

Public Health Advisory Board (PHAB)
April 18, 2019
Meeting Minutes

Attendance:

Board members present: Dr. David Bangsberg, Carrie Brogoitti, Dr. Bob Dannenhoffer, Dr. Katrina Hedberg (ex-officio), Dr. Jeff Luck, Kelle Adamek-Little, Muriel DeLaVergne-Brown, Akiko Saito, Dr. Eli Schwarz, Alejandro Queral, Dr. Jeanne Savage, Eva RippetEAU (by phone), Rebecca Tiel, Teri Thalhofer (by phone).

Board members absent: Tricia Mortell.

Oregon Health Authority (OHA) staff: Danna Drum, Sara Beaudrault, Katarina Moseley, Krasimir Karamfilov, Aaron Dunn, Rex Larsen, Dr. Ann Thomas, Dr. Tim Menza.

Members of the public: Kim Handloser (Jackson County), Katherine Duarte (Klamath County), Katrina Rothenberger (Marion County, by phone), Kristty Polanco (Polk County, by phone), Carla Munns (Willamette Valley Community Health, by phone), Dr. Jenny Faith (Deschutes County), Heather Kaisner (Deschutes county).

Welcome and updates

Rebecca Tiel, PHAB Chair

Ms. Tiel welcomed the PHAB and invited the board members to introduce themselves. She reviewed the agenda for the meeting.

- **Approval of March 2019 Minutes**

A quorum was present. Mr. Queral moved for approval of the March 21, 2019, meeting minutes. Dr. Schwarz seconded the move. The PHAB approved the meeting minutes unanimously.

Ms. Tiel informed the PHAB that the meeting packet did not include the Oregon Health Policy Board Subcommittee digest. The digest will be posted with the materials online.

- **Legislative Update**

There was no legislative update.

Ms. Tiel announced that the PHAB meeting in June would be a joint meeting with the Oregon Transportation Commission. It is an opportunity to have a meeting between two advisory



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boards. Dr. Charles Brown will facilitate a public health and transportation conversation around transportation. The PHAB has discussed that metric quite a bit, including the ways public health and transportation entities can work together. The time of the PHAB meeting in June will change.

Dr. Dannenhoffer remarked that this was a big problem, because CLHO (Coalition of Local Health Officers) met on the morning of the PHAB meeting. The meeting starts at 9:30 a.m. CLHO has a critical business to do next month. The change of the PHAB meeting will make it almost impossible for CLHO to get a quorum. It also means that those of us whose job is to represent those counties won't have a chance to do this. The change puts CLHO members in an almost untenable position. The meeting was probably scheduled for the convenience of the Oregon Transportation Commission, but the people who are coming from great long distances are put in a very awkward position. The question is: Could we move the meeting back, maybe from noon to 2:00 p.m., and then have the PHAB business meeting thereafter, so that CLHO could meet early that day and get its business done?

Ms. Tiel noted that that was good information to know, as she hadn't been tracking the CLHO meetings. The PHAB wants to make sure that it is accommodating the guest (i.e., Dr. Charles Brown). She would check with staff if there are any options, but, for now, the meeting is scheduled for 10:00 a.m. on June 20, 2019.

Ms. Moseley clarified that the change is in June, not in May. This was an opportunity that came back up, as these two board had tried to have a joint meeting together. What inspired the meeting was the Director of the Oregon Department of Transportation, who attended one of the Public Health Division's big conferences last fall, the Place Matters conference, and heard the speaker Dr. Charles Brown, who, as Ms. Tiel said, speaks about the intersection of not just health and transportation, but equity, health, and transportation. We wanted to create this joint opportunity for the boards to roll up their sleeves and really think about and talk about how we work together on this important social determinant. The Public Health Division and ODOT (Oregon Department of Transportation) do have a standing MoU (Memorandum of Understanding), recognizing both access to preventative health things, like parks and walking trails and roads that accommodate biking, and access to medical services. It is a joint responsibility of OHA and ODOT, working together to make sure that those things happen.

Ms. Moseley added that the meeting is a way to deepen that conversation and, perhaps, for the boards to establish some things that we want to continue talking about and things that we would like to move forward together around this important social determinant. The opportunity came up and the arrangement of this meeting time meant that neither board needed to schedule a different meeting day. Both the PHAB and the OTC convene on the third Thursday of every month. With the location in Salem, which was at the request of ODOT, which is hosting the speaker, this seemed to be what would work out for the boards.

Ms. Thalhofer stated that, in her view, the local public health administrators are not questioning the importance of this meeting or the validity of this being a huge public health topic. They are more concerned with the process of not recognizing that five members of the PHAB are significantly affected by this meeting, and that the meeting was confirmed without pre-conferencing with those five members to see if we could make another arrangement. This will mean that CLHO will not be able to have a quorum at that time of either its full board or executive board. At the end of the legislative session, that really puts us in a difficult place for decision making. In the future, it must be recognized that the LPHAs are a large part of the PHAB and that the two pieces of the system are intricately linked.

Dr. Dannenhoffer remarked that, because it was so important, that this was such a quandary. If this was a throw-away meeting, he would not go. But it is an important thing to do, so he needs to do it. If PHAB members got prizes for the most distance traveled, Ms. Thalhofer and Ms. DeLavergne-Brown would always get them. We should consider the fact that PHAB members can't be at two places at once. Could the meeting be moved? For the people in Salem, moving this meeting can be really hard, but they are meeting the same day.

Dr. Hedberg pointed out that a lot of PHAB members have many meetings conflicting with other meetings. One of the proposals could be for CLHO to change its meeting time. That oughtn't happen, but there are a variety of options. There are a couple of parts of PHAB, when we look at these agendas. Some of them are really concrete, where we need voting, or ex-officio, or there are voting members. We need to make sure that at least that part occurs. Meeting with another board to understand how we could collaborate – part of that might be figuring out the next steps moving ahead. We hope this is not a one-and-die. This is part of our upcoming State Health Improvement Plan (SHIP). We are talking about social determinants. Transportation has come up again and again.

Dr. Hedberg added that this meeting is more of a meet-and-greet. We don't know quite how to say, whether it's their board meeting or another, "Oh, but a couple of members of ours," without trying to belittle the number of members, "can't make it. Can you all change that?" We are the ones who are trying to figure out how we can collaborate with this group. One of the questions is, "Is there a way to have some of the CLHO members attend one versus the other, and who has more ability to do this?" This meeting is about establishing a relationship and we should think about ways for moving forward.

Ms. DeLaVergne-Brown said that she understood the challenge and noted that, for CLHO, we must look for possible other ways of doing the meeting, such as a webinar or some other way. Part of the challenge is that this all has to do with tobacco funding, because we have a vote. In a normal circumstance, we wouldn't have such a critical thing. We are trying to figure out how to do this, so CLHO can still have a quorum.

Dr. Hedberg remarked that her understating was that the tobacco funding has been mulled around for quite a while. If CLHO has a key vote around tobacco funding, is there is a way to reschedule the vote? We are reluctant to say to a key partner, with which we have really wanted to engage and are finally able to do it, and the boards are meeting, that some of the members of our board have another key vote outside of the PHAB meeting. It feels weird. We are open to suggestions, but we don't know how to get there. Maybe CLHO can move the move the vote to May. We need to understand why these two hours of overlap are the only two hours in the space of several months that are problematic.

Ms. DeLaVergne-Brown responded that, for the future, because the CLHO meeting is always before the PHAB meeting, please check with CLHO members when such meetings are scheduled, so CLHO members know and can plan accordingly.

Public Health Grant Block

Danna Drum (OHA staff)

Ms. Drum informed the PHAB that the Public Health Division at the Oregon Health Authority received a non-competitive grant. It is issued to all states and some territories to address the state-determined public state priorities. The grant was established in federal code back in 1980s. It gets zeroed out every year in the President's budget and then Congress brings it back. The PHAB is designated as the Block Grant Advisory Committee. Its role is to make recommendations regarding the development and implementation of the work plan.

