AGENDA

PUBLIC HEALTH ADVISORY BOARD

October 15, 2020, 2:00-4:30 pm

Join ZoomGov Meeting
https://www.zoomgov.com/j/1609326045?pwd=M3hGbmVMZ2RwNm1kYWJhc3Q4Tzh1Zz09

Meeting ID: 160 932 6045
Passcode: 107561

One tap mobile
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Meeting objectives:

- Approve September meeting minutes
- Adopt Health Equity Review Policy and Procedure
- Discuss COVID-19 response work by local public health authorities
- Provide input on social determinants of health screening
- Discuss public health survey modernization collaboration with communities of color

2:00-2:10 pm	**Welcome and agenda review** • ACTION: Approve September meeting minutes • Review letter from Health Equity Committee to Oregon Health Policy Board related to COVID-19 response	Rebecca Tiel, PHAB Chair
2:05-2:25 pm	**Health Equity Review Policy and Procedure** • Review updated policy and procedure • Discuss feedback from Health Equity Committee • ACTION: Adopt Health Equity Review Policy and Procedure	Rebecca Tiel, PHAB Chair
2:25-3:00 pm	**COVD-19 response update** • Discuss response activities to date • Review active monitoring strategy • Discuss equity in COVID-19 response	Jackson Baures, Jackson County Public Health Muriel DeLaVergne-Brown, Crook County Public Health
3:00-3:30 pm	**Screening for Social Needs Metric Development** • Share history and context, process, key considerations and current state of social needs measurement development • Gather high-level input to share with the SDOH Measurement Workgroup	Nancy Goff, Consultant Chris DeMars and Amanda Peden, OHA staff

3:30-4:00	**Public health survey modernization** • Share an overview of the survey modernization collaboration with the Latinx, Black/African American and Pacific Islander communities	Alyshia Macaysa, Macaysa Consulting Andres Lopez, Coalition of Communities of Color Kusuma Madamala and Margaret Braun, Program Design and Evaluation Services
4:00-4:15 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
4:15-4:25 pm	**Public comment**	Rebecca Tiel, PHAB Chair
4:30 pm	**Next meeting agenda items and adjourn**	Rebecca Tiel, PHAB Chair

Public Health Advisory Board (PHAB)
DRAFT September 17, 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, Alejandro Queral, Akiko Saito

Board members absent: Carrie Brogoitti, Dr. Dean Sidelinger

Oregon Health Authority (OHA) staff: Cara Biddlecom, Christy Hudson, Sara Beaudrault, Krasimir Karamfilov

Members of the public: None

Welcome, Anouncements, and Agenda Review
Rebecca Tiel

Ms. Tiel welcomed the PHAB to the meeting and reviewed the agenda.

- *Approval of July 2020 Minutes*

A quorum was present. Dr. Dannenhoffer moved for approval of the July 23, 2020 meeting minutes. Ms. DeLaVergne-Brown seconded the move. The PHAB approved the meeting minutes unanimously.

- *Lillian Shirley's Retirement*

Ms. Tiel informed the board that this was Ms. Shirley's last PHAB meeting. She shared that Ms. Shirley had been a member of the board since its inception. She expressed gratitude for Ms. Shirley's service in public health and wished her the best for her next chapter.

Ms. Shirley thanked Ms. Tiel for her kind words. She pointed out Oregon Public Health's north star – the State Health Improvement Plan and the Public Health Modernization Plan – and highlighted the importance of leading with race and evaluating assumptions in all work. She felt proud of the public health work in Oregon, both on the COVID-19 response and on the wildfire response over the last six months. She thanked the board members for their work in public health.

Leading with Race and PHAB Health Equity Review Policy and Procedure Update

Ms. Tiel reminded the board that one of the action items during the PHAB meeting in July was the formation of a health equity workgroup to review and look at PHAB's health equity policy and procedure. The workgroup made four changes: (1) Updated the definition of health equity to align with the OHPB definition adopted in 2019, (2) Reframed the procedure to emphasize centering equity while a work product is being developed in subcommittees, (3) Updated questions to specifically address racial equity and current and historic injustices – this aligns with the definition of equity, (4) Mirrored questions for presenters to the board with the questions for work products and votes.

Ms. Banks remarked that the alignment would allow the PHAB to have more chances for discussions about equity. While OHA staff did a lot of the work in advance, there is room for the PHAB to talk about and grapple with equity and leading with race.

Dr. Schwarz stated that the edits improved the document. He reminded the board that the PHAB started this work before OHPB settled on a health equity definition. Once the definition was in place, it was important for all subgroups under the OHPB to align with that definition. That makes it easier for organizations across the board to agree on equity issues. He suggested an edit to the alphabetized list of six items in #4 under Procedures: 4.c. begins with an adjective (i.e., *different*), while all other points begin with a verb. A verb should be placed before the adjective, so that it is a logical list of action-oriented items.

Dr. Irvin suggested to use the word *differ* instead of *different*.

Dr. Schwarz liked Dr. Irvin's suggestion and asked if a motion to approve the changes was needed.

Ms. Tiel answered that the PHAB needed to approve the document.

Ms. Biddlecom added that in terms of alignment with the work of the OHPB, after the health equity workgroup had met, she raised the subject with members of the OHPB and the Health Equity Committee (HEC). They were aware that the PHAB had had this policy and procedure since 2017. An outcome of these conversations was a real interest in adopting this policy and procedure across the OHPB and its committees, so that decisions were being made to ensure that they were advancing equity. A question that was raised at that time: Would PHAB be willing to share the policy and procedure with the HEC to get its feedback? She asked the board members if they approved that, so that the PHAB can solicit that feedback and bring it back in October for a potential motion.

Dr. Schwarz supported this proposal and added that he had shared the previous version of the policy and procedure with the Health Share of Oregon board, because it was also discussing

health equity. In those conversations, he had stressed the importance of alignment between auxiliary organizations and OHA, so that all organizations looked at health equity in the same way.

Dr. Schwartz reminded the board that he had raised an issue related to the PHAB's constitution at the board's last meeting. Now that the PHAB was approving a document in the area of health equity, he felt that the board needed to do something to include members of the minority groups that the PHAB was addressing with this policy. He is willing to give up his post, if the board finds somebody from one of the communities the PHAB is addressing. The board's approach must be consistent, so that it shows in action what it thinks in theory.

Ms. Biddlecom agreed with Dr. Schwarz and noted that the health equity workgroup talked about how this policy and procedure probably impacted PHAB's charter and bylaws. The board needs to go back and ensure that these documents resonate. Going forward, the board will link all these documents, so that they all get updated together. The point about required position on the PHAB is a discussion the board definitely can have. It comes back to conversations that Mr. Queral and other board members have raised around community engagement during the last PHAB retreat. The question is: How can the board have more opportunities to be engaged directly with community and have its work and decisions be community-informed?

Ms. Tiel stated that one area the workgroup wanted to discuss was using this policy to make a specific commitment to leading with racial equity. This is something the board discussed at its February retreat and the workgroup thought it would be better discussed with the full board. Included in the packet is one example of the City of Seattle's commitment to racial equity and rationale for why they lead with race. Questions for the board to consider: Should PHAB's commitment to equity and leading with race be just for the board, or be also on behalf of the public health system? What would the PHAB like to include in the commitment? Does the board feel the health equity workgroup needs to come back together to work a bit more on the commitment and policy and procedure before voting next month?

Dr. Dannenhoffer remarked that he was very happy with the progress the workgroup had made.

Dr. Savage shared that the paragraph that described where the PHAB was going, by putting race in the forefront of everything the board does, is different from other organizations where health equity and leading with race is often folded into policy and procedures. Leading with race deserves to be called out in its own paragraph at the front. That is the way the PHAB will change policy and put it into play.

Mr. Queral stated that this was a great opportunity to expand the conversation. Leading with racial equity has a larger forum. This is a great place to define what that means. He proposed a reason for leading with race, in addition to the three reasons of Seattle's Race and Social Justice

Initiative: creating a north star that indicates to the public health system that this may be a procedure and a way to go forward in our understanding of how public health policy affects anti-racist outcomes. He encouraged the board members to think beyond the procedures that the PHAB was adopting, as it merited much more attention.

Dr. Bangsberg commented that there had been some discussions at the OHPB between vice chair Oscar Arana and the chair of the HEC about creating a joint statement between the HEC, the PHAB, and the OHPB with the goal of a combined statement to elevate and center this work with the possibility of either sending it to OHA Director Pat Allen and Governor Kate Brown, or encourage them to write a letter to prioritize this work going forward, similar to the letter Governor Brown wrote about CCO 2.0 that identified equity, value-based care, and social determinants of health as priorities for us all to center. He asked if the HEC had reached out to Ms. Biddlecom.

Ms. Biddlecom answered that the HEC had not reached out to her. The workgroup has been working directly with Maria Castro, heath equity program analyst at OHA, who has read the draft policy and recommended bringing the document back to the HEC, knowing that there is an interest in using the same policy and procedure across OHPB and its committees.

Dr. Bangsberg added that he would like to see the HEC and the PHAB in a joint presentation to the OHPB, in terms of their collective recommendation to center and elevate this work.

Ms. Banks remarked that there was good alignment with local public health. She attended a training with Health Impact Partners at which they went over a theory of change for leading with race that was centered in public health practice. There is good synergy between the conversations that local public health systems are having and some good opportunity for alignment across the state.

Ms. DeLaVergne-Brown pointed out that it was a great training, with participants from all local health departments. The training blends well with this work.

Ms. Tiel stated that it would be good to tailor the health equity policy and procedure to public health practice and embed some of the insights from that training in the document. For Oregon, the PHAB can go a step further around leading with racial equity. It is a really good leadership opportunity. She suggested for the health equity workgroup to meet again and incorporate some of the information from the training and to ensure that there is alignment with the OHPB and the HEC.

Ms. Biddlecom offered to coordinate the workgroup again, as well as work directly with Ms. Castro, who could take the draft policy and procedure over to the HEC for their input. The workgroup will finish the draft of leading with race and move that section to the very top of the

policy and procedure, making it clear that the board is talking about the public health system and not just the PHAB. In October, the workgroup will present an updated draft to the board.

2020-2024 State Health Improvement Plan: Healthier Together Oregon
Christy Hudson (OHA Staff)

Ms. Tiel remarked that the PHAB had been tracking the development of the State Health Improvement Plan (SHIP), which launched as Healthier Together Oregon on September 2, 2020.

Ms. Hudson explained that she would like to talk about two things: a final project report for the 2015-2019 SHIP and the current state of the new SHIP. She offered four questions for discussion: (1) What lessons can be learned from the 2015-2019 SHIP? (2) How would the PHAB like to support implementation of Healthier Together Oregon? (3) How can the public health system use Healthier Together Oregon to advance racial equity? (4) How can we continue to engage affected communities in implementation?

Ms. Hudson noted that the full progress report of the 2015-2019 SHIP provided accomplishments and challenges, as well as a summary of what happened in each priority area. She added that out of the 28 data points that OHA monitored over the life of the plan, 5 of them were achieved, 11 moved in the right direction, and 12 moved in the wrong direction.

Ms. Hudson stated that accomplishments included: alignment of priorities within Community Health Improvement Plans (CHIP), public health modernization foundational capabilities and investments bolstered efforts, and CCO alignment in incentive metrics and performance improvement projects. Challenges included: race-based disparities persisted, affected communities were missing from the development and implementation process, and upstream determinants of health and equity were not addressed.

Ms. Hudson added that Healthier Together Oregon (HTO) website had been received very favorably by the community. The plan provides details about the framework and the process for developing it. The website was created with the intention to be public-facing and user-friendly for the various partners that would implementing the plan. The implementation framework consists of five components: (1) Vision: to achieve health equity, particularly racial equity, in the state (2) Five priorities, which are the state's most urgent health challenges, (3) Eight implementation areas that organize our collective work, (4) Sixteen indicators to measure the progress, (5) Sixty-two strategies, which are actions public health will take for improvement.

Ms. Hudson explained that the 62 strategies were threaded through 8 implementation areas: equity and justice, health communities, housing and food, behavioral health, health families, healthy youth, workforce development, technology and health. Each of the five priority areas has 2-5 long-term indicators for a total of 16 indicators. There are also short-term measures

that are being identified for each strategy. Some of the indicators are existing state health indicators (e.g., suicide rate). As the PHAB reviews the Public Health Accountability Metrics, it will be good to know how those metrics align with the 16 HTO indicators.

Ms. Hudson remarked that OHA collected feedback from communities on the drafted strategies. OHA funded seven community-based organizations. Despite COVID-19, the organizations were able to collect feedback. Surveys in English and Spanish were also sent out to collect feedback. Overall, the community was very supportive of the drafted strategies. Some of the feedback included interest in supporting activities to better understand implementation and in measurement and transparency in accountability. There were concerns for feasibility and misunderstanding about who the plan was for, among others.

Ms. Hudson stated that some of the next steps for implementing the plan included sharing Healthier Together Oregon with partners, reforming the PartnerSHIP for implementation, updating the Public Health Division's strategic plan, informing the OHA strategic plan, identifying strategy champions to collectively move actions forward, and developing and maintaining partnerships with other state agencies.

Dr. Savage asked if the PartnerSHIP had discussed partnering with the CCOs for the implementation. CCOs could, and should, help roll out the plan.

Ms. Hudson answered that CCOs were represented on the PartnerSHIP. Hopefully, they will be represented on the reformed PartnerSHIP. Some of the conversations Public Health Division staff have had with Health Policy & Analytics staff, especially those who support the community advisory councils and the CHIPS, were about the interest of the CHIP coordinators within CCOs to share how they were aligning the priorities, how they were digging into the strategies, and what kind of assistance OHA could provide. There is a webinar planned for CCOs and their employees who work on CHIPs on November 5, 2020, to start that conversation. The purpose of the webinar is to share information about the SHIP and get feedback, as well as to solicit ideas for what kind of technical assistance people around the state might be interested in.

Dr. Schwarz noted that all CCOs within CCO 2.0 have community advisory boards, which meant that the community was involved. When the plan gets sent to the CCO, OHA needs to ensure that it gets disseminated to the community advisory boards, which would be a natural fit for a lot of the activities. Another thing related to the CCOs is that within CCO 2.0, CCOs have a lot more flexibility in using their funds than they had in the past. Health Share of Oregon, for example, has become heavily involved in homelessness and housing issues. All these things are discussed across the CCO world at the moment. There is enormous potential for strengthening and promoting this work over the next five years.

Dr. Schwarz added that he had read the Healthier Together Oregon report, which he found beautiful. One thing that struck him was the use of words like *reduce*, *improve*, and *incentivize*

and the lack of concrete numbers for an increase or reduction. It is good to work with performance targets, so that it is clear how much it is expected to improve or decrease. The accountability metrics group was working on trying to identify some of these metrics in a more concrete manner.

Ms. Hudson answered that the SHIP team intended to set targets for the key indicators, but that work fell off because of COVID-19. It is the team's intention to set those targets. In terms of lack of detail and specificity in the strategies, there are more specifics about the short-term measures and about what it is anticipated as a result in the draft implementation plan.

Dr. Irvin asked if the SHIP team had looked at process evaluation for some of these strategies and activities, and how well they were received (i.e., quality and quantity), and how that might carry over into monitoring the strategies, activities, and programs that were being done under the new SHIP.

Ms. Hudson answered that OHA did not have any resources to do that kind of in-depth evaluation.

Dr. Irvin asked about what was done to make progress towards those targeted goals.

Ms. Hudson answered that the accomplishments were listed in the 2015-2019 SHIP report. Some of them include the tobacco priority and the increase of the price of tobacco, as well as the partnership with the healthcare system on improving immunizations, among others. In a lot of ways, the old SHIP summarized the work that was already happening in public health. It is hard to compare what was in the old SHIP with what is outlined in the new SHIP, which is very different and much more upstream, and broader than the Public Health Division.

