with clients and help them enroll in Medicaid or find a medical home. If the clients are hepatitis C positive, the peers will support obtaining confirmatory testing. The peers would help the clients make medical

appointments. They would go to medical appointments with them and, hopefully, the clients would be engaging with a medical provider, who would provide them hepatitis C treatment.

Ms. Byers remarked that the community advisory work included aligning community supports by engaging with local and cross-site community advisory groups, as well as sharing program and evaluation data, outcomes, and experiences with community stakeholders; training of PRIME peers across the state in infectious disease prevention, regardless of whether the peer is in a PRIME+ county; supporting sustainability by integrating with existing programs (PRIME and CCO peer initiatives).

Dr. Savage asked if community partners included the police, the county sheriff, and the law enforcement system.

Ms. Byers answered that the OHA team asked each of the counties to organize their own community advisory board. All will be involved with their LPAC (local programs advisory committee) that deals with their CCO. The people involved in the LPACs, at least in two counties, are meeting with the police because they will be talking about syringe exchange. The third county has had a syringe exchange on and off (now is off). She is working on supporting syringe exchange in each of the counties, so there will be a place for the peers to work.

Dr. Savage stated that syringe exchanges are political. She recommended to the OHA team to collaborate with the CCOs.

Ms. Byers expressed hope that the CCOs would be encouraged enough to support syringe exchange programs. A syringe costs 8 cents. The OHA team just finished a syringe service program manual that included a budgeting section. A CCO can run a syringe exchange program for 128K, with 70K going to supplies. This would prevent each one of the infections, with an infection costing 23K on average (a lot more for endocarditis). How many little infections does a CCO need to prevent to support a total syringe exchange program that benefits the community?

Dr. Dannenhoffer shared that Douglas County was one of the early counties and it had been great. Substance users are a tough crowd to get. They are fearful of police and public health. Having the peers would be great.

Ms. Thalhofer asked if there was any support for the peers, in terms of sending them back to the substance use culture.

Ms. Byers answered that for the work on HB 4143, or PRIME/PRIME+, one of the requirements was that whoever got the funding had to have peers contracted through agencies that already have the structure for supervision and support of the peers. There are existent peer-run agencies and peer-run structures. The peers do have support, such as one-on-one supervision

and group supervision. They also will be receiving additional training that OHA is organizing in each county, so that the peers don't have to travel to Portland.

Ms. Leahy added that for OR-HOPE, the peers were certified as recovering mentors and they had clinical supervision with a behavioral health specialist at HIV Alliance.

Ms. Shirley commented that the presented work met many of the PHM goals. The focus of the PHAB and in other venues has been on getting modernization money to the counties for specific work. This work is an example of how OHA is trying to take OHA's day-to-day work that public health does around these issues and diseases, understanding the impact and what public health can do to interject on the course of some of these diseases. This is one of OHA's attempts to change the culture at the state health department and do things in a modern way. Another goal is to have an overlap with the CCOs. OHA used the actual numbers provided by the CCOs to identify the cost and benefit of a syringe exchange program. That is the beginning of this prevention work.

Ms. Shirley added that, to Dr. Savage's point, CCOs have supported the work in that that they could be spending \$100K instead of over a million dollars. We need alliances and we need to figure out how we identify our goals beyond specific public health data. The point of all this work is the people the public health system serves and how we get them to have a better life. This project is a great example of how the Oregon Health Authority, not only the Public Health Division, should be doing its work. OHA will be using the project as an example when it kicks off OHA's strategic planning process. One thing about this team is that when they did their Hepatitis C work and went to prisons, the CDC people told them that they couldn't do that. They did it anyway and got their outcomes. Now everybody is coming to public health and asking them how they got into the prisons. It is that sense of innovation and leaning in that is, very often, how we operate to do what we need to do.

Ms. Thalhofer remarked that while this was great and finding the CCOs as a partner was really helpful, the missing piece was that LPHAs had to have this discussion every time with every CCO. It would be great when an LPHA approached a CCO with a project like this, the CCO had already heard how well it worked in another region and they were teed up to be ready to work with the LPHA. There are many examples across the state where great projects have come out and saved money, but LPHAs have to fight that battle every time. Whatever can be done at the OHA level to get that understanding spread across all CCOs, that would be incredibly helpful.

Dr. Savage agreed with Ms. Thalhofer and added that this OHA team presented at QHOC in a small portion of the Hepatitis C treatment part. All medical directors and CCOs were there. Presentations like this one have been given to CCOs. CCOs don't equally provide the same uptake or enthusiasm for those projects, as each CCO does its own thing. Some vision and leadership from OHA are definitely great, but also buy-in and follow from each CCO is really important. She promised to continue to work with the CCO medical directors in that setting.

Ms. Shirley pointed out that the reason the team was successful at the bottom line with the counties in the rural areas was because they followed the money and demonstrated the return of investment. OHA had to get better about even interim gains and successes.

Dr. Dannenhoffer agreed with Ms. Shirley and praised the approach taken by the OHA team. These diseases are the perfect ones to follow, because they happen soon after the use of the drugs, they are identifiable, and they are very expensive. Douglas County had a few endocarditis cases that were problematic, because it's \$100K the first time and, if they forget the antibiotics, they get it again, and some patients need a valve replacement. These diseases are incredibly expensive to treat.

Ms. Leahy remarked that the challenge with endocarditis was that as soon as someone gets endocarditis from rejection drug use, we might as well start a clock, because in terms of recovering their health and getting better with all the obstacles, it makes the peer program in the hospitals really important. Even if only endocarditis was prevented, it would be both healthy for the person and health for the community. One of the challenges is that Oregon has one of the highest morbidity and mortality rates for Hepatitis C. It should be known that the funding from CDC for Hepatitis C is very little. That's why the team is thinking hard about what it is doing, because the CDC is not coming. Once that phase is passed and the team leans in, there are many people who want to help, because many people are affected by substance use disorder and infections, including Hepatitis C.

Ms. Byers added that in terms of the primer 4143, the OHA team asked the CCOs to sit at the table with them. The CDC money is startup money to build the infrastructure and then they would carry on the project through the CCO. The Health Systems Division puts a lot of weight on CCO 2.0, because it is very significant. It will be the first time that CCOs are not allowed to carve out the behavioral health benefit and that they are held accountable to integrate it, which is where this project becomes even more powerful. There is a little bit more push from the substance use disorder (SUD) side to be able to leverage some partnerships that the team leveraged for smaller projects not quite as large as PRIME. Secondly, one of the structural areas that is not related to the CCO is that hospitals are incredibly reluctant to allow peers in. This pilot project was initiated by the legislature and inspired by Rhode Island's AnchorED program, but the legislation didn't mandate the medical community to participate in it. It is not specified what to do when the hospitals are not ready to participate. The peers are creating partnerships, they do panel discussions so they can meet people in recovery and feel comfortable around them, but the way it worked was through champions at medical locations. If that barrier was removed, more people would be accessed and served and not driven to the point where they are on a time clock.

Ms. Tiel expressed excitement about cross-division projects like this at OHA. She reminded the PHAB that the board meeting in December would be either canceled or be over the phone.

Public Comment

Ms. Tiel asked if members of the public on the phone or in person wanted to provide public comment. No public comment was provided.

Closing

Ms. Tiel thanked the PHAB for their time and adjourned the meeting at 4:48 p.m.

The next Public Health Advisory Board meeting will be held on:

**January 16, 2020
2:00-5:00 p.m.
Public State Office Building
Room 177
800 NE Oregon Street
Portland, OR 97232**

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Krasimir Karamfilov at (971) 673-2296 or krasimir.karamfilov@state.or.us. For more information and meeting recordings please visit the website: healthoregon.org/phab

OHPB Committee Digest

PUBLIC HEALTH ADVISORY BOARD, METRICS & SCORING COMMITTEE, HEALTH PLAN QUALITY METRICS COMMITTEE, HEALTH INFORMATION TECHNOLOGY OVERSIGHT COUNCIL, HEALTHCARE WORKFORCE COMMITTEE, HEALTH EQUITY COMMITTEE, PRIMARY CARE COLLABORATIVE, MEDICAID ADVISORY COMMITTEE, PERMANENT SUPPORTIVE HOUSING, SUSTAINABLE HEALTH CARE COST GROWTH TARGET IMPLEMENTATION COMMITTEE

Public Health Advisory Board

In November, the Public Health Advisory Board (PHAB) discussed state and local public health modernization investment from the perspective of communicable disease prevention through presentations by Deschutes County, North Central Public Health District and Oregon Health Authority communicable disease prevention staff. PHAB also discussed the process for funding Oregon’s nine federally recognized tribes and NARA for public health modernization beginning in December 2019. Finally, the Public Health Advisory Board discussed how the public health system is using a syndemic approach to address Hepatitis C prevention in collaboration with substance use, HIV and sexually transmitted infection prevention in rural communities across Oregon. The PHAB did not meet in December.

COMMITTEE WEB SITE: <https://www.oregon.gov/oha/ph/About/Pages/ophab.aspx>
STAFF POC: Cara Biddlecom, cara.m.biddlecom@state.or.us

Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative (PCPRC) is finalizing its progress report on the Primary Care Transformation Initiative for the Oregon Legislature and Oregon Health Policy Board. The report is an update on the activities the Collaborative has undertaken in 2019 to support implementation of the Initiative and will be published by early February 2020. The Collaborative will convene on January 7th to review the final draft of the report and discuss strategic planning for 2020.

The next Primary Care Payment Reform Collaborative meeting will take place on January 7th, 2020 from 9am to Noon in Portland.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx>.
COMMITTEE POC: Susan El-Mansy, SUMMER.H.BOSLAUGH@dhsola.state.or.us

The Healthcare Workforce Committee

The Workforce Committee met on November 6, and heard presentations on the following topics:

Primary Care Office Updates:

Marc Overbeck shared results of the Auto-Facility HPSA Updates for 2019 and how this affects access to

state and federal loan repayment awards.

