AGENDA

PUBLIC HEALTH ADVISORY BOARD
Strategic Data Plan Subcommittee

June 15, 2021
1:00 - 2:00 PM

Join ZoomGov Meeting
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Subcommittee members: Alejandro Queral, Eli Schwarz, Eva Rippeteau, Gracie Garcia, Hongcheng Zhao, Rosemarie Hemmings, Veronica Irvin

1:00-1:15	**Welcome, Introductions and Review of May 18, 2021 Meeting Minutes**	Diane Leiva, Oregon Health Authority
1:00-1:50	**Equity as the foundation of a Strategic Data Plan** • **White Supremacy and the Core Functions of Public Health** • **Public Health Survey Modernization Presentation** • **PHAB Health Equity Review Policy and Procedures**	All
1:50-2:00	**Public comment**	
2:00	**Adjourn**	All

Public Health Advisory Board (PHAB)
Strategic Data Plan Subcommittee
May 18, 2021
DRAFT Meeting Minutes

Attendance

Subcommittee members present: Eli Schwarz, Dr. Hemmings, Veronica Irvin, Hongcheng Zhao

Board members **absent** : Gracie Garcia, Alejandro Queral, Eva Rippeteau

Oregon Health Authority (OHA) staff: Cara Biddlecom, Kirsten Aird, Diane Leiva

Welcome and Agenda Review
Diane Leiva (OHA)

Diane shared that today's meeting will be on changes to our charter and ground the conversation on equity. There have been lots of changes related to equity and what data assessment means and how to move forward with equity and justice, using that framework to develop the strategic data plan. We will start discussion with PHAB's Health and Equity Policies and Procedures. The focus will be the types of values and approach we want to take. What a strategic data plan looks like moving forward with equity and justice. What we need to engage consistently and in a feedback loop with community on how we develop the plan and what the outcomes are and what that means.

We will probably have time for our public comment, so public members joining us today, thank you.

Meeting Minutes
(All)
Correction needed Meeting Minutes to spelling of Veronica's last name (to Irvin). Minutes of the last meeting were approved.

Subcommittee Charter
(All)

Review of the changes that were incorporated into the charter based on previous meetings feedback. In relation to the stakeholder question on whether they are needed or not, we need to focus on what types of questions need to be answered. As well as, what are the mile markers, what are the questions and who do we need to ask? For example, the questions posed in the Health Equity document addresses how we need to think when drafting this plan. What types of conversations do we need to have with communities and with each other?

Eli – indicates that when looking at stakeholders, health centers and clinics and hospitals, FQHC are not the totality of health care providers. Suggestion to change those to Healthcare Providers.

Reference is made to two types of stakeholders. Those who are purveyors of data and those who are end users. How do we reach out and engage them? For hospitals, outreach could be with the Hospital Association, but that from the data perspective. But who produces the data and how it's being used is the question? Mention on Data Justice and a strategic data plan and who should be the voices in the strategic data plan.

Health Equity Review Policy and Procedures
(All)

Review of the document. Kirsten indicates if the deliverable for us is a plan of action with key strategies and tactics of how to better collect, analyze and report data and create an understanding of ownership of that data with the end of community empowerment and community health; then the questions in the Health Equity Plan are relative to how does data collection and/or analysis, and reporting of data contribute to racial justice, rectify past injustices, differ from current status, support individuals in reaching the full health potential. It is in the frame of the processes around data to get it into the right hands with the right information to make change. That would be the end-product of the plan. It will help guide us. What steps, criteria, actions, and strategies that we, as a public

health profession, need to get to, to have a different state of data collection, analysis, and reporting.

Dr. Hemmings – notes that nowhere does it say that this data will be used to prevent inequities from happening in the first place. It addresses, rectifies, but do we also hope that this data will help drive change to the point where we prevent inequities from even happening.

Veronica – When we were drafting these questions, we were using language that could be used for multiple documents. I think for the data deliverable that we work on we need to have something that explicitly states around Dr. Hemmings' statement on rectifying and improving. Maybe it needs to be clearer in this document.

Eli – At the moment, the data we collect is incomplete. A fair analysis or policy statement in relation to deliverables. We need to have assurance that the data we are working with is representative and as complete as possible. These variables in item #5 are extremely sensitive and there is a considerable portion of the population that doesn't want to provide this information for those who are collecting the data. Whatever we collect, as far the analysis, will be faulty. Unless we can improve our data collection systems, our data will not be good enough to ensure work against inequities or toward equities.

Dr. Hemmings – That is where working with and involving the community that you are trying to get the data from comes into play. To build that relationship with the community for them to trust that if they disclose this information that is going to be used in a way that is going to benefit them.

Eli – We have been discussing this issue. We had subcommittee with OHA, Metrics and Scoring, and Health Policy Board and we stopped short of our conclusions because OHA said that we are not able to produce the data that you want. Until we get our IT system set up to collect data in a reasonable way, we are not to do this. It seems like we are going in circles.

Diane – The keyword is trust. The reason we have had success with Community-based Organizations is that we have had a level of trust between the Community-

based Organization and the people in that community. People do not want to report on their age, religion, or race because it may give them a visibility that is not beneficial to them so they would rather opt out.

Dr. Hemmings – You must factor that in within the context of any community but particularly in Oregon with the historical injustice that has existed and the foundations in which the state was formed within that context. You must invest in that community-based relationship building before you get to the data collection process. I am unsure how much we want to invest in that piece because we are very quick to want to collect that data.

Hongcheng – Even before we can talk about how we can collect and analyze; do we need to do a data inventory first? Do we have any real data sitting there? There are two problems. Health centers and hospitals have rich data so how can we have access to that data? Lots of ownership problems. We can address that to have access to that data. Additionally, there are community-based organizations. Their IT systems aren't as advanced as hospitals and health clinics. We need to look at their data and the data structure before we can move on to all the categories of data collection, analysis and reporting and the value added.

Diane – Thank you, Hongcheng. The question that comes to mind, echoing what Dr. Hemmings noted is how are we going to prevent those inequities? Some of the data is good and some of it may be deficient. Referring to Eli's comment in the last meeting quoting Dr. Sidelinger, only 40% of Public Health data is racially representative. We know that there are health inequities, so do we part from the premise that the data is incomplete and is biased and is this the conversation that we need to have with the community as a way of starting to foment that trust?

Hongcheng – The issue of health inequity is extremely important. The underinvestment of infrastructure in communities of color, there is a lot of work. Having racial equity in policy.

Diane – one of the key strategies that has come out of this conversation is improve data collection systems.

Hongcheng – Need to recognize the underinvestment of the infrastructure in communities and acknowledge that. We need to invest before we structure the data for public health. Otherwise there is a huge missing link. What can we do to address that?

Eli – how able is an organization like OHA to have conversations with a broad base of community organizations. Is there a list of organization that send out policies for public hearings from those organizations that Rosemarie was talking about? Or, do we need to identify which intermediaries we need to connect with to reach those different communities?

Kirsten – a data inventory across OHA is something that we have and are updating particularly due to COVID. But basically understanding of the landscape of what kind of data we collect with all of its imperfections and what data we recently collect from Community-based Organizations and to your point, Hongcheng, recognizing that it is a challenged infrastructure that hasn't had the investment put into it to adequately do something. That is something that is in process that we want to get in front of this group. Before addressing Eli's question on OHA's capacity getting back to Rosemarie's point that it is about trust. As we think again about the key elements of where we start, because this isn't about starting at a perfect place on trust and data. We aren't going to start there when we start this plan. This plan will help us get there. What is hard about collecting data is trust and community. That is their data to own or that it is there data to report on. Or that the community would have the trust to give us any of this information. I heard that what is hard about collecting data is local infrastructure and resources for the people that are interested in getting the data is insufficient. We don't have great REAL-D (Race, Ethnicity, Language and Disability) and SOGI (Sexual Orientation and Gender Identity) data that the legislature is working on; there are all those things that are missing. But each layer that we peel back on why it is hard and why data collection systems are inefficient, helps give things to think about and questions to out into the community and ask how to remedy this. What criteria should the Public Health Division apply to remedy these actions. To Eli's point, are the staff trained, are the capable enough to engage in those conversations around data application and data collection with our community partners? I would say it is evolving and that is an important strategy and tactic to take where we are today and where we want to be tomorrow. We need to have a

relevant Public Health profession that help built trust and help get the data to that shared understanding.

Hongcheng- Whenever you have this challenge there is an opportunity and I can push a bit harder. Aggregate data, a huge challenge, is how you want to put it together but at the same time you lose information. If we want to push Public Health to actionable things down the road, we need to address this first. We need to start from there and that will improve community data by 50%.

Eli – notes that outside the academic world we don't use data for policy decisions, and this is a different situation. However, there are some groups, like the North Portland Area Indian Health Board, they have very specific regulations around what data is allowed to be released. They know who owns the data. We have had presentations in PHAB by different groups and my suggestion is to invite some of these groups to the PHAB and perhaps Rosemarie has some groups to suggest from the BIPOC communities. I think it would be useful to have a few of those groups to give us presentation on how they look at data and data collections. That would help us achieve that trust building that Rosemarie mentioned. That might give us more concrete suggestions on what avenue to take. It could be brief presentations.

Veronica – I agree with Eli's suggestions and wonder if there has been any needs assessment with some of the communities about data use, data collection strategies, and what they prefer. Is that something that has been done or are you intending to do?

Kirsten – It is at varying levels. Our Program Design and Evaluation Services which is between the state and Multnomah county have done some amazing work particularly with PSU and OHSU. Division of Equity and Inclusion has done fantastic work. Part of it is, there are programs that have a funding source that may generate a great conversation and how do we get spread for that.

Veronica – Also looking at other organizations within the state and who are their community partners. For example, transportation and see if they have community partner groups who are also using the public health data.

Diane – A question that came up from previous meetings and more colleagues at Public Health around how representative are organization and community leaders representing community members? Often community leaders are in positions of power and may not be representative of individuals and what would be the way to capture that?

Eli – you cannot reach every individual in society and that is why you have these representative groups. We need to essentially use those groups that we do have access and communication with and when you do a public hearing allow the entire community to react to it if they do not agree. I recall when the SHIP (State Health Improvement Plan) was developed, OHA was travelling around 10 or 15 different places in the state and they counted the number of people who were at each event. This include community representatives and individuals who had a chance to input into the planning of the SHIP. I think this model should be replicated. It is very time consuming and resource demanding, and I don't know if we have that at our disposal.

Hongcheng – also for the current list of stakeholders and users such as the public-school system.

Kirsten – they are also the collectors of data you need to have them agree to participate in the Student Wellness Survey and then they would say that that is their data because it belongs to the district. They are both end users and collectors.

Cara – At Thursday's full PHAB meeting, we are going to discuss public health survey modernization. Did we already talk about this opportunity to learn how to connect some of these dots around equity? If not, I will preface what this will be about.

For the last couple of years, the Public Health Division has funded communities to look at the data we have been collecting around our Behavioral Risk Factor Surveillance Survey which is a random digit dial survey for Oregon adults. For lots of reasons including the use of cell phones and portability area codes from state to state and from jurisdiction to jurisdiction, we have needed to look at different ways to administer the survey, how the questions are asked, who owns the data,

how the data are interpreted and shared and how the data is used for program policy and budget decision-making. We have funded the Coalition of Communities of Color and a Pacific Islander Modernization Project as well as the Northwest Portland Area Indian Health Board to focus on community-specific public health data collection. On Thursday, we will get an update on the work the community partner projects have been doing and then their recommendations for the future. This will be the grounding place on which to develop our Public Health Strategic Data Plan. It will address some of the questions in the Health Equity Review Policy and Procedures. I encourage Hongcheng and Dr. Hemmings to join us and we will have the meeting recording available. Slides are posted and hopefully at our next meeting we will be able to reflect and build from there.

Dr. Hemmings – Can you tell me how these specific organizations were selected?

Cara – At a high level, we were trying to pair researchers of color with organizations that would be able to pull community members into conversations about data priorities and be able to test and field some surveys. Through our work we were able to build on work that happened before our survey modernization with the Coalition of Communities of Color. They are supporting our Black African American and Latino, Latina and Latinx surveys. The Northwest Portland Area Indian Health Board also services as our Tribal Epidemiology Center and that was the best fit for our work with the Tribes. There is also the Tribal Behavioral Risk Factor Surveillance System Survey. Lastly, the Pacific Islander Data Project, they are contractors working to support that and some of the key partners were selected by members of the Data Team.

Dr. Hemmings – We just had this discussion about trust with the community and I'm trying to understand the connection and/or how close these organizations are to the actual community. Just because an organization has the title of BIPOC doesn't it mean and that actually closely connected or in line with the community as it relates to that trust factor.

Cara – I think I would like to get more information from the project team and will follow up via email.

Eli – will offer the PHAB package to Rosemarie. I was thinking about all the other surveillance programs, e.g. PRAMS. They all collect data one way or the other. We were wondering where to extract dental data from these surveys.

Diane – from the 2016 Data Inventory, there were 116 datasets. Some are no longer in existence and now there are some new ones in addition to the COVID data.

Eli – were we supposed to approve the charter?

Diane – I would say the answer is yes but based on the conversation that we have had today; I am wonder whether we need to modify the charter.

Public Comments and Questions

Martin Mendelson – Free Stake Person for the Multnomah County Democratic Party so my affiliation you will have to understand and is somewhat political. I am also a professor in the Department of Health Services in the School of Public Health at the University of Washington and have been teaching in medical schools for the last 60 years. I am also a graduate of the CDC Fellowship in Public Health Informatics. I would like to be put on your mailing list. I have emailed Kirsten to be added. I am delighted at what is going gone and the attributes you are addressing on why data is only the beginning. Need to pay attention at how data is combined, interpreted into something that allows us to act. Thank you!