Ms. Biddlecom added that having a plan that had statewide strategies that OHA could continuously point to was helpful in and of itself. The priorities in the last SHIP were very health outcome-focused and lacked the focus on social determinants of health. Just having something that could align a lot of different sectors is useful. For example, a key piece was the movement that was made with CCO incentive measures and align them with the public health accountability measures. With Healthier Together Oregon being much broader, engagement will be more broadly toward those shared outcomes. The development of the plan got a little further, because it included many partners with different perspectives in the planning process. Their voice developed the strategies and they are going to be partners in making them happen.

Ms. Rippeteau noted that regarding the disciplinary action indicator for Institutional Bias, there was a group of childcare providers who had been looking at disciplinary action for preschool and early childcare. The hope is to have some legislation around that in the 2021 legislative session – to work toward reducing and eventually banning suspensions and expulsions in preschool and early learning. Regarding the childcare

taskforce at the legislature is looking at the true cost of care and how the state is not covering that with subsidies for parents and not meeting the true need for families more broadly.

Ms. Hudson stated that OHA had a data source for the childcare cost burden indicator. OHA research analysts did some work on it, which is available on the Healthier Together Oregon website.

Ms. Hudson concluded that, in reforming the PartnerSHIP, the SHIP team was looking for suggestions and ideas about how to put the group together. OHA leadership feels that the SHIP team are not the people to make these decisions. One idea that has come up from conversations with PartnerSHIP members is that a small group should be formed that would include invitations to all PHAB members, HEC members, and outgoing PartnerSHIP members. The purpose of this group over a few meetings will be to come up with a list of organizations to invite to the PartnerSHIP, review the information that comes in, and make the decisions. Any interested PHAB members should contact Ms. Hudson.

Dr. Present pointed out that interesting partnerships had been formed and fostered during the COVID-19 epidemic. New partnerships have been made with CBOs (community-based organizations) and a lot of them have worked to get grant funding. A lot of partnerships are being built right now, ensuring that people's needs are met around COVID-19. As the state builds on community engagement towards public health in general, the state should build on the relationships that are being formed and fostered right now. Many of these organizations are directing public health work in a new way, and there is a lot of work local health departments are doing to understand what these organizations are doing. She encouraged the OHA team to work on those relationships as it builds the new PartnerSHIP.

Ms. Little asked about the role of the PartnerSHIP moving forward.

Ms. Hudson answered that the role of the PartnerSHIP was to inform the implementation work. The PartnerSHIP will work on the strategies and decide which ones take priority. The SHIP will be a living document and the PartnerSHIP will indicate when changes need to be made. The group will also hold partners accountable, making sure that advancements are made. There is a little bit of funding and the group will make decisions about how that funding is used.

Ms. Tiel asked if the organizations that were funded through the mini grants for engagement would continue to be utilized.

Ms. Hudson answered that many of the organizations were on the initial list that was identified by the PartnerSHIP. There are still some gaps, in terms of priority populations. OHA is uncomfortable with its position of power. OHA is looking to the PHAB and others that support it to help it figure out who needs to be at that table. For example, one idea for the next PartnerSHIP is getting someone who can represent the youth voice. It would be great,

especially if that person was a younger person. That would be a new voice for the PartnerSHIP and it has to be decided how to identify that organization or person.

2020 Public Health Modernization Report to Legislative Fiscal Office
Cara Biddlecom (OHA Staff), Sara Beaudrault (OHA Staff)

Ms. Tiel remarked that, every biennium, OHA was required to submit a report to the Legislative Fiscal Office that included the PHAB funding formula and accountability metrics report, in addition to a recap of how the biennium's funding was being used for public health modernization, and what was needed to continue the work for the next biennium. PHAB has had a hand in all the work included in this report. Typically, the report is due by June 30, but OHA requested an extension to September 30, because of the COVID-19 response.

Ms. Beaudrault explained that the public health modernization report was provided to the Legislative Fiscal Office and gave Oregon Health Authority a way to communicate its needs, priorities, and direction for the public health system. The report is broken into two sections. The first section focuses on the current investment and the current biennium. From 2019 through 2021, the report shows how OHA has distributed funds, the public health priorities, what amount of work has been funded, and where progress is being made in the public health accountability metrics. The second section of the report sets the stage for the 2021-2023 biennium.

Ms. Beaudrault noted that the executive summary listed several areas where progress was made toward the goals that had been laid out. The first accomplishment is that, for the first time, the public health modernization formula was used to allocate funds to local public health authorities (LPHAs). The formula is also used for many streams of COVID-19 funding that is going out to LPHAs. Other accomplishments include: funds are now reaching all areas of the Oregon's public health system; ongoing investments in regional partnerships are showing results; public health modernization investments have supported Oregon's response to the COVID-19 pandemic.

Ms. DeLaVergne-Brown added that the regional partnerships were showing results, but individual health departments, due to additional funding, were also showing results.

Ms. Beaudrault stated that the second section in the report for the 2021-2023 biennium touched on the priorities for the next biennium. Earlier this year, the PHAB made recommendations to OHA to continue to focus on the direction the board had set previously: to use investments for communicable disease control, focus on health equity and cultural responsiveness, address health inequities, and assessment and epidemiology. As more funds come into the system, the work will be expanded to include environmental health, emergency preparedness and response, and leadership and organizational competencies.

Ms. Beaudrault remarked that this sets the direction for where Oregon public health wants to go in the next biennium. Coupled with that, the Incentives and Funding Subcommittee worked throughout the year, deciding whether to make changes to the funding formula for the next biennium. The subcommittee decided not to recommend any significant changes to the funding formula. Funds going out to LPHAs continue to go to individual LPHAs to support their local work, but also to continue to invest in the regional partnerships.

Ms. Beaudrault pointed out that OHA estimated that an additional $68.9 million would be needed in State General Fund to accomplish the goals and priorities set by the PHAB. Once OHA had the recommendations from the PHAB, it worked with a group of local public health administrators to begin developing details for how the priorities will be implemented. This includes the specific goals within the priorities, the impacts for populations in Oregon, and the impacts for people who are systemically underserved. Starting from the PHAB priorities, OHA continues to get narrower and clearer about how it can describe that work and what investment will result in.

Dr. Dannenhoffer shared that Douglas County health department had been working with local CBOs and it had been a great start. There is a lot more work to do.

Dr. Schwarz asked if it was known where public health modernization would land in the new budget.

Ms. Biddlecom answered that there were two realities: (1) The response to COVID-19 has illustrated serious gaps in the funding for the public health system and how the system needs to be prepared to respond, whether it's COVID-19 or wildfires. Both areas are directly addressed in the report as areas to fund and build on. (2) We are in a recession and it's going to be a tight budget development process for the next biennium. Nobody knows where all that will land.

Dr. Bangsberg noted that the case had never been stronger for this work and the resources had never been fewer.

Ms. Rippeteau stated that she appreciated the bolding of the sentence for the additional $68.9 million needed to do this work. While it is going to have a lot of legislators scoffing, it is important for them to see what the actual cost is. The board members will have to buttress this work and explain why this funding is necessary and give the examples of the work LPHAs have been doing over the last few months.

Ms. Beaudrault added that the report would be wrapped up over the next few days and submitted to the Legislative Fiscal Office by the end of September. She thanked the board for its contributions to the report.

PHAB Member Discussion

Rebecca Tiel

Ms. Tiel invited the board members to share issues, ask questions, or suggest future agenda items.

Ms. Rippeteau remarked that the COVID-19 numbers in the state over the last few days had been down and the OHSU testing site at the Expo Center closed. She asked if these two events were correlated. Regarding the wildfires, she was informed that a good number of people in the immigrant communities who had been impacted by the wildfires were not seeking resources because of rumors and fear that ICE (Immigration and Customs Enforcement) was at these locations. She asked what the PHAB could do to end those rumors and help people feel safe to get the resources they needed.

Dr. Savage commented that she worked at Yakima Valley Farm Workers Clinic in Woodburn, OR, and the clinic had faced these issues when ICE was doing its raids and there was a massive decrease in care. Then and now, the clinic provided people with little laminated cards that let them know of their rights. If they were stopped, they didn't have to talk to anybody who stopped them. They just showed them a card that said *I have rights*. It alleviated a lot of fear. A lot of public education was done through the clinic and its behavioral health counselors. It would be great to mass-produce those cards and get them out to a lot of people.

Ms. Rippeteau asked if Dr. Savage had a PDF file to share.

Dr. Savage responded that she would contact the clinic and have the clinic administrator send her the file, which she would forward to the board.

Dr. Dannenhoffer pointed out that this was a scary week in Oregon. The case numbers are down, but testing is down even more, and the positivity rate is up. When the positivity rate is up, the system is not seeing what is going on. There are a lot of people out there who may have COVID-19 symptoms – dry cough, scratchy throat – who are ascribing them to smoke and are not getting tested for COVID-19. Wildfires also resulted to riskier situations, such as families taking in other families. The hospitalization numbers look about steady this week, so that is good news.

Dr. Present added that half of Clackamas County's Legacy urgent care testing sites had been down due to smoke. Several clinics that do testing have been closed due to staffing and smoke. The state lab was closed for two days due to smoke inside the building. The lab is now open. Clackamas County included asking about evacuations during COVID-19 case investigations, which is now a part of the case investigations for positive COVID-19 cases throughout the state. The state will get some information about the migration of people evacuated during wildfires. Clackamas County called every COVID-19 case it had in the evacuation zone and tried to get

them safe isolation housing, but many of them ended up with family members and new exposures.

Ms. DeLaVergne-Brown suggested that it might be nice for the rest of the board to hear what was actually happening at the local health departments and learn about the process they went through when they had cases, and how the departments were using contact tracing, so that the board members knew the work happening at the local health departments and had that viewpoint.

Ms. Little supported the idea and said that tribal health departments did things a little differently and that it would be nice to see what the LPHAs were going.

Ms. DeLaVergne-Brown volunteered to do an update of the work in Central Oregon.

Dr. Bangsberg reiterated his suggestion for the PHAB and HEC to have a joint presentation.

Public Comment

Ms. Tiel invited members of the public to provide comments or ask questions in the chat box.

There was no public comment.

Next Meeting Agenda Items and Adjourn
Rebecca Tiel

Ms. Tiel adjourned the meeting at 3:43 p.m.

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

October 15, 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

HEALTH EQUITY COMMITTEE
Kate Brown, Governor

Equity and Inclusion Division
421 SW Oak St., Suite 750
Portland, OR 97204
https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee

Memorandum

To: Oregon Health Policy Board

From: Health Equity Committee

Date: September 28th, 2020

Subject: Recommendations from the Health Equity Committee (HEC) to the Oregon Health Policy Board(OHPB) : Putting health equity front and center in the COVID-19 response.

There is no doubt that everyone—no matter their race, economic, or immigration status, gender, age, or ability—are feeling the impact of COVID-19 in some way. But communities with the least social support and those impacted most by structural racism and other inequities are being burdened at a far greater rate. People who are already targeted, marginalized, and underserved will feel the pain more than others. For these communities, COVID-19 comes on top of existing economic, health, education, gender, and information inequities and violence that has shaped their everyday lives.

As the coronavirus pandemic spreads across Oregon, data from the Oregon Health Authority indicate that it has disproportionately struck communities of color, particularly Latinx, Black and African Americans, Pacific Islander and Tribal communities.

As members of the Health Equity Committee, we are concerned that inadequate attention to health equity has and will exacerbate the epidemic in the long run. Our committee was tasked with advising the Oregon Health Policy Board on recommendations to promote an equity centered approach to this pandemic from policy to implementation.

The Oregon Health Policy Board and the Oregon Health Authority adopted in October 2019 the definition of Health Equity developed by the Health Equity Committee that states:

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.*

Based on our experience and knowledge of how social injustices produce health inequities, we urge OHPB's consideration of the following recommendations. Health Equity must drive our policy responses to the COVID-19 pandemic starting with the **following recommendations**.

OHPB should fully support efforts to declare racism a public health crisis.
Many of the ailments of communities most impacted by COVID-19 are the product of policies and practices that create an unfair distribution of resources and the systems and structures that perpetuate these policies and practices.

The 2020-24 State Health Improvement Plan, **Healthier Together Oregon**, includes declaring racism as a public health crisis as a strategy[1] . The plan states that 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".*

Oregonians with limited access to these resources and opportunities are placed at a disadvantage; they often experience worse health outcomes and reduced lifespans. The legacy of racism is that people of color, including the tribes, due to historical and current unequal distribution of resources, experience overall worse health outcomes. This is true in times of relative calm, and it is further compounded during times of crisis.

Declaring racism, a public health crisis is an essential first step in advancing racial equity and justice and must be followed by the allocation of resources and strategic action.

OHPB should request OHA to use the Health Equity definition as a guide to ensure the response is truly centered on equity.

Equity must be reflected in the Agency's response. All public policies enacted to combat the Coronavirus pandemic and the alignment between the response and the health equity definition **must be evident**.

Approaches to bring health equity to the forefront of this response must be informed by Oregon's diverse communities' health concerns and perspectives. Often, these individuals' concerns and needs are overlooked or dismissed in creating public health policies in times of need and crises. These events often amplify racial biases that are deeply rooted in our history. Historically rooted structures, processes, and practices often get in the way of equitable security and opportunity for all. We ask OHPB to recommend some immediate actions to OHA to ensure the COVID-19 response is genuinely centered in equity such as:

- Protect and expand community voice and power. In times of crisis, taking the time to provide information and listen to the affected communities may seem like a luxury. However, community engagement should never be an option. Instead, it should be an integral part of every response from the onset of an emergency.

  The HEC understands that in an emergency, time is always of the essence. Life-saving assistance needs to be provided quickly and taking the time to consult with people may seem counterproductive. However, the more information communities have, that is culturally and

[1] 2020-24 State Health Improvement Plan, Healthier Together Oregon www.healthiertogetheroregon.org

linguistically appropriate, the less chance there is of confusion and misunderstandings. If communities are involved from the very beginning (ideally before a crisis or emergency occurs), resources and services will be allocated in a way that is appropriate for the context and tailored to the community's needs.

- Develop an equity action plan to every aspect of the response, including prevention, mitigation, and recovery, and to set equity goals and indicators for each part of the response. We ask for OHPB to guide OHA to dedicate time and resources to explore the impact of COVID-19 on special populations by examining the number of positive cases, deaths, age, gender, race, geographic location, and occupation; and to draft comprehensive equity action plans to address their safety and prevention of COVID-19. This recommendation includes the need to develop a State-wide Testing Plan for COVID-19 that reflects the need to focus on the communities most impacted, and that aims for the development of clear strategies and protocols to facilitate COVID-19 testing for vulnerable and at-risk communities (symptomatic and asymptomatic). Communities of color have experienced significant barriers to accessing testing.

- Racial and ethnic health disparities and inequities can only be eliminated if we have the appropriate information needed to track immediate problems and underlying social determinants and guide the design and application of culturally specific health, social services, and public health approaches. We must also track where resources and spending are going to ensure investments (or underinvestments) don't reinforce existing disparities.

- Develop measurable objectives to monitor progress toward achieving an equity centered response and creating an equity dashboard for the response. The HEC advocates for establishing a way to measure the progress of the equity action plan response and using that information to close opportunity gaps overall and, in particular, gaps according to race and ethnicity. As the saying goes, *"what gets measured, gets changed."* We must hold ourselves accountable. **Accountability is a keystone of equity work**. We must create the instances to report back to our communities with our progress. We are also responsible for assuring our communities with actions, not words.

- Work to ensure that the COVID-19 crisis does not exacerbate existing inequities. This includes the need for recognizing that risks and burdens are often borne disproportionately by communities of color, the elderly, people with disabilities, low income, and those who live in rural areas of the State. The response to COVID-19 must be grounded on a set of values that can inform a race-centered approach to crisis response that builds upon the work of community organizers who have for many years been demanding the public services that we so desperately need at this moment.

Ensuring that populations most impacted by the pandemic have a seat at the table in planning and carrying out the responses should not be an option; it should be a requirement. Communities can and should share directly the insights needed to develop effective, sustainable strategies for their communities. OHPB and OHA should be aware that engagement with communities is an ongoing process. Our communities have excellent reasons to distrust the government and the medical/public health system - all efforts should seek to address barriers, fast-track problem solving, and include plans for open and transparent communications to ease these concerns.

