AGENDA

PUBLIC HEALTH ADVISORY BOARD

March 18, 2021, 2:00-3:30 pm

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

Meeting ID: 160 932 6045
Passcode: 107561

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Meeting objectives:

- Approve February meeting minutes
- Discuss Public Health Advisory Board subcommittees
- Discuss COVID-19 response and vaccine equity

2:00-2:15 pm	**Welcome and agenda review** • ACTION: Approve February meeting minutes • Recap on Oregon Health Policy Board retreat	Veronica Irvin, PHAB Chair
2:25-2:35 pm	**Discuss PHAB subcommittees** • Provide update on subcommittee work ahead	Sara Beaudrault, Oregon Health Authority
2:35-3:10 pm	**COVID-19 response and vaccine equity** • Discuss culturally-specific approaches to COVID-19 response and vaccine roll out	Dolly England, Oregon Health Authority Quete Capuia and Teresa Johnson, Highland Haven Manumalo "Malo" Ala'ilima UTOPIA PDX Marin Arreola, Interface Network
3:10-3:20 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	Veronica Irvin, PHAB Chair

3:20-3:30 pm	**Public comment**	Veronica Irvin, PHAB Chair
3:30 pm	**Next meeting agenda items and adjourn**	Veronica Irvin, PHAB Chair

Public Health Advisory Board (PHAB)
DRAFT February 18, 2021
Meeting Minutes

Attendance:

Board members present: Dr. Eli Schwarz, Kelle Little, Dr. Bob Dannenhoffer, Dr. Sarah Present, Dr. Veronica Irvin, Muriel DeLaVergne-Brown, Rachael Banks, Carrie Brogoitti, Alejandro Queral, Dr. Jeanne Savage, Dr. David Bangsberg, Rebecca Tiel (Chair)

Board members absent: Dr. Dean Sidelinger, Eva Rippeteau, Sarah Poe

Oregon Health Authority (OHA) staff: Cara Biddlecom, Sara Beaudrault, Angela Allbee, Dr. Dagan Wright, Lisa Shields, Krasimir Karamfilov

Members of the public: None

Welcome and Agenda Review
Rebecca Tiel

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

- *Approval of January 2021 Minutes*

A quorum was present. Dr. Schwarz moved for approval of the January 21, 2020, meeting minutes. Dr. Irvin seconded the move. The PHAB approved the meeting minutes unanimously.

Elect New Chair
Cara Biddlecom (OHA Staff)

Ms. Tiel remarked that she had been in the chair role for over two years and it was time to elect a new board chair.

Ms. Biddlecom thanked Ms. Tiel for her chairpersonship. She reminded the board members that the chair position is a two-year commitment with an option to extend it. There is one nominee, Dr. Veronica Irvin, who is the PHAB's public health academia representative.

Ms. Biddlecom asked the board if there were any other nominations for the chair position. There were no other nominations. She thanked Dr. Irvin for being willing to step into the chair role.

Ms. Biddlecom called down the role of the voting members, in order to elect Dr. Irvin as the board chair. Dr. Irvin was elected as the new PHAB chair unanimously.

Dr. Irvin shared that she hoped to continue being as organized and efficient as Ms. Tiel had been. She thanked the board for electing her.

Discuss PHAB Subcommittees
Sara Beaudrault (OHA Staff)

Ms. Beaudrault stated that, last fall, the PHAB agreed to include community partners in two of its subcommittees, the Accountability Metrics subcommittee and the new Strategic Data Plan subcommittee. Including community partners is a great step forward toward PHAB's health equity policy, both in terms of making sure that PHAB's work is directed by community and that centering community and health equity are in everything the board does.

Ms. Beaudrault noted that there were six people for the board to consider. The OHA team reached out to these individuals yesterday to let them know that their names would be shared with the board today for this discussion. The review process had two phases. Seventy-five applicants applied for the six spots. Four PHAB members – Dr. Schwarz, Mr. Queral, Dr. Savage, and Dr. Irvin – took part in the first review, which was quantitative scoring of the applications that people submitted. In addition, four OHA reviewers focused on data and equity issues around community engagement in the candidates' daily work.

Ms. Beaudrault added that after the scores were compiled, the list was narrowed down. She and Ms. Biddlecom then looked at the secondary information that applicants provided to ensure that there was good representation of Oregon in the subcommittees. Secondary information included geographic representation, racial and ethnic diversity, and whether people identified as being a person with lived experience in the populations that they served or represented in their work. After these considerations, six people remained on the list.

Dr. Schwarz shared that his only complaint was that the Excel spreadsheet that the OHA team sent to the board was locked. He couldn't do anything.

Ms. Beaudrault responded that she would be happy to send out a different version of the file.

Ms. Biddlecom remarked that 3 or 4 board members were identified for each subcommittee, because the board had to split across three subcommittees.

Ms. Beaudrault added that a few alternatives had been identified in addition to the six selected individuals because some people might no longer be able to participate or their circumstances changed since they applied in December or January.

Ms. Beaudrault introduced the six community members. Kat Mastrangelo is the executive director of Volunteers in Medicine at the Clinic of the Cascades. Olivia Gonzales is a lead regional recruiter for the Willamette ESD Migrant Education Program. Sabre Patton-Fee is in a currently inactive position in southern Oregon. Juan Ugarte is a clinic manager at Virginia Garcia Memorial Health Center. Hongcheng Zhao is the president of the Oregon Chinese Coalition. Gracie Garcia is the community service director at Bienestar.

Dr. Schwarz asked if the numbers for the six people could be shared with the board, so that they could be linked to the information in the Excel spreadsheet.

Ms. Beaudrault agreed to share the numbers and clarified that the Excel spreadsheet was the document that the four PHAB reviewers used during the scoring stage. The applicants were deidentified during the selection process.

Dr. Present acknowledged that the Excel file was not sent to all board members. She added that she had a lot of trust in the board members who reviewed the applications and thanked them for their recommendations.

Ms. Tiel stated that the board did not need a formal action to adopt the list of community representatives on the subcommittees.

Ms. Beaudrault explained that the subcommittee meetings had not been scheduled, but they would be scheduled soon.

Ms. Tiel thanked Ms. Beaudrault for the great selection process and for encouraging the board to expand its subcommittee work.

2021 Legislative Session Bills
Angela Allbee (OHA Staff)

Ms. Allbee remarked that she would provide a very brief, high-level overview of the 2021 Legislative Session bills, and her focus would be on those bills that the Governor had introduced on behalf of the Public Health Division (PHD). She introduced herself as a senior policy adviser with the Oregon Health Authority, serving on the government relations team. She added that in 2019, which was a long session, the Public Health Division tracked over 600 bills, working on over 200 of them. The division is tracking over 400 bills at this time.

Ms. Allbee explained that Public Health Director, Ms. Rachael Banks, provided an overview of the PHD's budget on February 2, 2021, to the Joint Ways and Means subcommittee on human services. Public testimony on the budget was heard on February 9, 2021. Several PHAB members supported the budget and public health modernization.

Dr. Schwarz asked if the PHD asked for more money.

Ms. Allbee answered that it did. She added that, initially, in the OHA request budget, PHD asked for $68.9 million. The Governor prioritized $30 million in the Governor's recommended budget. While PHD supported the Governor's budget, many OHA partners supported the $68.9 million that was requested in the agency request budget. In addition to OHA's work with public health modernization, there are several policy option packages tied to legislation. There is a lot of legislative support, vocalized in public hearings, both in the last session in the last biennium and currently. Last year illustrated the importance of the work in public health, both in COVID-19 response and wildfire response.

