AGENDA

PUBLIC HEALTH ADVISORY BOARD

September 17, 2020, 2:00-4:00 pm

Zoom meeting
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Meeting objectives:

- Approve July meeting minutes
- Discuss updates to PHAB Health Equity Review policy and procedure
- Discuss implementation of 2020-24 State Health Improvement Plan: Healthier Together Oregon
- Review 2020 Public Health Modernization Report to Legislative Fiscal Office
- Discuss important topics for PHAB members

2:00-2:15 pm	**Welcome, announcements and agenda review** • ACTION: Approve July meeting minutes • Lillian Shirley's retirement	Rebecca Tiel, PHAB Chair
2:15-2:50 pm	**Leading with race and PHAB Health Equity Review Policy and Procedure update** • Discuss racism as a public health crisis • Review PHAB's commitment to leading with racial equity • Review updates to PHAB Health Equity Review policy and procedure	TBD, PHAB member
2:50-3:20 pm	**2020-24 State Health Improvement Plan: Healthier Together Oregon** • Review plan strategies • Discuss framework for implementation	Christy Hudson, Oregon Health Authority
3:20-3:40 pm	**2020 Public Health Modernization Report to Legislative Fiscal Office** • Review report • Discuss next steps	Cara Biddlecom and Sara Beaudrault, Oregon Health Authority

3:40-3:50 pm	**PHAB member discussion** • Discuss key issues that PHAB members should be aware of or should help problem solve on behalf of the public health system	Rebecca Tiel, PHAB Chair
3:50-4:00 pm	**Public comment**	Rebecca Tiel, PHAB Chair
4:00 pm	**Next meeting agenda items and adjourn**	Rebecca Tiel, PHAB Chair

Public Health Advisory Board (PHAB)
DRAFT 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

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. For more information and meeting recordings please visit the website: healthoregon.org/phab

Public Health Advisory Board (PHAB)
Health Equity Workgroup Meeting
DRAFT August 13, 2020
Meeting Minutes

Attendance:

Board members present: Rebecca Tiel, Veronica Irvin, Rachael Banks, Jeanne Savage

Oregon Health Authority (OHA) staff: Cara Biddlecom, Victoria Demchak

Welcome, introductions and updates

Cara Biddlecom, OHA staff

Ms. Biddlecom welcomed the PHAB to the meeting and shared that the workgroup was convening to discuss two topics: declaring racism a public health crisis and updating the 2017 PHAB health equity review policy and procedure.

Ms. Tiel started the meeting by sharing that PHAB is able to bring a public health framework to declaring racism as a public health crisis. Racism is a driver of the social determinants of health. PHAB had a conversation at its July meeting about not just declaring racism is a crisis, but actually doing the work that is needed for fundamental change. PHAB will need to make sure to engage the people in communities. This is also an opportunity to align with the SHIP.

Ms. Banks suggested having a follow up discussion with board about leading with racial equity in all of our health equity work. This was a part of the shared agreement the board made during its February 2020 retreat.

Ms. Biddlecom shared that the Oregon Health Policy Board and the Health Equity Committee are both interested in declaring racism a public health crisis and this is an opportunity to work together. In alignment with the SHIP, it is also an opportunity to work across sectors to advance racial justice.

Updates to Health Equity Review Policy and Procedure
Cara Biddlecom, OHA staff

The workgroup proposed several changes to the draft review policy and procedure, including:

1. Updating the definition of health equity in order to reflect the Oregon Health Policy Board's 2019 definition.
2. Determining that the policy questions should be responded to within subcommittees first, and then with the full board. Staff would be prepared for the equity review prior to any motions but would not prepare responses to the questions.
3. Revising questions in the policy to center racial equity and correcting historical injustices.

Ms. Banks recommended that PHAB take some time in the coming months to do some more work on racial equity, and that the work today and included in this policy is the "head" work of equity that is supported by important "heart" work.

Public comment
LeRoy Patton, Governor's Commission on Senior Services asked if this group will convene again.

Ms. Biddlecom let Mr. Patton know the workgroup would determine its next steps and that the Public Health Advisory Board generally meets the third Thursday of each month from 2:00-4:00 pm, with the exception of August and December.

Willow shared the need to invest in the population and using government funds for community health as a way. She agreed to allow heart work and time for these conversations. Systems that do not allow heart work are systems of white supremacy

Next steps
Workgroup agreed to convene again before the September PHAB meeting to continue working on the policy and procedure.

Ms. Biddlecom adjourned the meeting at 2:58 pm.

RACE & SOCIAL JUSTICE INITIATIVE

ADVANCE OPPORTUNITY. ACHIEVE EQUITY.

Why Lead with Race?

Challenging Institutional Racism to Create an Equitable Society for All

The City of Seattle and the Seattle Office for Civil Rights challenge many forms of oppression, including racism, sexism, heterosexism, ableism and many others. The Race and Social Justice Initiative (RSJI) focuses on eliminating institutional racism and racial inequity. We are sometimes asked, "Why lead with race?" RSJI leads with race because of:

1. The pervasive and deep disparities faced by people of color. We recognize that challenging institutional and structural racism is essential if we are to support the creation of a just and equitable society;
2. The many years of community organizing that demanded the City to address racial inequity. To this end, we recognize the necessity of supporting all communities in challenging racism; and
3. The necessity of focus. We recognize that efforts to eliminate racism are essential to achieving an equitable society, and that those efforts by themselves are insufficient. We "lead with race," and are also working on institutionalized sexism, heterosexism, ableism and other oppressions.

Why focus on institutions?

RSJI focuses on institutional racism because we recognize that while individual racism deserves our attention, for long term change to take place, it is necessary to elevate the discussion to how eliminating institutional racism can help lead to racial equity. By focusing on policies, practices and programs which advantage white communities while disadvantaging communities of color, we are able to better impact racial inequities.

Just as institutions work to the benefit of white people, they also work to the benefit of men, heterosexuals, non-disabled people and so on. We understand how critical it is to address all social justice issues, and that an institutional approach is necessary across the board. The definitions and tools we use to eliminate institutional racism can also be used to eliminate institutional sexism, heterosexism, ableism and other oppressions. As we deepen our ability to eliminate racial inequity, we will be better equipped to transform systems and institutions towards collective liberation for all.

What about people experiencing multiple oppressions?

All historically disadvantaged groups – people of color, lesbians, gay men, people who are transgendered, women, people with disabilities, low-income households, to name a few – experience systemic inequity. Many people and communities live at the intersection of these identities, for example lesbians of color, experiencing multiple inequities at once. By centering on race and using tools that can be applied across oppressions, we increase the ability of all of us to work for equity.

Are you saying racism is worse than other oppressions?

No. We know that racism is deeply embedded in the institutions in this society leading to inequities in all major indicators of success and wellness. We must look at how this country was founded on the attempted genocide of Native people and the enslavement of African people. This legacy was institutionalized in all aspects of our society, and continues to create racialized impacts born from structural policies, practices and procedures, often unintentionally. In fact, race is consistently a primary indicator of a person's success and wellness in society.

By focusing on race and racism, we recognize that we have the ability to impact all communities, including addressing the impacts of racism on LGBTQ people of color. We are prioritizing an anti-racist strategy in order to create an equitable society for all. This prioritization is not based on the intent to create a ranking of oppressions (i.e. a belief that racism is "worse" than other forms of oppression). For an equitable society to come into being, we need to challenge the way racism is used as divisive issue keeping communities from coming together to organize for change.

While the RSJI leads with race, we recognize that all oppressions are perpetuated by the interplay of institutions, individuals, and culture operating amidst the weight of history. For all people and communities to experience liberation, we must transform all aspects of our society.

I am focusing on addressing another form of oppression (for example, heterosexism, sexism, etc.). How does RSJI address these?

It is important that we all are committed to ending oppression to create an equitable society. It is crucial that as we prioritize our strategies, we maintain an approach that recognizes that all oppressions are inter-connected. Racism is one barrier keeping all marginalized communities from uniting to work towards their own liberation.

Recognizing the structural interplay between all oppressions, RSJI has supported many communities in addressing issues of racial justice and the inter-relationship between racism and other forms of oppression. RSJI has done workshops and presentations for a wide range of communities, including women, LBGTQ, people with disabilities, and so on. We continue to leverage resources to challenge all forms of oppression to create an equitable and just society for all.

I am primarily focused on addressing another form of oppression, but am supportive of efforts to eliminate racial inequities as well…How can I be supportive of RSJI?

For City of Seattle employees, we encourage you to: join or actively support your department's RSJI Change Team; attend RSJI sponsored trainings and events; insure that the Racial Equity Toolkit is implemented in your department and in your community; get to know your department's RSJI workplan and how you can help with implementation.

Whether a City employee or not, intentionally center the experiences and perspectives of people and communities of color as you do work towards ending oppressions other than racism. Strengthen your ability to understand how racism intersects with other forms of oppression and privileges, and how policies might have unintended consequences for communities of color. Support the efforts of the Race and Social Justice Community Roundtable in ending racial inequity in Seattle.

Public Health Advisory Board
Health equity review policy and procedure
September 2020 DRAFT

Background

The Public Health Advisory Board (PHAB), established by House Bill 3100 (2015), serves as the accountable body for governmental public health in Oregon. PHAB reports to the Oregon Health Policy Board (OHPB) and makes recommendations to OHPB on the development of statewide public health policies and goals. PHAB is committed to using best practices and an equity lens to inform its recommendations to OHPB on policies needed to address priority health issues in Oregon, including the social determinants of health.

Definition of health equity

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Equity framework

Identifying and implementing effective solutions to advance health equity demands:

- Recognition of the role of historical and contemporary oppression and structural barriers facing Oregon communities due to racism.
- Engagement of a wide range of partners representing diverse constituencies and points of view.
- Direct involvement of affected communities as partners and leaders in change efforts.

Leading with racial equity

Achieving health equity requires engagement and co-creation of policies, programs and decisions with the community in order to ensure the equitable distribution of resources and power. This level of community engagement results in the elimination of gaps in health outcomes between within and different social groups.

Health equity also requires that public health professionals look for solutions outside of the health care system, such as in the transportation, justice or housing sectors and through the distribution of power and resources, to improve health with communities. By redirecting resources that further the damage caused by white supremacy and oppression into services and programs that uplift communities and repair past harms, equity can be achieved.

Policy

PHAB demonstrates its commitment to advancing health equity by implementing an equity review process for all formally adopted work products, reports and deliverables. Board members will participate in an equity analysis prior to making any motions. In addition, all presenters to the Board will be expected to specifically address how the topic being discussed is expected to affect health disparities or health equity. The purpose of this policy is to ensure all Board guidance and decision-making will advance health equity and reduce the potential for unintended consequences that may perpetuate disparities.

Procedure

Board work products, reports and deliverables

The questions below are designed to ensure that decisions made by PHAB promote health equity. The questions below may not be able to be answered for every policy or decision brought before PHAB, but serve as a platform for further discussion prior to the adoption of any motion.

Subcommittees or board members will consistently consider the questions in the assessment tool while developing work products and deliverables to bring to the full board.

Subcommittee members bringing a work product will independently review and respond to these PHAB members will discuss and respond to each of the following questions prior to taking any formal motions or votes.

Staff materials will include answers to the following questions to provide context for the PHAB or PHAB subcommittees:

1. What health inequities exist among which groups? Which health inequities does the work product, report or deliverable aim to eliminate?
2. How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?
3. How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?

PHAB members shall allow the questions to be discussed prior to taking a vote. Review questions should be provided to the Board with each vote.

OHA staff will be prepared to respond to questions and discussion as a part of the review process. Staff are expected to provide background and context for PHAB decisions using the questions below.

The PHAB review process includes the following questions:

4. How does the work product, report or deliverable:
    a. Contribute to racial justice?
    b. Rectify past injustices and health inequities?
    c. Different from the current status?
    d. Support individuals in reaching their full health potential
    e. Ensure equitable distribution of resources and power?
    f. Engage the community to affect changes in its health status
5. Which sources of health inequity does the work product, report or deliverable address (race/racism, ethnicity, social and economic status, social class, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?
6. How will data be used to monitor the impact on health equity resulting from this work product, report or deliverable?

Presentations to the Board

OHA staff will work with presenters prior to PHAB meetings to ensure that presenters specifically address the following, as applicable:

1. What health inequities exist among which groups? Which health inequities does the presenter and their work aim to eliminate?
2. How does the presentation topic engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?
3. How was the community engaged in the presentation topic? How does the presentation topic or related work affect the community?
4. How does the presentation topic:
    a. Contribute to racial justice?
    b. Rectify past health inequities?
    c. Different from the current status?
    d. Support individuals in reaching their full health potential
    e. Ensure equitable distribution of resources and power?
    f. Engage the community to affect changes in its health status

5. Which sources of health inequity does the presentation topic address (race/racism, ethnicity, social and economic status, social class, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?
6. How will data be used to monitor the impact on health equity resulting from this presentation topic?

Policy and procedure review

The PHAB health equity review policy and procedure will be reviewed annually by a workgroup of the Board. This workgroup will also propose changes to the PHAB charter and bylaws in order ground the charter and bylaws in equity. Board members will discuss whether the policy and procedure has had the intended effect of mitigating injustice, reducing inequities or improving health equity to determine whether changes are needed to the policy and procedure.

Resources

The City of Portland, Parks and Recreation. Affirmation of Equity Statement.

Multnomah County Health Department (2012). Equity and Empowerment Lens.

Oregon Health Authority, Office of Equity and Inclusion. Health Equity and Inclusion Program Strategies.

Oregon Education Investment Board. Equity Lens.

Oregon Health Authority, Office of Equity and Inclusion. Health Equity Policy Committee Charter.

Jackson County Health Department and So Health-E. Equity planning documents and reports.

Updates on the State Health Improvement Plan

Christy Hudson, Cross-sector and Strategic Initiatives Coordinator
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Oregon Health Authority

Discussion

- What lessons can be learned from the 2015-2019 State Health Improvement Plan?
- How would PHAB like to support implementation of Healthier Together Oregon?
- How can the public health system use Healthier Together Oregon to advance racial equity?
- How can we continue to engage affected communities in implementation?

2015-2019 State Health Improvement Plan

Final Progress Report

PUBLIC HEALTH DIVISION

Office of the State Public Health Director

Oregon Health Authority

	Indicator	Baseline	2019	Target
Achieved	Cigarette smoking among 11th graders	10%	5%	7.5%
	Binge drinking among 11th graders	17.7%	12.8%	13%
	Third graders with cavities in their permanent teeth	15.5%	7.6%	14%
	11th graders with cavities	74.0%	64.6%	70.3%
	Adolescents with oral health problems	17.5%	10.8%	15.8%
Moving in the right direction	HIV infections per 100,000	6.1	5.5	4.5
	HIV viral load	68%	81%	90%
	Hospital onset C. Difficile (Standardized Infection Ratio)	.73	.71	.57
	E. coli cases per 100,000	2.3	1.9	.6
	Tuberculosis cases per 100,000	1.9	1.9	1.4
	Tobacco use among adults	17%	16%	15%
	Binge drinking among adults	17.4%	17.4%	16%
	Childhood vaccinations	60%	69%	80%
	HPV vaccinations	28%	51%	80%
	Flu vaccinations	42%	45%	70%
	Older adults who have lost all their teeth	17.7%	13.7%	12%
Moving in the wrong direction	Opioid related deaths per 100,000	6.8	7.0	3.0
	Alcohol related car crashes	110	150	98
	Gonorrhea infections per 100,000	57.8	142.7	72
	Syphilis infection per 100,000	10.4	17.2	11.1
	Vaping among 11th graders	18%	24%	15%
	Heavy drinking among adults	7.7%	8.7%	6.6%
	Suicide per 100,000	18.7	19	16
	Suicide attempts among 11th graders	7.9%	10%	7%
	Obesity among 2-5 year olds	15.4%	16.6%	14.5%
	Obesity among youth	11%	14%	10%
	Obesity among adults	27%	30%	25%
	Diabetes among adults	8.1%	9.8%	8%

2015-2019 SHIP Highlights

Accomplishments

- Alignment of priorities within Community Health Improvement Plans
- Public health modernization foundational capabilities and investments bolstered efforts
- CCO alignment in incentive metrics and performance improvement projects

Challenges

- Race based disparities persisted
- Affected communities were missing from development and implementation process
- Upstream determinants of health and equity not addressed

Healthier Together Oregon

Our 2020-2024 State Health Improvement Plan is called *Healthier Together Oregon*.

We want to live in a state where we can all have long, healthy lives. The social issues that affect health are the places we live, work, learn and play. They are the main reasons people are healthy, or not. These include things like:

Implementation Framework

Implementation Areas

Equity and Justice

Healthy Communities

Housing and Food

Behavioral Health

Healthy Families

Healthy Youth

Workforce Development

Technology and Health

Key Indicators

Priority area	Indicators
Institutional bias	Disciplinary Action (Department of Education) Premature death/Years of Potential Life Lost (Vital Statistics)
Adversity, trauma and toxic stress	ACEs among children (National Survey of Children's Health) Chronic Abseentism (Department of Education) Concentrated Disadvantage (ACS)
Behavioral health	Unmet mental health care need among 11th graders (Student Health Survey) Suicide rate (Vital statistics) Adults with poor mental health in past month (BRFSS)
Economic drivers of health	3rd grade reading proficiency (Department of Education) Opportunity Index – Economy Dimension (Opportunity Index) Childcare cost burden (TBD) Food insecurity (Map the meal) Housing cost burden among renters (ACS)*
Access to equitable preventive health care	Childhood immunizations (ALERT IIS) Colorectal cancer screening (BRFSS) Adults with a dental visit in past year (BRFSS)

Themes from community feedback process

- Overall, community is **very supportive** of drafted strategies
- Need for **increased messaging about Collective Impact**
- Interest in **supporting activities** to better understand implementation
- Interest in **measurement and transparency in accountability**
- **Concern for feasibility**, especially given resource constraints and ongoing COVID response
- Tension/misunderstanding between **equity vs. equality**
- Call to **center priority populations** in planning and implementation
- Strengthen strategies for **incarcerated, LGBTQ+, disabled, homeless, immigrant/refugee, and older** populations
- Strategies are "**Portland metro centric**" – rural needs aren't reflected
- Strengthen attention to **language related needs** – "linguistically appropriate"
- **White savior** complex

Next Steps for Implementation

- Share Healthier Together Oregon with partners
- Reform the PartnerSHIP for implementation
- Update the PHD Strategic Plan – tease out strategies for which PHD holds responsibility
- Inform the OHA Strategic Plan – tease out strategies for which OHA holds responsibility
- Support alignment of priorities and strategies with Community Health Improvement Plans
- Identify strategy “champions” to collectively move actions forward
- Develop and maintain partnerships with other state agencies

Discussion

- What lessons can be learned from the 2015-2019 State Health Improvement Plan?
- How would PHAB like to support implementation of Healthier Together Oregon?
- How can the public health system use Healthier Together Oregon to advance racial equity?
- How can we continue to engage affected communities in implementation?

