Public Health Advisory Board (PHAB)
July 23, 2020
Meeting Minutes

Attendance:

Board members present: Dr. Jeanne Savage, Dr. Eli Schwarz, Kelle Little, Dr. Bob Dannenhoffer, Rebecca Tiel (Chair), Dr. Sarah Present, Dr. Veronica Irvin, Dr. David Bangsberg, Eva Rippeteau, Lillian Shirley (ex-officio), Muriel DeLaVergne-Brown, Rachael Banks

Board members absent: Carrie Brogoitti, Dr. Dean Sidelinger, Akiko Saito, Alejandro Queral

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

Members of the public: None

Welcome and Agenda Review
Rebecca Tiel

Ms. Tiel welcomed the PHAB to the meeting.

- *Approval of June 2020 Minutes*

A quorum was present. Dr. Schwarz moved for approval of the June 18, 2020, meeting minutes. Dr. Savage seconded the move. The PHAB approved the meeting minutes unanimously.

Ms. Tiel informed the board that local public health administrators were discussing Teri Thalhofer's replacement and that appointment paperwork had not been submitted to the Governor's Office for consideration.

Leading with Race
Rebecca Tiel

Ms. Tiel remarked that the PHAB had been having conversations at its meetings and at its subcommittee meetings about taking a firm stance on racism. This is based on the board's conversations at its retreat in February about adopting a *leading with race* approach to its equity work. One idea that has been discussed in subcommittees is racism as a public health crisis, which is something that other jurisdictions have formally declared in different ways. The PHAB should think about what specific actions underlie an announcement or declaration rather than making an empty gesture not fueled by meaningful change.

Ms. Tiel added that Oregon's public health emergency statutes were not really designed for this type of emergency as they were primarily focused on communicable diseases. She asked for input on what a meaningful commitment to an anti-racist public health system would look like in Oregon and how the board can support leading with race in everything it does in public health. Another area the board discussed at its retreat was revisiting its Health Equity Review Policy and Procedure so ensure it was meaningful and centered its *leading with race* approach to equity. She proposed that a small group came together to work with OHA staff on edits to the policy and procedure.

Dr. Savage volunteered to be a part of the subgroup.

Dr. Schwarz shared that he had been thinking about how the PHAB was put together. The board doesn't have a member representing the underserved communities or the communities of color. The situation over the last two months has been very sensitizing and a reason to think up things in a different way. Many people in the communities of color are very skeptical about the approach to racial disparities, where what happened to the communities of color may be wrongly defined. He shared that he had big difficulties understanding it. It would help the board's conversations if there were people from those communities on the board, so that they could lay it out. It would be a clear sign to these communities, if such representatives got on the board.

Dr. Irvin agreed with Dr. Schwarz and asked if someone knew a way to start reaching out through the community engagement team (CET) on the Oregon SHIP. Maybe CET members can be invited to a PHAB meeting to share the community engagement findings before they are announced publicly.

Ms. Little suggested that, in regard to the inclusion and definition of American Indian/Alaska Natives and how that related to the board's discussion about leading with race, the board should invite representatives from the Northwest Portland Area Indian Health Board (NPAIHB) to speak on that matter. The reason for that is that American Indian/Alaskan Natives, by legal definition for many states and for the federal government, is not just a race or people of color, but it is a political designation. It is important for the board to recognize that and have a good understanding of that nuance as the PHAB moves forward with leading with race. Laura Platero, director of NPAIHB, would be a great person to discuss this with the board.

Ms. Banks volunteered to be a part of the subgroup. She appreciated the conversation around moving beyond the declaration and understanding the importance of the symbolism and noted the need to have concrete short-term and long-term actions that went along with that. The SHIP does a really good job at providing those social determinants of health and equity. Perhaps there is something in the SHIP that can get escalated, or enhanced, or moved faster in coordination with that effort.

Ms. Tiel stated that it might be worth having an update at a future meeting around the SHIP implementation and what opportunities existed for engagement. She volunteered to be a part of the subgroup.