Ms. Allbee noted that the Governor's Vaping Workgroup had two policy recommendations: tobacco retail licensure (House Bill 2071) and banning flavored tobacco products (House Bill 2148). Senator Kathleen Taylor has Senate Bill 587, which is an introduced version of a tobacco licensure program. OHA is supporting this bill and Public Health Director Rachel Banks will be testifying when that bill is up.

Ms. Allbee added that a lot of OHA partners had devoted their energy to the passing of the tobacco retail licensure bill during this session.

Ms. Allbee explained that Representative Pam Marsh and the Oregon Attorney General (Ellen Rosenblum) introduced, in partnership, House Bill 2261. This is an online sales ban to prohibit the remote sale of inhalant delivery systems and tobacco products online. It is not an OHA bill. Questions about the bill should be directed to Representative Marsh and the Oregon Attorney General.

Dr. Savage asked if the tobacco retail licensure bill, Senate Bill 587, was tied to dollars that would be revenue for the state.

Ms. Allbee answered that it would be a statewide tobacco retail licensure program. It would not prohibit local communities from being able to have their own more stringent program if they chose to. The work on how to price the licensure is in progress. Fees would cover the cost of implementing some of this work.

Dr. Savage asked if any money from the licensure fees would come to public health through the budget later or that the money would go into a general fund.

Ms. Allbee answered that, based on all the discussions that she had had in previous sessions, the fees would cover the cost of working the program, such as programmatic costs of technical support, especially with retailers, including outreach.

Ms. Allbee stated that another bill worth mentioning was House Bill 2621. It is Representative Sheri Schouten's bill and it has to do with the Indoor Clean Air Act. This bill expands the definition of a public place to include commercial and residential buildings with two or more units. It increases the Indoor Clean Air Act from 10 feet to 25 feet from a public place or place of employment.

Ms. Allbee explained that when the legislature created programs that were fee-based and required the agency to be able to meet certain guidelines and statute, the fees of the programs covered the cost of doing the work. When some of these fee programs are unable to raise the fees, the legislature has to do that through statute. A bill related to this is House Bill 2072. This is a home healthcare fee increase bill. OHA conducts surveys for home healthcare agencies and responds to complaint investigations. If there is a concern about abuse, or an agency is out of compliance, OHA responds and does that work. There are approximately 68-69 home healthcare agencies in Oregon. In order for the program to be self-sustaining, the fees must be raised. The smaller agencies might have a more difficult time than the larger ones in paying for that increase. OHA is working on language that will create a more equitable fee schedule.

Ms. Allbee remarked that the next fee bill was House Bill 2074. This is OHA's prescription drug monitoring program fee increase bill, otherwise known as the PDMP fee increase bill. Ms. Biddlecom will be presenting on that bill later today. It is a $10 increase, from $25 to $35, in order to continue to maintain this program sustainably.

Dr. Present asked who paid those fees.

Ms. Allbee answered that users of the PDMP system – physicians, pharmacists. licensed providers – paid the fees when they renewed their licenses.

Dr. Schwarz asked if there were any other changes taking place with the PDMP. One of the problems with the Oregon PDMP is that data cannot be taken out of it because of various restrictions.

Ms. Allbee answered that lot of conversations about some of the challenges and benefits the PDMP offered were directed to the PDMP advisory committee. In this session, this is the only bill that impacts the PDMP. She added that another fee bill was House Bill 2075, radiation protection services fee increase bill. There are three pieces to the radiation protection fee increase bill: (1) x-ray machine technology and usage inspection, (2) tanning beds, (3) radiation materials.

Ms. Allbee added that OHA had two policy bills. The first one is House Bill 2077 (lead-based paint remediation). Oregon is one of the states that administer a lead-based paint program on behalf of the Environmental Protection Agency (EPA). This bill proposes that OHA co-

administers the program on behalf of the EPA with the Construction Contractors Board. It is a complaint-driven program. If a property is not in compliance with lead-safety, a citation is issued. This bill allows OHA to compel contractors to clean up unsafe sites, especially HUD housing, low-income housing, and housing for communities of color and other vulnerable populations.

Ms. Allbee stated that the second policy bill was House Bill 2076 (EMS modernization). This bill creates a vision for EMS in the future. The bill has three parts: (1) reorganization of advisory committees on state and regional level, (2) preparation and creation of emergency healthcare plans, (3) fee increase. The vision is to create an emergency medical system that is responsive, efficient, and gets people the right resources at the right time.

Ms. Allbee noted that a bill that might be of interest to the PHAB was House Bill 2842. This bill is introduced by Representative Pam Marsh and it is about the creation of a healthy homes program within OHA. The program would administer grants to low income households or property owners that rent. The program would be administered by OHA. It would also create and interagency advisory group that would take a look at the healthy homes program and draw on the strengths of partnerships across the state. OHA has no position on this bill.

Dr. Schwarz asked if the landlords or the tenants would get the grants.

Ms. Allbee answered that the grants would be for both households and property owners renting to tenants. Those grants would be available for low-income households that either rent or own their home.

Dr. Schwarz asked if the purpose was to prevent allergies or something similar.

Ms. Allbee answered that this bill could address issues like lead, mold, outdated wood stoves that released environmentally toxic substances in the air, and moldy or leaking rooftops. The grants can address many things.

Dr. Present remarked that there were several grants and programs at the local level that had been called healthy homes for various things, such as home asthma mitigation, getting vacuum cleaners, and so on. She asked if the goal was to create a new department that would coordinate different programs that the counties have that have been sporadically funded.

Ms. Allbee answered that the bill would create a different program that would have a relief fund at its center, in order to administer grants. It is in partnership and parallel with the many programs that are already in existence. The intention is not to regulate or to control the existing programs, but to address some of the gaps that currently exist around the state.

Ms. Allbee pointed out that another bill that might be of interest to the PHAB was House Bill 2495 (Toxic-Free Kids Act). The state is in the implementation phase of the bill, which was adopted in 2015. Representative Courtney Neron has taken over that body of work with an interest in ensuring toxic materials are not available for certain parts of children's toys, such as mouthable items. OHA has no position on this bill.

Ms. Tiel thanked Ms. Allbee for the legislative update. She suggested that Ms. Allbee should return at a future board meeting to talk about how these bills were progressing and to inform the board of the bills she didn't cover today.

Ms. Allbee thanked Ms. Tiel for the invitation and agreed to come back for a post season debrief.

Dr. Schwarz asked if Ms. Allbee, when she came back, could talk about how OHA made the decision to not have a position on an issue that was really good.

Ms. Allbee agreed to cover that and provide the agency perspective.

Opioid Overdose Update
Dr. Dagan Wright (OHA Staff)

Dr. Wright introduced himself as a research analyst in the Injury and Violence Prevention Program (IVPP) at OHA, as well as a faculty member at the OHSU/PSU School of Public Health and a volunteer VA (Veterans Affairs) research fellow. He pointed out that he would share some observations on COVID-19 with overdose and coordinated services in Oregon.

Dr. Wright remarked that in early 2020, the state had a spike in overdose deaths, with a peak occurring around April and May of 2020, almost 70% increase compared to 2019. There is a lag in receiving results from proper coding and toxicology lab panels. August 2020 was the last month recorded. He added that overdose also peaked in April and May of 2020. It also showed a peak with specific drug categories, such as opioids, Fentanyl, meth, or amphetamine. Often there is more than one drug involved in a death, such as tramadol and meth/amphetamine. These data come from a CDC grant (i.e., SUDORS, or State Unintentional Drug Overdose Reporting System).