Healthier Together Oregon

- Healthoregon.org/ship
- Healthiertogetheroregon.org
- Christy Hudson (christy.j.hudson@state.or.us)

2015-2019 State Health Improvement Plan

Final Progress Report







Oregon Health Authority
PUBLIC HEALTH DIVISION

Contents

Executive Summary

The State Health Improvement Plan (SHIP) advances OHA's vision for a state where a healthy life is within reach for all people in Oregon. The 2015-2019 SHIP was focused on seven priorities. When identified in 2014, these priorities represented the leading causes of death in Oregon and areas where Oregon could make significant progress to improve the health of everyone in the state.

- Prevent and reduce tobacco use
- Prevent and reduce obesity
- Improve oral health
- Reduce harms associated with alcohol and substance use
- Prevent deaths from suicide
- Improve immunization rates
- Protect the population from communicable diseases

Each priority area included interventions in three broad categories: population health, health systems, and health equity. To measure progress, the Oregon Health Authority (OHA) identified 27 targets across the seven priorities. As of January 2020, across the priority targets:

5 were achieved

11 were on the right track

12 were moving in the wrong direction

More complete information can be found online at www.healthoregon.org/ship.

Introduction

History

The State Health Improvement Plan (SHIP) outlines Oregon's health priorities, with policy, systems and environmental interventions needed to advance improvement and indicators to measure progress. Developed every five years, the SHIP is a guiding strategic document for the Oregon Health Authority (OHA). This plan informs OHA's work with other partners in governmental and community public health agencies, Coordinated Care Organizations (CCOs), hospitals, health systems, and other state agencies.

The goal of the 2015-2019 SHIP was to make measurable improvements in health outcomes for each of the seven priority areas:

- Prevent and reduce tobacco use
- Prevent and reduce obesity
- Improve oral health
- Reduce harms associated with alcohol and substance use
- Prevent deaths from suicide
- Improve immunization rates
- Protect the population from communicable diseases

These priorities were identified based on data from the State Health Assessment (SHA) and feedback from partners and stakeholders collected during community engagement sessions held in 2014. The seven priority areas were selected because they were leading causes of death and disability, were issues that were worsening over time, were issues where Oregon ranked worse compared to other states, or because they had been identified by the Centers for Disease Control (CDC) as a winnable battle. Each priority area contained evidence-based strategies for the entire population and within the health system. Each area also included health equity strategies directed at populations that experience a disproportionate burden of disease.

Implementation and accountability

The Oregon Health Authority - Public Health Division (OHA-PHD) provided leadership for implementation and reporting progress, which occurred through a variety of mechanisms. OHA-PHD programs took the lead on strategy implementation of policy, system and environmental changes. OHA-PHD staff were identified as owners for each of the priority areas, charged with development and implementation of annual work plans. Priority owners gathered on a bi-monthly basis to share challenges and successes. Owners and other OHAPHD staff also contributed to annual progress reports, the SHIP website, and ongoing communications that were shared on the Oregon Health Authority Facebook and Twitter accounts.

The Public Health Advisory Board (PHAB) is the accountable body for governmental public health in Oregon. PHAB provides oversight for the OHA-PHD's strategic initiatives, including the SHA and SHIP. The PHAB received quarterly updates about the SHIP and provided feedback for improvement. Progress on the priority targets was reported annually to the PHAB as well.

Summary of accomplishments and challenges

The 2015-2019 SHIP saw areas of accomplishment and many persistent challenges. Overall improvements were witnessed in areas of oral health, adult tobacco use, HIV, and immunizations, while issues related to suicide, substance use, sexually transmitted infections, youth tobacco use and obesity continued trending in the wrong direction. More specific details about gains in the seven priority areas can be found in this report.

To measure progress, the OHA tracked and identified 27 targets across the seven priorities. As of January 2020, across the priority targets:

5 were achieved

11 were on the right track

12 were moving in the wrong direction

	Indicator	Baseline	2019	Target
Achieved	Cigarette smoking among 11th graders	10%	5%	7.5%
	Binge drinking among 11th graders	17.7%	12.8%	13%
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Accomplishments

While OHA struggled to achieve many of the intended targets, OHA made other accomplishments in alignment and communication about overall priorities, and our understanding of health disparities.

The priorities of the 2015-2019 SHIP were framed by the social determinants of health, or the economic, social and economic factors that affect people's health. Since the 2015-2019 SHIP was published, public health's attention to not only the social determinants of health, but the social determinants of equity, has evolved. In addition to working across systems like housing, education, and economic development, OHA needs to be breaking down the systemic bias that disadvantages communities based on race or ethnicity, income, gender identity, sexual orientation, ability, and other identities. To that end, the health equity strategies were significantly revised in 2018 to better address race and ethnicity-based disparities.

While PHAB provides oversight to OHA-PHD, the Oregon Health Policy Board (OPHB) is the policy and oversight board of OHA. In 2010, the OHPB created the Action Plan for Health tto address urgent health care issues in our state. This plan was refreshed in 2017 to consider the reforms that had taken place through implementation of the Affordable Care Act and start-up of Coordinated Care Organizations (CCOs). In the spirit of alignment, the 2017-2019 Action Plan for Health highlighted the need to work in tandem with the SHIP. This alignment helped to foster momentum and clear direction for OHA in its work to achieve a healthy Oregon. CCOs provided important opportunities to advance collective effort among low-income communities. During implementation of this SHIP, CCO incentive measures were in place or in development for six of the seven priority areas. To assist CCOs with successful achievement of incentives, OHA's Transformation Center provided training and technical assistance in alignment with many of the priorities. The SHIP also helped to inform CCO performance improvement projects aimed at reduction of opioid prescriptions.

2015-2019 SHIP & CCO Incentive Measure Alignment

SHIP measure	CCO incentive measure
Prevent and reduce tobacco use	Cigarette smoking prevalence (2016-2019)
Improve oral health	Dental sealants on permanent molars (2015-2019) Oral evaluation for adults with diabetes (2019)
Reduce harms associated with alcohol and substance use	Drug and alcohol screening (2015-2016, 2019)
Prevent deaths from suicide	Depression screening and follow-up plan (2015-2019) Follow up after hospitalization for mental illness (2015-2017)
Improve immunization rates	Childhood immunization status (2016-2019)
Slow the increase of obesity	Weight assessment and counseling for children and adolescents (2018-2019)
Protect the population from communicable disease	Metrics related to HIV and Hepatitis C screening were proposed to the Health Plan Quality Metrics Committee, but did not move forward.

The SHIP was also intended to be used as a guiding document for Community Health Improvement Plans (CHIPs) implemented by local public health authorities (LPHAs), CCOs and hospitals. While CCOs and non-profit hospitals are required by law to implement CHIPs, LPHAs do so voluntarily as part of the national public health accreditation process. OHAPHD staff worked closely with colleagues in OHA's Transformation Center, the Office of Rural Health and the Association of Oregon Hospitals and Health Systems to encourage alignment of priorities across the state. For example, an online map was created to enable sharing of Community Health Assessments (CHAs) and CHIPs across the state, and progress updates were frequently shared via these partners. There was significant overlap in CHIP and SHIP priorities; top priorities among CHIPs included substance use, chronic disease management, obesity and oral health.

Public health modernization also bolstered the priorities of the SHIP and shifted public health practice. The development and implementation of the SHIP is a core system function of the policy and planning foundational capability, and relies heavily on the other foundational capabilities. Increased investments in the foundational program of communicable disease control contributed to quality improvement, improved data collection, and partnership development, particularly in areas related to immunizations, health care acquired infections and sexually transmitted infections. Increased capacity in foundational capabilities helped strengthen health equity interventions. The SHIP also informed creation of the Public Health Accountability Metrics, a series of metrics used to track progress towards the modernization of Oregon's public health system. Four of the eight accountability metrics align with a SHIP priority target.

While OHA provided leadership for the SHIP, the achievements are a result of partnerships with other state and local agencies, such as Regional Health Equity Coalitions, LPHAs, CCOS, and the Department of Human Services (DHS), Department of Transportation (ODOT) and the Department of Education (ODE). OHA is grateful for these partners as we work collectively to improve health in our state.

Challenges

Even in priority areas where gains were made, unjust and unacceptable disparities persisted, especially among communities of color. These disparities exist due to current

2015-2019 SHIP & Public Health Accountability Metric Alignment (* indicates alignment)

Communicable disease control

- Two-year-old immunization rates*
- Gonorrhea rates*

Environmental health

- Active transportation
- Drinking water standards

Prevention and health promotion

- Adults who smoke cigarettes*
- Opioid overdose deaths*

Access to clinical preventive services

- Effective contraception use
- Dental visits for 0-5 year olds

and historical racism and disinvestment in communities of color. OHA recognizes that the design of this SHIP did not include communities nor a broad spectrum of partners, thus these priorities may not resonate with communities and have not effectively addressed health inequities from a systemic level. In recognition of these shortcomings, OHA is shifting the way data are collected, priorities are selected and strategies are designed for the 2020-2024 SHIP.

OHA is committed to improving its relationship with communities that have experienced systemic racism and oppression by building trust and co-creating culturally responsive public health interventions. The 2020-2024 SHIP will further our steps in this direction.

Challenges in implementation have also highlighted a continued need to effectively influence policy and systems change, especially in areas that lay outside of traditional public health, such as housing or education. While improving health is the job of OHA, it is not OHA's job alone, especially as public health grows in its understanding of the social determinants of health and equity. By increasing public health's capacity in the foundational capabilities such as community partnership development, policy and planning, and leadership competencies, OHA can strengthen its relationship with sectors whose work also influences health. While the social determinants of health framed the priorities of the 2015-2019 SHIP, the 2020-2024 SHIP will move even farther upstream with increased emphasis on the impacts of institutional bias, trauma and toxic stress and economic drivers of health such as housing, poverty and food security.

Prevent and Reduce Tobacco Use

Tobacco use remains the number one cause of preventable death in Oregon. Tobacco use kills approximately 8,000 Oregonians each year, and contributes to lung cancer, heart disease and other chronic illnesses. Cigarette smoking among adults and youth decreased overall; however, this was overshadowed by a dramatic increase in use of e-cigarettes among youth.

Population & Strategies

- Increase the price of tobacco
- Prohibit free sampling of tobacco products, tobacco coupon redemption and other price reduction strategies
- Increase the number of tobacco-free environments

The 2015-2019 SHIP influenced significant policy wins aimed at reducing tobacco use. In 2018, Oregon's Tobacco 21 law went into effect. This law raised the minimum age for a person to buy tobacco products or e-cigarettes from 18 to 21. In 2019, Governor Brown signed HB 2270 into law. The initiative was referred to Oregon voters by the legislature and will appear on the November 2020 ballot. The most effective way to help people quit tobacco and prevent kids from starting is to raise the price of tobacco.

At the local level, five counties in Oregon now require retailers to have a license to sell tobacco. This policy is gaining momentum in other counties, driven by a national outbreak of e-cigarette and vaping associated lung injury in 2019, and a dramatic rise in youth e-cigarette use.

Although Oregon saw a decrease in cigarette smoking among youth, this decrease was overshadowed by a significant increase in youth e-cigarette use. The types of e-cigarettes and vaping products on the market expanded rapidly in the past five years. These products are flavored, inexpensive, and heavily marketed to youth. Emerging evidence suggests that e-cigarettes are not an effective way for adults to quit smoking. And the science is clear that the new generation of e-cigarette products is addicting youth to nicotine who would not otherwise have tried a tobacco product. Addressing youth e-cigarette use will continue to be a priority for OHA.

Figure 1

Cigarette smoking among adults

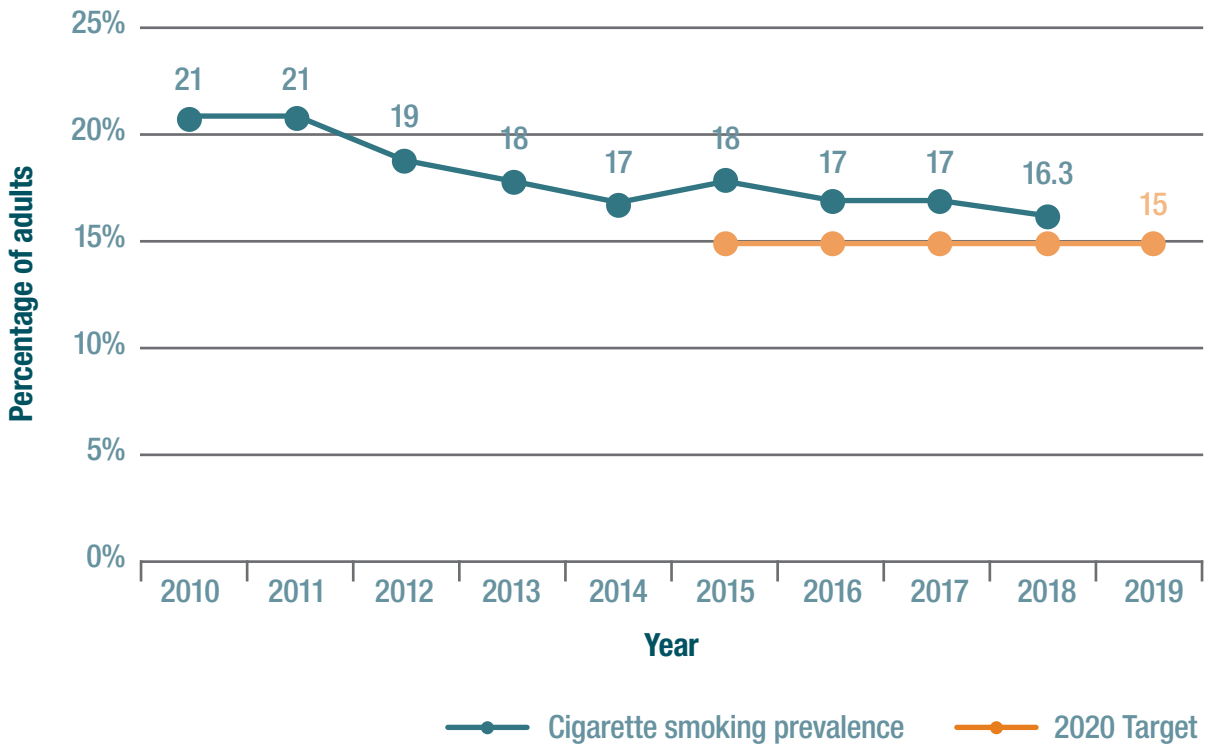
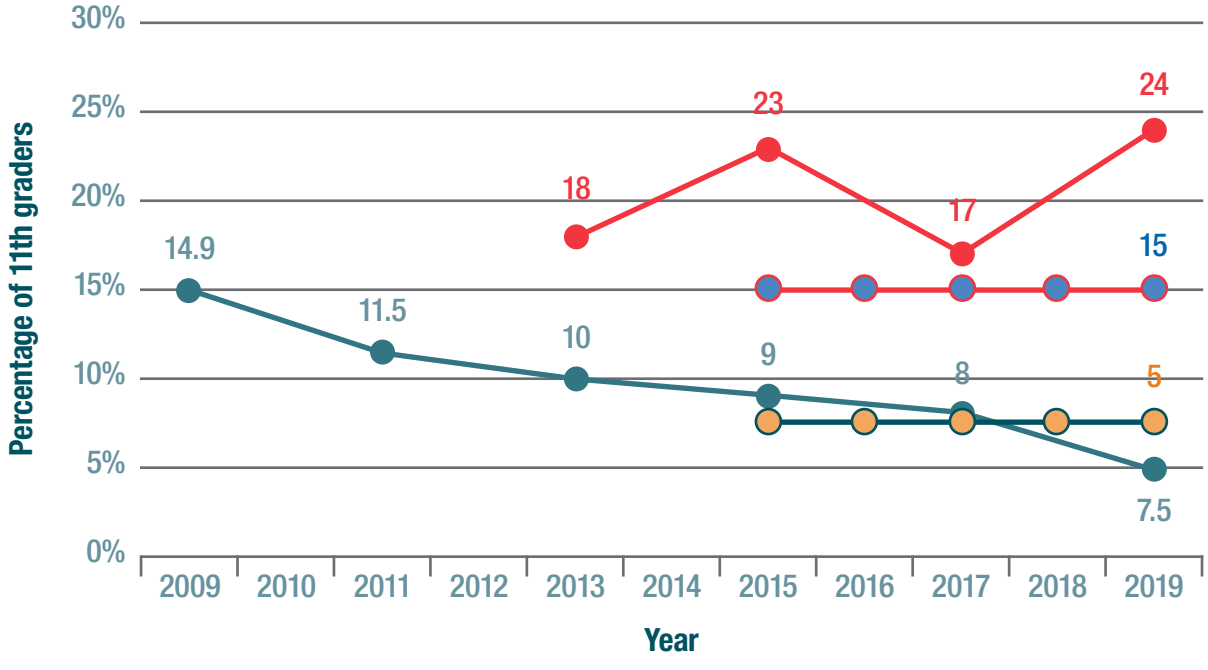


Figure 2

Tobacco use among youth



Health Equity Strategies

- Increase protections for secondhand smoke among low-income and service-industry employees
- Increase the number of DHS and OHA mental and behavioral health service providers that adopt tobacco-free campus policies, adopt tobacco-free contracting rules and refer clients and employees who smoke to evidence-based cessation services
- Build capacity among culturally specific organizations and communities disproportionately affected by tobacco industry targeting.
- Increase the number of American Indians/Alaska Natives accessing Quit Line services.

The burden of tobacco use falls hardest on lower-income Oregonians and communities of color. This is due, in great part, to tobacco industry advertising that disproportionally targets low income communities.

One in seven workers are still exposed to secondhand smoke in their workplaces, with low-income and service industry workers being most at risk. Counties, tribes, community-based organizations and other partners went to Salem during legislative sessions to express support for maintaining and expanding indoor clean air protections to ensure equal access to smoke-free environments. Since 2015, five jurisdictions in Oregon have passed policies that expand protections beyond Oregon's Indoor Clean Air Act.

