AGENDA

PUBLIC HEALTH ADVISORY BOARD

April 20, 2017
2:30-5:10 pm
Portland State Office Building, 800 NE Oregon St., Room 1A, Portland, OR 97232

Join by webinar: https://attendee.gotowebinar.com/register/2886920992444895491
Conference line: (877) 873-8017
Access code: 767068

Meeting objectives

- Learn about Multnomah County Health Department's Racial and Ethnic Approaches to Community Health (REACH) program
- Discuss and adopt PHAB health equity policy
- Discuss state health improvement plan priorities for immunizations and communicable disease control

Time	Agenda item	Presenter
2:30-2:50 pm	**Welcome and updates** • Approve March 16 meeting minutes • Share information from April 4 Oregon Health Policy Board discussion on PHAB charter and work plan • Share legislative updates, including public hearing on HB 2310 – public health modernization • Provide update on accountability metrics • Provide update on state health assessment planning	Jeff Luck, PHAB Chair
2:50-3:20 pm	**Racial and Ethnic Approaches to Community Health (REACH)** • Share how Multnomah County is engaging communities to address health disparities • Discuss how Multnomah County's model can be applied	Rachael Banks and Tameka Brazile, Multnomah County Health Department
3:20-3:50 pm	**Health equity policy** • Review updated PHAB health equity policy • Adopt policy	Jeff Luck, PHAB Chair
3:50-4:05 pm	**Break**	
4:05-4:55 pm	**State Health Improvement Plan** • Discuss immunization and communicable disease control priority areas • Highlight progress, achievements and barriers	Aaron Dunn, Oregon Health Authority Paul Cieslak and Sean Schafer, Oregon Health Authority

4:55-5:10 pm	**Public comment**	
5:10 pm	**Adjourn**	Jeff Luck, PHAB chair

Public Health Advisory Board (PHAB)
March 16, 2017
Draft Meeting Minutes

Attendance:

Board members present: Carrie Brogoitti, Muriel DeLaVergne-Brown, Katrina Hedberg, Safina Koreishi, Jeff Luck, Alejandro Queral, Eva Rippeteau, Rebecca Pawlak, Akiko Saito, Eli Schwarz Lillian Shirley, Tricia Tillman, and Jennifer Vines

Oregon Health Authority (OHA) staff: Cara Biddlecom, Sara Beaudrault, Christy Hudson, Britt Parrott, Angela Rowland

Members of the public: Kathleen Johnson, Kaleema Kerbs, Cate Theisen

Approval of Minutes

A quorum was present. The Board unanimously voted to approve the February 16, 2017 minutes.

Welcome and updates

-Jeff Luck, PHAB chair

- The accountability metrics development work is on track. The next subcommittee meeting is on March 22, 2017, where the group will be reviewing the stakeholder survey.
- There is a vacancy on the Board for a local public health administrator. It could take 2 – 6 weeks to appoint the new member.
- Lillian Shirley and Katrina Hedberg presented the Public Health Division budget at the Ways and Means Human Services Subcommittee, archived here: https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/101418. Legislators understand public health, its interconnectedness, and are supportive. Tricia, Eva, Alejandro, and Jeff testified in support of the budget.
- HB 2310, the public health modernization bill has not been scheduled for a hearing.

2017 work plan and charter

-Jeff Luck, PHAB chair

The Board reviewed the updated charter, which includes broader statements in the overview section, explains what the PHAB is responsible for, and adds health equity alignment. They also reviewed the 2017 work plan which was down-sized to one page with key visuals indicating updates, deliverables, and items requiring a vote.

The Board discussed options for the correct location for completed deliverables and tasks since they are utilized for accountability to the Oregon Health Policy Board (OHPB). More guidance could be provided once the OHPB designee has been appointed to the Board. An edit was recommended to change OHPB designee to liaison as seen on the OHPB subcommittee membership roster.

The Board agreed to send the updated charter with the 2017 work plan to the OHPB with Public Health Division staff deciding on where to place completed items and the Board to review annually.

Motion: The Board moved to approve the updated charter and send it forward to the OHPB for their review. All in favor.

Outcomes of the AIMHI regional public health modernization meetings
Kathleen Johnson, Oregon Coalition of Local Health Officials

Kathleen provided an overview of the ten regional meetings for Aligning Innovative Models for Health Improvements in Oregon (AIMHI). The purpose for these meetings was to identify unknown barriers to implementing public health modernization and communicate with state and local communities how to overcome those barriers.

The next steps are for the Rede Group to interpret findings, develop a conceptual roadmap to help facilitate modernization work, and to review and disseminate resources and tools.

The preliminary interpretation of findings are not concrete (qualitative) and are still in draft form. Some challenges identified were change management, funding, local politics, workforce capacity, and the role of public health. Some opportunities identified in cross jurisdictional sharing included assessment and epidemiology, leadership and organizational competencies, prevention and health promotion, communications, emergency preparedness and response, and communicable disease control. One of the projects resulted from the AIMHI meetings involves creating a current cross jurisdictional sharing library and identifying case studies.

Some of the main themes Kathleen noticed were in change management and support. Also some pieces of the cross jurisdictional model are easier shared than others. For example: assessment and epidemiology is not available at all local health departments and could benefit the work being shared among health departments. It might serve difficult for a health department to share non-regulatory environmental health work.

Alejandro commented on the importance for revisiting cross-jurisdictional sharing and how the Public Health Division (PHD) and the Coalition of Local Health Officials (CLHO) could pre-emptively support this issue. The PHAB could make templates, protocols, or guidelines. He

feels that cross jurisdictional sharing will soon be formalized and there is a need to determine how the PHAB can facilitate this process in a thoughtful way.

CLHO will return in June with more data, draft tools, and a roadmap.

The PHAB requests:
1. CLHO provide details on how the PHAB could help in the AIMHI work.
2. Review the cross jurisdictional library and if coordinated care organization (CCO) and local public health authority collaboration are noted, it could be helpful to pull out as a separate analysis.
3. Summarize AIMHI findings for HB2310 testimony.

Alejandro questions what other opportunities could be left behind and how the change in health care at the federal level could affect cross jurisdictional sharing.

Health equity policy
Jeff Luck, PHAB Chair

Jeff presented the updated health equity policy including the updated health equity definition and process instructions. The definition was created by the PHD health equity committee.

Eli stated that the definition is not at the same level and seems inconsistent. He finds it difficult to define health equity in its inverse meaning and possibly the Healthy People 2020 definition might serve better.

Katrina offered a potential compromise to define health equity by stating in order to achieve the positive it is necessary to focus on gaps or inequities or adding the definition of health inequity.

Tricia commented that this definition includes language from the World Health Organization definition and is consistent with other organization's definitions. All definition references should be cited. Also to remain precise with the language, since no system is equitable, and the Board should remain cautious about intent and history.

Jeff remarked that in a statistical sense the definition calls out how to measure how things are different. If health equity is achieved, certain statistics will not be seen. Also that due to social determinants of health, people are less healthy because society makes them less healthy.

Cara said that the Public Health Advisory Board could adopt a different definition of health equity or edit the current definition from the PHD health equity committee.

DRAFT

Akiko recommended a small PHAB ad-hoc subcommittee dive into the current health equity definition. Since many of the PHAB members interested in this topic sit on the Incentives and Funding Subcommittee, it was determined to use their next meeting time to further discuss the definition of health equity and the policy.

Lillian notified the Board that the OHPB is developing a health equity committee and will be producing a charter.

Action Item: PHD staff will convene the Incentives and Funding Subcommittee to make recommendations on the definition of health equity and the draft policy.

Guiding principles for public health and health care collaboration
Muriel DeLa Vergne-Brown, PHAB member

On March 6, 2017 an ad hoc PHAB subcommittee met including Muriel, Rebecca, Tricia, and Safina to discuss opportunities to collaborate public health in the health care sector.

Topics and strategies discussed

- A road map of current collaboration
- Collaborative service models
- Expertise and evidence-based interventions
- The action plan for health
- Shared metrics and data that are outcome oriented and sustainable
- Work to improve population health across sectors
- Leadership and governance and assuring public health representation on governing boards
- Community Health Assessments (CHA) & Community Health Improvement Plans (CHIP)

Tricia brought the draft guiding principles to the urban counties she represents and internally with Multnomah County. The feedback she received includes that the language needs to be more assertive and action oriented by increasing the use of the word *ensure,* for example ensure continued CCO partnerships. They would like to see a strategy focused on communication and policies for public health, for example, CCO partnership through tobacco prevention policy. They want to acknowledge the need to advance the workforce to achieve the triple aim and public health modernization goals. The principles need to address social determinants of health and health equity. For example, CCOs and public health could work around the housing strategy or better language access strategy.

Jeff recommends being more concrete with clear examples.

Eli suggested to use the State Health Improvement Plan priority summary page to discuss with CCO representatives who could review and explain what the guiding principles could potentially look like.

Safina and Cara presented at the March 13th Quality Health Outcomes Committee (QHOC) and gave an update to CCO medical directors about the work on these guiding principles. This document could be a good opportunity to get feedback and jumpstart systematic collaboration at a future QHOC meeting.

Katrina recommended using the *Practical Playbook* for more concrete examples of cross-sector collaborations.

Rebecca mentioned to also include the hospital association in system collaboration. The hospital association uses guiding principles as an important framework for evaluation policy or initiatives. Specific language is more helpful.

Health care organizations are the intended audience.

Action Item: PHD staff will incorporate the feedback from today and email out to the Board. The edited guiding principles will be reviewed at the May PHAB meeting. The Venn diagram that Safina developed will also be updated and sent out to the Board.

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<u>Review State Health Assessment Steering Committee and timeline</u>
Katrina Hedberg, Oregon Health Authority

Katrina announced that PHD is updating the State Health Assessment (SHA) to be in accordance with public health accreditation. There will be a robust planning process using the Mobilizing for Action through Planning and Partnerships (MAPP) model. This allows for community involvement through direction from a stakeholder steering committee. The state recommends 2 PHAB representatives in this steering committee from local and non-local public health areas.

PHAB volunteers:

- Alejandro Queral, PHAB – non-local representative
- Rebecca Pawlak, hospital representative
- *To be determined through email - local health representative*

<u>Preventative Health and Health Services Block Grant work plan</u>
-Danna Drum, Oregon Health Authority

Danna requested feedback for the direction of the Preventative Health & Health Services Block grant work plan. She held a public hearing last week with no attendance. The work plan addresses five Healthy People 2020 objectives including accreditation, quality improvement,

workforce training, state health improvement training, and sexual violence. There is $1.1 M available with $85,660 of that amount set aside specifically for rape prevention.