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes, please contact Lisa Rau at lisa.k.rau@dhsoha.state.or.us. For more information and meeting recordings please visit the website: healthoregon.org/phab/subcommittee

White Supremacy and the Core Functions of Public Health

Sirry Alang, PhD, Rachel Hardeman, PhD, MPH, J'Mag Karbeah, MPH, Odichinma Akosionu, MPH, Cydney McGuire, MPH, Hamdi Abdi, MPH, and Donna McAlpine, PhD

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Global outrage followed the murder of George Floyd by now former Minneapolis, Minnesota, police officers. The outrage was targeted at police brutality—police conduct that dehumanizes through the use of physical, emotional, or sexual violence as well as verbal and psychological intimidation, regardless of conscious intent—one of the oldest forms of structural racism.[1] In decrying police brutality, many public health organizations issued statements declaring racism a public health crisis, with promises of change. However, change is stymied if we do not critically evaluate how the discipline (scholarship, conceptual frameworks, methodologies), organizations (governmental, nonprofit, and private institutions that seek to promote population health), and public health professionals (in academia or practice) contribute to structural racism that is manifested in police brutality, among many other outcomes.

"Structural racism" here refers to policies and practices, in a constellation of institutions, that confer advantages on people considered White and ideologies that maintain and defend these advantages, while simultaneously oppressing other racialized groups.[2] Structural racism is sustained through White supremacy: the glossary of conditions, practices, and ideologies that underscore the hegemony of whiteness and White political, social, cultural, and economic domination.[3,4] White supremacy makes it possible for structural racism to reproduce over time, albeit with different mechanisms, from the enslavement of Black people to mass incarceration. Consideration of White supremacy makes visible that structural racism is "White controlled,"[4] and without examining the former, we will not dismantle the latter in public health.

Public health is organized in a framework of three core functions—assessment, policy development, and assurance—and 10 essential public health services (EPHSs). The framework is meant to help public health "speak with one voice" about what public health is and what it aspires to do.[5] This framework has been immensely influential. Accreditation of public health

departments and educational programs partially relies on EPHSs and is included in some state statutes. The EPHSs are taught in our classrooms, are used for performance measurement and evaluation, and have helped to communicate to the public and policymakers what public health is about.[5]

The revised EPHSs were recently released, 25 years after the original framework was developed. The most important change is that the framework now centers equity, defined as a "fair and just opportunity for all to achieve good health and well-being."[6] In the equity statement, racism is mentioned as one of the "forms of oppression" that the EPHSs should address. Living up to the potential of equity requires directly addressing structural racism and White supremacy. We provide examples of strategies in the core functions and EPHSs to do so (Table 1 presents a summary of these).

ASSESSMENT

The core function of assessment is a focus on surveillance. The first EPHS is to "assess and monitor population health status, factors that influence health, and community needs and assets." The revision to this EPHS emphasizes "root causes of inequities." If police brutality and structural racism are root causes, then our health surveillance systems and surveys, such as the National Health Interview Survey and the Behavioral Risk Factor Surveillance System (BRFSS), should routinely track experiences of police brutality, as well as exposure to structural racism. Embedding geocoded information on racial inequities in socioeconomic status in the National Longitudinal Study of Adolescent Health is a good example of this approach.[7] We should assess indicators of structural racism, such as racial inequities in

> **TABLE 1—** Public Health's Core Functions and Essential Services as an Organizing Framework for Dismantling White Supremacy

Core Functions	Essential Services	Example Strategies for Dismantling White Supremacy
1. Assessment	1. Assess and monitor population health status, factors that influence health, and community needs and assets	Routinely track and report respondents' exposures to and experiences of police brutality and other indicators of structural racism and White supremacy
	2. Investigate, diagnose, and address health problems and hazards affecting the population	Investigate the complex mechanisms through which White supremacy shapes health outcomes
2. Policy development	3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it	Educate the public and policymakers on indicators of White supremacy and how these might shape the social determinants of health
	4. Strengthen, support, and mobilize communities and partnerships to improve health	Ensure equitable allocation of resources and redistribution of power in community partnerships
	5. Create, champion, and implement policies, plans, and laws that affect health	Policies must center the experiences of those most affected by structural racism and White supremacy
	6. Utilize legal and regulatory actions designed to improve and protect the public's health	Develop and enforce regulations and policies to dismantle practices that maintain structural racism and White supremacy
3. Assurance	7. Ensure an effective system that enables equitable access to the individual services and care needed to be healthy	Acknowledge racist systems, advocate antiracist policies, and link Black people, Latinx people, Indigenous people, and other people of color with a range of resources
	8. Build and support a diverse and skilled public health workforce	Set clear expectations for education on equity. Schools of public health and public health institutions should set measurable goals on racial equity competency for students and practitioners
	9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement	Focus on critical race conceptual frameworks and antiracist methodologies. Mandate measuring and reporting diversity, equity, and inclusion efforts
	10. Build and maintain a strong organizational infrastructure for public health	The infrastructure for teaching, research, and practice should be grounded in critical race theory so that the implications of historical and contemporary manifestations of White supremacy are addressed

opportunities, legislation, and policy outcomes; criminalization and incarceration; and neighborhood- or zip code–level inequities in assets, debts, political participation, housing, and employment patterns.[8,9]

In 2002, BRFSS added an optional module, Reactions to Race, but few states administered it. That our surveillance systems do not routinely collect data on racism is one indication of how White supremacy plays out in public health: ignoring everyday experiences of, and exposures to, salient stressors among Black people, Indigenous people, and other people of color (BIPOC). Expanding analyses of the impact of structural racism and White supremacy on the distribution of needs and assets

in communities should be a critical aspect of assessment.

The second EPHS is to "investigate, diagnose, and address health problems and hazards." Using the example of police brutality, scholars need to continue to identify mechanisms such as mass incarceration, stress proliferation, institutional mistrust, and economic and financial strain that link health with exposure to and experiences of police brutality.[1] We must also investigate the mechanisms through which other indicators of structural racism and White supremacy shape health outcomes. Hitherto, public health has accounted for race in health disparities research but has rarely examined the role of structural racism.[10]

POLICY DEVELOPMENT

Public health's third essential service is to "communicate effectively to inform and educate people about health, factors that influence it, and how to improve it." Global protests against racism and the attention to racial inequities in the impact of COVID-19 present no better time to confront White supremacy in communication. However, public health institutions such as the Centers for Disease Control and Prevention did not issue any specific official statements on structural racism. Statements that some other public health organizations have released fall short. For example, the American Public Health Association stated:

[The organization] denounces the use of violent methods by law enforcement against peaceful protesters. The current protests are the result of the American people rightfully demanding an end to the racial profiling by some police officers and a system of structured racism resulting in disproportionate harm to the health of individuals and communities of color.[11]

Although the full statement acknowledges racism as a public health crisis, it neither educates readers on the meaning and manifestations of racism nor implicates White supremacy. Public health has largely failed to take advantage of this opportunity to educate the public about racism and White supremacy, beyond well-intentioned statements that can often be distilled to "racism is bad" and "'they' [the police, other institutions, and people who are racist] need to do better." Public health organizations, institutions, and practitioners must actively educate the public about the role of racism in producing health inequities. For example, speaking up against the recent surgeon general's report on maternal mortality,[12] which does not mention racism as a fundamental cause of racial inequities in maternal health outcomes, and against policies such as former president Trump's Executive Order 13950, which banned training in critical race theory, are necessary actions for educating the public about factors that influence health.

The fourth EPHS is "strengthen, support, and mobilize communities and partnerships to improve health." The revised version focuses on authentic relationships to promote equity. Authenticity is difficult to achieve given inherent power differentials. Public health leaders, most of whom are White,

primarily make decisions about the allocation of resources for research and practice, shape engagement of stakeholders, and determine whether and how the perspectives of community members are used.[13] Redistributing power in community partnerships can help challenge White supremacy. Our community partnerships should be characterized by frequent open conversations about power dynamics that are at play. We also think it is time for our funding agencies to not fund community-based research unless researchers demonstrate that the allocation of resources is fair and there is equitable compensation for community partners.

Public health's fifth EPHS is to "create, champion, and implement policies, plans, and laws that affect health." The knowledge that informs policy should be grounded in the experiences of those most affected. But policymakers and academic researchers are predominantly White.[14,15] As a result, White intellectual dominance characterizes the production of knowledge, its translation into practice, and the formulation of policy. As a profession, we need to address the reality that research led by Black scholars who have the experiential knowledge of how racism and White supremacy affect health is less likely to be funded than research led by their White counterparts.[16] We must also prioritize work that centers the experiences of historically excluded populations most affected by White supremacy. One way forward is to engage more meaningfully with grassroots organizations such as Black Lives Matter and to extend our professional responsibilities to include community-engaged advocacy for the policy priorities these organizations have articulated. Public health must be intentional about finding ways to create space for those

without formal power to influence decision-making through the expertise of their lived experiences, especially experiences of racism.[13]

The sixth EPHS is "utilize legal and regulatory actions designed to improve and protect the public's health." Public health performs this service well when it comes to enforcement in areas such as immunization, tobacco, and alcohol regulations. However, the field is yet to develop regulations to dismantle practices that specifically uphold structural racism and White supremacy. For example, public health should be at the forefront of enforcing regulations to prevent disposal of toxic waste in Black and Indigenous communities. Mandating restorative justice practices that prevent the disproportionate incarceration of BIPOC is necessary.

ASSURANCE

Under the core function of assurance, the seventh EPHS is ensuring "an effective system that enables equitable access to the individual services and care needed to be healthy." We must first recognize areas of significant need and acknowledge how historical and contemporary forms of racism act as barriers to accessing services that meet these needs. For example, public health institutions and organizations should address the ongoing mistrust in medical institutions and the COVID-19 vaccine hesitancy by first acknowledging the harm science and medicine have inflicted on Black, Latinx, and Indigenous communities. Promoting vaccine uptake must be done simultaneously with advocating policies to ensure access to testing, treatment, and other resources needed to survive the pandemic. For communities to trust in public health and utilize the services and systems we

provide, public health must first be trustworthy.[17]

The eighth EPHS is "build and support a diverse and skilled public health workforce." We know that the public health workforce is disproportionately White, especially at the supervisory and managerial levels.[14] Schools of public health are also disproportionately White. In 2017, only 0.2% of tenured faculty were Native American, 3.8% were Black, and 7.4% were Latinx/Hispanic, and those numbers have barely budged in years.[15] That a predominantly White profession and discipline is charged with educating and addressing the needs of communities that are disproportionately Black, Indigenous, and Latinx sustains White supremacy within public health. White frames dominate the information we convey, the interventions we develop, and the policies we implement, all of which are often completely disconnected from the experiences of the people most likely to experience health inequities.

The training that public health practitioners often receive is partially responsible for our inability to address structural racism and White supremacy. Leading textbooks intended for undergraduate education often fail to critically analyze the concept of race and barely touch on racism. Moreover, a recent review of 59 accredited schools of public health found that only 33% mentioned diversity, inclusion, or equity in their public mission, vision, or values statements, and 20% made no mention of any of these terms in their goals, objectives, or strategic plans.[18] It is encouraging that the revised EPHS now mentions building a workforce that "practices cultural humility." But cultural humility in place of discussions of structural racism and White supremacy will not change much and echoes hanging our hats on the term "implicit bias,"

rather than talking about forms of racism. To begin to make antiracist training real, it is imperative that the Council on Education for Public Health set clear expectations for education on equity and racism and that schools and organizations set goals for racial equity competency for students and practitioners that are measurable and for which someone is accountable. Metzl and Hansen[19] have made the case for structural competency to be integrated into medical education, and the same should be promoted in public health.

The ninth EPHS is "improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement." It has been 10 years since Ford and Airhihenbuwa[20] laid the foundation of how critical race theory could help examine and address health inequities, but much of public health research still documents how health risks, behaviors, and outcomes vary by race, rarely naming racism[10] and with the concept of White supremacy almost invisible. We fully support the recommendations of Boyd et al.[21] for standards that include rejecting the publication of articles that use race but do not examine racism. Dismantling White supremacy through quality improvement also requires us to make diversity, equity, and inclusion a meaningful part of the Public Health Accreditation Board and Council on Education for Public Health accreditation standards by requiring institutions and organizations to publicly report student, faculty, and workforce statistics by racial group.

The 10th EPHS is to "build and maintain a strong organizational infrastructure for public health." This service emphasizes ethical leadership, transparency, inclusivity, accountability, and equitable distribution of resources.

Yet, many public health teaching institutions reside on land and have built endowments by selling land taken from Indigenous people through displacement and genocide.[22] The wealth of other institutions is grounded in the selling of Black persons who were enslaved.[23] Public health institutions have to thoughtfully engage with the reparations movement within their own institutions and nationally. And the infrastructure for teaching, research, and practice should be grounded in critical race theory so that the implications of historical and contemporary manifestations of White supremacy are addressed.

CONCLUSIONS

The core functions and EPHSs have alternatively been called "guidelines," "vocabulary standards," a "framework," and "principles." They provide a way of making sense of what public health is to us and to others. It is encouraging that the most recent revision centers the concept of equity. But to live up to equity in our EPHSs, they must also tackle structural racism and its roots: White supremacy. In the tradition of public health, we advocate going upstream to deliver the EPHSs, but fully going upstream requires naming and dismantling White supremacy. Success requires building alliances across systems to address the range of social determinants of health caused by White supremacy.

Assessment must include data collection, monitoring, and reporting racism pertinent to the health of BIPOC. Policy development must center on communication about White supremacy, building authentic community partnerships, eliminating regulations that sustain White supremacy, and centering the experiences of people most affected by White supremacy. Assurance requires us to

analyze the impact of White supremacy on training curricula, scholarship, the racial composition of the public health workforce, and the public health infrastructure.

Sustained underinvestment in public health is a considerable barrier to achieving equity in the EPHSs, but this barrier fades in comparison with the disproportionately greater underinvestment in people who are more likely to experience early mortality because of White supremacy. We believe that addressing White supremacy does not require more money; it requires the reallocation of resources.