Dr. Wright stated that there was a significant higher rate in deaths for African American, American Indian/Alaska Natives, and males, compared to their proportion in the population. Other minorities or populations show a lower proportion of death rate relative to their population rate overall. Homeless people accounted for 16% of the overdose deaths. Around 9% were veterans. Around 97% of those deaths were unintentional.

Dr. Wright noted that, in Oregon, there had been a history, as well as concerns at the federal level within the state and institutions, around structural racism, with barriers having a negative impact on service and prevention efforts. In addition, these communities often have higher rates of trauma, including historical trauma. There is an interesting but alarming history around racism in the war on drugs. It is described in many books, such as *Chasing the Scream* by Johann Hari.

Dr. Wright explained that similarly to deaths, there was a bump in hospitalizations in April and May 2020. The rate is per 1,000 admissions. A drop in the overall hospitalizations was observed and by showing a rate, it accounts for this variation in the drop of hospital admissions versus the drug-related admissions. This is broken down by drug types: opioid, heroin, and stimulant overdoses. For in-patient hospitalizations, there is a significant higher rate for African American, but not for Native American and Alaska natives. Regardless of race or ethnicity or sex, the primary payer for majority of hospital admissions was Medicaid. This additional insight can be used as another opportunity to do outreach for support services, prevention, or do some more alignment around the state health improvement plan.

Dr. Wright pointed out that the data for emergency department (ED) admissions came from an administrative emergency department dataset. As with the hospitalizations and the deaths, there was a bump around April or May 2020. The rate showed an overall steady visit rate from ED, even though there was a plunge in ED visits around March through May 2020. People were scared and afraid to go to the ED, but there was a consistent admission rate for EDs.

Dr. Wright stated that another resource for ED data was the Syndromic Surveillance Reporting for Emergency Departments and Urgent Care (ESSENCE). The hospitals are pushing out ED visits to this system within 24 hours. There were 2,678 opioid overdose visits in 2019 and 2,719 in 2020. An overlay of the two graphs shows the wild fluctuation in counts. This is an ongoing and key information resource to better help and focus outreach efforts.

Dr. Wright remarked that similarly to ED, there was a higher proportion rate with African Americans being admitted, but again, not as much with Native American Indians, Alaska natives, the Hispanic population, and the Asian population. Along with the hospital admissions, the majority of ED admissions did show or report Medicaid as the primary payer. This could be another information source to help better inform or tailor outreach efforts for both services as well as prevention efforts.

Dr. Wright noted that Naloxone administrations per 1,000 EMS responses in 2020 showed a little bit of a different trend. There was a peak in April and May, a dip over the summer months, and another peak in December. Updated hospitalization and ED data will show how this trend looks with these Naloxone cases. EMS data can give very valuable insights for secondary prevention and outreach efforts. He added that the PDMP (Prescription Drug Monitoring Program) released an overdose report. In 2020, there is almost a 40% drop in the integrated

PDMP quarries from March until May, which rebounded in June and July. That was a profound drop.

Dr. Wright explained that the outreach efforts of the Oregon Opioid Initiative used a multiprong approach: reducing risk, reducing harm, protecting the community, and optimizing or making state and local data available. The Injury and Violence Prevention Program funds 11 local public health authorities (LPHAs) with over $1.4 million annually (2019-2022). The 11 LPHAs cover 22 of Oregon's 36 counties. They are combining grant dollars with local funding and community partnerships to develop overdose response plans, improve access to Naloxone, and implement evidence-based projects better tailored to their community needs.

Dr. Wright added that Reverse Overdose Oregon was another campaign that aimed to empower employers and bystanders to respond to overdose in the workplace. It provides Naloxone administration trainings to non-medical providers. In addition, the Oregon Heal Safely Campaign did a tremendous effort in reaching out to the community and listening to their needs. It worked on tailoring messages of hope, and messages with which people could identify, and built trust and connection with other communities that were missed or not addressed. Hearing lived experiences and having tailored messages often helps people identify with others in similar situations and promotes positive behavior change.

Dr. Wright stated that the Oregon Pain Guidance was another example in the multipronged approach in allowing communities to better manage pain, as well as empower patients and people to manage their own conditions. For peer education on pain and opioids, the Mental Health & Addiction Association of Oregon (MHAAO) provides peer-delivered services and peer-delivered education. This is critical for people struggling with chronic pain, as well as for people managing mental health or substance misuse.

Dr. Wright encouraged PHAB members and members of the IVPP on the call to comment or ask questions.

Ms. Shields added that the IVPP funded a large clinical quality improvement project through the Oregon Rural Practice-based Research Network to reach 60 clinics. They receive an 18-month intervention to improve opioid prescribing and pain treatment.

Dr. Dannenhoffer commented that Douglas County had been badly affected by the opioid crisis. The county has a grant that it shares with another county and the funding has been incredibly helpful. Results show that the use of Naloxone has really been amazing. Dozens of lives were saved due to Naloxone. Some people may think that these people are going to kill themselves anyway. It is clearly not the case. A save from Naloxone is truly a save. While the county teaches everybody how to do CPR and how to use a defibrillator, a person's chance of using Naloxone to reverse an overdose and save a life is far greater than those other

interventions, which are considered to be standard. He congratulated the IVPP team for their work.

Ms. Shields noted that the IVPP had gotten more organized with its statewide Naloxone efforts. OHA now has a statewide harm reduction clearinghouse in collaboration with OHA's Health Systems Division. This is another project to get Naloxone into the hands of those who need it.

Dr. Savage asked if the IVPP had partnered with the HIV Alliance throughout the state and if the program was working closely with HIV Alliance.

Ms. Shields answered that the IVPP funded the HIV Alliance with SAMHSA (Substance Abuse and Mental Health Services Administration) state opioid response callers. HIV Alliance is a very significant partner. The IVPP also works with other agencies. HIV Alliance now serves many counties in the state. It started with Lane County and now it is an entire area of the state.

Dr. Savage added that there had been many successes with HIV Alliance both in Lane and Marion counties.

Ms. Shields stated that the IVPP had partnered with Salem Health in Marion County for many projects, because there was have a very strong provider champion there (i.e., Dr. Paul Coelho). Dr. Coelho serves on the PDMP Advisory Commission. He has done a lot between Marion and Yamhill counties.

Dr. Schwarz commented that, looking at the shown curves, it didn't look like a lot was happening. He understood that there was a lot of anecdotal evidence that maybe this or that program might be useful in one particular county. The curves, however, appear either bubbling along flat or increasing a little bit. He felt a little bit disappointed.

Dr. Wright answered that a decrease was desirable. He shared an article published in JAMA. The CDC just shared with the IVPP national trends during COVID-19. In Oregon, there was an uptick with the deaths. While the OHA team did not see an uptick at the national level, the CDC did. Looking at just emergency department, the CDC included not only overdose, but they looked at domestic violence and some other trends. While the CDC saw increases in Oregon with ED and hospitalizations, the OHA team didn't see that trend during these COVID-19 times.

Dr. Wright added that everybody wanted to see the trend go down. Opioid dependency is a lifelong disease to manage. Some of these efforts may not be doing downward trends, but there has been leeway with the stressful times that kept Oregon from not following the national trend. Either there is some improvement in Oregon, or the state is not doing as rough as many others.

