

**Public Health Advisory Board (PHAB)**  
**January 16, 2020**  
**Meeting Minutes**

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**Attendance:**

Board members present: Dr. David Bangsberg, Akiko Saito, Dr. Jeanne Savage (by phone), Dr. Eli Schwarz, Kelle Little (by phone), Dr. Bob Dannenhoffer, Lillian Shirley (ex-officio), Teri Thalhofer (by phone), Muriel DeLaVergne-Brown (by phone), Carrie Brogoitti (by phone), Dr. Dean Sidelinger, Alejandro Qeral (by phone)

Board members absent: Rebecca Tiel, Eva Rippeteau

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

Members of the public: Morgan Cowling (CLHO), Sierra Prior (CLHO)

**Welcome and Agenda Review**

*Carrie Brogoitti*

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

- Approval of November 2019 Minutes

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

- Update on PHAB Mini-Retreat

Ms. Biddlecom informed the board that OHA has a slate of candidates to fill the three vacant positions on the PHAB. The list has been forwarded to Governor Brown's office for formal approval and appointment. The hope is that those individuals will be appointed prior to the PHAB retreat, because it is a critical time for the board to come together and think about the future.

Ms. Biddlecom thanked the board members for completing the survey that the retreat facilitator, Lillian Tsai, had asked the board to complete. The agenda is being finalized in response to the board's specific feedback. Board members are encouraged to attend the retreat in person. Travel expenses will be reimbursed. The PHAB has never had a retreat and it is important for the board to shape what the board would like to see in the future. The retreat is on February 19, 2020.

- Member Participation in PHAB Incentives and Funding Subcommittee

Ms. Brogoitti noted that today's agenda provided critical infrastructure related to the work of the Incentives and Funding subcommittee. The PHAB needs to confirm that existing members will continue and identify at least one new member to replace former PHAB member Dr. Jeff Luck on the subcommittee. The subcommittee will spend the next several months updating the local public health modernization funding formula. Major tasks for the subcommittee will include reviewing feedback on funding formula implementation in 2019-2021, revisiting the funding formula components for incentive and matching funds, and providing feedback on the funding formula section of the June 2020 Public Health Modernization Funding Report to the Legislative Fiscal Office. The subcommittee will meet monthly from February through June.

Ms. Biddlecom reminded the board that the existing subcommittee members were Dr. Dannenhoffer, Ms. Saito, Mr. Queral and Ms. Brogoitti.

Ms. Brogoitti asked if the existing members would like to continue serving on the subcommittee.

Dr. Dannenhoffer and Ms. Saito agreed to continue serving on the subcommittee.

Ms. Brogoitti asked if any other board members would like to join the subcommittee.

Dr. Savage asked if the subcommittee was the one dealing with the financial side of public health modernization.

Ms. Brogoitti confirmed that it was the same subcommittee. She asked about next steps.

Ms. Biddlecom answered that an email could be sent to all board members and this task could be put on the list for when the PHAB held members orientation. Typically, the two subcommittees are discussed and board members are encouraged to participate in them. Maybe there would be a new board member who would be willing to participate.

Ms. Shirley added that if any of the board members weren't sure if they wanted to participate, the packet that OHA sends out includes not only the meeting minutes from the PHAB meetings, but also the meeting minutes from the subcommittee meetings. This way, the board members could review the minutes of a subcommittee and get a sense of the issues the subcommittee deals with and how the subcommittee is making decisions. Maybe that would spark board members' interest.

- *Opportunity to Provide Testimony to Health Plan Quality Metrics and Metrics and Scoring Committees Related to Obesity and Health Equity Measures*

Ms. Brogoitti stated that there has been a significant amount of work to-date developing an obesity and health equity measures for the Health Plan Quality Metrics and Metrics and Scoring Committees. As a committee of the Oregon Health Policy Board, like the Health Plan Quality Metrics committee, the PHAB would like to encourage the adoption of transformative measures that will meet population health objectives. The PHAB is invited to provide written and/or oral testimony at upcoming meetings to support this work. The PHAB has a draft letter

of support, included in today's meeting packet. The PHAB needs to decide if it will put forward the letter and whether in-person testimony is needed.

Ms. Brogoitti asked the board members if they had any comments on providing this letter of support.

Dr. Savage shared that she didn't have any trouble with putting forth a letter that prioritized preventing obesity. She asked if there was a description of the metric that was being recommended in the packet, or if the metric was not fully out.

Ms. Biddlecom answered that the obesity measure was going to be in two phases. The first component, which will begin in January 2021, is to implement evidence-based interventions for the prevention and treatment of obesity. They fall into five different areas with point values assigned for each intervention. It is designed such that the Metrics and Scoring committee can increase the benchmark by increasing the number of points that are required each year. This is built off of the multisector interventions work that the Health Evidence Review Commission has been working on over the years related to obesity prevention. The second component is assessment via an online attestation tool to ensure they are meeting minimum annual requirements. This is a phased-in measure – the first piece being around looking outside of calculating BMI (Body Mass Index) and finding the interventions that are being done cross-sectors to support obesity prevention and treatment.

Dr. Schwarz commented that one thing he was missing was any reference to what the PHAB had been doing. He felt the PHAB should let the Metrics and Scoring committee know that the PHAB has been active in obesity prevention and that it is part of the PHAB's support for the metric.

Ms. Biddlecom noted that the PHAB had been weighing in on obesity, which was one of the seven focus areas in the 2015-2019 State Health Improvement Plan (SHIP). That language could be added in the letter.

Dr. Dannenhoffer supported the PHAB's support of the measures, but found both of the measures far from transformational. One of the difficult things of setting measures is either to set things that are really transformational and hard to do or set things that fog the glass, that is, be willing to go ahead and make the measures. These measures are more about fogging the glass than being transformational. The health equity measure basically says that one should have proper interpretation services, which is the law. While he supported the letter, he was concerned that the measures, which were quite transformational in some ways initially, have seemed to become more pedestrian.