CCO 2.0:

Megan AuClair provided an update on CCO 2.0, including timelines for future work.

COMPADRE Program:

Dr. George Mejicano of OHSU shared an overview of the COMPADRE program, under which OHSU has partnered with UC-Davis to train more medical students and place them on rotation in rural areas. There will be follow up.

Oral Health Workforce Grant Update:

The Committee received a presentation about the results and challenges related to implementation of our Oral Health Workforce Grant to expand oral health workforce FTE in Southwest Oregon and in the east Gorge area.

Committee Logistics:

The Committee decided to hold a planning meeting in January prior to the full Committee meeting. Election of a Chair and Vice-Chair will be on the agenda, as well as discussion of the Committee charter.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/HPA/HP-HCW/Pages/index.aspx>

COMMITTEE POC: MARC OVERBECK, Marc.Overbeck@dhsoha.state.or.us

Health Plan Quality Metrics Committee

At the December 9 meeting, the committee continued working on criteria for evaluating transformative measures. Transformative measures are those that support the goals of Oregon's health system transformation and are likely to be developed locally.

For this conversation, led by consultant Michael Bailit of Bailit Health, the committee explored four options for evaluating measures. Ultimately the committee got to consensus on one of these options and will further explore it at the January meeting. Also, at this meeting, OHA staff presented criteria to evaluate metrics for health equity developed by the Prevention Institute. From these criteria, committee members added that transformative measures should also be multi-sectorial.

Lastly, the committee heard from the chairs of the Health Equity Committee (Michael Anderson-Nathe and Carly Hood-Ronick) on the newly adopted, OHA-wide health Equity definition. To hear more about the definition, a link to the meeting recording can be found here:

<https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Meeting%20Documents/2019-12-12-HPQMC-leveled.mp3>

For the January 9, 2020 meeting, the committee will continue to work on evaluative criteria for transformative measures and begin reviewing measures for the 2021 measure menu set.

The next meeting is Thursday, January 9, 2020 from 12:30pm – 3:30pm.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/analytics/Pages/Quality-Metrics-Committee.aspx>

COMMITTEE POC: Kristin Tehrani, Kristin.Tehrani@dhsoha.state.or.us

Metrics & Scoring Committee

The Metrics & Scoring Committee did not meet in December. It will reconvene in January, when it will be joined by the Health Equity Committee chairs and the Director of OHA's Equity and Inclusion Division for a discussion about the definition of health equity adopted by the Board and OHA in October. It will also hear final proposals on two developmental measures being considered for 2021: obesity prevention and health equity (language access and interpreter services).

In February the Committee will finalize its recommendations for the 2021 Health Plan Quality Metrics Committee (HPQMC) aligned measures menu, which will be presented to the HPQMC in March. As part of this, the Metrics & Scoring Committee will further review and discuss the two developmental measures presented in January, including additional review of the specifications, reviewing any available data, and assessing the measures against its measure selection criteria to stimulate further discussion.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>

COMMITTEE POC: Sara Kleinschmit, SARA.KLEINSCHMIT@dhsaha.state.or.us

Health Information Technology Oversight Council

The Health Information Technology Oversight Council (HITOC) held a meeting on December 5, 2019, most of which focused on the newly released and much-anticipated 2019 Health IT Report.

The report, which provides an overview of Oregon's health IT landscape, was developed in collaboration with HITOC members and will help inform HITOC's 2020 strategic planning. It focuses on electronic health records (EHRs) and health information exchange (HIE), which are foundational to all other health IT efforts. HITOC members had positive feedback for the report, saying they're pleased to have a summary of Oregon's EHR and HIE landscape as they head into their 2020 strategic planning. The complete draft report is available [here](#).

HITOC also updated its bylaws to better support incoming committee leadership, reviewed plans for stakeholder and partner engagement for the 2020 strategic plan update and finalized its 2020 work plan for presentation to OHPB in February 2020.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/HPA/OHIT-HITOC/>

Committee POC: Francie Nevill, Francie.j.nevill@dhsaha.state.or.us

Medicaid Advisory Committee

The Medicaid Advisory Committee (MAC) met December 4 by webinar to hear a presentation from Leann Johnson, Director of OHA's Office of Equity and Inclusion and discuss how the MAC can integrate the Health Equity Committee's definition of *health equity*, recently adopted by the Board, into its own work. On December 12, MAC Co-Chair Jeremiah Rigsby attended the Health Equity Committee to continue the discussion and begin to build a more meaningful relationship between the two committees.

The MAC's next meeting on January 29 will focus on the Medicaid 1115 Waiver.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/hpa/hp-mac/pages/index.aspx>

COMMITTEE POC: Milena Malone milena.malone@state.or.us

Health Equity Committee

An essential part of the Health Equity Committee Charter is to work in close collaboration with other OHPB committees. The rest of this year will see presentations from staff from the Healthcare Workforce Committee, Metrics and Scoring, Health Plan Quality Metrics, OHITOC, Public Health Advisory Board, Medicaid Advisory Committee, and the Oregon Health Policy Board.

The purpose of these presentations is to find areas of alignment and or potential opportunities for partnership.

Medicaid Advisory Committee (MAC)

Jeremiah Rigsby, MAC Chair, and Milena Malone, OHA Lead Staff for the MAC, provided an overview of the committee. The MAC is responsible for developing and advising policy recommendations at the request of the Governor, the Legislature, and OHA. OHA explicitly directs the Committee to support the following functions:

- Monitoring: provide oversight and review of Oregon's administration of its Medicaid program.
- Advising: serve as an advisory body to OHA on issues relevant to those served by OHP.
- Policy Development: participate in Medicaid policy development by making recommendations to the OHA.

The MAC shared some of its past and current work. A highlight of the MAC's work was the development of a report with recommendations on how to address Social Determinants of Health in the second phase of health systems transformation. To inform that work, the MAC developed definitions for Social Determinants of Health and Social Determinants of Equity. The SDOH definition is based on the World Health Organization and the CDC's definitions, with modifications based on committee and stakeholder feedback. Importantly, the MAC also chose to put forward a definition of social determinants of health equity, based on the work of Dr. Camara Jones. She identifies social determinants of health equity or social determinants of equity as the structural factors that shape how populations experience the social determinants of health – things like historical oppression and institutional bias.

Based on the MAC's work, OHA adopted the term Social Determinants of Health and Equity for its work under CCO 2.0, to encompass both of these terms.

HEC members had the opportunity to engage with Jeremiah and Milena in a discussion on potential areas of collaboration between the HEC and the MAC

New member election

The HEC voted to move forward a slate of candidates selected to fill three vacant positions. The slate was approved, and it is moving on to the next step: OHPB confirmation and their January 2020 meeting.

Thank you to outgoing committee chairs

The HEC had the opportunity to thank Carly Hood-Ronick and Michael Anderson-Nathe for their work as co-chairs during the last two years. Under their leadership, the committee was able to develop its structure, bylaws, and practices that elevate equity; provided Health Equity Impact Assessment to the OHA and OHPB on CCO 2.0 policies and Developed Health Equity Definition to be adopted by OHPB and OHA. December is their last month as co-chairs, but they will continue their tenure at the HEC and remain committed to the work.

Policy workgroup presentation

The policy workgroup had the opportunity to present to the full committee on their work plan. A highlight of the plan includes the development of a process to provide OHA and OHPB and its committees with health

equity analysis on major initiatives brought forward to the committee to review. Also, there was a discussion of the selection of a health equity impact assessment tool to be used in this work.

There was also discussion general discussion about the continued use of the workgroup model. New Co-Chairs will be working on ways to improve the way the committee engages in its strategic work.

COMMITTEE WEB SITE: <https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx>

STAFF POC: Maria Elena Castro maria.castro@state.or.us

Permanent Supportive Housing Institute

Oregon Housing and Community Services (OHCS), in collaboration with OHA launched the Oregon Supportive Housing Institute on November 6, 2019. The Corporation for Supportive Housing will provide technical assistance for this institute, which is based on a successful model launched in Indiana. This institute will run from November to March with monthly sessions designed to give individualized support in project planning, including a specialized supportive services plan, operating procedures, and PSH team development. The Institute provides a pathway for OHCS and partners to achieve the ambitious goal of 1000 units of PSH over the next five years to implement the Statewide Housing Plan. Participants in the Institute will also receive preference when applying for PSH development funds. OHCS received \$50 million in the 2019 Legislative Session for the creation of PSH homes. The Oregon Health Authority received \$5.4 million for operations and supportive services. Through partnership beyond this institute the goal is to coordinate a robust suite of health services with Permanent Supported Housing to design effective interventions.

Ten teams were selected out of the 29 applications received, demonstrating the high demand for PSH. The cohort teams represent a diverse mix of urban and rural areas, with several in the Tri-County areas, as well participants from areas such as Warm Springs and Lake county.

1. Home Forward is partnering with Urban League to create a new PSH development in Portland's Kenton neighborhood.
2. Native American Youth and Family Center, working with Native American Rehabilitation Center of the Northwest, Housing Development Center, and Income Property Management Company, will create PSH homes within an existing affordable housing community in Portland's St Johns neighborhood to serve chronically homeless populations.
3. Homes for Good Housing Agency is partnering with Lane County Health & Human Services, ShelterCare, and Quantum Residential to create PSH homes in Eugene to serve chronically homeless populations.
4. Northwest Housing Alternatives, working with Northwest Pilot Project and Income Property Management, is creating PSH homes in existing Proud Ground affordable housing in North Portland to serve seniors and chronically homeless populations.
5. NeighborWorks Umpqua, Housing Authority of Douglas County, Adapt, and United Community Action Network are working together to create a PSH development in Roseburg to serve chronically homeless populations.

