

AGENDA

PUBLIC HEALTH ADVISORY BOARD

April 16, 2020, 2:00-3:30 pm

<https://global.gotomeeting.com/join/205813685>

United States: +1 (872) 240-3212

Access Code: 205-813-685

Meeting objectives:

- Elect PHAB Chair for 2020-2022
- Discuss updates to PHAB charter and bylaws
- Review draft PHAB work plan
- Discuss current COVID-19 response
- Review draft 2020-24 State Health Improvement Plan and provide input on draft strategies

2:00-2:05 pm	Welcome and agenda review <ul style="list-style-type: none">• ACTION: Approve March meeting minutes	Rebecca Tiel, PHAB Chair
2:05-2:10 pm	Officer position <ul style="list-style-type: none">• ACTION: Elect chair	Cara Biddlecom, OHA staff
2:10-2:25 pm	Updates to PHAB charter and bylaws <ul style="list-style-type: none">• Review PHAB charter and bylaws and propose updates	Rebecca Tiel, PHAB chair
2:25-2:35 pm	Review PHAB work plan <ul style="list-style-type: none">• Discuss work plan priorities	Cara Biddlecom, OHA staff
2:35-2:55 pm	COVID-19 response update <ul style="list-style-type: none">• Discuss response activities to date	Dean Sidelinger, OHA staff
2:55-3:10 pm	2020-24 State Health Improvement Plan <ul style="list-style-type: none">• Review revised SHIP timeline• Provide feedback on draft strategies	Liz Gharst, OHA staff

3:10-3:20 pm	PHAB member discussion <ul style="list-style-type: none">• Discuss key issues that PHAB members should be aware of or should help problem solve on behalf of the public health system• Discuss PHAB member roles and liaison responsibilities	Rebecca Tiel, PHAB Chair
3:20-3:30 pm	Public comment	Rebecca Tiel, PHAB Chair
3:30 pm	Next meeting agenda items and adjourn <ul style="list-style-type: none">• Determine agenda items for May meeting	Rebecca Tiel, PHAB Chair

Public Health Advisory Board (PHAB)

DRAFT March 19, 2020

Meeting Minutes

Attendance:

Board members present: Dr. Jeanne Savage, Dr. Eli Schwarz, Kelle Little, Dr. Bob Dannenhoffer, Dr. Dean Sidelinger, Alejandro Queral, Rebecca Tiel, Dr. Sarah Present, Dr. Veronica Irvin, Rachael Banks, Dr. David Bangsberg, Eva Rippeteau

Board members absent: Akiko Saito, Lillian Shirley (ex-officio), Teri Thalhofer, Muriel DeLaVergne-Brown, Carrie Brogitti

Oregon Health Authority (OHA) staff: Cara Biddlecom, Krasimir Karamfilov

Members of the public: None

Welcome and Agenda Review

Rebecca Tiel

Ms. Tiel welcomed the PHAB to the meeting.

- Approval of February 2020 Minutes

A quorum was present. Dr. Savage moved for approval of the February 19, 2020, meeting minutes. Mr. Queral seconded. The PHAB approved the meeting minutes unanimously.

- Debrief Action Items from February Retreat

Ms. Tiel remarked that the retreat gave the PHAB members a chance to think collectively about PHAB's goals and priorities, and to talk about operational changes the board can make to its meeting structure to support its work. One of those changes is reflected in today's agenda. At the end of today's meeting, the board will take some time to think about planning for its next agenda items. There will be an attempt to make things more interactive with the understanding that it is hard to do when the board meets remotely. The feedback was heard and it will be worked into the board's future agendas.

Ms. Tiel added that in terms of the priorities the board identified at the retreat, board members voiced support for establishing a commitment to leading with race to achieve racial health equity. In addition, the board talked about different strategies around community engagement, co-creation, power-sharing, leveraging opportunities with health system partners to address



Public Health Advisory Board
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social determinants of health, and other community priorities. With that in mind, the PHAB will review the board's 2020 workplan during the meeting in April.

Ms. Rippeteau stated that she missed the retreat. She wanted to abstain from approving the February meeting minutes, because she wasn't there.

Dr. Schwarz congratulated the board for the retreat. There is something about a retreat, especially when it is well facilitated, that is useful compared to a regular meeting. He asked what the process for the workplan would be like. Are the board members going to think about it over the next month, or the plan will be done centrally and sent out to the PHAB?

Ms. Biddlecom answered that the OHA team drafted a workplan based on the retreat. Due to other current pressures on public health, the workplan was not prioritized for the shorter PHAB meeting. The board needs to look at it and ensure that it reflects the conversation from the retreat and prioritizes appropriately. The OHA team already has a document for the board. It can be sent out so that the board members can look at it in between meetings and provide additional thoughts. Board members can reach out directly to her.

Officer Positions

Cara Biddlecom

Ms. Biddlecom reminded the PHAB that, according to the bylaws, the PHAB chair was elected for two years. Ms. Tiel has been in her position for two years. It is time to reup the chair. Each chair position can be reupped one time. Voting can be done via videoconferencing, but the board cannot do a non-public ballot procedure. The board needs to meet on the phone or via videoconference and have a quorum.

Dr. Schwarz noted that he attended a board meeting yesterday and the board voted on individuals by texting the chair to a phone number. That seemed to be acceptable.

Ms. Biddlecom explained that the PHAB must follow public meeting laws, so that the individual votes were transparent.

Ms. Banks pointed out that in terms of the emergency declarations, Multnomah County had suspensions of public meeting laws wrapped in with the emergency declarations. She wondered if OHA had something similar in the Governor's order.

Ms. Biddlecom responded that she would ask OHA's attorney. She was not sure if OHA had specifically addressed the suspension of public meeting rules.

Ms. Rippeteau added that at her organization, they vote in public meetings via Zoom.

Ms. Biddlecom shared that in the spirit of public meetings, the PHAB received additional advice from a public meeting attorney with the Department of Justice. The board can't continue to operate having a chair and co-chair the way it has had them. Both Ms. Brogotti and Ms. Tiel have been planning meetings and have been on conference calls to discuss agendas. The board needs to centralize that into the chair position. The board will have one chair for the PHAB. If that person cannot participate in a meeting, the board members will solicit someone else who is able to chair the meeting and facilitate it. There will be one chair in the next term.

Dr. Dannenhoffer recommended that until the PHAB had a formal vote, the current PHAB chair continued.

Oregon's COVID-19 Response

Dr. Dean Sidelinger

Ms. Tiel remarked that her work at the Oregon Association of Hospitals and Health Systems (OAHHS) had been intense with COVID-19 response over the last two weeks. OAHHS has been in contact with colleagues in Washington state and the experiences there has been very sobering.

