

# AGENDA

## PUBLIC HEALTH ADVISORY BOARD

May 11, 2023, 3:00-5:30 pm

Join ZoomGov Meeting

<https://www.zoomgov.com/j/1614044266?pwd=ekpYekxaMm92SHN0dngzTW9ZeldsUT09>

Meeting ID: 161 404 4266

Passcode: 938425

One tap mobile

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Meeting objectives:

- Approve April meeting minutes
- Approve public health modernization accountability metrics
- Approve public health modernization funding recommendation for 2023-25 biennium
- Hear about progress related to community-led data initiatives

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**3:00- Welcome, board updates, shared**

**3:10 pm agreements, agenda review**

- Welcome, board member introductions and icebreaker in the chat
- Share group agreements and the Health Equity Review Policy and Procedure
- **ACTION:** Approve April meeting minutes

Veronica Irvin,  
PHAB Chair

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**3:10- Public health modernization**

**3:45 pm accountability metrics**

- Discuss changes to accountability metrics
- **ACTION:** Adopt accountability metrics

TBD,  
Accountability Metrics  
Subcommittee

Sara Beaudrault,

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**3:45-  
4:10 pm Local public health authority funding  
formula**

- Review 2023-25 public health modernization funding formula
- Discuss recommendation about regional local public health funding
- **ACTION:** Approve 2023-25 public health modernization funding

Sara Beaudrault,  
OHA

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**4:00-  
4:10 pm Break**

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**4:10-  
5:05 pm Public health modernization  
investments and improvements, 2021-  
23**

Hear from Program Design and Evaluation Services staff about community-led data work this biennium

Tim Holbert,  
Program Design  
& Evaluation  
Services

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**5:05-  
5:15 pm Public comment**

Veronica Irvin,  
PHAB Chair

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**5:15-  
5:30 pm Next meeting agenda items and  
adjourn**

- June agenda items: PHAB retreat planning, health equity review policy and procedure update, accountability metrics report, Preventive Health and Health Services Block Grant, primary care and public health

Veronica Irvin,  
PHAB Chair

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Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters.
- Written materials in other languages.

- Braille.
- Large print.
- Audio and other formats.

If you need help or have questions, please contact Cara Biddlecom: at 971-673-2284, 711 TTY, or [publichealth.policy@odhsoha.oregon.gov](mailto:publichealth.policy@odhsoha.oregon.gov) at least 48 hours before the meeting.

# PHAB Accountability Metrics

## Group agreements

- Stay engaged
- Speak your truth and hear the truth of others
- Expect and accept non-closure
- Experience discomfort
- Name and account for power dynamics
- Move up, move back
- Confidentiality
- Acknowledge intent but center impact: ouch / oops
- Hold grace around the challenges of working in a virtual space
- Remember our interdependence and interconnectedness
- Share responsibility for the success of our work together



## **Public Health Advisory Board meeting minutes April 13, 2023, 3:00-5:30 pm**

### **Attendance**

Board members present: Rachael Banks, Dean Sidelinger, Marie Boman-Davis, Mike Baker, Bob Dannenhoffer, Veronica Irvin, Jackie Leung, Kelle Little, Meghan Chancey, Sarah Present, Jocelyn Warren, Nic Powers

Board members excused: Ryan Petteway, Erica Sandoval, Jeanne Savage, Jawad Khan

OHA Staff for PHAB: Tamby Moore, Sara Beadrault, Joyleen Mabika, Charina Walker, Victoria Demchak, Cara Biddlecom

### **Welcome and introductions**

- PHAB members, subcommittee and workgroup members and staff introduced themselves via chat as OHA Interim Director, Dave Baden came on to introduce himself to the Board. Interim Director Baden spoke to the important role of PHAB and public health.
  - Interim Director Baden has been with OHA for 4 years and worked at CDC for 18 years previously
  - Interested in PHAB work, especially as it relates to the new 1115 Medicaid waiver.
    - Question – How long expected in this position & when is recruitment going to start?
      - A lot of work to be done; external partners will support the recruitment, and this will be an external recruitment.
- Cara shared an update about the progress of Senate Bill 965A, which includes PHAB-recommended adjustments to membership, and the OHA budget.
- PHAB members voted to approve the March meeting minutes. All in agreement. March minutes were approved.
- Announcements from Cara:
  - Friday, July 14<sup>th</sup> has been scheduled for the PHAB retreat. This date worked for the majority of members who responded to the survey.
    - Reach out to Cara if you are unable to attend.

### **2023 PHAB work plan and deliverables**

Presentation by Veronica Irvin & Cara Biddlecom

- Goals for the rest of this year & early next year
  - Public health accountability metrics
  - Strategic data plan values and recommendations
  - PHAB health equity review policy and procedure
  - Public health modernization funding
  - PHAB Retreat: developing a vision for health equity
  - Provided advice for 2023 state health assessment
  - Preventative health & health services block grant work plan
  - Health systems transformation & CCOs
  - Timelines for deliverables
    - Adopt Public Health accountability metrics (priorities & indicators) (Spring)
    - Adopt updated Health Equity review policy & procedures (spring/summer)
    - Make recommendations to Public Health modernization funding for CBOs for 2023 – 2025 (Summer)
    - Adopt Strategic Data Plan values and recommendations (Summer)
    - Develop Strategic Vision for Health Equity & PHAB strategics (Summer/Fall)
    - Adopt Public Health Accountability Metrics (policy & process measures) (Late Fall)
  - No changes or suggestions to add to the work plan for 2023

## **Elect PHAB Chair**

Cara Biddlecom presented

- Veronica Irvin has reached her 2-year term as Chair.
  - Able to serve another 2 years
- 3 nominations came in for 2 people. Nominations were for Veronica and Bob. Bob declined the nomination.
- Cara took motion to re-elect Veronica for 2 more years as chair
  - There was a second to move the motion
- Voting members in favor: Mike Baker, Marie Boman-Davis, Bob Dannenhoffer, Veronica Irvin, Kelle Little, Meghan Chancey, Sarah Present, Jocelyn Warren, Nic Powers.
- Voting members absent: Jackie Leung, Ryan Petteway, Erica Sandoval, Jeanne Savage, Jawad Khan.
- Voting members abstaining: None.
- Voting members opposed: None.
- Veronica approved as chair for the next 2 years.

## **Public Health modernization investments & improvements, 2021 – 2023**

Presentation from OHA Tribal Affairs Director and Tribal Health staff about priorities, challenges, and accomplishments with current funding. Presented by Julie Johnson, Twila Teeman, Diann Weaver, Dennita Antonellis-John, Jessica Hamner, Katie Morioka.

- Julie Johnson, OHA Tribal Affairs Director, provided an overview about Oregon Tribes and OHA's Government-to-Government relationship with Oregon's federally recognized Tribes.

- Diann Weaver presented about the public health modernization work of the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians.
- Jessica Hamner presented about the public health modernization work of the Coquille Indian Tribe.
- Katie Morioka presented about the public health modernization work of Yellowhawk Tribal Health Center.
- PHAB members asked about how to best work with the Tribes. Jessica responded that it is important to consider the amount of work that Tribes are responsible for in addition to the mission of serving Tribal members. When seeking to partner, it is important to consider how an opportunity does or does not directly serve Tribal members.

## **Preventative Health and Health Services Block Grant**

Present by Sara Beaudrault

- Noncompetitive grant from CDC
- Work plan tied to healthy people 2030 objectives
- Portion of funding allocation for rape prevention & victim services
- Small increase from last year
  - \$88,458 allocated to rape prevention
- Funds support:
  - Implementation of HTO (state health improvement plan)
  - Public Health modernization
  - Primary sexual violence prevention
- PHAB acts as Block Grant advisory board as required. Required to meet 2 times a year to exercise its duties
  - This is the first meeting to meet that requirement, will meet again in another meeting.
- Sara shared that OHA is waiting for its allocation for the next year and will bring forward the subsequent year's work plan in either May or June.

## **Subcommittee updates**

### **Accountability Metrics Plan Subcommittee**

Sara Beaudrault presented

- Has meet twice since last PHAB meeting
- Bringing recommendation to be adopted by PHAB in May meeting
- Met with local public health to get recommendations
  - Sexually transmitted infections (STI) & vaccines for preventable disease were recommended as priority areas
- May meeting will bring forth the recommendations for STI indicators and June will bring forward indicators for vaccine preventable diseases

### **Strategic Data Plan Subcommittee**

Presented by Dean Sidelinger

- Early in process to create document with subcommittee values and recommendations

- Community participatory engagement for data collection
- The strategic data plan recommendations will support the next state health assessment, on which we are embarking.

#### **Health Equity policy & procedures workgroup**

Presented by Cara Biddlecom

- Added proposed language for rural equities to be included
- Meet with Health equity workgroup to finalize recommendations
- Hope to bring forward during retreat with possibility of some changes afterwards

#### **Scheduling for modernization funding workgroup**

- Meetings scheduled for May and June.

#### **Public comment**

- No comment provided

#### **May meeting agenda items**

- Discussion and adoption of some indicators for Accountability Metrics Data plan
- Discussion of Public Health Modernization Formula
- Discussion of Community Led Data Initiatives

#### **Adjourn**

- Meeting adjourned at 5:30 pm.
- The next Public Health Advisory Board meeting will be held on May 11, 2023, from 3:00-5:30 pm.



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# Public Health Accountability Metrics Communicable Disease

Sara Beaudrault  
Tim Menza, MD  
Rex Larsen



PUBLIC HEALTH DIVISION  
Office of the State Public Health Director

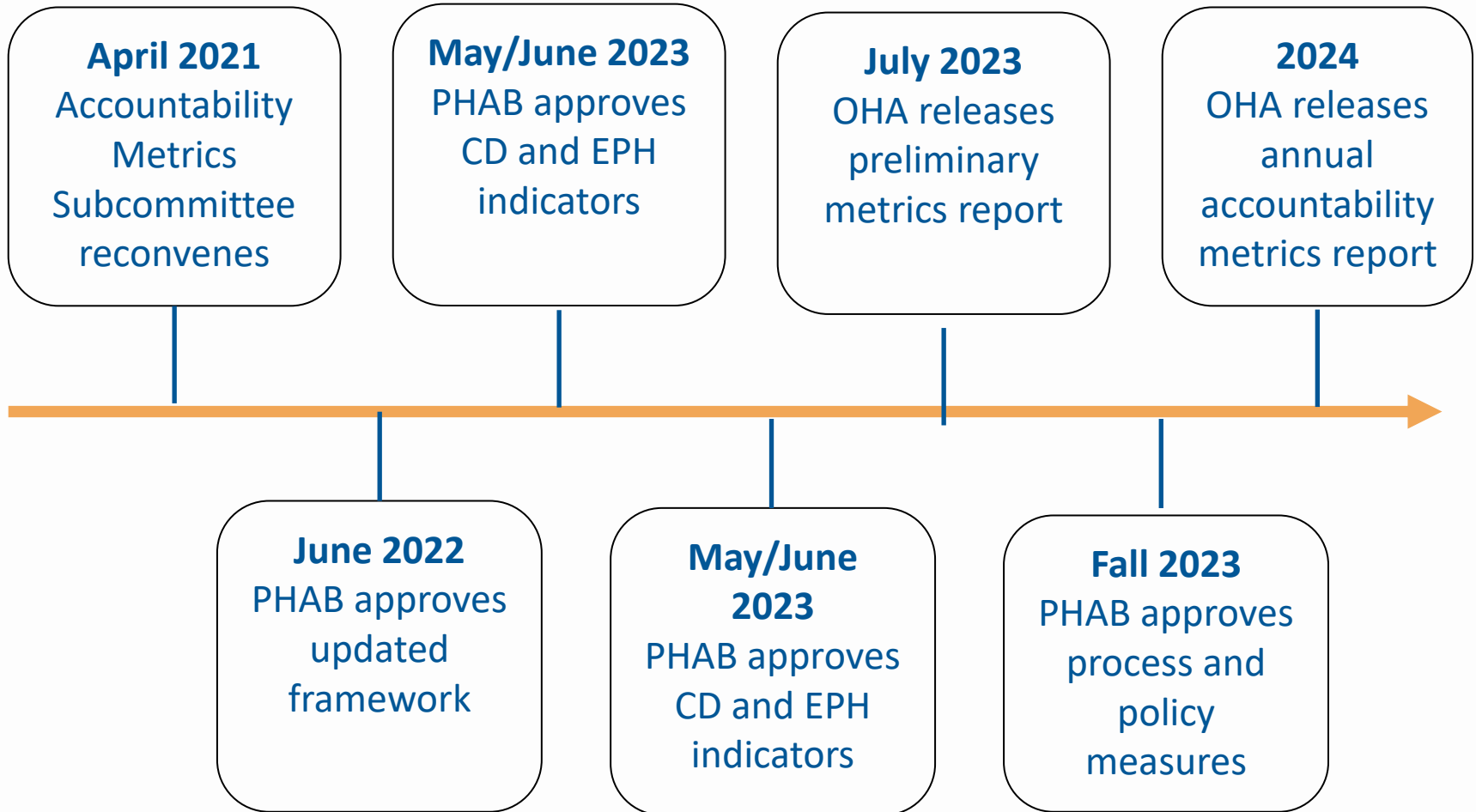
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# What we'll cover

1. Accountability metrics overview
2. Subcommittee recommendations for communicable disease priorities and indicators
3. PHAB health equity review questions
4. **Action:** Adopt communicable disease accountability metrics

# Public health accountability metrics overview

# Timeline



## Public health system metrics

The following set of metrics brings attention to health priorities in Oregon.