6. ColumbiaCare Services, Inc., with the support of the City of Ashland, Jackson County, Housing Authority of Jackson County, and the Oregon Health Authority, is building a PSH development in Ashland to serve chronically homeless populations, particularly those living with serious mental illness.

7. Community Development Partners is working with JOIN and Guardian Management to develop new PSH homes and create PSH homes in existing affordable housing in Portland to serve chronically homeless populations.

8. Housing Authority of Clackamas County (HACC), with the support of Metro and Clackamas County, is creating PSH homes in an existing housing development in Gladstone to serve chronically homeless populations. HACC recently acquired the development.

9. Warm Springs Housing Authority and Behavioral Health Center are working together to create PSH homes in Warm Springs to serve chronically homeless populations.

10. Lake Health District is working with Klamath Housing Authority to create PSH homes in Lakeview to serve chronically homeless populations. Other community partners include Lake County Community Justice, Lake County Veterans Service Officer, and the Oregon Department of Human Services.

OHC Website: <https://www.oregon.gov/ohcs/DO/newsreleases/2019/10-15-2019-Oregon-Supportive-Housing-Institute-Participants.pdf>

POC: Lori Kelley: LORI.S.KELLEY@dhsosha.state.or.us

Sustainable Health Care Cost Growth Target Implementation Committee

The Implementation Committee held its first meeting in November and met again in December. In November, the Committee heard an introduction to health care costs and the need to lower them, as well as how other states have approached this work. The Committee reviewed the planned process and timeline for developing recommendations. In December, the Committee began discussing how total health care expenditures will be defined and whose total health care expenditures are being measured (e.g. which sources of coverage – Medicaid, commercial, etc... are included).

COMMITTEE WEB SITE: <https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx>

STAFF POC: Sarah Bartelmann, sarah.e.bartelmann@state.or.us

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Portland, OR 97232
Phone: 971-673-1229
Fax: 971-673-1299

January 8, 2020

RE: Public Health Advisory Board support for adoption of the Obesity Incentive Metric for Coordinated Care Organizations

Dear [HPQMC/MSC],

This letter indicates the Oregon Public Health Advisory Board's (PHAB) support for the adoption of the obesity incentive metric and health equity metric currently under development and consideration.

Health equity was established as a core value for the Oregon Health Authority (OHA), the Oregon Health Policy Board (OHPB), and is a cornerstone of the CCO 2.0 contracts and the State Health Improvement Plan.

The OHA Public Health Division (PHD) has been working with staff in the OHA Health Systems Division (HSD) and Division of Health Policy and Analytics (HPA) over the past few years to inform the development of this metric and look for opportunities to align it with public health obesity prevention efforts. We believe the adoption of this metric will be a key first step in advancing more comprehensive and effective obesity prevention efforts in Oregon.

Preventing obesity is a top priority for OHA and the state of Oregon. As a result of the dramatic rise in obesity rates in Oregon and across the country, obesity is now the No. 2 preventable cause of death and disability among Oregonians and is responsible for more than 2,000 deaths annually. Currently, 29% of Oregon adults are obese. Obesity prevention was one of seven priority areas in the 2015-2019 State Health Improvement Plan. Addressing the upstream drivers of obesity and other chronic diseases is also a top priority for the 2020-2024 State Health Improvement Plan.

Physical inactivity and poor nutrition are the major drivers of obesity. When we address obesity, we also address most of the other leading causes of death and disability in Oregon, including diabetes, cancer, heart disease, stroke, and depression. According to a 2012 report from the Institute of Medicine, national costs attributed to treating obesity-

related diseases are estimated to be \$190.2 billion and represent 21 percent of spending on healthcare. Obesity-related chronic diseases cost Oregonians about \$1.6 billion in medical expenses each year, with \$339 million of that paid by Medicare and \$333 million paid by Medicaid.

- People who are obese are estimated to have annual medical costs that are \$1,429 higher than people who are not obese.
- Obesity affects about half of Oregonians with diabetes or heart disease. The cost of hospitalizations primarily caused by diabetes, heart disease and stroke were estimated at \$921 million in 2017.
- Nearly 73 percent of adult Oregonians with a history of heart attacks were overweight or obese in 2009.
- Compared to non-Latino Whites, African Americans, American Indians or Alaska Natives, and Latinos have higher rates of obesity, while Asian or Pacific Islanders have lower rates of obesity. The largest disparity is among American Indian or Alaska Natives, who are affected by obesity at a rate 55% higher than their White counterparts.

Given the enormous health burden that obesity and the drivers of obesity place on Oregonians and Oregon's health care system, we support the development and adoption of an obesity incentive metric for Coordinated Care Organizations (CCOs). By adopting an obesity incentive metric, CCO priorities will be positioned to address the second leading cause of death in Oregon, align with state health priorities and achieve the triple aim of health care transformation in Oregon.

A CCO obesity incentive metric has great potential to support and leverage Oregon's public health modernization efforts. These efforts focus on strengthening the ability of Oregon's public health infrastructure to work across sectors to address the upstream drivers of poor health and health disparities in Oregon. As research increasingly demonstrates, reducing obesity will require a multidimensional approach that includes policy and environmental changes in multiple settings, including not only clinical settings but encompassing worksites, schools, large institutions such as government and hospital campuses, and community settings such as parks and neighborhoods. As CCOs are driven to partner to implement obesity prevention efforts, Oregon's public health system can serve as a key partner to engage other sectors and advance collective efforts to meet CCO and community objectives related to obesity prevention.

Similarly, the Public Health Advisory Board supports the adoption of a health equity measure in the CCO incentive program. We therefore request your consideration of the health equity measure and other community based and transformative measures that will help OHA achieve its goal of ending health disparities.

Thank you for your consideration.

Sincerely,

The Oregon Public Health Advisory Board

DRAFT

Oregon
Racism
Timeline
Display



Office of
Equity & Inclusion

- Created by: Four Rivers Cultural Center (Curator - Quin Suzuki)
- An OEI Managed Display
- For more info, contact: OEI.Training@dhsosha.state.or.us

Specifications

- 28 panels
- Panels
 - Printed on rubberized canvas
 - Panel dimensions: 24"x36"
- Display methods
 - Utilize non-permanent adhesive pads to hang on painted walls
 - Utilize felt-covered collapsible display walls by applying Velcro stickers or tape to the back of each panel and Velcro the panels to collapsible display walls
 - Wall sections may be placed on long tables to display at an accessible height for people using mobility devices (wheelchairs, scooters, etc)

STRUCTURAL RACISM IN OREGON

QUINN SUSUKI
Curator

KELLY POE
MATTHEW STRINGER
Support in Exhibit Development

SARAH BRADBURY
Design and Layout



FOUR RIVERS CULTURAL CENTER | 676 SW 5TH AVE., OREGON, OR | (541) 889-8191 | 4RCC.COM

STRUCTURAL RACISM



1492 – 1700 (In the Common Era)

The Smithsonian Institute at the National Museum of the American Indian in Washington, D.C. estimates that 9 out of 10 indigenous people perished during the first two centuries after first contact between Europeans and the inhabitants of the Western Hemisphere due to disease and violence.

1823

Supreme Court ruled in *Johnson v. McIntosh* that because natives were wanderers, their rights were impaired and subordinate to the "discovery rights" of Europeans. While Indian tribes retained an occupancy right, they did not have title to the land. This ruling became a convenient justification for moving tribes from their ancestral homelands.

1830's

Methodist missionaries came to Oregon led by Jason Lee. Unfortunately they and the natives suffered from a horrendous epidemic which killed 70% of the Kalapuyans the missionaries had come to "save".





1843

Champoeg territorial government adopted a measure "prohibiting slavery" that required slaveholders to free their slaves with the added requirement that all Blacks must leave the territory within three years.

1844

Acts to prohibit slavery and to exclude Blacks and Mulattoes from Oregon were passed. The infamous "Lash Law," required that Blacks in Oregon – "be they free or slave – be whipped twice a year until he or she shall quit the territory." It was soon deemed too harsh and its provisions for punishment were reduced to forced labor.



STRUCTURAL RACISM

1851

Jacob Vanderpool, an owner of a saloon, restaurant and boarding house in Salem, was the only person known to have been kicked out of the Oregon Territory because of his skin color based on the Exclusion Laws. Other incidents may not have been officially recorded.

1854

Oregon's Exclusion Law was repealed, to be replaced three years later by amending the Oregon Constitution with similar exclusionary language to keep Blacks out of Oregon. (Much of this racist language was not removed from the official Constitution until 2000.)



Jacob Vanderpool



1848-1879

Three decades of continuous conflict between Whites and Indian tribes started with the Cayuse War continuing until the region's Indian tribes were forced onto and confined to reservations. Anson Dart, Oregon Territory's first Superintendent of Indian Affairs organized reservations on remote, semiarid land east of the Cascades. Tribes of the coast and Willamette Valley balked at the move. Efforts to obtain reservation land west of the Cascades ran afoul of the Oregon



Donation Land Claim Act. It sanctioned homesteading without regard for the legal obligations to Indian titles to the land. Only a few remote parcels of land not yet encumbered by white claims were procured as reservation land.



1850

The Oregon Donation Land Act was enacted by the U.S.

Congress to promote homestead settlement in the Oregon Territory; swelling the ranks of emigrants on the Oregon Trail. It granted free land to "Whites and half-breed Indians" in the Oregon Territory. (The language of the act prevented non-Whites from claiming land in Oregon even if they had already settled here whether they had previous deeds to the land or not.)

1856

Rogue River Indian Wars ended with the surviving Native Americans sent to two newly created reservations: the Siletz and the Grand Ronde.