Dr. Bangsberg shared that one of the most provocative and important discussions in the OHSU/PSU School of Public Health curriculum review was on this topic. Now that smoking is coming down, obesity will be the number one credible cause of chronic disease and preventable mortality. The discussion was around classes covering the topic of stigma related to obesity and fat shaming. As the PHAB moves this forward with health equity lens, the board needs to be careful about how it is messaged.

Ms. Thalhoffer added that, as a public health professional who was working on policy systems and environmental change, one of the biggest voices in the room for policy change in Oregon right now around health system transformation were the CCOs. But the CCOs are not taking up a stance on any population health policy changes. She would like to see those sorts of policy work requirements included in obesity work.

Ms. Biddlecom responded to Ms. Thalhoffer about the measure specifications question that those were the types of activities that would count in the attestation tool. Multi-sector interventions would include school or childcare settings and community-level policy settings that collectively address physical activity and nutrition. There are also points for community health assessments and obesity prevention and treatment that are integrated in the Community Health Improvement Plan (CHIP).

Dr. Schwarz remarked that, if remembered correctly, during the last year of his being in the Metrics and Scoring committee, obesity started to be discussed. There were a couple of presentations around the first attempt to define what the issues were around obesity and how they could be measured. The committee did not want to use the word *obesity*, because there is a certain stigma around that word. It's not that we don't want to say that it is a weight issue, but there is something about obesity that seems to tick off people. There are other ways to describe these issues.

Ms. Brogoitti asked if the board members wanted to make a motion for the approval of the draft letter.

Dr. Dannenhoffer made a motion to approve the letter.

Dr. Schwarz seconded the motion with the caveat that the proposed changes must be added to the letter.

Ms. Biddlecom assured Dr. Schwarz that the changes would be made.

Ms. Brogoitti asked the board to vote on the draft letter. The PHAB approved the letter unanimously.

Ms. Biddlecom asked if any board member would like to, or would like to discuss, presenting in-person testimony as a committee of the board to another committee of the Oregon Health Policy Board. Ms. Biddlecom clarified that the PHAB could submit a letter that would go into the meeting materials for both metrics committees, but the board could have a representative of the PHAB providing in-person testimony to this effect at the committee meetings. The PHAB used to have significant overlap in terms of the board's membership between Dr. Luck and Dr. Schwarz, but neither of them is now a member of these committees. This would be an additional opportunity to have that interface.

Ms. Shirley added that, like the tobacco metric, there were some problems and deficits, and maybe the metrics were not as transformative, but there had been a lot of pushback over the years when bringing in upstream or bottom of the pyramid issues to the attention of the clinical

community. It would be much stronger if someone could volunteer for the testimony. Interested board members should reach out to Ms. Biddlecom. It would be much more impactful. The more the PHAB can raise the real root causes of why we are getting the outcomes that we do in these venues, particularly clinical venues, the more the conversation will change toward what really matters.

Dr. Dannenhoffer expressed interest in presenting, if his schedule allowed it.

### **History of Racism in Oregon**

*Wendy Morgan (OHA Staff)*

Ms. Brogoitti stated that in order to continue the PHAB's commitment to learning about and driving its work to improve health equity, the board had an opportunity to learn about and reflect on Oregon's long history of racism. The PHAB thanks OHA's Office of Equity and Inclusion for allowing it to borrow their structural racism poster set that is set up in the room and included in the meeting materials. Ms. Morgan from OHA will be walking the board through this presentation to learn, reflect, and begin discussing how to fold actions that counter Oregon's racism history into the board's work. This presentation is timed well, given that the board will have an opportunity to reflect and think about the future next month.

Ms. Morgan introduced herself as the acting health equity coordinator in the Public Health Division. Her permanent role is with the Maternal and Child Health section. She shared that this was a very difficult activity to do in a short period of time. The activity is rooted in the PHAB's attempt to get some footing on Oregon's history before the PHAB retreat next month. Some of the information will be revisited by the board during the retreat, as some things come up over time. Before starting the activity, she reminded the PHAB that talking about dismantling racism on the government level, for which the government has been historically responsible for, could be uncomfortable and triggering. She encouraged the board members to take care of themselves by stepping back when needed or stepping out if needed. She also encouraged the board members, especially the white board members, to try to sit with being uncomfortable. That often means that something might be shifting or changing.

Ms. Morgan added that the U.S. had a troubled history with structural and interpersonal racism. Oregon has a unique history with racism, including land claims, institutional barriers, systemic limitations on the movement and civic and economic participation of different groups. Many of these events throughout history are on the wall panels in the room. Not all events are included in the display and events can be added, if need be. We can't turn away from the fact that Oregon's state and local governments have had a role in creating this history. Certain community groups have been instrumental in decreasing the safety of people who are unlike them. She asked the board members to be mindful of their discussions and their own positions in the system when discussing the elements of this history during the activity.

Ms. Morgan noted that a major part of this conversation was about power – what it is, who has it, and how governments, communities, and civic organizations chose to wield that power. She recommended for the board members to pair up in groups of two or three members so that they could discuss things as they went along the presentation. Another option is to go through

the activity in silence. Post-it notes are available around the room for board members to write down thoughts, feelings, or something missing and stick them on a panel. Board members on the phone can read through the slides and take notes of things that move them or any other thoughts or feelings. After the activity, participation in the discussion is voluntary.

Ms. Morgan remarked that the slides and panels had been used for the agency-wide OHA strategic planning process to help managers stay rooted in the history of Oregon. She encouraged the board members to think about ways the PHAB could support the goals of the statewide strategic planning and how the board is positioned in the system to make changes that dismantle Oregon's racist history with us.