Ms. Shields stated that there were certain metrics not shown in the presentation that were successful. Oregon has greatly reduced risky opioid prescribing and risky co-prescribing with other sedatives, such as benzodiazepines. As shown on the accidental overdose death slides, deaths due to prescription opioids have decreased very significantly. Oregon is still not where it was in 1999, but it is gotten better since 2006. That is due to a lot of efforts at once. The very first federal opioid prevention dollars that came into Oregon were focused on reducing prescription opioid deaths because the vast majority of overdoses at the time were due to prescription opioids prescribed in primary care.

Ms. Shields added that it was discouraging to look at the huge increase in illicit substances. One of the things the Public Health Division is working on is a shared risk and protective factor approach to see how silos can be broken down for different substances and different funding and have a syndemic primary prevention approach. This can potentially be a fun project to present to the PHAB in the future and get the board's input on. How this issue is approached must change. The OHA team is actively working on that.

Dr. Wright noted that what was needed was not only braided funding and resources, but also braided data to help the OHA team inform people that were out in the community. He encouraged the board members to provide feedback or suggestions.

Dr. Schwarz asked Ms. Shields if she could share web links to the dashboard and the PDMP upgrade.

Ms. Shields answered that the PDMP upgrade was being built right now for the provider reports. She will send the board a status update and a few resource links.

Dr. Dannenhoffer pointed out that Oregon had done a remarkable job in changing prescribing practices. He has been an external reviewer for Charge for the last ten years. The difference in the way providers prescribe opioids among the multiple clinics that are under review is truly remarkable. Five or six years ago, the number of people with worrisome prescribing was a very common finding. Now it is a rare finding to find somebody who is on scary providing. Although it has happened slowly, it is truly remarkable in the amount of decrease of prescriptions.

Dr. Dannenhoffer added that most people in Douglas County who used opioids and died of opioids started with prescription drugs, moved to elicit drugs when the prescription drugs got too expensive, and then overdosed. The first job in Douglas County was to stop digging, stop creating these people, these new addicted people. The county has done that, but it still has a long way to go.

Ms. Shields noted that Dr. Dannenhoffer was one of the early helpers. He was willing to call providers all over the area, including Lane County and Douglas County, and get prescribers to sign up for the PDMP before there was a mandate.

Dr. Dannenhoffer explained that providers didn't like doing this either. They felt that they were being forced. Then providers got together and agreed not to give everybody 90 days of narcotics when they had their wisdom teeth out and use ibuprofen. The dentists were some of the first people who adopted no-narcotics policy and it really changed their practices. When people would go to the dentist to get narcotics, dentists were sometimes doing unnecessary procedures so that people could get narcotics. Every dentist he talked to said that it had been so much better having a no-narcotic practice.

Dr. Savage seconded Dr. Dannenhoffer's comments. She has had many positive conversations with dentists. She follows the prescribing patterns of the dentists in the CCO. It's been amazing to see dentists going from 30 pills to 10 to zero. It makes dentists happier, too. Patients are happy because they don't need narcotics. They are still getting good pain control with Tylenol and ibuprofen.

Ms. Tiel thanked Dr. Wright and Ms. Shields for the update.

Dr. Wright concluded that the PHAB members could reach out to him at any time with questions, feedback, and things the OHA team could improve on, or things the team was missing.

Dr. Savage added that she would love to see the braided data with alcohol brought into it and what that would look like.

Dr. Wright responded that that conversation was happening right now at OHA's data transforming group. The group discussed that point at its meeting earlier today. That is an ongoing part of the conversation because any one of those drugs combined with alcohol, let alone just alcohol alone, is very troubling.

PHAB Member Discussion
Rebecca Tiel

Ms. Tiel encouraged the board members to share or discuss issues or topics. She was interested in continuing the opioid updates and also hearing more about the alcohol book of work in general from the Public Health Division and how that was going. Maybe this could be a future agenda item.

Dr. Present remarked that in thinking about the potential new Healthy Homes Program, and environmental health being part of the next round of modernization funding, she would love to hear more about programs that were active around non-regulatory environmental health issues. There were a lot of ideas and things moving on prior to the pandemic. It would be interesting to hear what has happened in the last year across the state. In Clackamas County, a

lot of those things have dropped for a minute and are now being picked back up with the county's climate change work.

Dr. Dannenhoffer shared that he was a little dismayed by what was happening in the equity world with this whole COVID-19 situation, but especially the vaccination situation. He saw a breakdown of who had gotten the vaccine and who had been offered the vaccine, not just in Oregon, but around the country. A news story from Florida suggested that high-income ZIP codes were the ones that got all the vaccines, and low-income ZIP codes were left out. He saw in his community how the doctors and dentists were able to drive to Deschutes County or Salem and get their vaccine, and poor people, or people without a car, or people worried about being served by the military, didn't do that. This issue cannot be overtalked.

Ms. Tiel stated that she didn't know when to have the vaccine conversation as vaccines continued roll out. It could happen in the PHAB or some other forum, as some sort of after-action discussion around some of the principles that were used. There is a lot to talk about, and lots of lessons learned around anything related to supply constrained environments and the decisions made around that. The board can provide a lot of guidance to agencies on that.

Ms. DeLaVergne-Brown noted that part of it was that, at the local level, it was the responsibility of LPHAs to find those groups in their communities that needed help, such as the IDD (Intellectual and Developmental Disabilities) group and individuals who might not be able very easily to sign up for clinics. Crook County reached out to the IDD case managers and found out that people were having a hard time signing up and getting into the clinic. The county did a special pod just for these individuals, with staff there to help them in the door and so on. One of the things that has been helpful is the state sending lists of populations that the LPHAs may have missed. For example, there was a foster home that Crook County missed. The DHS has a lot of that information, but it is important that LPHAs get it. It would be a great conversation to have on how things are happening throughout the state and how to make them better.

Mr. Queral suggested a conversation around how other states were managing their modernization efforts.

Public Comment

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

There was no public comment.

Next Meeting Agenda Items and Adjourn

Dr. Dannenhoffer thanked Ms. Tiel for her tremendous leadership as the PHAB chair.

Dr. Bangsberg, Dr. Schwarz, and Dr. Savage thanked Ms. Tiel for her service to the PHAB.

Ms. Tiel adjourned the meeting at 3:33 p.m.

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

March 18, 2021
2:00-3:30 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

Board Priorities (2021 – 2023)

IMPLEMENTATION OF THE COST GROWTH TARGET PROGRAM

OHA'S 1115 WAIVER RENEWAL

COMMITTEES OF THE BOARD WORK

ENSURING WORK IS CENTERED ON HEALTH EQUITY

Committees

Oregon Health Authority

Committee Work (2021 – 2022)

	2021	2022
HPQMC	Review measure development for equity & transformational measures; Approvals for metrics changes; Select targeted measures for Cost Growth Target Program focus	
M&SC	Select 2022 incentive measures and targets for CCO Quality Incentive Program August 2021; monitor pandemic impact on performance on 2021 measures	Move beyond medical model with introduction of framework & strategy around SDOH and equity for use in measure selection
PHAB	Health equity review policy and procedure; Support implementation of SHIP	Public health strategic data plan; Updates to public health accountability measures; Implementing 2021-23 public health modernization investments, if passed
HEC	Update health equity definition; Liaison between OHPB and RJC; Support Waiver Renewal and Cost Growth Target Program	Liaison between OHPB and RJC; Support Waiver Renewal and Cost Growth Target Program
PCPRC	VBP primary care adoption; Collaborate with Cost Growth Target on VBP; Adoption of health equity framework into PCPRC work	2020 Progress Report; Promote and monitor implementation of recommended behavioral health/primary care integration payment model