These metrics provide a framework to bring together governmental public health authorities, other sectors and partners, and state and local health officials to collectively change policies to create health for everyone.

These metrics also demonstrate improvements in Oregon Health Authority and local public health authorities' core system functions through public health modernization

Collective responsibility across sectors and partners	
Health priorities	Policy actions
Public health assessment	Public health policy development
Indicators of health outcomes  <i>What are priority health issues throughout Oregon?</i>  <i>Which groups experience disproportionate harm?</i>	Measures of policy landscape  <i>How are policies contributing to or eliminating root causes of health inequities?</i>
Level of accountability  The governmental public health system as a whole, other sectors and partners, elected officials.  Oregon's Public Health Advisory Board has a critical role to influence necessary policy changes.	

Oregon Health Authority and local public health authority accountability
Public health data, partnerships and policy
Public health assurance
Measures of foundational capabilities  <i>Are public health authorities increasing capacity and expertise needed to address priority health issues?</i>  <i>Are public health authorities better able to provide core public health functions within their community?</i>
Level of accountability  OHA and individual LPHAs

# Recommended communicable disease priority areas and indicators

Priority areas	Indicators
<b>Sexually transmitted infections</b>	<ul style="list-style-type: none"><li>• Rate of congenital syphilis</li><li>• Rate of any stage syphilis among people who can become pregnant</li><li>• Rate of primary and secondary syphilis</li></ul>
<b>Vaccine preventable diseases</b>	<ul style="list-style-type: none"><li>• Two-year old vaccination rate</li><li>• Adult influenza vaccination rate</li></ul>

# Other communicable disease priority areas and indicators that were discussed

Priority areas	Indicators
<b>Seasonal and emerging respiratory pathogens</b>	<ul style="list-style-type: none"> <li>• All respiratory outbreaks (influenza-like illness, RSV, COVID and others) in long-term care facilities</li> <li>• Influenza hospitalizations and mortality rates</li> </ul>
<b>HIV</b>	<ul style="list-style-type: none"> <li>• Rate of new HIV infections</li> <li>• Proportion of people living with HIV with an undetectable viral load within three months of diagnosis</li> <li>• Proportion of people living with HIV with an undetectable viral load in the prior year</li> </ul>
<b>Viral hepatitis</b>	<ul style="list-style-type: none"> <li>• Rates of acute hepatitis</li> </ul>
<b>Foodborne diseases</b>	<ul style="list-style-type: none"> <li>• Rates of foodborne diseases</li> </ul>
<b>Tuberculosis</b>	<ul style="list-style-type: none"> <li>• Rate of active TB infection</li> </ul>
<b>Sexually transmitted infections</b>	<ul style="list-style-type: none"> <li>• Gonorrhea rate</li> </ul>
<b>Vaccine preventable diseases</b>	<ul style="list-style-type: none"> <li>• Rates of high impact vaccine preventable diseases</li> <li>• Adolescent vaccination rates</li> <li>• Adult vaccination rates</li> <li>• School vaccination rates and nonmedical exemption rates</li> </ul>

# Sexually transmitted infections



# Issue summary:

**Why is this a priority now, and which groups are experiencing disproportionate harm?**

Syphilis diagnoses are higher than ever, including among people who can become pregnant, people who are pregnant, and infants. Persistent and systemic causes of inequities that impact the syphilis epidemic include poverty, housing instability, racism, stigma, the criminal justice system, substance use, and mental and behavioral health challenges.

# Recommendation

Adopt sexually transmitted infections and the following three indicators for public health accountability metrics.

- Rate of congenital syphilis
- Rate of syphilis (all stages) among people who can become pregnant
- Rate of primary and secondary syphilis

# Rationale

- The three indicators together provide a more comprehensive understanding of the dramatic increase in syphilis cases, which groups are most affected and areas for intervention.
- Syphilis rates are strongly determined by social and structural determinants of health. There are opportunities for public health interventions to eliminate root causes of inequities, including through policy.
- Congenital syphilis is an urgent public health issue.
- Adopting syphilis a priority for accountability metrics may result in increased partnerships with health care providers to increase screening and treatment.
- Healthy People 2030 goals:
  - STI-04: Reduce congenital syphilis
  - STI-03: Reduce the syphilis rate in people assigned female at birth
  - STI-05: Reduce the syphilis rate in men who have sex with men

# STIs are a community priority

- End HIV/STI Oregon is a community-engaged and community-driven plan that imagines an Oregon without new HIV transmissions; where everyone living with HIV lives a long, healthy life; we eliminate health inequities and stigma in HIV and STI.
- Community partners actively working on HIV/STI (including syphilis) education and prevention include:
  - Cascade AIDS Project
  - EducateYa
  - Familias en Accion
  - Haymarket Pole Collective
  - HIV Alliance
  - Northwest Portland Area Indian Health Board
  - Oregon Perinatal Collaborative
  - Portland Street Medicine

# Congenital syphilis campaign by the Northwest Portland Area Indian Health Board (stopsyphilis.org)

## Syphilis cases are on the rise.

Know your status,  
especially if you're pregnant.

Syphilis can be hard to spot, often starting with an easily missed sore or rash. While anyone can get syphilis, pregnant people and newborn babies face serious complications if left untreated.



When you're pregnant,  
make sure that you  
and your baby stay healthy.

Check in with your healthcare provider  
to get tested and treated for syphilis!

When caught early, syphilis can be treated with  
just one shot of antibiotics.

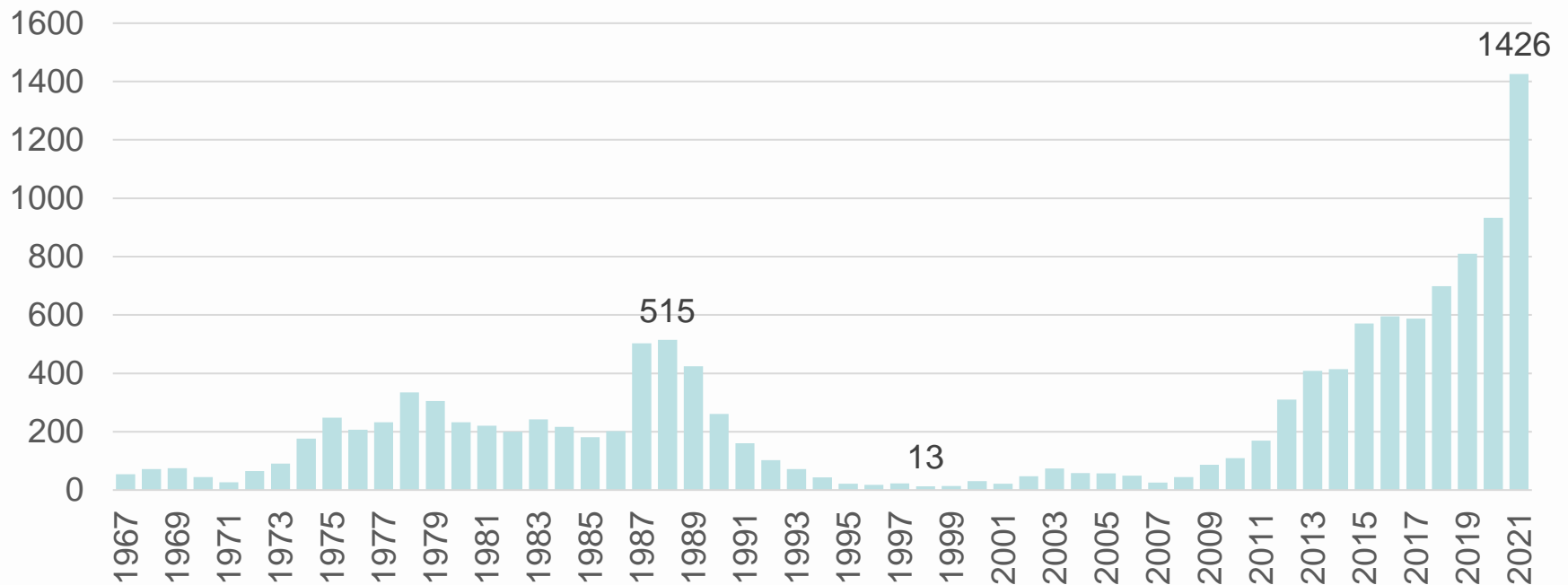


# Data for indicators

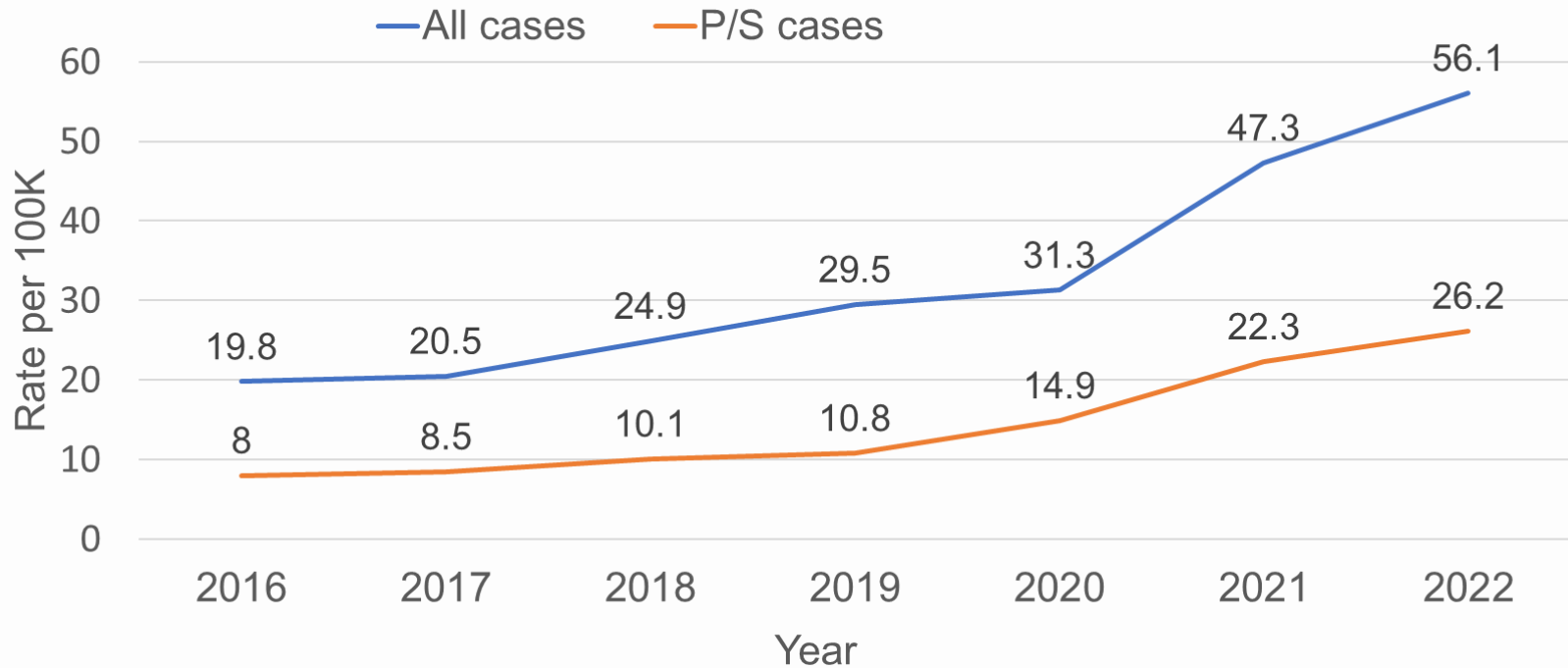
Proposed indicators	Data source	Other Oregon plans that use these measures (if any)	Populations that experience a disproportionate burden of illness, death or risks	Data are reportable at a county level or other geographic breakdowns	Data can be stratified*
<b>Sexually transmitted infections</b>					
Rate of congenital syphilis	ORPHEUS	END HIV/STI Oregon	Black, Native American/Alaska Native, Latinx, Native Hawaiian/Pacific Islander people, people who use drugs, people who are unhoused, people involved in the criminal justice system, youth, queer and trans people, people with prior STI diagnoses, people who live in rural and frontier areas	Yes	Yes
Rate of any stage of syphilis among people who can become pregnant	ORPHEUS	END HIV/STI Oregon	Same as listed above	Yes	Yes
Rate of primary and secondary syphilis	ORPHEUS	END HIV/STI Oregon	Same as listed above	Yes	Yes
Rate of gonorrhea	ORPHEUS	END HIV/STI Oregon, Healthier Together Oregon	Same as listed above	Yes	Yes