OHA continued implementation of the Tobacco Free Facilities and Services policy (formerly Tobacco Freedom). The policy sets requirements for addictions and mental health facilities licensed and funded by OHA to provide tobacco-free environments; promote healthy alternatives to using tobacco; increase access to peer-based and other tobacco cessation supports; and improve discharge planning to promote sustained tobacco cessation in recovery.

During the last five years, OHA continued to fund Tribes and Regional Health Equity Coalitions (RHEC) to build policy capacity among culturally specific organizations and communities disproportionately affected by tobacco industry targeting. For example, OHA developed the Community Policy Leadership Institute model to bring together community leaders, health departments and decision makers to co-lead local policy and system change among communities affected by health inequities.

OHA also worked with the Northwest Portland Area Indian Health Board, the nine federally recognized tribes, the Native American Youth and Family Center, NARA and Chemawa to co-develop the Oregon Tobacco Quit Line, a culturally-relevant commercial tobacco cessation program to meet the needs of American Indian and Alaska Native populations. The program, launched in 2019, is designed to include high intensity behavioral and pharmacological support provided by a team of dedicated Quit Coaches with experience

working with Oregon-specific AI/AN populations. Additionally, OHA co-created culturally specific communications materials featuring members of Oregon's tribal communities to promote the new service.

Health System Strategies

- Create incentives for private and public health plans and health care providers to prevent and reduce tobacco use
- Ensure availability of comprehensive cessation benefits through private and public health plans
- Create tobacco-free private and public health plans

Public health plans in Oregon are now required to provide comprehensive tobacco cessation services. CCOs provide comprehensive cessation services that align with the standards established by the Affordable Care Act (ACA), including no prior authorization or co-pays. Public health plans offered through the Public Employees' Benefit Board (PEBB) and Oregon Educators' Benefit Board (OEBB) also meet these ACA standards. In 2016, OHA introduced an incentive metric for CCOs to reduce cigarette smoking among members. The metric provides financial incentives to CCOs to offer or improve comprehensive cessation benefits and reduce tobacco use among members. In 2018, 15 of 16 CCOs met an improvement or benchmark metric related to tobacco prevention services. In addition, two CCOs invested significant resources in tobacco prevention and cessation campaigns to further reduce use among their members.

Prevent and Reduce Obesity

Obesity is the number two leading cause of preventable death in Oregon, second only to tobacco use. Obesity related conditions account for 1,500 deaths in Oregon each year. Preventing obesity among Oregonians lowers the risk of diabetes, heart disease, stroke, cancer, high blood pressure, high cholesterol, arthritis, stress and depression. Obesity rates have continued to increase over the past five years.

Population & Strategies

- Increase the price of sugary drinks
- Increase the number of private and public businesses and other places that adopt standards for healthy food and beverages, physical activity and breastfeeding
- Increase opportunities for physical activity for adults and youth
- Improve availability of affordable, healthy food and beverage choices

Due to lack of specific funding, action on the intended policy strategies was challenged, as seen by worsening obesity rates over the past five years. No movement was made on increasing the price of sugary drinks through taxation due to minimal political support. However, in 2019 Healthy Active Oregon (HAO), a statewide obesity prevention coalition was established. One of HAO's priority initiatives is to reduce consumption of sugary beverages. While progress was made in advancing individual state agency workplace policies for physical activity, healthy food and beverages, and especially breastfeeding, no state agencies adopted a comprehensive nutrition, physical activity and breastfeeding policy.

The Farm Direct Nutrition Program (FDNP) aims to increase the amount of fruits and vegetables purchased by families who receive WIC benefits. In 2017, the Oregon legislature increased FDNP funding. Despite the increase in funding, the amount of fruits and vegetables purchased remained flat or declined slightly over the five-year period.

To increase opportunities for physical activity among children and adults, PHD leveraged partnerships with the Safe Routes National Partnership to promote Safe Routes to Schools and Safe Routes to Parks programs in Oregon. The Oregon Arthritis Program funded three Safe Routes to Parks projects and PHD staff partnered with ODE and ODOT to promote Safe Routes to School programs across the state. PHD staff also continued to provide policy guidance to state and local transportation agencies on health supportive transportation policies. In addition, in the last five years, the Oregon Legislature passed a number of bills to increase

Figure 3

Obesity prevelance among youth

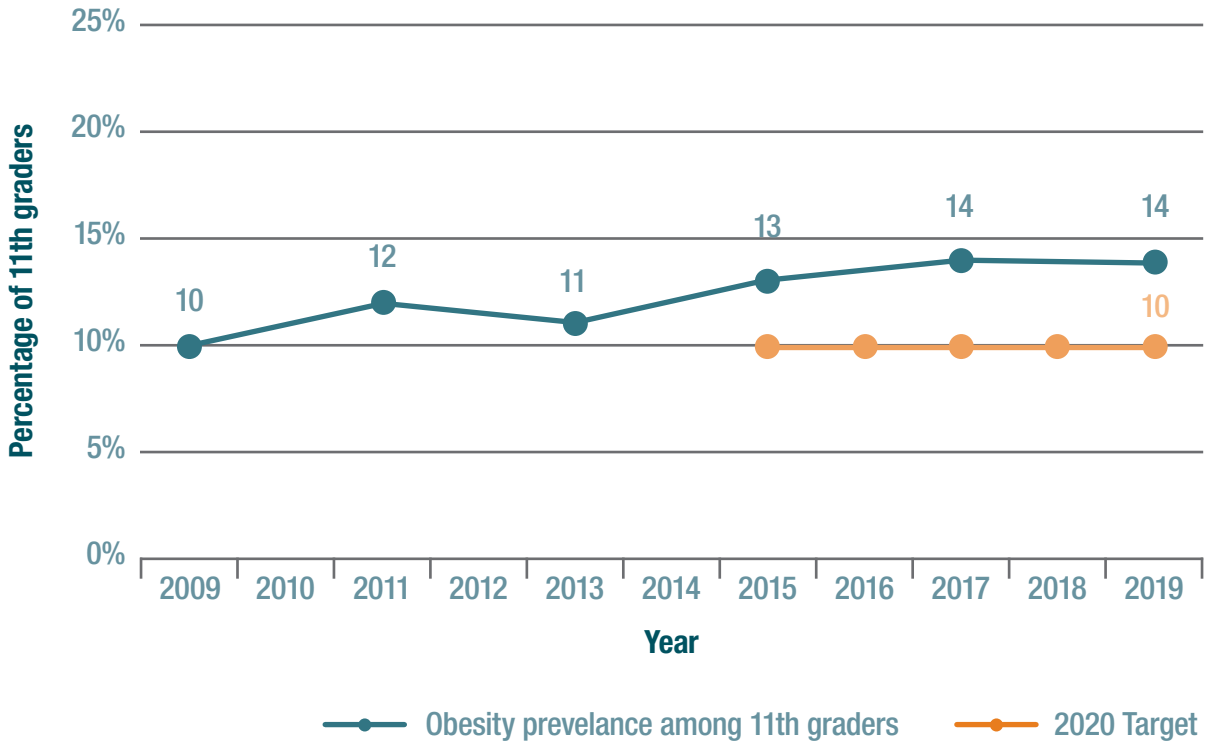
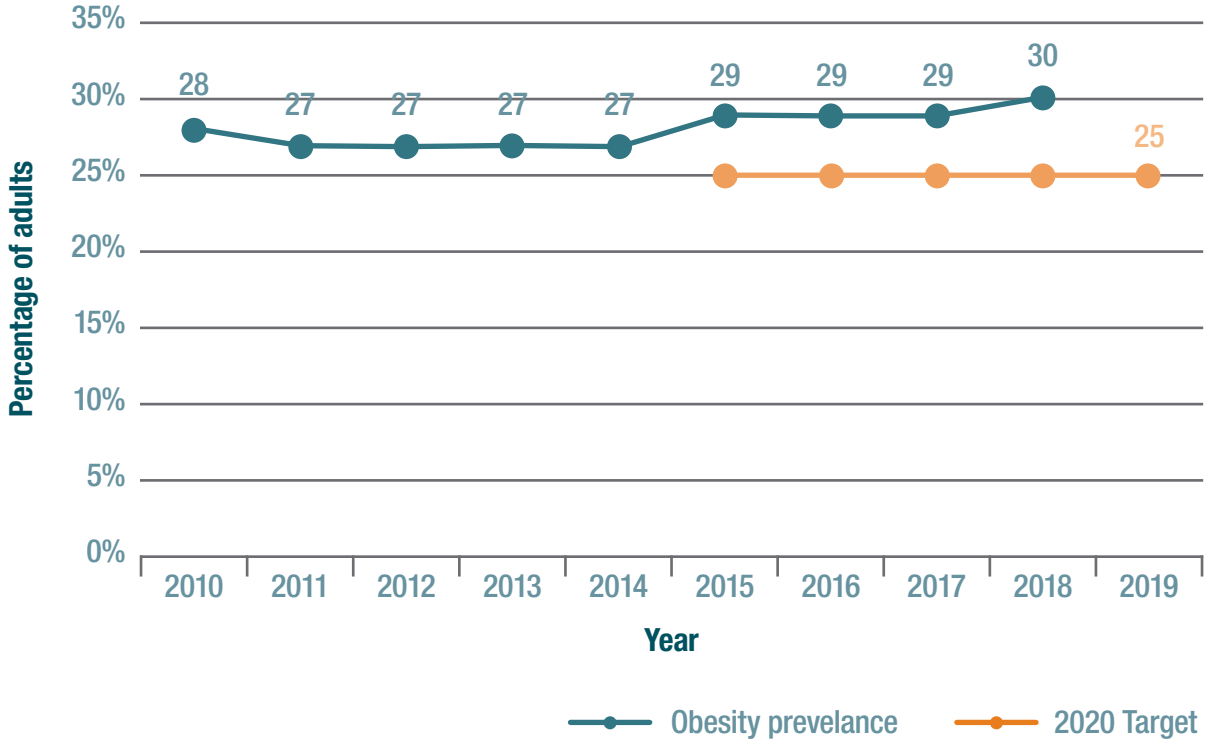


Figure 4

Obesity among adults



physical activity: SB 4 (2017) – strengthened physical activity requirements in schools; HB 2017 (2017) – Keep Oregon Moving provides investments in public transportation and infrastructure to support walking and biking; and HB 3427 (2019) – The Student Success Act allows for grants from the Student Investment Fund to be used to broaden curricular options, including access to physical education classes.

Health Equity Strategies

- Increase the number of DHS and OHA mental and behavioral health service providers that adopt standards for healthy foods and beverages, physical activity and breastfeeding for clients and employees
- Increase the number of people at high risk of type 2 diabetes who participate in the National Diabetes Prevention Program
- Increase the number of American Indian/Alaska Natives participating in evidence-based lifestyle change programs, including the Diabetes Prevention Program.
- Increase access to healthy foods in low income communities and with poor access to healthy foods
- Build capacity among culturally specific organizations and communities disproportionately affected by sugary beverage industry marketing.

Low-income communities, and some communities of color, are disproportionately affected by obesity. This is in large part due to the traumatic impacts of systemic racism and oppression, compounded by sugary beverage industry marketing, and state disinvestment in communities to ensure access to safe, active transportation and affordable, healthy food.

WIC increased availability of culturally appropriate foods in the food package benefit, enabling participants to access foods that are part of their traditional diet, such as tofu, yogurt, corn tortillas, bulgur and increased variety of dried beans.

The Diabetes Prevention Program (DPP) DPP is an evidence based, self-management program for people at risk of developing type 2 diabetes. In 2018, DPP became a covered benefit for people insured by Medicaid, PEBB and OEBB. While the number of people enrolled in DPP increased from 63 (2014) to 7,345 (2018), the number of American Indians/Alaska Natives identified participants remained stable at approximately 35 people per year. To increase access to services, OHA is funding the Northwest Portland Area Indian Health Board to work with Tribes and tribal health organizations to conduct an assessment to better understand what specific support is needed for National DPP implementation in tribal communities. Additional efforts include a Tribal Diabetes Community of Learning to determine a pathway for billing through a new Traditional Health Worker provider type, Tribal Lifestyle Coach, training new tribal lifestyle coaches and technical assistance for Medicaid billing and reimbursement processes.

Regional Health Equity Coalitions (RHEC) developed and advanced culturally appropriate and equity informed policy, system, and environment change strategies aimed at helping members of their community's eat better and move more.

Health System Strategies

- Create incentives for private and public health plans and health care providers to decrease the prevalence of obesity
- Increase the number of hospitals that meet baby-friendly standards
- Ensure coverage for weight management and chronic disease self-management programs by private and public health plans
- Adopt and implement standards for food and beverages sold or available at private and public health plans, clinics and hospitals.

OHA partnered with CCOs and other payers to support multi-sector interventions that address physical activity and nutrition. OHA conducted a pilot test of an obesity metric for CCOs and is developing implementation and evaluation plans to support a multi-sector intervention obesity prevention formal incentive metric.

Breastfeeding is a protective factor for obesity, and hospitals play an important role in breastfeeding initiation. Births in Baby Friendly Hospitals, which meet standards that support breastfeeding, increased from 32.4% in 2016 to 52.6% in 2018 according to CDC's Breastfeeding Report Card.

Reduce Harms Associated with Alcohol and Substance Use

Oregon continues to have one of the highest rates of alcohol and substance use in the country.

Population Strategies

- Increase the price of alcohol.
- Maintain Oregon's state alcohol beverage control
- Increase the number of jurisdictions covered by alcohol marketing, promotion and retail restrictions such as limiting outlet density, price promotions, and limits on days or hours of sale and point of purchase interventions
- Increase the number of colleges and universities with restrictions on alcohol promotion, sale or sponsorship at college or university events

Increasing the price of alcohol and maintaining state control are effective strategies to reduce excessive drinking, including youth and adult binge drinking, and related harms such as motor vehicle crashes, violence, intimate partner violence and liver disease and various cancers In 2018, OHA put forth a legislative concept to increase the retail price of beer, cider, and wine by 10%. While this concept did not move forward for consideration, it sought to increase taxes on alcohol and direct new revenues to alcohol and other drug prevention.

While Oregon was able to maintain control over the sale and regulation of alcoholic beverages, specifically distilled spirits, the Oregon Liquor Control Commission has a liquor outlet expansion plan that aims to expand liquor sales and increase liquor outlet density in communities throughout the state. Higher density of places that sell alcohol is associated with an increase in alcohol-related problems such as violence, crime and injuries. There is a continued public health and safety need to balance the availability of alcohol with the maintenance of state alcohol control.

In 2018, OHA conducted the Tobacco and Alcohol Retail Assessments, a statewide assessment of tobacco and alcohol advertising, marketing and promotion in locations where people shop daily. The assessment exposed the ways in which the alcohol industry targets Oregonians, particularly youth, through flavor offerings and low prices. The assessment provides a foundation to discuss how communities can take steps to limit youth access to alcohol and reduce excessive drinking by changing the rules for where and when alcohol can be sold.

Figure 5

Binge drinking among youth and adults

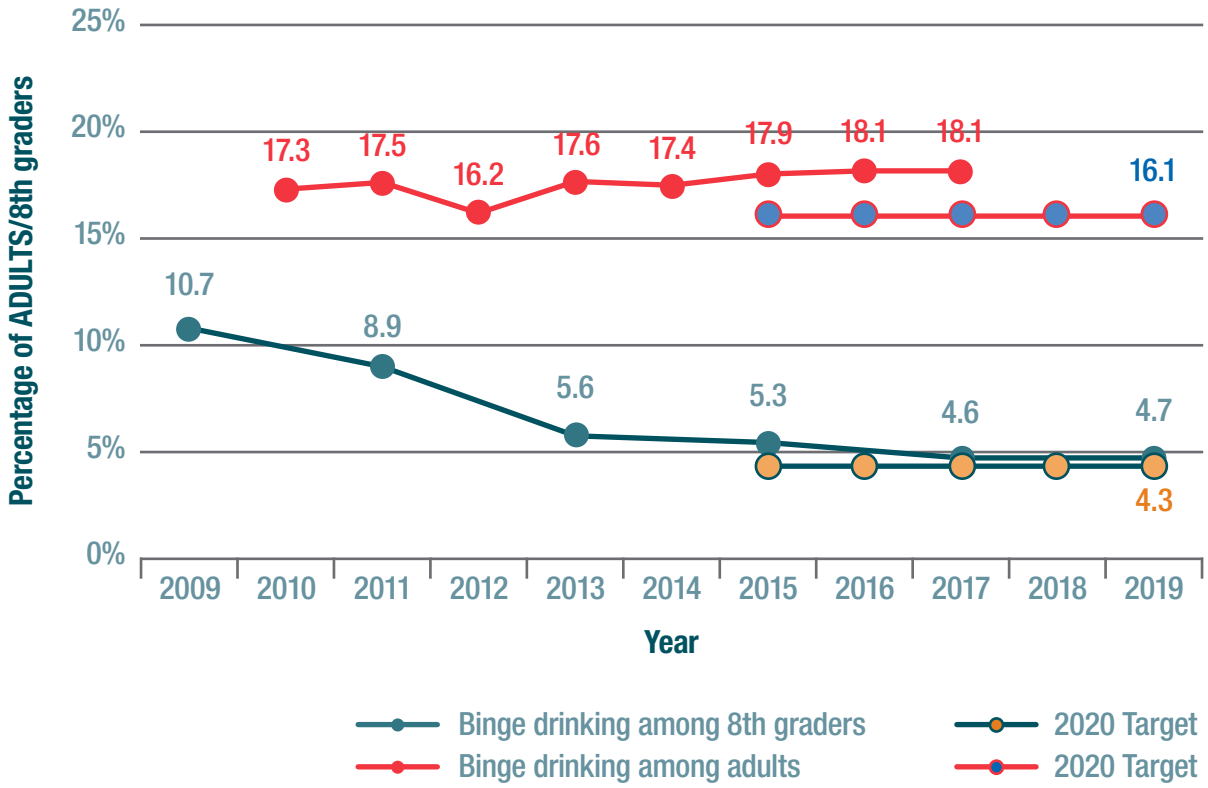
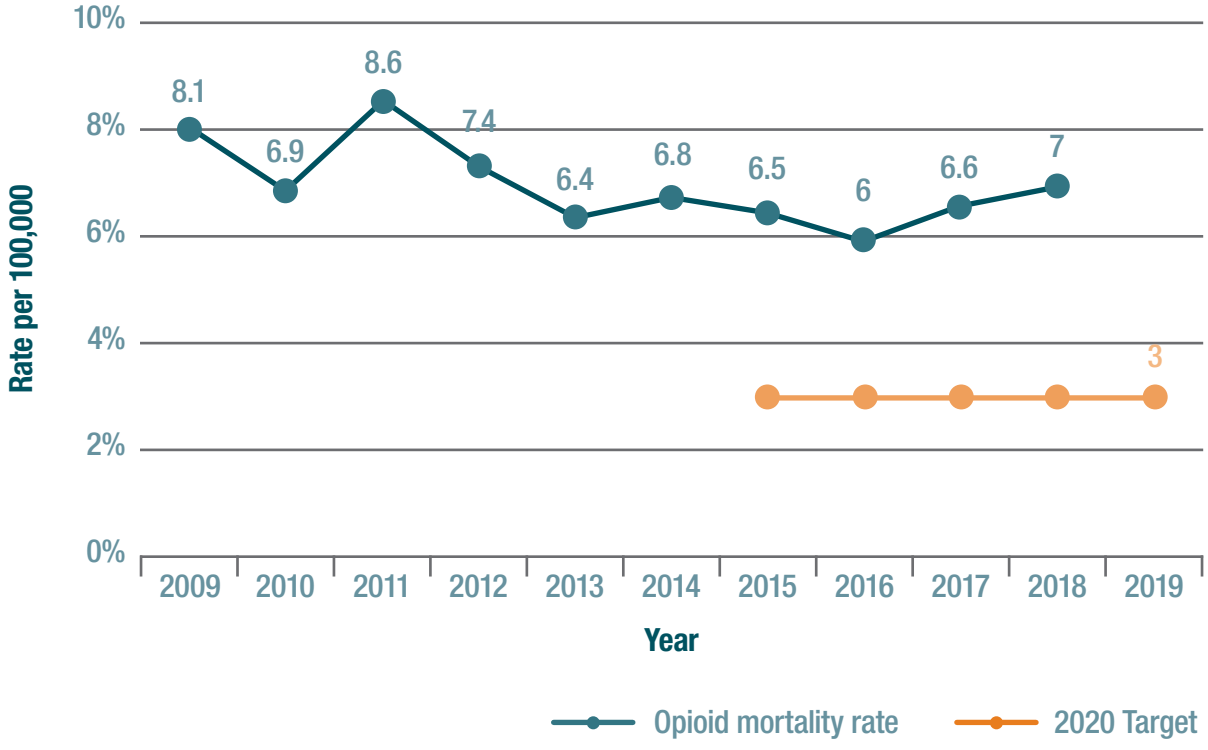