COVID-19 Response Update
Lillian Shirley, Cara Biddlecom

Ms. Shirley remarked that the daily COVID-19 updates showed the modeling of the three potential ways to go for the state. That was part of the reason why the Governor had a press conference this week – to remind everybody that if the state wanted to open the schools, it was in everyone's hands. The places with positive cases are workplaces and sporadic events. OHA finds it harder to communicate with people that large backyard gatherings of 5-20 friends are risky. These events are contributing to the number of cases in the state.

Ms. Shirley added that the OHA was hiring more people for its statewide response. As the counties are doing more contact tracing and testing, it is hoped that the grants that are going out will help governmental public health, as well as the community-based organizations (CBOs). It is a slog and there is no end in sight. People at both the county level and state level have been showing up seven days a week. There are no medical countermeasures and no vaccine. This will continue to put a lot of strain on the public health system going forward. OHA is working to ensure that the regular work within the public health system can support the work for the COVID-19 response.

Ms. Biddlecom stated that OHA added 173 community-based organizations into the mix to help provide culturally and linguistically responsive services related to COVID-19. OHA put out a grant announcement in June, asking community-based organizations to apply to do any one of the following things: community engagement, contact tracing, social services and wraparound support. OHA may fund additional organizations based on any needs that arise. The current work includes signing a memorandum of understanding with all grantees and connecting them with local public health to develop workflows for sharing information back and forth. OHA will try to get funds out to some of the hardest-hit areas of the state first, particularly where OHA may need help with contact tracing by organizations that have bilingual or trilingual staff.

Ms. Biddlecom explained that there was a new team that was supporting this new work. There are 11 community engagement coordinators. They will be assigned regionally to help bring the CBOs up to speed and connect them with local public health. There is a website that lists all organizations OHA is funding, the counties they are serving, and what population and language capacity they have. The intention is to make this work and how we do public health part of the state's long-term public health infrastructure. It is rooted in public heath modernization and health equity and anti-racism. It's an opportunity to build relationships and a really strong connection to communities, so that the work centers around equity.

Dr. Dannenhoffer congratulated OHA for making great state and local responses to the COVID-19 pandemic. Working with CBOs is what public health should be doing to get it right.

Ms. Rippeteau shared that she was getting questions from various work forces about finding guidance online. Getting access to PPE was also a problem until recently.

Ms. Shirley assured the board that OHA was working hard to interject equity considerations in its conversation with hospitals, federal agencies, and other states. In addition to equity considerations, OHA brings up the need to have data disaggregated.

Review Draft of 2020 Public Health Accountability Metrics Report
Dr. Myde Boles (OHA Staff, Retired)

Dr. Boles acknowledged the Accountability Metrics Subcommittee and the Coalition of Local Health Officials (CLHO) for their review and helpful suggestions, which have been incorporated in the report. She also acknowledged the contributions of OHA staff in the Public Health Division across sections and programs. She remarked that in the executive summary of the report, the subcommittee highlighted the key points in the report: (1) immunization rates have increased steadily, (2) gonorrhea rates have continued to rise, (3) public health modernization framework and funding, (4) health equity, (5) impact of COVID-19.

Ms. Rippeteau asked if the draft report had been shared with the local public health authorities.

Dr. Boles answered that the draft had been shared with the CLHO. She didn't know how the draft had been distributed since she retired at the end of June. Once the report is finalized, it will be publicly available.

Ms. Rippeteau asked if any feedback from engagement sessions with stakeholders had been incorporated into the draft report.

Ms. Beaudrault answered that two webinars were held to get feedback from local public health administrators. In terms of stakeholder engagement, that happened with the selection of the metrics two years ago. It was a broad engagement process to hear from stakeholders about what they thought of as priorities for measuring and reporting on. There has not been a stakeholder engagement process beyond local public health for reviewing this year's data in the report.

Ms. Tiel noted that, as a member of the Accountability Metrics Subcommittee, it was very important to include in the report something about health equity. For a while, public health strove to include data by race and ethnicity, language, and disability, when possible, to highlight health disparities. The paragraph in the executive summary about the reason why disparities exist in health outcomes due to generations-long social, economic, and environmental

injustices is super important. This is not seen in public health reports that highlight disparities. The paragraph contains model language that can be incorporated in various reports, presentations, and data around health disparities.

