Acute and Communicable Disease Prevention Section's Heath Equity Work Group

2019 Mini Grant Final Reports

In the final quarter of the 2018-2019 biennium, the ACDP HEWG allocated funds from their budget to the creation of a program of mini grants. The vision for these grants was to provide between $5,000-$7,500 to organizations that were engaged in communicable disease work with a health equity component.

Six awards were distributed to Local Public Health Authorities across the state: Malheur, Washington, Linn, Harney, North Central Public Health Department, and a joint project between Crook/Deschutes/Jefferson.

This document is a complication of the awardees' final reports of what they were able to do with the funds from ACDP's HEWG Mini Grants.

Crook County Report

ACDP Health Equity Mini-grant Reporting – Crook County Health Department

Data Report
Quantitative Data:

Deschutes County Public Health (DCPH) hosted two community meetings, one in Bend on June 26, 2019, and the other in Redmond on June 27, 2019.

- The Attendance at the Bend, Oregon event (6/26/19): 30 People.
- The Attendance at the Redmond, Oregon event (6/27/19): 19 People.
- The number of partner organizations represented in the two meetings: 23 Organizations.

Jefferson County Public Health (JCPH) scheduled two community events (Madras and Warm Springs).

- The attendance at the Madras, Oregon event (4/23/19): 52 People.
- Confederated Tribes of Warm Springs Event (6/11/19): Cancelled due CTWS Emergency Declaration and drinking water issues. Rescheduled for September 2019.
- The number of partner organizations represented in the meeting: 18 Organizations.

Crook County Health Department hosted two community events, one in Prineville on April 7th, 2019 and one on May 14th at the Early Learning Meeting in Prineville.

- The Attendance at the Prineville, Oregon event (4/7/19): 55 People.
- The Attendance at the Early Learning Meeting in Prineville event (5/14/19): 12 People.
- The number of partner organizations represented in the two meetings: 19 Organizations.

Qualitative Data (Crook, Jefferson, Deschutes)

Based on the community meetings, partners think that local public health should:

- Provide more education about the many varied public health services.
- Serve as the community catalyst and convener.
- Assure DCPH staff has training on health equity.
- Provide access to more community-level health equity data.
- Support access to services using an equity lens.
- Be more deliberate in discussions on Social Determinants of Health
- Provide more education about the many varied public health services offered locally and in the region.
- Increase focus in all communities of Jefferson County; not just Madras area.
- Serve as the community point of contact for Social Determinates of Health issues.
- Increase staffing levels to support this type of work.
- Work with local partners to develop, compile, and share community-level health equity data.
- Highlight the importance of providing services through a health equity lens
- Improve communication to community partners.
- Include community partners in the planning of programs.

Deschutes County Reflection Narrative:
Deschutes County Public Health (DCPH) hosted two community meetings, one in Bend and the other in Redmond. Forty-nine participants from twenty-three organizations attended the meetings. The Board of County Commissioners had planned to attend but due to a last-minute change in the FY20 county budget approval process, the Commissioners were unable to attend. The DCPH Deputy Director, Hillary Saraceno, and Healthy Communities Manager, Thomas Kuhn, presented the Health Equity Report, including BAR HII results, to the commissioners on June 24, 2019. The presentation included an overview of the 2018 Deschutes County Health Equity Report followed by a lively discussion about the role of public health in addressing the social determinants and health equity. The commissioner's feedback and defined scope for public health work on the social determinants was used to help guide the ~~community~~ conversation during the community partner meetings.

The community meetings goals were threefold:

1) Provide community partners with brief training on the social determinants of health and health equity, followed by an overview of the BAR HII assessment results including:
    a. What the top six social determinants of health (SDOH) issues are in Deschutes County as perceived by staff, by community partners and by community members representing vulnerable populations who participated in 30 different focus groups.
    b. How effectively DCPH is addressing health equity as perceived by staff and as perceived by community partners.
2) Increase understanding of the ten essential public health services and how the SDOH and health equity fit within those essential services and the local public health role, statutes and planning.
3) Engage community partners in small group discussions to identify: a) the health equity needs DCPH should prioritize within its scope; b) the recommended strategic approaches for addressing the prioritized needs, and c) common interests and opportunities for collaboration.