Ms. Drum reminded the PHAB that around this time of every year she shares with the PHAB what has been happening over the previous year. In May, she will present to the PHAB some proposals around what would be in the work plan for the following year. This is the most flexible grant funding we received from the federal government in the Public Health Division. This allows us to fund some things that we wouldn't have otherwise the opportunity to do. We have typically used the grant to fund infrastructure-related projects.

Ms. Drum noted that, in addition, the federal code has a specific carveout for sexual violence prevention and services. Currently, that funding goes to the Oregon Coalition Against Domestic and Sexual Violence. It's a pass-through to them through a grant from OHA. That's a specific allocation that the feds give us. The work plan must be tied to Health People 2020. Oregon, like several other states, use the grant to support infrastructure. Typically, we have used the accreditation-related Healthy People 2020 objective and the Quality Improvement 2020 objective.

Ms. Drum stated that for the current year OHA received a little over \$1.2 million, with 85.6K allocated and granted to the Oregon Coalition Against Domestic and Sexual Violence. Oregon's overall goal has been to support ongoing planning for an implementation of the modernization foundational capabilities. This funding has supported the development and analysis in the



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annual report of the public health accountability metrics. It's also supported the work with tribal public health modernization (i.e., the tribal assessment). We also have used this funding to support staff time to work through the school year 2018 expenditures collection, so we can capture the local investment that would support the matching funds component of the modernization funding formula. In May, Ms. Drum will share with the PHAB the results of that effort. That would be the baseline on the local investment, so that when we start to move into matching funds, we'll have those data.

Ms. Drum reported that a lot of work was done around implementing, in 2018, the new administrative rules, as a result of some statutory changes, as well as work that continues to integrate modernization foundational capabilities and programs into the scopes of work and the compliance review tool (i.e., the triannual review, program elements, and contract pieces). Also, within the Public Health Division, funding for staff for the Health Equity Workgroup, as well as some of that work. Some of things they have been doing over the last year include convening listening sessions to identify highest priorities for interventions and strategies to improve workforce diversity and inclusion within the division.

Ms. Drum added that a lot of this funding goes to support local and tribal training, technical assistance, and coordination. For example, last year we conducted 14 compliance reviews, known as the triennial review, and the funding supported the staff, and the travel, and all the work that goes into that. This is part of our accountability. We also developed a resource guide, because we have had in the past several LPHAs looking at alternative models for how they organize and do their business. We felt that we needed a resource that put all that information in one place. The funding was used for intensive technical support and coordination, in person and remote, with those LPHAs that are making some sort of transition, whether it be contracting out a lot of the public health work or, in the case of Wallowa County, when they transferred their LPHA to OHA. And then, last year, working closely with Douglas County, as they were trying to determine what their next steps were going to be. The funding also supports a lot of the coordination of the Public Health Division's work with tribes, including implementation within the division of OHA's new Tribal Consultation Policy, which was adopted in March 2018. It has been a significant lift to fully implement and respect those, so that we can be better positioned to honor the government-to-government relationship.

Ms. Drum pointed out that the State Health Assessment and the State Health Improvement Plan are supported by these funds. Without these funds, there wouldn't be any other kind of funding to support the SHA and the SHIP. The SHIP coordinator, Christy Hudson, has been doing a lot of work with state agency partnerships, such as ODOT, Oregon Department of Education, and Department of Housing and Community Services, as well as exploring new partnerships with the Department of Corrections. This funding has helped maintain our public health accreditation, including support for local and tribal partners that are seeking accreditation, the roll out of the OHA performance system, and a variety of things related to workforce development.



Ms. Drum highlighted the work done by the Oregon Coalition Against Domestic and Sexual Violence. Several years ago, OHA started a conversation with the coalition. Traditionally, the coalition used the funds to help support their local coalitions, but it was like giving everybody \$5. They were in a place where they were interested in moving towards primary prevention and doing that from a place of working with marginalized communities to leave that work around sexual violence primary prevention. It's gotten a lot of national recognition within the field and they have funded El Programa Hispano to identify and implement culturally-specific sexual violence primary prevention curriculum with Latinx youth. That has been very successful. They also discovered during the RFP process that they needed to do a lot of capacity building. A lot of their member organizations hadn't dealt in primary prevention. They also issued a number of capacity-building grants (i.e., mini-grants) to help prepare them to be able to move into primary prevention that resulted in a broader RFP process since the last time around. Now they are funding three organizations, with two of them being mini-grantees and have been able to build some capacity.

Ms. Drum invited the PHAB to ask questions.

Dr. Bangsberg remarked that Ms. Drum presented a long list of really important work. A long list for \$1.2 million dollars. There's nothing on the list that doesn't deserve funding. What is the average size of the subcontract? When does the pool become so big that you don't get much in return?

Ms. Drum responded that the contract with the Oregon Coalition Against Domestic and Sexual Violence is \$85,660. That was a strategic shift for them. They realized that, for years, they have been doing it for very little money. Several years ago, they made the shift, where they decided to fund fewer partners for a specific strategic purpose. That's been beneficial. It's taken several years to get there, but they and OHA, as the funder, are pleased with that work. In general, the rest of the funding, because it supports infrastructure, primarily goes to staff time and FTE, and there are some smaller contracts to help support that work, like the facilitation for the State Health Improvement Plan was paid for out of these funds, as well as the contract with Program Design Evaluation Services to do the accountability metrics. There are no significantly large contracts, because a lot of it is just paying staff to be able to do the work.

Dr. Bangsberg speculated that each subcontract was covering 10-15% of the staff and probably \$5,000-\$20,000, given the long list of activities.

Ms. Drum responded that there were a handful of subcontracts and that's just to support some of the work. Most of it is staff, Public Health Division staff who are implementing the work.

Dr. Savage asked if the 85K varied or it was the same every year.

Ms. Drum responded that for as long as she's been a part of it, it has been the same amount and it doesn't fluctuate. The number comes from the feds. It's based on a formula from decades ago. It doesn't seem to be any movement on the federal level to change it. It's not clear how that gets determined.

Dr. Schwarz wondered if, in the case of Wallowa County, some of the money could be used to correct the situation, so that the county be brought back to independent public health governance.

Ms. Drum responded that the funding wasn't so much for a specific Wallowa County project, but it funded my time and another staff person's time, plus significant amount of Department of Justice time to work through the intricacies of what needs to be dealt with when there is a transfer. In terms of the question about bringing Wallowa County back, the onus is on Wallowa County. They were very clear with us when they passed an ordinance. This is not something they are able to do. There is a bill making its way through legislature right now that would provide additional information or process on how a county could request a transfer of the LPHA responsibilities back to it. There will be a rule-making process that will need to happen as the result of that. Some of that will get clear over time.

Ms. Saito commented on the Wallowa transfer and the issue in Douglas County by reminding the PHAB that one of the foundational capabilities in public health modernization was emergency preparedness. In those two processes, the money did fund Ms. Drum's time, but we also had a large number of staff who were on the incident management team. Both of those potential transfers, and one was a real transfer, actually had an incident management team. Ms. Drum and one of our center administrators acted as the incident managers. We had multiple staff members who were also on the incident management team, doing the planning chief role, the operations chief role, et cetera. Even though the money did fund some of Ms. Drum's team, there were a lot of in-kind donations from the rest of the staff here to help the incident management team.

Ms. Drum added that that was true for most of this work. It enables us to have a basic infrastructure, so that then we can leverage a lot more resources across the system.

Ms. Tiel remarked that it is a lot less accomplishments with a little bit of money, but that's what we can get when we have infrastructure dollars to fund staff time that are so specific that you have to spend it in very specific areas.