Figure 6

Opioid deaths



Health Equity Strategies

- Build capacity among culturally specific organizations and communities disproportionately affected by alcohol industry targeting
- Reduce opioid overdose deaths among American Indian/Alaska Natives

RHECs are exploring evidence-based strategies related to alcohol outlet density, pricing policies and restrictions on alcohol promotion and point of purchase interventions in communities. The OHA-PHD also sustained funding to nine federally recognized Tribes to plan and implement culturally relevant alcohol and other drug prevention strategies.

Many efforts were in place to address the disproportionate number of opioid overdose deaths experienced by American Indian/Alaska Natives. The OHA-PHD Prescription Drug Overdose Prevention Program sponsored training, planning and capacity building related to opioid prevention, treatment and recovery for nine federally recognized tribes, Native American Rehabilitation Association (NARA), Northwest Portland Area Indian Health Board (NPAIHB), Indian Health Service and Local Public Health Authorities. The 2018 Oregon Tribal Summit on Opioids and Other Drugs had 224 attendees who attended conference and planning sessions. The 2019 Oregon Tribal Opioid Training Academy provided training on a variety of topics to more than 140 attendees, including tribal best practices for wellness and recovery, addiction pharmacology, adult and youth Mental Health First Aid, community emergency response, naloxone rescue, trauma informed care, pain science, medication assisted treatment, acu-detox and the Heal Safely pain management education campaign. The annual Oregon Conference on Opioids, Pain, and Addiction Treatment included a Tribal Best Practices track, with 429 attendees in 2018 and 416 attendees in 2019. In 2019, the nine tribes and NARA also received grants of $25,000 each to support implementation of projects supporting opioid prevention, treatment and recovery.

Finally, the OHA-PHD worked with Brink Communications to launch two media campaigns related to the opioid epidemic, Heal Safely (www.healsafely.org) and Reverse Overdose Oregon (www.reverseoverdose.org). Heal Safely supports safe and effective non-opioid pain management with culturally responsive messaging for communities disproportionately affected by the overdose epidemic. Reverse Overdose Oregon is a bystander training initiative on the administration of naloxone, focused on workplaces. Brink Communications worked closely with Tribes to ensure developed materials were culturally responsive and centered in Tribal traditions. Confederated Tribes of Siletz Indians, Confederated Tribes of the Umatilla, Klamath Tribes and the Native American Rehabilitation Association (NARA) are planning to distribute a total of 2,600 naloxone-ready kits in their local communities.

Health System Strategies

- Create incentives for private and public health plans and health care providers to prevent alcohol and substance use disorders
- Reduce high risk prescribing
- Ensure public health plans expand evidence-based alternative pain management therapies for patients with chronic non-cancer pain and patients with history of substance use disorder and mental health problems
- Ensure public health plans cover a full spectrum of inpatient and outpatient services for alcohol use disorder
- Ensure availability of medication-assisted treatment for opioid use disorder
- Reduce alcohol use around the time of pregnancy

The health care system has been an important partner in addressing substance use. The Screening, Brief Intervention and Referral to Treatment (SBIRT) was a CCO incentive metric for 2015, 2016 and in 2019. SBIRT is an evidence-based practice that identifies and helps individuals who are drinking above recommended amounts. The U.S. Preventive Services Task Force, as well as many other organizations, have recommended that the SBIRT be implemented for all adults, in primary healthcare settings.

High risk prescribing of opioids has meaningfully decreased in the last five years across all measures. OHA developed Oregon Opioid Prescribing Guidelines in 2017, followed by an online pain education module for health care professionals and pain education resources for patients. The module helps both incoming clinicians and seasoned professionals develop a new understanding of pain and pain treatment. To date, more than 15,000 clinicians have completed the course, and over 70% of completers report that they plan to change their treatment approach.

Clinics have undertaken a variety of quality improvement efforts to decrease the number of prescriptions and increase alternative pain treatments for patients. OHA also expanded availability of treatment for Opioid Use Disorder by collecting data on the number of providers licensed to prescribe buprenorphine. As of April 2020, 1,300 providers fit this criterion and 57% had prescribed buprenorphine at least once. OHA expanded treatment availability to 21 opioid treatment programs (OTPs) in Oregon, with the highest concentration of buprenorphine waivered providers and OTPs geographically located along the I-5 corridor.

Improve Oral Health

Oral health has improved since 2015. The SHIP has increased awareness about the importance of oral health for overall health and well-being for all ages. Oral diseases affect what people eat, how people communicate, the way people look, people's ability to learn, and how people feel about themselves.

Population Strategies

- Increase the number of fluoridated public water districts

Oregon's largest challenge in oral health is the number of people residing in areas served by optimally fluoridated water. Community water fluoridation is the controlled adjustment of fluoride in a public water supply to prevent cavities and dental disease. Oregon has the third lowest amount of fluoridation in community water systems nationwide - 21.9% in 2018.

Community water fluoridation is an evidence-based practice recommended by the Community Preventive Services Task Force, Centers for Disease Control and Prevention (CDC), Association of State and Territorial Dental Directors (ASTDD), and Healthy People 2020. Increasing access to fluoridated water is also a significant health equity intervention since it reduces dental cavities and disease across the entire population, regardless of age, race or ethnicity, insurance coverage, access to a dentist, or the ability to pay for care. It is especially beneficial for older adults who may not have access to dental care since routine dental care is not covered under traditional Medicare.

Figure 7

Oral health among children

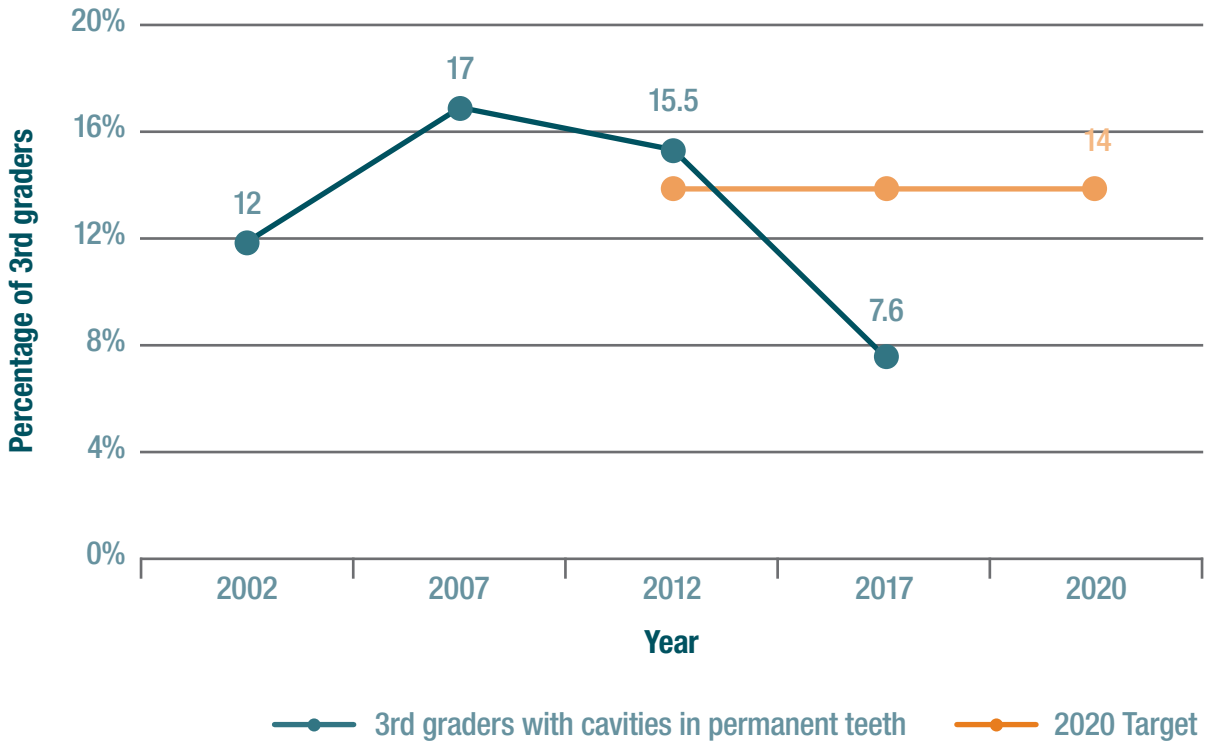
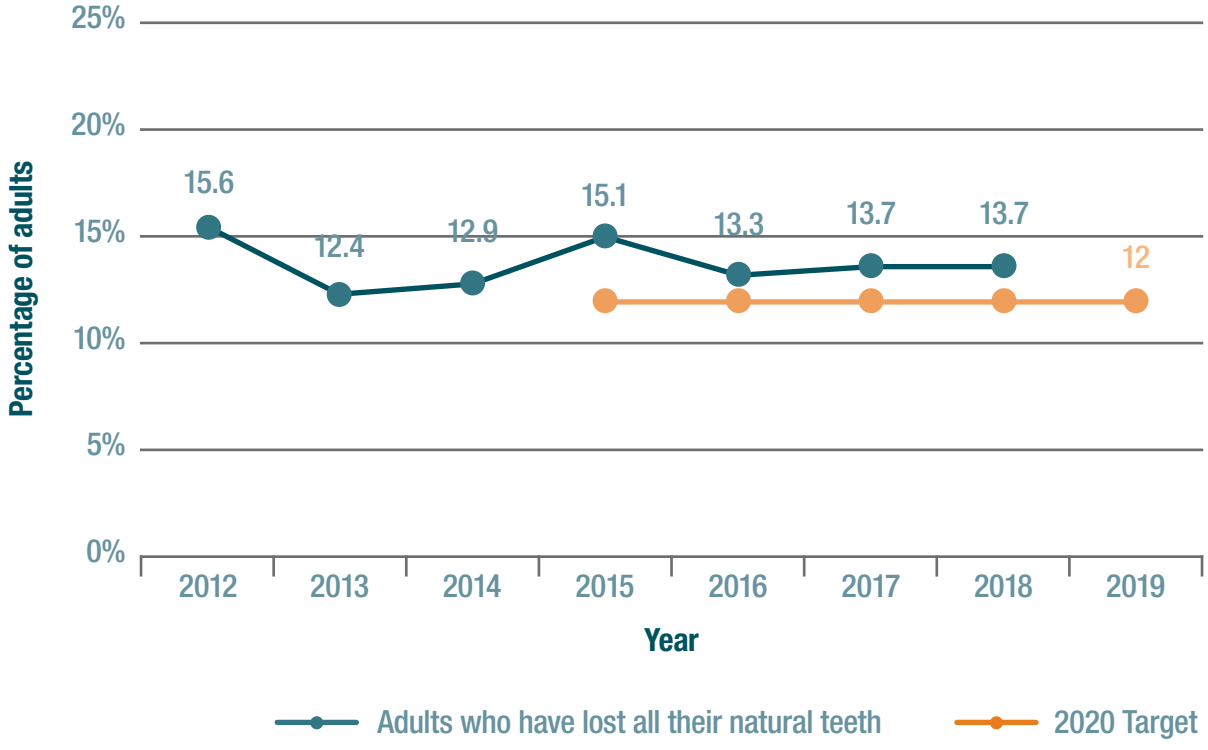


Figure 8

Oral health among adults



Health Equity Strategies

- Assess data needs for racial and ethnic disparities
- Provide oral health educational materials for racial and ethnic communities
- Provide dental sealants in schools that serve students at high risk of tooth decay
- Enhance oral health services through community clinics, including School-Based Health Centers
- Ensure that Oregon has an adequate number of oral health professionals
- Reduce the number of dental-related visits to emergency departments

Oral health services in school settings have significantly expanded. Nearly all schools with a higher proportion of children receiving free or reduced cost meals are now being offered dental sealant services. This is largely due to the CCO financial incentive metric for sealants and the ability to coordinate efforts statewide through the mandatory certification program for local school dental sealant programs.

Over the past five years, Oregon saw an improvement in oral health indicators for children ages 6-9 years old. Despite overall improvements in oral health, substantial disparities exist for children and adults based on geographic residence, household income, and race and ethnicity. The OHA Oral Health Program has applied a health equity lens, particularly in school oral health programs. Data on race, ethnicity, language and disability (REAL-D) is being voluntarily collected from those served by the statewide OHA School-based Dental Sealant Program. OHA trains school dental sealant program staff and dental hygienists from across the state on trauma informed care, health literacy, plain language and cultural responsiveness.

Health System Strategies

- Create incentives for private and public health plans and health care providers to improve oral health
- Increase early preventive care for children
- Include oral health in chronic disease prevention and management models
- Ensure dental benefit packages cover care and treatment to ensure optimal oral health maintenance

From 2015-2019, CCOs were accountable to an incentive metric for application of dental sealants, and public health had a modernization developmental accountability metric around dental visits for children ages 0-5. The message that children should have their first dental visit by age one is being widely accepted, as evidenced by an increase in children who

have received a preventive dental visit during their first two years (49.2% in 2017 compared to 43.9% in 2016). This has been most important for children insured by Medicaid due to disparities in access. In 2018, 44.6% of Medicaid children ages 0-5 had a dental visit in the past year.

OHA has been working with CCOs and LPHAs on oral health integration into physical and behavioral health, as well as chronic disease systems of care. Beginning in 2019, CCOs are accountable to an incentive metric around oral evaluation for adults with diabetes. OHA now collects body mass index (BMI) data for the Oregon Smile & Healthy Growth Survey that is conducted every five years to monitor the oral health and overweight/obesity status of Oregon children in grades 1-3. Efforts are underway to decrease HPV-associated oropharyngeal (mouth and throat) cancer. Oregon is the first state to allow dentists to administer all types of vaccinations as of January 1, 2020. OHA is partnering with the Oregon HPV Prevention Alliance and American Cancer Society to capitalize on this opportunity and increase HPV vaccination rates among dentists.

Protect the Population from Communicable Diseases

Over the last five years, there are have been significant advancements in control of communicable disease.

Population Strategies

- Reduce infections caused by pathogens commonly transmitted through food
- Reduce spread of emerging pathogens
- Reduce non-judicious antibiotic prescriptions
- Reduce and control the spread of Tuberculosis
- Identify people living with HIV who have not been receiving HIV-proficient care, and support engagement in care

On World AIDS Day 2016, OHA unveiled the End HIV Oregon plan, an ambitious plan aimed at ending all new HIV infections within five years. While the rate of new infections has remained stable, the number of people who are virally suppressed is increasing.