Dr. Sidelinger informed the PHAB that OHA activated its agency operations center (AOC) in mid-January in response to requests around repatriation. The level of activity and frenzy has picked up over the last two weeks. The current situation in Oregon:

- 88 confirmed cases of COVID-19; 3 deaths
- 437 people under investigation with pending test results
- 1329 people under investigation, who had negative results

Dr. Sidelinger explained that the public health lab was certified to do testing on February 28, 2020. The first identified case was discovered in the first run of tests. Commercial lab testing is up and running and OHA has been receiving results from the commercial labs since March 16, 2020. It is expected the testing results and positive testing results to increase significantly in the coming days and weeks. The people who tested positive are just the tip of the iceberg. Oregon might be two weeks behind the state of Washington, based on the first cases in each state. In modeling, OHA is working with Multnomah County, OHSU, research and scientists from hospital systems, and several modelers across the county and internationally. The Institute for Disease Modeling in Bellevue, Washington, has been very helpful.

Dr. Sidelinger added that OHA had a couple of different models that it was trying to coalesce, based on best assumptions that are coming out from other countries and across the U.S., and building on the data that we have from Oregon and Washington, to try to predict where Oregon is going. Some of those models, particularly out of OHSU, have shown that by April 11, 2020, we might have a need for around 1,000 hospital beds in Oregon, with 400 of those being ICU beds.

The slope of the curve at this point is still going up and we don't know where it will end. That model didn't take into account the community mitigation measures that we have in place in Oregon.

Dr. Sidelinger stated that Governor Kate Brown had issued several emergency orders. OHA has had guidance around community mitigation and non-pharmaceutical intervention measures over the last two weeks. Many of the measures in Oregon were set in place around the same time measures were set in place in Washington. It is believed that Oregon is a bit ahead of Washington because the epidemic in Washington was ahead of the epidemic in Oregon. The initial emergency orders focused on large gatherings and encouraging people to telework, reinforcing the message from CDC that older adults and people with underlying medical conditions should stay at home as much as possible.

Dr. Sidelinger noted that school closure was required by the Governor. The first order included restaurant closures and going to take-out only. Since then the school closures have been extended. Institutes of higher education, such as the state colleges and universities, as well as private colleges and universities, are required to go to online learning only, with certain rare exceptions, keeping some resident halls and food service open for those who don't have other options for housing and food.

Dr. Sidelinger added that there would be orders for canceling elective surgeries to help free up PPE (Personal Protective Equipment), as well as facilities and personnel to address people who were ill. It is anticipated that those emergency orders will continue to come. They are done in consultation with OHA, partners, and local public health authorities. Neither public health nor the Governor's office took lightly the community mitigation measures that are in place. It is recognized that the economic impacts are huge and particularly the equity piece of those impacts are huge. Low-wage workers and smaller business will be impacted the most. The impact will be lesser on large businesses and salaried workers who have a higher income and have savings or other things to fall back on, or access to other income during this time.

Dr. Sidelinger pointed out that Governor Brown had stepped up a taskforce that would help look at options and resources that could be brought to bear to try to blunt some of that impact. Governor Brown stood up a joint taskforce on healthcare system capacity that began meeting on March 18. Some of the work that was done in the Portland metro area by the hospital systems coming together formed some of the basis for this, as well as the crisis care guidelines that were developed about a decade ago by OHA, local public health, and the hospital systems. Working on three fronts simultaneously, the EMS system is looking at:

- The pre-hospital system of care and what are the impacts there and whether the need is going to be in that system.
- The hospital and in-patient infrastructure for people who need to be hospitalized, including those who need ICU care and ventilators and how we can increase that capacity.

- A long-term care step-down category, and whether we can create capacity so that we can differ people who are presenting to hospitals and don't need hospitalization, but perhaps need higher level of care than they would get at home, and can we find a way to discharge patients who no longer need the higher level of care offered in the hospital to this setting.

Dr. Sidelinger remarked that those committees and subcommittees started meeting on March 18. Early recommendations and plans for action are expected to come out early next week. A lot of planning is needed to get things in place before the surge arrives. It is hoped that social distancing will blunt the peak and spread the epidemiological curve, so that the system can handle the influx of cases as they come in. Another piece of system capacity that is going online on March 20 is the Oregon Medical Station, which will create a 250-bed step-down facility in Salem that can serve to keep some people from being admitted to the state hospital.

Dr. Sidelinger added that other things that were being monitored included the state's ED (emergency department) capacity. Overall ED visits are down slightly over the last two weeks. While the percentage of COVID-19 or COVID-19-like illness visits are a very small part of that, there is a dramatic increase in presentations for COVID-19-like illness or COVID-19, which have been the chief complaints since the beginning of March.

Dr. Sidelinger noted that personal protective equipment (PPE) was on everyone's mind. OHA is aware that there are shortages in the supply chain, both in Oregon and across the nation. Many of the healthcare providers and partners in the community are running critically low on PPE. OHA has released much of the material from the state of Oregon cache. Those requests come from healthcare providers to local public health and are funneled up to state public health for fulfillment. The state is currently only able to fill urgent needs based on the equipment the state has left. There was a request to release material from the strategic national stockpile (SNS) and 10% of that request came in last week. Fifteen percent more is expected to come in. Governor Brown will issue an executive order later today for conserving whatever PPE providers currently have and look for PPE in other settings, whether it's dental, veterinary, or other industries that could be used in a healthcare setting.

Dr. Sidelinger informed that PHAB that the initial response by the local public health partners and OHA's public health focused on returning travelers from China, with home quarantine for those without symptoms and isolation of those with symptoms while testing was performed. That quickly was subsumed by additional persons under investigation who were identified through community spread without links to those cases. During that time, the state received returning passengers from cruise ships, who required significant amount of work, both to repatriate them to Oregon as well as monitor them on behalf of the local public health partners.

Dr. Sidelinger clarified that the response had been led by OHA since the middle of January, because most of the situation focused on the public health response, as well as healthcare. As the situation has progressed, there are many impacts beyond what the OHA or the healthcare partners can do, such as things about childcare for healthcare workers and others with essential functions and working with schools and ensuring that they can get meals out. Now we are part of a structure with the Emergency Coordination Center (ECC) in Salem that brings together all state agencies and partners together. ECC is taking many of those emergency support functions that are not healthcare related in that venue and ensures that we work in a coordinated fashion.

Dr. Savage asked about the news that one of the buildings on the waterfront might be open as a homeless shelter or possibly to get homeless people who had been diagnosed in the housing.

Dr. Sidelinger answered that he didn't know that specific building and that specific situation. Having facilities for those who are houseless is a key need that was identified early. The Portland metro area partners in public health, along with social services, have had a lead on that front, because that's where the biggest population is. OHA is trying to adopt many of the documents and plans they have in place for other parts of the state and developing a plan. In addition to the taskforces about building healthcare capacity, we know that identifying housing for those impacted by this, who are either returning to a group or congregate setting, where we don't want to put them back while they are infectious, or for those who don't have a house to go to, to try to identify hotels and other locations for them to go to is a key part of this response.

Dr. Savage thought that it was a building that somebody owned and they thought about transitioning it into a big facility, where a lot of people could be housed.

Ms. Rippeteau shared that she saw a news release last night on Charles Jordan, a community center in North Portland, that was making spaces for shelter beds and provide for safer distances between beds. That is being staffed by existing social service agency people, like transition projects.