# Early (Infectious) syphilis diagnoses are higher than ever

Cases of primary, secondary and non-primary non-secondary (early) syphilis, 1967-2021

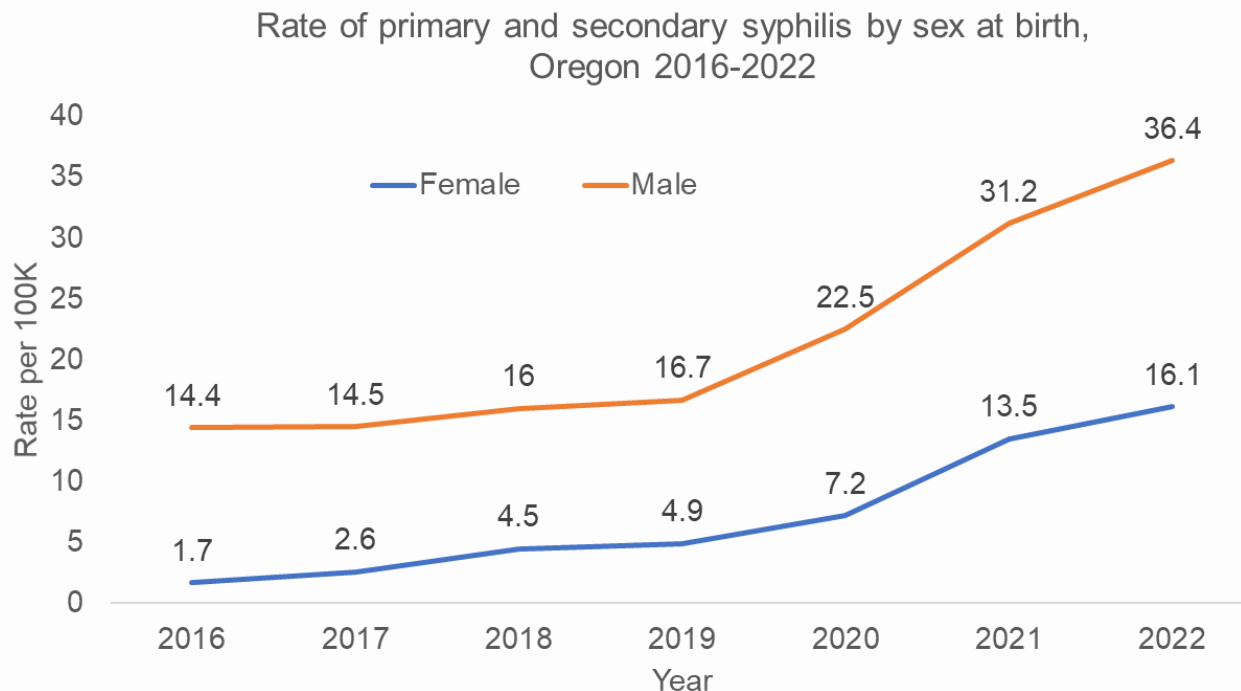


# Since 2019, the rate of syphilis diagnoses has been increasing rapidly





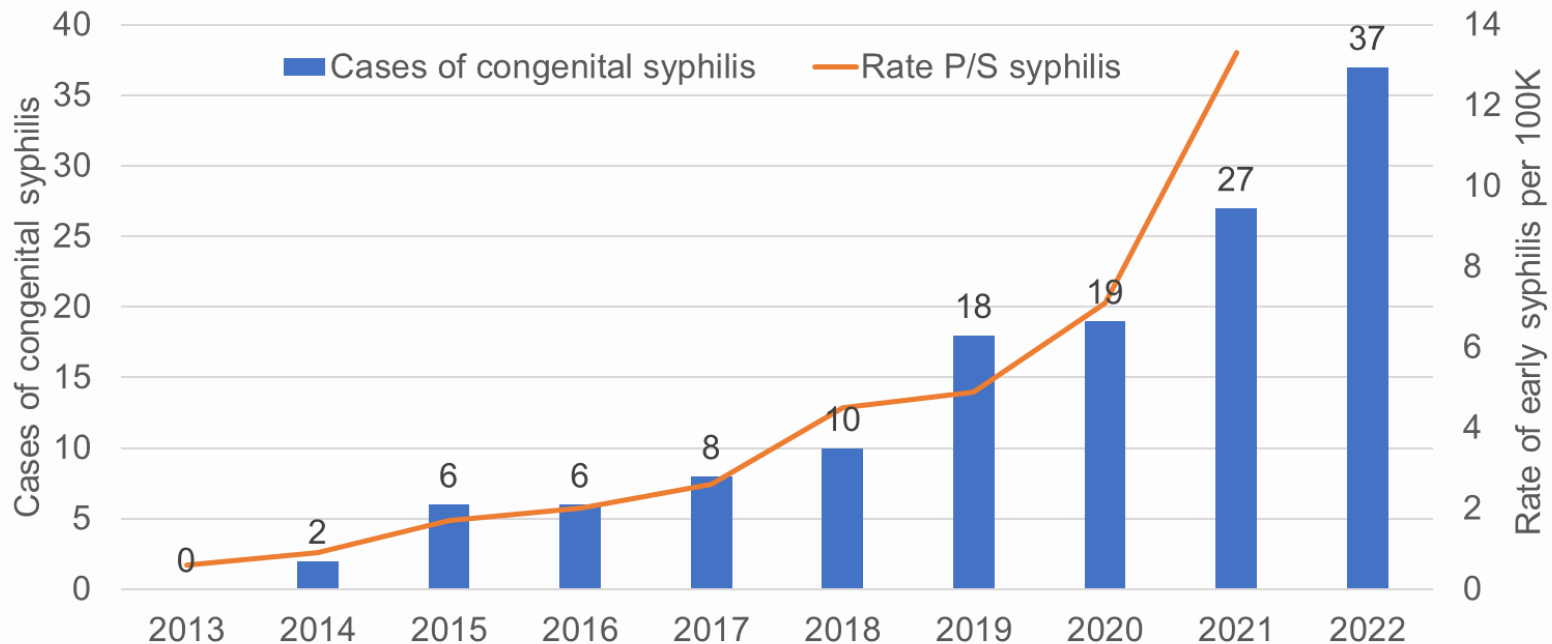
# Primary and Secondary (P/S) syphilis diagnoses almost tripled among people assigned female at birth between 2019 and 2021



Almost 50% of people assigned female at birth with syphilis in Oregon do not have an identifiable risk factor for infection (it's systems and structures not individual behaviors)

# There were no congenital syphilis cases in 2013 and 37 cases in 2022

Cases of congenital syphilis and rate of primary syphilis among people assigned female at birth, Oregon, 2013-2022

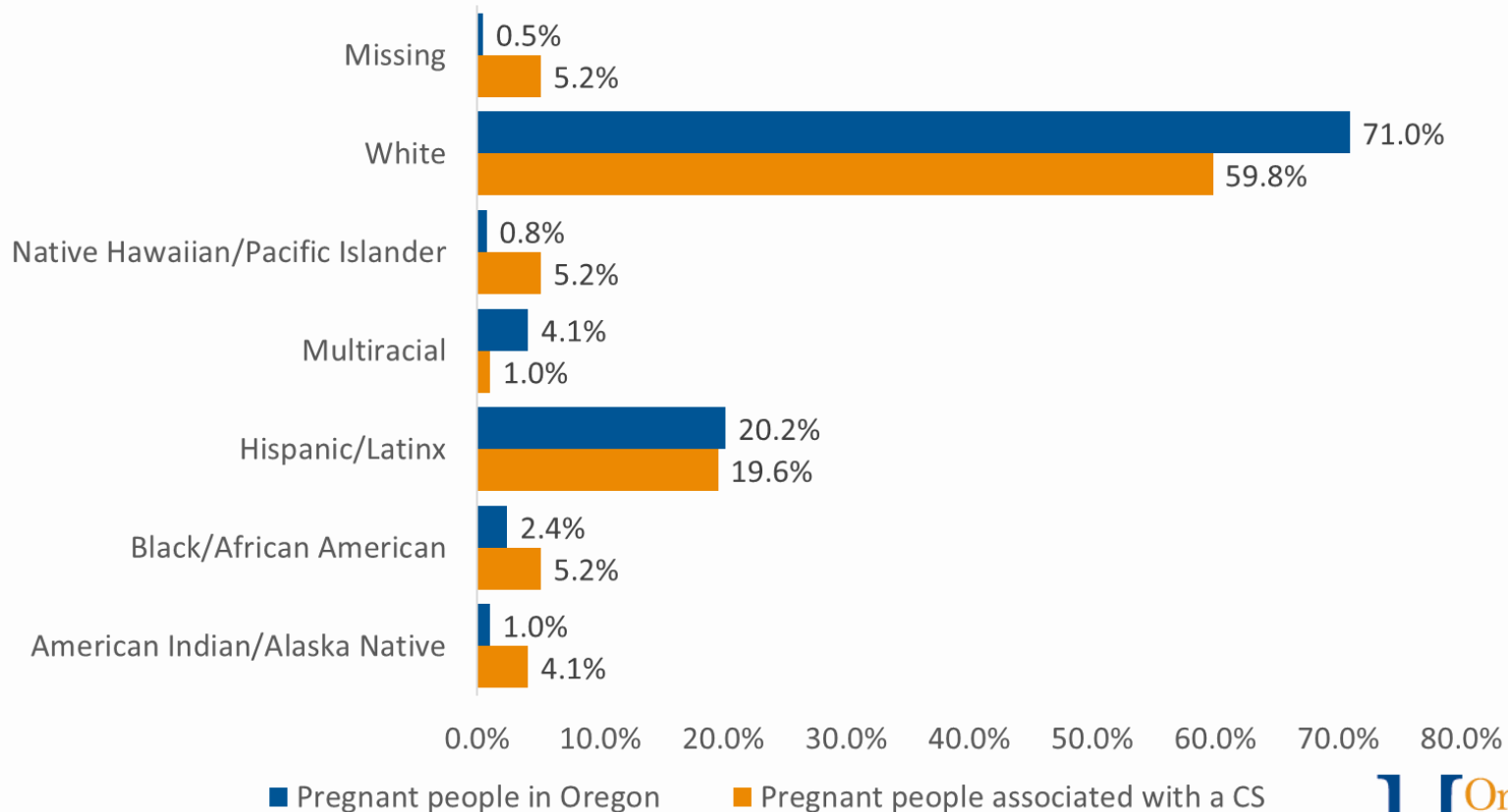


# Syphilis in Pregnancy, Oregon, 2014-2021

- 337 cases of syphilis in pregnancy from 2014 through 2021
  - 15 cases among 45557 pregnancies, or 3 cases per 10,000 pregnancies, in 2014
  - 86 cases among 40931 pregnancies, or 21 cases per 10,000 pregnancies, in 2021
- 95 (28%) of those pregnancies resulted in a case of congenital syphilis
  - 2/15 (13%) cases in 2014
  - 27/86 (32%) cases in 2021

# Racism leads to inequities in syphilis in pregnancy and congenital syphilis

Race/ethnicity of pregnant people associated with a CS case, Oregon  
2014-2022



# Housing Instability and Criminal Justice Involvement are Very Common

## Housing

- 49/133 (37%) were houseless or unstably housed
  - Unstable housing includes incarceration, moving homes, or residing in a substance use disorder treatment facility or group residence during pregnancy

## Criminal justice involvement (2014-2021 only)

- 61/95 (64%) had any history of criminal justice involvement
  - 17/95 (18%) had criminal justice involvement in the 12 months prior to or during pregnancy, including incarceration during pregnancy, community supervision, outstanding cases or warrants

# Many Report Substance Use and Have Had Prior STI and HCV Diagnoses

## Substance use

- 57/133 (43%) had a history of injection drug use
- 60/133 (45%) had a history of methamphetamine use
- 30/133 (23%) had a history of heroin/opiate use

## HIV/STI and HCV

- Most patients reported 1 male sexual partner in the prior 12 months
- None were known to be living with HIV
- 63/133 (47%) had a history of either chlamydia or gonorrhea
- 18/133 (14%) had chronic HCV prior to diagnosis of syphilis in pregnancy

# Vaccine preventable diseases

# Issue summary:

## Why is this a priority now, and which groups are experiencing disproportionate harm?

An unintended consequence of the response to COVID-19 was a sharp reduction in routine immunization of children, adolescents and adults, leaving groups at higher risk of diseases that are preventable. Public health can improve vaccination rates by addressing access barriers, providing culturally relevant outreach and education and working with health care and other partners. Vaccination rate disparities have existed in Oregon for decades, with communities of color less likely to be vaccinated, and experiencing a disproportionate burden of disease when compared to White communities.