Although the strategies presented here are based on deeply and honestly examining the field and profession of public health, we echo an earlier call for self-reflection by individual scholars and practitioners: "We must ask ourselves if our own research, teaching, and service are fundamentally and unapologetically antiracist."[1(p664)] *AJPH*

CORRESPONDENCE

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PUBLICATION INFORMATION

CONTRIBUTORS

S. Alang and D. McAlpine conceptualized the article and wrote the initial draft. R. Hardeman, J. Karbeah, O. Akosionu, C. McGuire, and H. Abdi edited subsequent versions. All authors contributed to the final revised version.

ACKNOWLEDGMENTS

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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Engaging Communities in the Modernization of a Public Health Survey System

Public Health Advisory Board
May 20, 2021

Reminder:
What is the survey modernization project?

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

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

Collaborate with communities

With Latinx, Black/African American communities:
- Analyze BRFSS/OHT data
- Community led data collection
- Create data briefs

With AI/AN communities:
- Analyze BRFSS/OHT data
- Create data brief

With Pacific Islander communities:
- Design & implement data collection methods
- Create data briefs

Identify innovative statistical & survey methods

Explore science to identify/pilot methods to modify adult survey system overall
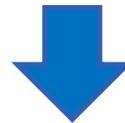
Solutions

Updated plan for adult survey system by June 2021

Collaborators

Coalition of Communities of Color:

Dr. Andres Lopez, Research Director

Dr. Mira Mohsini, Senior Researcher

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

Thoughts as Public Health Scientist

- Background is not in data justice
- Started working in community health assessment in late 90s
- Working in and examining governmental public health systems for over 20 years & serving on variety of national public health systems improvement efforts
- Survey modernization work has had me question my public health education & training
- Process – challenging and uncomfortable with a need to recognize the unintentional harm done
- Deeply grateful to our partners and project team members
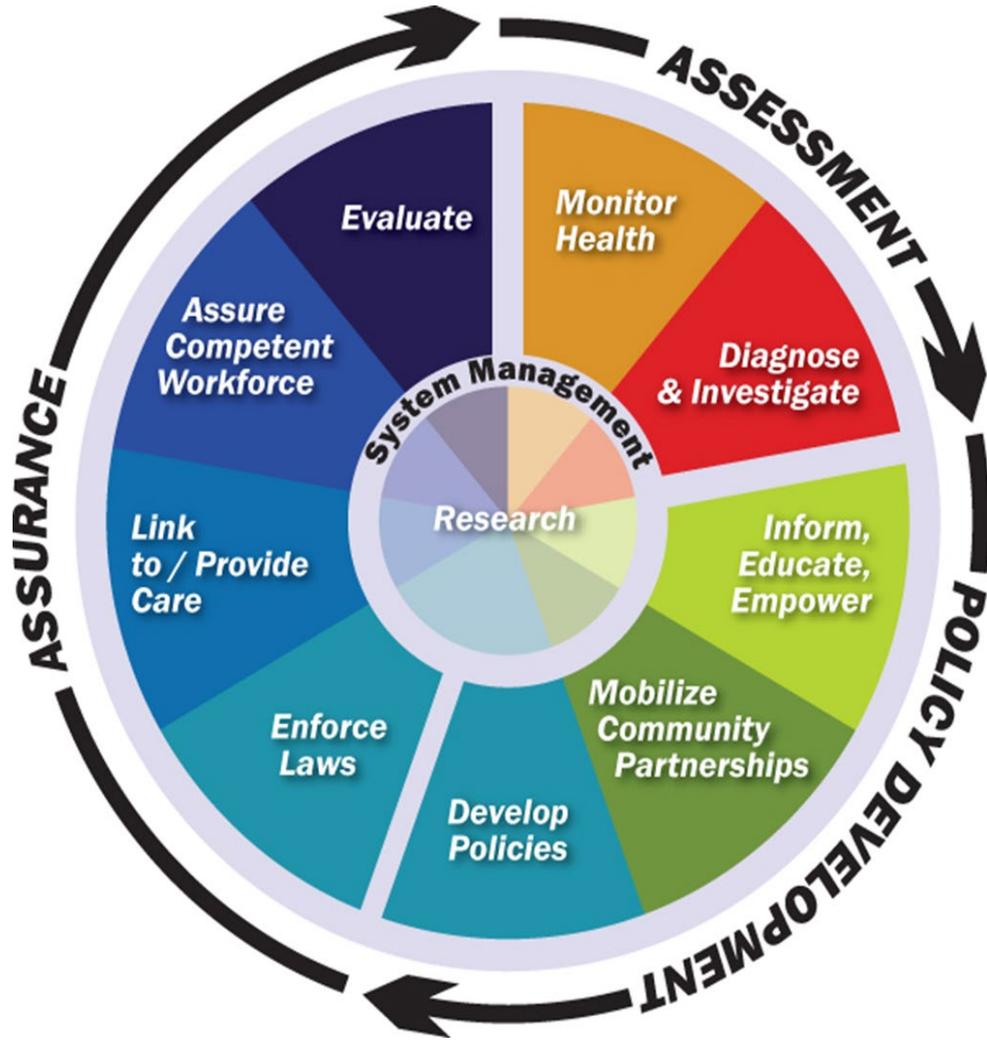
THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems, and services that enable good health and seek to remove obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression, that have resulted in health inequities. Everyone should have a fair and just opportunity to achieve good health and well-being.
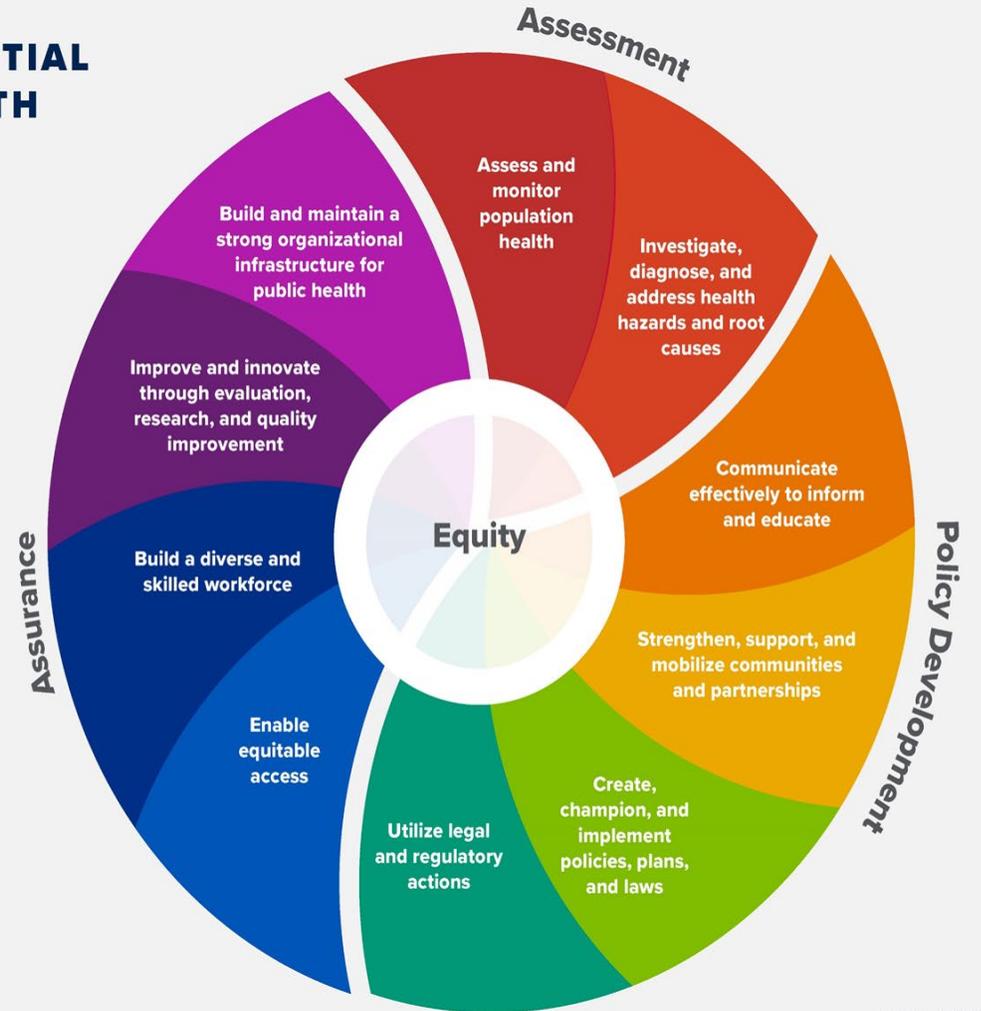
Created 2020

Early Lessons Shared in September 2020

- 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
- Equity as a starting point for survey design rather than being driven by siloed programmatic needs than community centered
- Community engagement at every step of the process from question design, data analysis and reporting
- Data justice – fairness in the way people are made visible, represented and treated as a result of their production of digital data (Taylor, 2017)

Methods

- 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

Data Project Team Process

Meeting #1
- Overview
- BRFSS & OHT Survey Topic Areas
- Project Team data priorities
- Suggested analyses

Meeting #2
Review results from suggested analyses & data interpretation

Meeting #3
Identify data gaps, prioritize areas for supplemental data collection & methods

Community Led Data Collection

Meeting #4
Assist in Community led data analysis & interpretation of results

Meeting #5
Review summary report & recommendations for future survey methods

Community Led Data Collection Topics & Methods

Positive Youth Development, ACES, & State Survey taking experience

Connecting empathy with data justice; discussing how state surveys (de)center students in question creation & uses; online survey
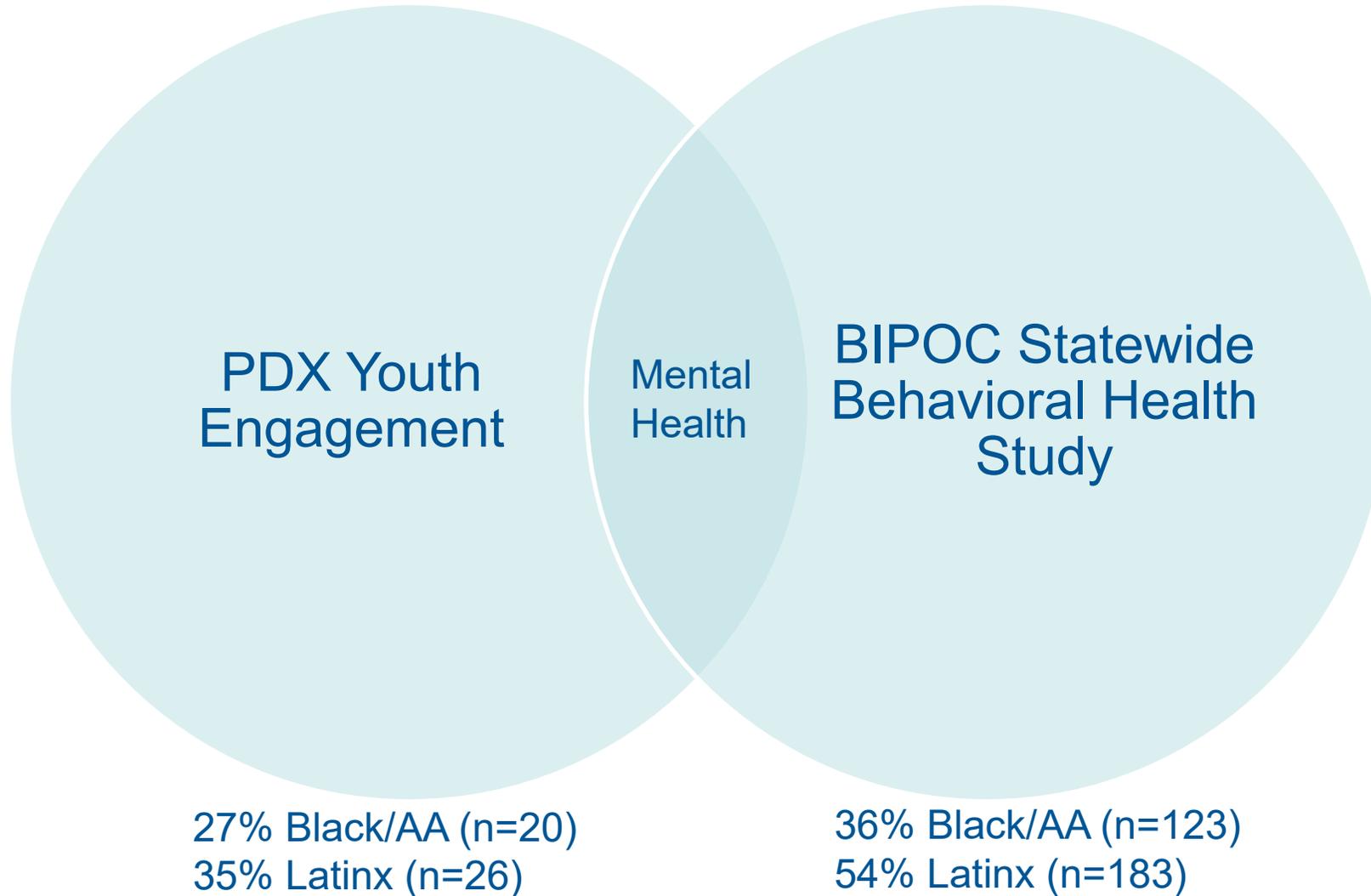
Access to culturally & linguistically specific mental & behavioral health services and providers, experiences of discrimination & medical mistrust

CBO & working group constructed and disseminated online survey

PDX Youth Engagement

Mental Health

BIPOC Statewide Behavioral Health Study

27% Black/AA (n=20)
35% Latinx (n=26)

36% Black/AA (n=123)
54% Latinx (n=183)

Findings

Six key themes - highly interrelated, each deserves to be highlighted in its own right as a lens through which we view the work of survey modernization and community engagement

1. Sample size
2. Survey translation and health literacy
3. Lack of meaningful context
4. Questions need to be actionable
5. Integration of other data sources
6. Intersectionality

Key Themes

1. Sample size
2. Survey translation and health literacy
3. Lack of meaningful context
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Sample size

Survey translation and health literacy

Key Themes

1. Sample size
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6. Intersectionality

Lack of Meaningful Context

Examples

- Health care access
- Experiences of discrimination and harassment
- Experiences of medical mistrust

BRFSS	Community led Data Collection – example access question
1.Do you have <u>any kind of health care coverage</u>, including health insurance, prepaid plans such as HMOs, government plans such as Medicare or Indian Health Services? 2. Are you <u>currently enrolled in the Oregon Health Plan (OHP)</u>, which is the State's Medicaid program? 3. Do you have one person who you think of as your <u>personal doctor or health care provider</u>? 4. Was there a time in the past 12 months when you needed to see a doctor but could not because of the <u>cost</u>? 5. About <u>how long has it been</u> since you last visited a doctor for a routine checkup?	Do any of the following **prevent** you or members of your family from seeking support from your Coordinated Care Organization (CCO) or other health provider with issues around stress, frustration, worry, anger, addiction, violence, and/or abuse? Please select all that apply. • CCO/health <u>provider is too far away</u> • Don't have access to <u>transportation</u> • Don't have access to <u>childcare</u> • Don't have consistent access to <u>internet</u> for virtual appointments • Don't have health insurance • Process for <u>making an appointment</u> with a provider is difficult • Don't feel <u>safe</u> visiting my provider • Provider cannot <u>communicate in a language</u> that I'm comfortable using • Provider doesn't have the same <u>cultural background</u> as me • The service(s) I/we need is <u>not covered</u> by my insurance • The service(s) I/we need is <u>not available</u> near me • <u>Not aware</u> of what services are available near me • Information about services is <u>not provided in a language that I'm comfortable using</u> • Don't trust that my CCO/health provider will be <u>respectful of my cultural values</u> • Other (please specify)

Lack of Meaningful Context: Healthcare Access

What's keeping individuals from going to the doctor apart from cost and coverage?