Dr. Schwarz pointed out that in a crisis like this, one thing that didn't go away was toothaches, abscesses, and other oral infections. With all dental clinics winding down, he was wondering if dental care was discussed. He met with the Dean of the OHSU School of Dentistry this morning. The school is planning to establish an emergency reception in one of the clinic areas,

where they can safely clean teeth. He wondered if OHA had an official connection with the dental world.

Dr. Sidelinger answered that OHA invited a representative from the Dental Society to participate in the Joint Taskforce meetings for several reasons: (a) knowing that there would be a large request on dental offices to postpone procedures that aren't urgent or emergent, (b) knowing that they are trained healthcare workforce, both the dentists and their staff, who might be able to assist in some of the lower levels of care. They were invited, but their participation is unknown. He will follow up. We need to keep some capacity to meet those urgent and emergent needs that will continue to exist in the dental community.

Dr. Schwarz asked if Dr. Sidelinger would like him to make an email introduction to the Dean of OHSU School of Dentistry, so that Dr. Sidelinger and Dr. Marucha could talk directly.

Dr. Sidelinger agreed and added that he would forward the contact to the people who arranged the taskforce.

Dr. Dannenhoffer reminded Dr. Sidelinger that he sent him a long note yesterday and asked if they could set up a time for discussion, because an answer was needed today.

Dr. Sidelinger answered that he could link him with Lori Coyner or one of her staff.

Dr. Dannenhoffer stated that there were two questions: one was about EMTALA (Emergency Medical Treatment & Labor Act) and the second was about the misinterpretation of the CT study. Lori Coyner is not going to know that. Who interpreted the study for Pat Allen?

Dr. Sidelinger answered that he talked to Pat Allen about CT studies as a diagnostic tool, not as something OHA would recommend when we have a very good RNA test.

Dr. Dannenhoffer explained that RNA was not a very good test. In fact, it is a terrible test that is not particularly sensitive and it's slow, while CT is incredibly sensitive and very fast. The note he saw from Pat Allen was as if he read the study and transposed it exactly backwards.

Dr. Sidelinger answered that if a provider wanted to order a CT scan, OHA was not going to step in the way, but OHA recommended testing for the virus as a way of identifying it.

Ms. Rippeteau stated that this was a time where she got to bring up a workforce issue that was broader than the direct public health workforce. We have a lot of social services agencies that are providing direct care for the unhoused, as well as behavioral health, who might not be considered emergency medical, but who don't have a lot of available paid sick time, or resources to help them stay home when they are sick, or maintain financial stability.

Ms. Rippeteau added that the American Federation of State, County and Municipal Employees (AFSCME) was working with these agencies to provide for these assurances that keep workforce safe, and also the people they are working with safe, should a worker become ill, and that they feel protected to take the time that they need to stay home and not spread illnesses. Public health, in general, has been really great about encouraging people to stay home when they are ill, but maybe if we could also have a message that says that employers should be working with partners to figure out ways to help pay for people to stay home. That would be helpful as well.

Dr. Sidelinger answered that OHA Public Health recommended that, recognizing that it was a burden and a barrier for some people to stay home if they didn't have that. The federal bill that passed has gaping holes in it, with huge amounts of exempted employers. The elected officials in Oregon have been concerned about this. It is unknown if they have a plan for it. Discussions will continue about ensuring people have the sick leave they need. In Oregon, employees are lucky. They have more paid sick leave than employees in many other states, but still not adequate for all the workforce to get through this crisis.

Ms. Rippeteau thanked OHA for working with the Early Learning Division and the Office of Childcare to help get guidance to childcare providers who needed to stay open to help provide care for those who were still working.

Dr. Present remarked that there were a lot of groups meeting on a lot of different things, including taskforces and multiagency coordinating groups for prioritization of supplies. She asked if OHA had any questions that the PHAB members could help with. She also requested more information about interactions with schools of public health. She asked if there was research that public health students could review while they were at home.

Dr. Sidelinger answered that students could help OHA keep up with the literature and provide summaries of what changes day by day. OHA has a contract with OHSU School of Public Health, so that faculty and students who can assist OHA and its public health authority partners can be identified, as needed in this response. That will help to extend the public health workforce. OHA is very grateful to Dr. Bangsberg and his team.

Dr. Bangsberg stated that the School of Public Health was really pleased to hear from OHA and offer assistance in terms of surge capacity and provide any research expertise that was needed. The School of Public Health was able to push the contract through OHSU within 24 hours, which is a record. He was in contact with Ms. Biddlecom 2-3 times a week, if not every day, to see how the OHSU School of Public Health can help.

Ms. Biddlecom noted that Dr. Savage was serving on the Medical Advisory Group and helping OHA to get a broader perspective on some of the guidance that OHA was putting out. That group is also helping to share information, because the situation is changing very quickly. Having all those points of contact with each one of the PHAB members is extremely important

for OHA to make sure information gets out, and that the needs that board members are seeing and needing on the local level are communicated back to OHA, so that OHA can help with their fulfillment. She thanked the PHAB members for the work they were already doing and were going to continue doing, and for stepping up as leaders.

Dr. Irvin shared that if other counties had a need for interns or graduate students to help with data or do literature searches, they could reach out to her and she would connect them to people on the Oregon State University campus. Certain students would be interested in helping out. There are pathways for exchange in credit hours.

Dr. Sidelinger thanked Dr. Irvin. He added that if PHAB members thought of things that OHA could task some of the students to do, whether it was through a formal contract like the one OHA's public health partners needed or some other assistance, OHA could get them funneled and try to see if the public health system could utilize that workforce to get them done.

Ms. Tiel thanked the board members for their updates.

Public Comment

Ms. Tiel pointed out that public comment would be kept to two minutes per person. She instructed members of the public on the phone who wanted to provide public comment to state their name and organization, if applicable.

A hair salon owner commented that many salons were closing and asked if OHA handled hair salon closures and if some advice could be provided.

Dr. Sidelinger answered that hair salons were not covered in the Governor's orders. From a public health perspective, OHA encouraged social distancing of everyone (i.e., trying to remain at least 6 feet apart). In gatherings, the distance can go down to 3 feet based on droplet spread. The work of salon workers and workers in many other industries requires, by definition, close contact. He encouraged workers to stay at home if they were sick and ask clients to stay home if they were sick or had symptoms and not come in the salon. There is transmission even when people don't have symptoms. Studies show that the transmission is higher with symptoms. Cleaning the environmental surfaces, commonly touched items on the chairs, railings, and cash registers more frequently could help to limit the spread of disease in that setting. The recommendation to close isn't there but trying to do things to protect the clients and the staff would be the best way to operate safely.

Ms. Rose, a woman aged over 60, thanked OHA and the PHAB from the bottom of her heart for all the work they were doing.