Tricia inquired on the amount of funds distributed to tribes or local health departments. Danna answered that these dollars have not been directly distributed to tribes or local health departments, but do fund the strategic partnerships manager and the two local public health consultants who work closely with these groups. Tricia questioned when the PHAB can weigh-in on state funding priorities and make sure they align with the State Health Improvement Plan and health equity goals.

Danna noted that the PHAB is the designated advisory committee for the block grant and has an opportunity to weigh in as they see fit. The block grant funding begins on October 1, 2017 with the final work plan deadline of July 1, 2017. This grant is funded through the Prevention and Public Health Fund. Tricia inquired if these funds will be ending after 2019. Lillian stated that in this current climate, the program element process may be changing.

Jeff stated these concerns would be a long-term discussion.

Lillian noted that the block grant helped to make public health modernization happen and the state did a lot of heavy lifting towards the beginning.

Jeff inquired if modernization is tied to the triennial reviews. Danna responded that program elements do not align with public health modernization, but the tools could be shifted. She sees an opportunity to frame the work being done in program elements to tie with foundational capabilities and programs. The Coalition of Local Health Officials (CLHO) negotiates program elements and decides on deliverables and accountabilities. The tools for the review are tied to federal funding requirements and to language in the program element.

Kathleen Johnson commented that CLHO can review the program elements and look at modernization.

The PHAB voted to formally support the block grant work plan proposal. All in favor.

Public Comment Period
No public testimony was provided in person or on the phone.

Closing
In anticipation of the Affordable Care Act repeal, the www.95percentoregon.com website was created in Oregon. Sara Beaudrault contributed the population health data and potential consequences for women's reproductive health to the website. This useful tool provides many talking points.

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The meeting was adjourned.

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

April 20, 2017
2:30pm – 5:30 p.m.
Portland State Office Building
800 NE Oregon St., Room 1A
Portland, OR 97232

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Angela Rowland at (971) 673-2296 or angela.d.rowland@state.or.us. For more information and meeting recordings please visit the website: healthoregon.gov/phab

DRAFT

Oregon Health Policy Board
Public Health Advisory Board
Charter
March 2017

Approved by the Oregon Health Policy Board on April 4, 2017

I. Overview and Authority

The Public Health Advisory Board (PHAB) is established by ORS 431.122 as a body that reports to the Oregon Health Policy Board (OHPB).

The purpose of the PHAB is to be the accountable body for governmental public health in Oregon. The role of the PHAB includes:

- Alignment of public health priorities with available resources.
- Analysis and communication of what is at risk when there is a failure to invest resources in public health.
- Oversight for Oregon Health Authority, Public Health Division strategic initiatives, including the State Health Assessment and State Health Improvement Plan.
- Oversight for governmental public health strategic initiatives, including the implementation of public health modernization.
- Support for state and local public health accreditation.

This charter defines the objectives, responsibilities, and scope of activities of the PHAB. This charter will be reviewed periodically to ensure that the work of the PHAB is aligned with the OHPB's strategic direction.

II. Duties, Objectives, Membership, Terms, Officers

The duties of the PHAB as established by ORS 431.123 and the PHAB's corresponding objectives include:

PHAB Duties per ORS 431.123	PHAB Objectives
a. Make recommendations to the OHPB on the development of statewide public health policies and goals.	• Participate in and provide oversight for Oregon's State Health Assessment. • Regularly review state health data such as the State Health Profile to identify ongoing and emerging health issues. • Use best practices and an equity lens to provide recommendations to OHPB on policies needed to address priority health issues, including the social determinants of health.
b. Make recommendations to the OHPB on how other statewide priorities, such as the provision of early learning services and the delivery of health care services, affect and are affected	• Regularly review early learning and health system transformation priorities. • Recommend how early learning goals, health system transformation priorities, and statewide public health goals can best be aligned.

by statewide public health policies and goals.	• Identify opportunities for public health to support early learning and health system transformation priorities. • Identify opportunities for early learning and health system transformation to support statewide public health goals.
c. Make recommendations to the OHPB on the establishment of foundational capabilities and programs for governmental public health and other public health programs and activities.	• Participate in the administrative rulemaking process which will adopt the Public Health Modernization Manual. • Verify that the Public Health Modernization Manual is still current at least every two years. Recommend updates to OHPB as needed. •
d. Make recommendations to the OHPB on the adoption and updating of the statewide public health modernization assessment.	• Review initial findings from the Public Health Modernization Assessment. (completed, 2016) • Review the final Public Health Modernization Assessment report and provide a recommendation to OHPB on the submission of the report to the legislature. (completed, 2016) • Make recommendations to the OHPB on processes/procedures for updating the statewide public health modernization assessment.
e. Make recommendations to the OHPB on the development of and any modification to the statewide public health modernization plan.	• Review the final Public Health Modernization Assessment report to assist in the development of the statewide public health modernization plan. (completed, 2016) • Using stakeholder feedback, draft timelines and processes to inform the statewide public health modernization plan. (completed, 2016) • Develop the public health modernization plan and provide a recommendation to the OHPB on the submission of the plan to the legislature. (completed, 2016) • Update the public health modernization plan as needed based on capacity.
f. Make recommendations to the Oregon Health Authority (OHA) and the OHPB on the development of and any modification to plans developed for the distribution of funds to local public health authorities.	• Identify effective mechanisms for funding the foundational capabilities and programs. • Develop recommendations for how the OHA shall distribute funds to local public health authorities.
g. Make recommendations to the OHA and the OHPB on the total cost to local public health authorities of applying the foundational capabilities and implementing the foundational programs for governmental public health.	• Review the Public Health Modernization Assessment report for estimates on the total cost for implementation of the foundational capabilities and programs. (completed, 2016) • Support stakeholders in identifying opportunities to provide the foundational capabilities and programs in an effective and efficient manner.

h. Make recommendations to the OHPB on the use of incentives by the OHA to encourage the effective and equitable provision of public health services by local public health authorities.	• Develop models to incentivize investment in and equitable provision of public health services across Oregon. • Solicit stakeholder feedback on incentive models.
i. Provide support to local public health authorities in developing local plans to apply the foundational capabilities and implement the foundational programs for governmental public health.	• Provide support and oversight for the development of local public health modernization plans. • Provide oversight for Oregon's Robert Wood Johnson Foundation grant, which will support regional gatherings of health departments and their stakeholders to develop public health modernization plans.
j. Monitor the progress of local public health authorities in meeting statewide public health goals, including employing the foundational capabilities and implementing the foundational programs for governmental public health.	• Provide oversight and accountability for Oregon's State Health Improvement Plan by receiving quarterly updates and providing feedback for improvement. • Provide support and oversight for local public health authorities in the pursuit of statewide public health goals. • Provide oversight and accountability for the statewide public health modernization plan. • Develop outcome and accountability measures for state and local health departments.
k. Assist the OHA in seeking funding, including in the form of federal grants, for the implementation of public health modernization.	• Provide letters of support and guidance on federal grant applications. • Educate federal partners on public health modernization. • Explore and recommend ways to expand sustainable funding for state and local public health and community health.
l. Assist the OHA in coordinating and collaborating with federal agencies.	• Identify opportunities to coordinate and leverage federal opportunities. • Provide guidance on work with federal agencies.

Additionally, the Public Health Advisory Board is responsible for the following duties which are not specified in House Bill 3100:

Duties	**PHAB Objectives**
a. Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters.	• Provide guidance and recommendations on statewide public health issues and public health policy.
b. Act as formal advisory committee for Oregon's Preventive Health and Health Services Block Grant.	• Review and provide feedback on the Preventive Health and Health Services Block Grant work plan priorities.

c. Provide oversight for the implementation of health equity initiatives across the public health system.	• Receive progress reports and provide feedback to the Public Health Division Health Equity Committee. • Participate in collaborative health equity efforts.

Membership Composition

Per ORS 431.122, the PHAB shall consist of the following 13 members appointed by the Governor:

1. A state employee who has technical expertise in the field of public health;
2. A local public health administrator who supervises public health programs and public health activities in Benton, Clackamas, Deschutes, Jackson, Lane, Marion, Multnomah or Washington County;
3. A local public health administrator who supervises public health programs and public health activities in Coos, Douglas, Josephine, Klamath, Linn, Polk, Umatilla or Yamhill County;
4. A local public health administrator who supervises public health programs and public health activities in Clatsop, Columbia, Crook, Curry, Hood River, Jefferson, Lincoln, Tillamook, Union or Wasco County;
5. A local public health administrator who supervises public health programs and public health activities in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Wallowa or Wheeler County;
6. A local health officer who is not a local public health administrator;
7. An individual who represents the Conference of Local Health Officials created under ORS 431.330;
8. An individual who represents coordinated care organizations;
9. An individual who represents health care organizations that are not coordinated care organizations;
10. An individual who represents individuals who provide public health services directly to the public;
11. An expert in the field of public health who has a background in academia;
12. An expert in population health metrics;
13. An at large member.

PHAB shall also include the following nonvoting, ex-officio members:

1. The Oregon Public Health Director or the Public Health Director’s designee;
2. If the Public Health Director is not the State Health Officer, the State Health Officer or a physician licensed under ORS chapter 677 acting as the State Health Officer’s designee;
3. If the Public Health Director is the State Health Officer, a representative from the Oregon Health Authority who is familiar with public health programs and public health activities in this state; and
4. An Oregon Health Policy Board liaison.

Membership Terms

The term of office for a board member appointed under this section is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

Of the PHAB members beginning their term in January 2016:

- Four shall serve for terms ending January 1, 2017.
- Three shall serve for terms ending January 1, 2018.
- Three shall serve for terms ending January 1, 2019.
- Three shall serve for terms ending January 1, 2020.

Officers

PHAB shall elect two of its voting members to serve as the chair and vice chair. Elections shall take place in January of each even-numbered year.

The chair and vice chair shall serve two year terms. If the chair were to vacate their position before their term is complete the vice chair shall become the new chair to complete the term. If a vice chair is unable to serve, or if the vice chair position becomes vacant, then a new election is held to complete the remainder of the vacant term(s).

The PHAB chair shall facilitate meetings and guide the PHAB in achieving its deliverables. The PHAB chair shall represent the PHAB at meetings of the Oregon Health Policy Board as directed by the Oregon Health Policy Board designee. The PHAB chair may represent the PHAB at meetings with other stakeholders and partners, or designate another member to represent the PHAB as necessary.

The PHAB vice chair shall facilitate meetings in the absence of the PHAB chair. The PHAB vice chair shall represent the PHAB at meetings of the Oregon Health Policy Board as directed by the Oregon Health Policy Board designee when the PHAB chair is unavailable. The PHAB vice chair may represent the PHAB at meetings with other stakeholders and partners when the PHAB chair is unavailable or under the guidance of the PHAB chair, or may designate another member to represent the PHAB as necessary.