# Recommendation (*preliminary, pending* )

**Adopt vaccine preventable diseases and the following two indicators for public health accountability metrics.**

- Two year old vaccination rates with a target of 80 percent by 2030
- Adult influenza vaccination rates for populations 65 and over with a target of 70 percent by 2030
- With both of these metrics it is critical to place specific emphasis on reducing disparities between individual races and ethnicities and the statewide average with the goal of reducing the disparity by a minimum of 10 percent each year

# Rationale

## *(preliminary, pending)*

- Seasonal influenza vaccination and 2-year-old vaccination rates have both been significantly impacted by the COVID-19 pandemic and urgent action is needed to recover.
- Preliminary data show influenza vaccination in Oregon for people 65 and older has dropped approximately 9 percentage points from pre-pandemic levels
- Preliminary data show 2-year-old vaccination has dropped approximately 2 percentage points in 2022 after steadily increasing each year since 2013

# Rationale

## *(preliminary, pending)*

- The public health system demonstrated the ability to close vaccine equity gaps among racial and ethnic groups with COVID-19 vaccination. Public health can apply lessons learned from COVID vaccination efforts to other vaccines.
- Two year old vaccination rates is a CCO incentive metric
- Healthy People 2030 objectives:
  - IID-09: Increase the proportion of people who get flu vaccine every year (target 70 percent)
  - IID-06/-04: Increase the proportion of children who receive 4 doses of DTaP (Target 90 percent) and 1 MMR (target 90.8 percent) vaccine by age two years (Target 90 percent)

# Vaccine preventable diseases are a community priority

- 160+ community-based organizations involved in community engagement and outreach strategies for COVID vaccination and many have expressed interest in applying similar strategies to routine vaccinations
- Lessons learned that can be leveraged for routine immunizations:
  - Mobile outreach strategies to reach communities where they are
  - Culturally and linguistically appropriate communications
  - Collaboration with community leaders to plan events, outreach

# Possible strategies

## Clear opportunities for OHA and LPHA interventions

- Community outreach –
  - Provide culturally relevant outreach and education
  - Collaborate with community organizations, health care providers and other partners
  - Conduct mobile vaccine outreach for hard to reach communities
- Use of public health data –
  - Identify populations with limited access to immunization services
  - Identify groups placed at increased risk of severe disease outcomes
- Health care provider partnerships –
  - Promote participation in the Immunization Quality Improvement for Providers (IQIP) program with local VFC-enrolled clinics

# Data for indicators

Proposed indicators	Data source	Other Oregon plans that use these measures (if any)	Populations that experience a disproportionate burden of illness, death or risks	Data are reportable at a county level or other geographic breakdowns	Data can be stratified*
Vaccine preventable diseases					
Adult vaccination rates	ALERT IIS		Elderly, infants and young children, people who live in congregate settings, Black, Native American/Alaska Native, Latinx, Native Hawaiian/Pacific Islander people, pregnant people, people with comorbid health conditions such as heart disease, lung disease, immunocompromising conditions		Data can be stratified by age, sex, race and ethnicity, Oregon Vaccine Access Program Participation for uninsured adults and geographic area down to zip code.
Two year old vaccination rates	ALERT IIS	Existing CCO incentive measure for HEDIS childhood combo 3  Existing PH modernization goal to increase rates of vaccinations in 2 year olds.	Elderly, infants and young children, people who live in congregate settings, Black, Native American/Alaska Native, Latinx, Native Hawaiian/Pacific Islander people, pregnant people, people with comorbid health conditions such as heart disease, lung disease, immunocompromising conditions		Data can be stratified by age, sex, race and ethnicity, Medicaid and Vaccines for Children Program participation and geographic area down to zip code.

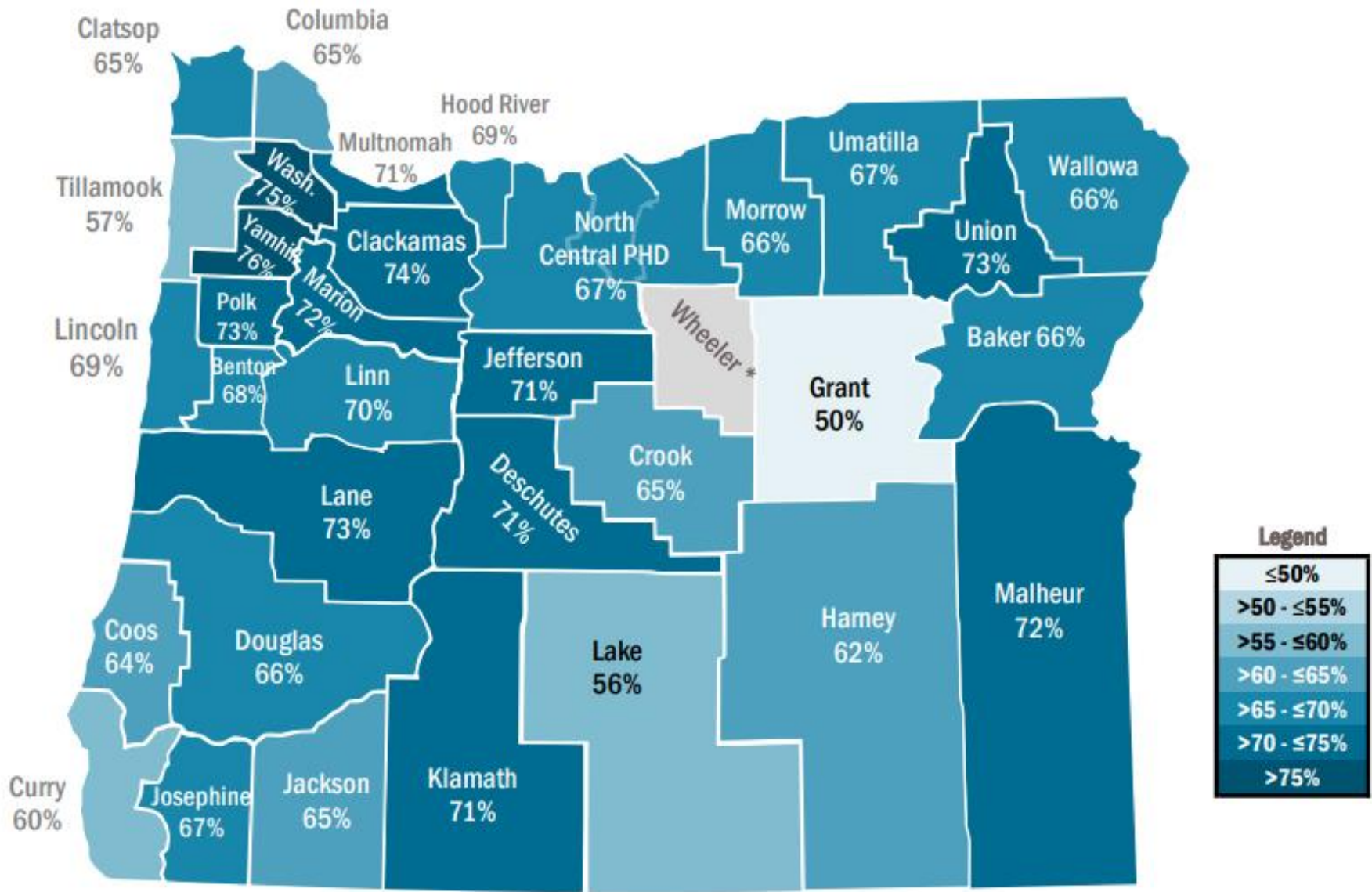
# Routine Vaccination

## 2 Year-Old-Vaccination Rates Preliminary

### Oregon Immunization Rates

	2014	2015	2016	2017	2018	2019	2020	2021	2022	Trend 2018-2022
Two-Year-Olds <sup>a</sup> Up-to-Date Rate <sup>b</sup>										
4:3:1:3:3:1:4 <sup>c</sup>	60%	64%	66%	68%	69%	71%	71%	71%	69%	
4 doses DTaP	76%	77%	78%	80%	80%	81%	81%	80%	78%	
3 doses IPV	87%	88%	89%	89%	89%	90%	90%	89%	89%	
1 dose MMR	87%	89%	88%	88%	88%	91%	90%	88%	87%	
3 doses Hib	87%	87%	88%	88%	88%	89%	89%	88%	87%	
3 doses HepB	82%	83%	85%	85%	85%	87%	87%	87%	86%	
1 dose Varicella	85%	86%	86%	87%	86%	88%	88%	87%	86%	
4 doses PCV	72%	75%	76%	77%	77%	78%	79%	78%	76%	
1 dose HepA	86%	87%	87%	87%	87%	88%	88%	87%	86%	
2-3 doses Rotavirus	65%	67%	68%	70%	71%	72%	74%	75%	74%	
1 dose Flu (in most recent season)	55%	52%	54%	55%	57%	61%	64%	58%	51%	
Hispanic <sup>d,f</sup>	63%	68%	70%	69%	72%	74%	72%	72%	72%	
White <sup>d,f</sup>	60%	64%	67%	69%	70%	72%	72%	72%	70%	
African American <sup>d,f</sup>	55%	59%	60%	62%	61%	61%	63%	63%	60%	
Asian <sup>d,f</sup>	64%	68%	69%	73%	73%	76%	77%	77%	72%	
American Indian and Alaskan Native <sup>d,f</sup>	60%	63%	65%	66%	66%	69%	67%	66%	64%	
Hawaiian/Pacific Islander <sup>d,f</sup>	54%	59%	61%	62%	61%	65%	64%	64%	61%	

# 2021 2 Year-Old-Vaccination Rates



\*Rates not displayed for populations of fewer than 50 people.