Health Equity Strategies

- Reduce new hepatitis C virus-associated mortality among African Americans, American Indians and other disproportionately affected groups.
- Reduce norovirus infections in long-term care facilities
- Promote routine syphilis screening for men who have sex with men
- Improve capacity to perform interviews for foodborne outbreaks with non-English Speakers
- Reduce hospital-onset *Clostridioides difficile* infection (CDI) in healthcare settings serving populations with limited access to care
- Collaborate with Tribal partners to promote communicable disease investigation and reporting to protect the health of Native Americans
- Understand HIV prevalence, risk and protective behaviors, and impact of stigma and resilience among African-American and Hispanic/Latino-identified individuals at elevated risk for HIV, including men who have sex with men.
- Improve collection of race and ethnicity data for foodborne illness cases

Figure 9

Syphilis incidence

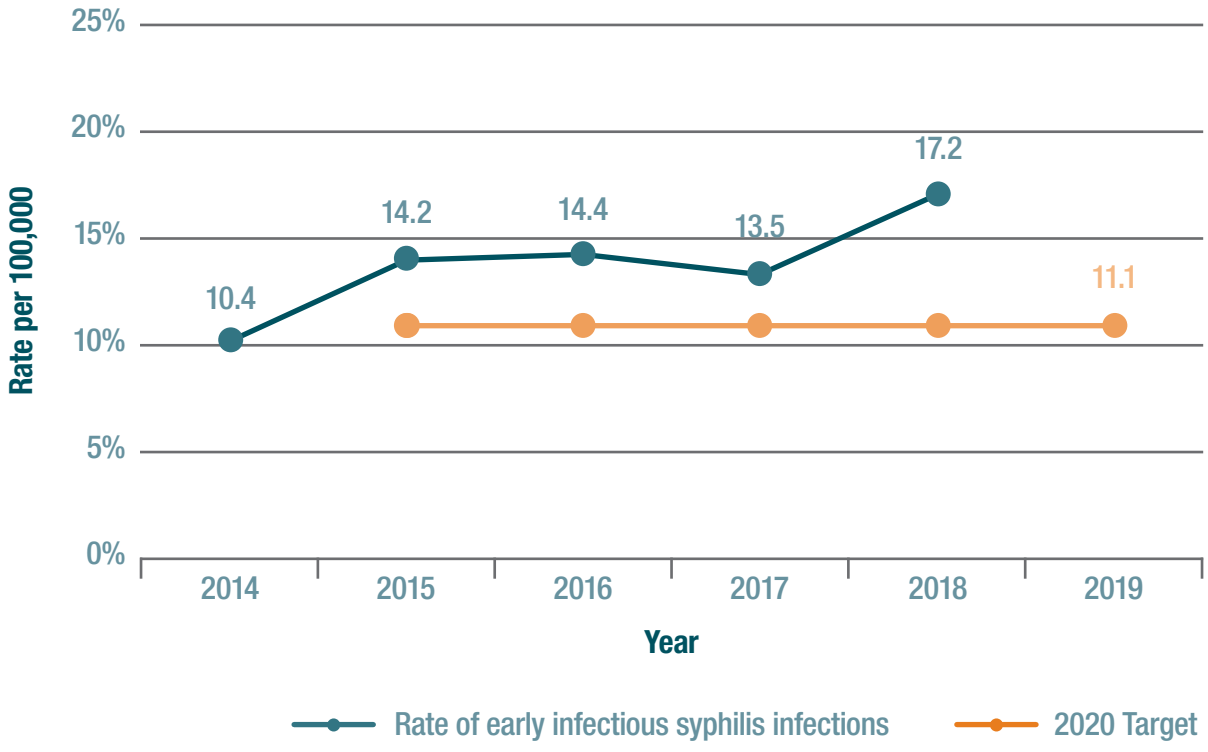
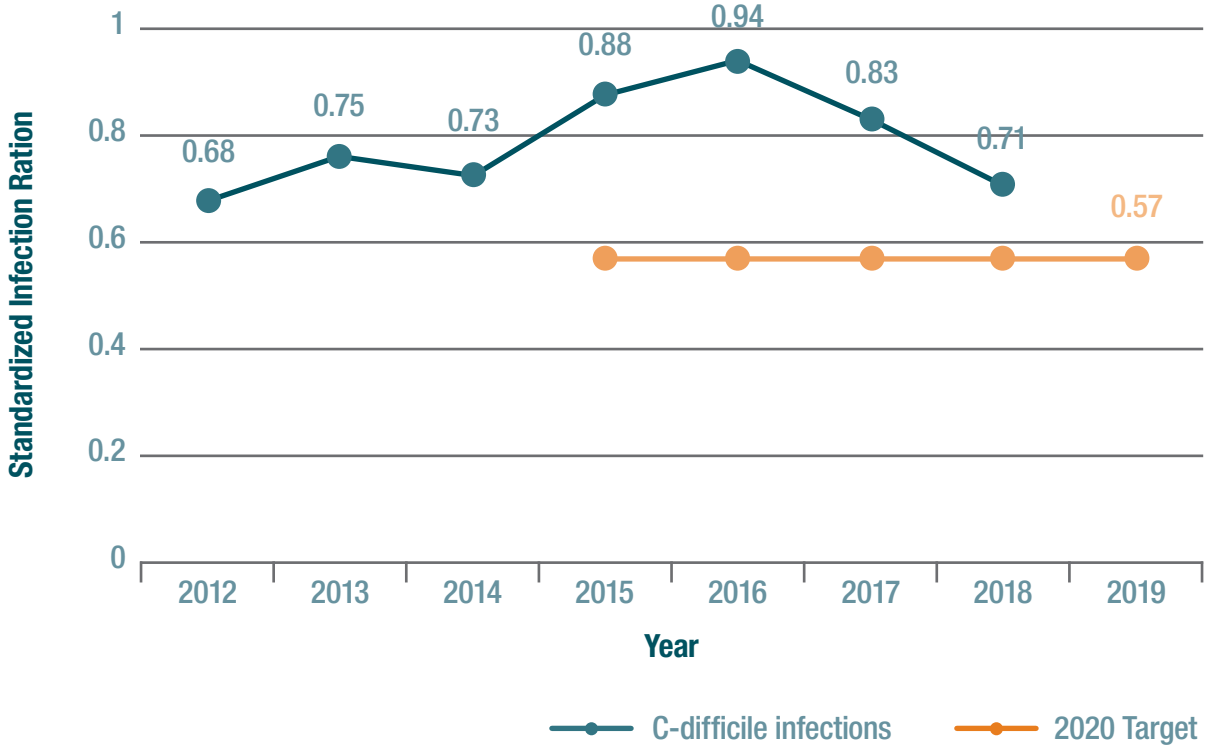


Figure 10

C-difficile early infectious infections



Deaths from chronic hepatitis C in Oregon have declined to 478 in 2018. OHA reduced barriers for use of direct-acting antiviral agents in Oregon Medicaid patients, and provided technical assistance to LPHAs, substance use disorder treatment facilities, and other non-profit organizations to promote harm reduction strategies. Despite this progress, racial disparities persist, with hepatitis C death rates highest in African Americans, American Indians, and Alaska Natives.

Over the last 5 years OHA worked with long-term-care facilities in Oregon and provided assistance with infection-control measures to improve norovirus detection and control. Through investigations, OHA confirmed the primacy of person-to-person transmission in these facilities; and provided training to improve infection-control capacity.

The state sexually transmitted disease (STD) program launched several initiatives promoting syphilis screening for men who have sex with men (MSM) while also advancing provider and public awareness of the current epidemic. STD testing was expanded for uninsured and underinsured individuals who meet certain risk criteria. The STD program issued "Dear Colleague" letters with updated syphilis screening recommendations in 2015 and 2016, timed to coincide with the launches of "SyphAware" campaigns in Portland and Lane Counties. These campaigns included public-service ads on TriMet buses and trains and development of the www.SyphAware.org website. Lastly, the two-day 2017 Syphilis Summit invited the participation of numerous stakeholders to discuss a range of issues; 63 persons attended.

Over the past two years, OHA worked with Oregon-based Tribes, the NPAIHB, and the Indian Health Service Portland Area Office to develop memoranda of understanding (MOUs) with eight of the nine Federally recognized tribes. These MOUs detail collaboration for laboratory services, immunization services, and communicable disease investigation and reporting.

OHA improved the ability to collect race and ethnicity data to identify disparities in foodborne illness. OHA now collects REAL-D -compatible data and provides training to LPHAs for collecting this information.

Health System Strategies

- Create incentives for private and public health plans and health care providers to prevent Communicable Disease
- Promote annual chlamydia screening of women aged 15-24 by health care providers
- Promote use of expedited partner therapies by health care providers and local health departments
- Improve hospital capacity to detect and prevent health care-associated infections

Critical access hospitals (CAHs) serve populations with limited access to care. From 2015 to 2018, CAHs decreased healthcare-onset Clostridium infections (CDI) from 1.32 to 0.51. This corresponds to 49% fewer infections than was predicted and it exceeds the 2020 U.S. Department of Health and Human Services (HHS) reduction target of 0.70. Over the past five years, we engaged more than 20 Oregon hospitals in the "targeted assessment for prevention" (TAP) strategy aimed at identifying gaps in CDI-related prevention practices to assist in implementing needed prevention strategies. Additionally, we recruited more than 20 hospitals to report antimicrobial-use data to the National Healthcare Safety Network (NHSN).

Patient-delivered partner therapy (EPT) was permitted for use to treat gonorrhea in 2015 and new protocols and educational materials for patients and providers were produced. In 2019 OHA began planning for implementation of a statewide pilot project to distribute EPT through LPHA sites beginning in 2020. The rate of chlamydia screening among young women as measured through HEDIS remained steady throughout the last five years but increased slightly from 64% in 2014 to 65.4% at the end of 2019. Finally, OHA promoted use of short course regimens for treatment of latent TB infection by offering education for medical providers and online toolkits.

Improve Immunization Rates

Many quality improvement efforts have led to increasing rates of immunizations, among children, adolescent and adults. Significant efforts are still needed to address the needs of communities with low childhood vaccination rates and address other immunization disparities within Oregon.

Population Strategies

- Increase the percentage of children who are fully vaccinated
- Increase the percentage of adults who receive annual influenza vaccine
- Increase the percentage of adolescents who complete the HPV vaccine series

Over the past five years, SHIP vaccination rates in children and adolescents improved. The number of providers participating in the adolescent Assessment, Feedback, Incentives, and Exchange (AFIX) quality improvement program increased significantly, including more than 20% of certified School-Based Health Centers (SBHCs). OHA and the American Cancer Society (ACS) hosted the 2nd annual HPV summit with broad participation from providers across the state. ACS also worked with the Oregon Pacific Area Health Education Center to host Oregon's first HPV vaccination week.

In addition to these initiatives, the HPV vaccination schedule was reduced from three doses to two in 2016, making it easier to complete the HPV vaccine series in a timely fashion. HPV vaccination rates increased steadily from 28% in 2015 to 51% in 2019.

Health Equity Strategies

- Increase flu vaccination in priority areas and populations.
- Improve Tdap and flu vaccinations in pregnant women.
- Increase the rate of 2-year-old who are fully vaccinated by race and ethnicity
- Increase adolescent (13 - 17) HPV completion rate by race and ethnicity

Figure 11

HPV vaccination rates among youth

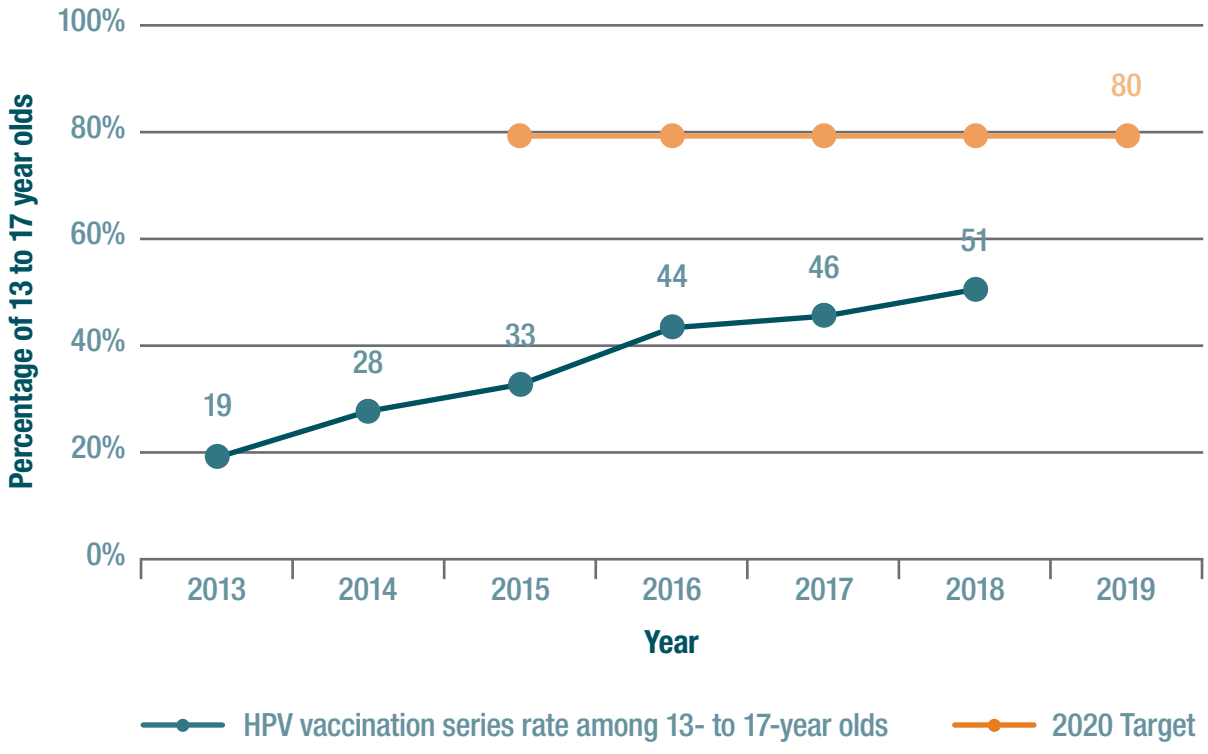
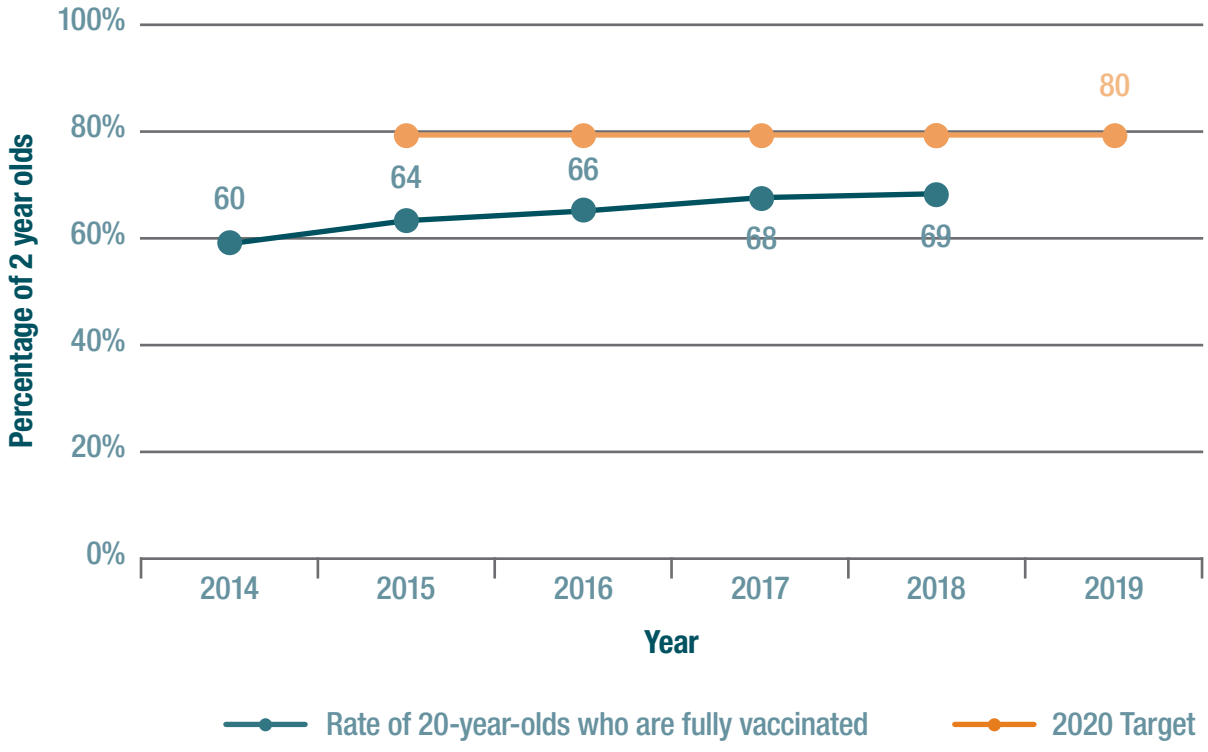


Figure 12

Immunization rate among 2 year olds



OHA and many clinical and health system partners throughout Oregon have worked to make flu vaccine available to uninsured adults and vulnerable populations through the OHA Flu Pool project. The flu pool program has grown each year since 2016 and helped foster partnerships with LPHAs and clinics focused on improving flu vaccination rates and access for people who are unable to afford it. During the 2019-2020 flu season, more than 60 providers participated in this project and OHA distributed more than 9,500 doses of flu vaccine. Disparities in flu vaccination rates between Latinx and other populations have led to culturally tailored flu messaging for Latinx communities. OHA partnered with Univision for an add campaign during the 2018-19 and 2019-20 flu seasons that corresponded with an increase in flu vaccine uptake in Latinx communities.

Health System Strategies

- Create incentives for private and public health plans and health care providers to increase immunization rates
- Promote strategies for health care providers to increase delivery of on-time immunizations
- Increase flu vaccination rates among health care workers

CCOs and LPHAs participated in the AFIX and Immunization Quality Improvement for Providers (IQIP) programs. AFIX and IQIP are programs that assist providers with analyzing rates, reviewing clinic workflow, and implementing evidence-based interventions to increase immunization rates. Eleven CCOs improved their 2-year-old vaccination rates with seven meeting their more stringent improvement targets for 2018.

Prevent Deaths from Suicide

While Oregon's suicide rate has continued to increase, major funding and infrastructure improvements over the last five years show promise for future decreases.

Population Strategies

- Promote Use of the National Suicide Lifeline
- Ensure communities implement an array of services and programs to promote safe and nurturing environments

In 2014, OHA received a SAMHSA Garrett Lee Smith Youth Suicide Prevention (GLS) grant to provide suicide prevention, intervention and postvention (support after a suicide or suicide attempt) for youth to five counties (Deschutes, Jackson, Josephine, Umatilla and Washington). This work included coalition building, gatekeeper (lay person) training, continuity of care work with schools and healthcare systems and public awareness events. OHA was awarded an additional five years of funding to build on this work through 2024.

Also in 2014, the Oregon HB4124 created the Oregon Youth Suicide Intervention and Prevention Plan (YSIPP). In 2016, the Alliance to Prevent Suicide was formed to support YSIPP implementation and ensure that stakeholders, including youth and those with lived experience, are providing their perspectives and input. During the 2019 legislative session, more than $6 million was allocated through Policy Option Package 402 to fund the YSIPP. OHA also established an annual Oregon Suicide Prevention Conference since 2016. Enhanced advocacy by suicide prevention partner organizations has led to additional legislation in the past five years.

- HB 3090 (2017): Requires hospitals to conduct an assessment, safety planning, case management, and follow-up with people who present to an emergency department with a mental health crisis.
- Extreme Risk Protection Order (2017): Prevents a person who is at risk of suicide from having or getting deadly weapons, including firearms through a court order.
- SB 561 (2017), SB 918 (2019), and SB 485 (2019): Requires Local Mental Health Authorities (LMHAs) to work with other sectors and county partners to provide postvention communication and response planning in the case of a youth suicide with the goal of providing support to affected family, friends and community and prevent suicide contagion.
- SB 52 (2019): Referred to as Adi's Act, mandates every school district to write suicide prevention plans before the start of the 2020/2021 school year.