STRUCTURAL RACISM

STRUCTURAL RACISM

1861

Abraham Lincoln took the Presidential Oath of Office. The southern Confederacy ratified a new constitution and elected Jefferson Davis as the first Confederate president. The Civil War began with Confederate soldiers firing upon Fort Sumter.

1861

The Knights of the Golden Circle, an anti-Union and pro-slavery group, opened chapters in many Oregon communities. Their ultimate goal in the Northwest was to secede from the U.S. and create a Pacific Coast Republic.



1862

Oregon adopted a law requiring all Blacks, Chinese, Hawaiians (Kanakas), and Mulattos (an archaic term referring to people of mixed ethnic heritage) residing in Oregon to pay an annual tax of \$5 (approximately \$125 today). If they could not pay this tax, the law empowered the state to press them into service maintaining state roads for 50 cents a day. Also, interracial marriages were banned in Oregon. It was against the law for whites to marry anyone 1/4 or more Black.

1862

The American Homestead Act allowed any white male over the age of 21 and a head of a family to claim up to 160 acres of land. He would improve it within five years or purchase the land at a small fee. The Homestead Act made 50 million acres of Indian land available to white homesteaders. It created the official policy for U.S. soldiers to wage war on the indigenous nations of the west to protect the white settlers encouraged to take their land.



STRUCTURAL RACISM

1865

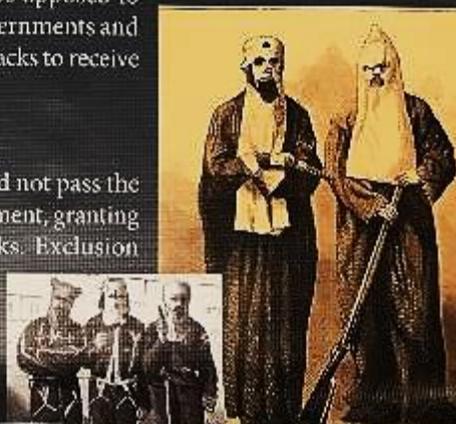
The Civil War ended and the Thirteenth Amendment, banning slavery in the United States, passed by referendum in Oregon and throughout the Union states.

1866

Ex-Confederates, to regain some sort of control during Reconstruction, formed secret organizations that used intimidation and terrorism against Blacks and unionists. Names like Pale Faces, Sons of Midnight and Knights of the White Camellia were used. A group formed in Pulaski, Tennessee named the Ku Klux Klan grew to be the largest and best known of the groups opposed to Reconstruction governments and attempts by freed Blacks to receive their rights.

1866

Oregon's citizens did not pass the Fourteenth Amendment, granting citizenship to Blacks. Exclusion Laws were still in effect making it illegal for Blacks to live in Oregon.



STRUCTURAL RACISM

1866

Oregon banned all interracial marriages. The state's ban on interracial marriages was extended to prevent Whites from marrying anyone who was 1/4 or more Chinese, or Hawaiian, and 1/2 or more Native American. It was previously illegal for Whites and Blacks to marry.



1867

Even though the total black population in Oregon in the 1860's number 128, Portland assigned black and mulatto children to a segregated school.

1868

The Fourteenth Amendment, endowing African Americans with citizenship, passed in Oregon and throughout the country. A clause in the 14th Amendment, "excluding Indians not taxed", prevented Native American men from receiving the right to vote. Though this amendment established full citizenship rights for people of Mexican heritage born in the U.S., often the Indian heritage of Mexicans was used to exclude and deny them rights.

The 14th Amendment to the Constitution of the United States

[Faded text of the 14th Amendment, including the Citizenship Clause and Equal Protection Clause.]

1870

The Fifteenth Amendment, granting black men the right to vote, was added to the U.S. Constitution despite failing to pass in both Oregon and California. This federal law banning voting qualifications based on "race, color or previous condition of servitude" superseded a clause in the Oregon State Constitution banning black suffrage.



1869

Mexican vaqueros drove large herds of cattle from California to eastern Oregon helping to develop the ranching business in that part of the state and therefore settlement.



1877

The Nez Perce Tribe clashed with the U.S. Army in their Wallowa homeland in northeast Oregon. Chief Joseph and his people refused to go to a reservation. Instead, Chief Joseph tried to lead 800 of his people to Canada and freedom. Fighting the U.S. Army all along their 1100 mile journey, they were trapped just 40 miles from Canada. After a five-day fight, with only 431 remaining Nez Perce, Chief Joseph made his speech of surrender stating: "From here to where the sun sets, I will fight no more forever."



STRUCTURAL RACISM

1879

Chemawa Indian Boarding School opened in Salem, Oregon as the third such boarding school in the nation. These schools were designed to assimilate Indian children into white culture and teach them vocational skills. Students were prohibited from speaking their tribal languages or practicing any of their traditional customs or culture. (This Indian School still operates in Salem, but without the extreme notions of assimilation of its original intent.)



1880

By this date, the U.S. government had forced most Indians of the Northwest onto reservations.

1880's

Chinese immigrants were driven by mobs out of Oregon City, Mount Tabor and Albina.



1882

Ignoring the crucial role Chinese immigrants played in constructing the infrastructure of the West, Congress passed the Chinese Exclusion Act. It suspended further Chinese immigration until 1892. It also made all Chinese immigrants ineligible for citizenship and barred them from several professions including mining.



1888

In a trial in Enterprise, Oregon, three men were acquitted of murder for the massacre of at least 34 Chinese gold miners. The ring-leaders fled the area and were never tried. Unknown is how much gold the gang might have plundered. Rumors put the figure from \$3,000 to more than \$50,000. The trial attracted little attention from the press, and Wallowa County folks swept the sordid saga under the carpet for more than a century. In 1995, a county clerk opened an old safe in the Wallowa County Courthouse and found a long-secreted cache of documents relating to the massacre.



1890's

Reduction in Chinese immigration contributed to a dramatic increase in Japanese immigrants to Oregon: typically young males arriving without families. They came to work on railroads, in lumber and canning industries and as farm workers. Many restaurants and businesses posted signs reassuring customers that they employed no Asian

1919

Portland Board of Realty approved a "Code of Ethics" prohibiting Realtors and bankers from selling property in white neighborhoods to people of color or providing mortgages for such purchases.



1920's

KKK flourished in Oregon. By the mid 1920's its membership was estimated between 14,000 - 20,000 with numerous sympathizers who were not official members. Oregon's Governor from 1922 - 26, Walter M. Pierce, though not a member, was overtly supported by the Klan and he promoted the Klan's agenda.

CHIEF KLUXERS TELL LAW ENFORCEMENT OFFICERS JUST WHAT MYSTIC ORGANIZATION PROPOSES TO DO IN CITY OF PORTLAND



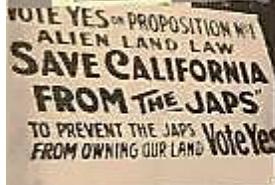
1922

The Supreme Court of the United States ruled in *Ozawa v. United States* that first-generation Japanese were ineligible for citizenship and could not apply for naturalization.



1923

The Oregon state legislature, dominated by members of the Klan, passed a number of restrictive laws. The Alien Land Law



prevented first generation Japanese Americans from owning or leasing land. The Oregon Business Restriction Law allowed cities to refuse business licenses to first generation Japanese Americans.

1923

An Oregon WWI veteran was denied U.S. citizenship. The U.S. Supreme Court unanimously ruled that Bhagat Singh Thind could not be a naturalized citizen. Anthropologists defined people of India as belonging to the Caucasian race. A previous ruling had

STRUCTURAL RACISM

affirmed that immigration law referring to "white" meant "Caucasian" as it applied to denying citizenship to light skinned Japanese immigrants. In this case, Justice Sutherland argued that the "common man's" definition of "white" did not correspond to all "Caucasians". Even though Indians were considered "Caucasian" they were not "white". Therefore they could not be naturalized. Thus the color of skin became the legal qualification for citizenship.

1927

The Oregon State Constitution was finally amended to remove a clause

denying Blacks the right to vote and eliminating restrictions that discriminated against Blacks and Chinese voters.

1928

Japanese American Citizens League founded. There are two chapters in Oregon. The Snake River Chapter is headquartered in Ontario.



1930's

The Great Depression decreased Mexican immigration and increased U.S. policies of deportation / exclusion. More than 1/3 of the nation's Mexicans and Mexican-

Americans were forced back to Mexico. This deportation / repatriation of 500,000 Mexicanos included U.S. born citizens.



1935

Oregon law officially segregated Mexican students on the basis of being of Indian descent. It made clear to exempt "White Mexicans" those fair-skinned descendants of the Spaniards who do not have "Indian blood".

1939

The Federal government's Farm Security Administration dispatched world famous government photographer Dorothea Lange to Nyssa/Ontario in 1939 to take pictures of local citizens who had just moved to this valley to pick apples and find work leaving the dust bowl of the Midwest. Some of her most stunning and famous photographs come from these photo sessions. The government was trying to educate the urban middle class to the plight of the rural poor and felt the best way they could do that was to viscerally photograph them so they could be seen rather than invisible.



1941

Residents of southern Oregon and northern California proposed creation of a new state, Jefferson. A group of young men gained national media attention when, brandishing hunting rifles for dramatic effect, they handed out copies of a Proclamation of Independence. It stated that the state of Jefferson was in "patriotic rebellion against the States of California and Oregon" and would continue to "secede every Thursday until further notice."



STRUCTURAL RACISM

1941

Japan's attack on Pearl Harbor, Hawaii, galvanized the U.S. war effort. Over 1,000 Japanese-American community leaders were incarcerated by the FBI because of national security concerns.

1942

President Roosevelt signed Executive Order 9066, authorizing the building of "relocation camps" for Japanese Americans living along the Pacific Coast.