Dr. Schwarz noted that the PHAB has never discussed a situation where, for example, ten counties next year found out that it was a really good deal to leave their responsibilities to the state. This is something the PHAB should talk about.

Ms. Tiel stated that there was a conversation to have an agenda item about some of those pieces and discuss that. It's an important topic, but something we don't necessarily hope to happen. Yet we need to have a plan in place, if that were to happen. It would be a public health emergency when that happens, so it's an important story for the PHAB to discuss as well. It's not just a contractual hand-off. We could have a discussion in a future meeting.

Accountability Metrics Subcommittee

Muriel DeLavergne-Brown

Ms. DeLavergne-Brown informed the PHAB that the subcommittee had a very good meeting on April 1, 2019. The subcommittee discussed the 2019 Public Health Accountability Metrics Annual Report, which has been updated. Another discussion revolved around the oral healthy developmental measure. The important outcome was that the subcommittee decided to keep it, as it is important to work on oral health. We do work on it without funding. We do campaigns. Our staff work on it. The issue is how do we measure public health on this when we are not the biggest player to make a big difference in it? It's dental offices and primary care. The subcommittee decided to keep it, but the issue should be kept on the horizon to think about it.

Ms. DeLavergne-Brown reported that the subcommittee discussed the development of public health metrics for 2019-2021. The biggest discussion was about not changing things too much. Another discussion, brought up by Ms. Thalhoffer and echoed by Ms. DeLavergne-Brown, was about the public health changes that could happen with the influx of money for public health modernization. One of the challenges has been that when little tiny bits of funding from different programs come, to have it written in all the contracts, and we are now supposed to do this, when we are not actually getting funding for it. There is a rub that happens between state and local over that. There is this push for modernization and we are totally behind that. At the same time, when it's a tiny bit of funding, and it's not true modernization funding, how are we to be held accountable for all of that? The subcommittee discussed that without reaching any answers.

Ms. DeLavergne-Brown shared with the PHAB that at the end of the subcommittee meeting she wondered about how we could rise all boats. This goes back to local health departments deciding not to stay in. In Crook County, she often reminds the county Commissioners that they are responsible for the health of the county. This subcommittee discussion centered around how to get all counties up to a point where all are performing well.

Ms. Thalhoffer added that the frustration the subcommittee has had when reviewing program elements is that there is more and more language about meeting the accountability metrics being worked into program elements. When the subcommittee developed the accountability metrics, they were not developed with the intent that LPHAs would be accountable for these measures now, before they were funded. To have them worked into current contract language

feels pretty disingenuous to what the intent was. While we all need to move toward the modernized public health system, it is not going to happen without more funding. We can't lean in anymore. It would be good if the PHAB at some point, maybe it can start with the Accountability and Metrics Subcommittee, comes up with a statement about the real intent of the metrics. It is not for now. It is for when we move toward the modernized system. I see us being accountable for the one around communicable disease – beginning that, because we did get partly funded to do that modernized work – but to have them showing up in contracts overall, it is pretty distressing.

Dr. Bangsberg remarked that having those metrics could be a really great argument to advocate for something, because if we are seeing something develop, like suicide, in certain demographic, then that becomes the data that go to legislature, with us saying that we need money for suicide prevention. The tension experienced by the counties is recognized. It is a situation in which you are measuring stuff you don't have money to intervene on and, therefore, you shouldn't or can't be accountable. The value of the data is to make the argument that we need funding in these areas.

Ms. Thalhoffer responded that she is not arguing about the data being there. The concern is that they are starting to show up as deliverables in the contracts the counties have with OHA. In the current contract, it says that we should be working on those items now. The Accountability and Metrics Committee should come up with a statement about what those were created for and get the PHAB to endorse a definition of why those were created. For example, let's say the AFIX is being done in every clinic in every county, which we looked at last month when we saw the report. Our modernization collaborative didn't choose to work on the AFIX immunization assessment. We chose instead to put our money into gonorrhea rates. It would be expected that eventually the counties that are participating in our collaborative would be able to show that we are addressing the gonorrhea rates. But the AFIX piece is being worked into our contract and our state partners, just this week, said, "Hey, have you thought about working on an AFIX assessment in every one of your counties, because you are getting modernization money and you should be working on that." There is a real disconnect between state staff and what's coming out in contracts and what's happening at the PHAB. There needs to be a little bit more work done on what the PHAB is saying. The PHAB is not saying, "Do it now with the money you have." The PHAB is saying, "We need this data to show the state what we need to do to move forward."

Dr. Bangsberg suggested that maybe one way to phrase is not just "accountability metrics," but "accountability surveillance and metrics." Some of these metrics are purely surveillance and some of them are metrics for which you want to move the needle and be accountable for.

Ms. Thalhoffer stated that that distinction is very helpful.

Ms. Moseley thanked Ms. Thalsofer for raising this issue. This is what Ms. Thalsofer is hearing from within the Public Health Division, and the division is out of alignment internally, and that's really helpful to know. Ms. Drum will follow up with Ms. Thalsofer to get more specifics and put some specifics around this, so that we could follow up internally and make sure that we are all in alignment around this, because what Ms. Thalsofer is experiencing is not where OHA's intention is right now. Ms. Thalsofer will hear back from OHA staff to try to sort it out outside of this meeting.

Ms. Thalsofer thanked Ms. Moseley.

Dr. Schwarz mentioned that, as far as he could remember correctly, there were 45 different program elements. The accountability metrics are very, very narrow band of deliverables, compared to the breadth of program elements. It might be interesting to try to get an overview of when and how the accountability metrics are related to the program elements. The subcommittee has never touched on that.

Ms. Tiel explained that she often has to remind herself of the scope of the PHAB. Its role is not to get it in operational and contractual details, but to set direction, set intention, advise, and if that's conflicting with how things are being implemented, that's important to bring up in this meeting, but certainly isn't our world to read and review contracts.

Incentives and Funding Subcommittee

Akiko Saito

Ms. Saito informed the PHAB that the Incentives and Funding Subcommittee convened on April 9, 2019. The subcommittee has been charged with understanding and formalizing how modernization funding will go out, if we do get funding. During the last meeting, the subcommittee discussed what we would do with \$5 million of funding. Last month, the subcommittee decided that the \$5 million would be given out to the ongoing projects. During this month's meeting, the subcommittee was charged to formalize how funding in the range of \$5-\$10 million would be distributed. The first part of the discussion was around the modernization collaborative projects that were funded at \$5 million in the last biennium. They only had 19 months to do the work and it was a 24-month biennium. That had a lot to do with having contracts some place.

Ms. Saito noted that, for this group, the subcommittee wants to ensure that we are seeing what can be done in those modernization projects. The subcommittee made the decision that if OHA received between \$5-\$10 million that it would increase the funding to the eight LPHA partnerships, so that the funding level would match the current funding for the full 24-month period. That would be an additional \$1.2 million. If the funding is anywhere between \$5-\$10 million, we would add that additional \$1.2 million, so we can make those projects full for 24 months. After that, we would then provide base funding to all the LPHAs. That total amount

would \$1.845 million. The base funding is between 30K and 90K, based on the size of the LPHA. Any remaining funds will be distributed through an RFP process for new partnerships and the new coordinated service delivery models.

Ms. Saito added that, based on a suggestion by Dr. Dannenhoffer, if OHA was going to do another RFP process, it would be good to have a toolkit or some other deliverable that staff at other counties can utilize for modernization.

Dr. Dannenhoffer mentioned that that was discussed this morning at the CLHO meeting and, with a deafening silence, it was supported.

Dr. Schwarz asked about the prospect of how much funding we might be getting.

Ms. Moseley answered that we would not know until the end of the legislative session. We are relatively confident that we will see an investment of some kind.