Figure 13

Suicide attempts among youth

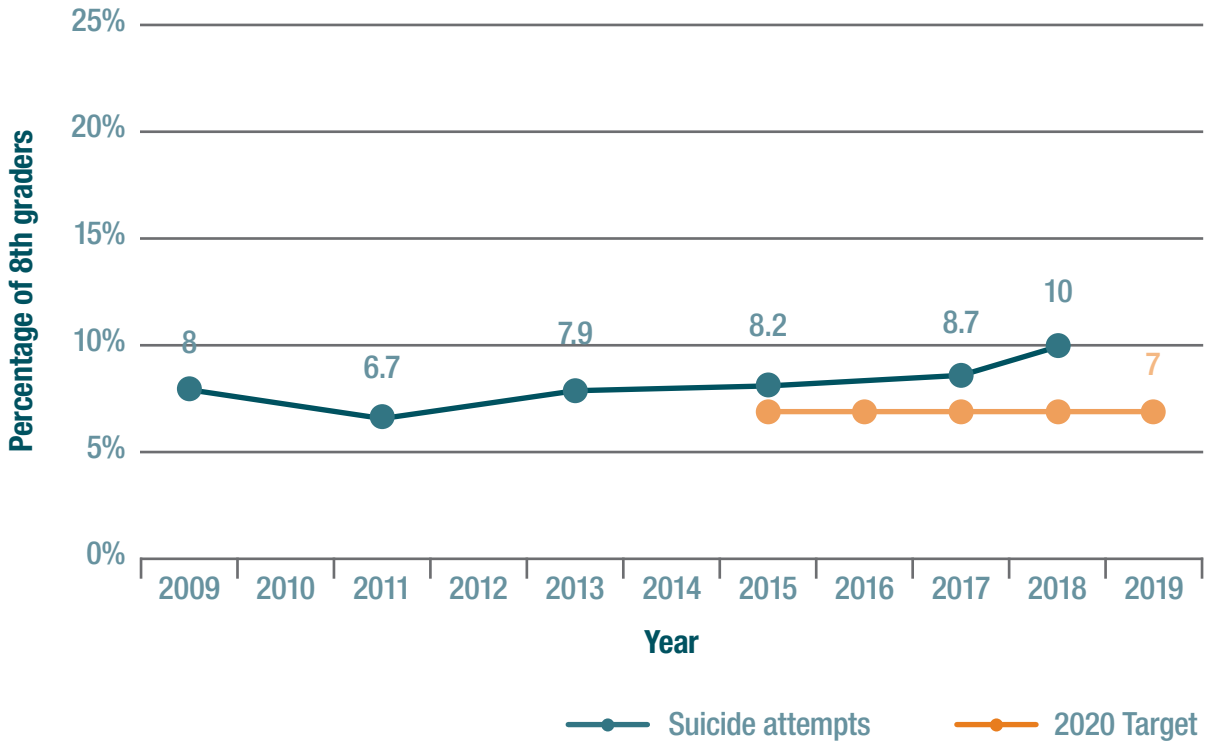


Figure 14

Suicide rate

Health Equity Strategies

- Reduce the disparity of suicide among American Indian/Alaska Natives

American Indian/Alaska Natives experience significant inequity in suicide deaths. Oregon Tribes and tribal entities were invited to attend the OHA hosted Zero Suicide Academy in September 2018. Two tribal entities, Native American Rehabilitation Association of the Northwest, Inc. (NARA) and Yellowhawk Tribal Health Center, sent teams to the two-day Academy. The Oregon Suicide Prevention Conferences have dedicated space for tribal focused presentations. These have included tribal veterans, utilizing health camps, Native American Evidence Based Practices, culture as prevention, social media for adults working with native youth, and Native American lived experience. Finally, during the 2019 legislative session, Policy Option Package 402 allocated $450,000 for tribes to increase suicide prevention efforts.

Health System Strategies

- Create incentives for private and public health plans and health care providers to prevent deaths from suicide
- Ensure training for health professionals is available to address suicide risk

In 2016, OHA began engaging healthcare systems in Zero Suicide, a bold commitment to provide suicide safer care in health and behavioral health care. Sixteen healthcare organizations attended the 2018 Zero Suicide Academy. OHA facilitated a Community of Practice (CoP) for Better Suicide Care through September 2019 and provided mini-grants to selected healthcare organizations to move Zero Suicide efforts forward. Evaluation of health care organizations participating in Zero Suicide showed substantial overall progress in Zero Suicide implementation, particularly in gaining leadership support and buy-in, training staff, and supporting patients as they transition from different levels of support and/or to other organizations for care. OHA support for Zero Suicide implementation in Oregon health care systems will continue with 2019-2024 GLS funding.

Researchers worked with both primary care providers and firearm owners in rural Central Oregon to develop and test culturally appropriate education and outreach materials on lethal means reduction. These included four brief videos for providers and clinicians about how to address firearm safety with patients at risk of suicide, which will be available for Continuing Medical Education (CME) credit in early 2020. A brochure for firearm owners

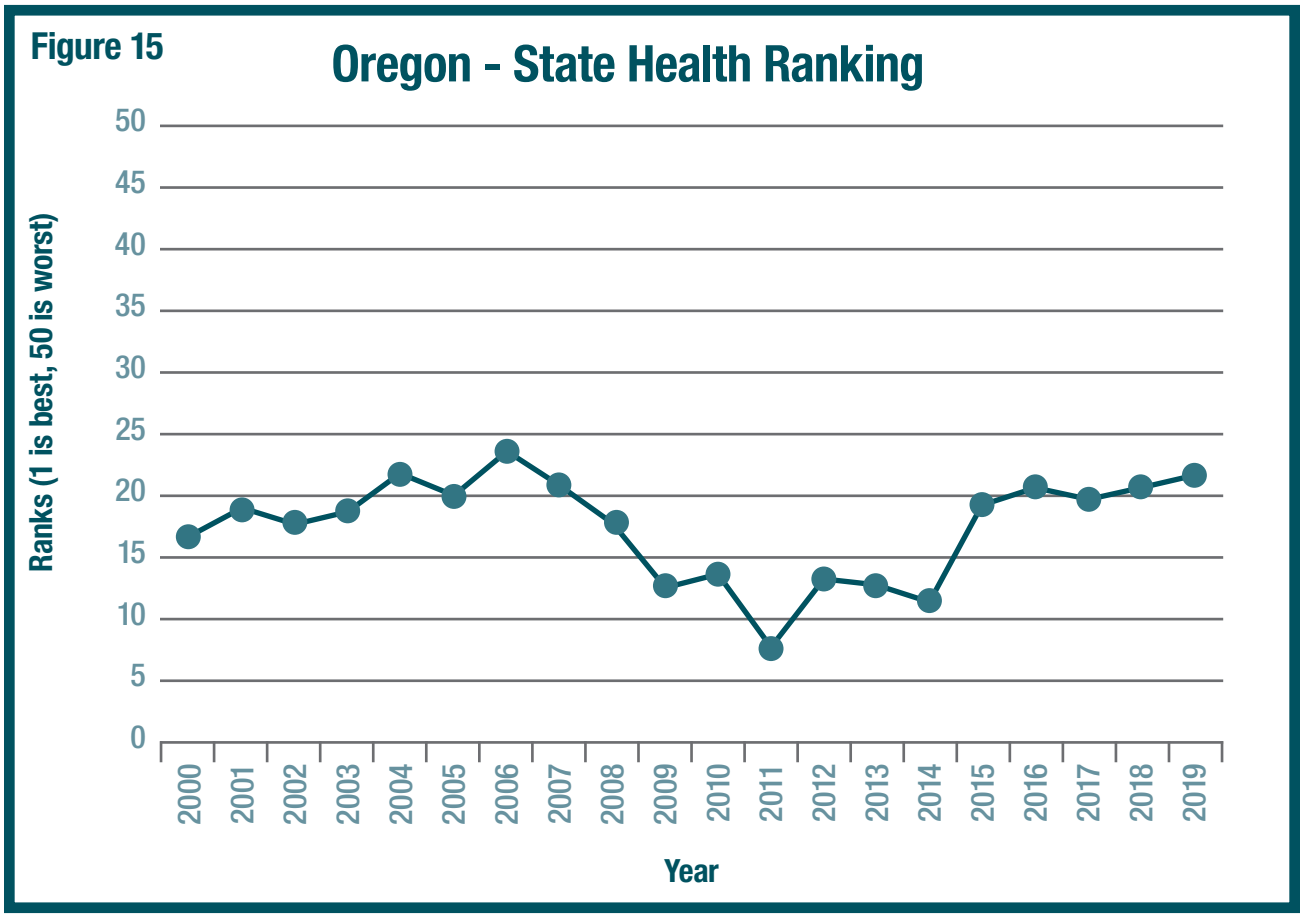
and a tip sheet for primary care providers are now available. An online course offering CME for providers on this research and its practical application, including practical implementation tools, is available online at https://www.oregonsuicideprevention.org/zero-suicide/firearm-safety/

Looking forward and the 2020-2024 SHIP

Oregon currently ranks 22nd among U.S. states for overall health (America's Health Rankings, 2019). This is down from 12th at the time the 2015-2019 SHIP was written. Although OHA had some significant gains in the last five years, OHA had difficulty turning trends in many areas. Witnessing health improvement can take decades, and many of the policy, system and environmental wins from these past five years will lead to decreased illness and saved lives in the coming years. However, even when improvement is seen in a population, that does not necessarily mean improvement for specific communities. Persistent disparities, especially based on race and ethnicity, are an important reminder of where OHA needs to focus efforts.

OHA has a clearer understanding of how it can affect change on the social determinants of health and inequities. Social determinants of health, like quality education, safe homes and neighborhoods, living wage jobs, and health care, are the primary reasons people are healthy, or not. Because of systemic oppression, discrimination and bias, people of color, people with low-income, people who identify as LGBTQ+, and people with disabilities face considerable barriers in accessing the social determinants of health. These barriers create great health disparities across the state of Oregon. More must be done to reduce the health inequities experienced by marginalized communities. Improving the health of everyone in Oregon is complex and takes time, and no single sector or agency can do this work on its own.

Figure 15



The established planning process for the 2020-2024 SHIP is a primary example of a modern public health approach. The 2020-2024 SHIP will use an evidence based planning framework called Mobilizing for Action through Planning and Partnerships (MAPP). MAPP is a community-driven strategic assessment and planning process for improving health. The State Health Assessment (SHA), published in 2018, is a result of this process. The SHA will provide primary data for the 2020-2024 SHIP.

MAPP is not an agency-focused process; rather, it relies on principles of collective impact. Collective impact uses a collaborative framework that brings together partners from a variety of sectors to enact change on an issue. Given the need to move upstream to improve health, working with other state and local agencies is critical. The collective impact framework has already enabled OHA to strengthen existing partnerships and create new ones as we work together to improve health.

The priorities of the 2020-2024 SHIP look very different than the seven priorities of the 2015-2019 SHIP. Rooted in data and community voice, the 2020-2024 SHIP will address: institutional bias; adversity, trauma and toxic stress; access to equitable preventive health care; behavioral health; and economic drivers of health, including issues related to housing, living wage, food security and transportation. Public health's work in the seven priorities of the 2015-2019 SHIP will not end here as federal and state mandates and funding mechanisms that direct much of our work will continue. Furthermore, the priorities of this 2015-2019 SHIP are all downstream health outcomes of upstream social determinants. When trauma and toxic stress are addressed, rates of substance use will decrease. When institutional bias is addressed, sexually transmitted infections and suicide attempts will decrease. In fact - the priorities of the next SHIP are all interconnected. Working collectively towards change in these priority areas will improve health exponentially. And most importantly, working to eliminate disparities will lift us all to better health.

Oregon Health Authority

You can find complete information, including progress made on specific interventions and strategies online at www.healthoregon.org/ship.

You can get this document in other languages, large print, braille or a format you prefer. Contact Oregon Health Authority at 971-673-1300 or email publichealth.policy@dhsoha.state.or.us. We accept all relay calls or you can dial 711.

OHA 8659 (08/20)

Healthier Together Oregon

2020–2024 State Health Improvement Plan

September 2020

Oregon Health Authority

Acknowledgments

- OHA acknowledges there are institutional, systemic and structural barriers that perpetuate inequity and have silenced the voices of communities over time.
- OHA is committed to partnerships, co-creation and co-ownership of solutions with communities disproportionately affected by health issues so they can actively participate in planning, implementing and evaluating efforts to address health issues.
- OHA recognizes community-engaged health improvement is a long-term and dynamic process.
- OHA is striving to engage with communities through deliberate, structured, emerging and best practice processes.
- OHA is striving to make engagement with public health effective for communities, especially those communities that experience institutional, systemic and structural barriers.

Healthier Together Oregon reflects the contributions of countless people in our state. The Oregon Health Authority (OHA) is humbled by the hundreds of partners who shared their lived and learned experiences by serving on the PartnerSHIP and related subcommittees. OHA is grateful to members of the public who responded to surveys, raised their voices at meetings and shared thoughts via email. Finally, OHA recognizes the colleagues across the agency who responded to requests for help.

Dear Colleagues,

OHA is launching Healthier Together Oregon (HTO), the 2020–2024 State Health Improvement Plan (SHIP), during extraordinary times. COVID-19 has shined a bright spotlight on the impacts of structural racism in our society. Black, Indigenous, people of color and American Indian/Alaska Native people (BIPOC-AI/AN) have lived with the effects of discrimination, bias and oppression for centuries. Their disproportionate experience of disease and death during the COVID-19 pandemic is a painful reminder of institutional failure to address historical and current racism.

The impacts of COVID-19 will be with us for years to come. HTO is a timely tool to ensure an equitable recovery from this pandemic. HTO is a tool for individuals, organizations and communities working to achieve health equity. The priorities and strategies contained within this plan get at the root causes of poor health. While the 2015-2019 SHIP addressed traditional public health concerns such as tobacco and immunizations, the priorities of HTO go further upstream to address the social determinants of health and inequities. These root causes of health include racism, economic stability, and access to quality education, healthy foods, and transportation options. These root causes of health are complex and require the focused attention of a number of sectors, including public health.

HTO is the outcome of a modernized public health system. OHA took a very different approach for developing this plan. Through relationship with trusted community partners, OHA put community in the driver's seat. The PartnerSHIP, a community-based steering committee, made the final decisions for the priorities and strategies. Those decisions were informed by public health data and qualitative stories from affected communities to add critical information to our data gaps.

While these have been trying times, the pandemic is highlighting the resilience of communities. Oregon is making national news for our efforts to undo systemic racism. OHA is committed to building off these strengths and to the strategies identified in this plan. While improving health is the work of OHA, it is not our work alone, and we look to strengthened partnerships with others who are already doing this work.

Respectfully,

Pat Allen
Director
Oregon Health Authority

Lillian Shirley
Public Health Director
Oregon Health Authority Public Health Division

Contents

Contents

Executive summary

Healthier Together Oregon (HTO) is the 2020–2024 State Health Improvement Plan for Oregon. HTO is a five-year plan that identifies our state's health priorities. It includes strategies that will lead to better health outcomes.

HTO is a tool for anyone wanting to improve their community's health. It is meant to inform community health improvement plans and state agency policies, partnerships and investments.

HTO's primary goal is to achieve health equity. Its vision reads:

> *Oregon will be a place where health and well-being are achieved across the lifespan for people of all races, ethnicities, disabilities, genders, sexual orientations, socioeconomic status, nationalities and geographic locations.*

Grounded in data and community voice, HTO identifies strategies to advance equity for these priority populations: Black, Indigenous, people of color, and American Indian/Alaska Native people (BIPOC-AI/AN), people with low incomes, people who identify as LGBTQ+, people with disabilities, and people living in rural areas.

In early 2019, the PartnerSHIP identified five priorities:

- Institutional bias
- Adversity, trauma and toxic stress
- Behavioral health
- Economic drivers of health, and
- Access to equitable preventive health care

COVID-19 has worsened the trend in each of these priorities. The pandemic has exacerbated unjust racial disparities. HTO is a tool for our state to recover from COVID-19.

More than 100 partners gathered to identify goals, strategies and measures for the priorities. They identified 62 strategies and wove them across an implementation

framework that speaks to the interconnectedness of our health priorities. HTO will report key indicators and short-term measures each year to help track and communicate our progress.

HTO is a key initiative of the Oregon Health Authority (OHA). However, OHA is not alone in this effort. We are all responsible for health. HTO welcomes new and existing partners to collectively and equitably improve Oregonians' health.

For more information about HTO and how to get involved, visit healthiertogetherOregon.org.

Introduction and background

Healthier Together Oregon (HTO) is Oregon's 2020–2024 State Health Improvement Plan. The five-year plan identifies our state's health priorities with strategies that will lead to improved outcomes. HTO's primary goal is to achieve health equity. It is a tool for anyone wanting to improve their community's health. HTO informs community health improvement plans and state agency policies, partnerships and investments.

HTO identifies strategies to advance health equity in five priorities:

- Institutional bias
- Adversity, trauma and toxic stress
- Behavioral health
- Economic drivers of health, and
- Access to equitable preventive health care.

Healthier Together Oregon

Vision

Oregon will be a place where health and well-being are achieved across the lifespan for people of all races, ethnicities, disabilities, genders, sexual orientations, socioeconomic status, nationalities and geographic locations.

Values

- Equity and social justice
- Empowerment
- Strengths-based
- Authentic community input
- Accountability

In early 2019, HTO named these priorities because they:

- Are upstream determinants of health
- Affect some communities more than others, and
- Have a major effect on our health.