What went well?

- Partners appreciated the overview of how the results of the BAR HII and the outcomes of the community meetings, fit within the context of other work being done in the community (i.e. the Regional Health Assessment, Regional Health Improvement Plan and the local Public Health Strategic Plans).
- Despite the time of year and other competing needs, the numbers of people attending the two community events were at, or near, capacity for the location.
- The local Public Health Advisory Board members attended the Bend meeting, participated in the small group discussions, and listened to community partner feedback and recommendations.
- There was a lot of interest in, and energy around, the topic of health equity and the SDOH. Community partners were very engaged during the meeting and in the discussion and many volunteered to collaborate on several of the identified priorities.
- Partners appreciated the respect for their time and appreciated how much we were able to accomplish within the amount of time we had allocated.
- Based on feedback from participants, while we went in assuming most of the attendees had a good understanding of public health, the information we included on the role and scope of public health and the SDOH was needed much more than we anticipated.

Feedback from partners during the meetings was valuable:

The top four priorities identified by community partners during the two meetings for local public health to focus on were:

1) **Cultural, language awareness/availability and stigmas:**
   Partners prioritized the importance of regularly scheduled staff trainings especially on LGBTQ+, cultural responsiveness, language access, and effective facilitation among people who are marginalized.

2) **Access to care:**
   DCPH should continue to focus on improving and assuring access to preventive health services, especially with an equity and SDOH lens.

3) **Behavioral and Mental Health*:**
   Substance abuse prevention and addiction, mental health promotion and early intervention needs to be prioritized, especially within the Latino population.

4) **Youth Health and Safety:**
   Need to focus on young children, youth and young adults, especially in areas of adverse childhood experiences, youth mental health, and substance abuse prevention.

Other learnings and general recommendations identified by community partners were:

- **Perceptions related to Mental Health Service Needs:** While staff and community partners identified mental health as the sixth highest SDOH need in the BAR HII assessment, vulnerable community members participating in the 30 focus groups identified it as the top SDOH need in Deschutes County.
- **SDOH Data:** A top priority focus area identified for public health is to provide access to data, including the impact of SDOH and health inequities on health, and on how to use the data.
- **Local Public Health Role:** There is a need to better define and educate the community about DCPH's scope of work, role and responsibilities, especially as it relates to the SDOH and health equity.

As always, there were also a few challenges:

- **Time of year impacted community meeting attendance:**
  - Summer vacations, end-of-year work closure and/or fiscal year wrap-up needs.
  - Partners in the education system (P-12 and higher ed) are generally very engaged partners in Deschutes County. However, "use-it-or-lose-it" leave time requirements and a variety of other competing events and trainings during the week of the community partner meetings, resulted in only one education partner being able to attend a partner meeting.
- **The mini-grant timeline did not align with our performance management system timeline**. While the information partners provided during the meeting was useful and will assist in local public health strategic planning, our regional health improvement plan will not be published until January 2020. It is difficult to commit to large projects or initiatives without knowing our Regional Health Improvement Plan priorities and strategies.
- **The role of public health in addressing the social determinants of health is not well understood** by many of our community partners. Our partners expressed an interest in public health playing a larger role as convener, catalyst and organizer – using the Collective Impact model – to bring people together to work on addressing the SDOH and health equity.

Moving forward, DCPH is committed to integrating health in all policies, to continuing to incorporate health equity into internal programs, policies and processes, and to including the community feedback in DCPH's strategic planning efforts. Resources to help DCPH explain the role and scope of public health, programs, and activities as it relates to health equity would help DCPH with needed capacity for external

facilitation, communication, and planning efforts with partners. To measure and assess progress, DCPH will continue to use the BAR HII health equity assessment.

Jefferson County Reflection Narrative:

Jefferson County Public Health (JCPH) had originally planned on hosting two (2) community meetings, one in Madras and the other with the Confederated Tribes of Warm Springs. The Madras community meeting had a strong turnout, 52 participants representing 18 separate local organizations, were able to participate. Three Jefferson County Public Health staff supported the development and delivery of the work; Health Services Director (Michael Baker), Public Health Nurse (Beth Ann Beamer) and AmeriCorps/VISTA (Courtney Barks).