Closing

Ms. Tiel thanked the PHAB members for using the Zoom platform. She reminded the board members that in one of the original meeting packets there was information about the State Health Improvement Plan. She encouraged the PHAB members to review it and, if they had any comments or questions, to provide them via email. It is unknown if the meeting in April will be on Zoom or in person. She adjourned the meeting at 2:50 p.m.

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

**April 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

Public Health Advisory Board

I. Authority

The Public Health Advisory Board (PHAB) is established by ORS 431.122 as a body that reports to the Oregon Health Policy Board (OHPB).

The purpose of the PHAB is to be the accountable body for governmental public health in Oregon. The role of the PHAB includes:

- A commitment to racial equity to drive public health outcomes.
- Alignment of public health priorities with available resources.
- Analysis and communication of what is at risk when there is a failure to invest resources in public health.
- Oversight for Oregon Health Authority, Public Health Division strategic initiatives, including the State Health Assessment and State Health Improvement Plan.
- Oversight for governmental public health strategic initiatives, including the implementation of public health modernization.
- Support for state and local public health accreditation.

This charter defines the objectives, responsibilities, and scope of activities of the PHAB. This charter will be reviewed no less than annually to ensure that the work of the PHAB is aligned with statute and the OHPB's strategic direction.

II. Deliverables

The duties of the PHAB as established by ORS 431.123 and the PHAB's corresponding objectives include:

PHAB Duties per ORS 431.123	PHAB Objectives
a. Make recommendations to the OHPB on the development of statewide public health policies and goals.	<ul style="list-style-type: none">• Participate in and provide oversight for Oregon's State Health Assessment.• Regularly review state health data such as the State Health Profile to identify ongoing and emerging health issues.• Use best practices and an equity lens to provide recommendations to OHPB on policies needed to address priority health issues, including the social determinants of health.
b. Make recommendations to the OHPB on how other statewide priorities, such as the provision of early learning services and the delivery of health care services, affect and are affected by	<ul style="list-style-type: none">• Regularly review early learning and health system transformation priorities.• Recommend how early learning goals, health system transformation priorities, and statewide public health goals can best be aligned.

<p>statewide public health policies and goals.</p>	<ul style="list-style-type: none"> • Identify opportunities for public health to support early learning and health system transformation priorities. • Identify opportunities for early learning and health system transformation to support statewide public health goals.
<p>c. Make recommendations to the OHPB on the establishment of foundational capabilities and programs for governmental public health and other public health programs and activities.</p>	<ul style="list-style-type: none"> • Participate in the administrative rulemaking process which will adopt the Public Health Modernization Manual. • Verify that the Public Health Modernization Manual is still current at least every two years. Recommend updates to OHPB as needed.
<p>d. Make recommendations to the OHPB on the adoption and updating of the statewide public health modernization assessment.</p>	<ul style="list-style-type: none"> • Review initial findings from the Public Health Modernization Assessment. (completed, 2016) • Review the final Public Health Modernization Assessment report and provide a recommendation to OHPB on the submission of the report to the legislature. (completed, 2016) • Make recommendations to the OHPB on processes/procedures for updating the statewide public health modernization assessment.
<p>e. Make recommendations to the OHPB on the development of and any modification to the statewide public health modernization plan.</p>	<ul style="list-style-type: none"> • Review the final Public Health Modernization Assessment report to assist in the development of the statewide public health modernization plan. (completed, 2016) • Using stakeholder feedback, draft timelines and processes to inform the statewide public health modernization plan. (completed, 2016) • Develop the public health modernization plan and provide a recommendation to the OHPB on the submission of the plan to the legislature. (completed, 2016) • Update the public health modernization plan as needed based on capacity.
<p>f. Establish accountability metrics for the purpose of evaluating the progress of the Oregon Health Authority (OHA) and local public</p>	<ul style="list-style-type: none"> •

health authorities in achieving statewide public health goals.	
g. Make recommendations to the Oregon Health Authority (OHA) and the OHPB on the development of and any modification to plans developed for the distribution of funds to local public health authorities, and the total cost to local public health authorities of implementing the foundational capabilities programs.	<ul style="list-style-type: none"> • Identify effective mechanisms for funding the foundational capabilities and programs. • Develop recommendations for how the OHA shall distribute funds to local public health authorities. • Review the Public Health Modernization Assessment report for estimates on the total cost for implementation of the foundational capabilities and programs. (completed, 2016) • Support stakeholders in identifying opportunities to provide the foundational capabilities and programs in an effective and efficient manner.
h. Make recommendations to the Oregon Health Policy Board on the incorporation and use of accountability metrics by the Oregon Health Authority to encourage the effective and equitable provision of public health services by local public health authorities.	<ul style="list-style-type: none"> • Develop and update public health accountability metrics and local public health authority process measures. • Provide recommendations for the application of accountability measures to incentive payments as a part of the local public health authority funding formula.
i. Make recommendations to the OHPB on the incorporation and use of incentives by the OHA to encourage the effective and equitable provision of public health services by local public health authorities.	<ul style="list-style-type: none"> • Develop models to incentivize investment in and equitable provision of public health services across Oregon. • Solicit stakeholder feedback on incentive models.
j. Provide support to local public health authorities in developing local plans to apply the foundational capabilities and implement the foundational programs for governmental public health.	<ul style="list-style-type: none"> • Provide support and oversight for the development of local public health modernization plans. • Provide oversight for Oregon’s Robert Wood Johnson Foundation grant, which will support regional gatherings of health departments and their stakeholders to develop public health modernization plans.
k. Monitor the progress of local public health authorities in meeting statewide public health goals, including employing the	<ul style="list-style-type: none"> • Provide oversight and accountability for Oregon’s State Health Improvement Plan by receiving quarterly updates and providing feedback for improvement.

foundational capabilities and implementing the foundational programs for governmental public health.	<ul style="list-style-type: none"> • Provide support and oversight for local public health authorities in the pursuit of statewide public health goals. • Provide oversight and accountability for the statewide public health modernization plan. • Develop outcome and accountability measures for state and local health departments.
i. Assist the OHA in seeking funding, including in the form of federal grants, for the implementation of public health modernization.	<ul style="list-style-type: none"> • Provide letters of support and guidance on federal grant applications. • Educate federal partners on public health modernization. • Explore and recommend ways to expand sustainable funding for state and local public health and community health.
m. Assist the OHA in coordinating and collaborating with federal agencies.	<ul style="list-style-type: none"> • Identify opportunities to coordinate and leverage federal opportunities. • Provide guidance on work with federal agencies.

Additionally, the Public Health Advisory Board is responsible for the following duties which are not specified in ORS 431.123:

Duties	PHAB Objectives
a. Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters.	<ul style="list-style-type: none"> • Provide guidance and recommendations on statewide public health issues and public health policy.
b. Act as formal advisory committee for Oregon’s Preventive Health and Health Services Block Grant.	<ul style="list-style-type: none"> • Review and provide feedback on the Preventive Health and Health Services Block Grant work plan priorities.
c. Provide oversight for the implementation of health equity initiatives across the public health system <u>by leading with racial equity.</u>	<ul style="list-style-type: none"> • Receive progress reports and provide feedback to the Public Health Division Health Equity Committee. • Participate in collaborative health equity efforts.