A member of the public asked what type of notes Ms. Morgan needed from each panel.

The same member of the public asked about the goal of the presentation.

Ms. Morgan answered that the reason the PHAB was going through the activity today was to have a shared understanding of Oregon's racist history while moving forward and figuring out how the inequity lens applied to its work, and how it would align with OHA's strategic planning efforts throughout.

Ms. Biddlecom added that this was an opportunity for the PHAB members to continue their learning and grounding in health equity, particularly as the board was going to a retreat next month. This presentation is an introduction and, hopefully, the PHAB will be able to unpack and apply the learnings and reflections, as the board thinks about its work.

A member of the public asked what to do when looking at the issues.

Ms. Morgan answered that the activity was to go through the panels and read them for the sake of education. If anything moved the viewer, or if they knew that something was missing, they should share it, so it can be noted. This is only one take on presenting this history.

The same public member asked if the information on the panels was available to look at somewhere else.

Ms. Morgan answered that the information was included in the slide presentation and in the printed meeting materials.

Dr. Schwarz commented that he was able to read the presentation before the meeting. What he reflected on was the Fair Housing Coalition of Oregon Bus Tour the board took around Portland on September 26, 2019.

The board members viewed the wall panels.

Ms. Morgan noted that it was hard to do this activity and dig into it, as it could be triggering, traumatic, and difficult to take in, especially if the information was heard for the first time or somebody had been personally impacted by it. She suggested for the board members to sit

with the presentation slides a bit longer and carve out some time at the PHAB retreat to revisit this experience. She asked the board if anything in the presentation was surprising to anybody.

Dr. Dannenhoffer stated that something so devastating and of importance was the third of one frame.

Ms. Morgan agreed that it was hard to do one gallery walk and incorporate every bit. The community members who put the exhibit together had their own take on the information.

Ms. Thalhoffer shared that she was struck that the racist language was not removed from the Oregon Constitution until year 2000. Nothing on the panels was a surprise to her. She had heard about all the incidents, because she had lived in Oregon her whole life. The fact that the racist language was left in the Oregon Constitution, as if the words didn't matter, is devastating.

Dr. Savage shared that she found shocking the degree of hate that existed and may still exist in some parts of our society. She tends to see things half-full and positive. This presentation can be very difficult to see and be exposed to it. To realize that a level of hate that severe existed is very disheartening. The Ku Klux Klan presence is incredibly sad and souring. To know that that was around at the time when her parents were kids and growing up in Oregon, it made her sad to know that that was what they grew up with and experienced.

Dr. Schwarz asked if the term *structural racism* was the same as *institutional racism*.

Ms. Morgan answered that the terms have been used interchangeably. Institutions can typically hold structural racism. Both terms work very closely together. Using them interchangeably is acceptable.

Dr. Schwarz remarked that seeing such long history of racism was scarier than seeing isolated racist incidents. Even though we call this *structural racism*, it is not clear what is the chicken and what is the egg. At some point in the past, Portland's city council was essentially made up of people who were racists. That's why, when there is such an environment, these people can make decisions and regulations and legislation that comes out and becomes institutional racism. What started it – the hating institutions or the hating individuals?

Ms. Morgan explained that institutional racism was the policies we put in place to keep the status quo. This comes directly out of interpersonal racism and interpersonal discrimination, and people who collect power put these policies in place to maintain power, and then we end up with the structure and the system that we are in right now.

Dr. Bangsberg shared that as someone who grew up in Portland, then moved away for many years, and then came back, the acts of racism in Baltimore and New York, where he used to live, were more in one's face. It is very different in Oregon, where racism is just as real, but not as visible, especially in a place like Oregon. In some ways, it becomes more difficult to have discussions around structural racism, because in Boston or New York racism is real, whereas in Portland, it is hard for people to acknowledge the benefits of systemic privilege, which is the same as the harms of systemic racism or structural racism. Especially in public health, where

people are committed to doing good in the world, the white fragility gets a little more severe – “I devote my life to doing good. How can I be a racist? How can I benefit from the structural privilege?” That is a challenge for us all to both recognize and try to dismantle.

Ms. Saito shared that she grew up in St. Louis, Missouri, and her parents could not get married in Missouri because at the time, Missouri had the law, as in Oregon, that prohibited interracial marriages. The reason why the population is so white is because the state has structural racism. We built the system in Oregon so that we could continue to be white. There is a reason for that. It is also difficult to have the conversations when the people don’t have the lived experience.

Ms. Morgan explained that it was no secret that Oregon was built as a white utopia. As liberal as Oregon is seen by many, it has a disproportionate number of hate groups compared to the population in the state. We are pushing ourselves to go that extra step and recognize and accept that this history is very real still, and it’s still impacting people in communities in real ways. She encouraged the board members to think about what all that information meant for the PHAB moving forward. It could mean incorporating some of this history into how the PHAB moved forward in developing policy and priorities. She recommended to the board to take the question *How does this history impact the health disparities in Oregon?* to the PHAB retreat and have a discussion.

Ms. Saito pointed out that the Oregon Health Authority recently embarked on a strategic planning process. On the same lines as OHA did with the State Health Improvement Plan (SHIP), OHA went out and had many different community meetings to get some feedback on where the agency should be going. Before the agency did the strategic planning process, OHA managers had antiracism trainings and looked at the structural racism panels. OHA has decided that the 10-year main strategic goal is to eliminate health disparities by year 2030. It’s a big push and a nice background for the Public Health Division, because the division has already been working closely with the social determinants of health. This gives the PHAB another opportunity to understand the work that has to be done. In terms of being transformational, the elimination of health disparities is a big goal.