Dr. Schwarz remarked that when the PHAB discussed this two years ago, the PHAB didn't have a clue. It wasn't in the Governor's budget and it came out of the legislature. Then we got the \$5 million, which was far away from what the PHAB had been discussing. Let's say we get \$5 million again and we continue to do these grants. Maybe next time we'll get \$5 million. We have to question at some stage: Are we actually modernizing the public health system or are we just becoming a grant body to hand out public health grants? Compared to what we were discussing a couple of years ago, it's not a very optimistic perspective.

Ms. Moseley agreed with Dr. Schwarz by noting that this was an important conversation to have. She would like to think about it and bring back some suggestions for how we do talk about that. She was not part of the PHAB years ago when that discussion took place. Now that we have this practical, applied system in place, it is a different conversation. Based on Dr. Schwarz's comments, it might be good for the PHAB to try to get back to some of the aspirational conversations that were more visionary for the public health system. That's the piece she would like to contemplate and think about how we move ourselves back there from the practical, legislative session place.

Mr. Queral remarked that we are not going to move into modernization as we thought about it unless we have the amount of funding that we need. That's evident to everyone. What's missing in this effort is that there are no public health advocates who are really pushing for public health modernization. We are proposing a new way of looking at the public health system but operating in the old model of advocacy. Certainly no advocacy from us, but also the other public health advocates – nonprofit organizations – that could be speaking on behalf of this. They are talking about the same things we have been talking about for decades, such as increasing the tobacco tax and sort of the old model. Where could we begin an effort to talk to other public health advocates? CLHO may be the place to instigate this conversation. How do

we make the link between the public health advocates and those of us who are sitting at this table?

Dr. Schwarz added that he went to the APHA meeting last year in November and he was looking in the program for other states doing public health modernization. He didn't find that title anywhere in the program. There must be some other state that is doing something similar and also trying to link up with some of these other activities that are going on. We don't know which states are doing it. There might be ideas that we could get from other states that have been more successful in terms of getting the legislators' convinced.

Ms. DeLavernge-Brown shared with PHAB that she just came back from The Occupational Safety and Health Administration (OSHA) meeting, which gathers public health directors from across the country. Oregon is so far ahead of everybody else. There are few other states, such as Ohio and Washington, that are doing things, but not as far as Oregon is doing. When the bill came up, there were a lot of people testifying from different health departments and health advocacy organizations. Morgan felt really good that day, because there was a lot positivity about modernization. A fair number of legislators came up to her afterwards, saying, "Oh, I get it now." We need to think about that from PHAB's standpoint – how do we build that bigger capacity for people to really advocate for this?

Ms. Saito underscored Mr. Queral's thought about meeting people who are not necessarily typical to public health. We were asked to provide some testimony from our partners and within four hours, we had multiple letters from people in emergency management and other walks of life. That's how we do it with not just the typical public health people.

Modernization Grantee Update: Health Equity Action Plans

Kim Handloser (Jackson County), Katherine Duarte (Klamath County), Katrina Rothenberger (Marion County), Kristty Polanco (Polk County), Carla Munns (Willamette Valley Community Health), Dr. Jenny Faith (Deschutes County), Heather Kaisner (Deschutes County)

Ms. Tiel remarked that we are starting the second round of updates. We have heard from all public health modernization grantees. This time around we are excited to hear more about each grantee's health equity action plan that they have developed to address communicable disease disparities. Today, we have three partnerships to present.

Ms. Duarte introduced herself and Ms. Handloser, who are the program coordinators for the Jackson-Klamath regional modernization partnership. Ms. Duarte stated the objectives of the partnership: (a) reduce hepatitis C rate, (b) reduce rates of STIs, (c) raise HPV vaccination rate for cancer prevention, (d) health equity and cultural responsiveness. She reviewed the targeted populations and the ways the partnership engaged with community partners.

Ms. Handloser noted that the root causes of health disparities included poverty, trauma, institutional racism, lack of health literacy, and lack of support. Many individuals are isolated due to these factors. The partnerships were required to address both proximal causes, such as needle sharing and risky sex behaviors, and root causes. In addition to identifying external opportunities to build capacity, both Jackson County Public Health and Klamath County Public Health will continue to strengthen internal capacity to address health equity.

Ms. Handloser added that some of the strategies from their health equity plans for addressing root causes included engaging directly with at risk and marginalized community members through the creation of a feedback loop and focus groups, open dialogue with health and social service professionals about the connection between mental health and trauma and health disparities, sustaining and expanding partnerships with nonprofits and coalitions that are addressing health inequities and social determinants of health. Outcomes include identifying appropriate and actionable steps for reducing communicable disease risk in high risk community members, as well as engaging in multi-sector efforts to address housing, behavioral health, trauma, and health outcomes.

Ms. Handloser remarked that to increase staff capacity both counties developed strategies to increase staff capacity through encouraging equity and culturally responsive professional development. For example, Jackson County Public Health promotes staff attendance to workshops offered by SO Health-E, such as the racial justice training that they have scheduled for next month. Klamath County plans to create a performance measurement goal for equity that will measure the equity-linked activities involving direct work by its public health staff. An example of that would be providing safe zone training to its staff and the staff in turn will provide that training to other organizations in the community. The outcomes from these strategies culminate in providing public health services that are effective, equitable, understandable, respectful, and responsive.

Ms. Handloser outlined the strategies for implementing the plan with the next round of funding: continue the momentum of 2017-2019 funding cycle, fit within organizational capacity, foster partnerships within and across counties, build upon current programs, and emphasize equitable culturally responsive programs and systems. Since the counties were developing strategies beyond this current funding cycle, the counties stayed mindful of organizational capacity while remaining open to future opportunities. In the event of additional funding, objectives and strategies can be expanded or added to reduce health disparities through addressing root causes, building partnerships, and increasing staff capacity.

Ms. Handloser thanked the PHAB for having her and Ms. Duarte. Ms. Tiel invited the public health officials from Marion and Polk counties to introduce themselves over the phone.

Ms. Rothenberger introduced herself as the public health division director for Marion County Health & Human Services. She explained that the presentation is a follow-up on what the counties have been up to since the last time they spoke to the PHAB.

Ms. Munns introduced herself as the director of quality and transformation at Willamette Valley Community Health (WVCH). WVCH is the coordinated care organization, currently serving Marion and Polk counties' OHP (Oregon Health Plan) members.

Ms. Polanco introduced herself as a public health administrator for Polk County Public Health. She articulated the statewide objectives for public health modernization: develop a modern communicable disease control system, emphasize elimination of health disparities, establish new systems for local public health service deliver, and increase accountability for health outcomes. Marion and Polk counties have focused on implementing their regional communicable disease control strategies, which are driven by the data that reflected a disparity in the increase of STIs/STDs within age groups with populations between 25 and 64 years, as well as focusing on increasing HPV vaccination rates.

Ms. Polanco highlighted Marion/Polk counties Year 1 accomplishments: developed policies describing regional partnerships between partners, convened a diverse communicable disease task force (meets monthly), developed a regional health equity action plan, increased provider knowledge of best practices for testing and treatment of CT and GC in Marion and Polk Counties. These accomplishments have equated to an increased adequate gonorrhea treatment in Polk County from 64% to 87%, maintained or improved rate of adequate gonorrhea treatment in Marion County, and improved HPV vaccine administration rates in Marion and Polk Counties.

Ms. Munns remarked that one of the most high-level shared goals that we can talk about with public health modernization from CCO's perspective with local public health is that we share the same vision for innovative and transformative healthcare systems. Public health modernization is a crucial component of that. The alignment that can happen between CCOs and a local public health department just makes sense. It is hard to imagine how a community can move forward with healthcare transformation, and being innovative, and on the cusp, and really making a huge difference without aligning CCOs with public health departments. That's the highest level alignment that we can have and WVCH has been fortunate to have such a great relationship through this process and through a bunch of other programs with the public health departments.