The Health Equity Committee has followed OHPB's lead, and since March it has established opportunities for the communities most impacted by Covid-19 to share their concerns. During the last few months, our committee has had the opportunity to hear public comments from members of the older Oregonians, Latinx, and Disabilities communities, specifically. The following examples highlight some of the downstream impacts of COVID-19 for minority and vulnerable groups.

Disabilities communities are experiencing a disruption in services and resources due to COVID-19 that must be addressed. People with disabilities (including but not limited to physical, intellectual, cognitive, mental health, and chronic illness disabilities) are particularly vulnerable in a wide range of areas. For example:

- Services have been disrupted due to staff cuts at community-based organizations due to funding shortages,
- Personal care attendants cannot commit to entering a medical bubble with a single vulnerable client because they don't receive a livable wage,
- Limited access to PPE supplies that they need to perform daily procedures that help keep their health stable. Additionally, low-income people with disabilities living in some congregant independent living settings must supply gloves for staff who enter their apartments. They are using their limited financial resources to purchase PPE that they wouldn't need to outside COVID.
- People with disabilities also experience stigma and discrimination as they access healthcare in hospitals and clinical settings, including assumptions about a person with disabilities' quality of life, mental capacity, or ability to represent themselves independently by a provider, among other things.

Latinx communities in our State are not receiving, consistently or in their primary language, the information and resources necessary to protect themselves and their families or survive economically. The Latinx communities, including undocumented Oregonians, make up an essential part of Oregon's year-round workforce and run thousands of small businesses across agriculture, health care, food services, manufacturing, retail, lodging services, etc. Yet they are an underserved population made vulnerable due to racial and economic inequities. A whole class of people long-neglected are now deemed essential during this crisis yet are being disproportionately impacted. Due to existing inequities, Latinx people account for at least 26% of all COVID-19 cases while making up more than 13% (560,960) of the State's population[2] .

The Latinx community and other communities, such as immigrants and refugees, have experienced different challenges. There is an alarming lack of access to mental health services that are culturally and linguistically appropriate; undocumented workers do not qualify for most relief resources such as unemployment insurance; the Latinx community has experienced overall lack of access to health services because of the lack of culturally and linguistically responsive services, or lack of health care interpreters and an over-reliance on telehealth that requires access to technology and data that is often expensive, or not available because they live in rural and frontier areas of our State.

Older Oregonians are struggling. They are at higher risk of comorbidities and mortality, and housing (e.g., nursing homes, congregate settings) have been identified as hot spots for infection. Adults who were receiving home and community-based services have seen those services disrupted. They are suffering

[2] OREGON LATINX LEADERSHIP NETWORK CALL TO ACTION: PROPOSED RESPONSES TO COVID-19 http://community.statesmanjournal.com/news/OR_Latinx_Leadership_Network_Call_to_Action.pdf

from social isolation; they feel forgotten. Tools such as telehealth have proven problematic because of barriers to access to technology.
We ask OHPB and OHA to invite members of these communities as well as LGBTQ, Black, and Indigenous communities to the table and engage in creating informed community solutions that can be implemented promptly.

The evidence from history is clear. The movement toward equity has always required health equity champions to fight from inside. Unless our responses to the COVID-19 pandemic challenge its racial framing and prioritize the needs of racial/ethnic minorities, immigrants, and other vulnerable groups, COVID-19 is likely to persist in these pockets of our society.

Equity must be our priority today. If equity is only a priority in times of ease and surplus, it was never really a priority. This is the time to show the community that we hold true to these commitments.

Signed by Health Equity Committee Co-Chairs on behalf of members of the Health Equity Committee.

Kate Wells
Co-Chair

Derick Du Vivier, MD, MBA
Co-Chair

Cc: Rebecca Tiel, Chair. Public Health Advisory Board, October 15, 2020.

Health & Transportation: Partnership Accomplishments

July 2017 – June 2019

Oregon Department of Transportation

Oregon Health Authority

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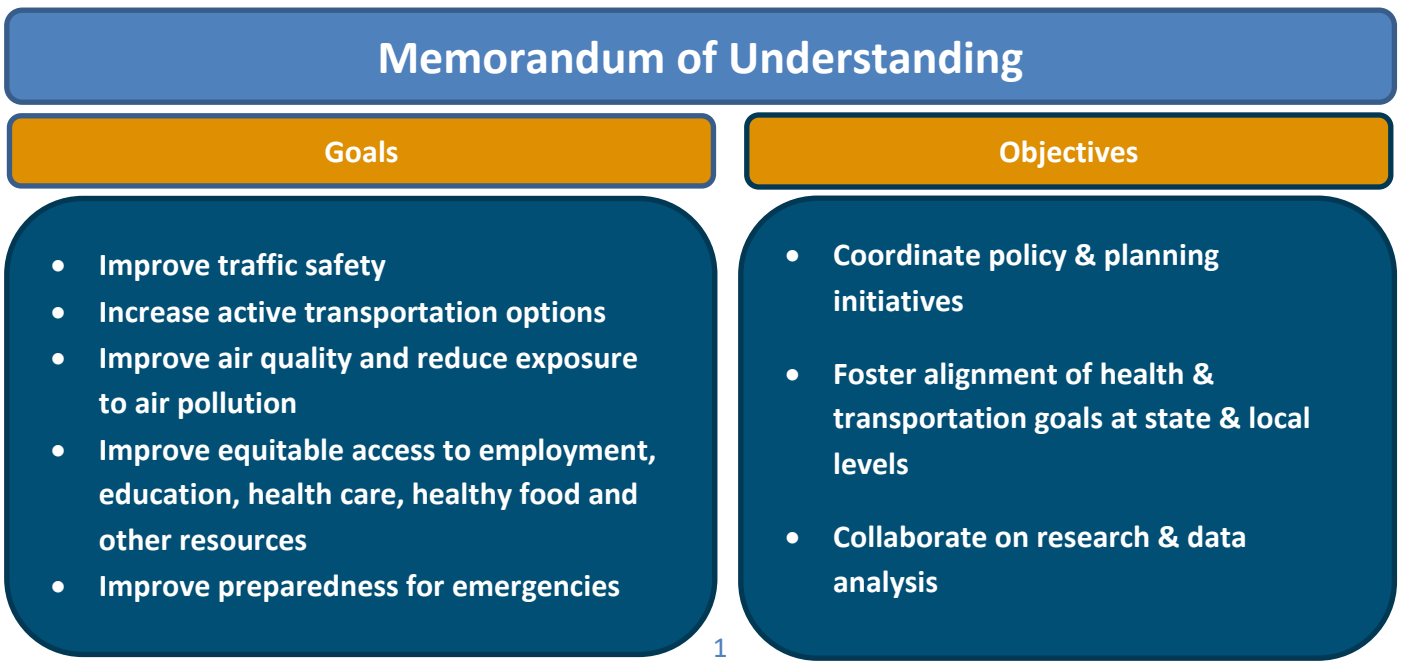
Introduction

History of the Partnership

Health and transportation are both critical to safe, livable and resilient communities across the state. The Oregon Department of Transportation (ODOT) and Oregon Health Authority – Public Health Division (OHA-PHD) are the two agencies in Oregon specifically dedicated to creating, implementing and maintaining mobility that supports Oregonians equitable access to jobs, schools, health services, community centers and more. By working together and leveraging efforts, ODOT and OHA-PHD can maximize the returns on the public's investment to improve health, transportation, and quality of life for Oregonians.

Transportation policy, infrastructure and decisions directly impact health in many ways: they affect exposure to air pollution, injury risk, physical activity levels and access to health supportive resources such as food, living wage jobs and education. To address these issues, ODOT and OHA-PHD reconfirmed a voluntary bi-agency agreement in 2018, first established in 2013, committing to work collaboratively to identify, develop and promote connections between public health and transportation. Staff and leadership from both organizations have collaborated to advance shared objectives related to improving the health and livability of Oregon communities, focusing activities consistent with the updated memorandum of understanding.



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Notable Partnership Activities

Coordinate Policy & Planning

Convening of Partnership Decision-Making Bodies

In June 2019, The Oregon Transportation Commission (OTC) participated in a joint workshop with Oregon Health Authority's Public Health Advisory Board (OHA-PHAB) to discuss the intersection of transportation, public health and social equity. The workshop had three objectives:

- Establish an understanding of the intersections between transportation, public health and social equity between the two decision-making bodies.
- Demonstrate why these intersections are important for both agencies and how it influences the work they do for communities throughout Oregon.
- Engage in a conversation about how both agencies can address these issues through the bi-agency partnership and memorandum of understanding, reconfirmed in 2018.

The workshop featured a nationally recognized speaker, Charles T. Brown, known for encouraging social equity in transportation. This was the first time the governance bodies convened to discuss opportunities of the partnership. A similar discussion was held with staff representing both agencies, further refining the dialogue that took place between the governance bodies.

Source: Charles Brown Workshop. June 20, 2019.

Joint Committee Participation

OHA-PHD staff, as well as, other public health stakeholders served on ODOT convened committees that provide guidance for transportation funding, program and project decision-making, and policy development. These committees advise on topics related to active transportation program delivery, transportation system improvements, public transportation

policy framework, and data sharing coordination. Some of the advisory committees that public health is participating on include, but are not limited to:

- Area Commissions on Transportation
- Public Transportation Advisory Committee
- Transportation and Growth Management Advisory Committee
- Safe Routes to School Advisory Committee
- Traffic Records Coordinating Committee
- Liaison to Governor's Advisory Committee on DUII
- Liaison to Governor's Advisory Committee on Motorcycle Safety
- Congestion Management and Air Quality Committee
- Oregon Modeling Steering Committee

Conversely, ODOT staff and other transportation partners have served on committees that provide guidance and oversight to the public health system. These committees have advised on topics related to health assessment:

- State Health Assessment Subcommittees

OR-Plan Statewide Planning Database

OR-Plan is an online resource that centralizes all of the transportation policies and strategies from ODOT's nine statewide modal and topic plans. OR-Plan provides a comprehensive view of how the statewide plans relate to one another and illustrates the policy framework related to specific transportation issues and modes.

Ten fundamental issue areas are identified across the modal and topic plans that further describe the vision for the transportation system. Health is identified as a fundamental issue area that focuses on the outcomes of transportation infrastructure and choices of personal and public health, such as physical activity associated with walking or biking, or the impact of vehicle pollutants on chronic disease.

ODOT and OHA-PHD collaborated in the development of a Healthy Communities Policy Brief that is incorporated into the tool. The Policy Brief demonstrates how statewide policies and strategies that support a safe, accessible and sustainable transportation system can also support Oregon's health system transformation efforts by reducing chronic disease rates and improving health and well-being in all Oregon communities.

Safe Routes to School

Safe Routes to School (SRTS) refers to efforts that improve, educate, or encourage children safely walking (by foot or mobility device) or biking to school. ODOT has two main types of SRTS programs: infrastructure and non-infrastructure grants and technical assistance. Infrastructure programs focus on making sure safe walking and biking routes exist through investments in crossings, sidewalks and bike lanes, flashing beacons, and the like. Non-infrastructure programs focus on education and outreach to assure awareness and safe use of walking and biking routes. Investments include developing SRTS Action Plans, educating students on walking and biking options and how to do use them safely (laws, rules, and guidelines), among other efforts.[1]

In 2017, the Oregon Legislature passed the landmark transportation funding package (House Bill 2017) which dedicates infrastructure funding to SRTS. The purpose of the funding is to build projects within a one-mile radius of schools to make it safer and easier for students to walk and bicycle to school.[2] The SRTS infrastructure program receives $10 million state highway dollars annually increasing to $15 million annually in 2023. The non-infrastructure program received $1 million annually. Figure 1 and Table 1 summarize the funded competitive construction projects for 2018-2020.

[1] Oregon Department of Transportation. Safe Routes to School Programs. November 14, 2019. https://www.oregon.gov/ODOT/Programs/Pages/SRTS.aspx.
[2] Oregon Department of Transportation. Safe Routes to School Competitive Infrastructure Grant program. November 14, 2019. https://www.oregon.gov/ODOT/Programs/TDD%20Documents/SRTS-Competitive-Program-One-Pager.pdf.

Figure 1: 2018-2019 SRTS Funded Competitive Construction Projects

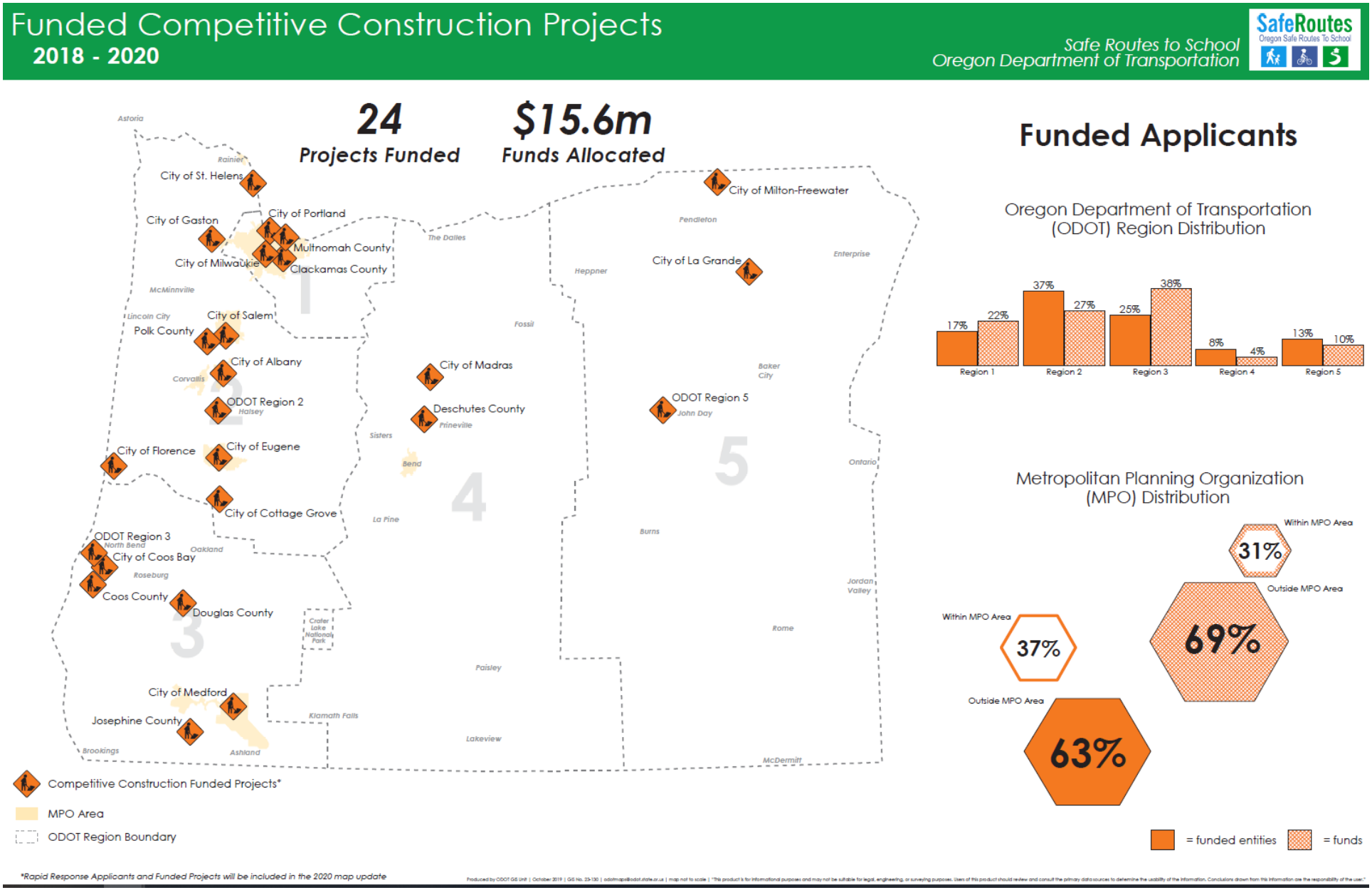


Table 1: SRTS Funded Competitive Construction Projects

Region	Applicant Agency	Project Name	Grant Award Request
5	ODOT- Region 5	Sidewalk and ramps for Grant Union Junior High School students	$1,136,000
5	City of Milton-Freewater	Crosswalks and sidewalks for Gib Olinger Elementary School students	$249,599
5	City of La Grande	Sidewalks and ramps for Central Elementary School students	$140,000
		Region Sub-Total	**$1,525,598**
4	Deschutes County	Sidewalks for Terrebonne Elementary School students	$349,271
4	City of Madras	Sidewalks and ramps for Madras Elementary School students	$212,000
		Region Sub-Total	**$561,271**
3	ODOT Region 3	Rapid Flashing Beacon and pedestrian refuge island for North Bend Middle School students	$97,400
3	Josephine County	Sidewalks for Williams Elementary School students	$154,000
3	Douglas County	Sidewalks and bike lanes for Green Elementary School students	$2,000,000
3	Coos County	Sidewalks, curb ramps, and bike lanes for Winter Lakes Elementary School students	$1,499,034
3	City of Medford	Sidewalks, ramps, and safety enhancements at crosswalks for Wilson and Washington Elementary School students	$208,000
3	City of Coos Bay	Sidewalk, ramps, crosswalk, rapid flashing beacon, and bike lanes for Millicoma and Eastside Elementary Schools students	$2,000,000
		Region Sub-Total	**$5,958,434**
2	Polk County	Bike lanes and crossing enhancements for Ash Creek Elementary School students	$704,400
2	ODOT Region 2	Enhanced crossings, rapid flashing beacons, and refuge island for Central Linn Elementary School students	$346,467