Both the PHAB chair and vice chair shall work with OHA Public Health Division staff to develop agendas and materials for PHAB meetings.

III. Actions and Deliverables

Actions

The PHAB may take the following actions:

- Make formal recommendations, provide informal advice, and reports to the OHPB;
- Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters;
- Identify priorities for Oregon's governmental public health system;
- Charter committees (for ongoing work) and/or work groups (for short-term work) on various topics related to governmental public health;
- Request data and reports to assist in preparing recommendations to the OHPB;
- Provide a member to serve as a liaison to other committees or groups as requested.

Deliverables/Actions

The PHAB shall deliver the following:

Deliverable	Time Frame
• **A work plan for the PHAB for 2016-2017**	Spring 2016
• **A proposal for reporting to the OHPB (e.g., frequency, format, etc.)**	Spring 2016
• **Report(s) to the OHPB (as agreed to with the OHPB)**	At least annually
• **Recommendations to the OHPB**	As needed
• **Public Health Modernization Assessment report**	June 2016 (complete)
• **Public Health Modernization Plan**	December 2016 (complete)
• **Report(s) to the legislature as requested**	As needed

In addition to the deliverables listed above, the PHAB shall charter committees and work groups as needed and take direction from the OHPB.

IV. Staff Resources

The PHAB is staffed by the OHA, Public Health Division, as led by the Policy and Partnerships Director. Support will be provided by staff of the Public Health Division Policy and Partnerships Team and other leaders, staff, and consultants as requested or needed.

V. Expectations for PHAB Meetings

The following expectations apply to all PHAB meetings:

- The PHAB will meet monthly from January 2016 through July 2017. In July 2017, the PHAB will determine if meetings should continue monthly or move to an alternate schedule, with meetings occurring at least quarterly. More frequent and ad hoc meetings may be called for by the chairperson.
- The PHAB shall meet at times and places specified by the call of the chairperson or of a majority of the voting members of the board.
- A standard meeting time will be established (with special exceptions).
- Meetings shall be conducted in accordance with Oregon's Public Meetings Law (ORS 192.610 through 192.710) and Public Records Law (ORS 192.001 through 192.505) and documented on the PHAB website: www.healthoregon.org/phab.
- Official subcommittee meetings shall also be conducted in accordance with Oregon's Public Meetings Law (ORS 192.610 through 192.710) and Public Records Law (ORS 192.001 through 192.505) and documented on the PHAB website: www.healthoregon.org/phab.
- A public notice will be provided to the public and media at least 10 days in advance of each regular meeting and at least five days in advance of any special meeting.
- A majority of the voting members of the PHAB constitutes a quorum for the transaction of business during PHAB meetings.
- PHAB members are expected to review materials ahead of the meeting and come prepared to discuss and participate.
- Written minutes will be taken at all regular and special meetings. Minutes will include: members present; all motions, proposals, resolutions, orders, ordinances and measures proposed and their disposition; the substance of discussion on any matter; and a reference to any document discussed or distributed at the meeting.

Conflicts of Interest

The purpose of this conflict of interest policy is to maintain the transparency and integrity of the PHAB and its individual members, understanding that many voting members have a direct tie to governmental public health or other stakeholders in Oregon.

PHAB members shall verbally disclose any actual or perceived conflicts of interest prior to voting on any motion that may present a conflict of interest. If a PHAB member has a potential conflict related to a particular motion, the member should state the conflict. PHAB will then make a decision as to whether the member shall participate in the vote or be recused.

If the PHAB has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member and afford an opportunity to explain the alleged failure to disclose. If the PHAB determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate corrective action including potential removal from the body.

Lastly, PHAB members shall make disclosures of conflicts using a standard conflict of interest form at the time of appointment and at any time thereafter where there are material employment or other changes that would warrant updating the form.

VI. Amendments and Approval

This charter may be amended or repealed by the affirmative vote of two-thirds of the members present at any regular PHAB meeting. Notice of any proposal to change the charter shall be included in the notice of the meeting.

Any amendments to the charter require approval by the OHPB before taking effect.

HB 2310 - Public Health Modernization -1 amendment

- Requires implementation of prioritized work on or before June 30, 2019 in:
  - Assessment and epidemiology
  - Leadership and organizational competencies
  - Health equity and cultural responsiveness
  - Communicable disease control
  - Environmental health

*does not include emergency preparedness and response

Oregon Health Authority

HB 2310 – Public Health Modernization -2 and -3 amendment

- Clarifies language for the distribution of state monies through the local public health funding formula;
- Gives OHA the authority to distribute funds through competitive means when funding is insufficient;
- Adds a requirement that Oregon Health Authority submit a biannual report to Legislative Fiscal Office and PHAB to estimate state funds needed to fully fund foundational capabilities and programs; describe how state funds made available were distributed and used; and report on public health accountability metrics
- Modifies requirements in HB 2310 Introduced for county relinquishment of public health authority;
- Adds a Public Health Advisory Board member who is a member or representative of Oregon's federally recognized tribes.

Oregon Health Authority

Racial & Ethnic Approaches to Community Health (REACH)

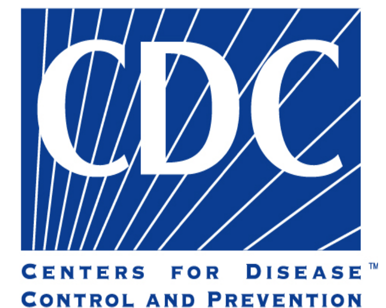
Presented to Public Health Advisory Board
April 20, 2017

Rachael Banks and Tameka Brazile – Multnomah County Public Health Division's Equity, Planning and Strategy

Today's Objectives

- Provide an overview of current REACH nutrition and tobacco strategies
- Learn about CDC's overall goals
- Share examples of the work
- Find out about the history and background
- Discuss the expansion of REACH as the key to a modernized Public Health System

- High Impact/Population Level Strategies
- Culturally Specific Community Partnerships
- Policy, System and Environmental Change Strategies
- Decrease health disparities for African Americans



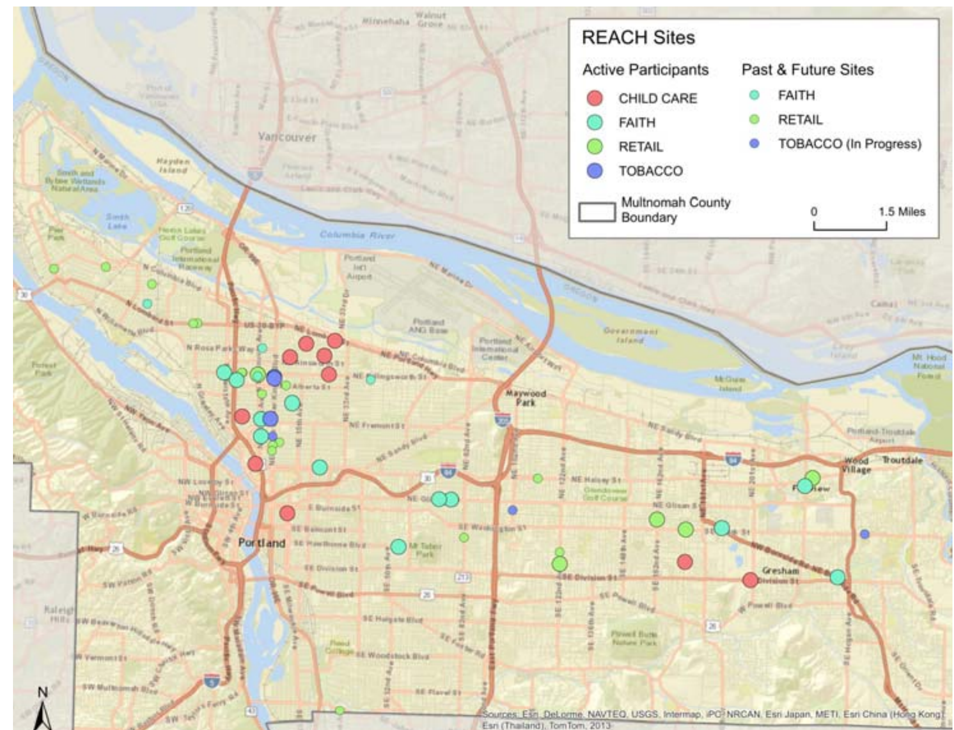
Sharing the Work

- ACHIEVE Coalition
- MCHD's Tobacco Control & Prevention
- Micro Enterprises Services of Oregon
- Design & Culture Lab
- OSU Extension Services

Nutrition Strategies

More people with better access and availability of healthier food options

Healthy Food Access Policies
- Faith-Based
- Child Care
- Retail Environments
- Transportation Policies



Faith-Based Settings

Child Care Settings

Retail Environments

Food Access & Transportation Policies

Gresham REACH funded Projects:

1. Rockwood Rising
2. Active Transportation Plan

CITY OF GRESHAM

food & health care desert = CHALLENGES

"The number one thing I hear is, 'We need access to healthy food' and number two is 'We need a community center.' It would be great to have a place to learn about each other's cultural heritage."

CATHERINE NICEWOOD,
ROCKWOOD NEIGHBORHOOD
ASSOCIATION PRESIDENT

FOOD

1. **FOOD DESERT:** Long identified as a significant food desert, residents have access to few major grocery stores.
2. **BARRIERS:** Low income residents with few transportation options shop at convenience stores, gas stations and fast food outlets.
3. **HUNGER:** 38% of households receive food stamps; 74% of students are eligible for free/reduced lunch.

HEALTH CARE

1. **INCREASED HEALTH RISKS:** Rockwood residents experience higher rates of chronic conditions such as obesity, Type 2 diabetes, and cardiovascular disease than anywhere in Oregon.
2. **HEATHCARE DESERT:** Greatest shortage of primary health care providers than nearly all other areas of Oregon. Highest dental care needs in all of Multnomah County*.
3. **LANGUAGE AND CULTURAL BARRIERS:** Navigating the complex heath care system is challenging for the many residents who don't speak English and/or are recent immigrants/refugees.