Dr. Boles informed the board that the report was organized by Public Health Modernization foundational program areas: communicable disease control, prevention and health promotion, environmental health, access to clinical preventive services. The public health accountability metrics include health outcome measures that reflect population health priorities, local public health process measures that reflect the core functions of a local public health authority, and developmental measures that reflect population health disparities.

Dr. Boles pointed out that one difference this year, compared to previous years, was that the report had a technical appendix. In the new report, the technical supplement is a separate document, in order to streamline the main report. This acknowledges the separate audiences for the technical information and the main body of the report. The technical supplement provides a lot of information on all previous years, data and data tables, measure specification, source of the benchmarks, and all technical notes that go with each one of the measures.

Dr. Boles explained that the format of the outcome measure pages was similar across all outcome measures. The data show a snapshot of the most recently available data (i.e., 2019). The data are shown by race/ethnicity and by county. Key highlights and contact statement are on the left side of the page. Footnotes on every page help navigate the page or clarify key information necessary to understand the information on the page. On the process measure pages, highlights of the top 2-4 most applicable foundational capabilities that are associated with the process measure are listed. Also included on all process measure pages are highlights of the ways OHA supports the measure. Where available, key findings of the data are included.

Dr. Irvin asked if there was any feedback from local health departments on process measure *gonorrhea rate*. Several counties that made the benchmark in 2018 didn't make it in 2019.

Dr. Dannenhoffer remarked that it was much more than a name change for this process measure. It was a very good program with AFIX that had really high participation. It has been challenging to get people to the new program. The measure needs to be looked at. It is not very easy or good to be in the new program, whereas AFIX was something the local health departments could sell.

Dr. Irvin asked whether the decline could be attributed to the change from AFIX in 2019.

Dr. Dannenhoffer answered in the affirmative.

Dr. Schwarz asked Dr. Boles to unpack a sentence on Page 8 that stated that the disparity in gonorrhea rates among Black/African American Oregonians could not be attributed to individual behaviors. Gonorrhea is a sexually transmitted disease.

Dr. Boles answered that there had been considerable amount of discussion around systemic racism related to sexually transmitted infections. There has been a lot of suggestions and massaging of the language in this paragraph.

Dr. Schwarz stated that, at some stage, the board needed to talk about what to do. The implication is that it is nobody's fault. It's because of 200 years of systemic racism.

Dr. Dannenhoffer added that the team looked at that. There were no big racial differences in behaviors such as the number of sexual partners and the use of condoms. A lot of it is the way one takes care of it. If a person is well-off, they go to the doctor and they take care of it the next morning. Other people, who don't have great access to care, go on with it and continue to spread it to others. He agreed with the sentence Dr. Schwarz referred to.

Dr. Schwarz noted that public health needed to change the way it addressed these things and made access to healthcare facilities.

Ms. Banks shared that a simpler way to say that was to note that the differences were not the result of Black folks having more or riskier sex than other people.

Ms. Rippeteau said that it was important to make that clarification because for people who might not be emmeshed in public health, like her, it was important to spell out that while the difference couldn't be attributed to individual behavior, it could be attributed to lack of access to medical care. The way it is written right now, it is not obvious that it is an access issue.

Dr. Boles thanked for the helpful suggestions and expressed hope that her former colleagues at the Public Health Division would rework the paragraph.

Ms. Banks offered another connection to help board members understand it. There is a metric on the effectiveness of COVID-19 contact tracing done by local public health that underscores the need to have culturally specific and diverse staffing, so that contact tracing is more effective. In addition to being an access issue, it is important to have culturally specific resources that build trust.

Dr. Dannenhoffer reported that, based on the data, for men aged 40-45, 43% of Black men used a condom the last time they had intercourse, compared to 19% among White men. Looking at the data, one could recommend the use of more condoms, but that is not going to solve this racial disparity.

Ms. Banks asked why Asian and Pacific Islanders had been disaggregated throughout most of the report but were combined for the smoking prevalence.