2	City of St. Helens	Sidewalk for McBride Elementary School students	$322,536
2	City of Salem	Median crossing island, and rapid flashing beacon for Liberty Elementary School students	$140,000
2	City of Gaston	Sidewalk and crosswalk for Gaston Elementary School students	$189,738
2	City of Florence	Enhanced crossing, and sidewalks for Siuslaw Elementary School students	$346,400
2	City of Eugene	Speed zone flashers, enhanced crossings, pedestrian islands, curb extensions and rapid flashing beacons for Cesar Chavez Elementary School students	$750,246
2	City of Cottage Grove	Sidewalk, ramps, and crosswalks for Lincoln Middle School students	$1,272,143
2	City of Albany	Sidewalks, ramps, and crossings for South Shore Elementary	$100,000
		Region Sub-Total	**$4,171,930**
1	Multnomah County	Crossing enhancements for Reynolds Middle School students	$90,957
1	Clackamas County	Sidewalks, ramps, rapid flashing beacons, and pedestrian refuge islands for Whitcolmb Elementary School students	$148,470
1	City of Portland	Sidewalks for Alder Elementary School students	$2,000,000
1	City of Milwaukie	Sidewalks, enhanced crossings, crossing beacons, and bike lanes for Linwood Elementary School students	$1,152,330
		Region Sub-Total	**$3,391,757**
		Total	**$15,608,990**

Statewide Transportation Improvement Fund

With the passage of House Bill 2017, the Oregon Legislature made a significant investment in transportation to help advance public transportation. A centerpiece of House Bill 2017 is the Statewide Transportation Improvement Fund (STIF). This fund provides a new dedicated source of funding to expand public transportation to access jobs, improve mobility, relieve congestion and reduce greenhouse gas emissions around Oregon. A new state payroll tax of one-tenth of one percent funds STIF transportation improvements in Oregon.[3]

Fund distribution includes:

- **Formula Program:** 90% of STIF funds will be distributed to qualified entities based on taxes paid within their geographic area.
- **Discretionary Program:** 5% of STIF funds will be awarded to eligible public transportation providers based on a competitive grant process.
- **Intercommunity Discretionary Program:** 4% of STIF funds will be used to improve public transportation between two or more communities based on a competitive grant program.
- **Technical Resource Center:** ODOT will use 1% of STIF funds to create a statewide resource center to assist public transportation providers in rural areas with training, planning and information technology and fund ODOT administration of STIF.

The first funding cycle for STIF Formula Fund's had two submittal deadlines, November 1, 2018 and May 1, 2019. Eighteen of the 42 eligible qualified transit entities submitted STIF service improvement plans that were approved for funding by the OTC in March 2019. The timing of the staggered review and funding approval process enabled the 18 qualified transit entities to receive their first disbursement of STIF Formula funds in May 2019. This was the only disbursement of STIF funds during the 2017-2019 biennium. During the coming biennium ODOT anticipates distributing over $200 million to local public transportation providers through both STIF Formula and Discretionary funding programs.

[3] Oregon Department of Transportation. Statewide Transportation Improvement Fund. November 14, 2019. https://www.oregon.gov/ODOT/RPTD/RPTD%20Committee%20Meeting%20Documents/STIF-Fact-Sheet-2018.pdf

Table 2: STIF Disbursements to Qualified Entities (May 2019)

Entity	Amount	Entity	Amount
Baker County	$88,257	Morrow County	$133,158
The Confederated Tribes of the Umatilla Indian Reservation	$50,000	Salem Area Mass Transportation District	$3,572,003
Coos County	$389,800	Tillamook County Transportation District	$164,842
The Coquille Indian Tribe	$50,000	Tri County Metropolitan Transportation District	$25,768,419
Curry County	$100,266	Umatilla County	$535,094
Grant County Transportation District	$50,000	Union County	$172,131
Harney County	$50,000	Wallowa County	$50,000
Hood River County Transportation District	$239,175	Wasco County	$209,267
Josephine County	$441,075	Yamhill County	$652,535

Transportation System Plan Guidelines

ODOT's Transportation Planning Unit, in partnership with OHA-PHD representatives, local staff and other stakeholders, updated the Transportation System Plan (TSP) Guidelines. The TSP Guidelines are an online tool that assist local jurisdictions in the preparation and update of TSPs, providing detailed direction on scoping, developing and administering TSPs. The TSP Guidelines answer the "What, Why, When and How" questions surrounding TSPs, and incorporates guidance for how to better integrate health considerations, amongst many other issues into local long-range planning.

Many of the highlighted opportunities to integrate health were new additions to the planning guidance, including:

- How to consider community health objectives when evaluating the need for an updated TSP.
- Involving local public health officials or health organizations in the development of the TSP, through active participation on advisory committees and targeted stakeholder engagement.

- Reflecting goals and objectives of other community plans and studies, including community health assessments and improvement plans in the TSP.
- Considering public health impacts and outcomes when conducting multi modal existing conditions inventory and developing solutions for the TSP.

The planning guidance is useful to jurisdictions of all sizes, geographies and mobility needs. A locally approved TSP provides a necessary linkage to the Statewide Transportation Improvement Program (STIP) to secure funding for the implementation of projects; it also provides the policy foundation and documentation of need to support other transportation funding decisions and requests. Opportunities have been identified to better link the TSP Guidelines to TSP assessment services and planning grant resources, such as the Transportation and Growth Management Program (TGM).

State Health Assessment and State Health Improvement Plan

The State Health Improvement Plan (SHIP) is a primary strategic initiative for the OHA-PHD. The SHIP identifies our state's health priorities with strategies and measures to monitor progress. Two of the seven priorities of the 2015-2019 SHIP rely on partnership with the transportation system, slowing the increase of obesity and reducing harms associated with alcohol and substance use. Shared activities related to increasing active transportation options and reducing the number of people driving under the influence of alcohol and other drugs have been beneficial to these priority areas.

The OHA-PHD published the 2018 State Health Assessment (SHA) and revised State Health Indicators (SHIs), an effort undertaken every five years to comprehensively describe health in our state. The SHA and SHIs are intended to be tools for local partners developing assessments and plans. Grounded in quantitative data and a community voice, issues related to transportation, air quality and climate change, and motor vehicle related deaths were highlighted as health-related concerns. ODOT staff participated on both the Health Status

Subcommittee and Themes and Strengths Subcommittee, helping to elevate transportation related data.

Emergency Preparedness and Response

ODOT and OHA participated together in Operation OX, a statewide exercise based on a response to an intentional plague outbreak across the entire state. ODOT partnered with OHA-PHD's Health Security Preparedness and Response (HSPR) to distribute medical countermeasures received from the Federal Strategic National Stockpile (SNS). On April 30th, 2019 the SNS shipment of medical countermeasures arrived in Oregon, as part of the exercise, and ODOT in conjunction with OHA-PHD initiated their distribution plan, staffing an emergency warehouse or Receipt, State, Store. The shipment was processed through and distributed out to counties, with Oregon State Police escort. The exercise was a culmination of years of joint planning and training on emergency preparedness, bringing the OHA-PHD and ODOT plans to validation.

Source: Operation OX. April 30, 2019.

Foster Alignment of Health & Transportation Goals at the State & Local Levels

Place Matters Conference Collaboration

The 2018 Oregon Place Matters Conference convened public health professionals to develop new insights, skills and connections to help address the leading preventable causes of death in Oregon, including, tobacco, poor nutrition, physical inactivity, and excessive alcohol use. Transportation has a significant influence on the built environment affecting people's choice to walk, bike or take active transportation. ODOT's Transportation Planning Unit served on a panel with local public health authorities to discuss the relationship between transportation and public health, and the benefits of coordinating efforts.

Public Health Active Transportation Accountability Measure

In June 2017, Oregon's Public Health Advisory Board (PHAB) established a set of accountability metrics to track progress towards improved health outcomes resulting from a modernized public health system. These metrics emphasize Oregon's population health priorities and help identify when goals aren't being met. These metrics also identify where public health can work with other sectors to achieve shared goals. Active transportation is one of two public health accountability metrics for environmental public health.

To support the accountability measures, a series of process measures have also been developed. The process measure related to active transportation measures local public health authority (LPHA) participation in leadership or planning initiatives related to active transportation, parks and recreation or land use. A survey was fielded to LPHAs in 2018 and found that just over half of LPHAs participate in leadership and planning initiatives. The survey also collected information on each LPHA's role in these initiatives, as well as barriers to involvement, and highlighted areas where ODOT and PHD may be able to work together to provide technical assistance to strengthen local collaborations. The LPHA active transportation survey will be fielded annually.

Oregon Avenue Protected Bicycle Lane Case Study

In an effort to increase opportunities for physical activity Klamath Falls, Oregon; a local health care provider collaborated with transportation planners and community members to generate ideas that would reimagine mobility to support active transportation. This effort resulted in The Oregon Avenue Protected Bicycle Lane Project. The purpose of this project was to combat high rates of chronic diseases by addressing a key social determinant of health and to serve as an economic growth engine for the area, attracting additional commercial activity to an emerging downtown business district.

Funding for the project was also collaborative, Cascade Health Alliance, a Coordinated Care Organization (CCO) provided grant funds leveraged with other funding sources to deliver the project. CCOs have flexibility to address member's health needs outside traditional medical services—recognizing that health is not just a clinical field, but is largely affected by our environment and policies.[4]

AN INNOVATIVE STRATEGY THAT COORDINATED CARE ORGANIZATIONS ARE BEGINNING TO EMPLOY SEEKS TO MITIGATE HEALTH PROBLEMS BEFORE THEY BECOME CHRONIC AND HARDER TO TREAT BY LOOKING UPSTREAM TO IMPACT AREAS WHERE PEOPLE LIVE, WORK, LEARN AND PLAY.

[4] Oregon Department of Transportation. Oregon Avenue Protected Bicycle Lane: A Case Study of a Health & Transportation Partnership in Klamath Falls, Oregon. https://www.oregon.gov/ODOT/Programs/TDD%20Documents/Oregon-Avenue-Protected-Bicycle-Lane-Case-Study.pdf. June 2018.

Collaborate on Research & Data Analysis

Linking Crash Data with Emergency Medical Service Data

ODOT has worked closely with PHD to address injuries and fatalities related to motor vehicle, pedestrian, and bicycle crashes and have provided funding to support a project to develop methods for reporting injury surveillance data in the state Emergency Medical Service (EMS) information system. This project seeks to move ODOT and PHD closer to a coordinated data management process by merging and supplementing ODOT crash data with information in the EMS data system.

Findings will be disseminated in an interactive, public-facing display to detail burden by region, patient, built environment or agency characteristic. This project would build on previous work completed by both agencies, as well as, efforts from other states and public entities that are already making these data connections.

Data integration will continue to be a strong priority of the partnership. Data available in the EMS information system could eventually link a whole sequence of events, from a crash to on-the-scene medical attention, to emergency transport, to hospital care, enabling better response to crash-related injuries. The link to each step of the emergency trauma process would be available to both OHA and ODOT for research, planning and quality improvement efforts.

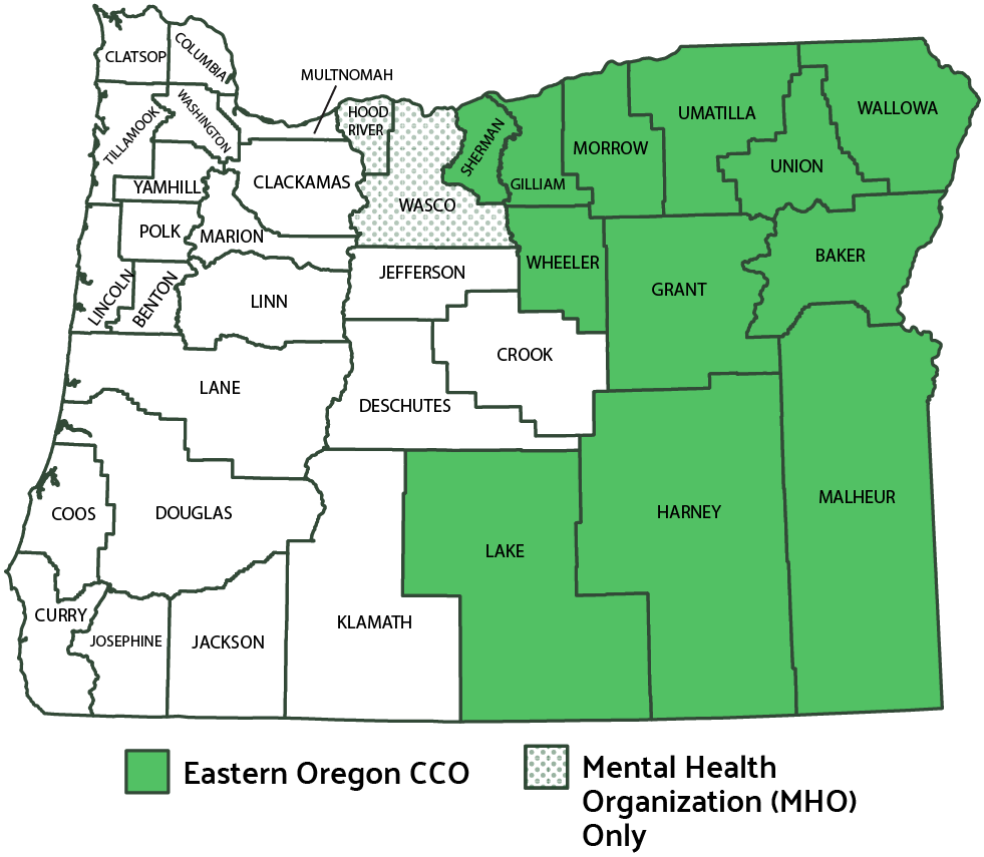
Non-Emergency Medical Transportation Trip Optimization Pilot Project

Greater Oregon Behavioral Health Institute (GOBHI) provides Non-Emergency Medical Transport (NEMT) in 14 counties in eastern and central Oregon through its brokered Medicaid network. NEMT rides can be disproportionately costly because they default to one of the most expensive modes of local access.

In order to optimize service and conserve resources, ODOT Region 5 in partnership with GOBHI, is testing a software (REMIX—an intuitive web-based platform for route modeling, development and optimization) to identify origin and destination pairs within a fourth-mile of public scheduled route service. Medicaid members within this zone who are medically able

can be assigned to a scheduled route by default. While not every recommendation may be a good fit, using technology to actively engage more stakeholders is likely to improve long term local delivery strategies. The pilot project is set to run through summer 2021 and will collect aggregated data from GOBHI about the impact of scheduled routes on NEMT; including estimated savings realized from assigning NEMT to scheduled routes.

