AGENDA

PUBLIC HEALTH ADVISORY BOARD

Public Health Equity Framework Workgroup

August 7, 2024, 2:00-3:30pm PST

Join ZoomGov Meeting:

https://www.zoomgov.com/j/1614465966?pwd=VlNRWVNwSlppZk5RVnhwblZaN1Vqdz09

Workgroup members:

Name	Role	Agency	Email
Meka Webb	Screenwise	OHA	Meka.Webb@oha.oregon.gov>
Dr. Marie Boman-Davis	LPHA , PHAB	(Washington County)	Marie_Boman-Davis@washingtoncountyor.gov
Dr. Bob Dannenhoffer	LPHA , PHAB	Douglas County	rldannen@co.douglas.or.us
Krizia Polanco	LPHA	(Umatilla County)	krizia.polanco@umatillacounty.gov
Rebecca Stricker	LPHA	Malheur County	rebecca.stricker@malheurco.org
Jackie Leung	CBO , PHAB	(Micronesian Islander Community)	jleung@micoregon.org
Misha Marie	CBO	Arc of Benton County	mmarie@arcbenton.org
Jennine Smart	CBO	ORCHWA	jennine@orchwa.org
Faron Scissons	CBO	Inter-tribal Fish Commission	scif@critfc.org
Natalie Carlberg	CBO	Boys & Girls Clubs of PDX	ncarlberg@bgcportland.org
Taylor Silvey	CBO	Ecumenical Ministries of Oregon	tsilvey@emoregon.org
Christine Sanders	CBO	Neighborhood House	csanders@nhpdx.org
Kimberly Lane	Tribe	Confederated Tribes of Siletz Indians	kimberlyl@ctsi.nsn.us
Beck Fox	Health Equity Committee Member, CCO	Samaritan Health Plans/InterCommunity Health Network	Bfox@samhealth.org
Margaret Sanger	OHA	Health Promotion and Chronic Disease Prevention	Margaret.m.sanger@oha.oregon.gov

OHA Public Health Division staff: Vanessa Cardona, William Blackford, Sara Beaudrault, Larry Hill, Tamby Moore

Topic	Purpose	Led by	Time
Welcome and Introductions	• Set tone and integrate new members • What to expect today	William Blackford, OHA Performance System Coordinator	10 min
Feedback Loop	• Show workgroup members how their feedback is used • Accountability for OHA	Vanessa Cardona, OHA Equity Analyst	0 min
Summary of new worksheet, phase 1 deliverable and next steps	• Level set for new process/tools for workgroup	Vanessa Cardona, OHA Equity Analyst	5 min
Small group work	• To meet phase one deliverable	All	20 min
Break	• Rest	All	5 min
Large group review	• To allow everyone the chance to inform all the roles	William Blackford, OHA Performance System Coordinator	40 min
Feedback (time permitting)	• Continue refining process and tools	Vanessa Cardona, OHA Equity Analyst	5 min
Public comment	• Public Comment	William Blackford, OHA Performance System Coordinator	5 min

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters.
- Written materials in other languages.
- Braille.
- Large print.
- Audio and other formats.

If you need help or have questions, please contact Vanessa Cardona at publichealth.policy@odhsoha.oregon.gov at least 48 hours before the meeting.

PUBLIC HEALTH ADVISORY BOARD

Health Equity Framework Workgroup Minutes

July 17, 2024, 2:00-3:30 PM

Subcommittee members present: Christine Sanders, Jackie Leung, Meka Webb, Margaret Sanger, Misha Marie, Taylor Silvey, Marie Boman-Davis

Subcommittee members absent: Dr. Bob Dannenhoffer, Rebecca Stricker, Beck Fox, Jennine Smart, Faron Scissons, Kimberly Lane, Natalie Carlberg, Krizia Polanco

OHA staff: Vanessa Cardona, William Blackford, Larry Hill, Sara Beaudrault, Tamby Moore

Welcome and introductions
William Blackford

- Members introduced themselves.
- William reviewed the agenda for the meeting.

Feedback loop, process improvements and intended outcomes and deliverables
Vanessa Cardona (pages 19-21 in meeting packet)

- OHA includes a feedback loop slide each meeting. This is a tool to track what was shared by workgroup members and steps OHA is taking to address the feedback. It is one way that OHA is accountable to workgroup members.
- Based on feedback provided, OHA staff have made changes to the roles worksheet. OHA will also share the worksheet through email, so it is easily accessible for members while working in breakout rooms.
- Vanessa reviewed the previous process for completing the roles worksheet and a new process. The new process focuses on dialogue in small groups and alternating between small and large group discussions. Roles from the

Public Health Modernization Manual are embedded in the worksheet and feedback is built into every meeting.