Dr Boles answered it was because of the data systems. Each one of the data elements in the report comes from a different system. There is a huge discrepancy in the race/ethnicity reporting between the data systems. This is how the adult smoking prevalence was reported in the system.

Dr. Schwarz pointed out that the Accountability Metrics Subcommittee should remember Dr. Boles comment when it talked about its health equity review. When the subcommittee evaluates its own report in the health equity review, it should say something about the weakness in the underlying data collection.

Dr. Boles clarified that in some cases, because of the way the data were collected, it was survey data. Populations that are underrepresented in the data tend to be aggregated in some cases or aggregated over multiple years. That's one difficulty with some of these data sources.

Ms. DeLaVergne-Brown remarked that for tobacco retail licensing, one thing that had thrown a kink in the process had been the coronavirus pandemic. In Crook County, public health was moving in that direction, had a great policy, and was talking to the County Commissioners. Now everybody is focused on the pandemic. The county doesn't want to put another burden on businesses unless it becomes a statewide initiative.

Dr. Irvin noted that for the local public health process measure for active transportation, it was hard to understand that statewide participation by LPHAs was 59%, as LPHAs participation was noted as yes/no. It would be good to have a footnote that explains the 59%.

Dr. Irvin also asked if CLHO or any of the local health departments had questions or concerns about the effective contraceptive use process measure. She asked if this process measure had the correct wording or if there should be nuance changes to the process measure.

Dr. Boles answered that CLHO looked at this process measure, which had been in the report for the last two years. Some of the CLHO suggestions have been incorporated into the language for this measure. This is about the strategic plan, or what local public health is working towards.

Ms. DeLaVergne-Brown explained that there were whole sections on reproductive health in many local strategic plans. This has to do with what button one presses when the statewide annual plans for family planning are done and what the priorities are. What is being measured was not what she had in mind when the metrics subcommittee first developed the measure.

Dr. Schwarz noted that Ms. DeLaVergne-Brown and Dr. Irvin raised issues around the process that was used in the metrics subcommittee to identify these measures. The subcommittee hasn't developed a process similar to the one developed by the Metrics and Scoring Committee for deciding when a measure should be retired, or when the specs for the measure should be changed. This is something that the metrics subcommittee should pick up when it meets again.

Ms. Beaudrault remarked that the metrics subcommittee was expected to resume its meetings in the fall. One of the things the subcommittee will be doing is reviewing the measures and talking about making changes to the metrics set against small changes. Criteria around measure retirement could be worked in.

Ms. Tiel thanked Dr. Boles for her presentation and reminded the board that it needed to approve the report with changes: (a) rewording of the paragraph around the gonorrhea outcome measure, (b) separating Pacific/Islander data from Asian data, (c) clarification on the active transportation process measure about the 59% statewide survey response.

Dr. Schwarz proposed to accept the report and the technical supplement and to put in the motion great thanks to Dr. Boles for her work on the report. Ms. Rippeteau seconded the motion for approval.

Dr. Schwarz added that the health equity review for the report was included in the meeting packet. He suggested not to write comments to the report in a negative light, because it depends on how one reads the report. There are a lot of implicated recommendations in the report as it stands. He suggested the board to discuss that at a future meeting.

Ms. Tiel stated that the group that came together to talk about the health equity policy could talk about the current format of the health equity review and who would fill it out.

The PHAB approved the 2020 Public Health Accountability Metrics Annual Report unanimously.

Incentives and Funding Subcommittee Update
Dr. Bob Dannenhoffer

Dr. Dannenhoffer remarked that the subcommittee met and decided that the funding formula had done a very good job and now was not the time to change it. If the funding formula changes in the future, the impact of migrant workers should be included. Right now, seasonal or migrant workers don't get counted in any of the current measures. As seen during the pandemic, they contribute greatly to the public health workload. The recommendation of the subcommittee is to continue the funding formula for the next year.

Ms. Tiel entertained a motion to approve the funding formula for 2021-2023 without any changes. Dr. Dannenhoffer moved for approval of the funding formula on behalf of the

subcommittee. Dr. Schwarz seconded the motion. The PHAB approved the funding formula. Dr. Present abstained.