Ms. Munns noted that WVCH and the public health departments in Marion and Polk counties has been sharing best practices through out the community, so it's a combined message, a shared message the providers are hearing. An example are the training series provided by the AIDS Education Training Center (AETC) throughout Marion and Polk counties. Fifty-seven people attended these trainings. People were happy with what they learned and WVCH were

able to utilize it in their clinics. WVCH is working with AETC and other agencies, including the counties, to try to help its providers with more focused trainings for their clinics, if they would like. WVCH will be offering more education and trainings for on-site clinics for HPV vaccination and AIDS, among others. WVCH held focus groups and listening sessions among vulnerable populations to make sure that their voices were heard. We used the health equity lens in the Health Equity Tool to ensure that we were creating a broad representation of our community's voice. WVCH used clinic-specific data, using our Medicaid data for OHP members, to provide outreach to clinics to try to reduce gender and clinic disparities that WVCH noticed in HPV vaccination rates. This was eye-opening and led to great partnerships with the county, which was utilizing data from the state directly on HPV vaccination rates. WVCH was able to narrow it down into more specific disparities using a gender disparities lens in some of the larger clinics to help target interventions to the population in the two counties. In addition, WVCH launched a mobile screening and treatment van for STIs and reproductive health and increased the community support for a regional Syringe Exchange Program that includes Yamhill County CCO.

Ms. Rothenberger explained that one of the first things the counties did around health equity was to conduct a community readiness assessment to look at some of the disparities relating to communicable disease control and what the community partners' attitudes and level of readiness was. After the counties did the assessment, the officials realized that they should probably look internally to their own health departments. Polk County conducted the BARHII, the Bay Area regional health and equities initiative. Marion County decided to do it as well, so it can be aware of its own biases and institutional issues that may have contributed to the health disparities in its communities. Pairing the community readiness model and assessment with the county's BARHII results may lead some good work in the future.

Ms. Rothenberger noted that the partnership's action plan includes the creation of a communication plan that was culturally responsive to the community's needs. Health officials heard from partners that going on the Spanish radio show was a good way to reach Latinx communities and they did that a couple of times. They are also doing collaborative Facebook live sessions in English and in Spanish, with a separate video in Spanish so that it can be shared with different audiences, rather than doing Spanish and English in the same video. As part of the action plan, the health departments are creating authentic partnerships with local community agencies, as well as creating awareness of STDs through posters, flyers, and brochures.

Ms. Rothenberger agreed with Ms. Munns that working with the CCO partners has been extremely beneficial to the local health authorities. They have been able to identify the rising rates of STDs. The AETC trainings are the results of everybody coming together to look at some regional data around STDs rates. As more partners are taking on this work, the partnership decided to do listening sessions to better understand where the communities are at and what they need in terms of communicable disease control. Willamette University has been a stellar partner. They conducted their own listening session. HIV Alliance has been wonderful at

removing barriers. Work is also ongoing work with communities of color with a partnership with NAACP (National Association for the Advancement of Colored People) in the Marion County region and started working on some collaboratives. This is a new relationship.

Ms. Rothenberger outlined some of the policies and strategies in Marion County's health equity plan: implementing employment recruitment for bilingual candidates for emergency preparedness by including health equity or diversity questions in their interviewing practices, beginning the work to collaborate with Willamette University and local school boards to discuss policy change regarding sex education curriculum, creating a regional policy for treatment of gonorrhea.

Ms. Munns laid out the priorities for the modernization future work plan. Marion County will conduct a BARHII organizational self-assessment (Polk County has already done it). This will help the organizations to identify and self-assess where biases are happening, or where inequities are happening in policies, in hiring practices, and in other areas. That will help from the most basic level of the health department access to the county's community members, really looking at health equity from an internal standpoint. The partnership will continue to convene a communicable disease coalition in conjunction with the Early Intervention and Outreach (EIO) grant. By June 30, 2019, the partnership will develop and implement a regional health equity action plan to improve practices and implement policies to reduce communicable disease control-related disparities. WVCH has taken on to improve HPV vaccine administration rates among VFC providers in Marion and Polk Counties. The partnership will continue to utilize a health equity lens in all aspects of public health work, will be culturally and linguistically responsive to diverse health needs, and will work on creating authentic partnerships with broad outreach.

Ms. Munn concluded by highlighting partnership opportunities with CCOs: CCO commitment to healthy equity, local public health partnerships, and the shared community; focus on population health, upstream approaches, and data-driven population health management regardless of whether individuals are members of WVCH or not; community health improvement plan; quality incentive metrics strategies; and contractual requirements around health equities and disparities and establish evidence-based guidelines. There are a lot of opportunities to get involved and align LPHAs' efforts with CCOs.

Ms. Tiel thanked Ms. Munn and invited the presenters from the Central Oregon public health partnership to introduce themselves.

Dr. Faith introduced herself as the Central Oregon tri-county epidemiologist. Ms. Kaisner introduced herself as a public health manager at Deschutes County, overseeing the Central Oregon partnership. Ms. Kaisner reminded the PHAB that Ms. DeLaVergne-Brown, who is a public health administrator at Crook County, is also a representative of the Central Oregon partnership.



Dr. Faith reviewed the health equity assessment components that have been done in Central Oregon over the last year and half. The assessment components include three different assessments done in reference to the modernization work: (a) analysis of local data, looking at demographics of the region and the populations vulnerable to communicable diseases and outbreaks, (b) internal staff assessment (BAR-HII), (c) external partner assessment (BAR-HII). In addition, a series of community focus groups (about 20) were done before the creation of the health equity action plan. Health equity questions were incorporated into these focus groups. That was another way to collect feedback from the community.

Ms. Kaisner explained that the results from these assessments are upcoming. That's going to be the next steps when it comes to the regional health assessment. As far as analysis of the local data, they were trying to determine what they were going to focus on as a tri-county region. The region was already doing a lot of work around AFIX rates with funds from the local CCO. In terms of STDs, the partnership received an EISO grant and had a team regionally working on that as well. The Central Oregon Health Partnerships has grown in many ways, with expanding capacity on many levels through many projects.

Ms. Kaisner remarked that the data showed that long-term care facilities (LTCF) in Jefferson, Deschutes, and Crook counties experienced a high burden of communicable disease outbreaks. Nearly 60% of all outbreaks in the tri-county area occurred in LTCF. This put a burden on local health departments and their resources, especially in smaller counties. Influenza vaccination among skilled nursing facility staff was lower in Central Oregon than the rest of Oregon. Proportion of older adults was higher in Central Oregon than the rest of Oregon. The data suggested that the tri-county needed its own epidemiologist (Dr. Jenny Faith). The results translated into action by prioritizing LTCF prevention activities and improving quality data and communication through epidemiology activities and reports, such as the Central Oregon Public Health Quarterly.

Dr. Faith noted that when we are talking about the BAR-HII assessments, they are looked at from a big-picture lens across all public health topics. If the assessments were being done, it was best to learn as much as possible about the entire public health area, not just communicable diseases. The BAR-HII assessments showed that there was a lot of work to be done internally. Some of the feedback indicated that staff had different levels of understanding and comfort with concepts of health equity. The goal was to focus on better incorporating health equity concepts in throughout the organizations through staff trainings, modeling it in day-to-day operations, and incorporating it into policies and procedures.