Barriers to Accessing Providers

Legend:
- Distance (1,2,10) — 13%
- Cultural and Linguistic (7,8,12,13) — 30%
- Communication (3,11) — 28%
- Process (5) — 10%
- Safety (6) — 4%
- Insurance (4,9) — 15%

n=306
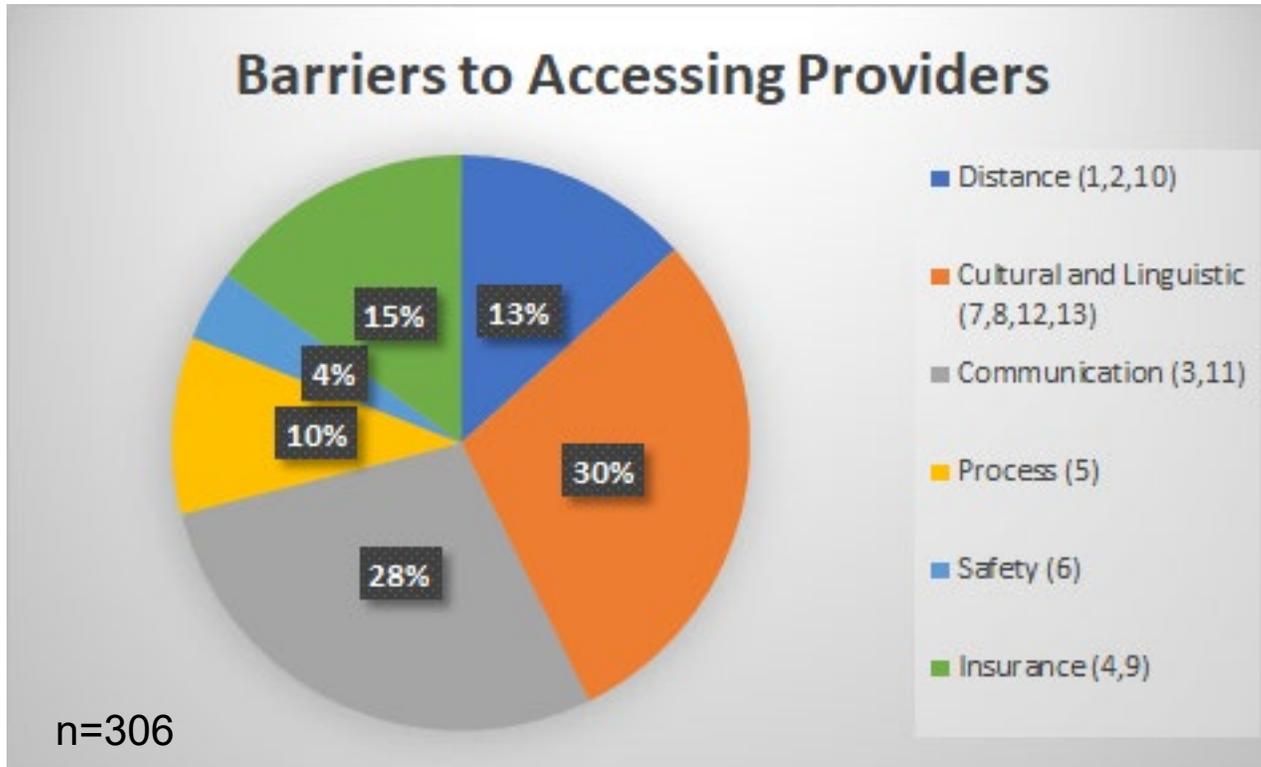
Key:
Distance - provider is too far away, services are far away, lack transportation
Cultural and Linguistic - information and services are not culturally and linguistically specific/responsive
Communication - not aware of services, lack internet
Process - making an appointment is difficult
Safety - feel unsafe visiting provider
Insurance - no insurance or services not covered

Communication	Insurance
Culture/Language	Process

| Top 3 Most Frequently Chosen Options	
Black/African American	**Latinx**
Not aware of what services are available near me	Not aware of what services are available near me
Provider doesn't have the same cultural background as me	The service(s) I/we need is not covered by my insurance
Don't trust that my CCO/health provider will be respectful of my cultural values	Process for making an appointment with a provider is difficult

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Lack of Meaningful Context: Healthcare Access

Culturally & Linguistically Responsive Providers

MANY OPTIONS — 41, 18
FEW/LIMITED OPTIONS — 46, 62
NO SUCH OPTIONS — 12, 20

- Providers who speak your language
- Providers who understand your cultural background

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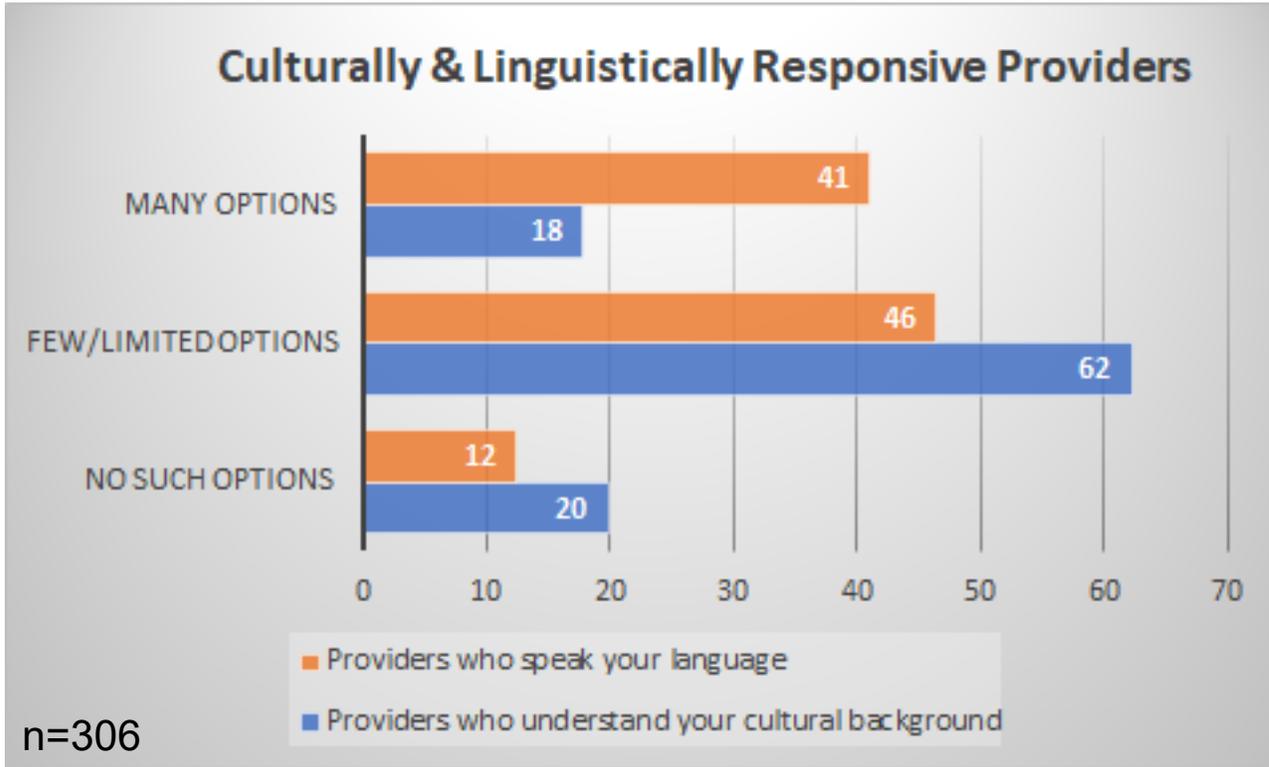
Narrative: 58% of respondents said they have *few or no options* for accessing <u>linguistically</u> responsive providers, and 82% said *few or no options* for accessing providers who understand their <u>cultural background</u>.

Understands your culture	Black/African American	Latinx
No such options	23	10
Few/limited options	74	51
Many options	22	11
Speaks your language	**Black/African American**	**Latinx**
No such options	13	6
Few/limited options	46	47
Many options	60	19

Lack of Meaningful Context: Experiences of Medical Mistrust

Do health providers make you feel heard, understood, affirmed, and informed?
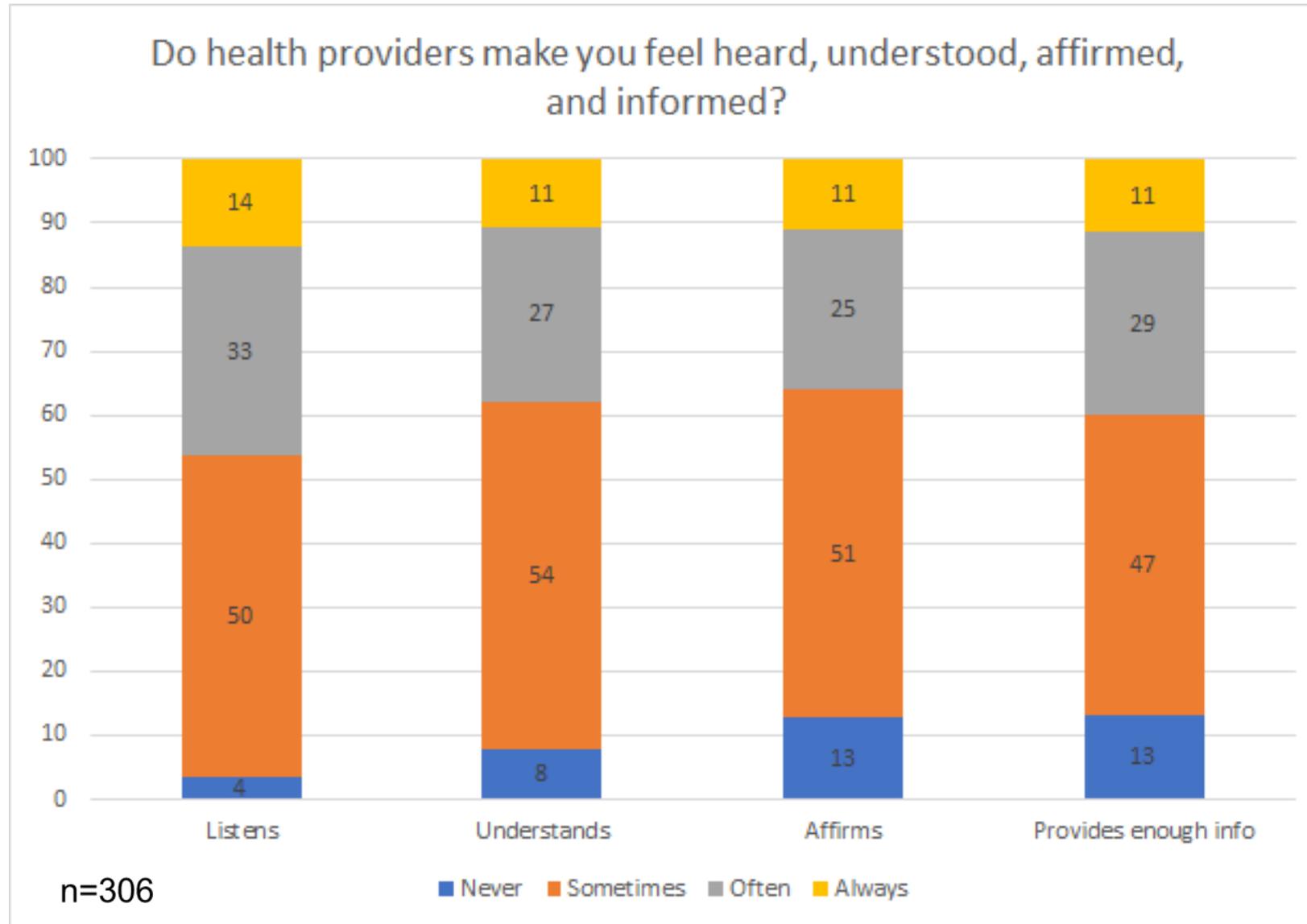
Lack of Meaningful Context: Experiences of Medical Mistrust

Top 3 Themes	Examples
Providers lack empathy	• Dismissive • Patient feels unheard • Disrespectful • Rushed appointments
Experiences of harmful care practices	• Denied care • Misdiagnosis • Unnecessary treatment • Need to self-advocate
Stereotyping by providers n=220	• Presumed incompetent • Assumed drug addiction

Key Themes

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Questions Need to be Actionable

Examples
- School Absenteeism
- Physical Activity

Questions Need to be Actionable: School Absenteeism

- For OHT, both teams noted the questions only focus on school and not the everyday lives that impact how, when, and why students show up at school.