(*SOURCE: US DEPARTMENT OF HEALTH AND HUMAN SERVICES' HEALTH PROFESSIONAL SHORTAGE AREA SCORE)

inventive + integrated =

FRESH FOOD MARKETPLACE

- 33,774 square foot fresh food marketplace with commissary kitchen
- Meats, bakery, produce, prepared foods
- Farmers market plaza
- Creating a food ecosystem of existing restaurants, farms, agriculture and food incubator businesses for affordable, healthy food options

MEDICAL CLINIC

- New primary care clinic providing reduced cost care
- Medical assistant training program with Mt. Hood Community College
- Culturally specific community health workers on site to assist residents to access primary and preventative healthcare

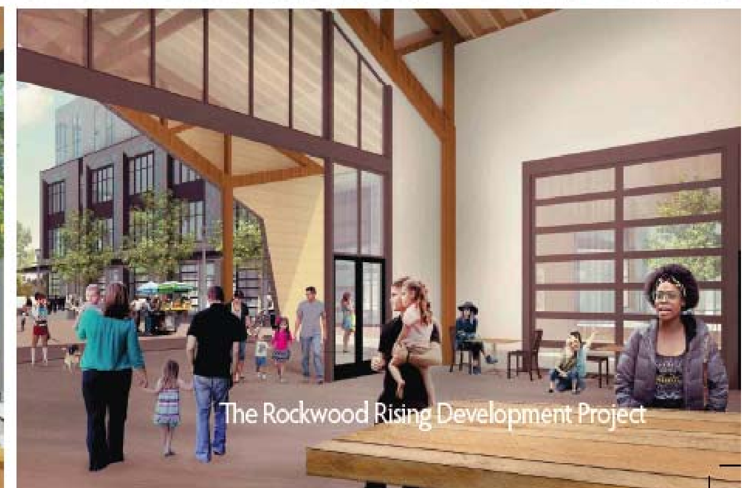
Conceptual renderings of pop-up retail stores, restaurants and community plaza by YBA Architects.

Project photography by Fred Joe Photography

Graphics by the City of Gresham

ROCKWOOD

MARKET



Community Engagement

- Walk, Talk & Eat
- Farmers Market
- National Night Out
- Gresham Arts Festival
- Nadaka Community Festival
- August Youth Jam
- Neighborhood Walks
- Door Knocking
- Advisory Group
- Website interactive map

Pedestrian Projects

Priorities

- Key Destinations
- Transit Access
- Level of Comfort
- Promote Safety
- Promote Health
- Equity

DRAFT

Active Transportation Plan

Pedestrian Network Improvements

Proposed Crossing Enhancement in This Area
Proposed Sidewalk Infill Project
Existing Sidewalk
Existing Trail
Existing Path
Existing Crosswalk with Flashing Beacons
School
Center
Park/Natural Area
Food Store

0 0.5 1 Mile

Map produced: December 2016.

CITY OF GRESHAM

alta PLANNING + DESIGN

Pedestrian Projects

Priorities

- Key Destinations
- Transit Access
- Level of Comfort
- Promote Safety
- Promote Health
- Equity

DRAFT

Active Transportation Plan

Pedestrian Network Improvements

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School

Center

Park/Natural Area

Food Store

0 0.5 1 Mile

Map produced: December 2016.

CITY OF GRESHAM

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Bike Projects

Priorities

- Key Destinations
- Transit Access
- Level of Traffic Stress
- Connectivity
- Promote Safety
- Promote Health
- Equity

Active Transportation Plan

Bike Routes for Everyone Project Map

Proposed Routes Most People Would Feel Comfortable Using

Existing Path
Food Store
Park/Natural Area
School
Center

Map produced: December 2016.

CITY OF GRESHAM

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Bike Projects

Priorities

- Key Destinations
- Transit Access
- Level of Traffic Stress
- Connectivity
- Promote Safety
- Promote Health
- Equity

Gresham Conclusions

- Developed innovative approaches to reaching diverse community members
- The City collaborated across departments on outreach efforts
- Built stronger relationships with the community
- Considered equity impacts and included them in policy

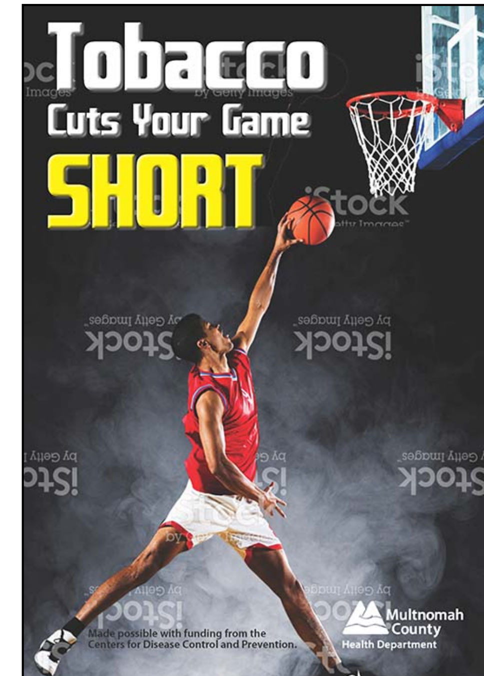
Tobacco Strategies

Promotion of tobacco/nicotine-free environments

1. Decrease youth access in retail settings (tobacco retail license)
2. Tobacco Cessation across 3 health care settings (system changes in community settings)
3. Smoke-Free policies (tobacco/smoke-free parks)

REACH Communication Strategies

- Designed by community
- Support environmental changes within community settings
- Support policy implementations
- Amplifying Community Voice
- Year-3: Anti-Tobacco Campaigns



ACHIEVE Coalition

Action Communities for Health, Innovation and Environmental Change

- Background & History
- Paved the Way
- Built & Cultivated Relationships

How ACHIEVE Evolved

- Trusted community members reached out to CBO's from MCHD
- Called out extractive relationship of MCHD
- Shared intentions to do something different

How ACHIEVE Succeeds

- Broad focus on Community Health
- Technical KSA's can be gained/shared; culture, history, and perspective live in the Coalition
- Addressing community health impacts and upstream causes

Return on Investment

- Leveraged over $10 million additional funding
- Increased capacity of culturally specific organizations
- 75% of African Americans impacted
- Contributing to knowledge base of evidence-based practice

REACH is Key to a Modernized Public Health System

- Assessment & Epidemiology
- Communications
- Policy & Planning
- Leadership & Organizational Competencies
- Health Equity & Cultural Responsiveness
- Community Partnership Development

REACH as a Framework

- Expanded culturally specific investments:
  - Native American
  - Hispanic/ Latino
  - Pacific Islander
  - Immigrant refugee
- Continued investment community assessment
  - Community led CHIP
- Re-seeding investments
  - Example: Pacific Islander; immigrant and refugee data
  - Maternal Medical Home

Questions?

Contact Us:

Rachael Banks, Director of Equity Planning and Strategy (EPS)
503.988.7778
rachael.m.banks@multco.us

Tameka Brazile, REACH Program Manager
503.988.7760
tameka.brazile@multco.us

Public Health Advisory Board (PHAB)
Health Equity Ad-hoc subcommittee
April 11, 2017
Draft Meeting Minutes

Attendance:
Board members present: Jeff Luck, Alejandro Queral

Oregon Health Authority (OHA) staff: Cara Biddlecom, Kati Moseley, Tim Noe, Angela Rowland

Members of the public: Mariotta Gary-Smith, Christina Lacy, Kelly McDonald, Maria Tafolla, Terresa White, Darren Yesser

Welcome and introductions
-Jeff Luck, PHAB chair

The goal of this meeting is to make a recommendation on the Public Health Advisory Board (PHAB) definition of health equity and the PHAB health equity policy. The policy will be used to ensure that decisions made by the PHAB are promoting health equity.

Health equity definition
-PHAB members

Alejandro proposed creating three sections:
1. Definition of health equity
2. How health equity is attained
3. Policy

As far as the sample health equity definitions, the CDC and Braveman definitions were most favored.

Tim Noe and Kati Moseley provided background on the creation of the PHD health equity definition for the PHD health equity work group. This definition was created in an internal PHD lens and wasn't considered it would be communicated externally. The process of aligning the work group members around the definition will allow the work to move in sync. Kati noted that no community input was gathered.

The PHD definition of health equity should not conflict with the PHAB's definition.
Tricia had appreciated the "isms" added in the PHD definition as it is more accurate.

The group discussed Eli's concern with the Public Health Division (PHD) definition regarding the negative aspect of health equity. The second sentence in the definition which defines health equity in negative terms will be removed.

The Oregon Health Policy Board (OHPB) is establishing a health equity committee. The PHAB's health equity policy will likely be of interest to the OHPB.

Alejandro asked if there is value in having separate health equity definitions among every board, or should there be one definition for all to help stay aligned across sectors. Tim appreciates the synergy between the Boards and suggests PHD adapt the PHAB definition.

The definition was shortened to include the Braveman and World Health Organization definitions for full Board review. Portions of the original PHD definition were shifted to the second section on how health equity is attained.

> Health equity exists when all people can reach their full health potential and are not disadvantaged from attaining it because of their social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance.[1]
>
> Health equity is also defined as the absence of unfair, avoidable, or remediable difference in health among social groups.[2]

Health equity policy

-PHAB members

The proposed procedure questions are more aligned with the updated proposed health equity definition.

1. How is the work product, report or deliverable different from the current status?
2. What health disparities exist among which groups? Which health disparities does the work product, report or deliverable aim to eliminate?
3. How does the work product, report or deliverable support individuals in reaching their full health potential?
4. Which source of health inequity does the work product, report or deliverable address (social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?
5. How does the work product, report or deliverable ensure equitable distribution of resources and power?

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[1] Braveman, P, (2006). Health Disparities and Health Equity: Concepts and Measurement. Annual Review of Public Health 27: 167-94.

[2] World Health Organization, Commission on Social Determinants of Health, (2007). A Conceptual Framework for Action on the Social Determinants of Health.

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6. 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?
7. 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?
8. How will data be used to monitor the impact on health equity resulting from this work product, report or deliverable?

Proposal

- Propose an up or down vote on the new definition of health equity to the Board. Determine if the World Health Organization definition be included.
- The questions in procedures are consistent with health equity and could be tested out for presenters in the May PHAB meeting.

Public Comment Period

No public testimony was provided in person or on the phone.

Closing

The meeting was adjourned.

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Angela Rowland at (971) 673-2296 or angela.d.rowland@state.or.us. For more information and meeting recordings please visit the website: healthoregon.gov/phab

DRAFT

Public Health Advisory Board
Health equity review policy and procedure
April 2017 DRAFT

Background

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

Definition of health equity

Health equity exists when all people can reach their full health potential and are not disadvantaged from attaining it because of their social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance.[1]

Health equity is also defined as the absence of unfair, avoidable, or remediable difference in health among social groups.[2]

Commented [RAD1]: PHAB will need to make a decision about the use of this definition.

Commented [RAD2]: PHAB will need to make a decision on whether to also include this second statement in the definition.

How health equity is attained

Achieving health equity requires the equitable distribution of resources and power resulting 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 or housing sectors and through the distribution of power and resources, to improve health with communities.

Policy

The Public Health Advisory Board demonstrates its commitment to advancing health equity by implementing an equity review process for all formally adopted work products, reports and deliverables. 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

[1] Braveman, P, (2006). Health Disparities and Health Equity: Concepts and Measurement. Annual Review of Public Health 27: 167-94.
[2] World Health Organization, Commission on Social Determinants of Health, (2007). A Conceptual Framework for Action on the Social Determinants of Health.