- Vanessa reviewed the intended outcomes and deliverables for the workgroup.

Health Equity and Cultural Responsiveness roles

Vanessa Cardona and William Blackford (Pages 22-29 in the meeting packet)

- William reviewed worksheet instructions, and members went into breakout rooms to complete a portion of the worksheet.
- Upon return, members reflected on ah-ha moments from their breakout rooms
  - Misha learned about REALD (Race, Ethnicity, Language and Disability) and SOGI (Sexual Orientation and Gender Identity) data, and it gave her a foundation to explain why public health collects those data.
  - Margaret shared that the process helped her to understand the limitations of the public health funding model, which often must be used for specific purposes and misses opportunities to work with community partners
- Taylor appreciated the new worksheet and small group discussions. The conversation can jumpstart thoughts and spark new ones, because roles can be daunting.
- Meka noted that people with differing perspectives, and there is recognition that there doesn't have to be a single answer. Meka appreciated getting specific examples of health equity and cultural responsiveness.
- Taylor asked about next steps and how the worksheets will be changed into the workgroup deliverables.
- Vanessa responded that a compiled worksheet will be provided for the next meeting with time for report-outs.
- Sara responded that workgroup members can talk about what they would like the final products to look like, and the Public Health Advisory Board can also provide input this.

- Jackie wished there were more people in the small groups but acknowledged that summer can be a hard time for meeting attendance.
- Vanessa noted that some groups did not benefit from having the perspective of a local public health authority staff.

Action Items and Next Steps

- OHA will compile all information onto one worksheet and send to members in the follow up email. Members will review at the next meeting.

Public comment

- No public comment.

Meeting was adjourned.

Health Equity Framework Workgroup

Meeting Summary 7/17/2024

Please see outcome column to learn what took place during the meeting.

Topic	Purpose	Outcome
Welcome and Introductions	Set tone and integrate new workgroup members, share what to expect today	Welcome and review of agenda. No new workgroup members today.
Feedback Loop	Show workgroup members how their feedback is used, accountability for OHA	We discussed feedback about the worksheet still not meeting needs of workgroup members. Revised worksheet to incorporate specific feedback from workgroup members.
Summary of new process and worksheet, ties to phase 1 deliverable	Level set new process/tools for workgroup	Went over changes to the worksheet as well as to the process. We are moving away from individual work on the worksheet to a small group dialogue involving different partner types.
Instructions for small group work	Provide clarity for small group work	We reviewed the new worksheet and described directions for small group work.
Break	Rest	We rested. :)

Small group work	To meet phase one deliverable	We worked in small groups with different partners for about 30 minutes. OHA Project Team staff sat in the groups and took notes.
Process and worksheet feedback	Continue refining process and tools	Workgroup members shared the following feedback: ○ New worksheet and small groups are helpful. The conversation helps to jumpstart my thoughts because roles can be daunting. ○ I really enjoyed small groups. When I was filling out the worksheet on my own, I wasn't sure if I was answering the questions correctly and this made me feel as if I wasn't adding anything of value. ○ The small group dialogue helps me to see different perspectives and step outside my own silo of thoughts on a topic. ○ It's helpful to hear concrete examples of the domain, provides a big picture of what is requested of my brain for the meeting.

Level 3 - Restricted

		○ Worksheet was a good start. I wish there were more people in the small groups (currently about 3 people). ○ Some groups did not benefit from having the perspective of an LPH staff.
Begin to review as large group (time permitting)	Working toward deliverable; review what's been shared to add/edit/comment further.	Ran out of time. We will review as group in a future meeting.
Public Comment Period	Public comment	No public comment.

Health Equity and Cultural Responsiveness Roles Worksheet

Sheet 1 of 4

Below you will find a table with state and or local public health roles from the Modernization Manual. In your small groups, review the role type and role and engage in a conversation to fill out the questions in the two columns (more explanation below).

How do CBOs support this role? – What role can CBOs play in the State and Local Public Health roles from the Modernization Manual? What strengths and or assets does a CBO have that could help state and local roles be achieved?

How do State and Local Public Health support the roles in the previous column (CBO roles)? – Can State and Local Public Health support CBO roles in column #3? If so, how? How can State and Local Public Health collaborate with CBOs to achieve roles from the Modernization Manual?