- Teams questioned why students are missing school beyond physical and emotional & mental health reasons.

- Are they working a job? Are they caring for a family member? Is there a hostile school climate? How is food insecurity affecting attendance?

Questions Need to be Actionable: School Absenteeism

Oregon Healthy Teens Survey	Community Led Data Collection - What would youth ask?
During the past 12 months, ○ how many days of school did you miss for any reasons? ○ how many days of school did you miss because of physical health reasons? ○ how many days of school did you miss because of emotional or mental health reasons? ○ how many days of school did you have unexcused absences (meaning you skipped or cut school? ○ did you miss one or more hours of school due to any of the following reasons? I had a toothache or painful tooth; My mouth was hurting; I had to go to the dentist because of tooth or mouth pain; I had to go to the hospital emergency room because of tooth or mouth pain; I had a mouth injury from playing sports.	● Just ask them "What's causing you to miss school?" ● Do you have problems at home/outside of school? ● Are you doing ok? ● After each question just add a "why section" ● What is elevated above school? Why does it come up? ● Do you have other things to do other than school? ● What are things affecting you outside of school that keep you from being successful? ● In what ways does school feel unsafe to you? ● Is someone making fun of you or are there stressful conditions you want to avoid at school like students or teachers? ● What would make school a safer environment? ● What at schools feels welcoming/accepting? What does not?

Questions Need to be Actionable: Physical Activity

BRFSS	What is needed to be actionable
During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?	Understanding of what's preventing them from being physically active Mapped in relation to policy-related PA contexts. Examples: • Joint use agreements between schools and public • Amount of greenspace • % of jurisdiction zoned for public recreation use • Density of free gym facilities as ratio of non-free ones • Traffic/pedestrian injury rates • Sidewalk existence & quality • % of tax revenue invested in parks This then renders PA responses open to deep examination and action, e.g., what is relationship between joint use agreements and PA rates for xyz county/neighborhood? Is there a demographically comparable area w/ similar level of agreements that has lower PA rates? Why?

"Behaviors evolve/match contexts. Policy creates/shapes/maintains contexts. This is not news to any of us. How come our surveys appear impervious?"

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"We don't need more detailed data about how black folks experience even worse ACEs - more toxic environments -- we already know that. We need data that can help drive policy."

Key Themes

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Integration of Other Data Sources

- Latinx team requested to see the OHA immunization registry data to provide better understanding of the self-report influenza vaccination data in BRFSS back in May 2020. Also shared with Black/African American team.

- Latinx team wanted to compare Oregon Department of Education (ODE) data and OHT. ODE Free and Reduced lunch data by ethnicity was found and shared. Also shared with Black/African American team.

- Policy related contexts – integration of legal epidemiology

Key Themes

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Intersectionality

- Racialization & Generational Groups

- Age, Country of Birth, and Language

- U.S. Born versus Foreign Born

- Collecting REaLD & SOGI for better disaggregation

Dominant Culture Perspective
Reflected in each of the themes presented

EXAMPLE OHT Bullying Question Response Options

- Bullying about your race or ethnic origin
- Unwanted sexual comments or attention
- Bullying because someone thought you were gay, lesbian, bisexual, or transgender
- Bullying about your weight, clothes, acne, or other physical characteristics
- Bullying about your group of friends
- Other reasons

Team member comments

- Inclusion of racial discrimination as simply a form of "bullying" is problematic
- Minimizes the extent/depth of interpersonal racism as connected to/enabled by institutional racism
- Should not lump forms of systemic devaluation, exclusion, and oppression in with getting bullied b/c of clothes, etc.
- Actions that are biased, hostile, or violent toward others based on race are racist, and appropriately viewed as hate speech/actions
- Subsuming them under the concept of "bullying" clouds the dynamics of power that are at play
- Serve as a reminder of the need for systemic/ institutional/organizational change. It is not the responsibility of the person/community to "cope", but for the environment (policies, practices, providers) to become welcoming, inclusive, and less discriminatory

Thoughts from a Community Based Researcher

- 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...

- Center community data & strategies for self-determination
  - Let communities of color frame how mainstream data fails to represent them
  - Help local and regional entities with community led question development, data collection strategies, data analysis, and data uses
  - Connect available mainstream data to community data. This process should be led by the community.
  - Establish decision making processes that defer to community

Early Lessons Shared in September 2020
Updates May 2021

- 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
- **As a result – misrepresents people's experiences, further blames and causes them harm "This approach (BRFSS and OHT) damages people to be misrepresented"**
- **If the data are not actionable, then we can't hold ourselves accountable**
- **We're accountable to the communities we serve and data from BRFSS and OHT prevent our ability to be accountable**
- Equity as a starting point for survey design rather than being driven by siloed programmatic needs than community centered
- 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
- Data justice – fairness in the way people are made visible, represented and treated as a result of their production of digital data (Taylor, 2017)

Project Team Recommendations
Next steps

- Build in **time and resources necessary for relationship development** between govt public health and community partners in data
- Continue **long term, sustained compensated Community led Data Collection**
- Conduct a **minimal BRFSS** – explore lessons from the **CA Health Interview Survey**
- Integrate **Community Leadership** in survey development, administration, analysis & use
- Establish a Survey **Translation Advisory Committee**
- Continue **data project teams** and ensure team members are made up of folks who share experiences of those who are being "researched"
- Engage **Community Based Organizations and/or Regional Health Equity Coalitions** in survey administration
- Reengage the Health Equity Researchers of Oregon (HERO) group

Call to action & funding of strategy development of what the work can look like and who should be engaged

Project Team Recommendations

Need for clear conceptual framework guiding OHA in general, and BRFSS/OHT more specifically, that spells out the multilevel, multilayered understanding of the issues
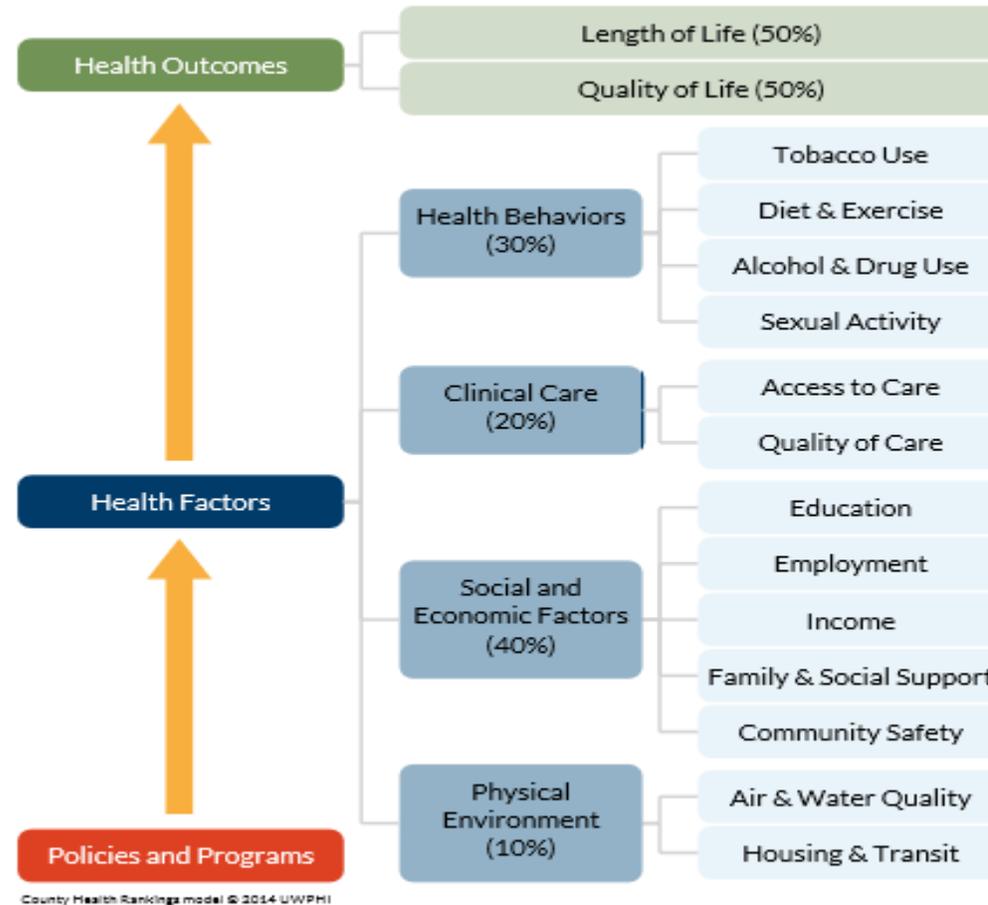
County Health Rankings Model

Key Lessons for Equitable Data Practices

- Recognition of **skill sets, background and respect** of each community & govt partner are valued

- Show respect to community members by **paying them for their time and expertise**

- See **community members as experts** in their areas – center & value community knowledge

- **Share data** and TA as needed – in this case BRFSS & OHT Datasets, requested contextual data (i.e. ALERT IIS & ODE) & BRFSS pilot results

- Resist letting the "small numbers" argument get in the way of sharing data with communities. Sometimes communities see this as intentional and can further distrust

- **Share project/survey budgets** with community partners

- **Share translated surveys** for review

- **Defer human subjects protections** to community research partners

- Increase collection of **contextual/environmental & actionable measures** collected by both Community led data collection and State BRFSS and SHS

- Improve **integration** and reporting population health outcome measures with collected contextual information

- Those measures should be considered for inclusion in the Healthier Together Oregon **SHIP** metrics

Thank you!

NPAIHB and NWTEC

- **Northwest Portland Area Indian Health Board (NPAIHB)**
  - Tribal organization formed in 1972
  - Serves 43 federally-recognized tribes in ID, OR, WA

- **Northwest Tribal Epidemiology Center (NWTEC)**
  - Formed in 1996 as a department of the NPAIHB
  - Guided by the Public Health Committee of the NPAIHB
  - Reports to the NPAIHB Tribal Delegates

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INDIAN HEALTH BOARD
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Tribal Epidemiology Centers (TECs)

- Established as public health authorities through permanent reauthorization of the Indian Health Care improvement Act (IHCIA) in 2010

- Function independently, but also as part of a national group called TEC-Consortium

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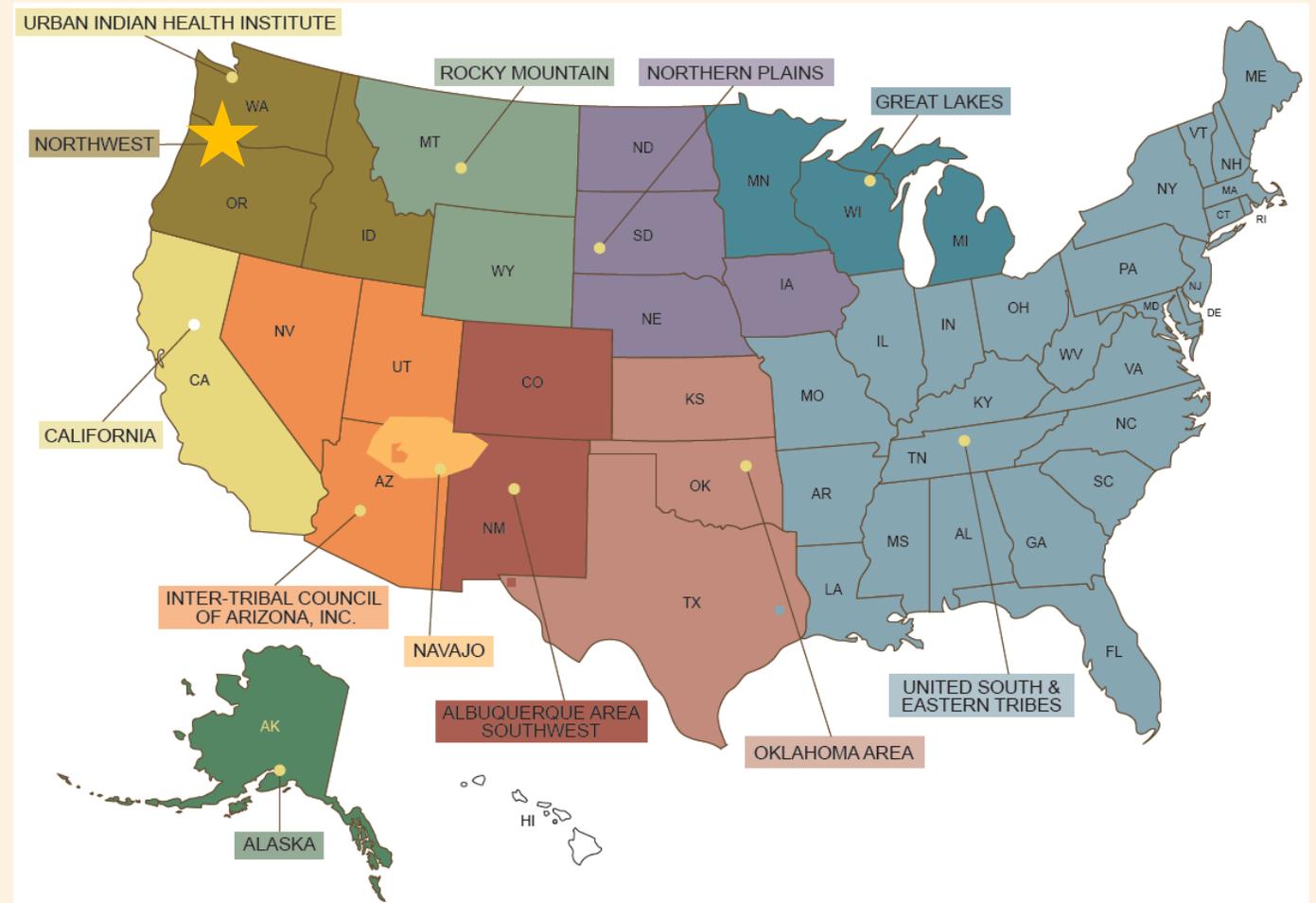
NWTEC as a Public Health Authority

> Does not alter Tribes' Public Health Authority as sovereign nations, but is supportive to it.