Dr. Dannenhoffer noted that obesity was a more concrete example or pedestrian versus transformational work. He expressed hope that the CCOs would not work at Whole Foods to double the amount of kale there. What they need to do is get rid of the food deserts, and they need to make it so that people in disadvantaged communities can get to a grocery store. There are places in Douglas County that are 30 miles away from a store that sells fresh fruit and groceries. That is something that would be truly transformational. He hoped that the metrics would capture that information eventually.

Dr. Schwarz reminded the PHAB that there was the Metrics and Scoring Committee, which, even though the committee doesn’t have the most transformational metrics in the world, it did look at health disparities measures. During discussions about the accountability metrics for public health, the committee discussed how to stratify the measures by race and ethnicity. In the Health Equity Measurement Committee, which was put together by several agencies, the committee came up with suggestions that were voted down by the Oregon Health Policy Board. One of the revelations during the process was that OHA is challenged at getting the statistics

right around the disparity measures. There is no other way to identify the measures than to be able to stratify them according to those variables that we know are important. If we can't do that, it doesn't matter what the board is discussing. It's a vicious cycle – if we don't do this, we can't do that, and if we can't do that, we can't do this. Hopefully, these things are taken seriously at the administrative level. This will help the committees across the board.

Ms. Thalsofer remarked that as the PHAB was doing this work, she hoped that the board members would think about how they engaged with these communities and not expect these communities to engage in the way the members expect from the general white middle-class way of doing business. She recently had this discussion with the North Central Public Health (NCPH) board, because another state agency had been pushing on NCPH to engage with the local native population and was frustrated that NCPH couldn't get enough native families to participate in a survey. When we look at the Columbia River gorge, the destruction of their cultural way of life was very recent. The flooding of Celilo Falls was a generation ago. To expect that people are going to come work with the state out of faith and trust, and answer its survey, is ridiculous. State agencies have to be really thoughtful about how they are working with these groups. If a board is not diverse, why would it be worried about a health equity metric, with board members not representing the population?

Dr. Sidelinger agreed that it was important to have better data, particularly looking at some of the healthcare data and doing better about having race and ethnicity data, so that OHA could truly look at what was occurring. In public health, much of the work is based on survey data. There is only so much OHA can do to get more minority populations to fill out the survey. The agency can look at ways to better approach the data collection, using innovative survey methods, or a snowball survey, with people identifying other people to take the survey. Also, engaging with the population by asking people what they would like to know. Once OHA has that data, the next question is what it means to them and what they would like to do. OHA is trying to do that in a meaningful way. Hopefully, this will result in getting better information, but, more importantly, better outcomes.

Ms. Brogoitti commented that she was grateful for the conversation and for the opportunity for the PHAB to think about how the history of the state, in which the board was trying to do important public health work, had played out, and how the PHAB could incorporate that history into the work the board would do going forward and into the upcoming retreat, as well as thinking about this to improve health equity in the state. She hoped to take more time to look at the presented information, as it was a lot to take in in a short period of time. She expressed gratitude for the opportunity to see the presentation today.

Dr. Schwarz asked Ms. Biddlecom about the thinking behind the retreat. There was nothing about this topic in the survey board members completed. He asked about the thinking behind the retreat, the racism discussion, and health equity, among other things.

Ms. Biddlecom answered that the retreat was an opportunity for the PHAB to think longer term about its work and how to orient the work of the board. It's impossible to have a long-term conversation about the work of the board and how it makes a difference in the state without having this grounding and what has occurred in Oregon's history, and how it has shaped our

ability to do the work that needs to get done, and how we need to recognize the roles that we play, and how they can be used either to the detriment or to the support of health equity outcomes. Today's presentation was an opportunity to ground the board in common understanding before the PHAB had more opportunity to dig into what work the board wants to do, what specific pieces the board members can contribute from their individual positions on the board, and how to move forward. In its current configuration, the PHAB started out and had legislative deliverables due within six months. The board members haven't had a chance to sit back and reflect on what they want to accomplish.

Dr. Schwarz completely agreed. Having participated in over 150 retreats during his career, he explained that the better one is prepared for a retreat, the better the outcomes. One of the things he has been thinking about is the State Health Improvement Plan (SHIP). Social determinants of health and health equity are some concepts that we know are going to be highly prioritized. If the PHAB doesn't know that plan by the time of the retreat, the board will be discussing in a black box. It will be important for the board to know what OHA is putting in that plan and then have that as part of the board's discussion.

Ms. Shirley remarked that part of what was being done throughout OHA, not only with the SHIP but with all high-level work that needed to be done, was that the agency was trying to gather all the information that public health, both academically and on the ground in community-based organizations, has come to understand about how to get to healthy outcomes and health communities. As Ms. Biddlecom pointed out, public health needs to step back and say, "Now that we know that, how do we socialize the concept, so it's not programmatic and it's not disease-specific?"

Ms. Shirley added that under the leadership of Pat Allen and the OHPB, the OHA is moving in that direction, and also moving toward having semi-permeable membranes between the different places in society that have the same goals, such as nonprofit and community based-organizations, mutual-assistance organizations for new arrivals in our community, and government. How can we get government to see that we have to have these common goals and strategies, which OHA can't make up?

Ms. Shirley stated that, this year, OHA decided to change the way the state health department thought about not only its own work, but also about its relationship with communities, and how OHA gets information not only from the data, but also from the stories in the community. This is a huge culture shift in the practice of public health. Its time has come and, in Oregon, we are lucky enough to have the political will to move in that direction, from Governor Brown all the way down. This may sound like a commercial, but the PHAB members have to see this all together. The board members have to understand how we got to where we are. This display is a good teaching tool for the board members to understand that these things didn't just happen and they aren't the result of personal moral failings.