Breakout Room Groups

- **Group 1** – work on roles **a** through **e**
- **Group 2** – work on roles **f** through **j**
- **Group 3** – work on roles **k** through **o**

If your group finishes early, please feel free to work on other roles before we come back to the large group.

Please send completed worksheets to publichealth.policy@odhsoha.oregon.gov

1. Role Type	2. Role	3. How do CBOs support this role?	4. How do State and Local Public Health support the roles in the previous column (CBO roles)?
State and Local	**a.** Collect and maintain data that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.	CBOs may be able to help access and build the bridges to collect data from communities. Also this is true in terms of harm reduction. Building trust is difficult and critical. Figuring out what data is valuable and how to collect data in a respectful non-transactional way is important. Examples include needle exchanges, data around drug use, etc., etc. CCOs have regional health assessments that gather data about our communities and have a responsibility to do that in ways that are equitable and responsive, invite and use feedback from community members. Data gathering processes community informed and community inclusive.	Opportunities for larger systems (LPHAs, OHA, universities, etc.) to support CBOs in guidance, tools, best practices, financial, how to use data, etc. How are we working together and not duplicating efforts and also not overburdening, and being sure that those who need/want the info know it's available, how to get it and how to use it.
State	**b.** Make data and reports available to local public health authorities, partners and stakeholders, and other groups.	CBOs may have access to data and reports that are very specific, maybe niche, kind of reports. CBOs maybe able to share more easily through their partners and	Need to invite CBOs to participate. To do the necessary legwork. Where/how/when can LPHA show up with the community? Repeated asks to show up at the larger organizations

		relationships. They interface, are involved to different degrees of connections with boards, workgroups, etc.	and agencies but need to do the reverse, reciprocate in showing up in CBO spaces.
State and Local	**c.** Compile comprehensive data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through partnerships with relevant state and local agencies.	Frame as strengths based. CBOs have lots of resources and opportunities, and know about these resources. Larger organizations often look at deficits and less at resources/strengths. Social capital can be found within and by CBOs.	
State and Local	**d.** Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health (e.g., quality parks and schools).	Many CBO work directly to address these issues so connecting with them can be informative in learning about adverse health and social resources.	Provide CBOs with $ (another resources) to do community needs/resource mapping. Let CBOs, in partnership with those they work with, determine what data is needed and how to collect it. Find ways within our institutions to advocate for data and types of data to be legitimized (example of oral data, stories). Uplift and value different sources and forms of data. Have a responsibility to see that data is returned to communities and there is joint ownership of data. THIS is important in all of these categories!

			Need to explain the why and what and how, transparency super super important. How will larger organizations involve communities as collaborators.
State	**e.** Implement the Race, Ethnicity, Language and Disability (REAL+D) law (ORS 413.161), and collect and maintain meaningful, disaggregated, standardized and actionable demographic data.	This kind of data is very deep, intrusive, time consuming - not person centered and user friendly. Need to explain why this is needed, what will be done with it. Unexplored opportunities to work with CBOs to partner on collecting this data. Need a better way to collect and not traumatizing people in the process. Need trauma informed process. (Overworked as opposed to traumatized, not always a trauma.) Relationships, trust, and connections. Relationships and context are key to the validity of the data gathered. Building trust. Community members may be more open to providing data and information depending on the relationship and level of trust.	Making sure that CBOs have access to information and data that already exists. The information may already be out there. Providing technical support in trying to implement REAL+D and SOGI in real settings. Advocate for more standardization with data collection. Different providers may be asking different questions. The more opportunity people have to answer these questions the more comfortable they become. Anyone should be able to explain why these questions are being asked and how they will be used. What alternatives are there to standardization? Education and outreach about the importance of gathering this data and how it benefits communities.

		Communicating with community members about data context and history. Training for data collectors on how to provide context and information about how data will be used.	LPHAs as a bridge to communicating with communities about the benefits of collecting data. Clear transparency about what is being done and why.
State	**f.** Based on REAL+D data, conduct cultural and linguistic assessments of relevant policies, programs and strategies to: i. Measure the gaps; ii. Develop continuous improvement plans; ii. Monitor and evaluate health equity outcomes; and iv. Inform implementation of policies, programs and strategies.	-Community connectors for people who fall through cracks, counties may not do this in the same way/have barriers doing this. -How are LPHAs explaining the data in a way that tells you what data really means. - Making sure data is disaggregated at the level community is comfortable with/feels okay with	-Learner, support role, should not be leader of community/telling community what to do, may not have all the answers -If leads, should be with great community input. -Notify CBOs if gaps in data for certain communities (works other way too, partners can share gaps they are seeing in case state/local doesn't identify that). -Overlaps and disconnect by LPH, especially with tribal community members, can cause more harm and difficulty doing public health work. -Humility, listen, able to acknowledge mistakes, know role of allyship in work with communities -Role is more of a partner vs. "authority"