The Warm Springs community event was unavoidably cancelled the day of the scheduled discussion due to a breakage in the primary drinking water distribution system. As no potable water was available to any of the buildings, the decision was made by Tribal Council to issue an Emergency Declaration and to cancel all planned events. Jefferson County Public Health is continuing to work on rescheduling and possible dates have been identified as early as late July or in the first weeks of September.

To continue the conversations identified in the Madras community meeting, Jefferson County Public Health staff will review the regional and departmental results of the BAR HII Health Equity Report at the all-staff meeting on August 1, 2019 in order to prepare for the follow up meeting in Warm Springs.

The community meeting goals:

4) There is a need to highlight the importance of working with a health equity lens and to provide training on the social determinants of health and health equity to local citizens, community partners, and local political leaders.
    a. Highlight the social determinants of health (SDOH) issues that impact the community.
    b. Explain how these SDOHs impact the entire community, not just those that are perceived as "in need".
    c. Identify how effectively local agencies (including Jefferson County Public Health) is addressing health equity as perceived by staff and as perceived by community partners.
5) Increase the overall awareness of, and understanding of, the ten essential public health services.
    a. Highlight how SDOH and health equity fit locally within the ten essential services and the local public health role, statutes, and planning.
6) Develop a mechanism to recruit and engage local and regional community partners to identify:
    a. The health equity issues or needs that can be prioritized locally;
    b. The ability of current partners to meet or address these health equity needs.

What went well?

- Strong turnout for the Madras community event.
- Partners, and individuals that attended, appreciated the ability to provide input on what they felt the greatest issues within the community are.
- Partners appreciated the respect for their time and appreciated how much we were able to accomplish within the amount of time allocated.
- Based on feedback from participants, more than just an initial session or discussion is needed.
- Many attendees voiced a desire to be more involved in follow up discussions and work.

Feedback from participants:

The top priorities identified by community partners during the meeting that local public health should focus on were:

1) **Behavioral and Mental Health:**
   Continues to be identified as the number one health priority for the community. Special attention needs to be directed towards substance abuse prevention and addiction as well as the mental health issues related to the high population of homeless in the county.
2) **Limited access to care:**
   The role of Public Health in providing direct client services is still unclear within the community (and among some of the staff). Jefferson County Public Health will have to identify how the preventive health services offered are essential when viewed with an equity and SDOH lens.
3) **School Health and Safety:**
   Graduation rates and attendance rates may be directly tied to health issues, including mental health. Schools and Public Health need to ensure the needs of the students are being met, especially as success measurements show a high variation among minority students.
4) **Socioeconomic factors:**
   Even with access to care, many in the community cannot afford adequate healthcare and therefore use it "inappropriately" (i.e. Emergency Room visits, no preventive care, only when needed for an illness).

General recommendations moving forward:

- **Local Public Health's Role:** There is a need to accurately detail and define the role of Jefferson County Public Health in working with Social Determinates of Health.
- **SDOH Data:** SDOH is not widely available or understood. Public Health should work on sharing data (including the impact of SDOH and health inequities on health), using the data, and how the data can be impactful in the community.
- **Mental Health Services:** Mental Health Services dominated much of the conversation and may need to become an additional or standalone conversation.

Challenges:

- **Scheduling:**
  - Mini-Grant implementation came during a time that there were several Public Health initiatives for public outreach and comments. Some participants asked why we were asking them to participate again.
  - Staff felt additional pressures to do another outreach event.
  - Water System breakage in June resulted in just Madras being presented in this work.
  - Limited duration of grant did not allow for rescheduling during timeline.
- **The mini-grant timeline did not align with the performance management system timeline**. As identified by other partners in this health equity grant, the Regional Health Improvement Plan (RHIP) will not be published until January 2020. It is therefore difficult to commit to large projects or initiatives without knowing the RHIP priorities and strategies.
- **The role of public health in addressing the social determinants of health is not well understood** by many in our community and within our own staff. While some of the attendees encouraged Jefferson County Public Health to be the lead agency in the discussion on Social Determinates of Health and health equity, others felt this was not the role of a governmental agency and Public Health should focus on those services mandated in each community. Others felt that there other

non-profit or community-based agencies that are better prepared to serve as the lead in this area, but their priorities would be different than that of Public Health

Moving forward, Jefferson County Public Health will continue to work on developing and implementing a structured health equity approach in all programs and services. Currently, the efforts have been limited to funding and program availability. As additional funding, resources, and focus on Social Determinants of Health increases, Jefferson County Public Health can utilize this momentum to create a successful foundation of health equity.