Ms. DeLavergne-Brown stated that Crook County also has been doing internal work. The assessment data was presented to staff and focus groups were established around the information and how it affected staff and programming. For external partners, a plan was put together for Public Health Week, as well as a thank-you breakfast, which was attended by over

fifty people and partners, including the commissioners. The information from the assessment was presented to the partners as “This is what you said. This is how you would like to see us improve and how work with you.” Each table then took a different topic and discussed through the perspective of health equity what needs to be done as a community around reproductive health, communicable disease, and other topics. Some of the groups came out with a page of information on how the partners worked together to improve some of these different areas around health equity. Crook County will do one more focus group with partners that could not attend the first session.

Dr. Faith pointed out that the assessment was not a one-time thing. The plan is to do the health equity assessment once every four years and use the data to inform the regional health improvement plan and agency strategic plans. The plan is to repeat the BAR-HII health equity assessment. The current data is baseline data to see where the tri-county partnership is and where it needs to go. Every four years, the new data will show how far the work has come. Other goals include: prioritize equity-focused data and communication (e.g., epidemiology reports, communicable disease fact sheets, website, and other external communications); continue LTCF prevention work with a focus on vulnerable older adults; increase focus on STD equity data and prevention activities; work with partners to identify additional needs.

Ms. Kaisner added that Deschutes County has a van that does needle exchange and HIV and HEP-C testing. The van will also be going to Crook County. Ms. Kaisner got an approval from the county commissioners to do syringe exchange in Crook County. In addition, a Central Oregon Public Health Partnership is being created.

Ms. Tiel invited the PHAB members to ask questions related to the three presentations.

Ms. Little introduced herself to the presenters as a tribal health administrator and asked how the partnerships have worked with the tribes within their regions. Central Oregon group has the largest tribe, which is the Confederated Tribes of Warm Springs, but each county has tribes that are part of the partnerships.

Ms. Kaisner stated that Jefferson County has a very close relationship with the Warm Springs tribe. The county’s public health department has a limited communicable diseases team. When the Deschutes County team met with Jefferson County’s team, it became clear that the Jefferson County team needed and wanted more training on Orpheus (i.e., epidemiology user system for communicable disease investigation). The communicable disease team from Deschutes County working on this grant is now in Jefferson County doing training. It has been a huge asset because of the search capacity. The Warm Springs tribe knows that they can call on the regional team when needed. The Deschutes County team is always there to help, if needed. Also, the van has been going to different Warm Springs events when requested by the tribe.

Dr. Faith added that the Warm Springs tribe requested to look at the STD data for the tribe, which is part of the STD data for Jefferson County. The data was separated to accommodate the request. That has been another opportunity to help the tribe with surveillance data that they might want or need, and they know that they can call on Dr. Faith as well, if they wanted or needed data.

Ms. Little shared with the presenters and the PHAB that there is a lot of sensitivity within Indian tribes at varying levels about data, data collection, and becoming identified as a Native American, and how that data would be used. There is also a wide range of capacity to do any public health work. There are always opportunities to do that.

Ms. Duarte commented that the Klamath County upper tribal lead liaison Valerie Lee has been working with the tribes for many years and has developed a close relationship with a lot of sensibility. She attends a lot of their activities and tribal events, as well as participates in different health row tabling at their events. Ms. Lee held a meeting with tribal providers last fall and was able to share some of the modernization topics that the county has in common with the tribe – hepatitis C, STIs, HPV vaccination – and worked towards having the same messaging throughout the county and being there as support for them with whatever they need, with a really light and sensitive touch. Klamath County continues to participate by attending their [...] council and their health equity coalition.

Ms. Polanco remarked that Polk County has had connections and collaborations with the tribes on its CD task force. That's an area of opportunity to expand collaboration beyond the task force, but there has been engagement there.

Ms. Munns reminded the PHAB that the CD task force is driving the strategic plan for these areas in those communities. Public health officials are weaving in those strategies that are recommended, which includes tribal representation for future implementation.

Dr. Schwarz congratulated the three groups on their work and reports. The PHAB was not quite sure what to expect from the project that it funded, but it sounds like the partnerships have gone beyond. It is encouraging and wonderful to see these collaborations across county borders and the collaboration between the CCOs and the counties. The focus on health equity is fascinating. Dr. Luck and Dr. Schwarz are members of the OHA Health Equity Subcommittee and they used the first half of the year to discuss what health equity was. It doesn't sound like the partnerships have been discussing the nature of health equity, but rather they have been doing something about it. It would be good to get the partnerships to talk to the Health Equity Committee and tell it how to go about health equity. The Health Equity Committee has been struggling with that.

Dr. Schwarz also noted that the way the state records race and ethnicity is very fragmented. There are internal IT issues at the state level, in terms of letting systems talk to each other,

which has led to only half of the information related to race and ethnicity being available. We don't have information about the race and ethnicity of half of the population we are recording. How do the partnerships get that information, which they obviously don't get from the state?

Dr. Faith responded that the partnership uses American Community Survey data or their assessments. When looking at Orpheus data, it is what it is. There are a lot of missing data. There has been a discussion on how to improve that – how staff can enter the data better and how the data can be extracted better. The partnership is moving in the right direction, but it's not there yet.

Ms. Munns added that one thing WVCH has done to narrow down the data and get more accurate data is to look at language preference. That has helped identify some of the smaller pockets of members and the culturally diverse perception that they might have. For example, a Russian population – they identify as white/Caucasian, but we know that we have a strong Russian population in our community. We broke it down by language and that's how we were able to identify that population a little bit further than what data we are provided by the state.

Dr. Luck explained that the Health Equity Subcommittee is charged with measuring health equity, which is why they were picky about the definition. There is the larger OHA health equity committee, which might be interested in hearing some of the presentations from some of these partnerships about health equity. The health equity work being done by the partnerships may not be on the radar screen of that committee. If some groups are willing to present, that would be good cross-fertilization.

Dr. Hedberg remarked that most of the data in Orpheus is collected at the local level. It is not that the state doesn't have good quality of data. The way to get better data is to report out, including how many missing there are, so people can see that it is an issue. When we know what's happening at the local level, then we can see that these data are really useful. That's an important feedback loop to have. It varies a lot from data set Orpheus and those data, including race and ethnicity, are collected by local health departments, which are the ones that are interviewing people. Birth and death are entirely different. It's different standards. We are interviewing people directly on surveys and they will respond directly to those data.

Dr. Hedberg noted that some of the state data stores has much better data, others – we don't have very good data. We are all in it together – this feedback loop, this presentation, looking at the data, including the missing data. The more we can say, "These are missing," that is a way for people to say, "That's a problem. If half of it is missing, how do we actually know what's happening in these groups?" Measuring or looking at race/ethnicity is extremely problematic, because we either have very large categories that we lumped together or, sometimes, we dice, split, and dice it so much that it's not meaningful. To try to figure out why a population is white/Caucasian, but Russian-speaking – that seems to be very important, including for things like measles outbreaks and other things. We need to figure out what's important for what

disease or outcome. Certain foodborne outbreaks – it is clear that it is important because our preference often relates with very concretely with what your cultural/racial /ethnic background is.

Ms. Saito praised the presentations, especially the great tools that the partnerships have been doing, such as the flyers, the posters, the health equity tools, the action plan's listening sessions. One way the Incentives and Funding Subcommittee talked about that was, if we did a RFP, we should have one of the deliverables be tools. It would be great to capture some of these tools now, so we can share them with people. Other LPHAs, tribes, and partners would be interested in that. Also, a lot of this is focused on the social determinants of health, especially around poverty. We do have an AmeriCorps VISTA program. Some people have an AmeriCorps VISTAs, but this would be a great opportunity also to have an AmeriCorps VISTA and our applications for host sites are due April 30.

Ms. Thalhoffer remarked that Ms. Saito's idea was great, but it is unknown what Wasco County's funding would be next year. It will likely be reduced, so it's impossible to commit to an AmeriCorps for the project. The timing is really, really difficult.