1942

A Japanese submarine shelled Fort Stevens near Astoria. Despite having caused no significant damage, the attack raised awareness of possible future threats. It is the only hostile shelling of a military base on the U.S. mainland during World War II and the first since the War of 1812. Also, a Japanese submarine launched seaplanes that dropped bombs on the southern Oregon coast. Incendiary (fire) bombs were to cause fires in the thick Siskiyou National Forest. If the trees had been as dry as normal, the Japanese plan might have worked, leaving forest fires to divert hundreds of firefighters and large amounts of money from the war effort while also triggering panic in Oregon's population.



1942

After the attack on Pearl Harbor, all persons of Japanese heritage living in the western portion of Oregon (and all western states) were forced to move to camps by the Wartime Civil Control Administration. More than 4,500 Japanese Americans from western Oregon were sent to internment camps; 2/3 were American citizens.



During WWII Oregon's African-American population grew substantially - in Portland increasing from 2,565 in 1940 to 25,000 in 1944. Over 7,000 "non-white" workers were employed in the Portland shipyards. Although Kaiser had promised good jobs in the shipyards, local unions resisted integration. Many help-wanted notices specified "white only." After pressure from NAACP, the Kaiser Brothers, a federal inspection team and a reprimand from President Roosevelt, the unions compromised. More skilled jobs were opened to Blacks, but only for the duration of the war. Blacks were allowed to work in union controlled shops and paid union dues, but were denied union benefits. To accommodate the influx of workers, a new town was built in the lowland area adjacent to the Columbia River just north of Portland. First called Kaiserville and then Vanport, it was the world's largest housing project with 35,000 residents making it the second largest community in Oregon. With this rise



in diversity in populations came signs throughout Portland: "We Cater to White Trade Only."

1943-1947

Large numbers of Mexican laborers under the Mexican Farm Labor Program (MFLP) or Bracero program (referring to brazos, arms of helping hands) came to Oregon. Migrant workers were used throughout the state.



1947

PI - 45, the new Bracero program, called for employers to pay for screening, selection and roundtrip transportation for workers from Mexico to the Northwest - previously paid for by the U.S. government. Northwest growers were shocked at the terms of the agreement. There was growing anti-Mexican sentiment and anxiety about the protests mounted by Braceros. Therefore, they decided to no longer contract Braceros; ending the program in Oregon.

1947

The Urban League of Portland took the Housing Authority to task for not enforcing the official federal policy of non-discrimination in housing. The Housing Authority's local policy was to separate tenants according to race, making it impossible to serve either whites or people of color on a first come, first served basis. Some vacant housing in Vanport and Guilds Lake were unavailable to white people because they were in an area designated for Blacks only. The Urban League's urging had little effect on the Housing Authority actions. The Portland Housing Authority did not integrate its operations until 1950 and even by 1957 was not offering housing to most Blacks.



1948

On Memorial Day, a Columbia River flood left 39 people dead and obliterated all of Vanport. It had become a declining settlement as war-time workers were replaced and non-whites were encouraged to leave the area. They were not needed for the war effort. There was no direct action taken by Portland's Housing Authority to resettle flood victims as patterns of segregation were reinforced. Most displaced Blacks were forced to congregate in the Albina section of town or left the Portland area. There were no places to live and no more well paying jobs now that WWII was over.



1951

Oregon repealed its law prohibiting interracial marriages.

1952

Hundreds of Oregon Issei, those born in Japan, applied for citizenship after Congress lifted the ban.

1954

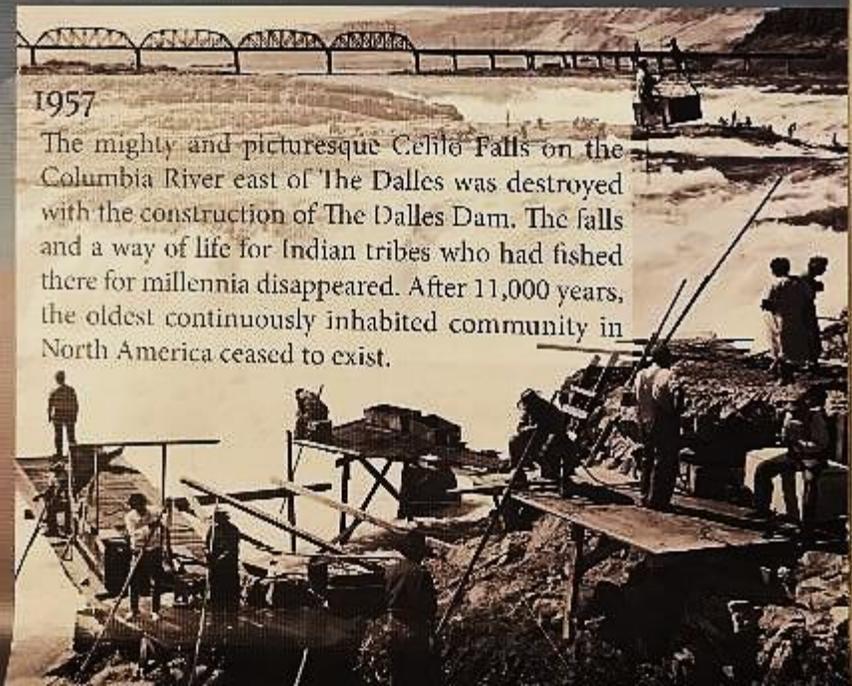
Operation Wetback began to round up and deport 1 million Mexicans who were not able to provide legal immigration documents. In some cases these "illegal immigrants" were deported along with their children who were U.S. citizens born in the United States. Mexican-looking people were often stopped and asked for official identification.

1954

Congress terminated federal aid granted by treaties with 109 tribes, dissolving the Klamath, Grand Ronde and Siletz reservations and sanctioning the selling of their tribal lands.

1957

The mighty and picturesque Celilo Falls on the Columbia River east of The Dalles was destroyed with the construction of The Dalles Dam. The falls and a way of life for Indian tribes who had fished there for millennia disappeared. After 11,000 years, the oldest continuously inhabited community in North America ceased to exist.



1957

Lawmakers passed the Oregon Fair Housing Act, barring practices that had discriminated against African Americans in buying and renting places to live. This law made it illegal for property owners or their agents receiving any public funding to discriminate "solely because of race, color, religion, or national origin."

1959

Oregon finally ratified the 15th Amendment to the U.S. Constitution which provided that no government may prevent a citizen from voting based on that citizen's "race, color, or previous condition of servitude" (slavery).



1962

NAACP charged Portland with having racially segregated schools.

1965

Busing of African American students began in Portland as the major means to desegregate schools.

1967-69

Racial tensions escalated into riots in Portland's African American communities.



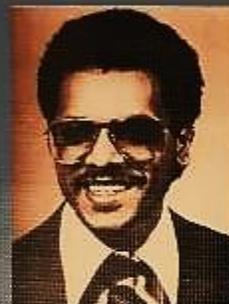
1981

Two police officers dumped dead opossums at an African American-owned restaurant in Portland. The incident evoked ugly KKK imagery and touched off one of the most contentious disputes between police, city government and the public. As a result a citizen's committee to review police actions in Portland was created.



1988

Congress approved Civil Liberties Act paying \$20,000 to each surviving interned Japanese-American, 40 years after their internment.



1988

A 28 year old Ethiopian student and father, Mulugeta Seraw, was fatally beaten in Portland by three racist skinheads.

1990

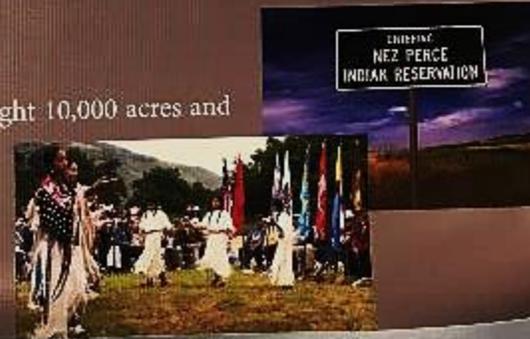
Mulugeta Seraw's father and son, represented at no cost by the Southern Poverty Law Center and the Anti-Defamation League, successfully filed a civil law suit against the killers and an affiliated organization. They won a civil case against White Aryan Resistance's operator Tom Metzger and his son John Metzger for a total of \$12.5 million.



The Metzgers declared bankruptcy, WAR went out of business and Metzger lost his home and went on welfare.

1997

Nez Perce Tribe bought 10,000 acres and returned to Wallowa County.



1999

The Oregon state legislature held a Day of Acknowledgment to recognize the past discrimination earlier legislatures had sanctioned.



2000

Oregonians finally voted to remove all racist language from its constitution which still had a clause that read: "No free Negro, or mulatto, not residing in this state at the time of the adoption of this constitution, shall come, reside, or be within this State, or hold any real estate." Though this and other discriminatory language was rendered unenforceable by federal laws and amendments to the U.S. Constitution, it was not until this election that removal of several examples of institutional racism and oppression was taken out of the Oregon Constitution.

Article 1, Section 26 of the Oregon Constitution, as amended, reads: "No free Negro, or mulatto, not residing in this state at the time of the adoption of this constitution, shall come, reside, or be within this State, or hold any real estate." This clause was removed by a vote of 57-43 in the Oregon Statewide Ballot Measure 5 in 2000.

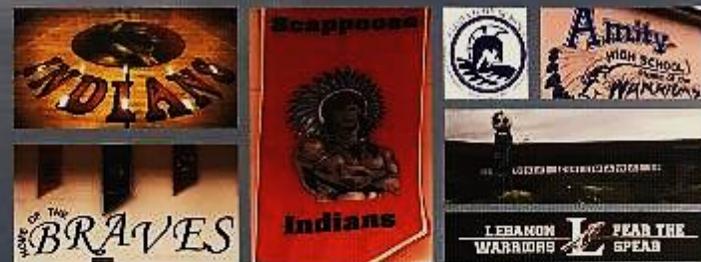
2006

Thousands of Latinos and supporters rallied in Portland, Salem and Hood River to protest a federal proposal that would make illegal immigration a felony.