			-Explain what this data actually means, break it down so it's understandable and tangible -Share data with community -Community funded data projects where community owns data -Access to have data and capacity to work with it -Tribes have ability to get data better than other state/LPH, -Cold data is prioritized over qualitative work, this is what community leaders who know their population/are of the population do best. -Raw data at community level may be better communicated to agency level sponsors with perspective and analysis. -Amplify and accelerate public health data through qualitative data
State and Local	**g.** Develop and promote shared understanding of the determinants of health, health equity and lifelong health.	Understanding what barriers are to the communities, do this first versus promoting shared understanding of determinants of health, health equity and lifelong health.	Promote grants that align with need of communities, what communities want to focus on, or at least flexibility with grant funding (e.g., maybe partially

		How are LPHAs explaining the data in a way that tells you what data really means. - Making sure data is disaggregated at the level community is comfortable with/feels okay with	related to scope of work but not the scope exactly). How do we move away from problem focused federal money (usually larger scale/broad topics like tobacco cessation) to individual community needs/most local level possible (e.g., childcare, diapers etc.); need to turn around financial model/augment it. Has any part of OHA ever asked CBOs what their greatest need is? Could there be needs spread across the state that we don't know about at the state level? Could findings correlate into funding streams?
State and Local	**h.** Promote a common understanding of cultural responsiveness.	Identify what this means for the communities CBOs are serving. Creating a space where presumptions (e.g., what cultural responsiveness is/means) can be identified and examined on a regular basis.	- Humility, listen, able to acknowledge mistakes, know role of allyship in work with communities -Role is more of a partner vs. "authority" -Slowing down in state/LPH system, push back so in more alignment with community partners -Making sure state and local public health understand what cultural

			responsiveness means for communities and that they operate with that understanding in mind.
State and Local	**i.** Promote understanding of the extent and consequences of systems of oppression.	If you are not asking community what their challenges are, this will miss the mark with many communities and further systems of oppression. Identify what this means for the communities CBOs are serving. Creating a space where presumptions (e.g., what consequences of systems of oppression is/means) can be identified and examined on a regular basis.	
State and Local	**j.** Make the economic case for health equity, including the value of investment in cultural responsiveness.		
State	**k.** Increase the value for cultural responsiveness in PHD and among local public health authorities.		
State	**l.** Develop or support mass media educational efforts that uncover the fundamental social, economic and	CBOs have important insight into the types and forms of media that the communities they work with access or use most frequently.	Supporting CBO-led educational campaigns. Giving freedom to CBOs to engage in communications and campaigns that

	environmental causes of health inequities.	• Face-to-face • Community outreach • Texting • Social media • Short-form videos Having a broad vision of what "mass media" can mean. Educational campaigns that are CBO-led and supported by state and LPHA. Freedom to develop educational materials, tools, and campaigns.	are relevant and appropriate to the communities they serve.
State and Local	**m.** Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, and other communication needs when releasing data and information		
State and Local	**n.** Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred		

	languages, health literacy and other communication needs.		
State and Local	**o.** Support, implement and evaluate strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations and social movements		