# Seasonal Respiratory Virus Vaccination

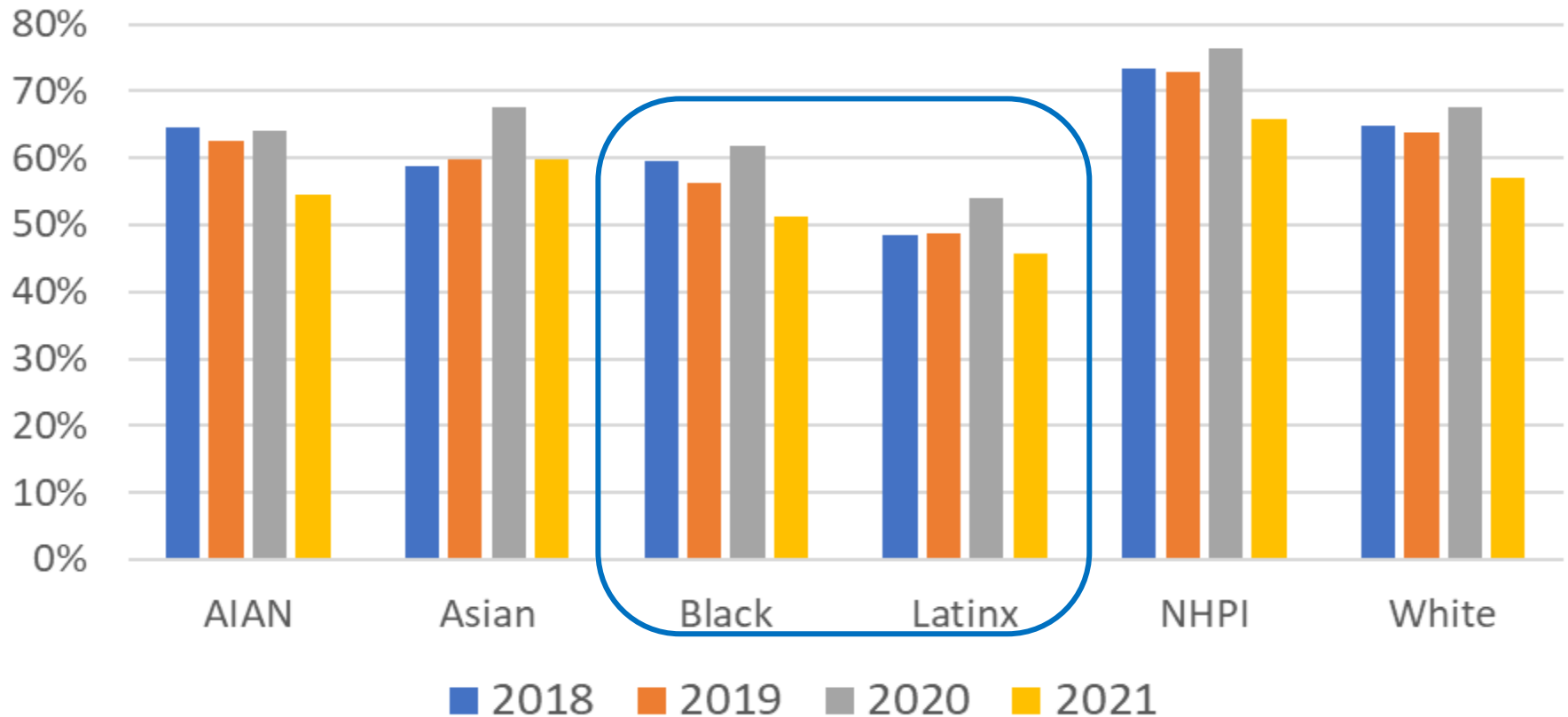
## Preliminary Adult Influenza Vaccination Statewide by Flu Season

	<u>Age group</u>			
Year	18-39	40-64	65+	Overall
22-23	26.2%	40.5%	58.7%	38.3%
21-22	27.1%	41.4%	57.6%	38.6%
20-21	36.2%	50.6%	65.7%	48.1%
19-20	32.4%	45.1%	67.4%	44.8%
18-19	29.2%	42.5%	67.6%	42.7%
17-18	25.5%	41.2%	64.5%	39.7%

# Seasonal Respiratory Virus Vaccination

## Adult Influenza Vaccination By Race and Ethnicity

Oregon Adult Age 65plus Influenza Immunization Rates  
2018-21 by Race & Ethnicity



# PHAB health equity review questions

What health inequities exist among which groups? Which health inequities does the work product, report or deliverable aim to eliminate?

PHAB's updated framework for public health accountability metrics is intended to bring sectors together to eliminate root causes of health inequities, including through policy actions.

Persistent and systemic causes of inequities that impact the syphilis epidemic include poverty, housing instability, racism, stigma, the criminal justice system, substance use, and mental and behavioral health challenges.

Systemic inequities that impact vaccination rates include those associated with access barriers and access to culturally relevant outreach and education.

# PHAB health equity review questions

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?

Accountability metrics can be used to foster shared responsibility and action across sectors. These metrics can also be used to strengthen public health and health care partnerships and alignment.

# PHAB health equity review questions

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?

The PHAB Accountability Metrics subcommittee has not directly engaged communities in the selection of priority areas or indicators for accountability metrics. The PHAB Accountability Metrics workgroup has looked to previous engagement and existing plans to understand community priorities for sexually transmitted infections and vaccine preventable diseases.

# PHAB vote

- Do members approve adopting the following communicable disease priority areas and indicators for 2023-25?

Public health accountability metrics  
 Metrics selection criteria summary  
 May, 2023

		Health equity and an antiracist society Community-leadership and community-led metrics			Data availability			Governmental public health system accountability					Direct connections to state and national initiatives
		Known health inequities exist	Measure is actionable by state and local public health through policy change and community-level interventions	Communities have provided input and demonstrated support	Data are reportable at the county level or similar geographic breakdowns	Data are routinely updated	Data are reportable by race, ethnicity, gender, sexual orientation, age, disability, income level, insurance status or other relevant risk factor data	State and local public health authorities have control over the measure, which includes influence	Funding is available or is likely to be available	Local and state public health expertise exists	Changes in public health performance will be visible in the measure	Measure is sensitive enough to capture improved performance or show differences between years	State and community health improvement plans CCO incentive measures Healthy People 2030
Sexually transmitted infections	Rate of congenital syphilis	Yes	Yes	End HIV/STI Oregon	Yes	Yes	Yes	Yes	Communicable disease funding	Yes	Unsure	Unsure	End HIV/STI Oregon
	Rate of any stage syphilis among people who can become pregnant			Community participation in education and prevention									Healthy People 2030 objective
	Rate of primary and secondary syphilis												
Vaccine preventable diseases	Two-year old vaccination rate	Yes	Yes	Community-led COVID-19 vaccine outreach	Yes	Yes	Yes	Yes	Immunization funding	Yes	Unsure	Unsure	Existing CCO incentive measure for HEDIS childhood combo 3
	Adult influenza vaccination rate			COVID-19 vaccine lessons from the community									Healthier Together Oregon

# **PUBLIC HEALTH ADVISORY BOARD**

## **Accountability Metrics Subcommittee**

April 11, 2023

9:00-10:00 am

**Subcommittee members present:** Jeanne Savage, Sarah Present, Kat Mastrangelo, Jocelyn Warren, Cristy Muñoz

**Subcommittee members absent:** Ryan Petteway

**OHA staff:** Sara Beaudrault, Kusuma Madamala, Rose Harding, Ann Thomas, Rex Larson, Zintars Beldavs, Jillian Garai, Kelly Mcdonald, Ernesto Rodriguez, June Bancroft, Amanda Spencer

**Guest presenters:** Kathleen Rees, Lauralee Fernandez, Kathleen Johnson, Brian Leon

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### **Welcome and introductions**

- Sara gave review of conversations from previous meetings and reviewed the agenda.
- Introductions
- Subcommittee voted to approve minutes from 3/3/2023 and 3/14/2023 meetings.

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### **Sexually Transmitted Infections (STIs)**

- Sara B:
  - If STIs are selected as a priority area, OHA recommends the following indicators:
    - Rate of congenital syphilis
    - Rate of syphilis (all stages) among people who can become pregnant
    - Rate of primary and secondary syphilis
  - CHLO metrics workgroup recommends staying focused on syphilis, though gonorrhea could also be added.
- Jocelyn: what was the rationale behind wanting to include gonorrhea?
  - Sarah P: Gonorrhea was a prior metric, so there is some desire among some health officers to have consistency across public health modernization work and it is believed that gonorrhea metrics make it easier track the impact of an LPHA.
  - Jeanne: Metrics should be used to help address root causes of disease, so if tracking gonorrhea metrics can help do that, then it makes sense to include them.
  - Sarah P: The public health approach to syphilis and gonorrhea are very different. Gonorrhea is treated as a general sexual health issue, where syphilis is approached in a way that also focuses on interventions aimed at preventing congenital syphilis.
  - Tim: Syphilis is greatly influenced by social determinates of health, so by looking at syphilis (especially congenital syphilis) we can clearly see the connection between sexual health and the social determinants of health.
  - Brian: Some of the approaches for finding gonorrhea cases don't work for finding syphilis cases, but all the approaches for finding syphilis cases can find gonorrhea as well. When trying to prevent congenital syphilis, case finding is key.



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- Kathleen R: Syphilis is a good place to start to show the impact of social determinants of health and the impact of interventions addressing social determinants. After being able to demonstrate change in syphilis related metrics, we can look at other more expanded metrics down the road.
  - Sarah P: Are there ways to track pregnant people who have had appropriate syphilis treatment?
    - Tim: OHA is currently working on a congenital syphilis dashboard which will focus on cases referred.
  - Is there a way to see the rate of pregnant people who are screened for syphilis?
    - Tim: OHA does not collect that through our surveillance system as we don't currently have the right systems or staff capacity to do that right now. We are looking to see if there are data sources that could be used (for example, claims data).
  - Subcommittee members agreed to recommend STIs as a priority area and using the indicators around syphilis.

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## **Vaccine Preventable Diseases**

*Rex Larson and Ann Thomas*

- Immunization rates are currently down following the COVID-19 pandemic. This is likely due to primary care interruptions during COVID, and the COVID-19 vaccine rollout interfered with routine vaccine administration especially the flu vaccine.
- OHA recommends any combination of the following indicators:
  - Rates of high impact vaccine preventable diseases, including by race, ethnicity, gender, sexual orientation, housing status, and injection drug use.
  - Adolescent vaccination rates and adolescent HPV rates
  - Adult vaccination rates
  - 2 year-old vaccination rates
  - School vaccination rates and non-medical exemption rate
- The data available for vaccination rates starts with ALERT IIS (Oregon's immunization registry).
- Immunization is a good synergy metric as CCOs have existing incentive metrics.
- With many vaccine-preventable illnesses, the very young and older individuals are most at risk. Most of the burden of disease disproportionately falls on minority groups.
- Data from ALERT IIS can be stratified in many ways. While there is race and ethnicity data, there is not REALD or SOGI data.
- Most vaccine preventable disease cases that are reportable have case interviews through which REALD/SOGI information can be obtained.
- Ann reviewed Oregon pertussis data and included breakdowns by age, race, and ethnicity.
- Rex gave overview of 2 year-old vaccination rates in Oregon and highlighted some of the disparities based on race and ethnicity and private/public insurance type.

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**Subcommittee business**

*Sara B*

- Subcommittee will meet again on 4/28/2023 to further discuss vaccine preventable diseases and seasonal/emerging respiratory pathogens.
- Subcommittee should be ready to take communicable disease recommendations to PHAB meeting on 5/11/2023.
- Subcommittee will take environmental health priorities to PHAB in June.

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**Public Comment**

- Duane West provided comment noting that his concern is radon induced lung cancer.

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**Meeting was adjourned**

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# **PUBLIC HEALTH ADVISORY BOARD**

## **Accountability Metrics Subcommittee**

April 28, 2023

11:00am – 12:00pm

**Subcommittee members present:** Jeanne Savage, Jocelyn Warren, Cristy Muñoz

**Subcommittee members absent:** Ryan Petteway, Sarah Present, Kat Mastrangelo

**OHA staff:** Sara Beaudrault, Kusuma Madamala, Diane Leiva, Ann Thomas, Rex Larson, Ernesto Rodriguez, Victoria Demchak, Amanda Spencer

**CLHO members:** Brian Leon

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### **Welcome and introductions**

- Sara gave review of conversations from previous meetings and reviewed the agenda.
- Introductions
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### **Vaccine Preventable Diseases**

*Rex Larson and Ann Thomas*

- Immunization rates are currently down following the COVID-19 pandemic. This is likely due to primary care interruptions during COVID, and the COVID-19 vaccine rollout interfered with routine vaccine administration especially the flu vaccine.
  - There are still clinics without adequate staffing.
  - There are less after hours or walk-in immunization clinics.
- OHA Recommends any combination of the following indicators:
  - Rates of high impact vaccine preventable diseases, including by race, ethnicity, gender, sexual orientation, housing status, and injection drug use.
  - Adolescent vaccination rates and adolescent HPV rates
  - Adult vaccination rates
  - 2 year-old vaccination rates
  - School vaccination rates and non-medical exemption rate
- The data available for vaccination rates starts with ALERT IIS (Oregon's immunization registry).
  - ALERT IIS is already used for CCO incentive metrics.
- With many vaccine-preventable illnesses, the very young and older individuals are most at risk. Most of the burden of disease disproportionately falls on minority groups.
- Data from ALERT IIS can be stratified by age, race and ethnicity, sex, and Medicaid status.
- There is not REALD or SOGI data for ALERT IIS, but those are available for some of the infectious disease data.
- Most vaccine preventable diseases that are reportable have case interviews through which REALD/SOGI information can be obtained.
- Ann reviewed Oregon pertussis data and included breakdowns by age, race, and ethnicity.