Committee Work (2021 – 2022)

	2021	2022
CGT	Accountability legislation; Reviewing cost growth data and drivers; Monitoring for unintended consequences; Advancing Data Use Strategy; Developing guidance for performance improvements plans; and Recommending future governance	
HCWF	Development and completion of Equity Framework; Member listening training; Listening engagements; Evaluation of future charter topics; Recommendations and use of the Health Care Provider Incentive Fund	
MAC	Monitoring CCO 2.0 implementation through a consumer & community lens; Subcommittee to improve OHP consumer experience (work began in January, with recommendations expected in Q3 2021); and Supporting OHA and OHPB with the 1115 Waiver renewal	
HITOC	Community Information Exchange (CIE); Legislative Session: Implications for HITOC; Federal Interoperability Rules Coordination; Recruit new members; and Restart Statewide Health IT Strategic Plan Update Work	

Committee Requests for OHPB Support

	2021	2022
HPQMC	Ongoing review of slate of appointees	Ongoing guidance for menu set alignment and equity lens
M&SC	Guidance on set of questions will help in ensuring measure selection meets broader OHPB goals (regarding definition of transformation, goals, balance of priorities, etc.)	
PHAB	Summer/Fall 2021: Updates to public health accountability metrics	Winter/Spring 2022: Public Health Strategic Data Plan
HEC	Guidance on how HEC can support OHPB work on: Advancing Health Equity, Oregon's 1115 Waiver Renewal Implementation of SB 889, Approval of 2021 membership slate (April), Update on HEC Charter (June)	
PCPRC	Q2/Q3: Guidance to connect with other OHPB committees (e.g., HCWF, 889) Q3: Provide guidance on payment models to sustainably support THWs	Q1 – Provide guidance on future primary care-specific payment models in line with the Sustainable Health Care Cost Growth Target Program

Committee Requests for OHPB Support

	2021	2022
CGT	Q1/2 – review data reports Q2/3 – review proposals for monitoring for unintended consequences, quality, equity Q3/4 – review charter for new committee	Continuing reviewing data Convene public hearing
HCWF	March or April – Vote on proposed membership slate September or October- Review of recommendations on HCIF allocations	Review of new strategies for the health care workforce of 2030
MAC	Q3 – Discussion/feedback on initial workgroup recommendations regarding improving consumer experience	Q1 - Review & discussion of MAC CCO 2.0 monitoring report and how it informs MAC workplan for 2022
HITOC	June: Vote on proposed membership slate, annual report June: OHPB revised direction for HITOC strategic plan work (if applicable)	Approve Strategic Plan Update

Health Care Cost Growth Target

Milestones & Proposed OHPB Roles

Oregon Health Policy Board Retreat

February 18, 2021

Oregon Health Policy Board: Framework of Roles

The Board's policy-making and oversight role influences the work of its committees and OHA.

Leader

Responsible for the work; actively involved in planning, development and oversight

Collaborator

Active role in developing, guiding and finalizing the work in partnership with other entities

Supporter

Provides guidance and direction; not actively involved in development or decisions

Communicator

Champions and supports the work; not actively involved in development or guidance

2021

Cost Growth Target Program	When	OHPB Role
Submit Implementation Committee recommendations to Leg	Q1	Leader
Develop charter and recruit for successor Committee	Q4	Leader
Plan for monitoring for unintended consequences	Q2-3	Collaborator
Plan for quality measurement	Q2-3	Collaborator
Develop Performance Improvement Plan template/process	Q2-3	Supporter
Publish new reports: cost growth trends, hospital cost comparison	Q1	Communicator
Accountability legislation (HB 2081)	Q1-2	Communicator
Publish temporary and final rules for data submission	Q2-3	--
Collect and validate initial data (2018-2020)	Q3-4	--
Launch Technical Advisory Group (TAG)	Q1	--

2022

Cost Growth Target Program	When	OHPB Role
Launch successor Committee	Q1	Leader
Develop and hold first annual public hearing	Q4	Collaborator
Develop and publish first annual public report	Q4	Communicator
Collect and validate 2021 data	Q3-4	--

Resources

OHPB educational webinar series on the Cost Growth Target

- Part 1 (November 10, 2020)
  *Link to Recording:
  https://www.oregon.gov/oha/OHPB/MtgDocs/Webinar%20Video%20Recording_11.10.2020.mp4
- Part 2 (November 17, 2020)
  *Link to Recording:
  https://www.oregon.gov/oha/OHPB/MtgDocs/Webinar%20Recording_11.17.2020.mp4
- Part 3 (December 22, 2020)
  *Link to Recording:
  https://www.oregon.gov/oha/OHPB/MtgDocs/Webinar%20Recording_12.22.2020.mp4

(*copy and paste links into your web browser)

Cost Growth Target Implementation Committee Final Recommendations

Link to Report:
https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf

1115 Demonstration Waiver
Proposed OHPB Roles

Oregon Health Policy Board Retreat

February 18, 2021

Oregon Health Policy Board: Framework of Roles

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Communicator

Champions and supports the work; not actively involved in development or guidance

2021

1115 Medicaid Waiver Development	When	OHPB Role
Ensure alignment with CCO 2.0 & Transformation goals	Q1-4	Leader
Identify opportunities for OHPB committees to engage	Q1	Leader
Lend expertise to policy development	Q1-2	Collaborator
Advise OHA on input & feedback gathered through committees	Q2-3	Collaborator
Endorse final vision in support of OHA application to CMS	Q4	Supporter
Receive updates on project status & timelines	Q1-4	Communicator
Share information on community engagement opportunities	Q1-4	Communicator

Resources

OHPB educational webinar: Oregon's 1115 Demonstration Waiver

Date: February 9, 2021

*Webinar recording: https://youtu.be/PwS3Oec_PHk

*Webinar slides: https://www.oregon.gov/oha/OHPB/MtgDocs/Oregon%E2%80%99s%201115%20Medicaid%20Demonstration%20Waiver.pdf

(*please copy and paste links into your web browser)

2010 – 2020

10 Years of the Board and its Committees' Accomplishments

Steph Jarem, Director
OHA Office of Health Policy

February 17 and 18, 2021

Today's Outline

- Successes of the Board and its Committees

- The Evolution of Committees of the Board

- The Decade Ahead and the System of the Future

- Questions and Discussion

Oregon Health Authority

Top Themes Over 10 Years

- Healthcare Integration
- Health System Transformation
- Healthcare Payment and Costs
- Community and Public Health
- Health Equity

Oregon Health Authority

Board Successes

Leader

- Led PCPCH model development and standards
- Led establishment of Health Equity Committee
- Led development of CCO 2.0

Oregon Health Authority

Board Successes

Collaborator

- Collaborated on developing legislation for CCOs
- Collaborated with Early Learning Council in joint workgroup
- Collaborated with HCWF on development of the Health Care Provider Incentive Program

Oregon Health Authority

Board Successes

Supporter

- Supported development of HITOC Strategic Plan
- Supported SB 440 plan for development of HPQMC
- Supported recommendations that led to SB 889

Oregon Health Authority

Board Successes

Communicator

- Communicator for Oregon's State Health Improvement Plan (SHIP)
- Communicator for COVID-19 response and community experience
- Communicator for health equity definition, formally adopted for OHA