Dr. Bangsberg pointed out that there had been a lot of great discussion at the OHPB that had been stimulated by the PHAB, particularly the attention to social determinants of health and alignment with community advisory councils and LPHA. This topic didn't make it into the contract in an explicit way as it was hoped, but that discussion is there. There are also

discussions around bringing sectors together. OHA is getting a lot more of this work. He proposed to use some of the retreat time to discuss where the PHAB made progress in this direction, where else should the board go, and what progress needs to be made to keep the momentum going.

### **PHAB Funding Principles**

*Cara Biddlecom (OHA Staff)*

Ms. Brogoitti reminded the PHAB that the board developed its funding principles in 2018. They are intended to be a guide for making decisions about all public health funding streams and to be applicable for both increases and decreases in funding. As the PHAB Incentives and Funding subcommittee begins developing the 2021-2023 modernization funding formula, this is a good time for the PHAB to review the funding principles and decide whether updates are needed.

Ms. Biddlecom explained that the board has utilized the funding principles in several ways. The principles were the foundational source for developing the 2019-2021 public health modernization funding formula. The Incentives and Funding subcommittee routinely went back to them when making decisions. There have been other local public health funding formulas that have used health indicators to determine LPHA funding allocations (e.g., reproductive health program element, maternal and child health Title V). LPHAs have developed a companion document with a set of questions for each funding principle that could be applied to the development of funding formulas that fall outside of the purview of the PHAB.

Ms. Biddlecom added that in order to move forward with developing the LPHA funding formula for the 2021-2023 biennium, which OHA would need to submit to the legislature by the end of June, the board needed to go back to the funding principles to check whether they were accurate, relevant, and reflective of the board's work and its priorities. LPHAs and OHA want to provide some guidance for distributing public health funding when funding is not sufficient to cover every single LPHA. This has come up with a few funding opportunities of late, where OHA had dollars to go out to communities, but not quite enough money to make a meaningful impact if the money was to be spread among all 33 LPHAs.

Ms. Biddlecom read the five principles under *Public health system approach to foundational programs* and the two principles under *Transparency across the public health system*.

Dr. Schwarz asked how the PHAB can ensure that there was a feedback loop regarding principle #2. Over the time this PHAB has been doing this work, there have been dramatic changes in burden of disease, such as the opioid crisis and mortality from changing drugs. With the funding streams being so slow and the burden of disease changing quicker than the funding streams, how can a feedback loop be created so that the PHAB and OHA can address changes in burden of disease, risk, and so on?

Ms. Thalsofer interpreted Dr. Schwarz's question as meaning that if OHA and LPHAs had all their foundational programs and capabilities where they needed to be, then OHA/LPHAs might have to worry about being able to shift funding quickly when the burden of disease changed. Right now, LPHAs are trying to get the foundation under them. Whatever the disease burden is

that occurs in the regions, LPHAs don't have enough resources. LPHAs are taking these foundational capabilities, use them to build on them, and apply them to the changes in the regions. Right now, that is the best LPHAs can do, because they don't have enough infrastructure to be nimble with the funding that they get. LPHAs are not funded enough to be really responsive to the need by issue at this point in time.

Ms. Biddlecom asked the PHAB a question: What aspects of the funding principles drive the board's commitment to health outcomes and health equity, and if the PHAB sees any conflicts?

Ms. Saito noted that when OHA started the funding principles, the agency didn't have the funding or the legislation around including tribes. It has been wonderful to have a tribal representative on the PHAB. She asked if OHA can expand the funding principles to include tribes, so that they were not left out. OHA allocated modernization funds to the tribes this year. How do we integrate tribes into OHA's work and into the funding principles, so that they are included and have a voice?

Ms. Saito added that in terms of principle #5, the language says "other sectors," and OHA already works with Oregon Department of Transportation (ODOT) board. She asked if other top-level agencies, such as housing, be included. In terms of principles #3 and #4, the language says "may include." She proposed to change that phrase to "which includes" or "which will include" so that the language is more instructive.

Dr. Schwarz remarked that the principles were written in February 2018 and the discussion about CCO 2.0 happened in 2019. There isn't much in this language that points to the collaboration with the CCOs. He shared that he was on the board of Health Share of Oregon, where Oregon's three largest counties (i.e., Multnomah, Clackamas, Washington) were represented. At a recent meeting, the Health Share of Oregon board voted on a housing policy, using the flexible dollars and Medicaid. He doesn't see some of that reflected in the PHAB's funding principles. A word like "leveraging" could go in the document, because that could help public health modernization's pittance of a funding with much larger funding from the healthcare community when it comes to public health issues.

Ms. Biddlecom suggested to change "coordinate resources" to "leverage resources" under principle #5.

Dr. Dannenhoffer stated that the principles are remarkably good two years later. They don't need to be changed much. However, there is a long-standing conflict between health outcomes and health equity. We are going to give more money to places that have a higher burden of disease, which means that they failed in the past and have this higher burden of disease, whereas if we give money to places for having good outcomes that are decreasing the burden of disease, we will decrease the amount of money that does to those places. There is always a tension between those two concepts. For example, CLHO talked earlier about the suicide plan. If a county was successful in the first round and had no youth suicides, the county would now be ineligible for funds, which creates a perverse incentive not to be so good at it, so that a county would be able to get funds. He is not suggesting for the OHA to do that, but it should be

recognized that there is always going to be a tension between looking for outcome and looking for burden of disease.

Ms. Biddlecom acknowledged that Dr. Dannenhoffer's comments were a nice segue to a second question: Which principles seem to most closely align with the public health modernization funding formula and which are least aligned?

Dr. Dannenhoffer said that to many public health administrators would say principle #7, which was to scale work according to the available funding. It seems that LPHAs do as much as they can do and never go down when funding goes down. If we look at the funding per capita for several PEs (program elements), they have gone down over the years while costs have gone up. Most public health departments, rather than doing less, do more with less, especially North Central Public Health (NCPH), led by Ms. Thalhofer.