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- There are disparities in 2 year-old vaccination rates based on race and ethnicity, private/public insurance type, and population density (urban/rural).
  - The major focus for adolescent vaccination rates is HPV. The HPV vaccine can prevent cervical cancer and oropharyngeal cancer.

### Discussion

- Brian: Is the reason for the HPV vaccine completion rate being low compared to other adolescent vaccines is that is 2-3 doses and not just one?
  - Rex: That is part of it, but also Tdap is required for school attendance which is part of why the vaccination rate for it is so high. There is also some hesitancy around the HPV vaccine due to it being for a sexually transmitted infection prevention.
- Rex: Flu vaccination rates for adults is likely going to need a lot of attention in the coming years, as flu vaccination rates dropped more than any other vaccine during the COVID-19 pandemic. The advisory committee for immunization practices recently changed the COVID vaccination schedule to an annual vaccine, so it may not be a great metric this year.
  - Brian: In Yamhill County, during the last few months nearly 90% of deaths due to COVID have been among individuals who had one vaccine but have not had a booster in over a year.
  - Rex: COVID is still an important vaccine. In the future it will also being important to look at covid vaccination alongside flu vaccination as joint metrics for seasonal repository vaccination.
- Sara B reviewed input that Sarah P (who could not attend) shared from Health Officers:
  1. This doesn't exclude work on respiratory pathogens in high-risk settings as we now have vaccines that are protective against COVID and flu—but there is much less local or even state-wide control over this compared to other vaccine preventable disease, but there is support of ongoing work around increasing annual flu vaccine amongst LTCF staff and the work PH does with outbreaks in high risk settings.
  2. Definite support for vaccination metrics over vaccine-preventable disease rates for a number of reasons: different vaccines have different efficacy, many vax-preventable diseases are imported, more difficult to take meaningful actions on this data. The one vaccine preventable disease that may be worth tracking would be pertussis, but only in a defined group of individuals <6 months old as this preventable by vaccination of mom and family during pregnancy and has some clear prevention actions for the public health system to do that would be reflected in the metric.
  3. On the idea of “adult vaccination rates”—generally being up to date on full recommendations doesn't seem that useful as it's too broad. However, there was some interest in rates of pneumococcal vaccination as strep pneumo is the number 1 bacterial pneumonia, a top cause of hospital readmission rates, and a top cause of congestive heart failure—which is quite expensive to the health system and individuals.
  4. On the idea of childhood vaccination rates-there is support here as well. However, a focus on “up to date at 2 years old” has been found to have some problems. For example, the age cutoff, when many kids don't get their 2 y/o shots until they have been 2 y/o for a month or more. Also, there are some vaccines that are more acceptable to parents than others. For example, many vaccine hesitant parents will

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get some vaccines, but not all. Tdap again came up as one worth considering following as it has lower hesitancy and many will accept this one first. On the flip side, MMR rates could be followed as a vaccine that has more hesitance, and also is one of the most effective vaccines ever in disease prevention. But, looking at all vaccines according to schedule may be too broad.

5. There is some interest in HPV vaccine in adolescents, but our discussion drifted to wanting legal clarification on age of consent without parent knowledge for this, as many kids want it but their parents don't, and whether this fits into the current legislation on reproductive health care.
- Cristy in chat: "Thanks Rex, your team likely has something similar but I wanted to share maps our org uses to track underserved people of color communities in Oregon via ACS (American community survey). I'm wondering if you have any recommendation on how metric indicators could further address vaccination rates for communities needing direct culturally linguistic/relevant outreach : <https://drive.google.com/file/d/1jBMhEdgObjeAEKSGxoonrL-R61Bxb2A6/view?usp=sharing>"
    - Rex: Figuring out how to tailor immunization measures each community is difficult to do on a state level with how unique they are. Emphasizing race and ethnicity in our metric selection and working to improve specific vaccination rates for those communities at the county level.
    - Rex: We have a State Health Improvement Plan, but counties also have own health improvement plans. The things that have had the most success were broad partnerships of LPHAs working with local providers and CBOs to address the needs of communities. You can see the success of those programs in the county vaccination rates. But creating process measures, to drive and measure the implantation of those effective outreach strategies, is difficult.
    - Cristy: There seems to be a lot around cultural competency with specific communities in some counties, but then not as much in other counties or with other communities. How do we create metrics that promote equitable processes for counties, especially those that don't have an equity lens?
    - Brian in chat: "sometimes metrics can be accompanied by a strategic focus requirement where LPHAs need to speak to their local communities' gaps in race/ethnicity or other equity lenses... this was done with covid, though I'm not clear on how successful this was"
    - Jeanne: During covid OHA made vaccination rate requirements for specific racial and ethnic communities for CCOs to receive funding for covid. This is a strategy we could use for these metrics, but it would be important to reach out to community organizations and members to get their input on how well they felt this approached worked for covid vaccination.
    - Sara B: Counties had similar COVID equity plans that they had to develop and implement. Through those plans, we may have some information we could look at as far as what was successful and how partners and communities felt about it.
    - Rex: As Jeanne stated, CCOs were required to improve immunization rate for each race and ethnicity subgroup in their population and meet the same benchmark as the overall population in order to receive full funding. This was significant because previously CCOs could just focus on their largest population groups to meet the metric requirements without ever doing culturally specific outreach.
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- Cristy: Do we know if the culturally specific outreach OHA did through CBOs caused an increase of vaccinations outside of hospitals in those communities?
  - Rex: We don't have data to say how well it worked in isolation from all the other COVID vaccination strategies; however, the individuals who provided vaccines at those events had some of the highest levels of vaccinating people of color in the state. Those community-based vaccine clinics vaccinated a higher proportion of people of color than most other clinics in the state.

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**Subcommittee business**

*Sara B*

- Next subcommittee meeting will be 5/9/2023. During that meeting the subcommittee can make a recommendation on using vaccine preventable diseases as a metric.
- No public comment.

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**Meeting was adjourned**

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# Local public health authority funding formula

- Key changes for 2023-25
- Matching and incentive funds
- Regional partnership funds

# Key changes for 2023-25

1. At higher funding levels, increased base funding amounts. As funding and the breadth of work expands, this change ensures that improvements occur in all counties and across the entire state.
2. Increased allocations for indicators that describe community conditions. This change shifts funds to counties where the community may have a greater need to access public health services, or where there may be added complexities for serving the community.



# 2021-23 funding to LPHAs: \$33.4 million

County population size band	Funding range	Average award amount	Total funding to size band
Extra small <20,000 n=7	102,484-216,378	157,811	946,867
Small 20,000-75,000 n=12	283,044-597,333	413,585	4,963,021
Medium 75,000-150,000 n=7	611,017-909,989	770,207	5,391,448
Large/Extra-large >150,000 n=7	1,085,770- 4,772,878	2,539,102	17,773,712