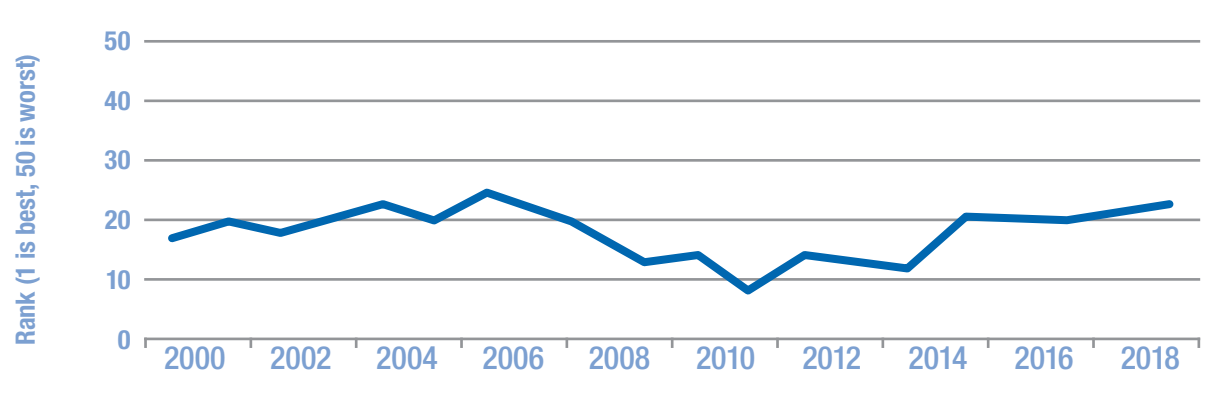
The COVID-19 pandemic has worsened the short- and long-term trajectory for health in vulnerable communities. The pandemic highlights the unjust racial disparities in each of these five priority areas. It also underscores the need for connecting, collaborating and taking care of one another. HTO is a timely tool for our state's recovery from COVID-19.

The Oregon Health Authority Public Health Division (OHA-PHD) provides backbone support and coordination for HTO. As part of requirements for public health accreditation, OHA-PHD completes a State Health Assessment and State Health Improvement Plan every five years.

HTO is a key initiative of the Oregon Health Authority (OHA). However, OHA is not alone in this effort. We are all responsible for health. HTO welcomes new and existing partners to collectively and equitably improve Oregonians' health.

According to America's Health Rankings, Oregon's state of health is declining. Since 2012, our national ranking in health has dropped, and we currently sit 22nd of 50 states for overall health.

Figure 1: Oregon health ranking among U.S. states



OHA has developed a clearer understanding of how the agency can affect change to the social determinants of health and equity. Quality education, safe homes and neighborhoods, living wage jobs, and access to health care are examples of social determinants of health. They are the primary drivers for people's good or poor health. Significantly changing people's access to these social determinants can increase all Oregonians' health and especially for the priority populations in this plan. These groups face major barriers because of systemic racism, oppression, discrimination and bias. These barriers create great health disparities across Oregon, especially in rural areas. More must be done to reduce the health inequities affected communities experience. Improving the health of everyone in Oregon is complex and takes time. No single sector or agency can do this work on its own.

Priority populations for HTO:

- Black, Indigenous, people of color, and American Indian/ Alaska Native people (BIPOC-AI/AN)
- People with low incomes
- People who identify as lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ+)
- People with disabilities
- People living in rural areas of the state

OHA's investment in modernizing the public health system will bolster Healthier Together Oregon. Developing and carrying out the SHIP is a core public health function of policy and planning. It will rely heavily on public health's other foundational capabilities. The 2020–2024 SHIP planning process is a primary example of a modernized approach to our work.

Health equity framework

HTO's primary goal is to achieve health equity for BIPOC-AI/AN, people with low incomes, people with disabilities, people who identify as LGBTQ+ and people who live in rural areas. These groups experience major health inequities because Oregon and U.S. systems that determine access to these resources are designed for people who typically identify as white, straight, English-speaking, able-bodied, cis-gendered and male. People at the intersection of more than one affected community, e.g., people who are Black and transgender, find these systems especially oppressive and hard to navigate. People in power positions may not be intentionally racist. However, our systems are racist because of implicit and institutional bias.

Health equity:

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class or the intersections among these communities or identities or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address:

- The equitable distribution or redistributing of resources and power, and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

(Oregon Health Policy Board – Health Equity Committee, 2019)

In Figure 2, the fence illustrates structural racism and discrimination. The fence was erected centuries ago, with our national and state history of genocide, slavery and exclusion. Although these overtly racist actions are now a part of our past, this fence is still standing today as seen in countless examples of modern-day racism and discrimination. As shown in the "Equality" section, the fence continues to make it impossible for some of us to see the field, which contains the social determinants of health. The social determinants of health are the primary drivers of our health. To ensure everyone's access to the field, we can take two steps. The first is "Equity," or equitable action, which redirects resources to oppressed communities as seen in the shifting of boxes to uplift the most marginalized.

Figure 2: Equality, equity and liberation

Equality

This image depicts EQUALITY. All individuals are being treated equally with the same supports. As shown, not all start from the same position; some have a height advantage. This challenges the assumption that everyone benefits from the same supports.

Equity

This image depicts EQUITY. The people are being treated equitably. It demonstrates that when different individuals are given different supports, it makes equal access possible for all of them.

Liberation

This image depicts LIBERATION. The barriers have been removed and supports are no longer needed. The inequity has been addressed.

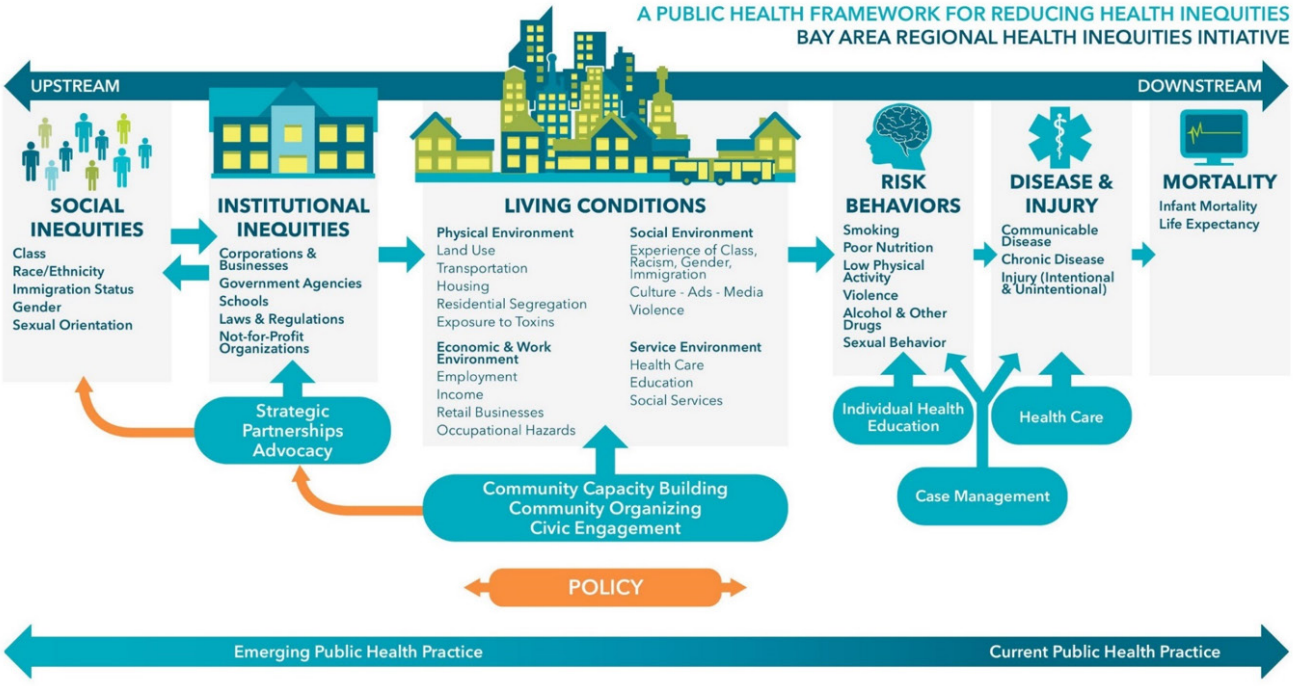
Second, we need to tear down the fence, or dismantle the institutional bias that has created these barriers in the first place, leading to liberation for us all. It is only when we remove the fence that everyone can see the field or access the social determinants of health.

Figure 3 illustrates how the upstream social and institutional inequities (the fence) lead to impacts on our living conditions (ability to see the field), and downstream behaviors and health outcomes. The strategies of HTO will enact change in partnerships, policy and investment to affect improvement in inequities and living conditions. Enacting equitable change in the social determinants of health will lead to improvements in downstream health outcomes. These improvements will come from increased access to the personal and community resources needed for health as well as changes in health behaviors used to cope with the trauma and toxic stress of oppression, discrimination and inequities. These changes will ultimately lead to flattening disparities in disease, injury and death, and to improving life for us all.

The COVID-19 pandemic has reminded us of the urgent need to end race and other identity-based inequities. While the road to liberation is our ultimate destination, undoing and redressing centuries of oppressive systems will take time. The equitable strategies and actions provided in this plan provide immediate solutions for the next five years to ensure an equitable recovery from COVID-19.

Figure 3: Public health framework for reducing health inequities

(Reproduced with permission from the Bay Area Regional Health Inequities Initiative)

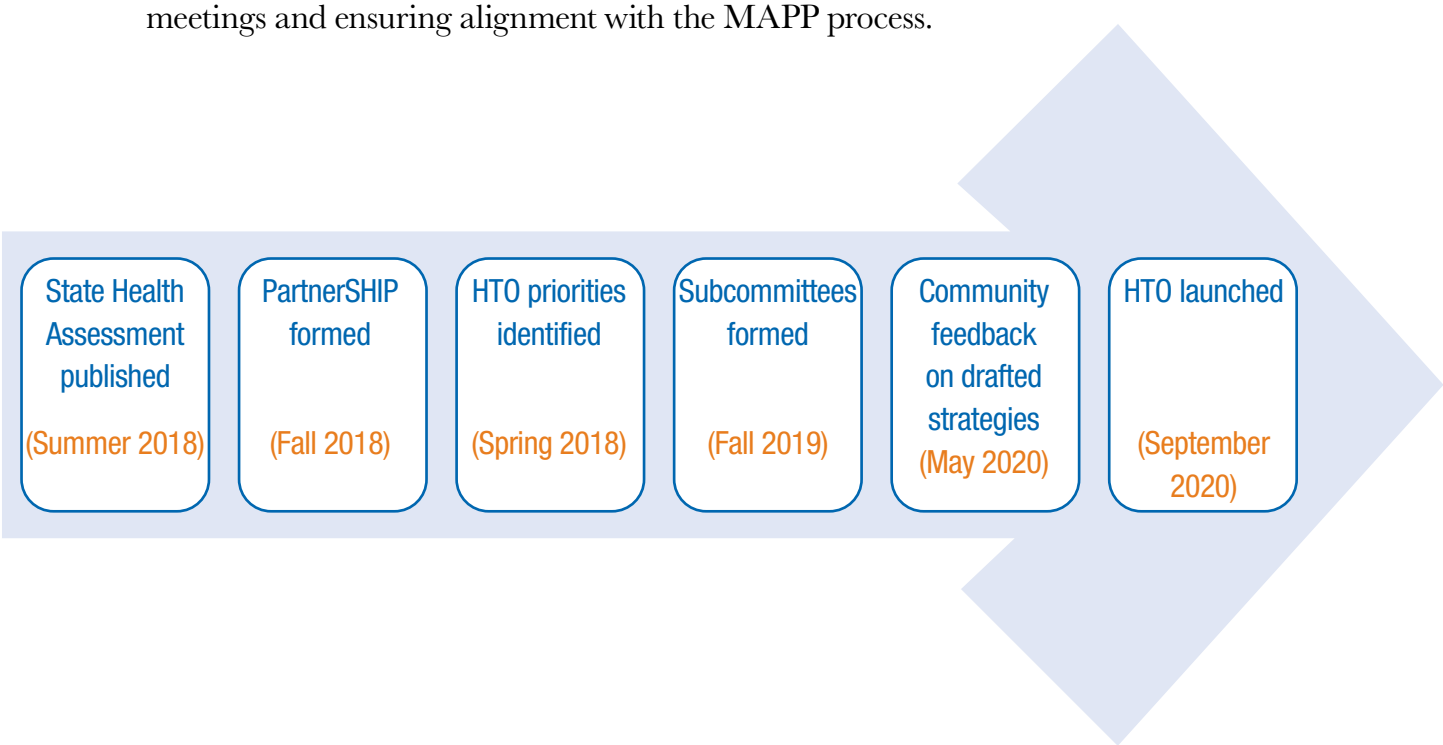


Process of development

The Oregon Health Authority designed HTO as a community-driven strategic planning process for improving health, using the Mobilizing for Action through Planning and Partnerships (MAPP) framework. The MAPP framework informed the 2018 State Health Assessment (SHA) and the planning process for HTO. The PartnerSHIP, a community-based steering committee, formed in 2018 to provide guidance, direction and decision-making for Healthier Together Oregon. The PartnerSHIP is made up of agencies serving priority populations and potential implementers of the plan. The PartnerSHIP set the vision and values, and identified the five priorities for the plan based on State Health Assessment and Indicators data and extensive community feedback.

In fall 2019, subcommittees formed with people from more than 68 organizations representing public health, health care, social services, education, academia, transportation, housing and the business community. Subcommittees were charged with identifying goals, key indicators, strategies, short-term measures and activities to inform implementation.

Finally, a core group of staff within OHA-PHD provided overall coordination support to the planning process, staffing the PartnerSHIP and subcommittee meetings and ensuring alignment with the MAPP process.



HTO included significant community input. Two community feedback processes occurred during development: the first identified priorities and the second informed strategy development. Community-based organizations that work in and with affected communities received funding to amplify their voices. OHA also disseminated surveys in English and Spanish through partners around the state.

Implementation and accountability

HTO aims to affect change in complicated, persistent social problems. The Oregon Health Authority, under direction of the PartnerSHIP, will provide overall coordination for this work. However, HTO will only make progress in partnership with others. This plan aims to be a tool for agencies and organizations to work together, align efforts, and share what's working and not working to improve health.

The PartnerSHIP will provide oversight and direction throughout HTO's implementation. As the advisory body to OHA-PHD, the Public Health Advisory Board will also support implementing the strategies and advising on funding to implement HTO.

HTO will broadly share annual progress reports. This will provide:

- A summary of actions undertaken in strategy implementation
- Updates to measures and indicators, and
- Revisions to annual work plans.

OHA hopes this annual reporting will provide effective and meaningful accountability for partners engaged in this work. OHA also hopes this reporting will ensure transparency for affected communities to whom this work is ultimately accountable.

Community-based organizations that helped inform HTO

BIPOC-AI/AN communities

Self Enhancement, Inc.; Portland metro area

Northwest Portland Area Indian Health Board; statewide

The Next Door; Columbia River Gorge

SO Health-E; Southern Oregon

Unite Oregon; Southern Oregon

Micronesian Islander Community; Willamette Valley

LGBTQ+

Q Center; Portland

People with disabilities

Eastern Oregon Center for Independent Living; Eastern Oregon

Priorities

The PartnerSHIP identified five priorities for HTO:

- Institutional bias
- Adversity, trauma and toxic stress
- Behavioral health
- Economic drivers of health, and
- Access to equitable preventive health care.

These priorities, which affect many people with often serious consequences, are upstream determinants of downstream health outcomes and affect some communities more than others. Subcommittees identified the goals for each of the priority areas.

Institutional bias

Institutional bias is defined as the tendency for resources, policies and practices of institutions to operate in ways that advantage white, heterosexual, cis-gendered, able-bodied individuals and communities. This discrimination results in adverse health consequences for underrepresented groups, such as people of color, people with low incomes, people with disabilities and people who identify as LGBTQ+.

Goals:

- Expose and reduce the impact of institutional biases that influence health, by
- Identifying and championing work across systems, structures, polices, communities and generations, so that
- All people in Oregon are empowered and have the opportunity to participate fully in decisions to achieve optimal health.

Adversity, trauma and toxic stress

Conditions that cause adversity, trauma and toxic stress include abuse and neglect, living in poverty, incarceration, family separation, and exposure to racism and discrimination. These events have a lifelong effect on health and are correlated with things such as substance use, suicide and heart disease.

Goals:

- Prevent trauma, toxic stress and adversity through data-driven policy, system and environmental change.
- Increase resilience by promoting safe, connected and strengths-based individuals, families, caregivers and communities.
- Mitigate trauma by promoting trauma-informed systems and services that assure safety and equitable access to services and avoid re-traumatization.

Behavioral health

Behavioral health includes mental health and substance use. Oregon has one of the highest rates of mental illness in the country. Mental distress can lead to lower quality of life, unemployment and increased rates of suicide. Use of alcohol, opioids, methamphetamine and other substances have a significant impact on many families. Although described as behavioral health, these strategies are specific to mental health. While all of the priorities impact substance use, strategies related to alcohol and drug use can be found in the Alcohol and Drug Policy Commission Strategic Plan.

Goals:

- Reduce stigma and increase community awareness that behavioral health issues are common and widely experienced.
- Increase individual, community and systemic resilience for behavioral health through a coordinated system of prevention, treatment and recovery.

Economic drivers of health, such as housing, transportation and living wage jobs

Economic drivers of health include housing, living wage, food security and transportation. Poverty is a strong predictor of poor health. Many people who have a job are struggling to get out of poverty due to the high cost of living or raising a family. People living in poverty experience higher rates of premature death, houselessness, mental distress and food insecurity.

Goals:

- Increase the percentage of Oregonians earning a livable wage by raising public awareness of the correlation between health and economic sufficiency and advocating for evidence-based policies to improve economic sufficiency.

- Ensure that all people in Oregon live, work and play in a safe and healthy environment and have equitable access to stable, safe, affordable housing, transportation and other essential infrastructure so that they may live a healthy resilient life.
- Increase equitable access to culturally appropriate nutritious food regardless of social or structural barriers by addressing the underlying issues in food availability.

Access to equitable preventive health care

Despite an increasing number of people with health insurance, many are challenged to get to a health care provider or see a dentist due to provider shortages, transportation barriers or health care costs. They also may not feel comfortable with their provider due to language or other cultural difference.

Goals:

- Increase equitable access to and uptake of community-based preventive services.
- Increase equitable access to and uptake of clinical preventive services.
- Implement systemic and cross-collaborative changes to clinical and community-based health-related service delivery to improve quality, equity, efficiency and effectiveness of services and intervention.

Implementation framework

To achieve the goals, subcommittees identified 62 strategies across the five priorities. Subcommittees identified strategies within three levels of intervention:

- Individual health-related factors
- Daily living conditions, and
- The broader social, economic, political, environmental and cultural context that affects our health.

To determine strategies, subcommittees aligned with other state agency strategic plans, community health improvement plans, other state health improvement plans, and technical guidance documents provided by partners and subject matter experts.

The implementation framework weaves the strategies across eight areas. This implementation framework attends to the intersectionality of the priority areas, reduces redundancies in strategies, and provides a framework for communicating about the plan to a broad audience. This framework will also help make progress on strategies while partnering with others. Annually updated implementation plans will provide more details about the supporting activities, short-term measures and accountable partners.