Ms. Saito responded that there would be another host site application that would be out. She had just emailed Daniel to discuss the Corporation for National Community Service and asking for the modernization VISTA program. That was done with the CCOs when they first began and also with Health Communities.

Dr. Schwarz asked that since this was a process evaluation and process presentation, when would the process finish.

Ms. Tiel answered that the process will end on June 30, 2019. The attention of these presentations is a process, checking in specifically on the health equity component of it. We will continue doing updates in whatever form or fashion the projects would like, moving forward.

Ms. Tiel introduced the State Health Improvement Plan (SHIP) update from the immunizations and communicable disease section. This is the last year of the current SHIP. We have been hearing a lot about the future state of the plan, but this is the final update on the current priorities. As the new SHIP workplan takes shape, OHA will be offering more opportunities to talk about it. Today, we are here to hear progress on improving immunization rates and protecting the population from communicable disease.

SHIP Update: Immunization and Communicable Disease

Aaron Dunn (OHA staff), Rex Larsen (OHA Staff), Dr. Ann Thomas (OHA staff), Dr. Timothy Menza (OHA staff)



Public Health Advisory Board
Meeting Minutes – April 18, 2019

Mr. Dunn introduced himself to the PHAB as the manager of the Oregon immunization program.

Mr. Larsen introduced himself as the quality improvement program manager for the immunization program.

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

Dr. Menza introduced himself as the program director of the HIV/STD/TB program.

Ms. Dunn informed the PHAB that with the measles outbreaks in Clark County, we've had 10 cases in Oregon (4 of them are related to the Clark County outbreak). Across the nation, we have seen 465 cases in 19 states. The two key questions are: (1) How does our public health work change if the level of measles activity seen this year becomes normal? (2) With the legislative activity related to immunization school requirements this year (HB3063), what do your providers and populations need to hear from us?

Mr. Dunne provided an update of the priority targets of the immunization program: (a) immunization rate among two-year-olds (at 68% in 2018, up 8% since 2014; 2020 target at 80%), (b) HPV vaccination rates among youth (at 46.4% in 2018, up 18.4% since 2014; 2020 target at 80%), (c) seasonal flu vaccination (at 45% in 2018, up 3% since 2014; 2020 target at 80%). A number of factors contribute to these increases.

Mr. Larsen explained that the childhood immunization rates are improving year over year. This reflects the work CCOs are doing and the local health departments' modernization work. Next year, OHA will be releasing the two-year-olds rates increase by another one percent. That rate is not likely to keep increasing at the same rate. It will probably start to taper off. The high rates can hide pockets of need in rates. According to CDC, 75% of the measles cases in the past five years have come from close-knit communities. As we look at these improving rates, we start to talk about ways to identify those pockets of need in those close-knit communities that we know we need to work with. One big thing the program is working on is trying to link the IIS data to more vital records data, such as country of origin and other data points that may be available, to start to identify pockets of need.

Mr. Larsen pointed out that improving rates can hide at-risk communities. For example, the median vaccine completion rate by the 1,670 schools in Oregon, grades K-12, in 2018, was 94%. One in five of these schools falls below the threshold for measles. The schools with low vaccination rates represent communities that are at-risk for communicable disease outbreaks. How do we identify those schools and those communities that they represent? Behind each of those schools are families. The program has started to link additional demographic data from

Oregon Department of Education to the program's school data to see if there is any way to get a better description of the communities that these schools represent.

Ms. Larsen pointed out that HPV vaccination rates are improving dramatically across the state, but those improvements are focused in metropolitan regions. There is a significant urban-rural disparity. There is a lot of work happening to try to address the urban-rural disparity. Right now, there is a research partnership with OHSU and OHSU's provider research network. The goals identify ways that we can improve rates at the practice level in rural clinics. Rural clinics struggle with HPV vaccination. The takeaway message is that rates are improving across the board, both two-year-old rates and adolescent rates, but we need to find better ways to target the specific pockets of need: close-knit communities in childhood vaccination and our rural clinics and rural rates for adolescent rates.

Ms. Tiel commented that we just heard from the modernization grantees about some health equity assessment work that they were doing. Root cause comes down to poverty and income. In these pockets of need, which are different from the pockets targeted by other work, such as chronic disease, are we talking about communities of color or a different type of population that needs to be targeted?

Mr. Larsen answered that it is hard to know. It depends on the disparity mentioned by Ms. Tiel. With adolescent vaccinations in rural communities, there is an income disparity and education disparity. There are access disparities in rural areas, but we also know that there are complex social issues that are intertwined with this. In close-knit communities is the same thing. We have seen outbreaks in orthodox communities in New York (Orthodox Jewish communities) and we have our Russian-speaking population here. There may be income disparities that are intertwined with social issues as well.

Dr. Schwarz remarked that in the table that showed the increase of immunization rates among two-year-olds from 60% to 68%, is that what is meant by 8% increase? It is rather 8 percentage point increase. It's not 8% increase.

Ms. Larsen confirmed that it is an 8 percentage point increase.

Dr. Schwarz noted that this was very important because when we go out to apply the numbers, we should say what it is. Another thing is that the target is so far away from where we are. Who set the target?

Mr. Larsen answered that Healthy People 2020 set the target.

Dr. Luck commented that the HPV vaccination rates map shown in the presentation was a striking map. He asked if other states also showed such a big urban-rural disparity and whether

any other states have identified any successful strategies for improving vaccination rates in rural areas.

Mr. Larsen answered that other states have identified an urban-rural disparity, but there is not a lot of research that talks about successful strategies. We know that resources are an issue in rural clinics. We know that travel time is an issue and that there are a lot of economic issues around parents not being able to take time off work. There is not a lot of research that shows us the most effective interventions to address the issue. Oregon is unique in a couple of ways. We have a different, sometimes social divide between urban and rural groups. Many states that have large rural areas also have more homogenous populations politically sometimes, so there might be some issues there.

Ms. Larsen added that one thing to point out on the HPV map is that we have outlier counties in rural areas, such as Malheur County or Jefferson County. There are rural counties that have high rates, some of the highest in the state. That is usually driven by a single provider or provider office, such as Snake River Pediatrics or Warm Springs. Those practices have addressed the issue. We are trying to figure out what those practices are doing and how to make sure that we can help all our rural practices do that. Because if one provider office can change the rate for the entire county, then we are looking at providers having a significant amount of influence on that rate. There will be some really promising interventions, but we don't quite yet know what they are.

Dr. Thomas reviewed the key questions for protecting the population from communicable disease: (1) How do we leverage policy, health systems and public health to decrease infections among people who use drugs? (2) How do we bring all stakeholders to the table for a unified response to the syndemic of substance abuse and infection diseases? (3) How can we increase funding for surveillance, primary prevention, screening and linkage to care for HIV, HCV, and STI?

Dr. Menza explained that the top two priority targets were syphilis incidence and gonorrhea incidence. Like nationwide, we have been seeing increases in STIs across the board. Oregon is not exception to that rule. Syphilis incidence (rate per 100,000) has increased from 10.4 (2014) to 13.5 (2017), with 2020 target of 11.1. It's even higher in 2018. Gonorrhea incidence has increased from 57.9 (2014) to 121.3 (2017), with 2020 target of 72. HIV incidence has decreased from 6.0 (2014) to 4.8 (2017), with 2020 target of 4.5. HIV oral suppression rates have increased from 68% (2014) to 75% (2017), with 2020 target of 90%. In some areas we are at that target. Tuberculosis incidence has decreased from 1.9 (2014) to 1.7 (2017), with 2020 target of 1.4.

Dr. Thomas stated that if we excluded gonorrhea and chlamydia, the number of annual reports equals the sum of all other infectious diseases combined. It's hard for us to track it, because most of them are asymptomatic and we don't have properly funded screening programs.