Figure 2: GOBHI Service Area



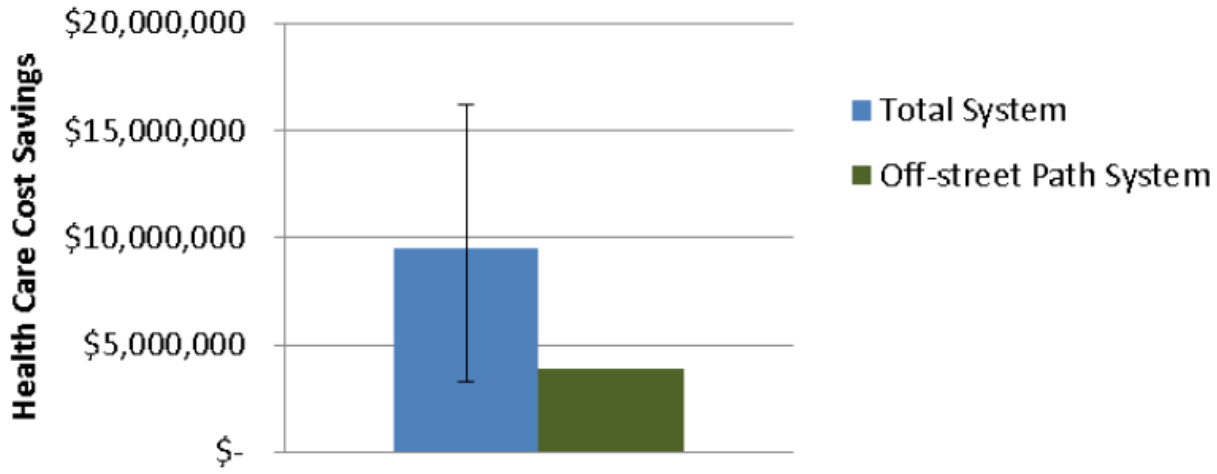
Bicycle Travel Activity Study

A Bicycle Travel Activity Study[5] was conducted, by the ODOT Research Section, in the Central Lane Metropolitan Planning Organization planning area to document the use of bicycle traffic volume data for the purposes of travel monitoring, crash analysis, and health impact assessment. The study showcases a new method for utilizing bicycle traffic estimates in crash analysis to highlight the injury-crash risk disparity between motorized and bicycle travel.

[5] Oregon Department of Transportation. Bicycle County Data: What is it Good for? A Study of Bicycle Travel Activity in Central Lane Metropolitan Planning Organization. June 2018. https://www.oregon.gov/ODOT/Programs/Pages/Research-Publications.aspx

An analysis of the health benefits associated with the bicycle activity was also conducted in order to highlight the positive health outcomes derived from the physical activity related to bicycling. The positive health outcomes were then quantified using a cost of illness methodology to reveal the health care cost savings associated with the estimated bicycle travel activity in the study area.

Figure 3: Central Lane Metropolitan Planning Organization Bicycle System Related Healthcare Cost Savings[6]



[6] Health outcomes translate into at least $3.5 million in health care cost savings for the total system, after accounting for fatal and severe bicycle injury associated costs. The off-street path system alone accounts for nearly $5 million in health care cost reductions.

Moving Forward

New initiatives have continued to take shape as the partnership continues work. Staff, senior managers and leaders of both agencies are committed to being responsive to emerging issues and opportunities.

Transportation, Public Health & Social Equity

ODOT and OHA will continue to work together on the intersection of transportation, public health and social equity; especially as these connections support marginalized and vulnerable communities. There is opportunity to continue a dialogue between the agency decision making-bodies related to equity, and strengthen coordination of efforts between state agencies.

The OHA-PHD will continue to advance health equity through implementation of the 2020-2024 State Health Improvement Plan (SHIP) and public health modernization investments that will enable local public health authorities to develop and execute health equity plans. Similarly, the PHD will implement a strategic plan to recruit and retain diverse employees.

Source: Robert Wood Johnson Foundation. Visualizing Health Equity: One Size Does Not Fit All

Executive leaders at ODOT selected equity as an agency core value, this is supported by the creation of an Equity Officer position within the Director's Office. The Equity Officer is responsible for providing direction and advancing this initiative both internally—in terms of ODOT's workforce, as well as, externally—how we influence and involve the community in the work the agency does. Transportation is the enabling network that provides for equitable access and must be attentive to the needs of all community members. OHA also has an established Office of Equity and Inclusion that works with diverse communities to eliminate health gaps and promote optimal health in Oregon. As ODOT and OHA continue in the

partnership the next step is to develop an understanding of how work overlaps between the agencies related to these issues.

Statewide Policy Development

ODOT and OHA are initiating work on significant policy efforts including updates to the Oregon Transportation Plan (OTP), Oregon Highway Plan (OHA), Oregon Transportation Safety Action Plan (TSAP) and the State Health Improvement Plan (SHIP). Each of these plans will conduct collaborative processes that will include new areas of work to advance policies that support both health and transportation goals.

Climate Change Adaptation Framework

The Climate Change Adaptation Framework is an inter-agency and cross sector effort that identifies climate impacts and risks, and helps identify policy priorities and a range of actions the state should consider to prepare for and adapt to climate change. ODOT and OHA will address public health and built environment considerations and are featured sectors that will be tasked with addressing this work.

Partnership Goals

The ODOT-OHA partnership Memorandum of Understanding (MOU) outlines five key goal areas that both agencies have agreed to communicate, coordinate, and collaborate on activities that support the link between public health and transportation. The partnership goals include:

- Improve traffic Safety
- Increase active transportation options
- Improve air quality and reduce exposure to air pollution
- Improve equitable access to employment, education, health care, healthy food and other resources
- Improve preparedness for emergencies

The partnership conducts quarterly meetings between agency leadership and staff with the primary purpose of furthering the goals of the MOU.

Appendix A: Acronyms

CCO: Coordinated Care Organization
DUII: Driving Under the Influence of Intoxicants
EMS: Emergency Medical Services
GOBHI: Greater Oregon Behavioral Health Institute
HSPR: Health Security Preparedness and Response
LPHA: Local Public Health Authority
MOU: Memorandum of Understanding
NEMT: Non-Emergency Medical Transportation
ODOT: Oregon Department of Transportation
OHA: Oregon Health Authority
OHA-PHD: Oregon Health Authority – Public Health Division
OHP: Oregon Highway Plan
OTC: Oregon Transportation Commission
OTP: Oregon Transportation Plan
PHAB: Public Health Advisory Board
SHA: State Health Assessment
SHI: State Health Indicators
SHIP: State Health Improvement Plan
SNS: Strategic National Stockpile
SRTS: Safe Routes to School
STIF: Statewide Transportation Improvement Fund
STIP: Statewide Transportation Improvement Program
TGM: Transportation and Growth Management Program
TSP: Transportation System Plan
TSAP: Transportation Safety Action Plan

Public Health Advisory Board
Health equity review policy and procedure
October 2020

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

PHAB acknowledges historic and contemporary racial injustice and commits to eradicating racial injustice. PHAB acknowledges the pervasive racist and white supremacist history of Oregon, including in its constitution, in the theft of land from indigenous communities, the use

of stolen labor and the laws that have perpetuated unjust outcomes among communities of color and tribal communities.

Because of Oregon's history of racism, the public health system chooses to lead explicitly — though not exclusively — with race because racial inequities persist in every system across Oregon, including health, education, criminal justice and employment. Racism is embedded in the creation and ongoing policies of our government and institutions, and unless otherwise countered, racism operates at individual, institutional, and structural levels and is present in every system we examine.[1] The public health system leads with race because communities of color and tribal communities have been intentionally excluded from power and decision-making.

The public health system leads with race because within other identities — income, gender, sexuality, education, ability, age, citizenship and geography — there are inequities based on race. Knowing this helps the public health system take an intersectional approach, while always naming the role that race plays in people's experiences and outcomes.

To have maximum impact, focus and specificity are necessary. Strategies to achieve racial equity differ from those to achieve equity in other areas. "One-size-fits all" strategies are rarely successful.

A racial equity framework that is clear about the differences between individual, institutional and structural racism, as well as the history and current reality of inequities, has applications for other marginalized groups.

Race can be an issue that keeps other marginalized communities from effectively coming together. An approach that recognizes the inter-connected ways in which marginalization takes place will help to achieve greater unity across communities.[2]

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

[1] Health Equity Guide. (2019). Why lead with race. Available at https://healthequityguide.org/about/why-lead-with-race/.
[2] Government Alliance on Racial Equity. (2020). Why lead with race? Available at https://www.racialequityalliance.org/about/our-approach/race/.

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. Differ 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. Differ 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.

Local and state roles for community partnership development and health equity and cultural responsiveness

State and local roles for Community Partnership Development (from the Public Health Modernization Manual)

State and local	Seek and sustain relationships with health-related organizations, organizations representing populations experiencing health inequities, private businesses and federal, tribal, state and local government agencies and non-elected officials.
State and local	Specifically engage communities disproportionately affected by health issues so they can actively participate in planning and funding opportunities to address their needs.
State and local	Earn and maintain community trust at the grassroots level by working towards common goals and mutual benefits.

State and local roles for Health Equity and Cultural Responsiveness (from the Public Health Modernization Manual)

State and local	Engage with the community to identify and eliminate health inequities.
State and local	Leverage and engage partnerships in health equity solutions
State and local	Play a leadership role in reducing or mitigating existing social and economic inequities and conditions that lead to inequities in the distribution of disease, premature death and illness.

CROOK COUNTY HEALTH DEPARTMENT

COVID-19 RESPONSE IN CROOK COUNTY

- How we created the infrastructure in Crook County to directly work with and support communities experiencing COVID-19 Disparities?
- ***ORGANIZE THE TEAM!***

CROOK COUNTY HEALTH DEPARTMENT

INCIDENT COMMAND

REGIONAL LEADERSHIP

CBO's

PARTNERS

REPORTS AND SITUATION REPORTS

Crook County

Wednesday, July 8, 2020

Situational Status Report (SitRep #15)

A weekly COVID-19 report for community partners
Prepared by
Crook County Public Health Department

Incident: Crook County COVID-19 ORES#2020-0584

Health and Medical Situation Status Report (SSR#15); 5 pages

New or updated information is identified in blue.

Go to https://co.crook.or.us/health for previous Situational Status Reports.

Report Period: A recap through July 7th; Continued Weekly

Incident Manager: Muriel DeLaVergne-Brown, Health & Human Services Director
-Work Phone: 541-416-1980
-Cell: 541-233-8534
-Email: mdelavergnebrown@h.co.crook.or.us

PIO: Vicky Ryan, Public Health Preparedness Coordinator
-Work Phone: 541-323-2467
-Work Cell: 541-233-8504
-Email: vryan@h.co.crook.or.us

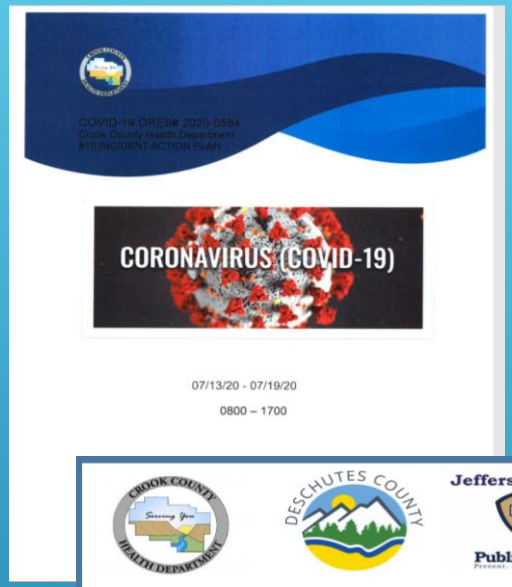
Operations Chief: Jo McCabe, Clinical Nursing Supervisor
-Work Phone: 541-447-5165
-Email: jmccabe@h.co.crook.or.us

Planning Chief: Katie Plumb, Health & Human Services Deputy Director
-Work Cell: 541-233-9177
-Email: kplumb@h.co.crook.or.us

Activation Level: Crook County Health Department EOC is currently activated.

General Objectives for the Incident:

1. Monitor public information needs and develop accurate and timely messaging in coordination with Deschutes, Jefferson, and COEIN.
2. Provide Surveillance, investigation and monitoring of suspect and confirmed cases of COVID-19 within Crook County.
3. Support the logistical needs of hospital, health clinics, first responders, and critical services in coordination with Emergency Management.
4. Provide accurate situational awareness to support operational and policy decisions for Crook County as well as offices and departments within the county.
5. Support planning efforts.
6. Develop plans to increase medical capacity with regional partners and provide for the safety of responders and medical personnel.



COVID-19 (Novel Coronavirus) Daily Situation Update

June 29, 2020

COVID-19 Updates for Today:

- Since Friday's situation update, Oregon Health Authority reports that total case counts:
  - Increased by 1 in Crook County (10)
  - Increased by 13 in Deschutes County (172)
  - Increased by 9 in Jefferson County (100)
- Since Friday's situation update, Oregon Health Authority reports that total COVID-19 case counts in Oregon increased by 667, bringing the total number of known cases statewide to 8,485. Since Friday's situation update, statewide COVID-19 deaths have increased by 2, bringing the total number of COVID-19 deaths in Oregon to 204.
- CDC reports there are >2.5 million cases of COVID-19 in the United States.
- Worldwide case counts are >10 million.

COVID-19 Situation in Central Oregon

(Click here for source: Oregon Health Authority Situation in Oregon)

Data as of 6/29/20, 12:01AM Pacific Time

Central Oregon COVID-19 Cases:

- 10 in Crook County
- 172 in Deschutes County
- 100 in Jefferson County

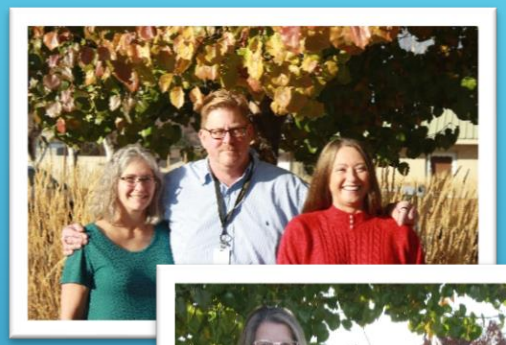
Central Oregon COVID-19 Deaths:

- 0 in Crook County
- 0 in Deschutes County
- 0 in Jefferson County

The chart below shows the number of new COVID-19 cases reported from Crook, Deschutes, and Jefferson County each calendar week beginning the week of 3/9/20-3/15/20 (when the first cases were reported in Central Oregon).

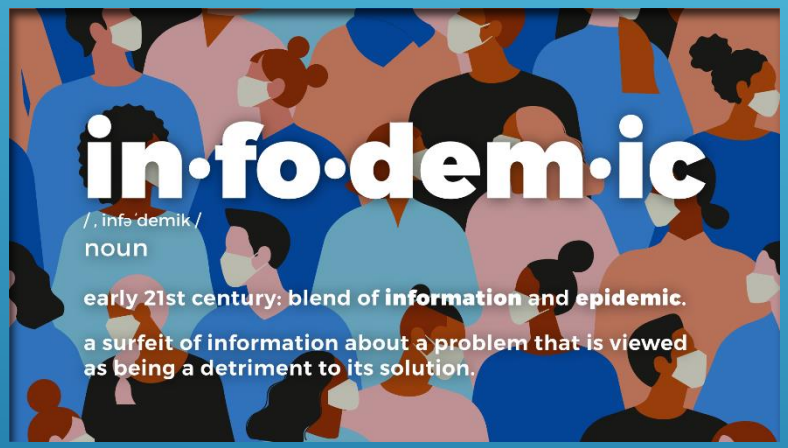
Data for this week is not yet shown. This chart will be updated **weekly** to show the number of new COVID-19 cases that were reported each week in Central Oregon.