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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 the Public Health Advisory Board promote health equity. The questions below may not be able to be answered for every policy or decision brought before the Public Health Advisory Board, but serve as a platform for further discussion prior to the adoption of any motion.

The answers to the following questions will be submitted to PHAB for review with the meeting materials prior any official Board action involving a vote to adopt a work product, report or and deliverable. The subcommittee or Public Health Advisory Board member responsible for bringing the work product, report or deliverable forward for a motion will begin by walking through the responses to these questions prior to introducing the work product, report or deliverable for a motion.

1. How is the work product, report or deliverable different from the current status?
2. What health disparities exist among which groups? Which health disparities does the work product, report or deliverable aim to eliminate?
3. How does the work product, report or deliverable support individuals in reaching their full health potential?
4. Which source of health inequity does the work product, report or deliverable address (social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?
5. How does the work product, report or deliverable ensure equitable distribution of resources and power?
6. 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?
7. 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?
8. 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 Board meetings to ensure that presenters specifically address the following, as applicable:

1. What health disparities exist among which groups? Which health disparities does the presentation topic aim to eliminate?
2. How does the presentation topic support individuals in reaching their full health potential?

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3. Which source of health inequity does the presentation topic address (social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?
4. How does the presentation topic ensure equitable distribution of resources and power?
5. How was the community engaged in the presentation topic? How does the presentation topic content impact the community?
6. How does the presentation topic engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?
7. How will data be used to monitor the impact on health equity resulting from the presentation topic?

Policy and procedure review

The PHAB health equity review policy and procedure will be reviewed annually by the Board. Board members will discuss whether the policy and procedure has had the intended effect of reducing disparities 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.

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State Health Improvement Plan

Immunization & Communicable Disease

OFFICE OF THE STATE PUBLIC HEALTH DIRECTOR
Public Health Division

Improve immunization rates

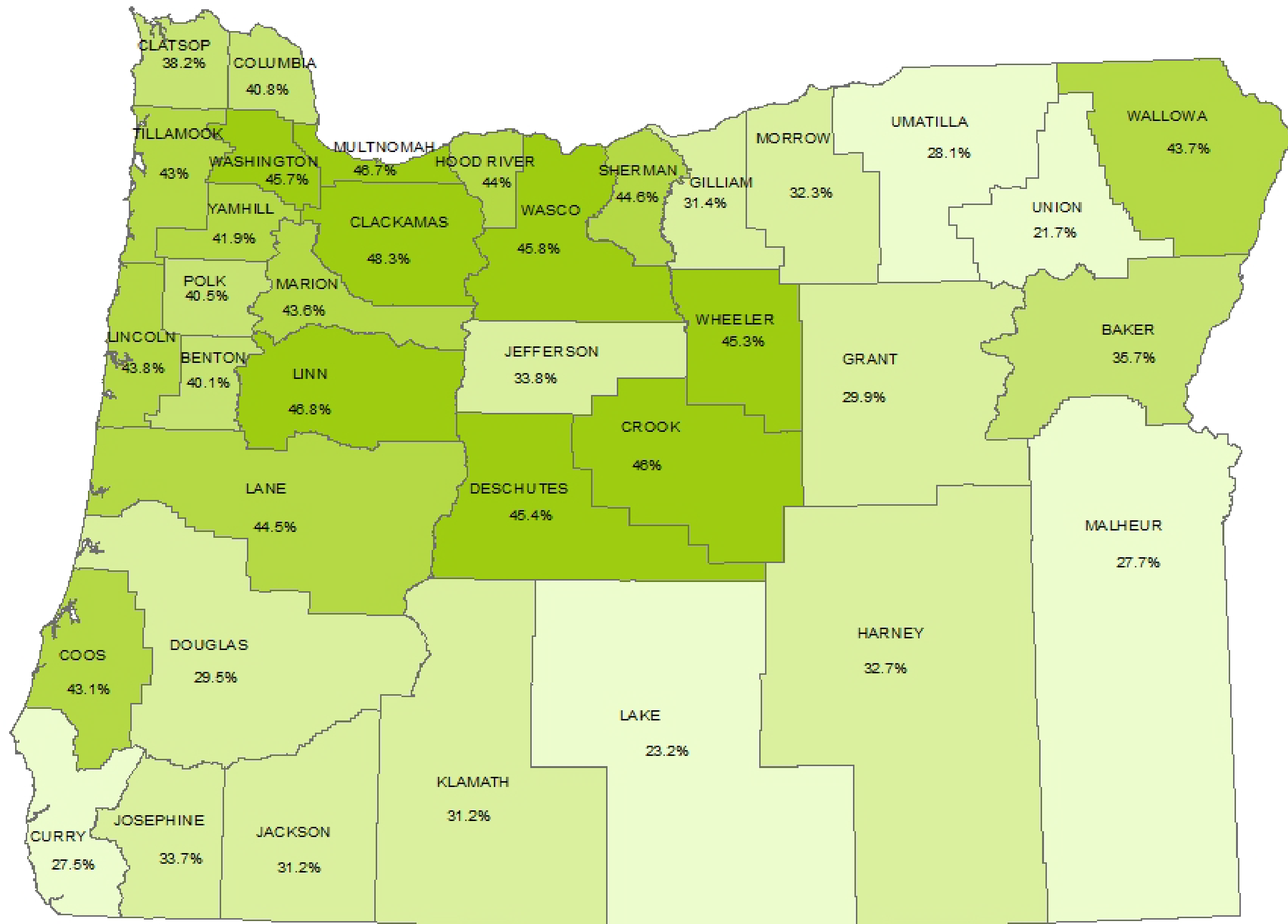
Oregon Health Authority

Immunization
Priority Targets

Measure	2015	2016	2020 Target	Data Source
Rate of 2 year olds who are fully vaccinated	58%	70%	80%	ALERT
HPV Vaccination series rate among 13 – 17 year olds	28%	33%	80%	ALERT
Seasonal flu vaccination	42%	43%	70%	ALERT

Oregon Health Authority

Oregon 2015-16 ALERT IIS All-Age Influenza Immunization Rate



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Successes to date

- American Cancer Society partnership
- Oregon Human Papilloma Virus (HPV) Roundtable
- HPV Strategic Plan coming soon
- CCO Incentive Measure approved for 2-year old rates
- HealthInsight & ALERT Immunization Information System (IIS)
- School Based Health Centers added optional key performance measure for adolescent immunization (Meningococcal & Tdap)

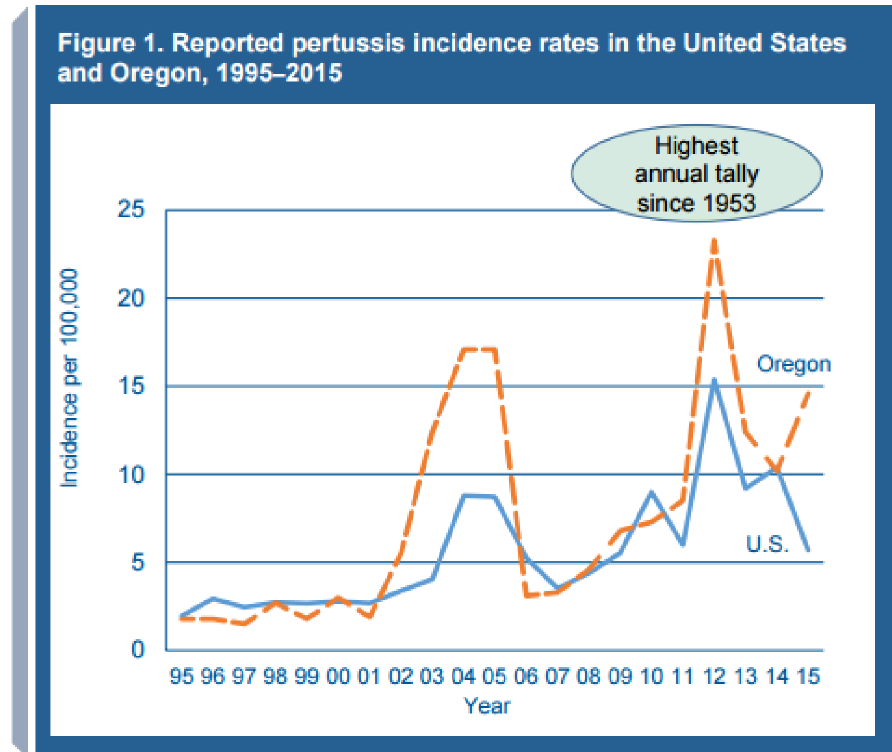
Oregon Health Authority

Successes to date

Evidence-based Strategies for Improving Childhood Immunization Rates: A Guide for CCOs

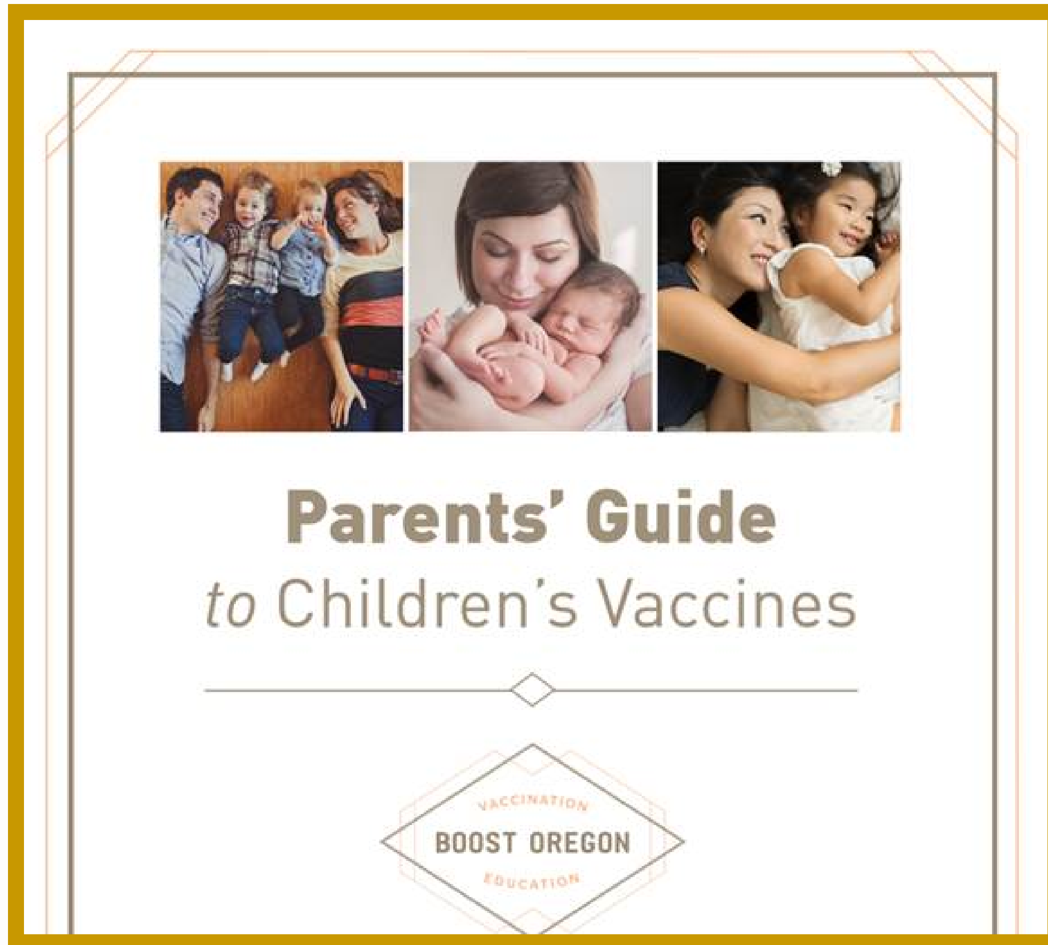
Challenges

- Key partnerships & SHIP
- Flu challenges
  - Success in target populations
- Outbreaks
  - Mumps
  - Pertussis
  - Meningitis