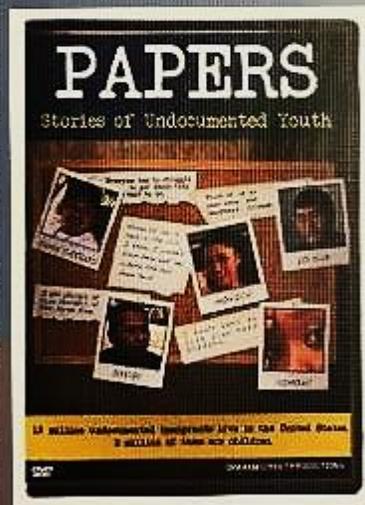
2008

OSAA lists 16 Oregon high schools with mascots that many Indians feel ridicule their heritage. The OSAA has no regulatory authority. Only the Oregon Department of Education can address this issue.



2009

The film, Papers, debuted in Portland Oregon. It is the story of undocumented youth and the challenges they face as they turn 18 without legal status. Currently there are more than 1.8 million undocumented children who were born outside the U.S. and raised in this country. 65,000 undocumented students graduate every year from high school without "papers." In most cases, it is against the law for them to go to college, work or drive, yet they have no path to citizenship.

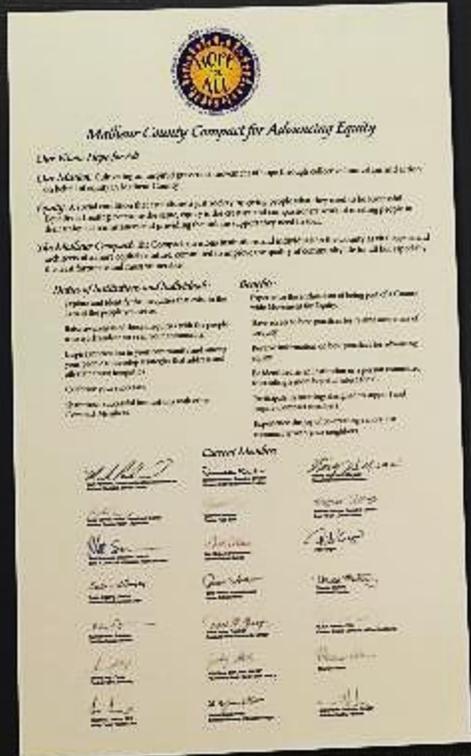


Many organizations and institutions are requiring diversity, equity and inclusion training in an effort to create a better place to live. Others are engaged in an effort to undo the deep structural racism that has existed in Oregon since it became a U.S. Territory.

November 1, 2017 - Malheur County held its first Equity Summit and launched its second cohort of Equity Stewards.



2017 Equity Summit
Compact created by first Equity Stewards cohort

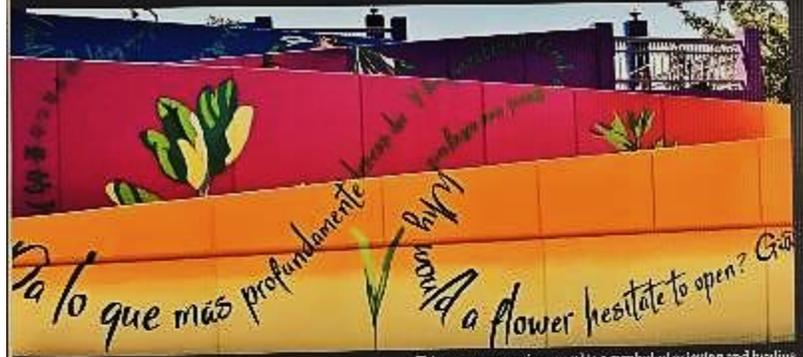


2017 - MAX Train Stabbing - 2 Dead In Train Attack In Portland On Eve of Ramadan

Jeremy Christian pleaded not guilty to a 15-count indictment that includes two counts of aggravated murder and one count of attempted murder. Prosecutors say Christian boarded the light-rail train on the afternoon of May 26, 2017, and shouted racist remarks at two African American girls. One of the girls was wearing a hijab. As Christian grew increasingly upset and passengers intervened, Christian took out a nearly 4-inch knife, prosecutors said in previous court filings. Christian then stabbed three victims in the neck and head 11 times in 11 seconds, police have testified during previous hearings. Taliesin Namtkai-Meche and Ricky Best died in the attack. Portland State University student Micah Fletcher survived.



Namtkai-Meche and Ricky Best died in the attack. Portland State University student Micah Fletcher survived.



This commemorative mural is a symbol of grieving and healing located at the Hollywood Transit Center, site of MAX train stabbing.

2018 BUILDING MOMENTUM FOR EQUITY ACROSS OREGON

Voters upheld Oregon's 31-year-old sanctuary state law with a dramatic lead on "no" votes for Measure 105. About 63 percent of the 1.4 million votes counted elected to keep the existing statute that prohibits local police from enforcing immigration law. Proponents of the measure claimed the sanctuary law emboldens undocumented immigrants to commit crimes and ties the hands of law enforcement. Opponents said the law prevents racial profiling and insist if the law is repealed, immigrant communities and people of color will feel unsafe and too frightened to report crimes to police out of fear of deportation.

This panel is intentionally blank
so that you can contribute other
examples of structural racism in
Oregon. This isn't the whole story.

What is yours?



STRUCTURAL RACISM

Public Health Advisory Board
Funding principles for state and local public health authorities
February 15, 2018

The Public Health Advisory Board recognizes that funding for foundational capabilities and programs is limited, but innovations can maximize the benefit of available resources. These funding principles are designed to apply to the public health system, which means state and local public health authorities in Oregon. These funding principles can be applied to increases or decreases in public health funding.

Public health system approach to foundational programs

1. Ensure that public health services are available to every person in Oregon, whether they are provided by an individual local public health authority, through cross-jurisdictional sharing arrangements, and/or by the Oregon Health Authority.
2. Align funding with burden of disease, risk, and state and community health assessment and plan priorities, while minimizing the impact to public health infrastructure when resources are redirected.
3. Use funding to advance health equity in Oregon, which may include directing funds to areas of the state experiencing a disproportionate burden of disease or where health disparities exist.
4. Use funding to incentivize changes to the public health system intended to increase efficiency and improve health outcomes, which may include cross-jurisdictional sharing.
5. Align public health work and funding to coordinate resources with health care, education and other sectors to achieve health outcomes.

Transparency across the public health system

6. Acknowledge how the public health system works to achieve outcomes, and direct funding to close the identified gaps across the system in all governmental public health authorities.
7. Improve transparency about funded work across the public health system and scale work to available funding.

Since 2018, PHAB funding principles have been used in the following ways

- Foundational resource for developing the 2019-21 modernization funding formula.
- More public health funding formulas include health indicators to determine LPHA funding allocations.
- LPHAs have developed a companion document that includes a set of questions to ask for each funding principle when making funding decisions.

2020 funding principles review and update

- Will be a resource for developing the 2021-23 modernization funding formula.
- LPHAs and OHA have identified a need for additional guidance for distributing public health funding when funding is not sufficient to distribute to all LPHAs.

Questions for PHAB

1. What aspects of the funding principles drive our commitment to health outcomes and health equity? Do you see any conflicts?
2. Which principles seems to most closely align with the public health modernization funding formula? Which are least aligned?
3. Are there principles that should be emphasized as more important to achieving public health modernization goals?

Public Health Advisory Board (PHAB)
Accountability Metrics Subcommittee meeting minutes
December 19, 2019
2:00 p.m. – 3:30 p.m.

PHAB members present: Muriel DeLaVergne-Brown, Eva Rippeteau, Dr. Jeanne Savage, Teri Thalhofer, Rebecca Tiel

PHAB members absent: Dr. Eli Schwarz

Oregon Health Authority (OHA) staff: Sara Beaudrault, Dr. Myde Boles, Krasimir Karamfilov

Welcome and introductions

Ms. Beaudrault introduced the meeting. She noted that Zoom web conferencing would be used during the meeting. She invited subcommittee members to introduce themselves. Subcommittee members introduced themselves.

Ms. Beaudrault remarked that one of the meeting objectives was to pick up where the subcommittee left off last April/May and discuss the purpose of the report, its usefulness, the requirements around the report, and OHA's use of the report, so that changes could be made before the publication of the 2020 report. When the PHAB approved the 2019 report, the board requested OHA to look at some of the process measures and consider making changes. She will provide an update on those changes. Last month, the Conference of Local Health Officials (CLHO) provided feedback on the proposed changes.

Ms. Beaudrault noted that in terms of minutes, the subcommittee wouldn't be able to approve the minutes, because Dr. Savage was absent. Ms. DeLaVergne-Brown and Dr. Savage were the two subcommittee members at the last meeting.

Subcommittee timeline and scope of work

Ms. Beaudrault stated that as in previous years, the bulk of this subcommittee's work was going to be during the first half of 2020. In December 2019, the focus of the meeting will be on the purpose and use of the annual report, with the subcommittee recommending changes to the framing and layout of the report. There will be no need to meet in January 2020. In February 2020, the subcommittee will review the changes to the report framing and layout and provide feedback on the overall look and feel of the report, as well as some of the framing language that goes into the introduction and background portions. In April 2020, most of the data will be available and the subcommittee will discuss key findings and messages. This was pushed back a little bit to allow some of the Public Health Division programs to report 2019 data, instead of 2018 data.