THE TEAM – EVERYONE BEFORE COVID-19 AND MASKS



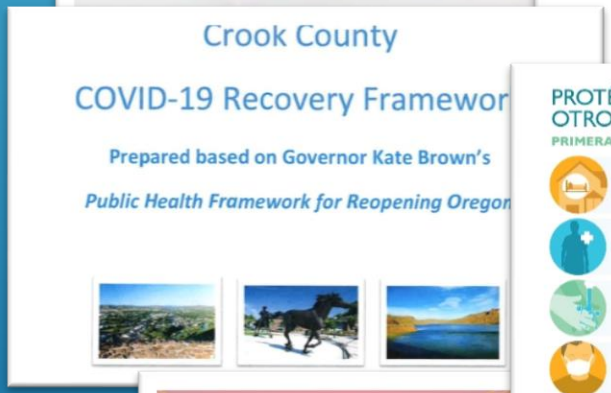
- Case Investigation – OHA Guidelines
- Contact Monitoring
- Wrap Around Services - bilingual
- Facilitation of testing approvals
- Communication/Liaisons/Regional
- Respond to public calls
- Hired bilingual staff and nurse

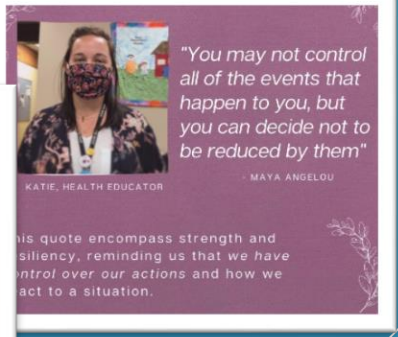
THE COMMUNITY LIAISONS

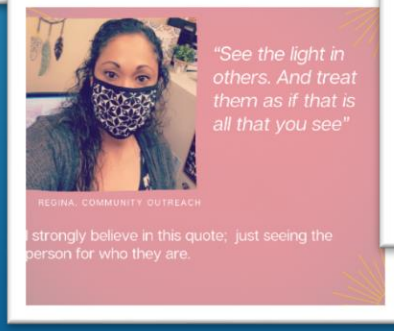


- Communication Team – PIO
- EMS/Hospital/Medical
- Businesses, Chamber
- Schools, Daycare
- Long-term Care
- County Court/City
- Faith-Based Network
- Environmental Health

EXAMPLES OF THE WORK







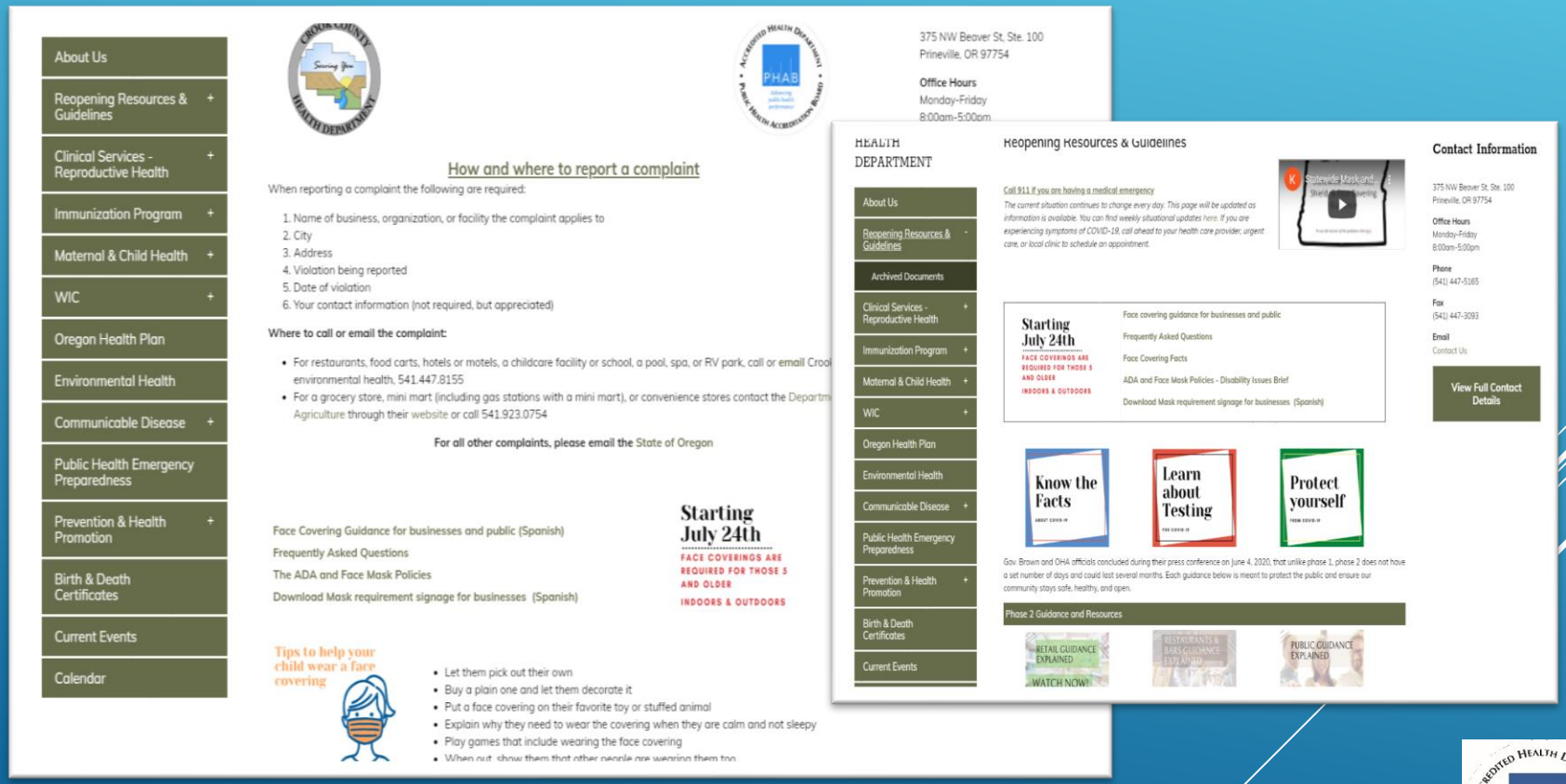
SUPPORTS FOR THE COMMUNITY

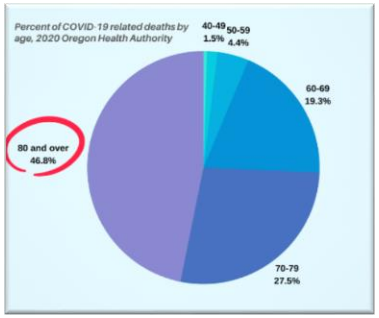
- Community Grants through the Chamber
- Drive Through Food Distribution Event at the Fairgrounds

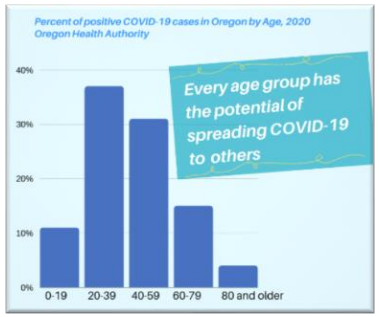
MESSAGING

Three W's
Wear a face covering
Watch your distance
Wash your hands

REOPENING CROOK COUNTY ENFORCEMENT CHALLENGES

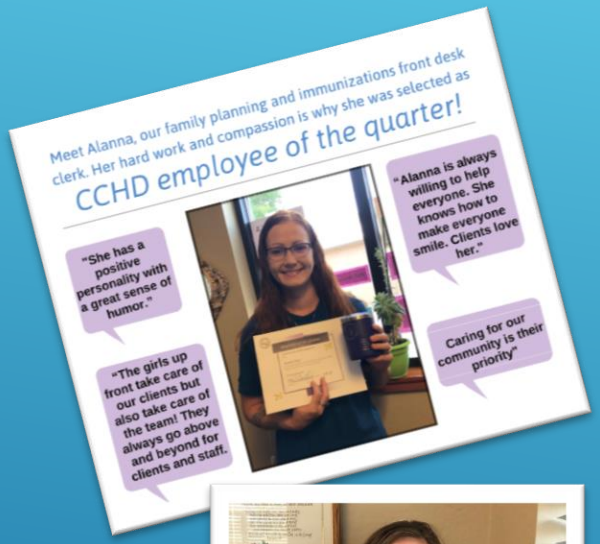






WE CREATED VIDEOS FOR EDUCATION AND RE-OPENING DIRECTIONS IN ENGLISH AND SPANISH

STAFF CARE



Exercise June of 2019

Microsoft Teams

Nothing can stop a team.

WHAT'S NEXT AND HOW DOES THIS WORK ALIGN WITH FUTURE GOALS?

- Continuing the day to day work
- Messaging
- Coordinate additional testing high risk
- Planning for Influenza clinics and COVID-19 Clinics
- Continue to work with schools for reopening
- FUTURE GOALS
  - Finish Strategic Plan, Health Equity, QI
  - Completed Public Health Reaccreditation In June of 2020
  - Ongoing training of staff

WEBSITE:

https://co.crook.or.us/health

Muriel DeLaVergne-Brown, RN, BSc, MPH

Public Health Director (Incident Commander for Event)

mdelavergnebrown@h.co.crook.or.us

QUESTIONS?

COVID and Latinx Outreach in Jackson County

JACKSON BAURES, MM, GCPH, REHS
Public Health Division Manager

Presented to:
Oregon Public Health Advisory Board
October 15, 2020

JACKSON COUNTY
Health & Human Services

ACCREDITED HEALTH DEPARTMENT
PHAB
Advancing public health performance
PUBLIC HEALTH ACCREDITATION BOARD

Background

2

- Jackson County Agriculture
  - Pears, grapes, hemp, marijuana
  - Hundreds of seasonal agriculture workers
- Jackson County Population
  - 13.5% Hispanic or Latino (2019 Census estimate)

Seasonal Agricultural Worker Outreach

3

- Weekly agricultural worker meetings
  - Agricultural businesses, La Clinica, Unete, Dept of Employment, Dept of Agriculture, Dept of Human Services, OSHA, Jackson County Emergency Operations Center, others
  - Encourage testing, promote worker safety, supportive services and resources
- Jackson County Environmental Public Health
  - On-site health and safety consultation
- Developed agricultural worker brochure

Seasonal Agricultural Worker Brochure

4

Post-Employment

Identifying symptomatic workers as early as possible is key to minimizing effects to operations and workforce. If a worker becomes symptomatic employers should isolate them **immediately** and contact Jackson County HHS at (541) 774-8209.

If workers are housed in communal housing, employers are required per OHA and OR-OSHA to provide alternative housing for workers that have been tested and are awaiting results, or are determined to be COVID-19 positive. If employers are having a difficult time securing isolation housing, please contact Jackson County HHS at 541-774-8209.

The Jackson County EOC can assist employers in obtaining PPE, such as face masks and hand sanitizer as needed.

Please contact JC_EOC_LOGISTICS@jacksoncounty.org for PPE assistance.

Medical Providers

The following is a list of medical providers for assessment and testing of employees. Please call ahead of visit for a virtual assessment.

Asante Urgent Care
(541) 789-2273

Providence Urgent Care
(541) 732-3962

Valley Immediate Care
(541) 773-4029, (541) 858-2515

La Clinica
(541) 535-6239

Help us keep our agricultural operations growing and our community safe this season!

JACKSON COUNTY
Health & Human Services

Helping to protect and promote the health and well-being of our community.

140 S. Holly St. Medford OR, 97501
8 a.m. to 5 p.m., Mon - Fri
(Across from Alba Park)

For more information visit:
www.co.jackson.or.us *& then select*
Health & Human Services Department

Seasonal Farm/Agricultural Worker Safety During COVID-19

JACKSON COUNTY
Health & Human Services

JACKSON COUNTY
Health & Human Services

Seasonal Agricultural Worker Brochure

5

Introduction

As the Jackson County agricultural community prepares for the return of the migrant worker community, there are new challenges to be navigated during the COVID-19 public health emergency.

The Oregon State Health Authority (OHA), along with OR-OSHA have issued guidance and temporary rules surrounding the safe operations of agricultural sites during this pandemic.

Agricultural managers are highly encouraged to review the documents and have a COVID-19 management plan in place prior to the on-boarding of migrant workers.

The Jackson County Health and Human Services Department, along with the Jackson County Emergency Operations Center (EOC) is committed to partnering with our local agricultural managers to ensure that workers are safe, outbreaks are avoided, and impacts of an outbreak to farm operations, workers, and the Jackson County community are minimal.

Overview

Employers are required per OHA and OR-OSHA to ensure worker safety and have plans in place for COVID-19 outbreaks including alternative housing locations should a worker become infected.

OHA guidance for agricultural employers and workers in Oregon can be found at govstatus.egov.com/OR-OHA-COVID-19

In addition to guidance, the site contains several useful posters and informative flyers for posting at work sites. English and Spanish versions are available.

OR-OSHA temporary rules can be found at osha.oregon.gov/Documents/COVID-19-Emergency-Ag-Rule-Q-A.pdf

Outbreaks can severely effect agricultural operations and the ability to continue production in an effective manner. As a result, it is in the employer's best interest to comply with guidance and rules to minimize operational impacts.

COVID-19 Mitigation Assistance Funds for complying with guidance is available through the Food Security and Farmworker Safety Program.

Information can be found at oregon.gov/oweb/fsfs/Pages/index.aspx

The testing of workers pre-employment is a very important step to minimizing the spread of COVID-19 throughout your workforce.

Pre-Employment Testing

- While pre-employment testing is not mandatory, it is highly recommended as a way to ensure that your workforce is not exposed to COVID-19 as new workers arrive.
- This one, simple step can result in agricultural operations continuing throughout the season and help to ensure the safety of employees. A worker that is asymptomatic and showing no effects of COVID-19 can rapidly infect a workforce, severely disrupting operations.
- Jackson County HHS is coordinating with La Clinica to ensure that pre-employment testing services are available as migrant workers arrive to Jackson County.
  - Testing will be completed at La Clinica's Wellness center located at 730 Biddle Rd., Medford.
  - Employers will need to provide La Clinica with a letter identifying that the employee is an agricultural worker, along with the employee's name and who within the company should receive test results and their contact information. The employer will receive documentation that test was administered.
  - Employees will be required to sign a release to provide medical results to their employer. When results are confirmed, the employer will receive a copy. Results typically take 2-5 business days.
  - If employers are interested in receiving more information on pre-employment testing for their arriving migrant workforce at no cost, please call (541) 774-8082.

Additional Latinx Outreach

6

- Latinx communication workgroup
  - Public Health, CCOs, Health Equity Coalition, Unete, La Clinica, Kids Unlimited, Migrant Education, and Latin Interagency Committee
- Public Service Announcements
  - TV, radio, Pandora, and Facebook
  - Print materials
- Current project
  - Collaboration with school districts

Questions?