Oregon Health Authority

Challenges



Vaccine Hesitancy

A unique positive partnership with a parent led non-profit organization

Oregon Health Authority

Attention to Health Disparities

TEXT SIZE: A+ A- A • TEXT ONLY

Select Language

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Rock formations along Harper Westfall Road – Malheur County (photo: Gary Halvorson)

Oregon Health Authority

Public Health

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Immunization Provider Information

- Vaccines for Children Program (VFC)
- Provider Training
- AFIX Immunization Assessment System
- Model Standing Orders for Immunizations
- Pharmacist Information
- AFIX Resources
- AFIX Resources for CCOs and Health Plans

Ready to Quit Tobacco? Learn more

Public Health > Prevention and Wellness > Vaccines and Immunization > Immunization Provider Information > Healthcare Provider Influenza Vaccination Tool Kit

Healthcare Provider Influenza Vaccination Tool Kit

Resources to help health care workers stay up-to-date on important immunizations

Employers and health-care personnel (HCP) have a shared responsibility to prevent occupationally acquired infections and avoid causing harm to patients by taking reasonable precautions to prevent transmission of vaccine-preventable diseases.

Resources

- Local Health Departments
- Pharmacy Protocols
- Provider Resources
- VFC Clinic Map

Contact Us

Oregon Immunization Program

Definition of HCP/HCW

HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

Immunization of Health-Care Personnel – MMWR; 11/25/11

Influenza Materials

Please feel free to download the Oregon Long Term Care Facility Toolkit booklet. Additional resources may come in the future.

Powerpoint Presentations

- For LTC Families
- For LTC Staff
- For CAH

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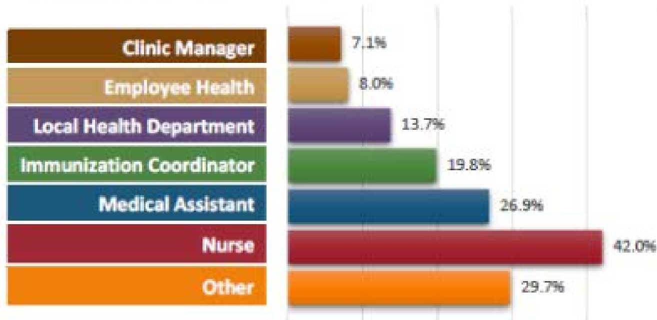
Attention to Health Disparities

Oregon Flu Summit & More: Attendee Feedback

Overall Rating

Who Attended the Summit?



#1 Rated **General Presentation**

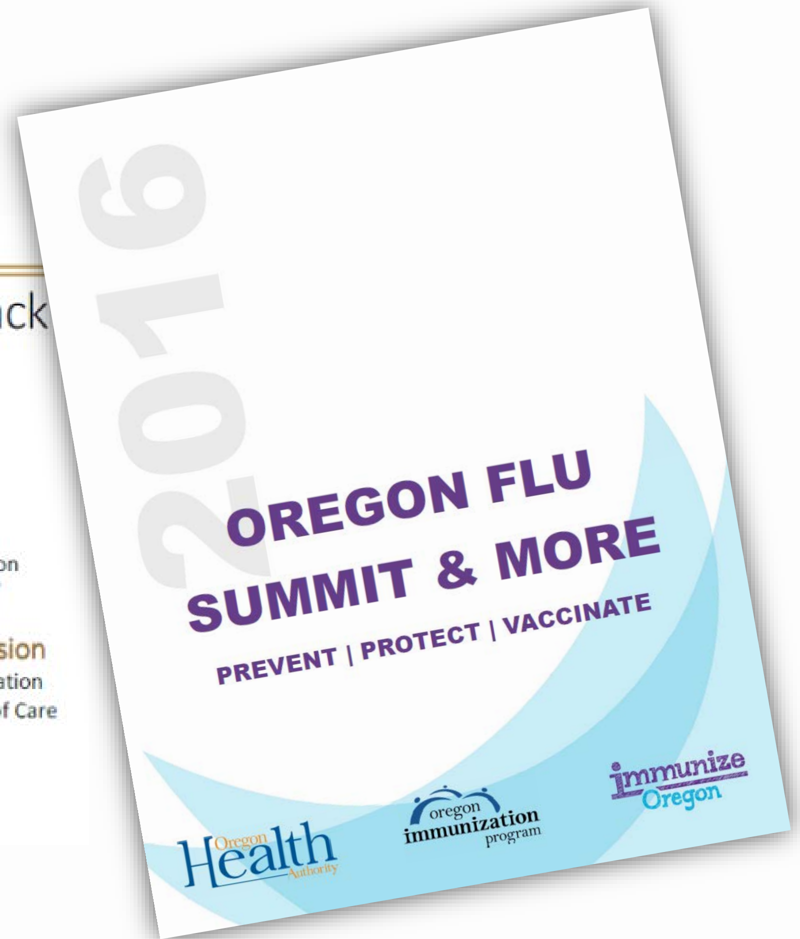
What I Learned in Legislation

Senator Steiner Hayward

#1 Rated **Breakout Session**

Best Practice Panel: Immunization Efforts Across the Continuum of Care

Bob Dannenhoffer & Virginia Chambers



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Attention to Health Disparities

Coordinated Care Organization provider trainings in rural Oregon

Improving Childhood Immunization Rates

Oregon Immunization Program
Erin Corrigan, Scott Jeffries

Oregon Health Authority

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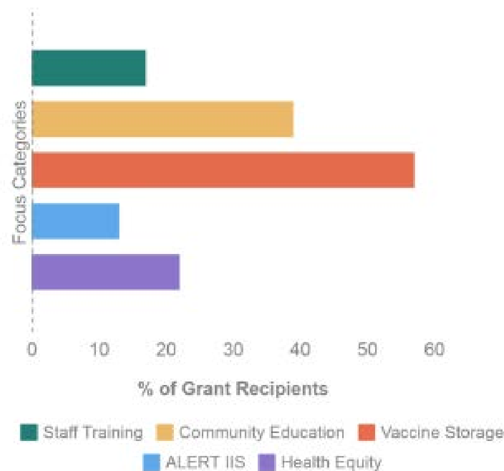
Attention to Health Disparities

IMMUNIZE OREGON 2017 MINI GRANTS



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Feedback & Discussion

- Future direction for Immunize Oregon coalition activities
  - Finding a home
  - Priorities for OR

Oregon Health Authority

Aaron Dunn, MPH, OPMA
Program Manager
Oregon Immunization Program
971-673-0318
aaron.dunn@state.or.us

Oregon Health Authority

Protect the population from communicable disease

Oregon Health Authority

Communicable Disease

Priority Targets

Measure	2015	2016	2020 Target	Data Source
Rate of Gonorrhea infection	79.2	80.4	72 cases per100,000	Orpheus
HIV infection	5.8	5.3	4.5 cases per 100,000	Orpheus
Proportion of people living with HIV with a suppressed viral load in past 12 months	71%	74%	90%	Orpheus
Rate of early syphilis infection (primary, secondary and early latent infections)	10.4	14.1	11.1 cases per 100,000	Orpheus

Communicable Disease

Priority Targets

Measure	2015	2016	2020 Target	Data Source
Incidence of TB disease	0.7	0.7	0.4 cases per 100,000	Orpheus
Infections caused by Shiga toxin-producing *Escherichia coli* O157	2.3	2.4	0.6 cases per 100,000	Orpheus
Hospital-onset *Clostridium difficile* infections	SIR .76	SIR .88	SIR .57	National Health care Safety Network

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Successes

- End HIV Campaign launched to eliminate new HIV infections
- ‘SyphAware’ campaign on public transit
- 15% reduction in reported *E. coli* O157 infection
- Creation of hepatitis C action plan
- Containment of carbapenemase-producing organisms

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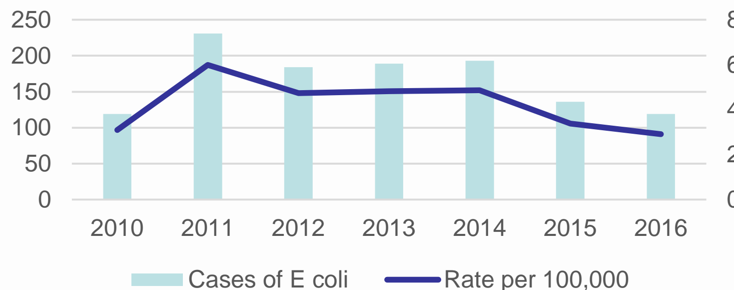
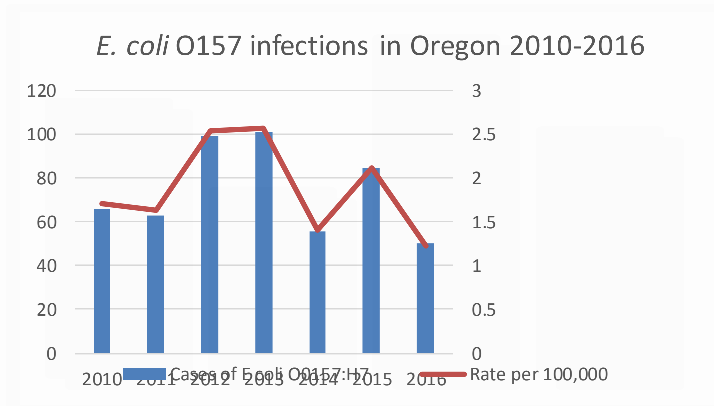
Shiga-toxigenic *E. coli* infections Oregon, 2010-2016