Unfortunately, one of the more impressive statistics we were able to come up with was the long terms to quality, which is mortality. We have the unfortunate distinction to have the highest Hepatitis C mortality rate in the nation. The rate climbed from 8.4 (2014) to 9.3 (2017), with 2020 target of 6.0. The rate has stabilized since then, but it's still too high. It's twice the national average.

Dr. Thomas presented a complicated slide of the syndemic model. Once broken down, it is an elegant approach to thinking about how to understand the relationships between several ongoing, concurrent epidemics. The model covers substance use and misuse, overdose, infections (e.g., HIV, HCV, syphilis, and bacterial infections), suicide, and alcohol use. The term *syndemic* comes from the Greek *syn*, which means "with" or "together". These things are all happening together. We don't call them comorbidities or cooccurring epidemics. They are more interacting. From a modeling standpoint, these are multiplicative. They share common causes and consequences. There are also some shared responses that can be used to address the epidemics.

Dr. Thomas stated that there some common things we can work on together, but, structurally, who works on these epidemics in the health department? What departments are they from? Do they often work together? The short answer is no. For example, substance use and misuse are in another OHA section (i.e., addictions and mental health). There's more work being done on those now in OHA's chronic disease program, which focuses more on alcohol. Others are covered by OHA's injury and violence prevention program. Others are covered by maternal and child health.

Dr. Thomas showed the PHAB two charts of the recent trends in injection drug use and selected infectious diseases in Oregon (2013 vs. 2018). Cases have increased in HIV, early syphilis, acute HCV (capturing only 15% of occurring cases), and invasive GAS (Group A strep). The rate of GAS had been mostly same between 1995 and 2015, but the rate has tripled in the last 3-4 years. Much of the increase has been in people who inject drugs with a big contribution in the homeless population. In terms of hospitalizations for bacterial infections related to IDU, the rate has increased five-fold in the state between 2008 and 2015.

Dr. Menza reviewed the numbers for HIV diagnoses among heterosexual PWID by reported substance use. The number of cases of HIV diagnoses among persons who inject drugs has almost tripled between 2013 (12 cases) and 2018 (34 cases). There has been an interesting trend in substance use in Oregon and across the nation. In terms of percent of cases reporting a particular substance use, the cases are reporting less and less heroin mono use and more and more combination use. A lot of that is methamphetamine and opiates taken together. In contrast to the hospital admissions for serious bacterial infections, which are opioid related, the HIV infections and the syphilis diagnoses are methamphetamine-related. It is a sort of a flip. It is almost 70% of the people diagnosed with HIV in Oregon.

Dr. Menza pointed out that in terms of HPV vaccinations and urban-rural divide, this is something we are seeing across the state, especially in rural areas. Interestingly, the rates of new HIV diagnoses in the Portland area have declined since 2012, while the rest of the HIV diagnoses for the rest of Oregon have increased slightly in the same time period. With chronic Hepatitis C, the prevalence of cases is in the more rural areas, such as Douglas County. Cases of early and congenital syphilis among women who inject drugs have risen steadily both in Portland Metro area and the rest of the state between 2013 and 2018.

Dr. Bangsberg commented that some metropolitan areas, such as San Francisco and New York, can see an increase in gonorrhea and syphilis among men having sex with men, who take HIV medications and realize that they won't transmit HIV. These strategies are great for HIV, but not very good for syphilis and gonorrhea. It doesn't look like that's what's happening in Oregon.

Dr. Menza remarked that what we are seeing among the cases of syphilis and even HIV among men having sex with men (MSM) is that methamphetamine use is flat. In the cases of syphilis, about 10-15% of MSM are reporting methamphetamine use. It's about 40% in the HIV cases. There are still increasing trends, but they are not as severe. The slope is not as deep as they are among women.

Dr. Dannenhoffer agreed that that was exactly what was happening in Douglas County. The increase in HIV, gonorrhea, and syphilis – whoever thought that in 2019 we would be spending time on measles and congenital syphilis? It's an absolutely tragic thing. The syndemic model is great. There's always the desire to add more circles. Housing clearly has to be part of it, as the homeless drug addicts are causing much of the issues with the addicts. As a pediatrician, it's interesting to see that this model also accounts for much of the foster care that Douglas County has. About two-thirds of the kids who are in foster care now are in foster care because of the syndemic drugs. We are seeing very little true abuse at this point.

Dr. Luck asked Dr. Bangsberg is there have been any particular strategies that have been effective in rural areas that are different than approaches in urban areas.

Dr. Bangsberg answered that he could not speak about the rural areas. Meth use drives the frequency of injection drug use, which is associated with [...] sex. Heroin is a bad drug, but meth makes it much, much worse. Probably there is more meth use in rural areas.

Dr. Thomas noted that Dr. Dannenhoffer knew about a study in collaboration with OHSU trying to increase screening in linkage to care to HIV, Hepatitis C, and STIs. The work is conducted in Linn and Douglas counties. There is a quantitative questionnaire and there's some qualitative work that's been done with these people. The issues are on housing. Seventy percent of our enrolled clients are homeless, among people who inject. In using the CDC's Vulnerability Assessment, which predicts how many people on the county level have chronic drug, we see that for cases of HEP-C and people under the age of 30, the predictor is lack of transportation.

It's true. You can't get to needle exchange. You can't get to healthcare and access the services you need.

Ms. Tiel asked the participants on the phone if they had any questions to the presenters.

Ms. DeLavergne-Brown commented that, in terms of the question brought up about the different agencies and different groups, Crook County includes drug and alcohol prevention with tobacco, communicable disease, and other areas. It makes a big difference when all these areas sit in public health and we have the ability to do that. If you can't, you don't have to work with those other partners. Crook County is working very closely with law enforcement. Counties have to work with law enforcement and the jail. In Crook County, that's that population. We've got to bring that group in to work with public health also.

Dr. Bangsberg praised the slide about the heterogeneity of vaccine penetration among schools and how a small number of schools account for a significant portion of unvaccinated kids. Why aren't we funding public health nurses in those particular schools to provide vaccines on the spot?

Ms. DeLavergne-Brown joked that parents won't let us.

Dr. Bangsberg added that we need interventions with the parents. We can put a lot more resources in a small number of schools to have more intervention effect.

Dr. Schwarz noted that Mr. Dunn asked if this was the new normal. That reminded him that there were no measles vaccinations when he was a kid. Kids were sent to the homes of kids who had measles, so that they could get measles. This included mumps and chicken pox. The kids were cycled around between those who had the disease, in order to get the disease. Maybe that is the new normal. It's back to the future.

Dr. Dannenhoffer remarked that back in the old normal we didn't have kids with transplants and we didn't have kids with cancer. Now we are thinking about the great advances we have made in medicine and putting those kids at risk for those diseases. When they get those disease, they are going to die. They are relatively weak. Back in the old days, one or two out of a thousand died. Now we think the death rate would be just as high, because we have these new vulnerable populations. In terms of the schools that had low vaccination rates, these are not the schools that lack resources. It turns out that in Douglas County, when we look at the poor schools, they have the best vaccination rates. It's the rich schools that have low vaccination rates. A recent study in California looked at the rate of vaccination by the cost of tuition. There's an almost linear relationship between the cost of tuition and the vaccine refusal rate. This is not met by bringing a nurse there to vaccinate the kids. It's about convincing the parents, and they are hard to convince.

Mr. Larsen stated that we do have school-based health centers in public schools, but there's no organized system of providing care to students in a private or many other types of schools. Maybe part of the answer is that we have to push for some way to have better healthcare in the school for private schools. OHA doesn't have any power over that.

Ms. Tiel thanked the presenters for their time.

Public Comment Period

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 4:45 p.m.

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

**May 16, 2019
2:00-5:00 p.m.
Portland State Office Building
800 NE Oregon St Room 1D
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