III. Dependencies

PHAB has established two subcommittees that will meet on an as-needed basis in order to comply with statutory requirements:

1. Accountability Metrics Subcommittee, which reviews existing public health data and metrics to propose biannual updates to public health accountability measures for consideration by the PHAB.
2. Incentives and Funding Subcommittee, which develops recommendations on the local public health authority funding formula for consideration by the PHAB.

PHAB shall operate under the guidance of the OHPB.

IV. Resources

The PHAB is staffed by the OHA, Public Health Division, as led by the Policy and Partnerships Director. Support will be provided by staff of the Public Health Division Policy and Partnerships Team and other leaders, staff, and consultants as requested or needed.

PHAB Executive Sponsor: Lillian Shirley, Public Health Director, Oregon Health Authority, Public Health Division
Staff Contact: Cara Biddlecom, Director of Policy and Partnerships, Oregon Health Authority, Public Health Division

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PUBLIC HEALTH ADVISORY BOARD BYLAWS

~~November 2017~~ April 2020

ARTICLE I

The Committee and its Members

The Public Health Advisory Board (PHAB) is established by ORS 431.122 for the purpose of advising and making recommendations to the Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB).

The PHAB consists of the following 14 members appointed by the Governor.

1. A state employee who has technical expertise in the field of public health;
2. A local public health administrator who supervises public health programs and public health activities in Benton, Clackamas, Deschutes, Jackson, Lane, Marion, Multnomah or Washington County;
3. A local public health administrator who supervises public health programs and public health activities in Coos, Douglas, Josephine, Klamath, Linn, Polk, Umatilla or Yamhill County;
4. A local public health administrator who supervises public health programs and public health activities in Clatsop, Columbia, Crook, Curry, Hood River, Jefferson, Lincoln, Tillamook, Union or Wasco County;
5. A local public health administrator who supervises public health programs and public health activities in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Wallowa or Wheeler County;
6. A local health officer who is not a local public health administrator;
7. An individual who represents the Conference of Local Health Officials created under ORS 431.330;
8. An individual who is a member of, or who represents, a federally recognized Indian tribe in this state;
9. An individual who represents coordinated care organizations;
10. An individual who represents health care organizations that are not coordinated care organizations;
11. An individual who represents individuals who provide public health services directly to the public;
12. An expert in the field of public health who has a background in academia;
13. An expert in population health metrics; and
14. An at-large member.

Governor-appointed members serve four-year terms and are eligible for reappointment. Members serve at the pleasure of the Governor.

PHAB shall also include the following nonvoting, ex-officio members:

1. The Oregon Public Health Director or the Public Health Director's designee;
2. If the Public Health Director is not the State Health Officer, the State Health Officer or a physician licensed under ORS chapter 677 acting as the State Health Officer's designee;
3. If the Public Health Director is the State Health Officer, a representative from the Oregon Health Authority who is familiar with public health programs and public health activities in this state; and
4. An OHPB liaison.

Members are entitled to travel reimbursement per OHA policy and are not entitled to any other compensation.

Members who wish to resign from the PHAB must submit a formal resignation letter. Members who no longer meet the statutory criteria of their position must resign from the PHAB upon notification of this change.

If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

ARTICLE II

Committee Officers and Duties

PHAB shall elect ~~one~~two of its voting members to serve as the chair ~~and vice chair~~. Elections shall take place ~~no later than January of~~within the first quarter of each even-numbered year and must follow the requirements for elections in Oregon's Public Meetings Law, ORS 192.610-192.690. Oregon's Public Meetings Law does not allow any election procedure other than a public vote made at a PHAB meeting where a quorum is present.

The chair ~~and vice chair~~ shall serve a ~~two~~-year terms. The chair ~~and vice chair are~~is eligible for one additional two-year reappointment.

If the chair were to vacate their position before their term is complete, ~~the vice chair shall become the new chair to a chair election will take place to~~ complete the term. ~~If a vice chair is unable to serve, or if the vice chair position becomes vacant, then a new election is held to complete the remainder of the vacant term(s).~~

The PHAB chair shall facilitate meetings and guide the PHAB in achieving its deliverables. The PHAB chair shall represent the PHAB at meetings of the OHPB as directed by the OHPB designee. The PHAB chair may represent the PHAB at meetings with other stakeholders and partners, or designate another member to represent the PHAB as necessary.

~~Should the PHAB chair not be available to facilitate a meeting, the PHAB chair shall identify a voting member to facilitate the meeting in their place.~~

~~The PHAB vice chair shall facilitate meetings in the absence of the PHAB chair. The PHAB vice chair shall represent the PHAB at meetings of the OHPB as directed by the OHPB designee when the PHAB chair is unavailable. The PHAB vice chair may represent the PHAB at meetings with other stakeholders and partners when the PHAB chair is unavailable or under the guidance of the PHAB chair, or may designate another member to represent the PHAB as necessary.~~

Both the PHAB chair ~~and vice chair~~ shall work with OHA Public Health Division staff to develop agendas and materials for PHAB meetings.

ARTICLE III

Committee Members and Duties

Members are expected to attend regular meetings and are encouraged to join at least one subcommittee.

Absences of more than 20% of scheduled meetings that do not involve family medical leave may be reviewed.

Date approved: ~~November 17, 2017~~

In order to maintain the transparency and integrity of the PHAB and its individual members, PHAB members must comply with the PHAB Conflict of Interest policy as articulated in this section, understanding that many voting members have a direct tie to governmental public health or other stakeholders in Oregon.

All PHAB members must complete a standard Conflict of Interest Disclosure Form. PHAB members shall make disclosures of conflicts at the time of appointment and at any time thereafter where there are material employment or other changes that would warrant updating the form.

PHAB members shall verbally disclose any actual or perceived conflicts of interest prior to voting on any motion that may present a conflict of interest. If a PHAB member has a potential conflict related to a particular motion, the member should state the conflict. PHAB will then make a decision as to whether the member shall participate in the vote or be recused.

If the PHAB has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member and afford an opportunity to explain the alleged failure to disclose. If the PHAB determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate corrective action including potential removal from the PHAB.

Members must complete required Boards and Commissions training as prescribed by the Governor's Office.

ARTICLE IV

Committee and Subcommittee Meetings

PHAB meetings are called by the order of the chair or vice chair, if serving as the meeting facilitator. A majority of voting members constitutes a quorum for the conduct of business.

PHAB shall conduct its business in conformity with Oregon's Public Meetings Law, ORS 192.610-192.690. All meetings will be available by conference call, and when possible also by either webinar or by livestream.

The PHAB strives to conduct its business through discussion and consensus. The chair or vice chair may institute processes to enable further decision making and move the work of the group forward.

Voting members may propose and vote on motions. The chair and vice chair will use Robert's Rules of Order to facilitate all motions. Votes may be made by telephone. Votes cannot be made by proxy, by mail or by email prior to the meeting. All official PHAB action is recorded in meeting minutes.