Ms. Beaudrault added that in Spring 2020, the SHIP indicators will be finalized. It's hard to say if the PHAB would discuss changes to the accountability metrics report, based on the direction

that the SHIP goes. In May 2020, the final 2020 report will be completed and the PHAB will be asked to adopt it at the board's meeting in May. In June 2020, the report will be published and OHA will submit a funding report to the Legislative Fiscal Office.

Purpose and use of public health accountability metrics

Dr. Boles reviewed the legislative requirements, stipulated in ORS 431, for the accountability metrics. One of the things that have been discussed from the previous report is the use of the term *accountability metrics*. Although the report is in statute about accountability metrics, it is really about public health system metrics and the value and contributions of the whole public health system. The purpose of the report is to help us identify a need or gaps. One of the ideas is to retain *accountability metrics* in the title of the report and have a two-part title that says that it is a public health system metrics report. A smaller, secondary title could say that it is an accountability metrics report. This could also be framed more specifically in the introductory section of the report.

Dr. Boles added that accountability component reflected on the link between accountability and funding, with both being primarily focused on communicable disease control. There hasn't been direct modernization funding for some of the other metrics in the report. OHA will continue to highlight the lack of funding for many of the metrics in the report.

Ms. DeLaVergne-Brown shared that she liked the idea about reframing the report. There's much more to the report than accountability and demonstrating the need and where the state is going. It's really about the system, not just every county.

Ms. Tiel said that she liked the framing focused on the public health system, but the subcommittee shouldn't lose sight of accountability. That's what is in the statute and it is important to the system. She was unsure what problem the title change would solve.

Dr. Boles answered that in past meetings, LPHAs have been concerned about the term *accountability* when there was no incentive funding, or funding to support efforts related to the metrics. The point is not to remove the word *accountability*, but downplay it, and emphasize the overarching public health system component.

Ms. Tiel noted that what made the modernization initiative innovative was that the public health system was holding itself to something collectively. *Accountability* is what makes Oregon so unique in its approach.

Ms. Thalhoffer agreed that the way the report has been framed was that LPHAs were held accountable for meeting something without holding the OHA accountable for meeting something. The report doesn't show that the system is working together. The way it is framed now is still state against local. A new way is needed to express that this is not what the state is trying to do.

Ms. Rippeteau reminded the subcommittee that it was hard to hold people accountable when they didn't have funding to do the work. It's not about removing accountability or the focus on it, but recognizing that all parties involved, whether it is the legislature as the funder, or the state, or LPHAs that do the work, are in this together. Doing the work without being funded properly puts the onus back on the legislature. Accountability should be more about the relationship between the parties, rather than an expectation. The people working in public health are already accountable to the people in the state to do their best and prevent communicable disease and other diseases. Without getting funding to do the work, one can be accountable to only so much.

Dr. Boles stated that the report was organized by the modernization foundational programs: communicable disease control, prevention and health promotion, environmental public health, and access to clinical preventive services. The importance of health equity is highlighted in the report. There is race and ethnicity reporting for the overall health outcome measures. The report also includes the outcome measures and the process measures. She asked the subcommittee members how they used the report and if they knew others who were using the report.

Ms. DeLaVergne-Brown shared that in Crook County, the staff used the report when they were creating operational plans. The LPHA is in the process of starting a new strategic plan and the reports is included as one of the data points.

Dr. Boles asked if the Crook County team was pulling the data points that they needed from the report.

Ms. DeLaVergne-Brown answered that in addition to that, the report was used to gauge where Crook County was for each measure and what work was needed to do. Funding was lacking in some cases, but the question was how to still move forward based on operational plans.

Ms. Thalhoffer remarked that she shared the report with the North Central Public Health District board and the local public health advisory councils. The sharing is in print format.

Ms. Tiel added that she used the report to prepare the annual PHAB presentation to the Oregon Health Policy Board. She found the slide deck format more helpful for sharing the information in the report with other stakeholders. The downside of a slide deck is that the footnotes in the report don't end up on the slide.

Dr. Savage pointed out that as an outsider to public health, the report was used for education with legislators. When the subcommittee looked at it, the discussion revolved around ease of understanding, and readability, and a way of modeling what public health was looking at and doing, and also, when accountability is discussed, being accountable for outcomes resulting from funding. That is, showing people what public health does with the funding that it gets, whether it's big or small, and showing the impact the work has with whatever funding public

health receives. The report was also used at QHOC, where all CCOs met and discussed what projects public health was doing to create a connection with the CCO and work on similar projects together.

Dr. Boles stated that the OHA team has been thinking about streamlining the report this year. Some of the introductory material will be removed. Instead of a lot of textual narrative in the introduction, the section will include short blocks of text and bullet points. The key elements will include the outcome measures, statewide data by race and ethnicity and by county, and the local public health process measures by county. The new report will have less text and more white space. It will still include an executive summary, introductory key points, and metrics pages. A longer technical document with narrative, notes, and data tables will be available online. The format may not be a slide deck format, but something that is briefer and can be used easily.

Dr. Boles added that the map format would be retained. Some horizontal information could be presented vertically. The process measures will have three time points instead of two and will be presented in a timeline-oriented way as spark lines, because there is a lot of data. Most of the information in boxes and notes will be transferred to the technical document, except the most key contextual information that needs to be included on the page.

Ms. Rippeteau reiterated her suggestion that accountability didn't only mean being accountable to providing services, but the legislature was accountable to public health to fund it. Often the questions are *What are we buying? What are the services? What's the FTE that's associated with this?* Maybe the detailed report should include some sort of indicator that shows the dedicated staff for the work and the FTE, or an indicator that shows why a benchmark was or was not met.

Dr. Boles answered that this information is not currently collected statewide. It's information that each LPHA must have, but it's not available on the state level. Local public health staff have the general contextual information and know the connection between resources, staffing, and funding, and what can and cannot be accomplished.

Ms. Thalsofer remarked that LPHAs braided and blended funds to such an extent that people worked in multiple programs. Losing funding from what seems to be a small thing hits an LPHA's capacity in a huge way.

Ms. Beaudrault pointed out that in addition to the accountability metrics report, OHA did an evaluation report that focused more directly on the legislative investments. This conversation has come up with the evaluation planning group as well. How do we talk about improvements with a \$15 million investment within the broader context when some LPHAs are at a net loss, not a gain?

Ms. Tiel agreed that Ms. Rippeteau's comments fit in an evaluation bucket. It should be clear that public health is buying staffing. It takes people and systems to run a public health system. It should be very clear in the report that the public health system is run by FTE and requires sophisticated data systems, which are very different than the investment the legislature might make in the education system or other systems. In the evaluation report, there can be a more specific breakdown of what happens when there are gains and losses in specific programs. When the investment is bigger, there is more money in the system, but that doesn't necessarily mean that specific areas of the state or programs are seeing gains. It's helpful to have two reports.

Ms. Rippeteau added that if the legislature wanted to know what it was paying for and expected public health to be accountable by moving the marker on things, public health staff could show what it takes for public health to do this work. The legislature won't give public health another \$5 million or \$15 million without fully understanding what the funding does and whether or not it moves the marker.

Dr. Boles noted that the discussion was beyond the scope of the report. Talking about it in the context of modernization evaluation is appropriate. The two things are linked. One is more on the result, while the other is more on the process and the investment. The modernization evaluation is focused on communicable disease control because that's where the money has gone. All the rest doesn't make a connection in the report, in terms of modernization funding.

Ms. Rippeteau commented that maybe it should be noted in the report that there hadn't been any modernization money focused on most metric in the accountability report and LPHAs hadn't been able to fund any additional staffing to focus on this work, but the LPHAs were still accountable to their communities in these areas.

Dr. Boles summarized the discussion around the importance of retaining the context around the funding and the resources available to do the work. The feedback supported the pairing down of the report and making it cleaner and less busy, resulting in a brief report with a reference to a technical document online.

Ms. Beaudrault suggested to use the couple of sentences and bullet points at the top of each page to highlight the problem that was being solved, what the state public health system did to address that problem or should be doing, and something about the funding.

Dr. Boles acknowledged the suggestion and thanked the subcommittee members for their feedback. The OHA team has started collecting the data and will present a draft layout of the report at the subcommittee meeting in February.

Measure set updates

Ms. Beaudrault reminded the subcommittee that the PHAB asked OHA to look into a few of the process measures for the 2020 report. The OHA team has been working on that with OHA program staff, as well as talking with CLHO and CLHO committees to get their feedback. The first two measures—*dental visits for children 0-5*, *prescription opioid mortality*—are outcome measures, not process measures. PHAB voted on both measures in August. For process measure *percent of top opioid prescribers enrolled in PDMP*, both OHA and CLHO recommended to remove the measure from the 2020 report. OHA will work with CLHO to identify a new process measure that will tie to opioid mortality in 2020.

Ms. Thalsofer asked whether somebody kept track of where the wins were. The law change for prescribing opioids was a public health win. It's a mistake to say that it isn't applicable anymore. Somebody should keep track of the wins, because with policy systems and environmental change, there was a policy change through advocacy that fixed the problem.

Ms. Tiel agreed with Ms. Thalsofer and wondered where that might be listed in the report. The prescription opioid law was a huge win and there is regulation in place now. That happened because public health worked toward that big goal. It would be good to see the wins over time.

Dr. Boles answered that this information can be noted in the executive summary of the report.

Ms. Rippeteau suggested to include a table in the report, maybe at the end of it, that listed measures that had been removed from the report over the last five years along with explanations for their removal. This way, people could see that the public health system was able to accomplish much more when it started making modernization efforts and having better funding.

Ms. Beaudrault reviewed the changes for process measure *percent of population reached by tobacco-free county properties policies*. The PHAB recommendation was to differentiate comprehensive and partial policies. OHA proposed a change, but CHLO was not supportive of it.