During 2010-2016:

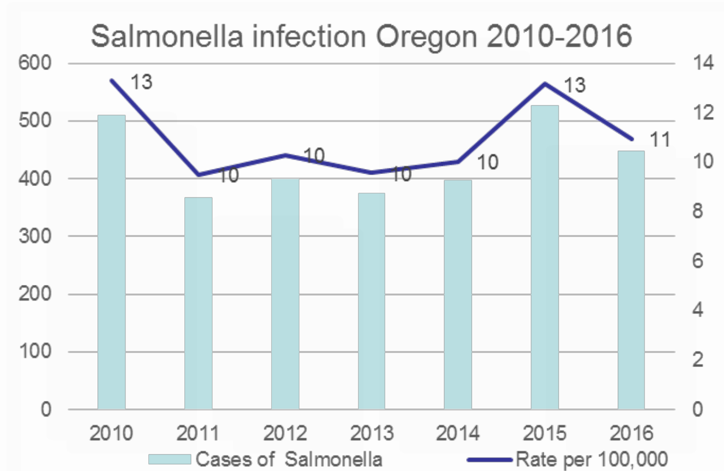
- 15% reduction in cases of *E. coli* O157

Strategies:

- Conduct investigations
- Consult with clinicians and public health staff on cases
- Investigate HUS cases

Oregon Health Authority

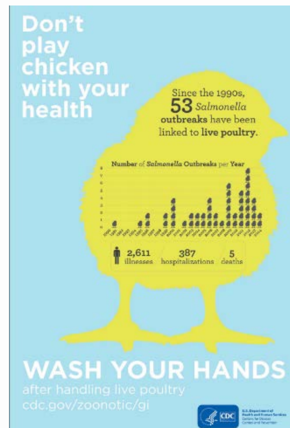
Salmonella infections, Oregon 2010-2016

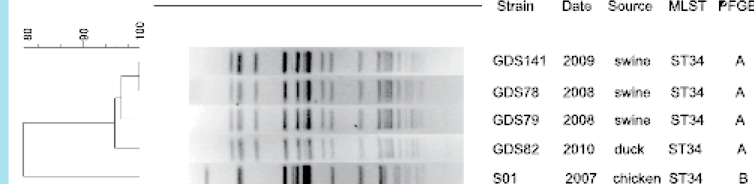


2020 Benchmark: 11.4/100,000

Strategies:

- OSPHL Conduct PFGE or DNA
- Investigate all *Salmonella* clusters and outbreaks
- Work with Dept. of Ag regarding *Salmonella* infection from animals Collect and publish data on *Salmonella* outbreak investigation





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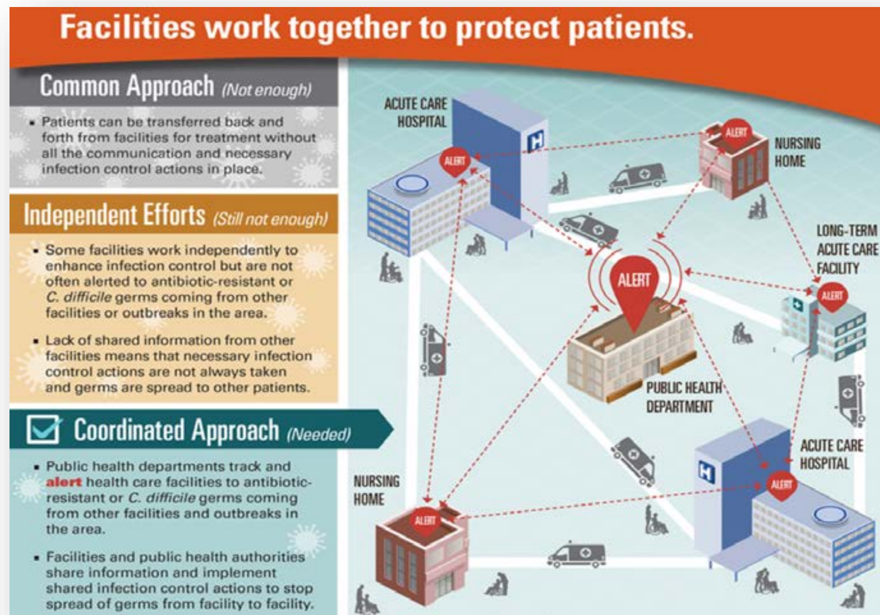
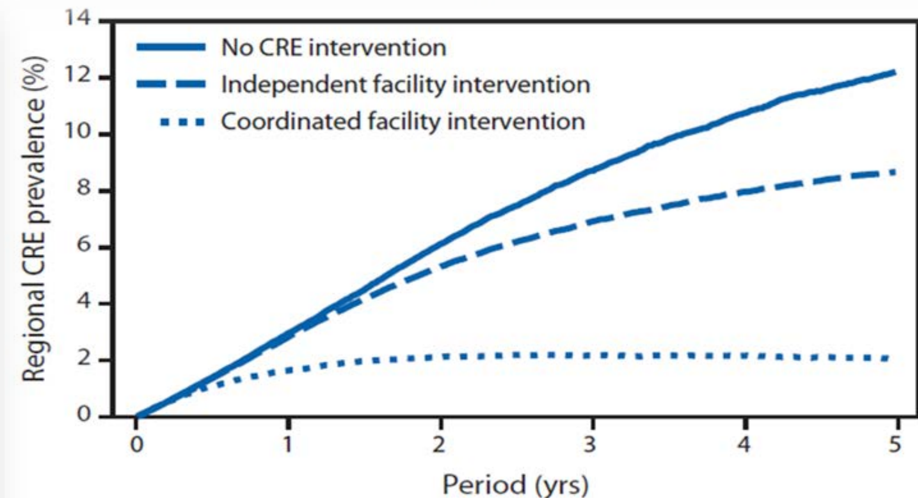
Preventing antibiotic resistance

Created Statewide network to control (MDROs): no spread of CP-CRE





* Additional information available at http://www.cdc.gov/drugresistance/resources/publications.html. A video of the model simulations is available at http://www.cdc.gov/drugresistance/resources/videos.html.

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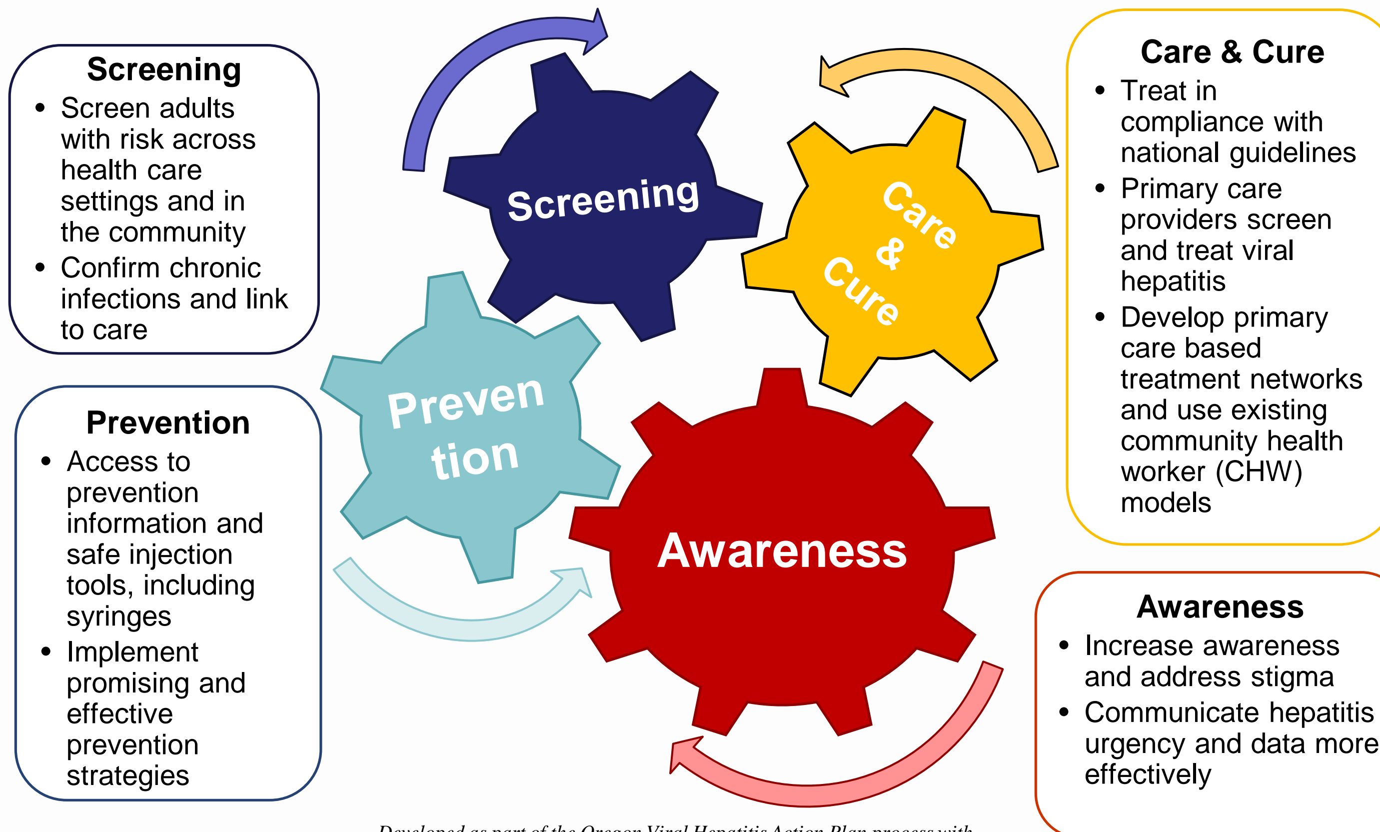
Oregon Viral Hepatitis Action Plan

GOALS: ➲ Prevent new infections ➲ Improve health outcomes
➲ Eliminate community and population disparities ➲ Decrease future medical care costs

Screening
- Screen adults with risk across health care settings and in the community
- Confirm chronic infections and link to care

Prevention
- Access to prevention information and safe injection tools, including syringes
- Implement promising and effective prevention strategies



Care & Cure
- Treat in compliance with national guidelines
- Primary care providers screen and treat viral hepatitis
- Develop primary care based treatment networks and use existing community health worker (CHW) models

Awareness
- Increase awareness and address stigma
- Communicate hepatitis urgency and data more effectively

Developed as part of the Oregon Viral Hepatitis Action Plan process with input from subject matter experts and community stakeholders.