Meeting materials and agendas will be distributed one week in advance by email by OHA staff and will be posted online at www.healthoregon.org/phab.

ARTICLE V

Amendments to the Bylaws

Bylaws will be reviewed annually. Any updates to the bylaws will be approved through a formal vote by PHAB members.

**Public Health Advisory Board
2020 work plan - draft**

Key to workplan symbols

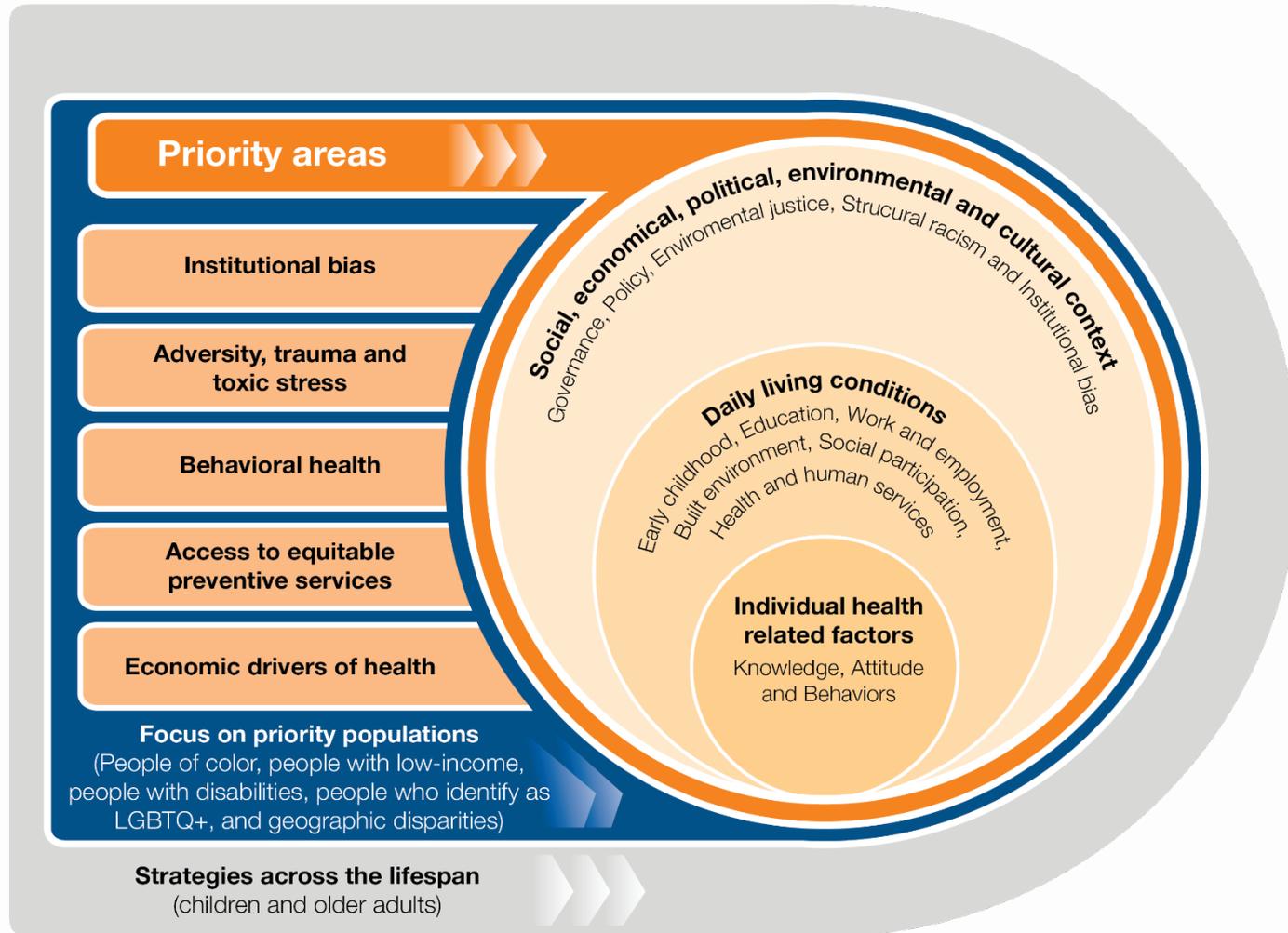
★ = Updates, discussion and feedback

◆ = Deliverables, decisions or formal recommendations, including but not limited to formal votes

Topic		Month													
		January	February	March	April	May	June	July	August	September	October	November	December		
Board structure	PHAB 2020 work plan, charter and bylaws		PHAB Retreat		★	◆		★	August meeting dependent on agenda items.				December meeting dependent on agenda items.		
Statewide population health priorities and policies	Leading with race to achieve health equity	★				◆									
	Leveraging CCO, health system and public health collaborations, and building partnerships to address social determinants of health							★							
	2020-24 State Health Improvement Plan (SHIP)			★				◆			★				
	Member priorities and member-led discussions			★	★	★	★	★			★	★		★	
	Preventive Health and Health Services Block Grant						★	◆							
Public health modernization	2019-21 implementation and system improvements							★				★			
	Public health funding	★						★		★		◆			
	Public health system accountability							★		★		◆			

	Topic	Purpose	Decisions, deliverables and agenda topics
Board structure	PHAB 2020 work plan, charter and bylaws	Adopt work plan that is structured to support PHAB priorities and deliverables. Ensure charter and bylaws are up-to-date.	April: Review draft work plan. May: Approve work plan, charter, bylaws. Elect Chair and Co-Chair positions. September: Mid-year work plan review.
Statewide population health priorities and policies	Leading with race to achieve health equity	Develop and adopt PHAB framework for leading with race and establish board commitments. Provide guidance and oversight for how communities are engaged in decision-making. Maintain connections to Oregon Health Policy Board (OHPB) and its Health Equity Committee and provide feedback into OHPB policy decisions.	Dates to be determined: Learn about frameworks for leading with race and what leading with race looks like in practice; update and adopt PHAB Policy and Procedure for Health Equity Reviews; identify PHAB's role in community engagement and implement ensuing changes; hear updates from OHPB and the Health Equity Committee.
	Leveraging CCOs and health system collaborations; building partnerships to address social determinants of health	Ensure PHAB members are aware of and have opportunity to provide feedback on statewide strategies with potential impacts for the public health system. Continue to recommend policies that strengthen collaborations and shared governance across sectors.	Date TBD: Health care cost growth target Date TBD: Hospital community benefits Topics for the remainder of the year to be identified.
	2020-24 State Health Improvement Plan (SHIP)	Approve and provide oversight for SHIP. Provide guidance to OHA on strategy for implementing the plan across sectors and with partners.	March: provide feedback on draft plan and on community outreach efforts. July: Approve final 2020-24 SHIP. Topics for the remainder of 2020 to be identified.
	Member priorities and member-led discussions	Ensure members are engaged in agenda development and have the opportunity to for member-led discussions.	Monthly: Agenda time for board members to propose agenda items and discussions.
	Preventive Health and Health Services block grant	Review and provide guidance on PHHS block grant work plan	May: Receive an overview of the Block Grant. June: Approve Block Grant annual work plan.
Public health modernization	2019-21 implementation and system improvements	Hear regular updates to inform board members of local, regional, tribal and state implementation activities and system improvements occurring through public health modernization. Understand how existing funds are being used to advance systemwide priorities. Provide guidance for statewide initiatives.	Dates TBD: Regular updates on local, regional, tribal and statewide initiatives.
	Public health funding	Finalize 2021-23 public health modernization funding formula, including recommendations for use of funding to support shared service delivery models. Use PHAB funding principles to ensure public health funding is used to achieve improved outcomes and eliminate health disparities.	March: Finalize PHAB funding principles. June-August: PHAB Incentives and Funding subcommittee updates September: Adopt 2021-23 public health modernization funding formula and recommendations for use of 2021-23 legislative funding; and approve OHA Public Health Modernization Report to Legislative Fiscal Office. September: Hear update on OHA Agency Request Budget.
	Public health system accountability	Use public health accountability metrics to track progress toward improved health outcomes through a modern public health system. Provide oversight for ongoing evaluation of public health modernization investment.	June-August: PHAB Accountability Metrics subcommittee updates. September: Adopt 2020 Public Health Accountability Metrics report. Date TBD: Discuss changes to metrics set to ensure alignment with population health priorities, including those in the 2020 SHIP. September: Review interim evaluation report on 2019-21 legislative investment.