Crook County Reflection Narration

Crook County Health Department hosted two community meetings with very good attendance. Katie Plumb presented at the meeting on April 7th, 2019 and Muriel DeLaVergne Brown provided information at the May meeting along with providing information on the BAR HII Results to the county commissioners. The presentation included an overview of the Partner Survey followed by small group discussions focusing on the role of public health in addressing the social determinants and health equity. The team of Muriel DeLaVergne-Brown (Director), Katie Plumb (Prevention and Health Promotion Supervisor) along with the AmeriCorps – Katie Walsh created the materials.

The community meeting goals:

1) Provide the community partners with a brief training on the Social Determinants of Health, followed by the overview of the BAR HII assessment results.
    a. Highlight the social determinants of health (SDOH) issues that impact the community through a presentation and handout.
    b. Identify how effectively Crook County Health Department is addressing health equity as perceived by staff and as perceived by community partners.
2) Increase the overall awareness of, and understanding of, the ten essential public health services.
3) Engage community partners in small group discussions to identify:
    a. How well is CCHD addressing health equity in Crook County and how do we engage partners to help.
    b. Recruit partners for projects.

What went well?

- Strong turnout for the two events in Prineville.
- Partners, and individuals that attended, appreciated the overview on SDOH and the BAR HII results (We were listening).
- Partners appreciated the respect for their time and appreciated how much we were able to accomplish within the amount of time allocated due to the short presentation and the small group discussions.
- Many of the partners work with the health department regularly.
- Many attendees voiced a desire to be more involved in follow up discussions and work.

Feedback from participants:
The comments and priorities identified by community partners in each area during the meeting included:

1) **Behavioral and Mental Health:**
   Rewrite stigma, The WHOLE Person, Inclusion, Incorporating behavior health into primary care, homelessness, and expand out networks to increase partnership communication and referrals, opioid taskforce, education for kids.
2) **Reproductive Health; Limited access to care:**
   Access to care is still an issue in Crook County, provide more education in the schools, work with COCC campus for reproductive health assess, partner with the Landing (homelessness), need urgent care in Crook County. Continue to focus on access to care.
3) **Health Promotion:**
   Graduation rates and attendance rates may be directly tied to health issues, including mental health. Schools and Public Health need to ensure the needs of the students are being met, especially as success measurements show a high variation among minority students.
4) **Healthy Children and Families**
   Work with community development to help quantify and identify need, address issues with homelessness, rental properties are economic barriers (too high), create a "grandparents program" to educate on the effects of disease for the immunization program, provider education collaborations, utilize partners, importance of parenting classes.

General recommendations moving forward:

- **Local Public Health's Role:** There is a need to accurately detail and define the role of Crook County Public Health in working with the Social Determinates of Health.
- **SDOH Data:** SDOH is not widely available or understood. Public Health should work on sharing data (including the impact of SDOH and health inequities on health), using the data, and how the data can be impactful in the community.
- **Include partners in the planning of Programs:** There was a request to include partners in the planning and grant writing.

Challenges:

- **Scheduling is always challenging due to Health Department priorities.**
- **The mini-grant timeline did not align with the performance management system timeline**. As identified by other partners in this health equity grant, the Regional Health Improvement Plan (RHIP) will not be published until January 2020. It is therefore difficult to commit to large projects or initiatives without knowing the RHIP priorities and strategies.
- **The role of public health in addressing the social determinants of health is not well understood** and partners were encouraged by the discussion and department taking a lead in this area.

CCHD will continue this work as an area, integrate a health in all policies approach and improve our incorporation of health equity into programs and processes. This is one of the areas in public health accreditation of which we participate.

Harney County Report

ACDP Health Equity Mini-grant Reporting Template

Data

We served the community of PWID with our grant. There was not a syringe service program in Eastern Oregon prior to our program starting up. We had an estimate from law enforcement that there were approximately 100-150 PWID throughout Harney County.

