AGENDA

PUBLIC HEALTH ADVISORY BOARD

Public Health Equity Framework Workgroup

August 21, 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
Group agreements	• Remind and center guidelines about how we interact/work together, add to agreements (newer workgroup members)	Vanessa Cardona, OHA Equity Analyst	20 min
Large group review	• To meet phase one deliverable	William Blackford, OHA Performance System Coordinator	5 min
Break	• Rest	All	5 min
Small group work	• To meet phase one deliverable	Vanessa Cardona, OHA Equity Analyst	40 min
Feedback (in small groups)	• Continue refining process and tools	OHA Project Team Staff	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.

Health Equity Framework Workgroup

Meeting Summary 8/7/2024

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 briefly discussed feedback on how much OHA representation is appropriate in the workgroup to meet everyone's needs.
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.
Small group work	To meet Phase 1 deliverable	We worked in small groups with different partners for 20 minutes. OHA Project Team staff took notes for each group.
Break	Rest	We rested. :)

Large group review	To meet phase one deliverable	We reviewed roles a through l to allow everyone to provide feedback on all of the roles.
Feedback	Continue refining process and tools	Due to the large group review, we ran out of time for specific feedback.
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. This is also 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,	CBOs may have access to data and reports that are very specific,	Need to invite CBOs to participate. To do the necessary legwork.

	partners and stakeholders, and other groups.	maybe niche, kind of reports. CBOs may be able to share more easily through their partners and relationships. They interface, are involved to different degrees of connections with boards, workgroups, etc.	Where/how/when can LPHA/OHA show up with the community? Repeated asks to show up at the larger organizations and agencies but need to do the reverse, **reciprocate in showing up in CBO spaces**. Having the ability for CBOs to ask for data and reports that the state/local have and sharing that information back to them.
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.	-OHA and LPHAs will reach out to CBOs to collect information and share it out with the wider community – central home for these resources. -Ownership and upkeep of databases? How to centralize, keep it updated, relevant and comprehensive. -Tribally and culturally relevant, able to share out in a timely matter to communities.
State and Local	**d.** Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or	Many CBO work directly to address these issues so connecting with them can be informative in learning	Provide CBOs with $ (another resources) to do community needs/resource mapping. Let CBOs,

	socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health (e.g., quality parks and schools).	about adverse health and social resources.	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. -Contextualization so that data does not misrepresent what is going on with and in communities -Is the story being told by OHA/LPHA the same one that is being told by the communities the data represents?

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. Communicating with community members about data context and history.	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.

		Training for data collectors on how to provide context and information about how data will be used.	OHA/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 who have limited resources dure to systemic oppression, OHA may not do this in the same way/have barriers doing this. -How is OHA 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. How are OHA/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	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 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	Inviting CBOs who work with these communities to share this with those communities and engage them in conversation about it. Hearing oppressed communities at the OHA/LPHA table. Build and improve, trust, understanding and relationships. -Setting a precedent in using this language (DEI), talking about it

		identified and examined on a regular basis.	openly, and using it in materials. Accessibility.
State and Local	**j.** Make the economic case for health equity, including the value of investment in cultural responsiveness.	Making tools for better communication, showing the impacts. Pros and cons of advanced directives. Advocating for patients where possible, informing patients and health care providers. Highlight success stories, statistics and case studies that show the benefits of cultural responsiveness. (Considering external factors and circumstances) Who is making the "economic case" and to whom?	We are all richer in tangible and intangible ways when everyone has their basic needs met and is empowered and supported to live their fullest life. One thing large institutions like state government can do is to lean into actively subverting the scarcity model. This is a huge lift as it's deeply culturally embedded, but, as we know, "it's not pie". There is no scarcity of health, though there is scarcity at present of funding for and access to (currently standard) healthcare delivery systems. Teasing out the difference between these two is important. Meeting people where they are, considering financial impacts of access to healthcare.
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	Supporting CBO-led educational campaigns.

	environmental causes of health inequities.	the communities they work with access or use most frequently. • 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.	Giving freedom to CBOs to engage in communications and campaigns that are relevant and appropriate to the communities they serve.

Health Equity and Cultural Responsiveness Roles Worksheet

Sheet 2 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 **p** through **t**
- **Group 2** – work on roles **u** through **y**
- **Group 3** – work on roles **z** 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	**p.** Partner to enhance multidisciplinary and multi-sector capacity to address health equity. Support health equity in all policies.		
State and Local	**q.** Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity.		
State	**r.** Advocate for health equity in health system reform.		
State and Local	**s.** Play a leadership role in reducing or mitigating existing social and economic inequities and conditions that lead to inequities in the distribution of disease, premature death and illness.		
State and Local	**t.** Use existing evidence-based measures or develop public health measures of neighborhood		

	conditions, institutional power and social inequalities that lead to prevention strategies focused on the social and environmental determinants of health.		
State and Local	**u.** Advocate for comprehensive policies that improve physical, environmental, social and economic conditions in the community that affect the public's health.		
State	**v.** Ensure routine review and revisions of statutes that govern PHD and other regulations and codes to ensure nondiscrimination in the distribution of public health benefits and interventions.		
State and Local	**w.** Monitor relevant issues under discussion by governing and legislative bodies.		
State and Local	**x.** Leverage health system reform funding for health equity and to build cultural responsiveness into health care delivery and funding mechanisms.		