- US Health and Human Services (HHS) directive gives TECs access to HHS data systems and protected health information

- CDC must provide technical assistance to TECs

- Each Indian Health Service (IHS) Area must have TEC access

- Role as Public Health Authority at the request of tribes for data and provision of technical assistance

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Tribal Data Sovereignty

As sovereign nations, tribes are the owners of data for their citizens and should have primary control and voice in the use, interpretation, and disposition of data related to their citizens.

NPAIHB Project Team

NPAIHB/NWTEC

- Bridget Canniff
  Project Director, Public Health Improvement & Training (PHIT)

- Kimberly Calloway
  Project Specialist, PHIT

- Kerri Lopez
  Project Director, Western Tribal Diabetes and NW Tribal Comprehensive Cancer Projects

- Natalie Roese
  Contractor

Tribal Workgroup

- Nicole Barney
  University of Oregon/Klamath Tribes

- Pamela Gutman
  Cow Creek Tribe

- Jessica Hamner
  Coquille Tribe

- Obinna Oleribe
  Klamath Tribes

- Richie Thomas
  University of Oregon

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

PROJECT WORKPLAN

Meeting #1
- Introduce project
- Identify areas of concern
- Discussion

Meeting #2
- Discussion with OHA
- Finalize project team data priorities
- Identify areas for additional analyses
- Suggestions for supplemental data review

Meeting #3
- Review additional results from suggested analyses
- Finalize areas for supplemental data review

Meeting #4
- Assist in interpretation of supplemental data review and presentation of results
- Draft report due to OHA **May 21**

Meeting #5
- Review summary report & recommenda-tions for future survey methods
- Final report due to OHA **July 31**

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Project Team Topics of Interest

- **Adverse Childhood Events (ACEs)**
- **Chronic health conditions**
- **Suicide**
- **Behavioral health**
- Substance use disorder
- Physical activity and nutrition
- Healthcare access
- School attendance

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Key Findings

- AI/AN definition
- Strengths of Tribal BRFSS model
- Lack of meaningful context
- Need for actionable data

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NPAIHB/NWTEC Approach: AI/AN Definition

- Include American Indian or Alaska Native (AI/AN) data, whether alone or in combination with other race/ethnicity
- Linkages of state datasets with NWTEC tribal registry to provide more complete data reporting to tribes
- Focus on our population of interest

"American Indians and Alaska Natives are often incorrectly classified as another race (usually White) in vital statistics, cancer registries, and other public health datasets. In the Northwest, AI/AN misclassification in health datasets can range from 10-60%... Without accurate data, tribes are limited in their ability to identify and allocate resources to the areas of greatest need."

- IDEA-NW Project, NPAIHB/NWTEC

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AI/AN Identification by Race/Ethnicity Classification

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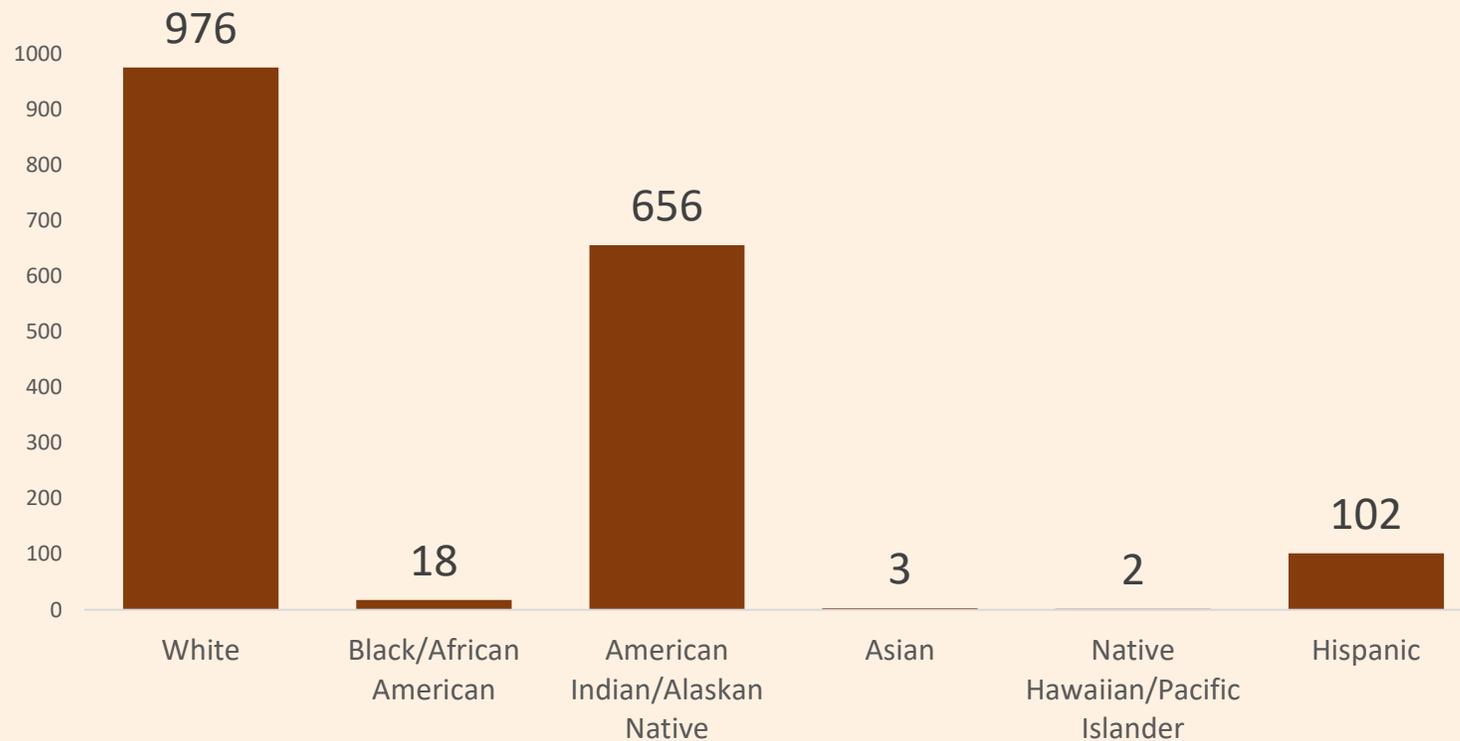
Tribal BRFSS

- NWTEC supports tribes, upon request, in conducting tribal-specific surveys

- Questions can be tailored to the health priorities and services of each tribe, such as:
  - Point of access for healthcare (tribal clinic vs. other)
  - Use of or need for specific services, such as Elders programs
  - Cultural activities that support health and wellness

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Strengths of Tribal BRFSS Models

- Community trust
- Customized approach to recruitment of participants
- Actionable data and informed program planning
- Tribal ownership of data

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Context: Question Wording

CDC BRFSS

Section 4: Hypertension Awareness

4.1 Have you EVER been told by a doctor, nurse, or other health professional that you have high blood pressure?

(101)

Read only if necessary: By "other health professional" we mean a nurse practitioner, a physician's assistant, or some other licensed health professional.

4.2 Are you currently taking medicine for your high blood pressure?

(102)

1 Yes
2 No
7 Don't know / Not sure
9 Refused

CDC BRFSS

SAMPLE TRIBAL BRFSS

Section 8: HYPERTENSION AWARENESS

8.1. Have you had your blood pressure taken in the past 12 months?

1 YES
2 NO
7 DON'T KNOW/NOT SURE
9 REFUSED

8.2. Have you ever been told by a health provider that you had high blood pressure? [**read only if necessary**]: not including high blood pressure while pregnant.

1 YES
2 NO ➔ **GO TO NEXT SECTION**
7 DON'T KNOW/NOT SURE ➔ **GO TO NEXT SECTION**
9 REFUSED ➔ **GO TO NEXT SECTION**

NOW, I AM GOING TO READ A LIST OF REMEDIES YOU MAY BE USING TO TREAT YOUR HIGH BLOOD PRESSURE.

8.3. Are you using…

	READ CHOICES	YES	NO
A.	ORAL MEDICINE (MEDICINE YOU TAKE BY MOUTH)	1	2
B.	TRADITIONAL MEDICINE (PLEASE DESCRIBE) _____	1	2
C.	ACUPUNCTURE	1	2
D.	MASSAGE THERAPY	1	2
E.	DIET	1	2
F.	EXERCISE	1	2
G.	YOGA	1	2
H.	LIFESTYLE & WELLNESS COACH	1	2
I.	NO LONGER HAVE HIGH BLOOD PRESSURE	1	2
J.	OTHER (SPECIFY): _____	1	2

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Lack of Meaningful Context

Oregon Healthy Teens (OHT) Survey

"During the past 30 days, did you ever sleep away from your parents or guardians because you were kicked out, ran away, or were abandoned?"

"During the past 12 months, did you have any physical health care needs that were not met? (Count any situation where you thought you should see a doctor, nurse, or other health professional.)"

Actionable Data

- For tribes, the BRFSS is not as useful for looking at AI/AN data across multiple counties within a tribe. Data require complicated cross-tabulations and often lacks necessary context.

There is a need for more funding to meet the needs that have already been determined, and not simply more surveys to further assess needs.

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Next Steps

- Draft report
- Review draft at Meeting 5 in June with Project Team
- Submit final report to OHA in July
- Share and discuss report recommendations with NPAIHB delegates and tribes

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Thank You

For more information about NPAIHB and the work of the Northwest Tribal Epidemiology Center, please visit www.npaihb.org

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OPHD Survey Modernization with Pacific Islander Communities

PACIFIC ISLANDER DATA MODERNIZATION (PIDM)

Pacific Islander Data Modernization (PIDM)

- PIDM's aim was 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

Community Engagement

High-level Advisory
Outreach network
Holds DSA

CBOs
Cultural advisors
Hosted workshops

CRWs
Support facilitation and data analysis

Natlie Dutro - Native Hawaiian
Siiri Visto - Native Hawaiian
Sisilia Afemui - Tongan
Adri Jones - Filipinx
Kianna Angelo - Marshallese
Jonathan Cruz - Native Hawaiian
Jasmine Kahananui - Native Hawaiian
Bella Borja - CHamoru
Dr. Jacinta Galeai - Samoan
Elizabeth Paulson - Samoan

Core Team
Research and Engagement Leads

Maria Dizon - Filipinx / lived in Saipan

Virginia Luka - Palauan / lived in Guahan

Alyshia Macaysa - Native Hawaiian and Filipinx

PI HEAL Workshops & Assessment

- Each CBO sponsored a 3-hour Pacific Islander **H**ealth, **E**quity, **a**nd **L**iberation (PI HEAL) virtual community workshop

- CBOs led recruitment of community member participants and compensated them directly

- CRWs and Core Team members worked with each CBO to plan and develop content for their workshop, generally:
  - Welcome, Blessing, and Land Acknowledgement
  - Who is a scientist? What is data? What is research?
  - What is Pacific Islander Data Modernization?
  - Consent
  - Independent completion of PI HEAL Assessment (online)
  - Small group breakout
  - Large group share out

PI HEAL Assessment

- Core team co-developed the Pacific Islander **H**ealth, **E**quity, and **L**iberation (PI HEAL) Assessment
  - Adapted from Prevention Institute's THRIVE assessment, informed by PIDP, previous work on PI-specific SDOH, and Community Counts
  - Consulted with CBOs, CRWs, and broader PI community

- Four priority areas with 16 community health factors **specific to Pacific Islander community health:**
  - **People:** Community Connections, Care for Community, Community Values
  - **Place:** Housing, Food, Access to Land, Getting Around, Cultural Centers
  - **Opportunity:** Living Wages, Local Wealth, Education, Information
  - **Healing:** Self Determination, Decolonization, Spiritual Health, Healthcare

- REAL-D and SOGI questions

- Translated into Tongan, Pohnpeian, Marshallese, 'Ōlelo Hawai'i, and CHamoru/Chamorro*, which were centralized and accessible through the project website https://www.pacificislanderheal.com/

PI HEAL Assessment, cont.

- PI HEAL respondents rated each community health factor based on **how accessible and abundant** they believe the factor is to Pacific Islanders in Oregon

- Ratings are based on a "fish" scale:

  - Bonefish: Myself, my family, and my community do not have this

  - One little fish: This is something I have personally, but is not something that my family or community have

  - One large fish: This is something I have and my family have, but not my community

  - Two fish: This is something I have, my family have, and some of my community have

  - Three fish: This is something I have, my family have, and my community have

- Respondents then ranked each factor as low, medium, or high priority for future health improvement efforts and chose their top 3

PI HEAL ASSESSMENT RESULTS

Whose voices are present?

Age, Gender, SO, Language, and Disability

- 136 respondents

- Average age = 39 (SD=12), range = 18-74

- Most identified as a woman (n=90) or man (n=33)

- Most identified as straight/heterosexual (n=96), and others listed LGB, Queer, Pansexual, Asexual, Questioning, etc.