Oregon Health Authority

Board Committees

20 former committees

TBD future committees

Oregon Health Authority

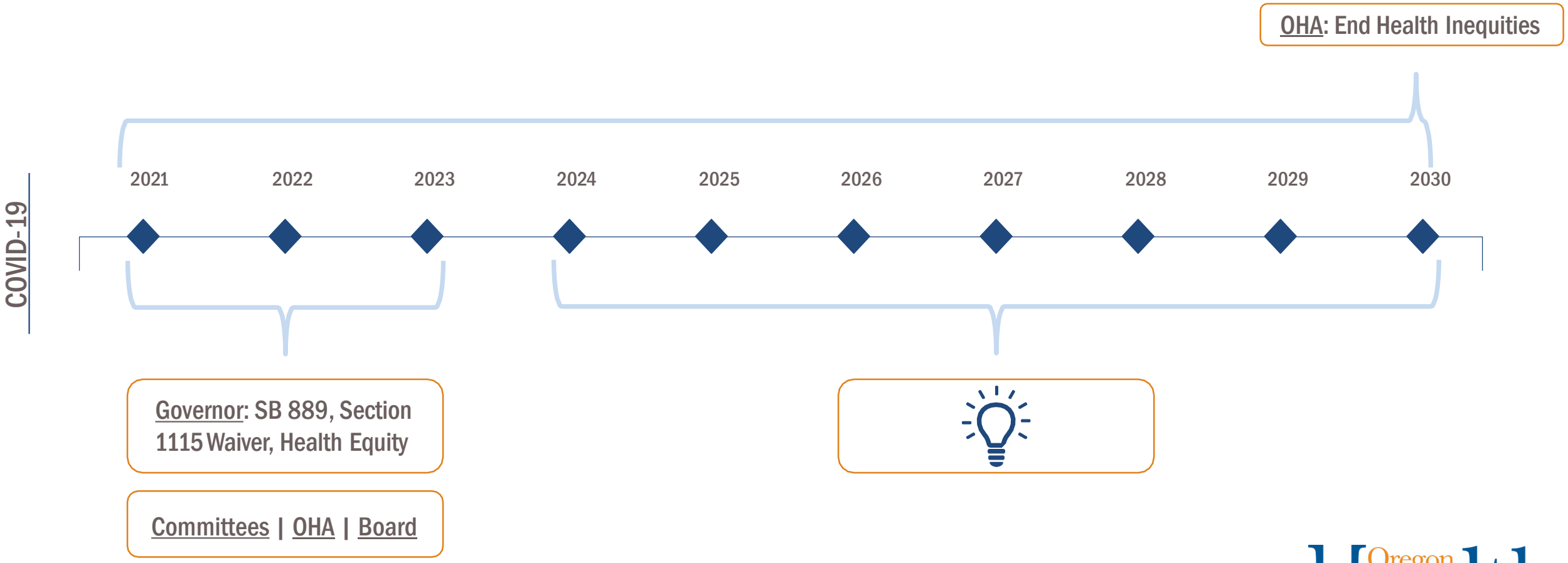
The Decade Ahead

- Governor's priorities for the board and committees:
  - SB 889: Healthcare cost growth target
  - Section 1115 Waiver
  - Health equity

- OHA strategic goal:
  - End Health Inequities by 2030

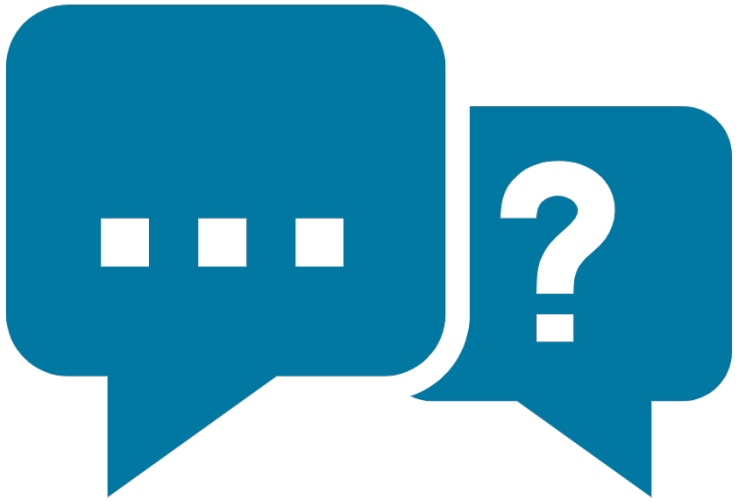
Oregon Health Authority

The Decade Ahead and the System of the Future



Oregon Health Authority

Questions and Discussion



Oregon Health Authority

Updated 3.2.21

Oregon Health Policy Board 2021 Retreat
February 17-18, 2021
Retreat Summary

On February 17-18, the Oregon Health Policy Board (OHPB) held its annual retreat over two days. Below is a summary of the OHPB's discussions. Specific issues for follow up are attached as 4.1 Retreat Follow-up.

The goals for the retreat were to affirm the OHPB's roles and responsibilities and to come to a shared understanding of the board's 2021 priorities. The agenda for the retreat was based on interviews with board members, pre-retreat board sessions (no quorum and no decision-making at these discussions), and input from staff and the chair and vice chair.

Day 1
The goals for Day 1 were to celebrate and learn from past OHPB work and to receive updates from committees and discuss how to best support their work.

The retreat began with a presentation on ten years of board accomplishments. During that discussion, the board reviewed its new agreed-upon framework of roles: leader, collaborator, supporter and communicator. The presentation on past work used this framework to categorize the board's efforts.

The rest of Day 1 of the retreat was focused on committee work; oversight of the committees is a board priority. The board heard presentations from its committees, all of which outlined committee highlights from 2020, current and future committee work, and where the committee needed board support. The "asks" from each of the committees will translate into the board's workplan/calendar for 2021.

Discussion of committee work

- The board stressed the need for connections between committees.
    - These connections are especially important around the priorities of the cost growth target work, the waiver renewal and equity.
        - Equity shouldn't be siloed. At the same time, the board wants to be mindful of overwhelming the Health Equity Committee.
    - The board asked staff for a proposal to facilitate connections and communication between committees. Committee staff already meet once a month. It may make sense to bring together committee chairs occasionally as well.
- The board discussed the liaison role.
    - The board agreed that all members, except the chair and vice chair, should serve as a liaison to a committee. For the chair and vice-chair, being a liaison will be optional. There could be a short grace period before becoming a liaison if new board members express the need.
    - New members should be recruited with the expectation that they will serve in a liaison role, which requires they understand the time commitment.

- The board could consider grouping committees that have potentially overlapping work (like 889 and the Primary Care Payment Reform Collaborative) and have a member serve as a liaison to overlapping committees. That could require board members to serve as liaison to more than one committee, which might be overly burdensome.
- The board may want to consider what responsibilities are common across committees, such as centering equity and communicating with other relevant committees. This could be common language across all committee charters or a "global" committee charter that applies to all board committees.
- The board discussed the need for new board members as soon as possible. One idea is to see if there are committee members who might be appropriate for board membership.
- As it oversees the work of its committees, the board wants to be strategic, focused on equity, thinking about the levers it can pull and considering how it is uniquely positioned to advance the work.
- The board also discussed that it may want to think about what it means to sunset a committee and how that would happen if necessary.

February 18

The goals for Day 2 were to affirm and agree on the board's work on the waiver renewal and the cost growth target and to come to a shared understanding of how equity will continue to be integrated and elevated into the board's work.