Ms. Thalhofer agreed with Dr. Dannenhoffer.

Ms. Biddlecom noted that the last question would be guidance from the PHAB to the Incentives and Funding subcommittee: Are there principles that should be emphasized as more important to achieving public health modernization goals?

Dr. Dannenhoffer answered that they were all important and they were not too many to balance.

Dr. Schwarz asked about the effect the latest round of funding had, including the additional money that OHA received from the legislature in the second round of funding.

Ms. Biddlecom answered that \$3 million went out to regions to continue the work that had been started in the 2017-2019 biennium. The other \$7 million was put through the local public health modernization funding formula, which the PHAB was responsible for. Some of the initial things to keep mind are that the dollars going out to the extra small jurisdictions were very small. Some of them have taken some of their own local dollars and put them back into the region to ensure that they had the services covered, particularly the communicable disease program area. She asked Ms. Thalhofer if she wanted to elaborate.

Ms. Thalhofer explained that the regional funding for the Eastern Oregon Modernization Collaborative (EOMC) was decreased. Each of the LPHAs agreed to put \$2,000 of their local funding into the regional effort to be able to maintain the regional staff. That's not a lot of money to do anything with. If a LPHA wants to do something cross-jurisdictional, it takes work to meet with partners and set up a meeting. It's difficult to do that when an LPHA doesn't have any additional staff and everybody is at the top of their limit. One of the other things CLHO talked about was not only equity among individuals and groups, but also the equity of funding across of the state. This was really an issue this time. We all wanted for the money to go out per LPHA, but we may have been too anxious and it may not have been enough money yet to roll it out that way.

Ms. Thalhofer pointed out that the EOMC will spend some time in this biennium deciding how to continue the work going forward, because while it has a MOU (Memorandum of Understanding) that the LPHAs will work together, she is planning to retire at the end of June. Being the fiscal agent for the collaborative, it has fallen on North Central Public Health to drive a lot of the work. The EOMC needs to look at its structure and make sure that its work could be continued past the people who are doing the work right now. There is a lot of work that goes into working together and it doesn't happen immediately. It's going to be time-consuming and hard and it will take a lot of thinking to figure out how to do this in a different way.

Ms. Biddlecom remarked that the suggested changes in the language could be made, but the principles were not off case in terms of going into 2020. The Incentives and Funding subcommittee will unpack the principles a little more as it goes back to the funding formula and does some more work.

### **Subcommittee Updates**

*Teri Thalhofer*

Ms. Thalhofer stated that the Accountability Metrics subcommittee met and most of the conversation was about the report. Myde Boles led a lot of the conversation. The subcommittee talked about how the report was used in the past, what the statutory requirements were for the report, the perception of the phrase *accountability metrics* and how the framing was around the word *accountability* and what that meant when there was no funding for all the metrics and how was that framed. There was conversation about how the report had been used by LPHAs and how members of the PHAB used the report to make sure that changes were made in the report to make it more useful.

Ms. Thalhofer added that the discussion was also about some of the accountability metrics that the PHAB had asked the group to look at again. Some of the process measures that the subcommittee had been asked to look at were *dental visits for children 0-5* and *prescription opioid mortality*. The subcommittee also discussed removing and changing the measure *top opioid prescribers enrolled in PDMP* because of the change in law. When these law changes happen, that is a big public health win, and wins should be tracked. Another topic included how things looked different location to location and how to do the tobacco metric. The subcommittee will meet again on February 12, 2020, before the retreat. It will have updated information on how the report is going.

### **2021-2023 Public Health Modernization Funding Priorities**

*Cara Biddlecom (OHA Staff)*

Ms. Brogoitti remarked that every two years OHA asks the PHAB to make recommendations for public health modernization funding priorities. PHAB's recommendations are used to develop the OHA policy option package and give OHA and LPHAs direction for planning for modernization investments. Ms. Biddlecom will review the phased approach to implementing public health modernization that the PHAB developed in 2016, as well as PHAB's funding priority recommendations from 2018. The board will review the recommendations and vote to approve board recommendations for 2021-2023.

Ms. Biddlecom said that back in 2016, the PHAB did some work looking at the current capacity around foundational capabilities and programs across all LPHAs and OHA. The PHAB had put forward a model (represented by a graphic) for how work would be phased in over time and how, with additional funding and capacity, the public health system would be taking on more work. When the PHAB looked at the model in February 2018, the board voted to continue focusing on communicable disease, health equity and cultural responsiveness, and assessment and epidemiology. If there were additional funding available, expand that focus to include environmental health, leadership and organizational competencies, and emergency preparedness and response. This was a recommendation that the Incentives and Funding subcommittee took back and built a tiered approach. At certain dollar levels, there would be more work in these additional areas. The funding didn't get to that level. Where the dollars have gone out through the public health modernization funds, the work has been around communicable disease control, health equity, assessment and epidemiology, and a little bit of leadership and organizational competencies.

Ms. Biddlecom reiterated that the PHAB needed to vote at the end of the discussion on the 2021-2023 priorities. Two questions could help frame the discussion. In terms of the phasing: Is the board bringing enough attention to the foundational capabilities as essential for effective public health programs? This is a good question, because as OHA has rolled out this current funding in the 2019-2021 biennium, it's been difficult to tease apart foundational capabilities. It's the natural way of doing the work. Even though OHA has tried to be focused on the phasing with PHAB's guidance, there has been more capacity built around the foundational capabilities out of necessity, in order to do the work well. The second question is: Do these phases effectively demonstrate the interconnectedness between foundational capabilities? OHA hasn't called out community partnership development, but it's a critical tool for doing health equity and cultural responsiveness work.