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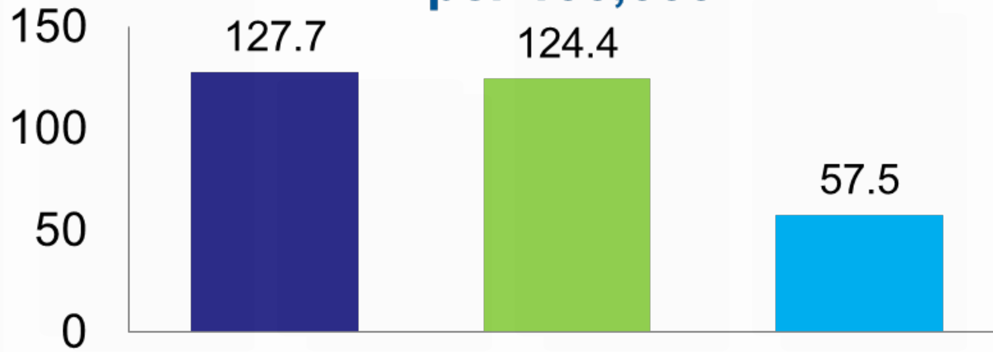
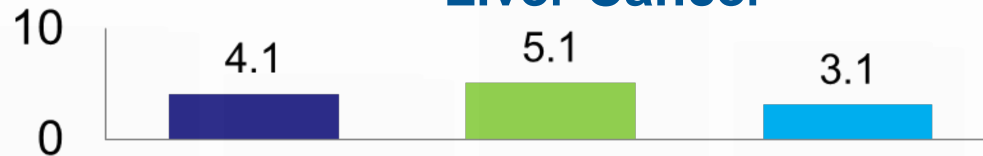
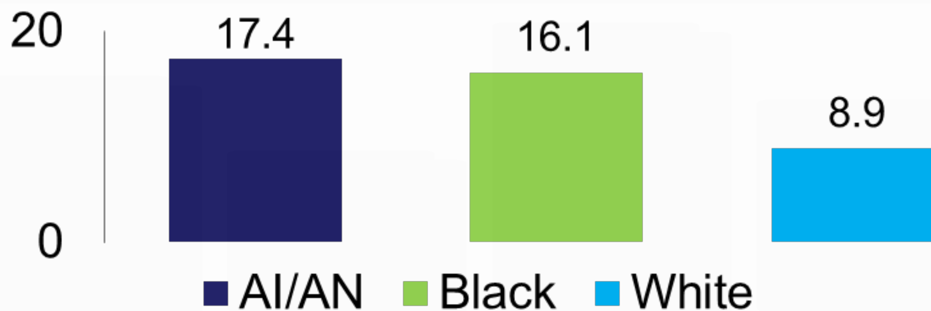
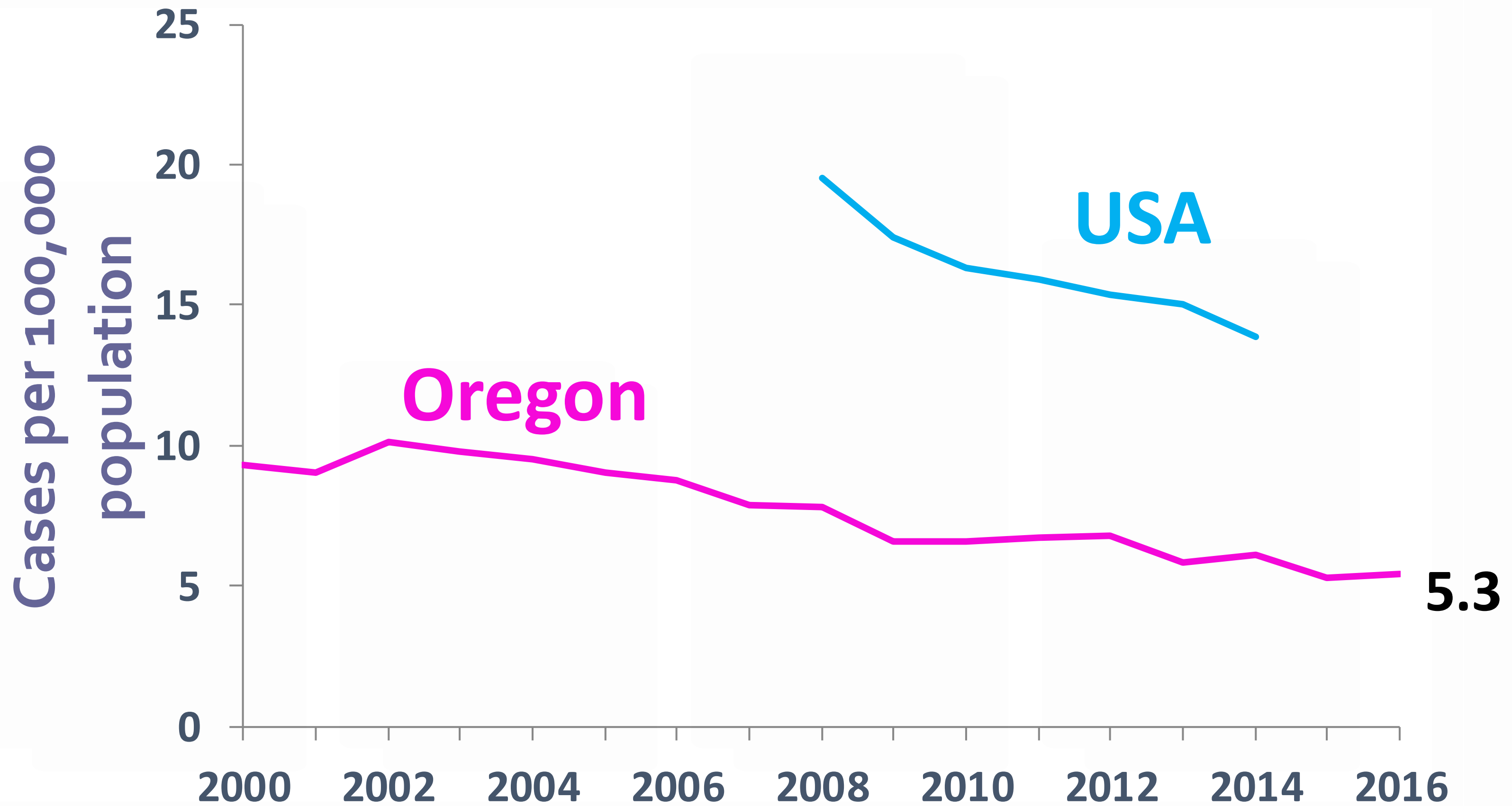






Racial disparities in rates of chronic infection, liver cancer, and deaths related to HCV, Oregon, 2009-2013

New HIV infections declining



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is an Oregon Health Authority and community initiative.

- Introduced on World AIDS Day 2016.
- 200 New HIV infections expected in 2017
- Three strategies can eliminate new HIV infections in Oregon:

1. Testing
   - Universal HIV testing could prevent 160 new HIV infections over 5 years
2. Treatment
   - 100% viral suppression could prevent >100 new HIV infections per year
3. Pre-Exposure Prophylaxis
   - Could prevent ~10 new infections per year

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Health Disparities—Relative Risk of Infection by Race

	Gonorrhea	Chlamydia	HIV	Syphilis
White	1	1	1	1
African American	6	4	4	0.1
Hispanic	1.3	2	1	2

Disparity-specific activities

- Early Intervention Services
- Innovation Grants focused on increasing testing in communities facing HIV- related disparities
- Enhanced case management for people with unsuppressed viral load

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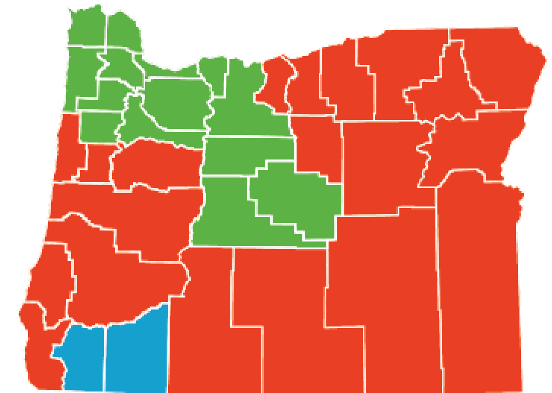
PrEP Survey Completed:

- Provider awareness and capacity low
- Inconsistent insurance coverage
- Financial barriers for low income individuals
- Stigma exists

What Oregon Providers are Saying About PrEP

Oregon accounted for **1.2%** of all PrEP prescriptions from 2012-2015 nationwide, equating to 950 people in Oregon receiving a prescription.

- PrEP is not covered by all Coordinated Care Organizations (CCOs).
- Not all prescribers in Oregon know about PrEP and, of those that do, not all feel comfortable recommending it to high risk patients.
- More than 1/3 of Oregon providers are not at all familiar with PrEP.

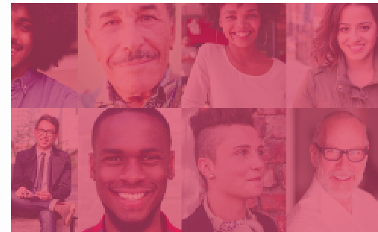


CCO Coverage of PrEP for Medicaid patients

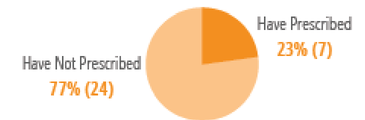
- Significant barriers (limited coverage for PrEP and/or labs, prior authorization required, etc.)
- Some barriers exist (required use of specialty pharmacy, etc.)
- PrEP and labs are covered with minimal or no barriers

Lack of access to PrEP Navigators

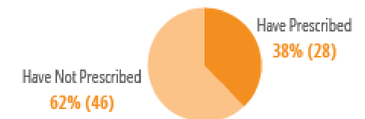
- PrEP Navigators help patients navigate the PrEP process from evaluation to continued treatment and follow-up.
- Unfortunately, less than half of Oregon providers reported having access to a case manager or PrEP navigator.



Rural Providers That Have Prescribed PrEP



Urban Providers That Have Prescribed PrEP



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STD Interventions

- SyphAware transit campaign raises awareness in Lane and Metro/Portland.
- Regional STD/HIV trainings statewide improve local disease control efforts.
- End HIV Oregon Early Intervention Services initiative aims to integrate STD and HIV testing and linkage to care services at the local level.
- Increase access to Expedited Partner Therapy.

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Feedback & Discussion

- Challenges of culture-independent diagnostic tests
- Reducing barriers to Hepatitis C treatment
- Reducing barriers to PrEP
- Encouraging universal HIV screening
- Promoting judicious antimicrobial use

Paul R. Cieslak, MD
Medical Director
Immunization & Communicable Diseases
paul.r.cieslak@state.or.us

Sean Schafer, MD
Medical Director
HIV, Sexually transmitted diseases & TB
sean.schafer@state.or.us

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