Level setting

- The board reviewed documents that had been revised as a result of their pre-retreat discussions, including the policymaking and oversight document, the framework of board roles, and the guiding principles for decision-making. The board didn't have additional changes to these documents, with one exception.
    - The board wants to apply an **equity-centered framework** to its decisions, asking how the work impacts health equity - does it advance efforts, does it have a neutral impact or does it deter these efforts. This can be added to the decision-making document.
- The board heard from OHA Director Pat Allen about the intersection of OHA's priorities with the board's areas of focus. Pat shared that equity is central in all of OHA's work, just as it is for the OHPB.
- Director Allen outlined the significant oversight and efforts on the response to COVID-19.
    - The board would like to be apprised of lessons learned from the COVID -19 efforts, especially as those lessons might inform their work.
- Behavioral health has been a focus for the board in the past and it wants to be sure the work progresses. Director Allen shared that there are many groups and efforts focused on improving the behavioral health system.

    - Behavioral health will be a topic for the board as it does its work on 889, the waiver and equity. The board can also receive updates about progress on improving the behavioral health system.
- The board can be a communicator around COVID -19 and behavioral health.

Cost growth target and waiver renewal

The board heard presentations on the cost growth and waiver work that included proposals for their role. The board stressed the importance of centering equity in this work and ensuring communication and connection across the committees that are involved in these priority areas.

For both of these areas, the board wants to understand the critical intersection points for the board and what the work looks like in 2021 and beyond (e.g., how it translates into the board's calendar). The board also sees a role in maintaining momentum, especially for the cost growth target work. The board highlighted the importance of community engagement with regards to the waiver renewal effort.

The board agreed to the outlines of the work for both the waiver and cost growth target work.

Equity

- The board wants to continue integrating and elevating equity in all of its work, including in its committee oversight.
- The board wants to consider how its efforts help achieve the 2030 goal of eliminating health inequities.
- Instead of thinking about "unintended consequences," we may want to talk about "equity consequences."

Past priorities

The board referred to its previous discussions on COVID-19 and behavioral health. The board will have a "watch" list of issues, including behavioral health and OHA's strategic planning. They will receive updates on these issues, either when there is significant news to convey or when requested by the board.

Board recruitment

The board got an update from OHA. Applications have been reviewed and are under consideration by the Governor's office. Confirmation of new members depends on when Senate holds confirmation hearings.

Disproportionate COVID-19 impact on the Native Hawaiian and Pacific Islander community

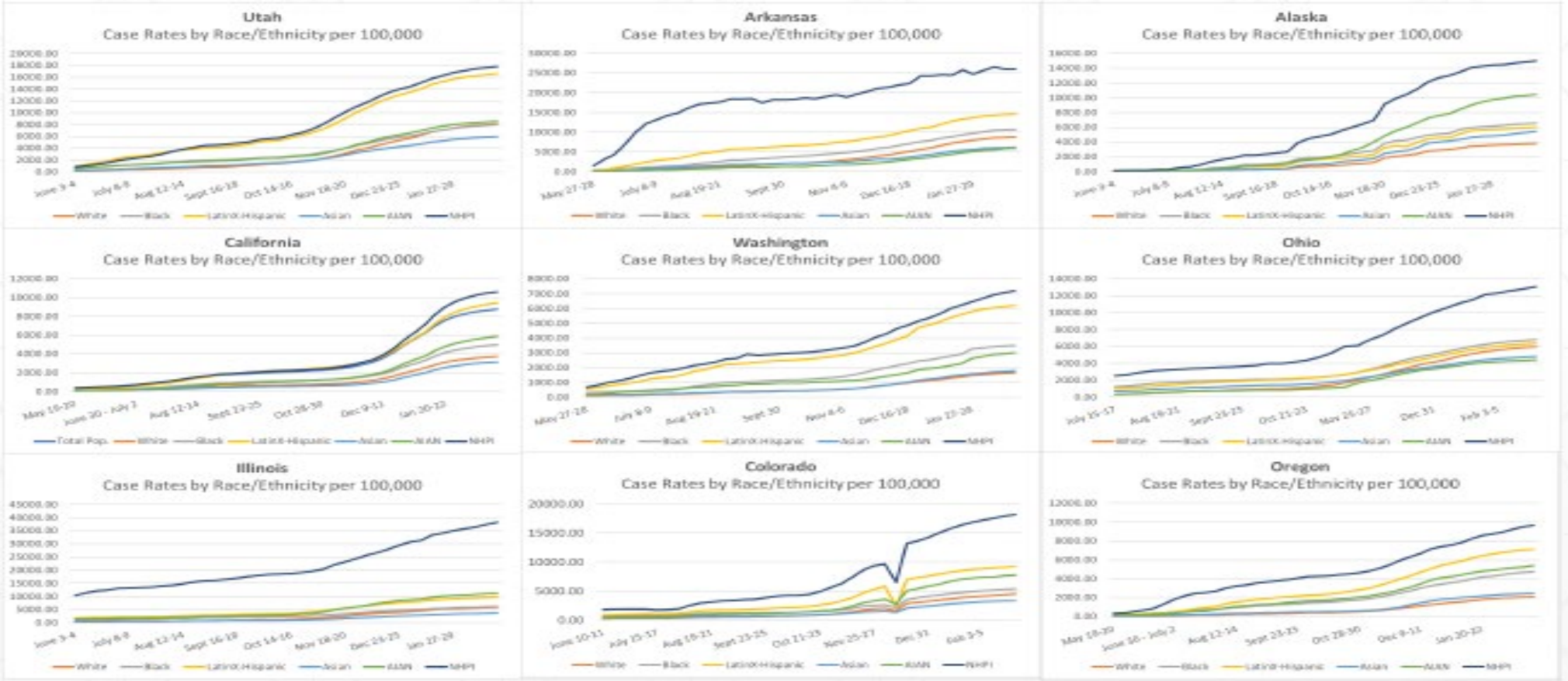
By Manumalo Ala’ilima

March 16, 2021

The Native Hawaiian and Pacific Islander (NHPI) COVID-19 Data Policy Lab

UCLA CENTER FOR HEALTH POLICY RESEARCH

Cases per 100,000 by Race and Ethnicity Over Time
As of Feb. 24, 2021



Source: The COVID Tracking Project, https://covidtracking.com/race/dashboard, last accessed Feb. 24, 2021

The Native Hawaiian and Pacific Islander (NHPI) COVID-19 Data Policy Lab

UCLA CENTER FOR HEALTH POLICY RESEARCH

NHPI Monthly Change in Cases and Deaths

Jan. 22, 2020 to Feb. 24, 2021

State	Previous Month's No. of Cases	Current Month's No. of Cases	Pct Change from Previous Month's Cases	Previous Month's No. of Deaths	Current Month's No. of Deaths	Pct Change from Previous Month's Deaths
Alaska	1416	1490	5%	16	16	0
Arkansas	3313	3341	1%	52	55	6%
California	12830	15066	17%	187	292	56%
Colorado	1100	1228	12%	9	9	0
Georgia	628	726	16%	6	8	33%
Hawai'i	7073	7814	10%	95	130	37%
Iowa	824	824	0	15	16	7%
Idaho	357	404	13%	No NHPI Data	No NHPI Data	No NHPI Data
Illinois	987	1107	12%	16	20	25%
Kentucky	282	369	31%	1	2	100%
Louisiana	421	489	16%	10	13	30%
Maine	16	22	38%	0	0	0
Minnesota	501	542	8%	6	6	0
North Carolina	No NHPI Data	No NHPI Data	No NHPI Data	No NHPI Data	No NHPI Data	No NHPI Data
Nebraska	214	223	4%	1	1	0
Ohio	608	691	14%	4	5	25%
Oregon	1219	1370	12%	17	18	6%
Tennessee	467	542	16%	4	6	50%
Utah	8110	8857	9%	49	56	14%
Washington	3120	3610	16%	65	78	20%
Wyoming	127	132	4%	1	1	0

Please note: reductions in cases or deaths may be due to reclassifications and corrections reported.

