PUBLIC HEALTH ADVISORY BOARD
Health Equity Framework Workgroup Minutes
August 7, 2024, 2:00.pm – 3:30 p.m.

Subcommittee members present: Meka Webb, Misha Marie, Bob Dannenhoffer, Christina Sanders, Margaret Sanger, Kimberly Lane, Taylor Silvey, Beck Fox, Marie Boman-Davis, Faron Scissons, Kimberly Lane
Subcommittee members absent: Jennine Smart, Krizia Polanco, Rebecca Stricker, Jackie Leung, Natalie Carlberg
OHA Staff: Vanessa Cardona, William Blackford, Sara Beaudrault, Tamby Moore

Welcome and Introductions:

- No new workgroup members introduced in this meeting.

Feedback Loop

- More OHA staff needed in space to understand organization's needs (e.g. Inter-Tribal Fish Commission)
    - Followed-up with workgroup member to understand questions and need and begin outreach.

New Domain Worksheet

- Embedded relevant materials from modernization manual into worksheet.
- Worksheet has been broken up into different questions based on Partner Type, i.e. State and Local Public Health, CBOs, Federally Recognized Tribes.
- Questions focus on the ways that different groups can provide support and fill gaps, with the aim of cooperatively achieving goals.

Public Health Advisory Board (PHAB) Health Equity Framework
Intended Outcome and Deliverables

- 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 involves
    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
        - PHAB has requested that the role of CBOs be the focus of this deliverable, and Federally Recognized Tribes as well as other health partners will have separate avenues to inform this work.

Domain worksheet in small groups

- Workgroup members were divided into small groups and took notes on the five remaining roles.
- OHA staff assigned to breakout rooms took notes and sent to publichealth.policy@odhsoha.Oregon.gov
- After a break, workgroup members returned and reviewed worksheet in large group.

Large Group Review

a. **Role: Collect and maintain data thar reveal inequirites in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.**
    - CBOs can support by collecting trust in ways that minimize harm, determining which data is valuable and collectable non-transactionally. CCOs have regional health assessments that gather data about communities and are responsible for pursuing that in ways that are equitable and responsive, inviting and using feedback from community members.
    - State and Local Health system can support CBOs by providing guidance, tools, best practices and processes to ensure cooperation and not duplicated or overburdened efforts.
b. **Role: 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 highly specific and niche, with relationships and partners that allow for easier sharing.
    - Local and State Health systems can assist CBOs by inviting CBOs to participate, and doing the legwork to determine where / how / when can LPHA / OHA show up with the community. They can also assist by reciprocating CBO assistance by showing up in CBO spaces, and providing data / reports to CBOs as needed.
c. **Role: Compile comprehensive data on health resources and health threats (e.g. schools, parks, housing, transportation, employment, economic well-being and environmental quality) through partnership with relevant state and local agencies.**
    - CBOs have resources and opportunities to acquire this information, focusing in on resources / strengths which may be overlooked when prioritizing deficits.
    - OHA and LPHAs can reach out to CBOs to collect information to share with the wider community, providing a central home for these resources. In doing so, State and Local Health Systems can take the brunt of owning / performing upkeep on databases, ensuring proper centralization / updates / relevance and timely sharing with Tribal and other culturally relevant communities.
d. **Role: 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).**
    - CBOs work directly to address these issues and provide a resource that can inform on adverse health / social resources.
    - Local and State Health systems can provide CBOs with funding and resources to do community needs and resource mapping. They can also allow for CBOs and their

partners to determine what data is need and how best to collect it. As well, they can uplist and value different sources / forms of data, and advocate for legitimizing types of data (i.e. oral data, stories). These systems would have a responsibility to ensure data is returned to communities, with joint ownership and clear transparency wrt why / what / how. As well, ensuring data is contextualized to properly represent what is going on with and inside communities.

e. **Role: 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 and time consuming, making it comparatively inaccessible to the public and not person-centered. This data requires an explanation of necessity and what it will be used for. Working with CBOs on collecting this data is unexplored, and will require a trauma informed process while searching for better ways to collect this data. Trust, connections and relationships to the community would also be key to build trust and ensure that the data has validity and context / history, which would require training for data collectors.
    - Local and State Health systems would ensure that CBOs have access to information and data that is already extant, as well as providing technical support in implementing REAL+D and SOGI in actual settings. They can also advocate for more standardization with data collection, ensuring providers are similar questions and providing more opportunities to answer these questions. In this standardization it would also be easier to explain why these questions are being asked and how they will be used. If standardization isn't pursued, education and outreach about the importance of gathering this data and the benefit it will offer to communities should be a strong focus. Clear transparency on the use and reasoning behind the data collection would be required, with OHA/LPHAs acting as a bridge to communicating with communities.
f. **Role: 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; iii. Monitor and evaluate health equity outcomes; and i. Inform implementation of policies, programs and strategies.**
    - CBOs can act as community connectors for those who have limited resources due to systemic oppression, able to act in ways that counties may not be able to. They can also ensure data is disaggregated at level community is comfortable with.
    - Local and State health systems can provide a support role, only leading with strong community input and guidance. They can notify CBOs in case gaps in data for communities becomes apparent. When overlaps and disconnects occur due to LPH, it can cause more harm and increase the difficulty in performing public health work. Government health partners can share data with the community and explain what it actually means, breaking it down to make it more tangible for public understanding. Raw data at community level may be better communicated to agency level sponsors with perspective and analysis, community leaders who know and are of their populations able to acquire needed data. Tribes have a stronger ability to acquire data than other state / LPH.

g. **Role: Develop and promote shared understanding of the determinants of health, health equity and lifelong health.**
    - CBOs can identify barriers to communities prevent access to health, and ensuring information is communicated and disseminated.
    - State and Local Health systems can promote grants that align with community needs and provide more flexibility with grant funding (e.g., partially related to scope of work but not exact wording). Move away from problem-focused federal money (larger scale / broad topics e.g., tobacco cessation) to individual community needs / most local level possible (e.g., childcare, diapers etc.); requires reworking of financial model. OHA can reach out to CBOs and identify greatest needs, potentially identifying state-wise needs that aren't being noticed at the state level, potentially correlating findings into funding streams.

h. **Role: Promote a common understanding of cultural responsiveness.**
    - CBOs can identify what this means for their respective communities, creating spaces where presumptions (e.g., what cultural responsiveness is/means) can be identified and examined on a regular basis.
    - State / LPH systems can begin slowdown, entering more in alignment with community partners to ensure state / LPH understand what cultural responsiveness means for the communities that they are operating in.

i. **Role: Promote understanding of the extent and outcomes of systems of oppression.**
    - CBOs can provide insight and identify within their community what challenges exist and are emerging, and identify what this means for their communities.
    - OHA/LPHA can invite CBOs to share this and engage with their communities about this, bringing this to the OHA/LPHA table. They can also build / improve trust, understanding and relationships with these communities. They can also set a precedent in using accessible language, talking about this openly and using it in materials.

j. **Role: Make the economic case for health equity, including value of investment in cultural responsiveness.**
    - CBOs can make tools for better communication, showing impacts on health and pros / cons of advanced directives. They can advocate for patients where possible, informing patients and health care providers as well as highlight success stories / statistics / case studies showing the benefits of cultural responsiveness (considering external factors and circumstances).
    - Large-scale institutions (i.e. state governments) can push to subvert the scarcity model of health, as the only scarcities that exist are funding and access. As health is not a finite resource, it's important to stress and define the differences between those two. They can also meet people where they are now and reduce the financial impacts of healthcare access.

Public Comment

- No public comment was given.

Meeting Adjourned