Dr. Dannenhoffer stated that Phase 1 was now really Phase 1A and 1B. For clarity, it should be Phase 1, 2, 3, 4, and 5. Community partnership development is clearly very important for every one of the capabilities. Maybe the visual should be an increasing slope. What we have noticed on health equity and cultural responsiveness is that it totally related to community partnership development. Maybe community partnership development, environmental health, communications, and leadership development are incremental public health foundational capabilities. Community partnership development is not done in many areas, but it is certainly done in the areas of health equity and communicable disease. Maybe a different graphic is needed, although the staging is probably fine.

Dr. Bangsberg asked if the new influx of funding covered Phase 1A and touched on Phase 1B.

Ms. Biddlecom answered that the way the funding for local public health and tribal public health got structured was such that everything that was in the far-left column of the graphic was included and then there were options for environmental health. Leadership and organizational competencies are expressly called out as being necessary to think about how to develop the organization and one's staff to be able to do these foundational capabilities. About 10 or 11 LPHAs included in their workplans some objectives related to the nexus of

communicable disease control, environmental health, and emergency preparedness and response. This wasn't a requirement, but it was an option.

Dr. Bangsberg agreed that if there wasn't enough money to do it all, LPHAs needed to prioritize. The PHAB should be more explicit about what is unfunded in the plan as we approach future biennia. Although it seems that there is new money and everything is going to be good, we have a long way to go. In terms of community partnerships, that's a nice way to move them to CCOs, because CCOs are supposed to work with LPHAs and the Community Advisory Council and also convene these partnerships. So maybe there are other resources to help with it.

Ms. Biddlecom asked the PHAB if it would recommend any changes to the funding priorities for 2021-2023. Essentially, the board would be saying that with the level funding, LPHAs would be continuing the work that they have been doing and the Incentives and Funding subcommittee would be scaling out with additional funding what would be rolled in at what levels. With the priorities of Governor Brown around climate change and wildfire, particularly calling on the governmental public health system to be doing some work around environmental health, we don't expressly have any dollars or staffing initiatives going on across the whole system, which is something to consider.

Ms. Thalhoffer stated that when the PHAB has been talking about whether it has moved the system, it has been looking at the accountability metrics. It has lost sight of the system assessment that was done in the past related to who had capacity to do what, and was that moved. At some point, we need to, as a system, talk about if we are moving the needle in that initial assessment and whether we have more capacity. For local public health administrators, the public health modernization manual is at their desks all the time, as they are looking at the local actions and the state activities and the shared activities when they are writing work plans and other documents. We don't want to lose sight of the pieces that got the system started on this journey. We want to ensure that we are making improvements and investments where the assessment showed the system needed to. Communicable disease was chosen because it was something that was easy to explain to legislators. The system needs to look at the assessment at some point.

Ms. Biddlecom shared that as a part of the public health modernization evaluation plan that the PHAB heard about two meetings ago, the team would be going back to some of the key pieces that have received funding, in terms of looking at how our capacity and expertise has changed over time.

Dr. Schwarz asked if the PHAB had to vote on this today.

Ms. Biddlecom answered that it would be very helpful for the next steps in the process, in terms of framing out the work to have a good understanding of where the PHAB would like this work to be focused in the next biennium.

Dr. Schwarz clarified that the reason he asked was because, typically, when the PHAB has done this kind of voting, there has been a recommendation from the subcommittee on the funding,

based on a thorough conversation about the various perspectives. He asked if the Incentives and Funding subcommittee had discussed the vote.

Dr. Dannenhoffer said that the subcommittee had not met recently.

Dr. Schwarz asked if it would be helpful to get a recommendation from the subcommittee.

Ms. Biddlecom explained that, in terms of timeline, the plan was to check with the PHAB to see who wanted to continue participating on the Incentives and Funding subcommittee, which was done today. Next, the subcommittee can start to dive into the funding formula and what the work needs to be in the next biennium so that the OHA can work on its policy option package for the next biennium. The same conversation was held with the Conference of Local Health Officials (CLHO) this morning and there was support for continuing on the path from the local public health perspective.

Ms. Brogoitti commented that the way she saw it, this was based on the assessment that Ms. Thalhofer was talking about. Without an updated assessment, this is still a valid direction. She didn't feel that there was information that would cause the system to change direction, given that this direction was based on information the LPHAs gathered and collected and analyzed. She felt comfortable moving forward with it as it was now, given the available information right now and the work done thus far.

Dr. Dannenhoffer remarked that there might be a little bit of wordsmithing or changing, but he didn't see that there was any move for changing the directions – for example, putting clinical and preventive services ahead of other priorities. The other thing that the PHAB might think about is that environmental health is pretty much stuck in most people's minds as restaurant and pool inspection. There is a whole lot more than that, but yet, if we look at the staffing and the expertise of the people in the areas, it is really about these very limited areas. Climate change is going to look for public health. If we don't deal with this now, they are going to say, "What were you doing? Were you asleep at the switch, like in 2020, when you saw that Australia was burning and you didn't do that?" This is why, the PHAB might think about pointing that out. When he showed the graphic to his team in Douglas County, they said, "Oh, great. This means more money for restaurant inspections."

Ms. Biddlecom stated that when OHA assessed in this area, it wasn't the fee-based regulatory inspections where the public health system was falling short. It was around the non-regulatory space, for which there haven't been any resources, even for epidemiology. There is a lot of work going on right now around wildfire that the OHA is involved in. That's the space that would be discussed, along with the gap that Ms. Thalhofer mentioned.