2020-2024 State Health Improvement Plan



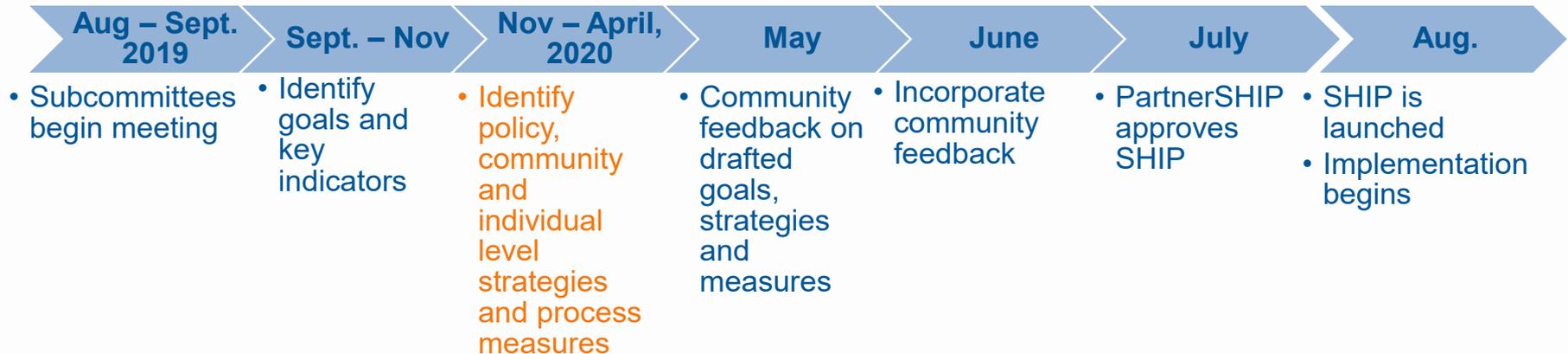
Subcommittees

Includes representation from **97** individuals and **62** distinct organizations



Community-based organizations, tribal partners, state agencies and other implementation partners, subject matter experts, health system partners, people with lived experience

Timeline for developing 2020-2024 SHIP



PUBLIC HEALTH DIVISION

Office of the State Public Health Director

Fitting it all together



Strategy Criteria	
Selection criteria	Definition
Proven impact on disparities	<ul style="list-style-type: none"> • Strategy addresses disparities in priority populations (POC, low income, disability, LGBTQ, rural/frontier)
Will achieve intended outcome	<ul style="list-style-type: none"> • Right strategy for the goal • Strategy aligns with evidence-based or promising practice
Politically feasible	<ul style="list-style-type: none"> • Ability to influence and implement a policy change
Resourced or likely to be resourced	<ul style="list-style-type: none"> • Funding is available or likely to be available • Local expertise exists
Relevant to community	<ul style="list-style-type: none"> • Strategy is in use in local community • Strategy is realistic and of interest from a local perspective
Alignment with other strategic initiatives (locally or federally)	<ul style="list-style-type: none"> • Strategy nationally recognized or recommended
Change likely in next 5 years	<ul style="list-style-type: none"> • Impacts likely to be seen within 5 years of implementation
Addresses lifespan	<ul style="list-style-type: none"> • Relevant to a wide range of age • Relevant to young children or older adults

Strategy notes

- Aim is 10 – 15 per priority area, so total of 50 - 75
- Interconnectedness and artificial divisions
 - Many of the sub priority areas overlap
 - Many strategies may be in more than one layer of the framework
- This is not the final plan, it will evolve after community engagement and vetting period.
- Once the plan is finalized, the aim is to create a logic model or driver diagram to illustrate connections between strategies in different priority areas

Access to Equitable Preventive Healthcare

Goal 1: Increase equitable access to and uptake of community-based preventive services

- Increase patient health literacy by training healthcare providers.
- Expand reach of preventive services through evidence based and promising practices
- Locate support services for low income people and families at or near health clinics.
- Increase access to affordable, healthy and culturally responsive foods for people of color and low income communities
- Expand recommended preventive health related screenings in schools.

Access to Equitable Preventive Healthcare

Goal 2: Increase equitable access to and uptake of clinical preventive services

- Support alternative healthcare delivery models in rural areas.
- Increase access to dental care that is offered in schools, such as dental sealants and fluoride varnish.
- Increase access to prenatal care for low-income and undocumented women
- Improve access to sexual and reproductive health services.
- Increase the cultural responsiveness of health care through use of traditional health workers and trainings.

Access to Equitable Preventive Healthcare

Goal 3: Implement systemic and cross-collaborative changes to clinical and community-based health related service delivery to improve quality, equity, efficiency and effectiveness of services and intervention.

- Expand use of tele-medicine in rural areas.
- Improve electronic health record coordination and data sharing among providers
- Use healthcare payment reforms to support the social needs of patients.
- Create a statewide community information exchange to facilitate referrals between health care and social services.
- Use electronic health records to promote delivery of preventive services.

Behavioral Health

Goal 1: Reduce stigma and increase community awareness that behavioral health issues are common and widely experienced

- Enable community based organizations to destigmatize behavioral health by providing culturally responsive information to people they serve
- Implement public awareness campaigns to reduce the stigma of seeking behavioral health services
- Expand programs that address loneliness and increase social connection in older adults.