Ms. DeLaVergne-Brown remarked that there were county commissioners in the state who advised LPHAs to not talk about tobacco policy. It has to be taken into consideration what the counties and the LPHA directors are dealing with locally with their policy makers.

Ms. Thalsofer added that this was one of those things where the system must be discussed. It hasn't been that long since the state adopted tobacco-free properties. For a long time that was one of the deliverables in the tobacco program at North Central Public Health District, but state properties were not tobacco-free. The frustrating thing is that the effort is not strength-based. The discussion is not about how the process is moving forward, but about what is lacking. One of the conversations that was brought up by the locals was that sometimes the cities are more progressive and they are making great strides with city government, but the county government isn't ready to switch. It's the same with the state's message to LPHAs to turn the counties tobacco-free, but sometimes the work has to be done city-to-city. The OHA proposal

didn't recognize all the local work that was happening. Maybe the initiative needs more narrative.

Ms. DeLaVergne-Brown agreed with Ms. Thalsofer and stated that in Crook County, they went department by department. A lot of questions came up that people had gotten approval for the parks and other health care organizations in their area and it wasn't just county property. Maybe the wording of this measure is confusing.

Ms. Tiel shared that she would love to see if ten cities in a county had passed such policies, even if the county building facilities were not tobacco-free. It's a very important process measure where it can be shown that county health departments and public health are leaders in policy change and in bringing people together around complex issues. The process measure shouldn't be removed. It is maybe a framing issue and how the data is presented visually to show the progress. She asked about the four categories in the OHA proposal.

Ms. Beaudrault explained that the categories were *no county policy*, *county policy that covers only health department buildings*, *a comprehensive policy that has exemptions to it*, *a county-wide policy with no exemptions*. The categories don't allow for a city-to-city look. It also doesn't reflect the strength of the coalition that is moving in the right direction.

Dr. Boles added that it was also complicated because the measure was *percent of population reached*. The assumption is that it's possible for anybody in a county's population to be affected, because they may go to any one of those locations where there is a tobacco-free policy, such as a park or health care system or a county building. Because everybody had the potential to be affected, the measure was all or nothing. The *population reached* portion of the measure is not very valuable, because it is imprecise. If the measure is changed, it has to identify the places that had tobacco-free policies, whether that is cities, parks, or county buildings, and the measure lists where that happened instead of the percent of population.

Ms. Tiel reiterated that this was a great process measure, because incremental change can be seen. Every year, there are more and more policies that are passed, or existing policies, including policies about e-cigarettes, or policies expanding in different ways. It is a challenge to visualize that information.

Dr. Boles asked if the measure could be returned to HPCDP to pull out every tobacco-free policy area, not just county properties.

Ms. Beaudrault answered that she didn't know whether that was possible. The OHA team can be asked to put the data into these four categories. CLHO will have a chance to look at it before anything goes into the report. The subcommittee will have a chance to look at it as well. Maybe a decision about what would go into the 2020 report should be made when the data has been reviewed. Moving forward from the 2020 report, the OHA team can continue to work on this process measure and refine it so it best shows where progress has been made.

Dr. Boles remarked that one of the three contextual points on every page could be about what the system has done or does, so it was very clear.

Ms. Beaudrault provided the next steps for the subcommittee: (1) whether it was possible to get information about where some LPHAs have city tobacco-free policies, (2) run the data by the four categories and let everyone see what those data looks like before a final decision is made about what goes in the report, (3) add some information about the state role.

Ms. Beaudrault explained that for process measure *active transportation*, the recommended change was for the measure to reflect an LPHA's participation in implementation, in addition to planning. Two CLHO committees—prevention and health promotion, environmental health—supported the change. For process measures related to drinking water, most measures are at close to 100% for all LPHAs. The recommendation from OHA and CLHO is to show the measures in the 2020 report and work through CLHO on identifying new, more meaningful process measures. For the process measure on *effective contraceptive use*, PHAB requested to expand the data collection mechanism to capture strategic plans not reported annually to OHA's reproductive health program. The recommendation from OHA and CLHO is to keep data collection as is and, if a local public health administrator has a strategic plan that addresses access to reproductive health services and effective contraceptive use, they can send it to the program and be counted as met.

Ms. Tiel remarked that in terms of the role discussion, what if there was a different entity in a community, such as a nonprofit or a health system, that led the strategic plan and the LPHA was an active participant in developing the plan. Does the plan have to be an internal LPHA strategies plan, or it can be a community plan?

Ms. Beaudrault answered that the strategic plan didn't have to be under the LPHA's name.

Subcommittee business

Ms. Beaudrault asked who would like to give a subcommittee update at the PHAB meeting on January 16, 2020.

Ms. Thalhoffer volunteered to provide an update.

Ms. Beaudrault informed the subcommittee that the next meeting would be in the first half of February so that the meeting was before the PHAB meeting.

Subcommittee members identified February 12 at 3:30 p.m. for the next meeting date and time. Ms. Beaudrault will schedule the meeting.

Public comment

Ms. Beaudrault invited members of the public to ask questions and provide testimony.

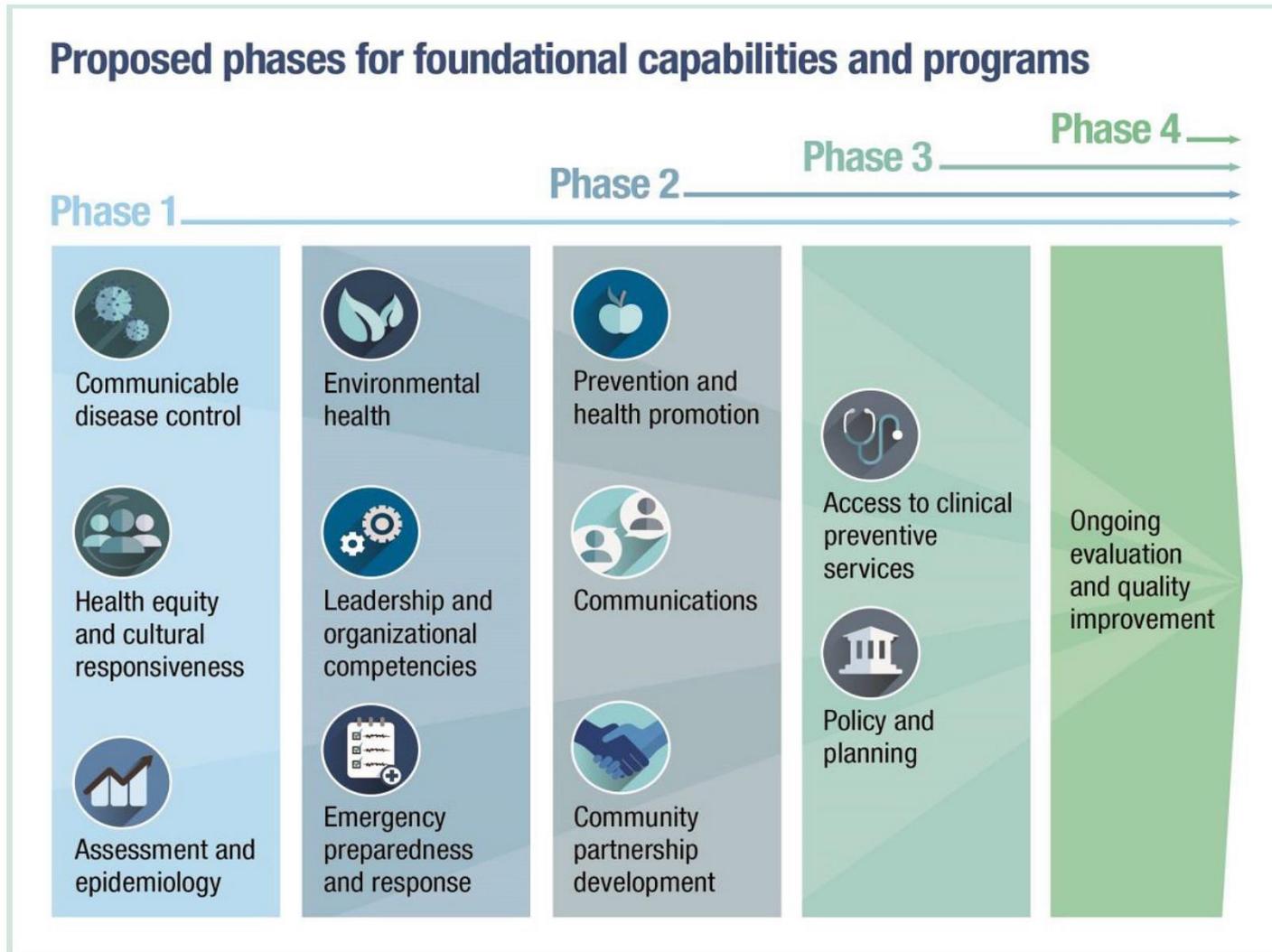
There was no public comment.

Closing

Ms. Beaudrault adjourned the meeting at 3:07 p.m.

DRAFT

Public health modernization phases for implementation



PHAB funding priority recommendations for 2019-21

(February 2018)

1. The public health system continue to focus on Communicable Disease Control, Health Equity and Cultural Responsiveness, and Assessment and Epidemiology; and
2. With additional funding, expand focus to include Environmental Health, Leadership and Organizational Competencies, and Emergency Preparedness and Response.

2021-23 public health modernization funding priorities

Questions:

1. Do the phases for implementation:
 - a. Effectively bring attention to the foundational capabilities as essential for effective public health programs?
 - b. Effectively demonstrate the interconnectedness between foundational capabilities?
2. Does PHAB recommend changes to the funding priorities for 2021-23?

Action: Vote to approve 2021-23 funding priorities.