The eight implementation areas are:

- Equity and justice
- Healthy communities
- Healthy families
- Healthy youth
- Behavioral health
- Housing and food
- Workforce development, and
- Technology and innovation.

Figure 4: Implementation framework

Figure 4 illustrates how the strategies, indicators, implementation areas and priorities drive toward the HTO vision of health equity.

Equity and justice

Oregon has a unique history of white supremacy. This history and current institutional racism has created disadvantages for communities that are real, unjust and unacceptable. COVID-19 has shined a spotlight on the impacts of systemic racism; COVID-19 has disproportionately affected BIPOC-AI/AN communities in infections and death. All people in Oregon feel the stress of COVID-19, but non-white communities have the most burden. To increase health and reduce inequities for affected communities, institutions need to change how they do business. We will only reach our equity goals through co-creation and power-sharing with communities.

Racial equity needs to be built into everything state agencies do. Policies and initiatives need to rectify past injustices while honoring the resilience of communities of color. Until historically marginalized populations share decision-making authority in our state, decisions will favor the dominant culture, reinforcing institutional bias and contributing to disparities. Funding needs to reflect greater investment in communities that have been affected. BIPOC-AI/AN-led committees should be funded to inform state agency plans, policies and budgets. Agencies need to collect and analyze data to understand the unique needs of communities. The following strategies have been identified to advance equity and justice:

- Declare institutional racism as a public health crisis.
- Ensure state health indicators are reported by race and ethnicity, disability, gender, age, sexual orientation, socioeconomic status, nationality and geographic location.
- Require state agencies to commit to racial equity for BIPOC-AI/AN in planning, policy, agency performance metrics and investment.
- Ensure state agencies engage priority populations to co-create investments, policies, projects and agency initiatives.
- Build upon and create BIPOC-AI/AN-led community solutions for education, criminal justice, housing, social services, public health and health care to address systemic bias and inequities.
- Require all public-facing state agencies and state contractors to implement trauma-informed policy and procedure.
- Reduce legal and system barriers for immigrant and refugee communities, including people without documentation.
- Ensure accountability for implementation of anti-racist and anti-oppression policies and cross-system initiatives.

Healthy communities

Everyone wants to live in a healthy and vibrant community where people can thrive, feel safe and supported, and have opportunities for financial well-being. Healthy neighborhoods include access to healthy foods, active transportation options, safe housing, and safe places to be physically active, play and relax. Resilient communities increase social connection, especially for those affected by gentrification and in preparation for a changing climate. We will feel the economic impacts of COVID-19 for many years. We need to address barriers to higher education, finding jobs and earning a livable wage in order to create more equitable employment opportunities.

Built environment

- Center BIPOC-AI/AN communities in decision-making about land use planning and zoning in an effort to create safer, more accessible, affordable and healthy neighborhoods.
- Provide safe, accessible and high-quality community gathering places, such as parks and community buildings.
- Increase affordable access to high-speed internet in rural Oregon.
- Co-locate support services for low-income people and families at or near health clinics.

Community resilience

- Enhance community resilience through promotion of art and cultural events for priority populations.
- Build climate resilience among priority populations.
- Expand culturally responsive community-based mentoring, especially intergenerational programs and peer-delivered services.
- Expand programs that address loneliness and increase social connection in older adults.
- Develop community awareness of toxic stress, its impact on health and the importance of protective factors.

Economic wellness

- Invest in workforce development and higher education opportunities for priority populations.
- Strengthen economic development, employment and small business growth in underserved communities.
- Enhance financial literacy and access to financial supports among priority populations.

Healthy families

Raising a family is challenging. Families with young children know the childcare system is in crisis; high-quality day care and preschool experiences are unaffordable and often unavailable. There are other families who take on caregiving for older adults or for family members with disabilities, often without pay or adequate support. Despite Oregon's aspirational approach to health care delivery that includes coordinated care organizations, many families still face barriers in accessing preventive services.

We need to ease families' challenges to ensure they are supported and thriving. These strategies seek to build on family strengths, help families feel closer and more supported, and build skills in communication. These strategies also build on the gains in our health care system and seek to expand access to immunizations, harm reduction services and routine screenings provided in and outside of a doctor's office. Patients need linguistically appropriate information about their health conditions, medications and self-management of chronic conditions.

Supporting families

- Expand evidence-based and culturally responsive early childhood, home visiting programs.
- Ensure access to and resources for affordable, high-quality, culturally responsive childcare and caregiving.
- Build family resiliency through trainings and other interventions.
- Use health care payment reforms to support the social needs of patients.

Access to health care

- Increase patient health literacy.
- Expand reach of preventive health services through evidence-based and promising practices.
- Improve access to sexual and reproductive health services.
- Ensure access to culturally responsive prenatal and postnatal care for low-income and undocumented people.
- Support Medicare enrollment for older adults through expansion of the Senior Health Insurance Benefits Assistance (SHIBA) program.

Healthy youth

Educational outcomes are a critical determinant of health. Young people need opportunities for healthy upbringing and supportive learning environments. Existing structures, especially in schools, offer inconsistent access to these opportunities; COVID-19 has reinforced these school-based inequities. Addressing structural racism in the school system will have a positive impact on student well-being. Black students are twice as likely to be disciplined for disruptive behavior and more than twice as likely to be suspended or expelled. When used in place of suspension or other traditional discipline approaches, restorative justice and mediation can improve outcomes and graduation rates.

Health-related issues are a major cause of student absenteeism. Increasing school-based health services helps. Health-related screenings include asking students about their social needs, disabilities, mental health and chronic diseases. By identifying and addressing these barriers to learning, schools can help youth get to and stay in school every day. Oregon also has some of the most comprehensive health education laws in the country. These laws provide important information about preventing pregnancy, healthy relationships, preventing sexual violence, and preventing suicide. School districts need support to implement these standards.

Racial equity

- End school-related disparities for BIPOC-AI/AN children and youth through teacher training, data monitoring and follow-up with teachers, administrators and schools.
- Increase use of mediation and restorative justice in schools to address conflict, bullying and racial harassment.

Health care and education

- Ensure all school districts are implementing K-12 comprehensive health education according to state standards.
- Expand recommended preventive health-related screenings in schools.
- Ensure schools offer access to oral health care such as dental sealants and fluoride varnish.
- Provide culturally and linguistically responsive, trauma-informed, multi-tiered behavioral health services and supports to all children and families.

Housing and food

Safe and affordable housing is a primary concern for many people in Oregon. One in two Oregon households pays more than one-third of its income toward rent, and one in three pays more than half of its income toward rent. Despite legal protections from evictions, many households have less financial stability and, thus, less secure housing and food. BIPOC-AI/AN communities, in particular, face a greater housing-cost burden than other communities in Oregon. Home ownership is a major contributor to the wealth disparity seen between white families and BIPOC-AI/AN families. Convenient ability to safely walk, bike and use public transportation near home is also important for health.

Many households also struggle to afford healthy food. Oregon has one of the highest rates of food insecurity in the country, especially in families with children. Some people, especially in rural areas of the state, must travel long distances to get to a grocery store. Other people live in neighborhoods with a lot of fast-food and convenience stores, but few places to buy fresh fruits and vegetables. A resilient food system provides enough food to meet current needs while maintaining healthy systems that ensure food for future generations.

Housing and transportation

- Increase affordable housing with close access to active and public transportation options.
- Increase home ownership among BIPOC-AI/AN through existing and innovative programs.
- Require Housing First principles be adopted in all housing programs.

Food security

- Increase access to affordable, healthy and culturally appropriate foods for BIPOC-AI/AN and low-income communities.
- Maximize investments and collaboration for food-related interventions.
- Build a resilient food system that provides access to healthy, affordable and culturally appropriate food for all communities.

Behavioral health

Behavioral health describes the relationship between behaviors, physical health and overall well-being. Behavioral health includes, but is not limited to, mental health, substance use and gambling. Oregon has the highest prevalence of mental health conditions among youth and adults in the nation. Access to behavioral health care is a challenge. Communities describe many barriers related to provider shortages, long wait times, transportation challenges, and difficulty finding a culturally and linguistically responsive provider. The following strategies are specific to mental health. For strategies specific to alcohol and substance use, please see the Alcohol and Drug Policy Commission 2020-2025 Statewide Strategic Plan.

- Conduct behavioral health system assessments at state, tribal and local levels.
- Enable community-based organizations to destigmatize behavioral health by providing culturally responsive information to people they serve.
- Implement public awareness campaigns to reduce the stigma of seeking behavioral health services.
- Create state agency partnerships in education, criminal justice, housing, social services, public health and health care to improve behavioral health outcomes among BIPOC-AI/AN.
- Improve integration between behavioral health and other types of care.
- Incentivize culturally responsive behavioral health treatments rooted in evidence-based and promising practices.
- Reduce systemic barriers to receiving behavioral health services, such as transportation, language and assessment.
- Use health care payment reform to ensure comprehensive behavioral health services are reimbursed.
- Continue to strengthen enforcement of the Mental Health Parity and Addictions Law.
- Increase resources for culturally responsive suicide prevention programs for communities most at risk.

Workforce development

Oregon's demographics are changing. Our population is growing and becoming more diverse. To meet this growing diversity, we need a workforce that provides culturally and linguistically responsive services. This is especially important for those providing health and human services. Policies, standards and trainings can help to create a workforce better equipped to meet the needs of our community, especially for BIPOC-AI/AN communities. Traditional health workers are also a valuable part of Oregon's health and social support system. They often come from the community they serve and provide a critical link to services.

- Expand human resource practices that promote equity.
- Implement standards for workforce development that address bias and improve delivery of equitable, trauma-informed, and culturally and linguistically responsive services.
- Support alternative health care delivery models in rural areas.
- Create a behavioral health workforce that is culturally and linguistically reflective of the communities served.
- Ensure cultural responsiveness among health care providers through increased use of traditional health workers and trainings.
- Require all public-facing state agencies and state contractors receive training about trauma and toxic stress.
- Require sexual orientation and gender identity training for all health and social service providers.

Technology and innovation

Modernizing the health care system includes adoption of emerging technology. This includes use of electronic medical record technology, centralized referral systems that address social needs and expansion of telehealth. Telehealth can be used to address barriers to health care, including transportation, provider capacity and access to specialty care. It has proven to be a critical tool in the response to COVID-19. Most health care providers use electronic health record systems; however, it is difficult for health care providers to share data with each other. Electronic health record reminders can also prompt providers to ask questions or order tests to prevent illness or diseases. Referral and information systems such as 211 exist to address social needs such as housing, food and childcare. However, a comprehensive referral system doesn't exist. Once a referral is made, it's also challenging to follow up to ensure the person received the service they needed.

- Expand use of telehealth, especially in rural areas and for behavioral health.
- Use electronic health records to promote delivery of preventive services.
- Improve exchange of electronic health record information and data sharing among providers.
- Support statewide community information exchange to facilitate referrals between health care and social services.

Key indicators

Key indicators have been identified to indicate progress across the five priority areas. Visit the data dashboard at healthiertogetheroregon.org for definitions, baseline data, analysis by race/ethnicity and other demographic data.

Priority area	Indicator and data source
Institutional bias	Disciplinary Action (Department of Education) Premature death/years of potential life lost (Center for Health Statistics)
Adversity, trauma and toxic stress	Adverse childhood experiences (National Survey of Children's Health) Chronic absenteeism (Department of Education) Concentrated disadvantage (American Community Survey)
Behavioral health	Unmet emotional or mental health care need among youth (Student Health Survey) Suicide rate (Oregon Vital Statistics) Adults with poor mental health in past month (Behavioral Risk Factor Surveillance Survey)
Economic drivers of health	Third-grade reading proficiency (Department of Education) Opportunity Index economy dimension (Opportunity Index) Childcare cost burden (OSU Oregon Child Care Market Price Study, and American Community Survey) Food insecurity (Map the meal gap) Housing cost burden among renters (American Community Survey)
Access to equitable preventive health care	Childhood immunizations (ALERT IIS) Colorectal cancer screening (Behavioral Risk Factor Surveillance Survey) Adults with a dental visit in past year (Behavioral Risk Factor Surveillance Survey)

Conclusion and next steps

HTO is an ambitious plan. While some of the identified strategies are already in progress, much of this work is new and innovative. Certainly, the long-term impacts of COVID-19 are difficult to predict and the related economic downturn may threaten some of these ideas. The good news is that many of these strategies can happen even in the absence of funding. An equitable future is within reach by working together, aligning our goals and measures, and co-creating with affected communities. The work ahead will require brave conversations, moments of discomfort and mistakes. It will also offer opportunities for new relationships, trust building and easy wins. We will use our gains to keep pushing toward improved health for everyone. As the state agency with primary responsibility for health, OHA is poised to offer backbone support for overall coordination. But we know we won't get this right unless others join us in this effort. We look forward to your partnership as we work together to eliminate the disparities that will lift us all to better health.

Appendix

Definitions

Active transportation means walking, biking and use of public transportation.

Affordable housing is housing (rent or mortgage) that costs equal to or less than 30% of the gross household income.

Alternative health care delivery model means allowing providers such as nurses, dentists and pharmacists to deliver services that doctors typically provide.

Bias means prejudice in favor of or against one thing, person or group compared with another, usually in a way considered to be unfair. Bias happens within individuals (e.g., implicit) or institutions. Institutional bias is defined as the tendency for resources, policies and practices of institutions to operate in ways which advantage white, heterosexual, cis-gendered, able-bodied individuals and communities.

BIPOC-AI/AN is an acronym that stands for Black people, Indigenous people, people of color and American Indian/Alaska Native people. It is used to emphasize the particular racism they and their communities in the United States experience. American Indians/Alaska Native people in Oregon are citizens of the nine federally recognized tribes in Oregon or from other tribal nations outside Oregon. The PartnerSHIP approved this term in consultation with the Northwest Portland Area Indian Health Board.

Climate resilience is the ability to cope with the stress and changes created by climate change.

A **community information exchange** is a centralized referral and information system, such as 211.

Comprehensive behavioral health services mean all services provided to someone being treated for a behavioral health issue, including outreach and care coordination.

Cultural responsiveness is the ability to learn from and relate respectfully with people of your own culture as well as those from other cultures.

Diversity is the appreciation and prioritization of different backgrounds, identities and experiences collectively and as individuals. It emphasizes the need for

representation of communities that are systemically underrepresented and under-resourced. (Oregon Governor's definition)

An **electronic health record** is a software platform where your medical information is stored.

Equality is the state of being equal, especially in status, rights and opportunities

Equity is the effort to provide different levels of support based on an individual's or group's needs in order to achieve fairness in outcomes. Equity acknowledges that not all people, or all communities, are starting from the same place due to historic and current systems of oppression. Equity empowers communities most affected by systemic oppression and requires the redistribution of resources, power and opportunity to those communities. (Oregon Governor's definition)

Evidence-based means a practice that is based in scientific evidence.

Financial literacy means ability to effectively manage one's money.

Financial services include financial planning, tax services, paid family leave, debt management, savings and investment, and SSI/SSDI enrollment assistance.

Health care payment reform means changing the way health care is paid for to improve the quality of care a person receives.

Health equity: Oregon will have established a health system that creates **health equity** when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class or the intersections among these communities or identities or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power, and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

(Oregon Health Policy Board – Health Equity Committee)

Health literacy is the degree to which individuals can access and understand health information needed to make decisions about their health.

Housing First is a recovery-oriented approach that quickly moves people from houselessness into independent and permanent housing and provides additional supports and services as needed.

Human resource practices include hiring, recruitment and retention.

Inclusion is a state of belonging when persons of different backgrounds, experiences and identities are valued, integrated and welcomed equitably as decision makers, collaborators and colleagues. Ultimately, inclusion is the environment that organizations create to allow these differences to thrive. (Oregon Governor's definition)

Intersectionality is normalization and legitimization of an array of dynamics – historical, cultural, institutional and interpersonal – that routinely advantage whites while producing cumulative and chronic adverse outcomes for people of color. (Miriam-Webster Dictionary)

The **Mental Health Parity Act (1996) and the Mental Health Parity and Addiction Equity Act** (2008) require that health plans and insurers offer mental health and substance use disorder benefits comparable to their coverage for general medical and surgical care.

Neighborhoods are the physical communities in which we live and that provide housing, transportation, childcare, education, employment opportunities, healthy foods and health care services.

Preventive health-related screenings include social determinants of health, disabilities, mental health, oral health, vision, hearing and other chronic conditions.

Preventive services are health care services that prevent illness or disease. They include vaccination, contraception, harm reduction, overdose prevention, screenings and chronic disease self-management programs.

Priority populations for the State Health Improvement Plan are BIPOC-AI/AN, people with low incomes, people who identify as LGBTQ+, people with disabilities and people living in rural areas.

Public-facing means an agency (OHA, OYA, ODE, DHS, etc.) provides a direct service to people.

Promising practice means a practice that reports positive outcomes but may not have yet been studied scientifically.

Protective factors include family resilience, social connections, social and cultural supports, parenting support, and social and emotional development in children.

Resilient food system means the ability to produce and access nutritious and culturally acceptable food in the face of disturbance and change.

Restorative justice repairs the harm done by conflict or crime by organizing a meeting for the victim, the offender and the wider community.

Social determinants of health are the conditions in which people are born, grow, live, work and age. They include factors such as socioeconomic status, education, neighborhood and physical environment, employment, and social support networks. They also include access to health care. (Kaiser Family Foundation)

State Health Improvement Plan (SHIP) is a five-year plan that identifies the state's health priorities with strategies to advance improvement and measures to monitor progress.

Structural racism is the normalization and legitimization of historical, cultural, institutional and interpersonal dynamics that routinely advantage whites while producing cumulative and chronic adverse outcomes for people of color.

Support services include housing and food assistance, health care, child care, and employment, education and financial supports.

Targeted universalism means setting universal goals pursued by targeted processes to achieve those goals.

Telehealth means using information and communication technologies, such as video calls, to provide health care services.

Traditional health workers is an umbrella term that refers to health care workers who are usually from the community they serve, and have knowledge of language and culture that other providers don't have. Includes health navigators, community health workers, peer specialists and doulas.

Trauma-informed approaches acknowledge the impact of trauma and promote a culture of safety, empowerment and healing.

Trauma-informed system and services ensure safety, consistency, transparency, peer support, collaboration, empowerment, choice and cultural responsiveness.

White supremacy is the belief that white people are superior to those of all other races and should dominate society.

Workforce development and higher education includes job training, vocational programs, community college, universities and continuing education.

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