Behavioral Health

Goal 2: Increase individual, community and systemic resilience for behavioral health through a coordinated system of prevention, treatment and recovery

- Conduct behavioral health system assessments at state, tribal and local levels.
- Strengthen agency partnerships in education, law enforcement, housing, social services and health care to improve mental health among people of color.
- Improve integration between behavioral health and other types of care.
- Incentivize treatments that are rooted in evidence-based and promising practices.
- Reduce systemic barriers to receiving behavioral health services, such as transportation, language and assessment.
- Use healthcare payment reform to ensure comprehensive behavioral health services are reimbursed.
- Strengthen enforcement of the Mental Health Parity and Addictions Law.
- Create a behavioral health workforce that is culturally reflective of communities they serve.
- Create community driven solutions for education and law enforcement systems that address bias and disparities among communities of color.
- Require Housing First principles be adopted in all housing programs.
- Increase resources for culturally responsive suicide prevention programs for communities most at risk.

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Economic Drivers of Health: Economic Viability

Goal: Increase the percentage of Oregonians earning a livable wage by raising public awareness of the correlation between health and economic sufficiency and advocating for evidence-based policies to improve economic sufficiency.

- Invest in workforce development and higher education opportunities for priority populations.
- Develop data driven policy solutions for affordable childcare and caregiving.
- Strengthen economic development, employment and small business growth in underserved communities.
- Enhance financial literacy and access to financial services among priority populations
- Increase affordable access to high speed internet in rural Oregon

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The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange font above the word "Health" in a large, blue, serif font. Below "Health" is the word "Authority" in a smaller, orange font.

Economic Drivers of Health: Physical Environment

Goal: Ensure that all people in Oregon live, work, play in a safe and healthy environment and have equitable access to stable, safe, affordable housing, transportation and other essential infrastructure so that they may live a healthy resilient life.

- Ensure state agencies engage priority populations to co-create investments, policies, projects and agency initiatives.
- Integrate racial equity as a key criterion in state agency planning, policy, and investment.
- Build climate resilience among priority populations
- Create safe, accessible and affordable neighborhoods for communities of color, low-income communities and people with disability through use of green infrastructure.
- Increase affordable housing that is co-located with active transportation options.
- Increase homeownership among communities of color through existing and innovative programs.

PUBLIC HEALTH DIVISION

Office of the State Public Health Director

The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange font above the word "Health" in a large, dark blue font. Below "Health" is the word "Authority" in a smaller, orange font. A thin orange horizontal line is positioned above the "Health" text.

Economic Drivers of Health: Food Insecurity

Goal: Increase equitable access to culturally appropriate nutritious food regardless of social or structural barriers (e.g., age, location or employment) by addressing the underlying issues in food availability and stigma associated with food insecurity.

- Maximize investments and collaboration for food related interventions.
- Build a resilient food system that provides access to healthy, affordable and culturally responsive food for all communities.
- Increase supports that address food insecurity, like SNAP, WIC and school based food programs.
- Decrease stigma associated with using food banks and food vouchers through creation of an education campaign

Institutional Bias

Goal 1: Expose and reduce the impact of institutional biases that influence health, by

- Expand human resource practices that promote equity
- Ensure State Health Indicators are reportable by race and ethnicity, disability, gender, age, sexual orientation, socioeconomic status, nationality and geographic location.
- End school related disparities for black youth through teacher training, monitoring of data and follow-up with teachers and schools.

Institutional Bias

Goal 2: Identifying and championing work across systems, structures, policies, communities and generations, so that.

- Implement standards for workforce development that address bias and improve delivery of equitable, trauma informed, and culturally responsive services.
- Require state agencies to commit to racial equity through investment to BIPOC (Black, Indigenous, and People of Color) communities and agency performance metrics.

Institutional Bias

Goal 3: All people in Oregon are empowered and have opportunity to participate fully in decisions to achieve optimal health.

- Increase use of meditation and restorative justice in schools to address conflict, bullying and racial harassment.
- Support Medicare enrollment for older adults through expansion of the Senior Health Insurance Benefits Assistance (SHIBA) program
- Mitigate barriers to the development and maintenance of affordable housing.
- Require sexual orientation and gender identity training for all health and social service providers.

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Oregon
Health
Authority

Adversity, Trauma, and Toxic Stress

Goal 1: Prevent trauma (e.g. intergenerational and historical trauma), toxic stress, and adversity through data driven policy, system and environmental change.

- Ensure access to family friendly policies, such as affordable, high quality, culturally responsive childcare and paid family leave.
- Ensure all school districts are implementing K-12 comprehensive health education according to law.
- Implement anti-racism and anti-oppression policies and initiatives
- Expand evidence based and culturally responsive prenatal and early childhood home visiting programs.

Adversity, Trauma, and Toxic Stress

Goal 2: Increase resilience by promoting safe, connected and strengths-based individuals, families, caregivers and communities

- Provide safe, accessible and high quality community gathering places, such as parks and community buildings.
- Expand community based mentoring, especially inter-generational programs.
- Develop community awareness of toxic stress, its impact on health and the importance of protective factors.
- Promote art and cultural events for priority populations.
- Build family resiliency through trainings and other interventions

Adversity, Trauma, and Toxic Stress

Goal 3: Mitigate trauma by promoting trauma informed systems and services that assure safety and equitable access to services, and avoid re-traumatization.

- Require that all public facing state agencies and state contractors receive training about trauma and toxic stress.
- Require all public facing state agencies and state contractors to implement trauma informed policy and procedure.
- Implement House Concurrent Resolution 33

Proposed outcome indicators – *in review*

Adversity, Trauma, and Toxic Stress:

1. Chronic absenteeism (Oregon Department of Education)
2. ACEs among children (National Survey of Children's Health)
3. Concentrated Disadvantage (Calculated from American Community Survey)

Access to equitable preventive health care :

1. Childhood immunizations (ALERT IIS)
2. Colorectal cancer screening (Behavioral Risk Factor Surveillance System/BRFSS)
3. Third graders with cavities in their permanent teeth (Oregon Smiles Survey)

Institutional Bias - *All will be disaggregated by race:*

1. Disciplinary Action (Oregon Department of Education)
2. Premature death /Years of Potential Life Lost (Vital Records)
3. Housing Burden - % of income spent on rent/mortgage (American Community Survey)

Behavioral Health:

1. Suicide rate (Vital Records)
2. Unmet mental health care need (Student Health Survey)
3. Adults with poor mental health in past month (Behavioral Risk Factor Surveillance System/BRFSS)

Economic Drivers of Health - Economic Viability:

1. Opportunity Index – increase Oregon's economy score by 2.5 point over 5 years. (Opportunity Index – Economy Dimension)Third graders with cavities in their permanent teeth (Oregon Smiles Survey)
2. Childcare cost burden (Consumer Expenditure Survey, Bureau of Labor Statistics)

Economic Drivers of Health - Food Insecurity:

1. Food Insecurity (USDA's US Food Security Survey)

Economic Drivers of Health - Physical Environment:

1. Housing Burden - % of income spent on rent/mortgage (American Community Survey)
2. 3rd grade reading proficiency (Oregon Department of Education)

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Thank you!