- Most reported speaking English "very well" or "well"
  - Other language abilities included CHamoru, Chuukese, Marshallese, Samoan, Tongan, and ʻŌlelo Hawaiʻi

- About 18% reported experiencing one or more disabilities

- Multiple Pacific Islander ethnic identities
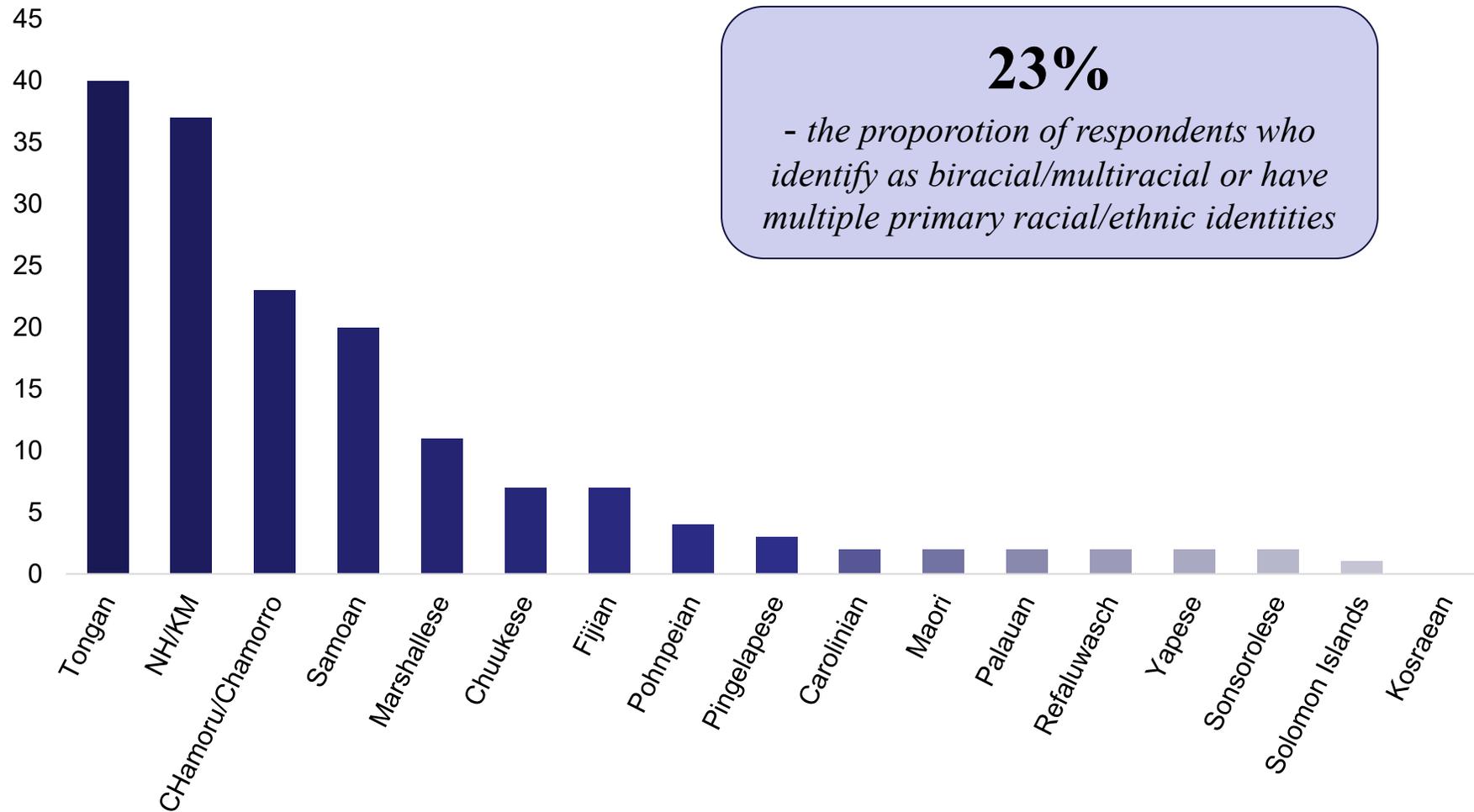
PI HEAL ASSESSMENT RESULTS

*How abundant or accessible are the Community Health Factors?*

"People" Community Health Factors
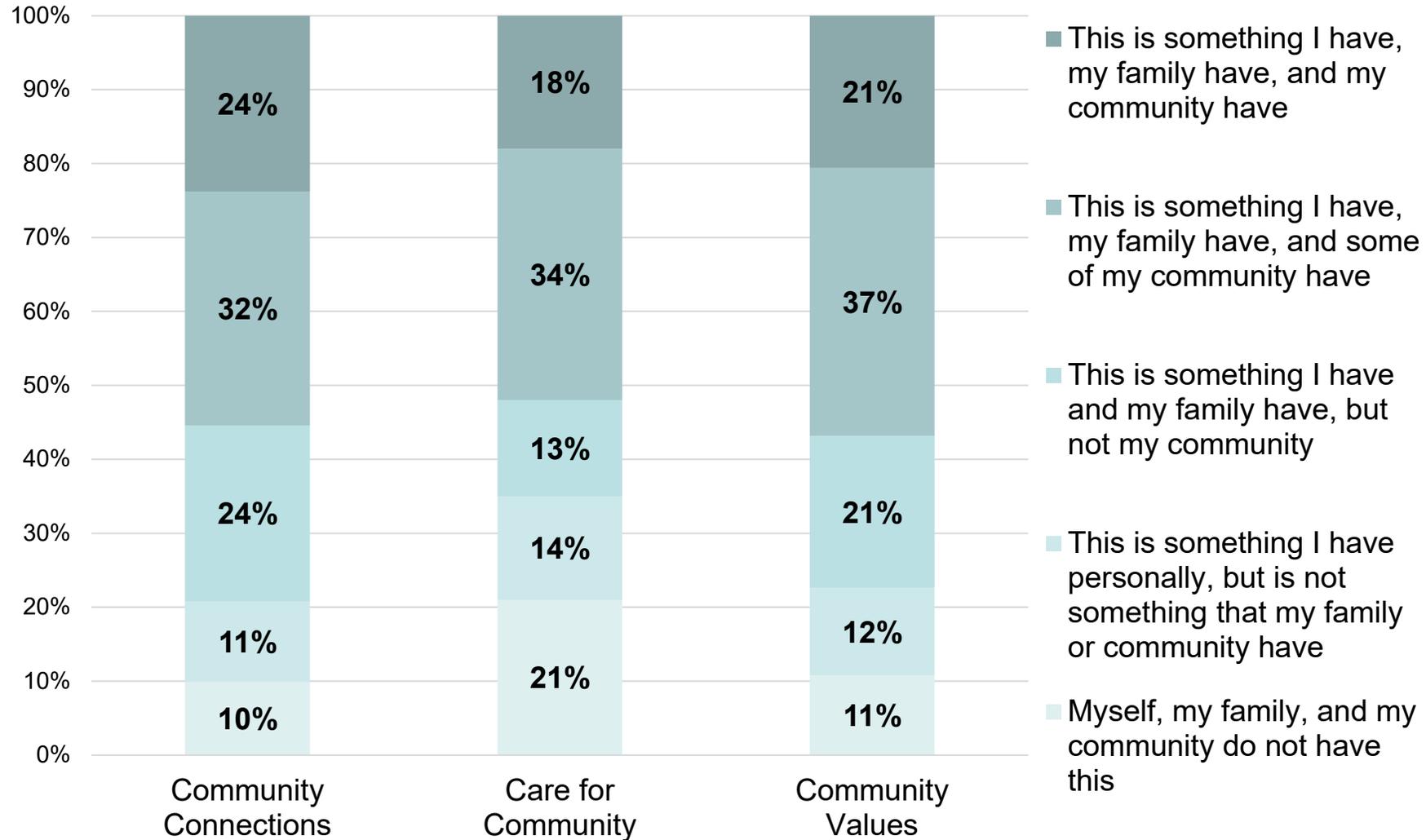
"Place" Community Health Factors
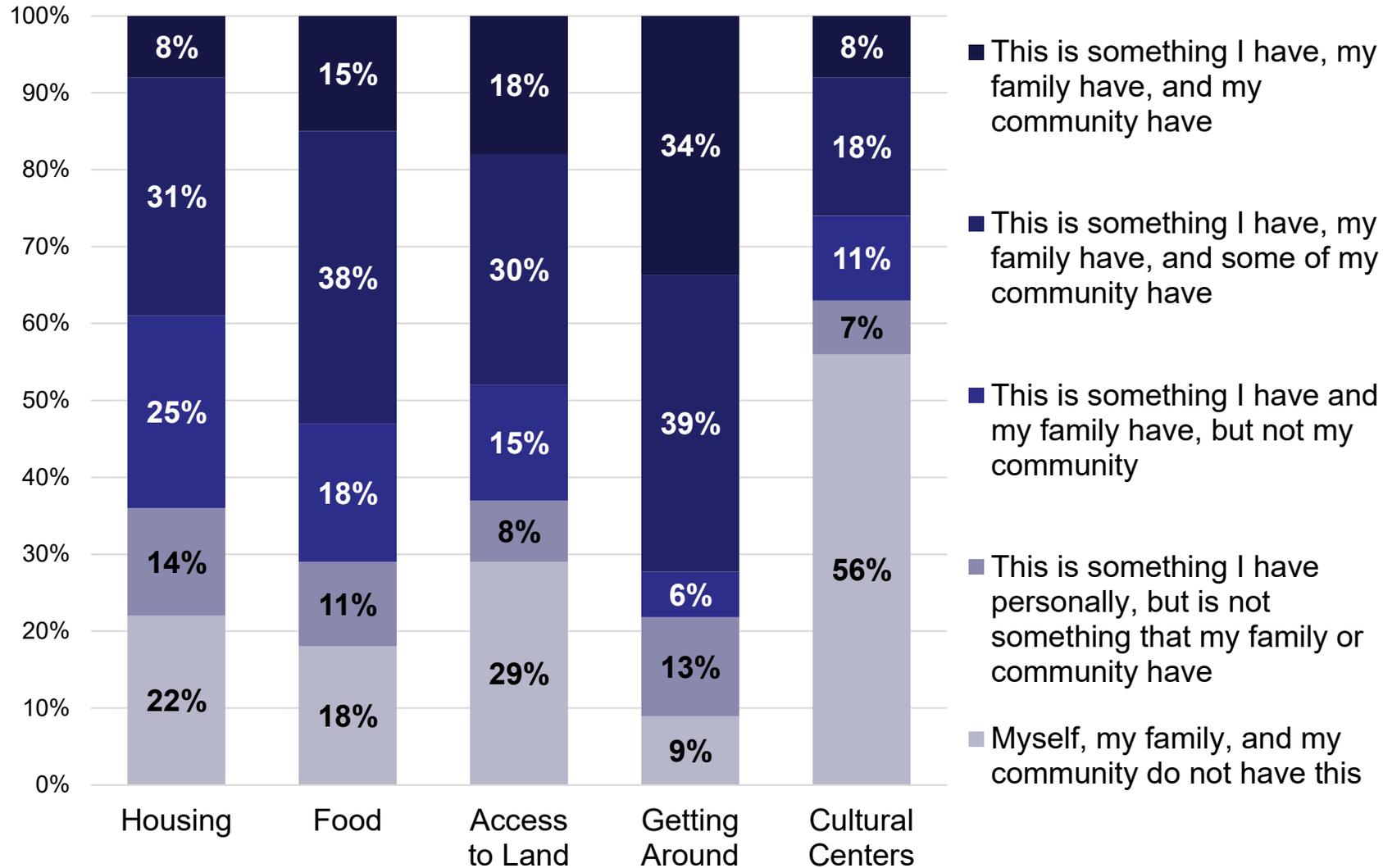
"Opportunity" Community Health Factors
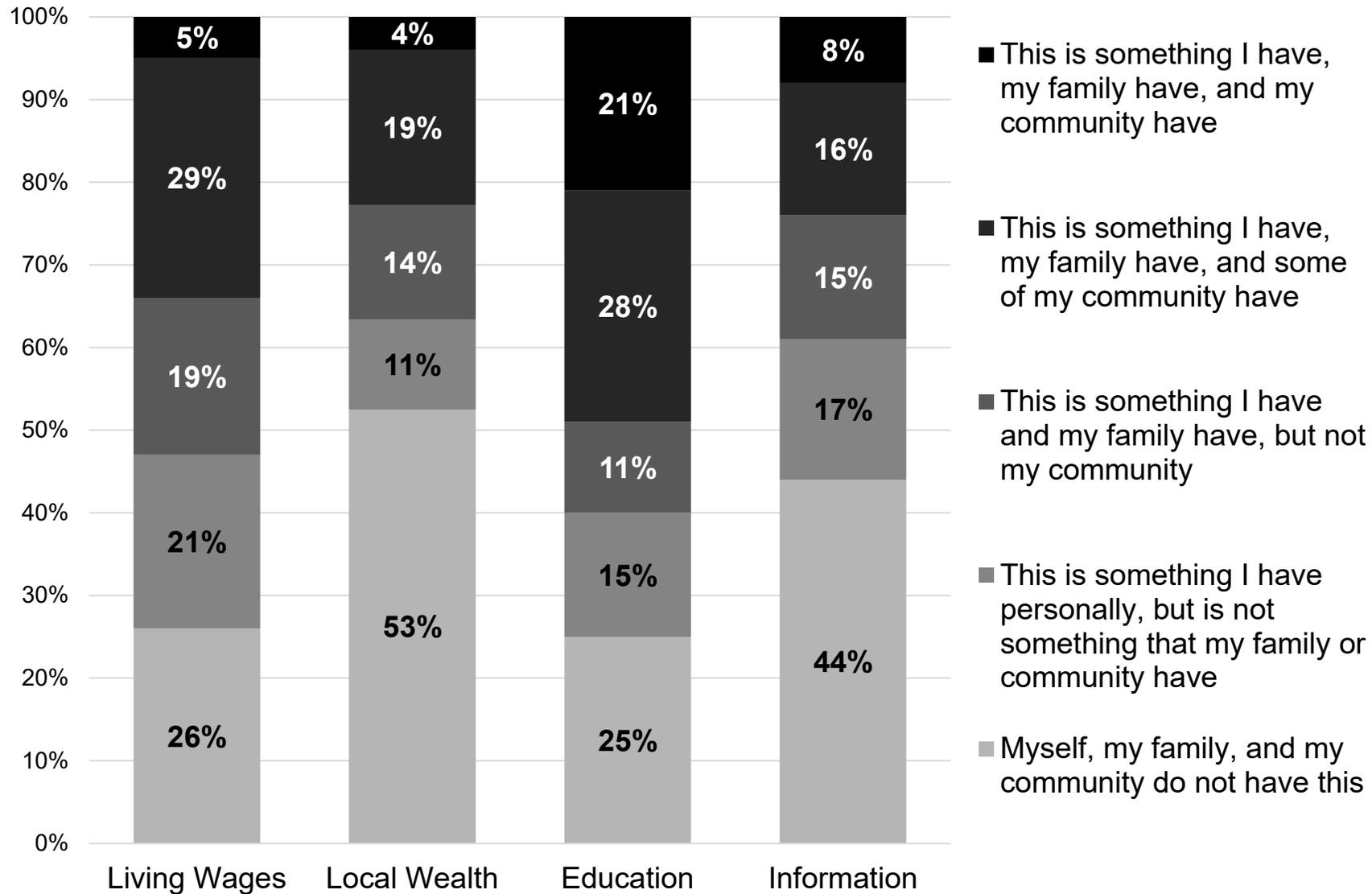
"Healing" Community Health Factors
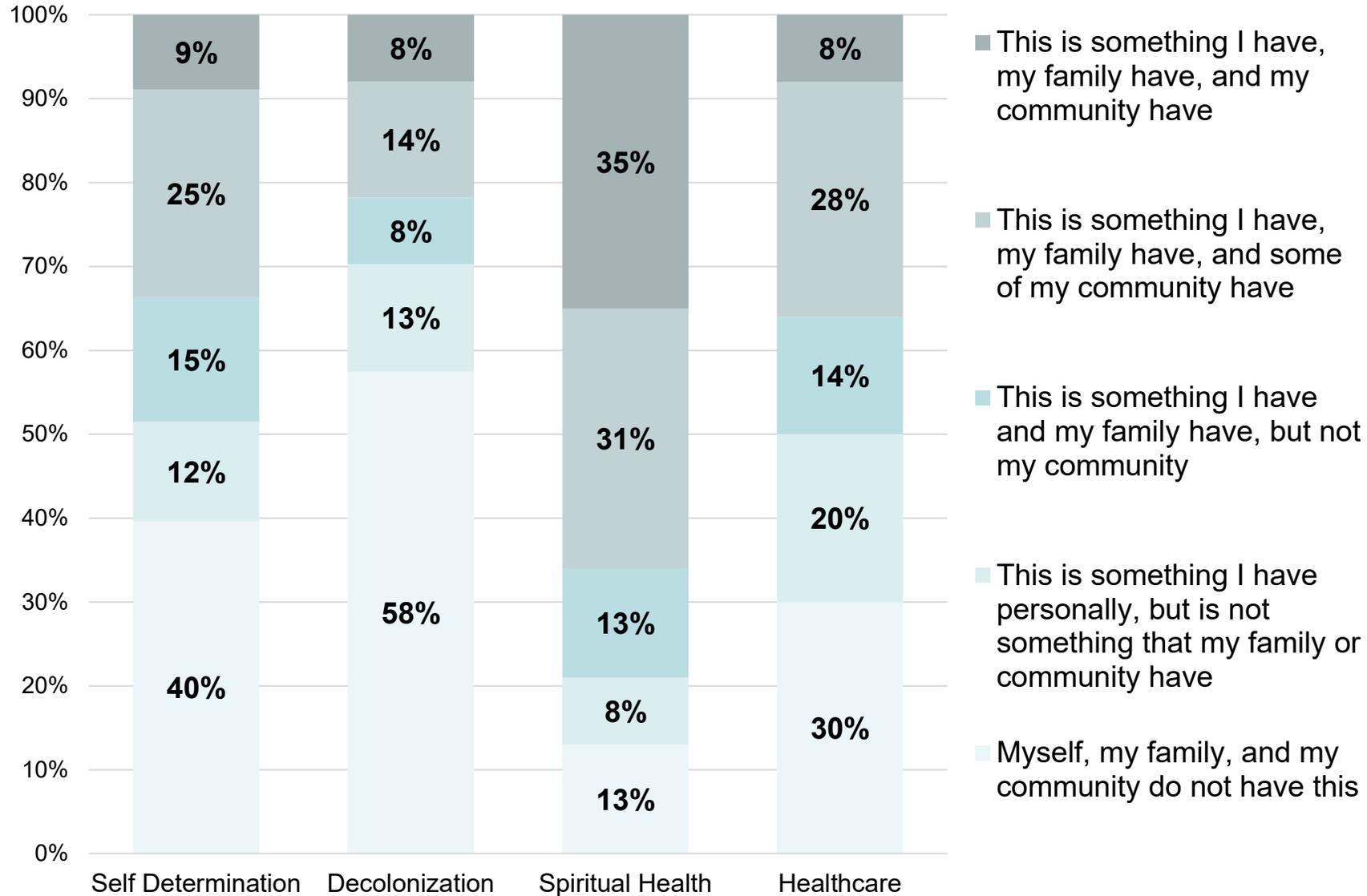
PI HEAL ASSESSMENT RESULTS