7

Screening for Social Needs Metric Development

Overview for OHA Committees
October 2020

***Chris DeMars**, Executive Sponsor, Transformation Center and*
Deputy Director, Delivery Systems Innovation Office
***Amanda Peden**, Workgroup staff and Health Policy Analyst*

Goals for today

1) Share history & context, process, key considerations and current state

2) Gather high-level input from OHA committees and Community Advisory Councils on a social needs screening metric*

**Note: the SDOH Measurement Workgroup, which convenes Oct-Dec, is the decision-making group for the final measure recommendations to the Metrics & Scoring Committee. Your feedback will be shared with the Workgroup in November for their consideration.*

History

- **2015:** Metrics and Scoring Committee begins considering measurement around SDOH, which resulted in development of a clinic-level food insecurity screening measure (not adopted)
- **September 2017:** Governor Brown directed CCO 2.0 to include goals/requirements for CCOs related to SDOH and health equity
- **Late 2018/early 2019:** Metrics & Scoring and Health Plan Quality Metrics Committees endorsed development of broader, plan-level SDOH measure (to include, but not be limited to, food insecurity)
- **June 2019:** Letter from Governor Brown called for the CCO Quality Incentive program to include transformational measures aligned with CCO 2.0 goals

Social determinants of health vs. social needs

Social determinants of health:
The social determinants of health refer to the social, economic, and environmental conditions in which people are born, grow, work, live, and age, and are shaped by the social determinants of equity. Examples: housing availability/quality, access to healthy foods, income

Health-related social needs:
The social and economic barriers to an individual's health. Examples: housing instability, food insecurity

Metrics and Scoring Committee request

- Metrics and Scoring Committee **approved overall social needs screening measurement direction** in 2019, in alignment with prior interest in food insecurity screening
  - Includes **social needs screening completion and reporting** of data
  - May include **referral data**
- **National social needs screening trend** (RI, MA, NC)

SDOH Measurement Workgroup

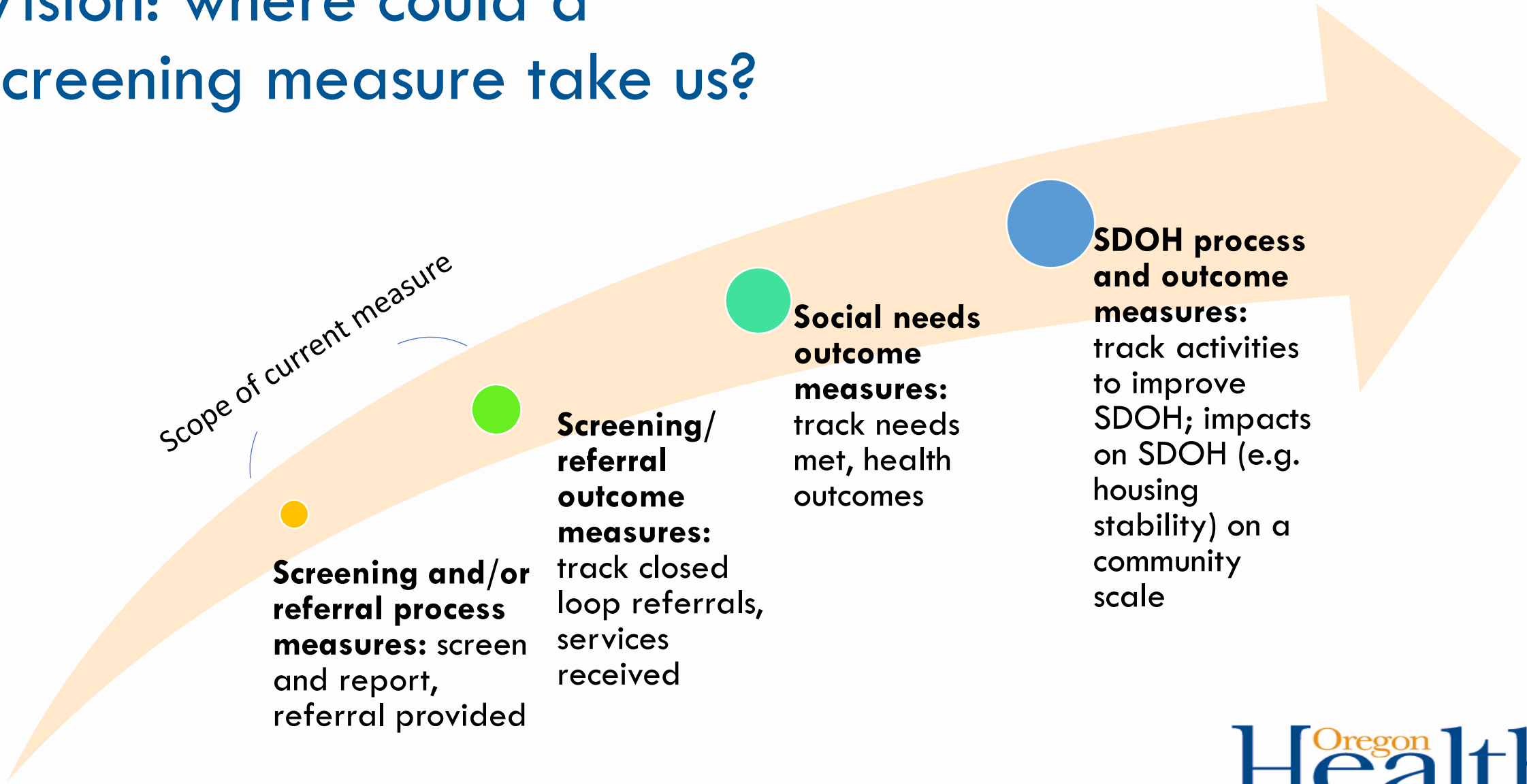
Goal

More CCO members have their social needs acknowledged and addressed

Objective

By December 2020, we will identify a proposed measure concept that incentivizes social needs screening to recommend for the Metrics and Scoring and Health Plan Quality Metrics Committees

Vision: where could a screening measure take us?



Social needs screening measure development timeline

2019

Planning, workgroup recruitment

2020

Measure development and proposal

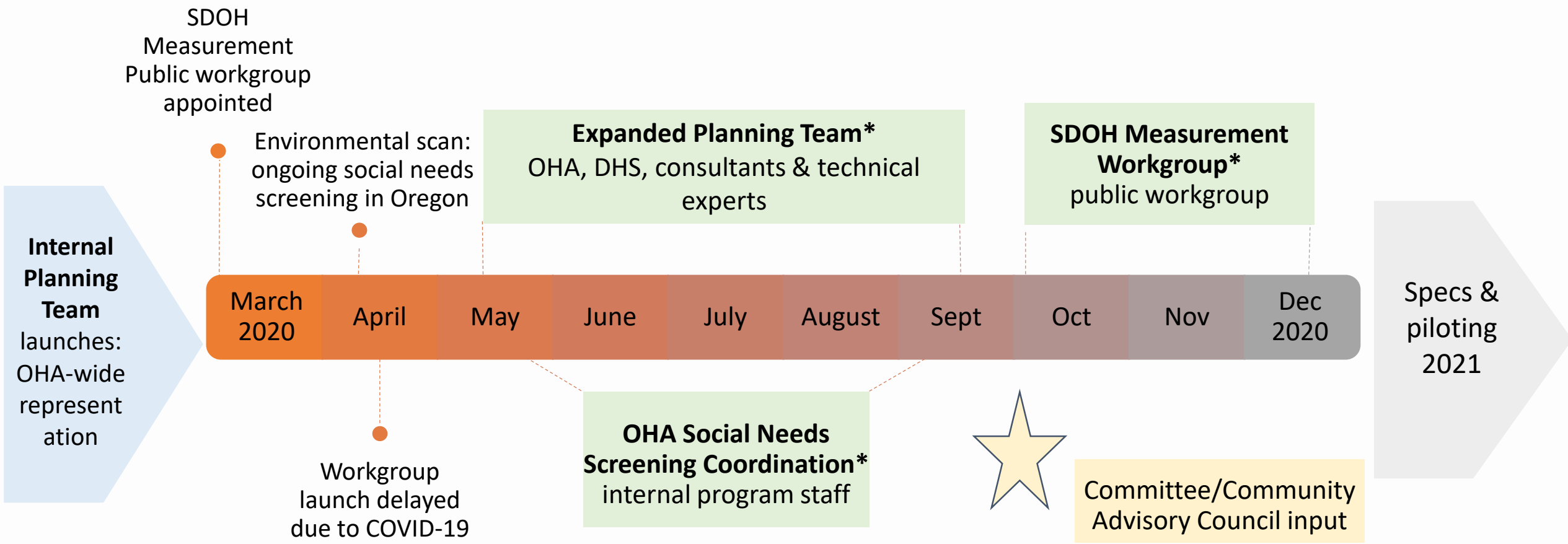
2021/2022

Measure piloting/testing

2023

Measure ready for implementation

Measure development timeline (2020)



*Project management and facilitation by Nancy Goff & Associates, with technical expertise from OHSU/ORPRN

Guiding principles for measure concept

EQUITY

- Centers equity and trauma-informed practice
- Remains focused on the ultimate outcome of improved health and wellbeing for all Oregonians
- Acknowledges limitations and potential harms (especially to patients/members) that could result from our work

ALIGNMENT

- Aligns with broader OHA SDOH goals (and Medicaid 1115 waiver)
- Is driven by a shared definition of and framework for addressing SDOH and social needs
- Lays the foundation to spur meaningful and sustainable action to address social needs into the future
- Builds collective action toward shared goals and standardization in priority/approach
- Considers alignment with other OHA (and partners) current social needs screening practices

FEASIBILITY

- Is feasible, especially for the health system to report or collect data for the purposes of a metric

Equity framework: Health Equity Definition

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 redistributing of resources and power; and
Recognizing, reconciling and rectifying historical and contemporary injustices.

-Oregon Health Policy Board & Oregon Health Authority

Considerations for designing an equitable and trauma-informed metric

Design for the most underserved/marginalized communities

- ❑ Promotes equitable distribution of resources and power
- ❑ Avoids disadvantaging due to race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class or intersections between these factors
- ❑ Recognizes, reconciles and rectifies historical and contemporary injustices
- ❑ Linguistic & cultural appropriateness

Center those screened

- ❑ Patient-centeredness (promotes autonomy & respect, focuses on strengths)
- ❑ Family-centeredness
- ❑ Includes people with lived experience in process

Encourage equitable/trauma-informed screening practices

- ❑ Prioritizes trust between screener & patient
- ❑ Clarity & accessibility of questions and format
- ❑ Ensures adequate training for screeners
- ❑ Avoids inability to address needs identified

Align with and support community initiatives

- ❑ Supports ongoing work of Community Based Organizations (CBO)
- ❑ Promotes accessibility of information by CBOs
- ❑ Avoids overburdening CBOs
- ❑ Prioritizes local knowledge & allows for local flexibility
- ❑ Avoids the potential of retraumatization due to re-screening

Key considerations for measure development

The SDOH Measurement Workgroup will consider the following in developing a social needs screening measure concept…

- Who is screened
- Where are they screened and who screens
- How often are people screened
- What are they asked about
- How do we collect the data

Discussion

- When we are asking people about their social needs (i.e. social needs screening) in the context of CCOs or the health system, what issues or experiences would you like to elevate for Workgroup consideration?

- What is one critical thing you want the Workgroup to keep in mind when developing a social needs screening metric for the CCO Quality Incentive Program?*

**Note: the SDOH Measurement Workgroup, which convenes Oct-Dec is the decision-making group for the final measure recommendations to the Metrics & Scoring Committee. Your feedback will be shared with the Workgroup in November for their consideration.*

Thank you!

For more information:

Chris DeMars, Chris.DEMARS@dhsoha.state.or.us

Amanda Peden, AMANDA.M.PEDEN@dhsoha.state.or.us

SDOH Measurement Workgroup Website

Progress Update: Modernization of a Public Health Survey System

Public Health Advisory Board Meeting
October 15, 2020

Oregon Health Authority

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Reminder: What is the survey modernization project?

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Reliance on Behavioral Risk Factor Surveillance System (BRFSS)

- Telephone survey of adults in Oregon
- Part of national survey
- Range of topics: risk and protective factors, prevention/screening, health outcomes, demographics
- Every few years, racial and ethnic oversample conducted

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Current challenges with BRFSS

- Expensive
- Lack estimates for smaller geographic areas
- Survey is long
- Concerns about representativeness and validity of data
- Lack of community engagement
- Lack data for Pacific Islander communities

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Modernization framework for identifying new approach

- Assessment & epidemiology
- Health equity & cultural responsiveness
- Community partnership development
- Policy & planning

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Taking a new approach

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Instead of conducting the usual BRFSS racial and ethnic oversample:

- Combine 4 years of standard BRFSS data for analysis for communities of color
- **AND**

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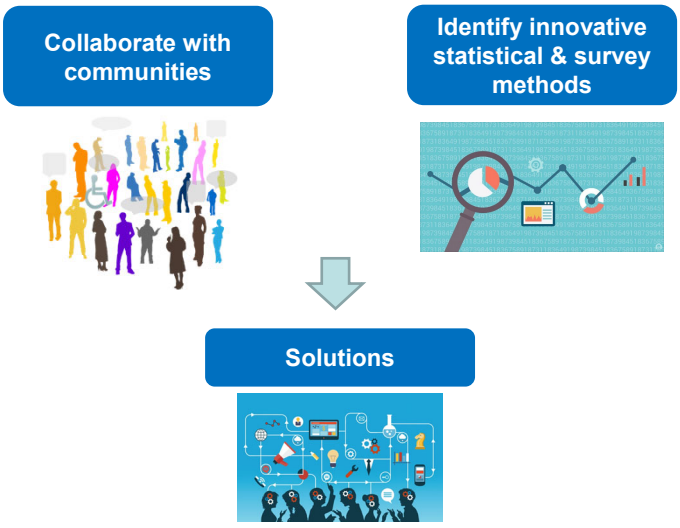

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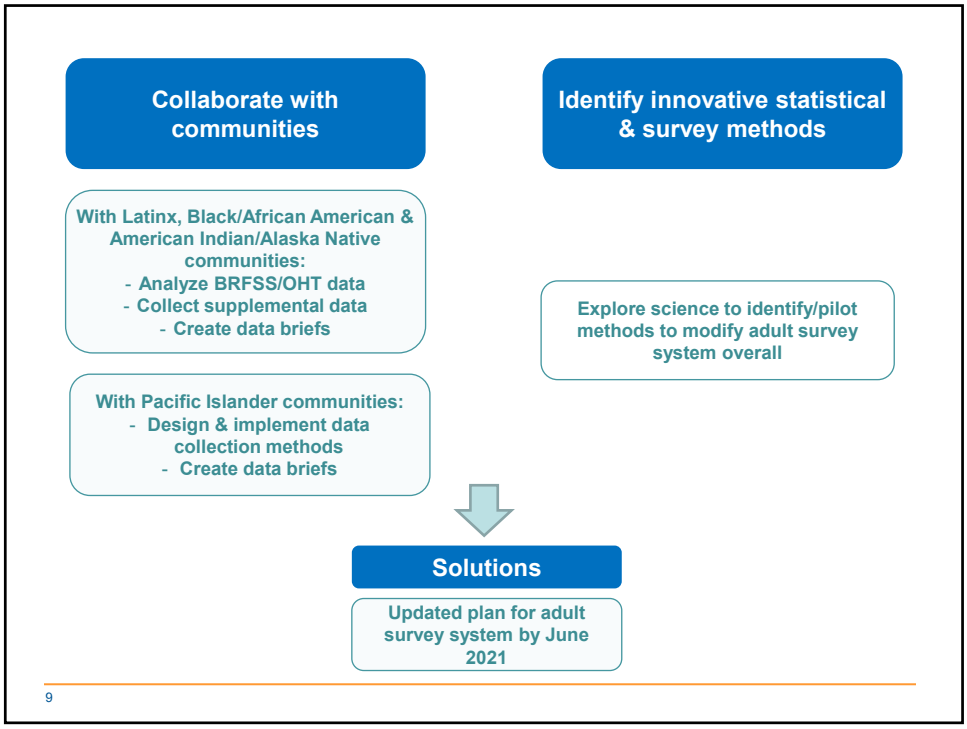
Collaborate with communities
Identify innovative statistical & survey methods
With Latinx, Black/African American & American Indian/Alaska Native communities:
- Analyze BRFSS/OHT data
- Collect supplemental data
- Create data briefs
Explore science to identify/pilot methods to modify adult survey system overall
With Pacific Islander communities:
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Solutions
Updated plan for adult survey system by June 2021
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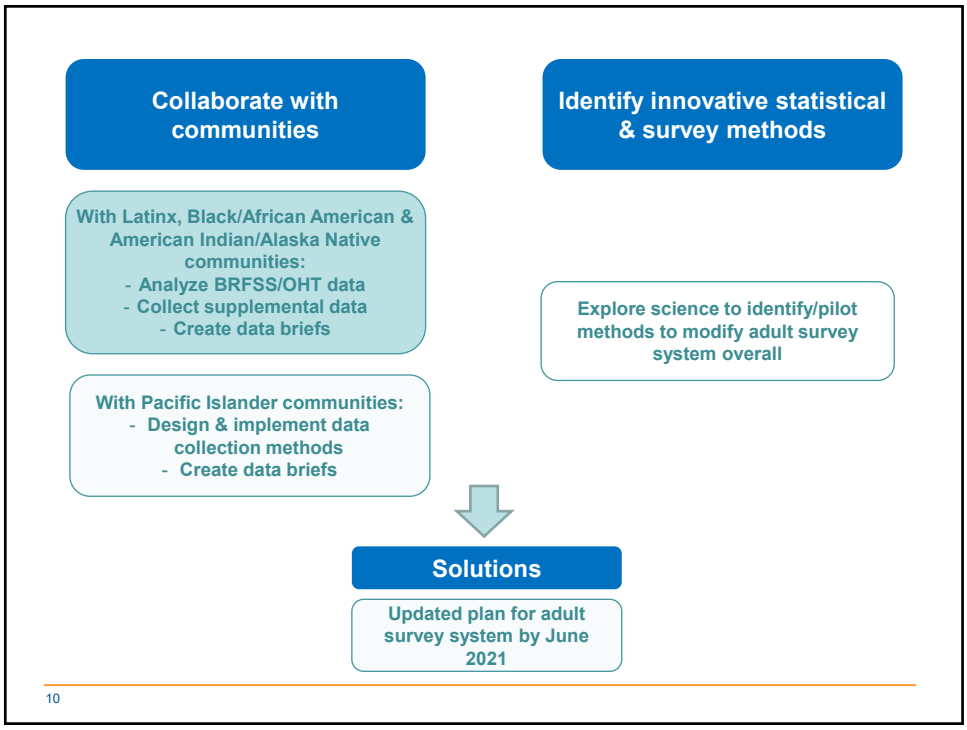
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Collaboration with Latinx, Black/African American & American Indian/Alaska Native communities

- Created a four-year BRFSS file, weighted for analyses by race/ethnicity
- Extensive partnership infrastructure building took place between October 2019 - March 2020
- Internal team project team - Partnership between Coalition of Communities of Color (CCC) & PDES
- Latinx and Black/African American project teams of 4-5 individuals consisting of both representatives from community-based organizations (CBOs) and researchers who are community members and have conducted community specific health related research
- NPAIHB will identify and lead the American Indian/Alaska Native project team

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Global Pandemic & Political Uprising

- Communities of Color are hit the hardest – health, economics, education, hate, housing, etc.
- Mainstream data bolsters research oppression
- Communities of color are fed up with the same responses and lack of accountability
- Demands for systems change is the new normal

What we can do...