State and Local	**y.** Monitor funding allocations to ensure sustainable impacts on health equity.		
State	**z.** Increase flexible categorical and non-categorical funding to address health equity.		
State and Local	**k.** Increase the value for cultural responsiveness in PHD and among local public health authorities.		
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

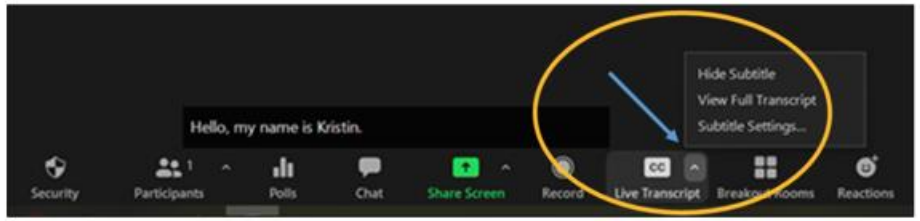
August 21, 2024

Health Equity Framework

Oregon Health Authority

Real-time captioning and transcription service

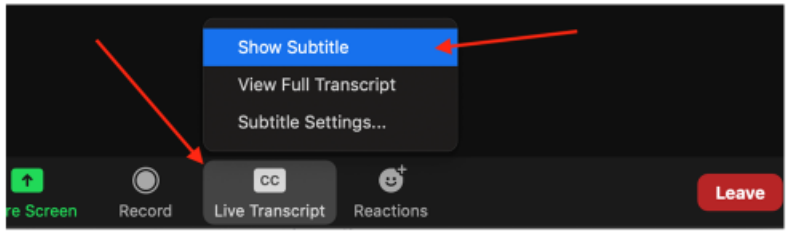
Enabling Closed Captions

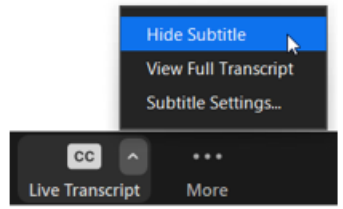


Click the small arrow next to “CC Live Transcript” to access caption controls. You can hide the subtitles or view the full transcript.

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.

Oregon Health Authority

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
Group agreements	• Remind and center guidelines about how we interact/work together, add to guidelines (newer workgroup members)	4-6	Vanessa	20 min
Large group review	• To meet phase one deliverable	7-9	William	5 min
Break	• Rest	11		5 mins
Small group work	• To meet phase one deliverable	10	Vanessa	40 min
Feedback (in small groups)	• Continue refining process and tools	12	OHA Project Team	5 min
Public comment	• Public comment	13	William	5 min

Group Agreements (1 of 3)

- Confidentiality
- Name and account for power dynamics
- Speak your truth and hear the truth of others
- Stay engaged (e.g., move up, move back)

Group Agreements (2 of 3)

- Slow down to support full participation by all group members
- Hold grace around the challenges of working in a virtual space
- Experience discomfort
- Acknowledge intent, but center impact (ouch/oops)

Group Agreements (3 of 3)

- Expect and be okay with non-closure
- Learn from previous experience and focus on moving forward
- Remember our interdependence and interconnectedness
- Share responsibility for the success of our work together

Large Group Review–5 mins

Refer to intended outcomes and worksheet questions on slide 8 and 9.

- We have one more role to discuss
- Remaining 4 roles that were not discussed going to be batched with next group of 15 roles
- We are still on the domain of Health Equity and Cultural Responsiveness

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.

Oregon Health Authority

New Worksheet

Domain: Health Equity and Cultural Responsiveness

Partner Type	Questions you'll be responding to:
CBOs, Federally Recognized Tribes, other Health System Partners	-What role can you play to uplift the roles outlined for state and or local public health? -What assets or strengths do you have that could help state and local public health roles be achieved? -What gaps might exist that you 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?

Break time!

Small Group Breakouts – 40 mins

Refer to intended outcomes and worksheet questions on slide 8 and 9.

- Focus on turning response to the state/local public health role into a CBO role (third column on worksheet)
- If it's not a role and more a comment, notetaker will record in other place

Process and Worksheet Feedback (in small groups)

- How would you describe the conversation in the small groups?
- How is this feeling?
- How did it feel to review as a large group?
- Can any part of this be more helpful? If so, how?

Public Comment

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

Thank You!

We hope to see you for our next meeting on Sept. 4th!