Ms. Thalhofer noted that the environmental health staff at the NCPH were all people who had degrees in environmental health or biology. They are required to have a fairly high level of education and they are very excited to be able to look at something other than regulatory environmental health. She was able to take a tiny amount of money in the NCPH's grant and have them have the opportunity to do an assessment, or start to come up with a list of environmental health risks in her region. The registered environmental health specialists

working in the county government are the people to start leading these efforts. The never had the opportunity to do that. Another thing is that the board missed to note is that communications and community partnership development and policy development are all needed to do the communicable disease work. It is true that it is hard to separate the foundational capabilities. It should be recognized that there is growth and work happening there that requires capability support around those areas as well.

Dr. Bangsberg agreed that the environmental health people wanted to rise to the occasion.

Ms. Saito suggested that one of the things that the PHAB could do was moving up the foundational capabilities, because the other ones were programs. On phase #1, have health equity be the first one, because that is the foundational capability, and then communicable disease and assessment and epidemiology are the programs, and then moving up emergency preparedness and response to the top, because environmental health and leadership and organizational competencies are more programmatic. That could be a possible way of arranging them, if people are feeling a little bit anxious. In phase #2, community partnership development can be moved above prevention and health promotion.

Ms. Shirley acknowledged that the conversation was part of the public health system's success. When the model was originally designed, everybody thought of these areas as discrete areas. As the system matured in its understanding of the practice of public health to get to some of these foundational issues, one can't wait for community partnership to start a biennium. Trying to do the work has taught us that these are not discrete activities, nor are they discrete capabilities. This is also part of changing the culture at the Public Health Division. If one were to lead in any of these areas to change the outcomes for Oregonians, the areas have to be applied all together. This conversation couldn't have happened two years ago.

Ms. Biddlecom summarized that across the capabilities, communicable disease had to be advanced for sure and, with additional funding, adding on environmental health as the other program area. There are likely to be resource impacts with an approach like that, but it wouldn't be so difficult that the Incentives and Funding subcommittee couldn't find a way of looking at that work. In order to take on this work in environmental health, we may just need more different types of capabilities supporting it. It should be recognized that all areas are interrelated and it's the work that has to be done to see the desired outcomes in the system.

Ms. Shirley reminded the PHAB that when the journey started, part of the reason that communicable disease control was picked was not because it was the biggest gap on the check report. It was what made sense to our audience (i.e., legislators). They asked questions like, "Why would I fund public health? Why is this important to fund in the state overall?" There were different variables.

Dr. Savage informed the PHAB that she switched jobs and now spent two days a week in Eugene, working with Trillium Community Health Plan, which was now her designated CCO. She had been able to meet and work closely with the counties in that area of the state. She met Dr. Patrick Luedtke, who asked her to bring up some issues with communicable disease next time the PHAB met. One thing he asked, if there was any way, when the PHAB went through the nuts

and bolts of communicable disease, was to tighten down disease outbreak requirements. Over and over again, Dr. Luedtke deals with assisted living facilities and long-term care facilities and their requirements, but he keeps responding to these large, gastrointestinal and respiratory outbreaks that would have been smaller, if the requirements on them were tighter. Having public health people approach Dr. Savage about communicable disease control strengthens the current discussion, which is about funding it, and maybe it should not only be funded, but it should be funded in a way that increased those controls and have a bit more oversight. That would satisfy not just the legislators, but also the people who are doing a lot of work for public health on the ground in the community.

Dr. Dannenhoffer moved to tentatively approve the funding priorities without making any changes and suggested to send the funding priorities to the Incentives and Funding subcommittee for further review, with the sense that the board didn't make big changes, and consider some of today's comments.

Ms. Saito seconded the motion. Ms. Brogoitti asked the PHAB to approve the funding priorities. The board approved the funding priorities for 2021-2023 unanimously.

### **Public Comment**

Ms. Brogoitti asked if members of the public on the phone or in person wanted to provide public comment.

Ms. Morgan Cowling from the Coalition of Local Health Officials (CLHO) introduced herself to the PHAB. She praised the board for the discussion on the funding priorities. As Ms. Thalhofer pointed out, the model is working, but it's working maybe better than first anticipated, where we are seeing that to do good communicable disease work, one has to be communicating, connecting with partners and providers. Maybe the graphic needs to be tweaked a little, so that comes through more clearly for legislators and decision makers. It would be helpful for the PHAB to show how that worked. There are great examples, such as engaging with long-term care facilities or providers to improve immunization rates, that show that the work is happening. That is what we thought would happen with all of them – we have a program and we need these capabilities to do good work.

Ms. Cowling added that in terms of the discussion about the funding principles and their alignment with health care and early learning, she wanted to give a little caution. Sometimes the role of local public health is to look at a community and find holes or gaps and where public health needs to step in. Although that coordination still happens, the coordination may not be around the funding, because public health needs to step in and lean forward in an area where, for whatever reason, there is a gap. Whether that is immunization or other area, there is a need for public health to lean in and do work. There is probably work in alignment, but there is some additional teasing out that OHA might want to look at in terms of the funding.

Ms. Cowling shared that the structural racism exercise and discussion were great. This is an area where we, collectively, as a public health system, need to continue to grow. Some of the work CLHO is doing with local health officials is bringing in a national organization, [Human](#)

[Impact Partners](#), to do a health equity training, Leading with Race, to talk about how we, as public health, can do more in this space. The PHAB is doing a lot at these meetings, the OHA is doing a lot, the OHPB is doing a lot, and the CLHO is also working with local health official to ensure that a lot of work continues to be done locally.

### **Closing**

Ms. Brogoitti thanked the PHAB for their time and adjourned the meeting at 4:38 p.m.

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

**February 19, 2020  
12:00-4:00 p.m.  
DoubleTree Hotel  
Broadway Conference Room  
1000 NE Multnomah 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](mailto:krasimir.karamfilov@state.or.us). For more information and meeting recordings please visit the website: [healthoregon.org/phab](http://healthoregon.org/phab)