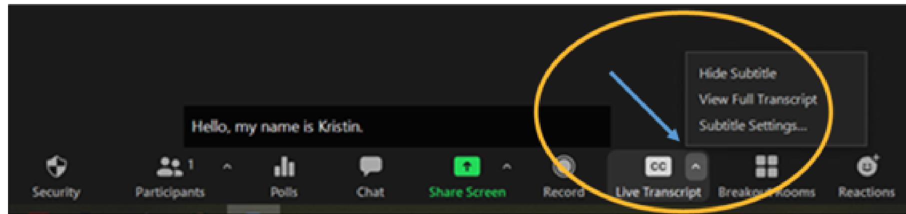
PHAB Workgroup Meeting

August 7, 2024

Health Equity Framework

Real-time captioning and transcription service

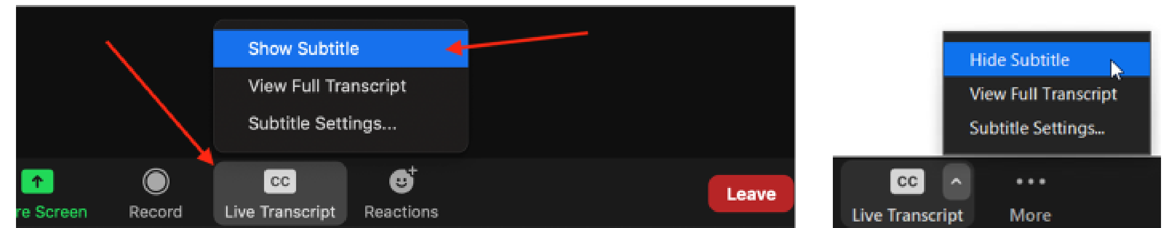
Enabling Closed Captions



Click the small arrow next to "CC Live Transcript" to access caption controls. You can hide the subtitles or view the full transcript.

Cómo habilitar los subtítulos en Zoom

- Haga clic en el botón 'CC Live Transcript' para activar los subtítulos.
- Haga clic en la flecha pequeña al lado del botón 'CC Live Transcript' para acceder a los controles de los subtítulos.
- Puede esconder los subtítulos—'Hide Subtitle', o mirar la transcripción completa de los subtítulos—'View Full Transcript'.



Send a direct message to Tamby Moore for support with accommodation related questions during this meeting.

Workgroup Agenda

Topic	Purpose	Slide #	Led by	Time
Welcome and introductions	• Set tone and integrate new members • What to expect today	1-3	William	10 min
Feedback Loop	• Show workgroup members how their feedback is used, accountability for OHA	4	Vanessa	0 min
Summary of new worksheet, phase 1 deliverable and next steps	• Level set new process/tools for workgroup	5-7	Vanessa	5 min
Small group work	• To meet phase one deliverable	8	All	20 min
Break	• Rest			5 mins
Large Group Review	• To allow everyone the chance to inform all the roles	10	William	40 min
Feedback (time permitting)	• Continue refining process and tools	11	Vanessa	5 min
Public comment	• Public comment	12	William	5 min

Feedback Loop

What was shared?	What was done?	Status/Follow Up
1. More OHA staff needed in this space to understand organization's needs (e.g., Inter-Tribal Fish Commission)	Follow up with workgroup member to better understand ask to be able to follow up with leadership.	In progress, outreach to workgroup member started

Oregon Health Authority

New Worksheet

Domain: Health Equity and Cultural Responsiveness

Partner Type	Questions you'll be responding to:
CBO, Federally Recognized Tribe, other Health System Partner	What role can CBOs, Tribes or other Health System Partners play to uplift the roles outlined for state and or local public health? What assets or strengths do CBOs, Tribes or other Health System Partners have that could help state and local public health roles be achieved? -What gaps might exist that CBOs, Tribes or other Health System Partners could help with?
State and Local Public Health	-Can you support the role outlined by CBOs, Tribes or other Health Systems Partners? What are limitations and work arounds? -How do you work collaboratively to achieve roles in Modernization Manual?

Oregon Health Authority

Intended Outcomes and Deliverables

Public Health Advisory Board (PHAB) Health Equity Framework

Intended outcomes

Shared understanding of:

1. The role of CBOs as part of Oregon's public health system, separate and distinct but in concert with governmental public health.
2. How governmental public health and community partners work together to serve community and achieve health equity.

Deliverable

A health equity framework that includes:

1. A companion document to the Public Health Modernization Manual that describes the role of CBOs to fulfill the foundational capabilities of Health Equity and Cultural Responsiveness and Community Partnership Development.

Next Steps

- Small group work (~20 mins)
  - Three groups, each group will work on remaining roles
  - OHA staff will take notes, send notes to: publichealth.policy@odhsoha.Oregon.gov
- Break (~5 mins)
- Large group review (~40 mins)
  - Opportunity to inform roles you didn't work on in small groups

Small Group Breakouts – 20 mins

Refer to questions on slide 5

Oregon Health Authority

Break time!

Large Group Review – 40 mins

Oregon Health Authority

Process and Worksheet Feedback

- How would you describe the conversation in the small groups?
- How did it feel to review as a large group?
- How can the worksheet be more helpful?

Public Comment

- Please introduce yourself for the record.
- Please keep comments under 3 minutes.

Oregon Health Authority

Thank You!

We hope to see you for our next meeting on August 21st!

Oregon Health Authority