**Public Health Modernization LPHA Funding Formula**

**Updated May, 2023**

**Total biennial funds available to LPHAs through the funding formula = \$20,000,000**

County Group	Population <sup>1</sup>	Base component								Matching and Incentive fund components		Total county allocation				Avg Award Per Capita
		Floor	Burden of Disease <sup>2</sup>	Health Status <sup>3</sup>	Race/Ethnicity <sup>4</sup>	Poverty 150% FPL <sup>4</sup>	Rurality <sup>5</sup>	Education <sup>4</sup>	Limited English Proficiency <sup>4</sup>	Matching Funds	Incentives	Total Award	Award Percentage	% of Total Population	Award Per Capita	
Wheeler	1,436	\$ 200,000	\$ 163	\$ 329	\$ 479	\$ 1,031	\$ 3,968	\$ 932	\$ 264	\$ -	\$ -	\$ 207,166	1.0%	0.0%	\$ 144.27	
Gilliam	2,071	\$ 200,000	\$ 343	\$ 263	\$ 617	\$ 1,205	\$ 5,722	\$ 849	\$ 11	\$ -	\$ -	\$ 209,009	1.0%	0.0%	\$ 100.92	
Wallowa	7,541	\$ 200,000	\$ 1,020	\$ 803	\$ 1,572	\$ 2,962	\$ 20,835	\$ 2,820	\$ 574	\$ -	\$ -	\$ 230,586	1.2%	0.2%	\$ 30.58	
Harney	7,640	\$ 200,000	\$ 1,560	\$ 963	\$ 2,154	\$ 5,664	\$ 9,360	\$ 4,446	\$ 798	\$ -	\$ -	\$ 224,946	1.1%	0.2%	\$ 29.44	
Grant	7,337	\$ 200,000	\$ 1,469	\$ 850	\$ 1,479	\$ 4,466	\$ 20,271	\$ 4,335	\$ 871	\$ -	\$ -	\$ 233,741	1.2%	0.2%	\$ 31.86	
Lake	8,246	\$ 200,000	\$ 1,789	\$ 1,545	\$ 2,698	\$ 6,449	\$ 14,429	\$ 7,180	\$ 2,842	\$ -	\$ -	\$ 236,933	1.2%	0.2%	\$ 28.73	
Morrow	12,315	\$ 200,000	\$ 1,883	\$ 3,545	\$ 8,382	\$ 9,327	\$ 15,607	\$ 17,336	\$ 18,330	\$ -	\$ -	\$ 274,411	1.4%	0.3%	\$ 22.28	
Baker	17,148	\$ 200,000	\$ 3,480	\$ 2,658	\$ 4,090	\$ 11,470	\$ 19,428	\$ 9,868	\$ 1,446	\$ -	\$ -	\$ 252,441	1.3%	0.4%	\$ 14.72	\$ 29.33
Crook	26,162	\$ 200,000	\$ 4,724	\$ 5,370	\$ 5,869	\$ 13,133	\$ 34,708	\$ 14,962	\$ 1,237	\$ -	\$ -	\$ 280,004	1.4%	0.6%	\$ 10.70	
Curry	23,897	\$ 200,000	\$ 5,500	\$ 3,603	\$ 6,999	\$ 14,106	\$ 25,573	\$ 12,070	\$ 7,292	\$ -	\$ -	\$ 275,141	1.4%	0.6%	\$ 11.51	
Jefferson	25,404	\$ 200,000	\$ 5,766	\$ 5,972	\$ 23,108	\$ 15,919	\$ 44,304	\$ 19,282	\$ 13,490	\$ -	\$ -	\$ 327,842	1.6%	0.6%	\$ 12.91	
Hood River	23,894	\$ 200,000	\$ 2,514	\$ 2,829	\$ 12,264	\$ 9,613	\$ 34,444	\$ 24,994	\$ 33,358	\$ -	\$ -	\$ 320,016	1.6%	0.6%	\$ 13.39	
Tillamook	27,868	\$ 200,000	\$ 5,307	\$ 4,439	\$ 7,776	\$ 14,899	\$ 53,593	\$ 16,240	\$ 12,925	\$ -	\$ -	\$ 315,177	1.6%	0.7%	\$ 11.31	
Union	26,673	\$ 200,000	\$ 4,947	\$ 3,976	\$ 6,715	\$ 17,256	\$ 31,023	\$ 12,081	\$ 3,249	\$ -	\$ -	\$ 279,246	1.4%	0.6%	\$ 10.47	
Sherman, Wasco	28,733	\$ 400,000	\$ 5,358	\$ 4,674	\$ 22,884	\$ 33,862	\$ 105,637	\$ 46,038	\$ 18,708	\$ -	\$ -	\$ 637,162	3.2%	0.7%	\$ 22.18	
Malheur	32,095	\$ 200,000	\$ 5,841	\$ 6,397	\$ 18,138	\$ 27,988	\$ 42,935	\$ 37,097	\$ 25,887	\$ -	\$ -	\$ 364,282	1.8%	0.8%	\$ 11.35	
Clatsop	41,971	\$ 200,000	\$ 7,797	\$ 6,685	\$ 13,714	\$ 21,771	\$ 45,193	\$ 20,618	\$ 9,318	\$ -	\$ -	\$ 325,096	1.6%	1.0%	\$ 7.75	
Lincoln	51,090	\$ 200,000	\$ 11,297	\$ 8,181	\$ 20,030	\$ 30,238	\$ 53,060	\$ 23,157	\$ 12,377	\$ -	\$ -	\$ 358,340	1.8%	1.2%	\$ 7.01	
Columbia	53,156	\$ 200,000	\$ 8,772	\$ 8,421	\$ 15,350	\$ 23,898	\$ 64,051	\$ 31,681	\$ 2,686	\$ -	\$ -	\$ 354,860	1.8%	1.2%	\$ 6.68	
Coos	65,112	\$ 200,000	\$ 14,212	\$ 11,646	\$ 22,303	\$ 45,907	\$ 68,997	\$ 40,829	\$ 8,569	\$ -	\$ -	\$ 412,463	2.1%	1.5%	\$ 6.33	
Klamath	70,848	\$ 200,000	\$ 16,792	\$ 10,983	\$ 32,814	\$ 56,627	\$ 73,563	\$ 51,459	\$ 20,355	\$ -	\$ -	\$ 462,593	2.3%	1.7%	\$ 6.53	\$ 9.48
Umatilla	80,302	\$ 200,000	\$ 14,314	\$ 12,859	\$ 45,851	\$ 50,975	\$ 64,488	\$ 84,050	\$ 67,064	\$ -	\$ -	\$ 539,602	2.7%	1.9%	\$ 6.72	
Polk	90,593	\$ 200,000	\$ 12,461	\$ 15,278	\$ 40,050	\$ 48,651	\$ 49,875	\$ 47,668	\$ 38,485	\$ -	\$ -	\$ 452,470	2.3%	2.1%	\$ 4.99	
Josephine	88,695	\$ 200,000	\$ 20,060	\$ 13,976	\$ 25,396	\$ 69,486	\$ 110,187	\$ 50,908	\$ 14,326	\$ -	\$ -	\$ 504,339	2.5%	2.1%	\$ 5.69	
Benton	95,594	\$ 200,000	\$ 8,498	\$ 9,934	\$ 46,776	\$ 62,958	\$ 49,559	\$ 22,125	\$ 43,620	\$ -	\$ -	\$ 443,470	2.2%	2.2%	\$ 4.64	
Yamhill	108,993	\$ 200,000	\$ 15,379	\$ 15,411	\$ 50,869	\$ 50,636	\$ 68,067	\$ 67,273	\$ 54,204	\$ -	\$ -	\$ 521,838	2.6%	2.5%	\$ 4.79	
Douglas	111,716	\$ 200,000	\$ 25,403	\$ 21,600	\$ 30,398	\$ 70,454	\$ 127,100	\$ 65,958	\$ 11,655	\$ -	\$ -	\$ 552,568	2.8%	2.6%	\$ 4.95	
Linn	131,194	\$ 200,000	\$ 23,053	\$ 21,008	\$ 44,426	\$ 77,378	\$ 114,681	\$ 80,428	\$ 35,135	\$ -	\$ -	\$ 596,109	3.0%	3.1%	\$ 4.54	\$ 5.11
Deschutes	207,561	\$ 200,000	\$ 25,005	\$ 27,579	\$ 51,921	\$ 94,161	\$ 158,528	\$ 73,485	\$ 44,982	\$ -	\$ -	\$ 675,660	3.4%	4.9%	\$ 3.26	
Jackson	224,013	\$ 200,000	\$ 38,337	\$ 35,680	\$ 75,949	\$ 137,154	\$ 124,111	\$ 127,717	\$ 71,260	\$ -	\$ -	\$ 810,208	4.1%	5.2%	\$ 3.62	
Marion	348,616	\$ 200,000	\$ 51,532	\$ 65,326	\$ 241,933	\$ 220,485	\$ 126,118	\$ 311,895	\$ 349,139	\$ -	\$ -	\$ 1,566,428	7.8%	8.1%	\$ 4.49	\$ 3.91
Lane	383,958	\$ 200,000	\$ 61,417	\$ 56,251	\$ 166,166	\$ 259,641	\$ 185,891	\$ 170,544	\$ 88,866	\$ -	\$ -	\$ 1,188,776	5.9%	9.0%	\$ 3.10	
Clackamas	430,421	\$ 200,000	\$ 55,676	\$ 54,625	\$ 193,403	\$ 145,827	\$ 214,993	\$ 152,220	\$ 175,266	\$ -	\$ -	\$ 1,192,009	6.0%	10.1%	\$ 2.77	
Washington	606,378	\$ 200,000	\$ 60,005	\$ 81,088	\$ 481,651	\$ 215,529	\$ 93,654	\$ 265,273	\$ 496,125	\$ -	\$ -	\$ 1,893,325	9.5%	14.2%	\$ 3.12	
Multnomah	810,242	\$ 200,000	\$ 118,325	\$ 115,251	\$ 579,777	\$ 432,872	\$ 30,048	\$ 386,183	\$ 619,286	\$ -	\$ -	\$ 2,481,742	12.4%	18.9%	\$ 3.06	\$ 3.03
<b>Total</b>	<b>4,278,913</b>	<b>\$ 7,200,000</b>	<b>\$ 640,000</b>	<b>\$ 640,000</b>	<b>\$ 2,304,000</b>	<b>\$ 2,304,000</b>	<b>\$ 2,304,000</b>	<b>\$ 2,304,000</b>	<b>\$ 2,304,000</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 20,000,000</b>	<b>100.0%</b>	<b>100.0%</b>	<b>\$ 4.67</b>	<b>\$ 4.67</b>

<sup>1</sup> Source: Portland State University Certified Population estimate July 1, 2022

<sup>2</sup> Source: Premature death: Leading causes of years of potential life lost before age 75. OHA, CHS, Oregon Death Certificate data, 2017-2021.

<sup>3</sup> Source: Quality of life: OHA, Oregon Behavioral Risk Factor Surveillance System (BRFSS), county file 2016-2019

<sup>4</sup> Source: U.S. Census Bureau, American Community Survey (ACS), 5-year estimates, Table B02001, B15002, C16001, C17002, 2017-2021.

<sup>5</sup> Source: U.S. Census Bureau, Decennial Census, SF1 Table P2, 2010

County Size Bands				
Extra Small	Small	Medium	Large	Extra Large
up to 20,000	20,000-75,000	75,000-150,000	150,000-375,000	above 375,000

# Incentive and matching funds

1. To be awarded when there is at least \$15 million allocated to LPHAs.
2. OHA will collect data for both incentives and matching funds in 2023-25.
3. Funds will be awarded to LPHAs at the beginning of the 2025-27 biennium, based on performance in the current biennium.

# Regional partnership funding

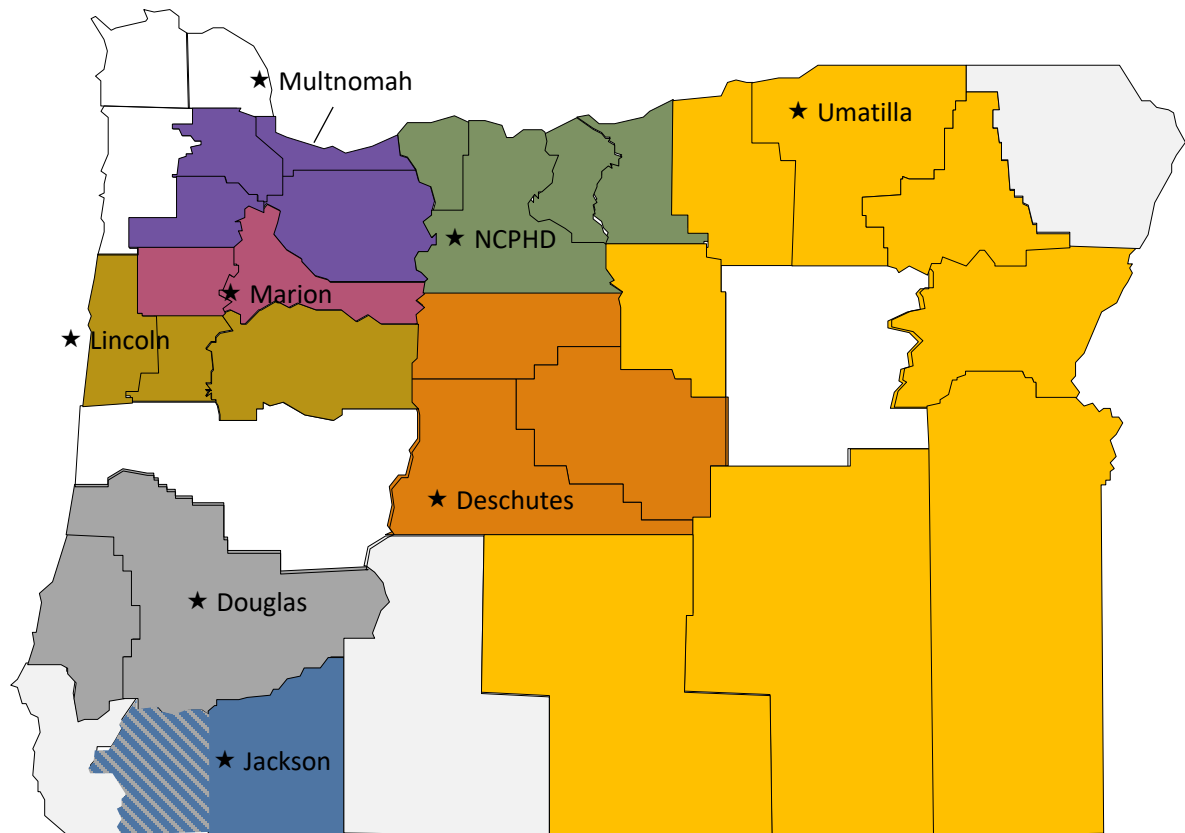
1. Based on PHAB recommendations, each biennium a portion of total LPHA allocations have been set aside for regional partnerships.
2. The amount of funds set aside for regional partnerships has remained flat while funding has increased overall.
3. Regional partnership funding provides unique benefits to rural and remote counties.

# 2021-23 public health modernization regional partnerships

Supporting communicable disease prevention and investigation, regional climate and health strategies, and community health improvement plans

“Ultimately, we have better communication and a better understanding of our region when we undertake joint projects”

*LPHA Administrator*



★ Fiscal agent for regional partnership

# Recommendation for regional funding in 2023-25

If there is an overall increase in public health modernization funding, increase funding for regional public health modernization partnerships to \$4.4 million (10% increase).

If there is no increase in funding, maintain funding at \$4 million for regional partnerships.

Continue funding current regional partnerships. No funding for new regional partnerships.

# PHAB health equity review questions

What health inequities exist among which groups? Which health inequities does the work product, report or deliverable aim to eliminate?

All of them. ensuring an equity- and community-focused public health system through public health modernization investments is critical for achieving Oregon's goal to eliminate health inequities by 2030.

The indicators in the funding formula address areas where inequities exist, including socioeconomic status and educational attainment, English language proficiency, and rurality. The base funding is intended to ensure that local public health authorities can establish the workforce and infrastructure needed for working directly with communities to address community priorities.

Funding for regional partnerships builds infrastructure for coordinated approaches to serving communities, regardless of county lines.

# PHAB health equity review questions

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?

Regional partnership funding does not require engaging other sectors. However, many regional partnerships are using funds to support cross sector efforts, including through community health improvement plans.



# PHAB health equity review questions

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?

Communities have not been engaged in recommendations for regional partnership funding to LPHAs.

# PHAB vote

- Do members approve the recommendation for regional partnership funding in 2023-25?

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# Engaging Communities to Modernize Our Public Health Survey Systems



OHA Public Health Accountability Board

May 2023

**Health**  
Oregon  
Authority

# PURPOSE

Overview of PDES survey modernization activities. Focusing on data equity, community engagement...