Data Source: The COVID Tracking Project, https://covidtracking.com/race/dashboard, last accessed Feb. 24, 2021

The Native Hawaiian and Pacific Islander (NHPI) COVID-19 Data Policy Lab

UCLA CENTER FOR HEALTH POLICY RESEARCH

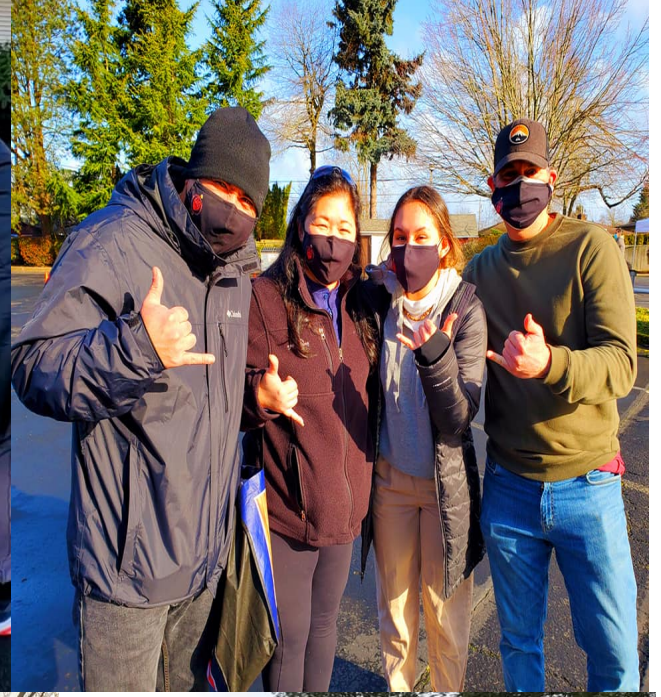
NHPI Case and Death Rates

As of Feb. 24, 2021

*Compared to other races/ethnicities in state; does not incl. Other or Unknown race

State	Cases per 100k	Case Rate Ranking*	Deaths per 100k	Death Rate Ranking*
Alaska	15015.62	1	161.24	1
Arkansas	26042.56	1	428.72	1
California	10621.38	1	205.86	1
Colorado	18254.79	1	133.79	1
Georgia	10450.55	1	115.16	3
Hawai'i	2201.21	1	36.62	2
Iowa	40611.14	1	788.57	1
Idaho	16323.23	1	No NHPI Data	No NHPI Data
Illinois	38211.94	1	690.37	1
Kentucky	8760.68	4	47.48	5
Louisiana	50360.45	1	1338.83	1
Maine	9909.91	2	0.00	5
Minnesota	20702.83	1	229.18	1
North Carolina	No NHPI Data	No NHPI Data	No NHPI Data	No NHPI Data
Nebraska	5091.32	3	22.83	5
Ohio	13102.01	1	94.80	4
Oregon	9660.13	1	126.92	1
Tennessee	15624.10	1	172.96	1
Utah	17793.72	1	112.50	2
Washington	7199.98	1	155.57	1
Wyoming	6407.77	3	48.54	5

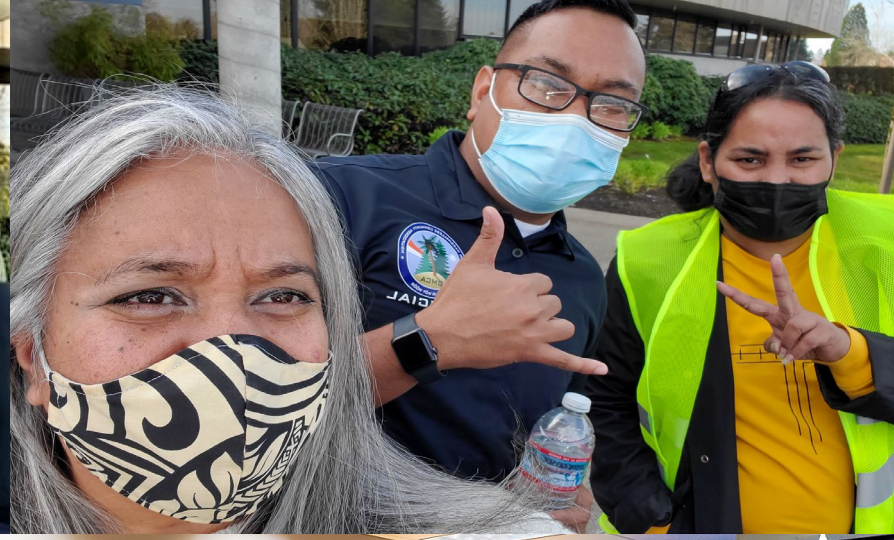
Data Source: The COVID Tracking Project, https://covidtracking.com/race/dashboard, last accessed Feb. 24, 2021



Oregon Pacific Islander Coalition (OPIC) CBOs hosting vaccine clinics together:

- Ka ʻAha Lāhui O ʻOlekona Hawaiian Civic Club (KALO HCC)
- Leʻo ʻo e OFA
- Living Islands
- Micronesian Islander Community (MIC)
- Oregon Marshallese Community Association (OMCA)
- Rengelkel Belau (RB)
- Samoa Pacific Development Corporation (SPDC)
- Tongan Community Association
- Tongan Women's Association
- United Territories of Pacific Islanders Alliance Portland (UTOPIA PDX)

- Culturally specific vaccine clinics for our community elders that had difficulty getting appointments online due to no internet access or website issues and in-language barriers over the phone. We registered them ourselves.
- Holding several drive-thru clinics so elders didn't have to stand too long or walk or use mobility aids to cover long distances.
- On-site language interpreters. At least five Pacific Islander languages and other interpreters by request.
- We've helped vaccinate 423 of our elders on 2/27/21 in Portland, Multnomah County. Plan to vaccinate 200 elders on 3/13/21 in Salem, Marion County, and 400 elders on 3/20/21 in Beaverton, Washington County.
- We also opened our clinics to other eligible BIPoC elders that also had difficulty securing appointments online and over the phone.



Through UTOPIA PDX' partnership with Kaiser Permanente (KP), UTOPIA PDX was able to secure 200 vaccines on Saturday March 13th, 2021 for a walk-in clinic for eligible Pacific Islander elders at the North Salem KP site in Marion County. OPIC CBOs Living Islands, MIC, OMCA and UTOPIA PDX were able to do direct outreach to signup and register our eligible seniors and provide food boxes, bags of rice, cooked food snacks and gift cards. Over 25 volunteers and interpreters.




- Some of our precious Pacific Islander elders getting their first dose of the Moderna Vaccine on Saturday, March 13th, 2021 in North Salem, Marion County.
- There was an array of emotions from joy, gratitude and relief.
- Our ability to help our elders get vaccinated and receive some resources has been incredibly rewarding.