How important is each factor for future efforts to improve community health?

Low priority for future efforts to improve health

Medium priority for future efforts to improve health

High priority for future efforts to improve health
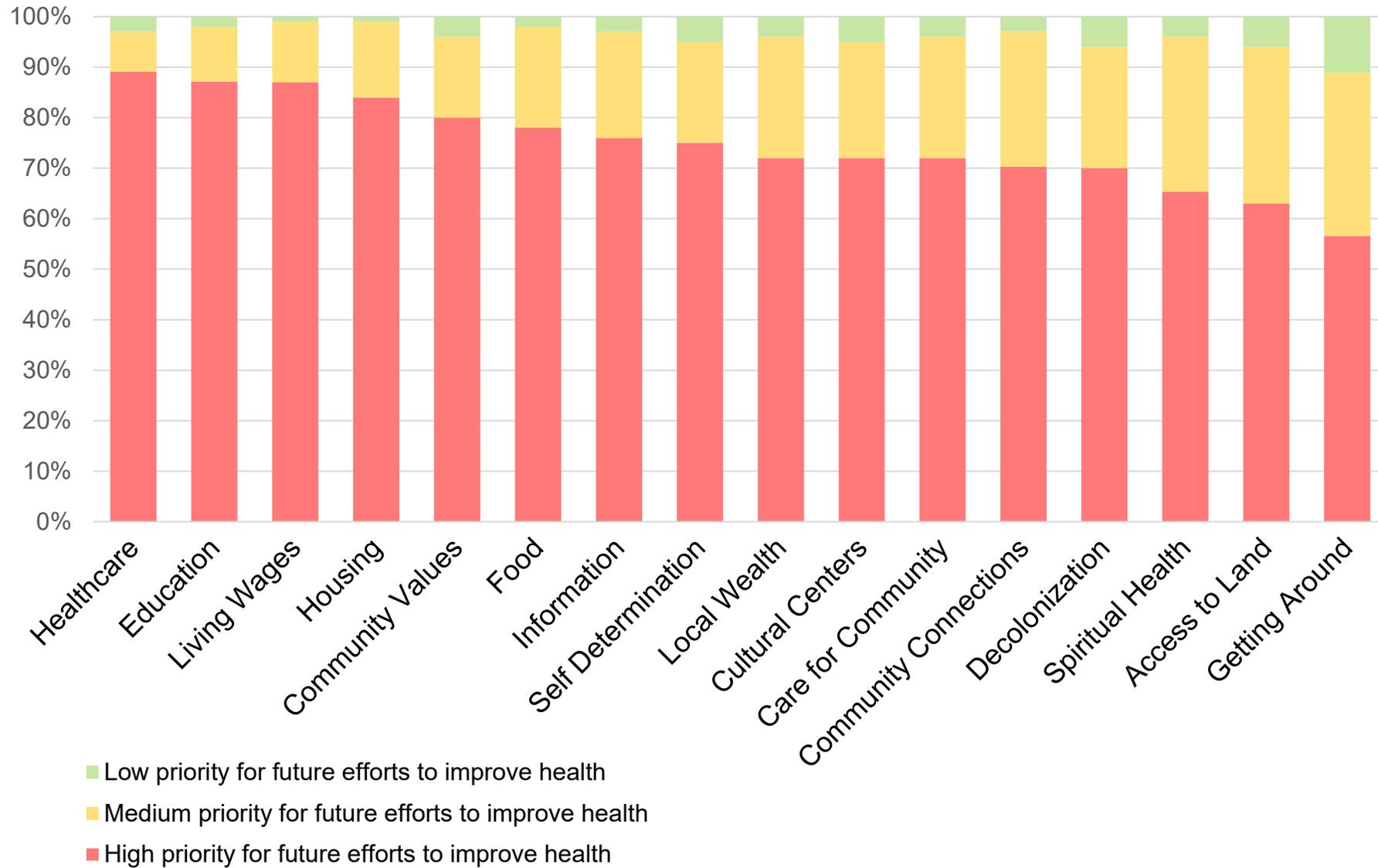
Top 3 Priorities

⭐ **HEALTHCARE**

⭐ **HOUSING**

⭐ **EDUCATION**

PIDM LESSONS LEARNED & RECOMMENDATIONS

A larger budget is needed for equitable implementation and engagement

- Need enough technical skills and capacity to ensure there is robust project coordination, research/data expertise, and cultural advising

- Particularly with language support to take the survey, and technology to participate in workshops.

- Funding a review board or validation process for translated work

- Being able to engage multiple organizations that serve the same community. Even within a specific identity, the community is not a monolith.

Improve upon the assessment so that it is digestible and accessible

- Host community<>community conversations on SOGI

- Hone in on writing the assessment in plain language

- Potentially add in a category on safety to measure experiences of discrimination and racism across each factor

- Provide more succint definitions or break up a community health factor into multiple factors

Pacific Islanders are ready to engage in research and do a deeper dive

- Consider having reports specific to particular Pacific Islander identities or by specific community health factors

- Need to integrate multi generational values of community and ensure there is a youth specific component to future research

- Still need to engage a larger number of Pacific Islanders <u>across</u> Oregon (see next slide)

PI HEAL Reach
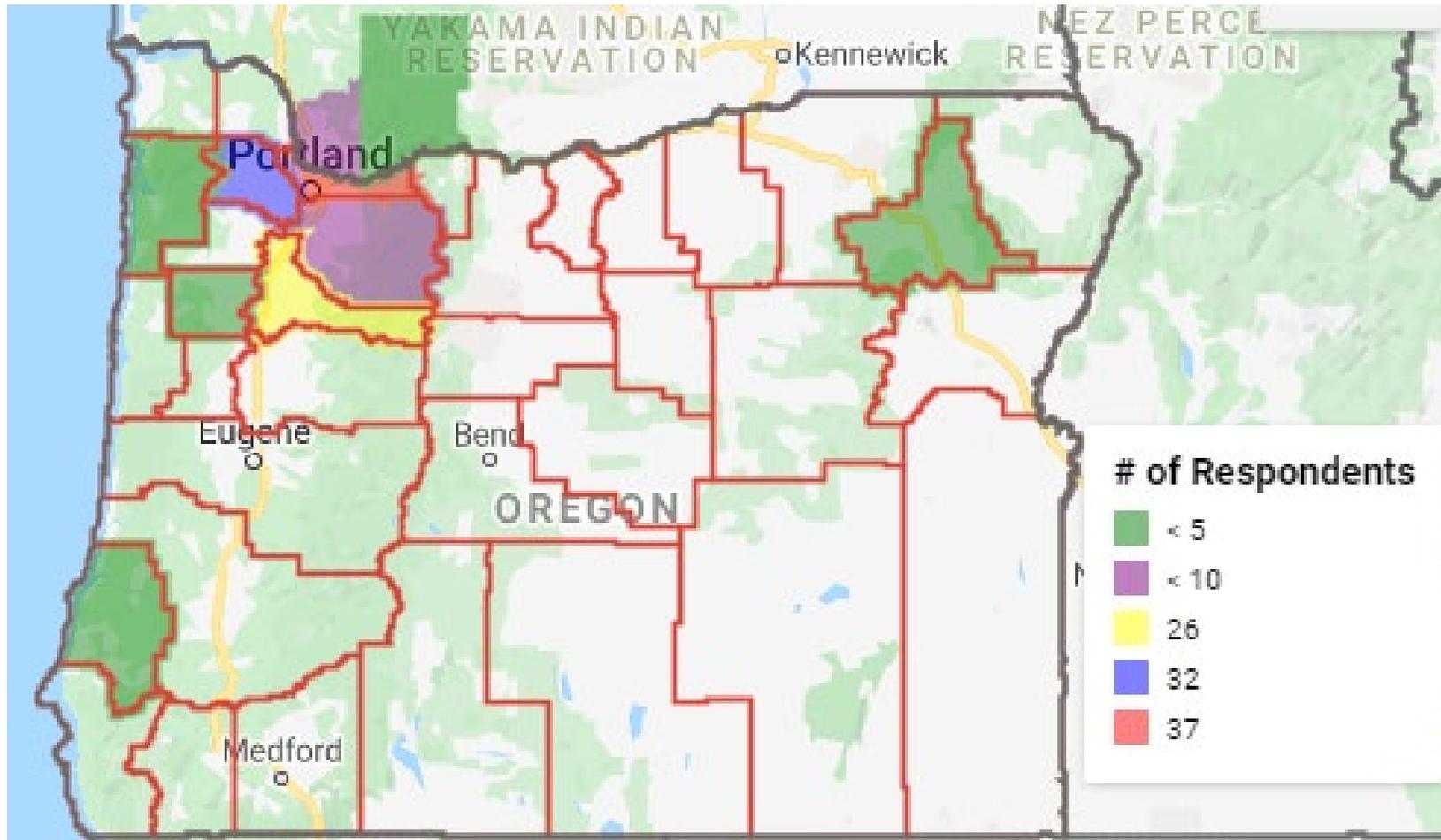
THANK YOU!

Public Health Advisory Board
Health equity review policy and procedure
September 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

How health equity is attained

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

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

Policy

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

Procedure

Board work products, reports and deliverables

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

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

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

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

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

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

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

The PHAB review process includes the following questions:

4. How does the work product, report or deliverable:
    a. Contribute to racial justice?
    b. Rectify past injustices and health inequities?
    c. 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.

Resources

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

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

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

Oregon Education Investment Board. Equity Lens.

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

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