- Collaboration with communities through culturally specific project teams
  - Lessons learned
  - Dissemination of results
  - Implementation of community recommendations
  - A proposed model for state survey system
  - The next step – participatory budgeting and community-led data collection
-

# PROGRAM DESIGN & EVALUATION SERVICES (PDES)

- Who we are
    - Research and evaluation unit within both the Multnomah County Health Department and the Oregon Public Health Division with experience in health equity, public health, sociology, psychology, social and structural determinants of health.
  - What we do
    - Design, evaluate, and refine public health programs/policies; conduct health assessments, population-based surveys, epidemiologic studies, and applied research.
    - Use qualitative and quantitative methods.
    - Work in HIV, tobacco prevention, physical activity and nutrition, maternal child health, and many other content areas.
  - What we value
    - Collaboration, Flexibility, Integrity and Equity.
-

# ACKNOWLEDGING...

## Oregon Pacific Islander Coalition

- Maria Dizon, Filipinx/lived in Saipan
- Virginia Luka, Palauan/lived in Guahan
- Alyshia Macaysa, Native Hawaiian, Filipinx
- Natlie Dutro, Native Hawaiian
- Siiri Visto, Native Hawaiian
- Adri Jones, Filipinx
- Kianna Angelo, Marshallese
- Jonathan Cruz, Native Hawaiian
- Bella Borja, CHamoru
- Dr. Jacinta Galeai, Samoan
- Elizabeth Paulson, Samoan

## Black/African American/African Immigrant & Refugee Project Team

Dr. Roberta Hunte, Assistant Professor, Portland State University  
Oluchi Onyima, formerly of Urban League  
Sherly Paul, Community Health Nurse, Multnomah County Healthy Birth Initiative  
Dr. Ryan Petteway, Assistant Professor, OHSU-PSU School of Public Health

## NPAIHB/Northwest Tribal Epi Center

- 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

## 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, OSU  
Claudia Montano, Projects Manager, The Next Door, Inc  
Karla Rodriquez, Community Health Worker, Oregon Latino Health Coalition

## PDES & OHA Staff

Julie Maher  
Virginia Luka  
Victoria Demchak  
Kristen Rohde

## Tribal Work Group

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

Kusuma Madamala  
Margaret Braun  
Kim Phillips  
Renee Boyd  
Kari Greene  
Jamie Matson



# DEFINITIONS & CONSIDERATIONS

## Data Equity

To achieve equitable data representation for diverse communities, we must work to dismantle historic and ongoing systems of oppression in data science. Communities must be engaged at all levels of planning, implementation, and evaluation of data systems and power must be shared through transparency and accountability measures whenever possible. (Strategic Data Planning PHAB Subcommittee)

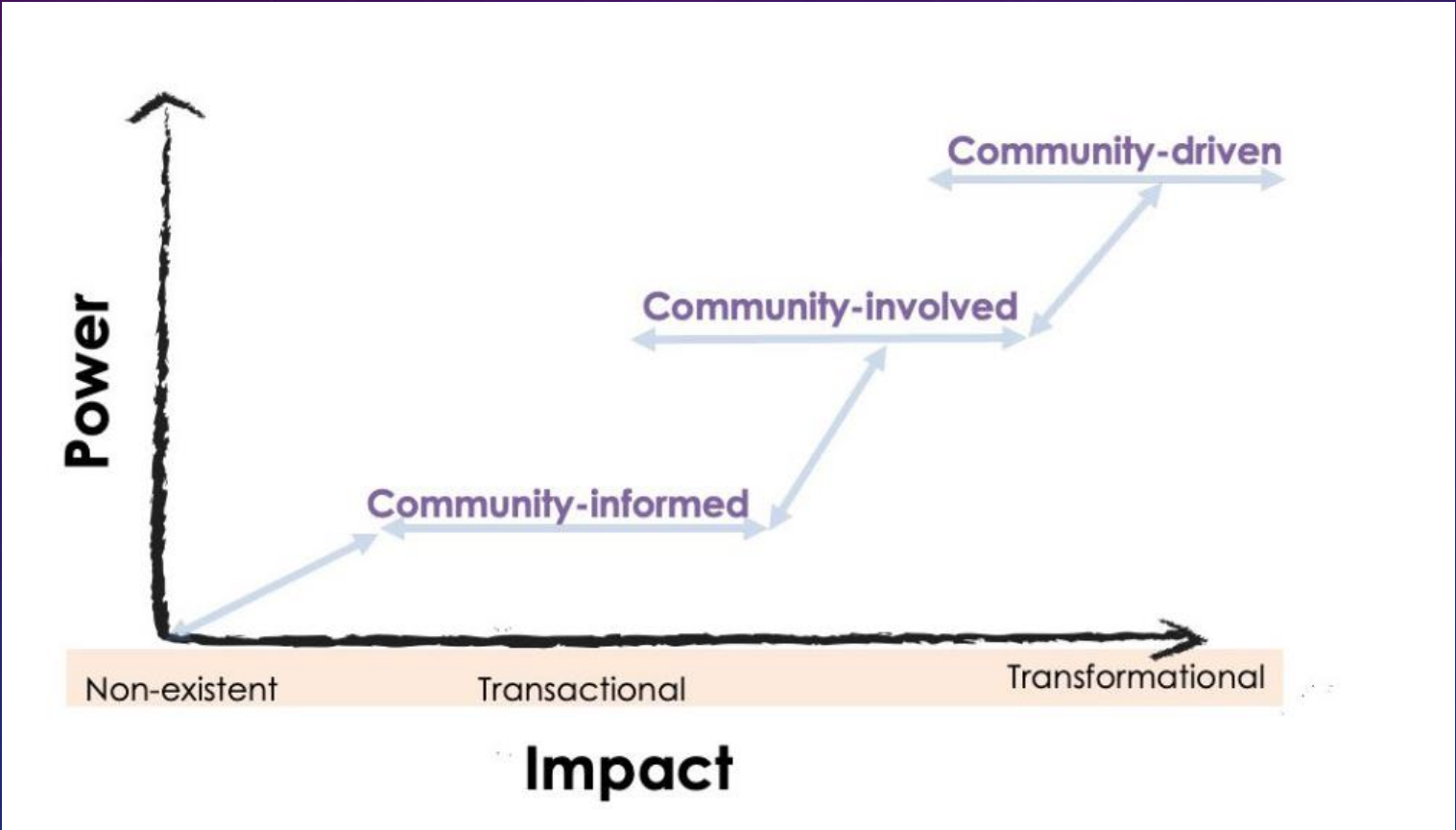
## Community Driven

Projects and processes in which communities engaged have both power and impact. Community leads the work and has power to make meaningful choices. (Health Equity Services)

## Community Engagement

- Transactional
  - Transformational
-

# COMMUNITY-DRIVEN





# THE SPECTRUM OF COMMUNITY ENGAGEMENT

Levels of Engagement				
<b>County Informs</b> King County initiates an effort, coordinates with departments and uses a variety of channels to inform community to take action	<b>County Consults</b> King County gathers information from the community to inform county-led interventions	<b>County engages in dialogue</b> King County engages community members to shape county priorities and plans	<b>County and community work together</b> Community and King County share in decision-making to co-create solutions together	<b>Community directs action</b> Community initiates and directs strategy and action with participation and technical assistance from King County
Characteristics of Engagement				
<ul style="list-style-type: none"> <li>Primarily one-way channel of communication</li> <li>One interaction</li> <li>Term-limited to event</li> <li>Addresses immediate need of county and community</li> </ul>	<ul style="list-style-type: none"> <li>Primarily one-way channel of communication</li> <li>One to multiple interactions</li> <li>Short to medium-term</li> <li>Shapes and informs county programs</li> </ul>	<ul style="list-style-type: none"> <li>Two-way channel of communication</li> <li>Multiple interactions</li> <li>Medium to long-term</li> <li>Advancement of solutions to complex problems</li> </ul>	<ul style="list-style-type: none"> <li>Two-way channel of communication</li> <li>Multiple interactions</li> <li>Medium to long-term</li> <li>Advancement of solutions to complex problems</li> </ul>	<ul style="list-style-type: none"> <li>Two-way channel of communication</li> <li>Multiple interactions</li> <li>Medium to long-term</li> <li>Advancement of solutions to complex problems</li> </ul>
Strategies				
Media releases, brochures, pamphlets, outreach to vulnerable populations, ethnic media contacts, translated information, staff outreach to residents, new and social media	Focus groups, interviews, community surveys	Forums, advisory boards, stakeholder involvement, coalitions, policy development and advocacy, including legislative briefings and testimony, workshops, community-wide events	Co-led community meetings, advisory boards, coalitions, and partnerships, policy development and advocacy, including legislative briefings and testimony	Community-led planning efforts, community-hosted forums, collaborative partnerships, coalitions, policy development and advocacy including legislative briefings and testimony

# COMMUNITY ENGAGEMENT MUST BE TRANSPARENT ABOUT...

- Scope of work & expectation
  - Timelines
  - Roles
  - Funding
  - Power and decision authority
  - Accountabilities
-

# PURPOSE OF SURVEY MODERNIZATION

The primary purpose of this project was to improve the validity, representativeness, and utility of our population surveys by providing an opportunity for community partnership and leadership in

- Understanding, analyzing and interpreting BRFSS and OHT/SHS survey data
  - Identifying strengths, gaps and limitations of BRFSS and OHT/SHS data and methodologies
  - Facilitating community led data collection on identified gaps in the data
  - Developing recommendations for further improvements that would lead to better representativeness, accuracy and equity in the survey data collection, analysis and dissemination
-

## RESULTING IN...

“This collaboration illustrates how strong community-government partnerships can lead to more equitable data practices that truly center the needs and desires of communities closest to the issues being researched.”

Coalition for Communities of Color Community Brief Spring 2023

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## 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

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

## Solutions

Disseminate findings & community recommendations

Implement community recommendations for Student Health Survey

Modernized content and methods for adult survey systems

Build internal capacity & support for community engagement

Align with HTO

Grant for community led data systems using participatory budgeting process

# DISSEMINATION

The results (process, community recommendations, and OHA response) are being disseminated:

- Internally through PHD newsletters
  - Project team reports distributed through professional and social networks and on PHB website
  - Presentations to public health entities like CSTE and CLHO
  - Peer reviewed articles
  - Community briefs written and distributed by CBOs
  - Presentations to national audiences – the annual BRFSS conference
-

# LESSONS LEARNED & RECOMMENDATIONS

- Public health survey methods must be revamped
  - Integrate long-term, compensated community engagement at every step from design to dissemination
  - Allow sufficient time and resources for relationship building
  - Fund communities directly and sufficiently
  - Build capacity among community members
  - Build internal OPHD staff capacity
  - Share power and be transparent
  - Be flexible and willing to recognize mistakes and change course
  - Avoid overburdening community partners
-



# IMPLEMENTATION OF COMMUNITY RECOMMENDATIONS

## YOUTH SURVEY - STUDENT HEALTH SURVEY

Collaborate with community partners, OPHD programs & ODE to implement recommendations

- Designed and launched a Youth Data Council in 2022 focused on content, analysis, reporting and communication
    - ✓ Youth-led and grounded in principles of youth-adult partnership
    - ✓ 2023 cohort developed a video, analyzed data and are holding a data party this month
    - ✓ 2024 cohort will focus on survey content/making questions more relevant
  - Included open-ended questions in the 2022 SHS for greater context and to inform policy
    - ✓ Coalition of Communities of Color providing guidance on coding, analysis and communication of findings with an equity focus
    - ✓ Youth will be involved in coding, analysis and communicating findings
-

# IMPLEMENTATION OF COMMUNITY RECOMMENDATIONS ADULT SURVEY –BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

- Goals for modernized state surveys are to align with/support community-centered efforts/needs, be sustainable, and stay nimble to adapt to evolving methods
  - Working with OHA leadership and programs to plan for BRFSS
    - ✓ Vision for the need for data equity
    - ✓ Build division-wide commitment and infrastructure for sustained collaboration
    - ✓ Division-wide assessment and coordination of community engagement activities
    - ✓ Training & technical assistance
    - ✓ Flexible contracting and funding mechanisms that support sustained partnerships
-

# PROPOSED INITIAL FRAMEWORK FOR STATE ADULT SURVEY SYSTEM

- **Federally funded population-based surveys** to monitor core public health measures (e.g., Core BRFSS, Pulse Survey)
  - **Community-led data collection models** for specific community needs and priorities
  - **State BRFSS** that improves on Core BRFSS methods based on community recommendations, BRFSS pilot, and scientific research
  - **Complementary surveys** that are quick to implement and less expensive (e.g., panel surveys, Facebook surveys)
  - **Other existing data sources**
-

# PARTICIPATORY BUDGETING AND COMMUNITY LED DATA COLLECTION

More shall be revealed at the next PHAB meeting about this project.

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THE END

The background is a dark blue gradient with a field of small white stars. On the right side, there are several technical diagrams. One is a large circular gauge with a scale from 0 to 210 and a needle pointing to approximately 180. Another is a smaller circular diagram with concentric circles and arrows. A horizontal orange line is at the bottom of the page.