- Use data to help our communities
  - Let communities of color frame how mainstream data fails to represent us
  - Connect available mainstream data to the data driven by our communities
  - Help local and regional entities with supplemental data collection strategies
  - Better yet, let communities lead the discussion on data needs

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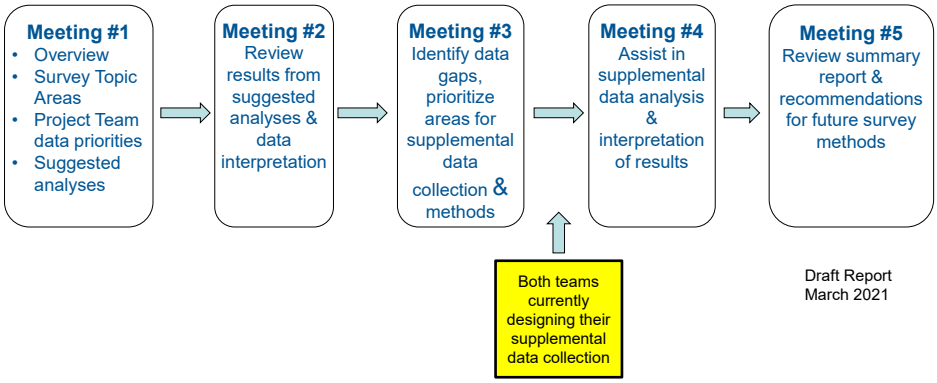
Project Team Process Goals



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Success to date

- Engagement & enthusiasm despite competing and numerous internal and external demands
- Understanding of clear limitations to data quality
  - Construct validity
  - Data relevancy

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Healthcare Access

- Current BRFSS health care access questions – healthcare coverage, OHP enrollment, personal doctor, not go to doctor because of cost, length of time since last check up
- Questions need to include what's keeping them from going to the doctor apart from cost and coverage
- Examples include:
  - Availability of service
  - Do you know how to use health care coverage
  - Do you know what you are covered for
  - Experiences of health care discrimination & medical mistrust
  - Feel listened to by your provider

"When you are poor you don't have time to be sick."

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Lessons Learned

(Tom Peterson – BRFSS/OHT Data Manager past 10 years)

- There is a strong need to partner with communities and to share in the data discovery process in order to produce more relevant data.
- The survey format itself may be a limitation or barrier to collecting accurate data from communities. We need to continue to explore alternative methods in partnership with communities to better collect data that communities find relevant.
- Not letting the "small numbers" argument get in the way of sharing data with communities. Sometimes communities see this as intentional, which can create distrust. Sharing potentially flawed data is better than no data.

  ⇨ Recommendation – Provide cautionary narrative about possible interpretation of small numbers
- Our survey translations were largely well received from the community, but in some instances asking for their feedback helped refine the question text to better reflect the actual intention of questions.

  ⇨ Recommendation from Latinx Team – External Advisory Group on Translation

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Key Lessons to Date

- Scientific integrity is compromised without community engagement
  - Validity, relevancy and generalizability
  - Behavior questions presented without context shift entire responsibility to the individual and let institutions off the hook for their part in creating, perpetuating and exacerbating disparities
  - Design questions so that they result in data that is actionable and can drive community program policy change
  - Community engagement at every step of the process from question design, data analysis and reporting
- Equity as a starting point for survey design rather than being driven by siloed programmatic needs than community centered (OHT)
- Some of the data affirms community concerns
- Data justice – fairness in the way people are made visible, represented and treated as a result of their production of digital data (Taylor, 2017)

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Collaborators

Coalition of Communities of Color:
Dr. Andres Lopez, Research Director

Latinx Project Team:
Dr. Lorraine Escribano, Director of Evaluation, Latino Network
Roberto Gamboa, Operations Manager, Euvalcree
Dr. Daniel Lopez-Cevallos, Associate Professor, Oregon State University
Claudia Montano, Projects Manager, The Next Door, Inc
Karla Rodriquez, Community Health Worker, Oregon Latino Health Coalition

Black/African American Project Team:
Dr. Roberta Hunte, Assistant Professor, Portland State University
Oluchi Onyima, formerly of Urban League, now independent consultant
Sherly Paul, Community Health Nurse, Multnomah County Healthy Birth Initiative
Dr. Ryan Petteway, Assistant Professor, OHSU-PSU School of Public Health

NPAIHB Collaborators:
Bridget Canniff, Project Director
Dr. Victoria Warren-Mears, Director Tribal Epidemiology Center

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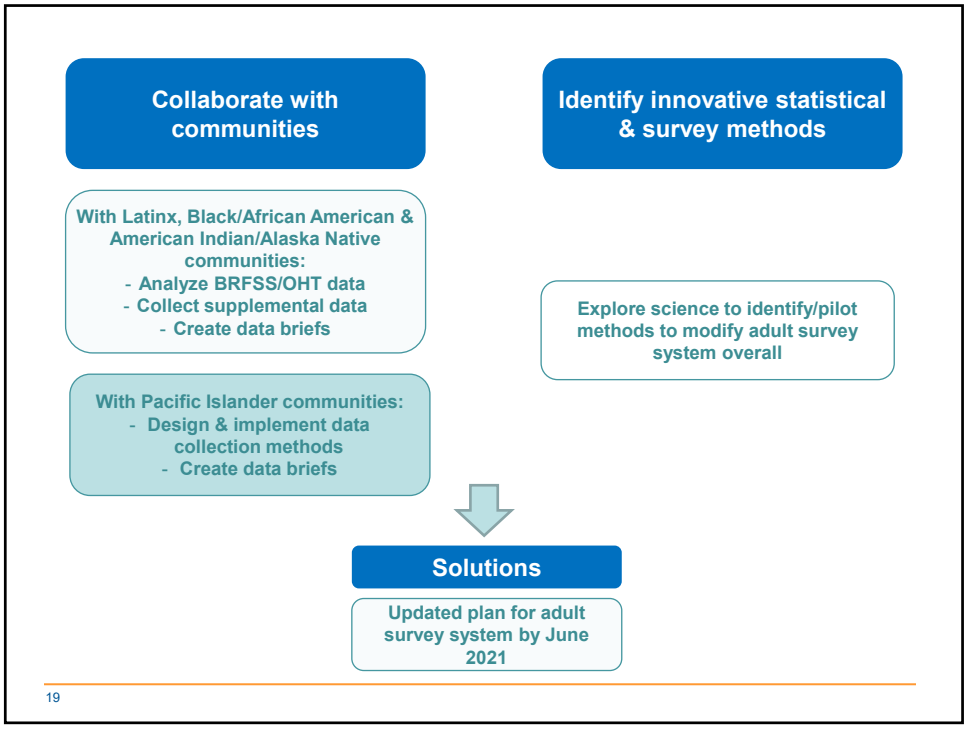

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Collaboration with Pacific Islander communities

- Extremely low Pacific Islander response on the BRFSS
  - Latest race and ethnic oversample combined year dataset includes responses from just 106 Pacific Islander people
- Not possible to calculate population estimates with low response rate, so data are not useful
- Previous work with Pacific Islander communities suggests methods like BRFSS are not the correct approach

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Collaboration with Pacific Islander communities

- Developed new relationships and strengthened ongoing partnerships in the Pacific Islander community
  - Alyshia Macaysa, Community Lead
- Built partnership with Multnomah County's Pacific Islander Data Project (PIDP) team
- Established small project team, including members of the County's PIDP
- Work is informed by community leaders as well as the Multnomah County Pacific Islander Coalition and the Oregon Pacific Islander Coalition

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Pacific Islander Data Modernization (PIDM)

- PIDM aims to utilize Pacific Islander leadership to study *Community Determinants of Health* for Oregon's Pacific Islander communities
- PIDM builds off Multnomah County's PIDP:
  - Community-based participatory research (CBPR) model
  - Put Pacific Islander wisdom at the center of this work
- Goal: Collect relevant data through a community-based and action-oriented approach to tell the story of what it means to be a Pacific Islander in Oregon
  - Utilizing the Prevention Institute's THRIVE Tool

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THRIVE Framework and Community Assessment

- PIDM will utilize the Prevention Institute's THRIVE Framework
  - Assesses how structural drivers (e.g., racism) play out at the community level in terms of social-cultural, physical/built, and economic/educational environments
  - These *community determinants of health* have consequences for health, safety, and healthy equity
  - PIDM Community Lead worked on THRIVE tool during tenure at Prevention Institute

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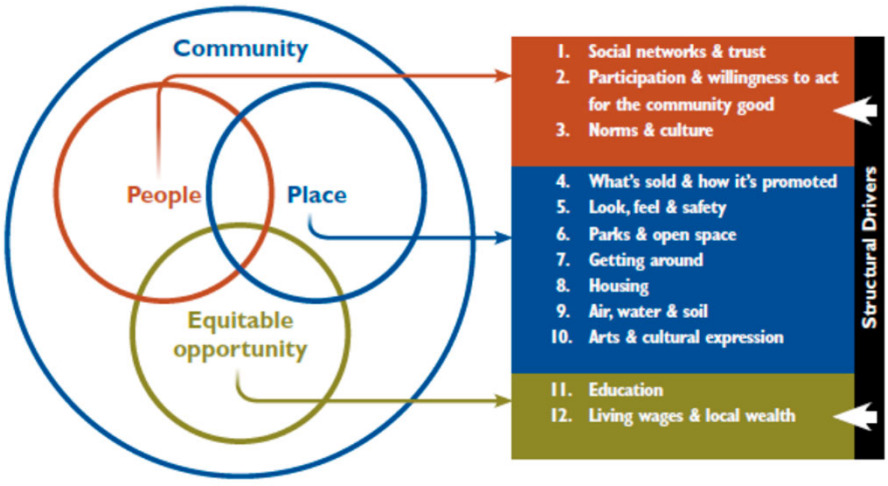

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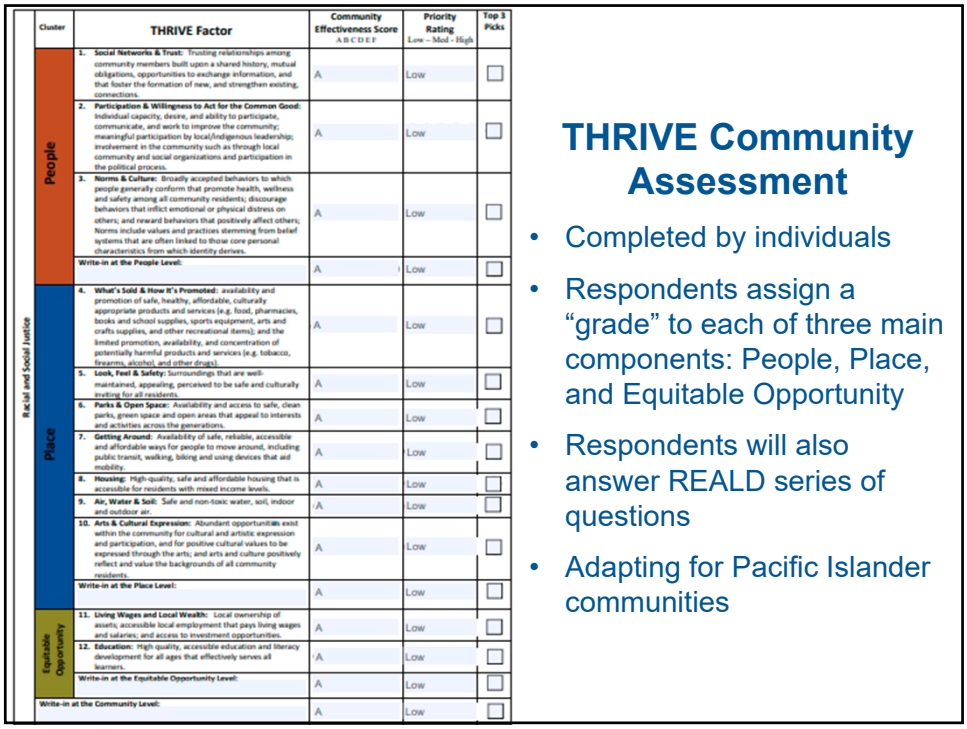

THRIVE Community Assessment

- Completed by individuals
- Respondents assign a "grade" to each of three main components: People, Place, and Equitable Opportunity
- Respondents will also answer REALD series of questions
- Adapting for Pacific Islander communities

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Pacific Islander Data Modernization, cont.

- Adapting PIDP community engagement model into "train the trainer" approach
- Engage CBOs during Project Kickoff: November 7, 2020
  - Gauge interest and capacity to support PIDM
- Help CBOs identify Community Research Workers (CRWs)
  - CRWs trained on CBPR, THRIVE Framework, and THRIVE Community Assessment Tool in November and December 2020
- CBOs recruit community members and host data collection workshops in January and February 2021
  - CRWs co-facilitate workshops, support community members completing assessment, support data analysis and reporting

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Successes to date

- Centering Pacific Islander community to lead this work
- Engaged weekly meetings with core team, despite pandemic and other competing projects
- Enthusiasm among broader community
- Recent selection of key dates:
  - Kickoff meeting with CBOs: Saturday, Nov 7th
  - Train the trainers session: Saturday, Nov 21st
- Drafted scopes of work for CBOs and CRWs
- Relationships and engagement are built-in through team

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PIDM Collaborators

Oregon Pacific Islander Coalition, Pacific Islander Data Project (PIDP)
Alyshia Macaysa, Health Equity Strategist, Macaysa Consulting

Pacific Islander Data Project (PIDP)
Virginia Luka, Multnomah County
Maria Dizon, Multnomah County
Dr. Aileen Duldulao, Multnomah County

Oregon Pacific Islander Coalition

Multnomah County Pacific Islander Coalition

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