PHAB Member Discussion
Rebecca Tiel

Ms. Tiel invited the board members to discuss ideas for future agenda items, reflect on the day, or share anything they would like the board to consider from the areas they represented, or problems they thought needed to be raised to the board level.

Dr. Dannenhoffer pointed out that the public health system had responded beautifully to the pandemic. Many public health employees were ready for a few months of incident command, but this is really starting to wear on the state. As much as the increasing COVID-19 case count is demoralizing to the country, it is also demoralizing to what is happening to the economy and may well strain the health departments. The tiny health departments (i.e., Umatilla, Union, Malheur) are really getting hit. Douglas County has many fewer cases and many more resources and the employees feel that they are stretched. It is worrisome that the small, rural areas will get overwhelmed.

Ms. DeLaVergne-Brown added that the pushback against public health had been challenging. What is the best way to address that? Public health is trying to help, but sometimes it is looked upon as the one causing the trouble. It is an important discussion.

Dr. Schwarz asked if there were examples in Oregon of public health officials being attacked.

Ms. DeLaVergne-Brown answered that some of the phone calls received by the front desk at Crook County Public Health had not been nice. She has experienced a little bit of hostility and knows that other public health directors are dealing with it as well.

Ms. Shirley remarked that public health received threats at the Portland State Office Building. That's why the building has increased security. No one has been harmed, or has had their personal information breached, or has received threats to their family or home addresses.

Ms. Banks stated that some of Multnomah County's employees out in the field (e.g., restaurant inspectors) had experienced it. There have been issues with the country cars. There are issues even when talking to people who are really struggling, who are losing a lot, or who are scared and don't feel that they have adequate ways to shape policy. The staff on the front lines who are answering phones are experiencing sometimes threats, frustration, and despair.

Ms. Rippeteau acknowledged the tremendous burden public health officials and employees dealt with and how it trickled out to other people. She expressed gratitude and offered to help to get information out to people and to help brainstorm solutions, so that people felt safer and

knew that the information coming from public health was based on the best science that was available.

Ms. Tiel thanked the board members for the discussion and noted that there were two more items that needed approval. The first one was the funding principles. She entertained a motion on the document.

Dr. Present made a motion to approve the funding principles. Ms. Rippeteau seconded the motion. The board approved the revised funding principles for state and local public health authorities unanimously.

Ms. Biddlecom explained that the second item was a statement of expectation for use of funding principles in funding decisions. It is a letter from the PHAB to OHA and the Conference of Local Health Officials (CLHO), requesting that they use the funding formula in distributing funds to local public health authorities.

Dr. Savage made a motion to approve the letter. Dr. Schwarz seconded the motion. The board approved the letter unanimously.

Public Comment

Ms. Biddlecom invited members of the public to provide comments or ask questions within a two-minute limit per person.

There was no public comment.

Next Meeting Agenda Items and Adjourn
Rebecca Tiel

Ms. Tiel asked the board if the PHAB meeting in August should be canceled.

Dr. Schwarz asked if there were any urgent things that needed to happen in August.

Ms. Biddlecom answered that there were none. She noted that OHA requested an extension on the OHA's biennial report to the Legislative Fiscal Office. The components the PHAB approved today, the funding formula and the accountability metrics, are key pieces of the report. The PHAB will have time to review the biennial report on September 17, 2020, in order to get it to the Legislative Office by September 30, 2020.

Ms. Tiel stated that the board meeting in August would be cancelled unless there was any urgent board business that came up.

Dr. Present commented that in relation to the modernization funding that went toward communicable disease regional planning prior to the pandemic, she saw interesting ways of working around data in Clackamas County. She expressed interest in discussing in future meetings how prior modernization work and preparing for it, such as communicable disease emergency, had played out in reality and if there had been some interesting learnings with regional work in the state.

Ms. Tiel adjourned the meeting at 3:59 p.m.

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

September 17, 2020
2:00-4:00 p.m.
ZoomGov

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