Reflection Narrative

This grant helped fund the startup of our Syringe Services Program. 1 staff and 1 volunteer were able to attend harm reduction training at the beginning of the grant cycle which provided a framework for the work of the syringe service program.

With the resource of the Oregon Syringe Service Program manual, the volunteer put together the Harney county syringe service program manual, policies, and procedures and fliers regarding safer injection practices as part of her public health degree internship. She also developed a resource list which is included in each exchange "kit". She logged 300 hours of time doing this project.

We have advertised the program through peer-based efforts, posters in the health department exam rooms and local food banks. We plan to expand that through posters/fliers in the other major PCP office in the county and posters placed around town at the library, early child center, local parks, single-room occupancy hotels, convenience stores, smoke shops, cannabis stores

The director of the health department (myself) is the staff person involved in the program. We were successful in getting the program up and running in May and are keeping an exchange log of each encounter. Thus far in 7 weekly exchange opportunities we have had clients attend on 4 of those days. We have received approximately 900 syringes in 9 sharps containers, issued 1200 syringes and 12 sharps containers, dispensed 250 condoms and have done 1 rapid HCV and 1 rapid HIV test, drawn 1 HCV and 1 HIV test to be sent in.

We have purchased 1 outdoor medical waste container (sharps) which has been paid for and will be delivered mid-August and installed outside the health department so syringes can at least be disposed of safely at all hours of the day/night.

In my opinion the most essential part of this program startup was the planning phase. That included assessing community needs, stakeholder identification and engagement, developing procedures, holding an all health department staff training, meeting with community stakeholders independently and then providing a joint meeting where their concerns were addressed was essential to the success of the program. We engaged with city mayors, county commissioners, librarian, school officials, EMS supervisor, Hospital CEO, PCP's, law enforcement, pharmacies, faith-based recovery program, a tribal counselor, OHA staff, Symmetry Care, and EOCCO.

The biggest limitation is availability of staff to do this on a daily basis. I have carved out 1.5 hours every Friday afternoon to do the syringe exchange program but have had 3 occasions when PWID's showed up at other times to do an exchange when the SSP staff was not available. These were missed opportunities but due to staff shortages could not be avoided. An additional limitation is lack of funding for Naloxone purchase for distribution.

Participation in this grant has afforded me (director) the opportunity to be involved with the HIV, Hep C, and Opioid prevention programs at OHA. As a result, I was put in touch with Mike Stensrud who, through a grant he received earlier this year, is going to help us put on an Overdose and Naloxone awareness event in September of this year. Through that I hope to increase awareness of opioid overdose, increase availability of Naloxone to all interested stakeholders in the community, increase number of RX's of Naloxone dispensed by Safeway and Rite-Aid pharmacies, increase PCP RX's written for patients who also receive oral opioid RX's, and finally increase awareness of the syringe service program.

This grant has created a ripple effect of awareness and prevention in our community and throughout EOCCO. I have been asked by the EOCCO Clinician Advisory Panel/Opioid work group to give a presentation at one of their quarterly meetings. They are hoping to use our program as a model for other programs throughout the EOCCO region.

Sharing
Please include any materials created with the grants, such as flyers, posters, brochures, assessment reports, and any relevant handouts. Feel welcome to publicize or share about the impact of this grant so the community can learn about the ways we are working together. We in-turn want to do the same and share the great things you're doing and to publicize the partnership between your organization and our health equity work group. Providing a suitable photo of your program/project/activity that can be shared would be appreciated!

Financials Attach a budget report that shows both budgeted and actual numbers for the program or project to date. If you prefer, you may use a budget format common to your organization as long as it addresses the items requested. Please describe any "In Kind budget items or "Other" revenues and expenses in the section provided.

Other attachments If you would like to provide additional, pertinent information about your program, project or organization, please use the space provided. Attachments are permitted.

Linn County Report

Linn County Public Health (LCPH) was awarded grant funds totaling $5173.56 to purchase equipment for the Immunization program. LCPH purchased a refrigerator/freezer for the East Linn office, a freezer for the Albany office and power adapters for the vaccine coolers. In deciding how to best utilize the funds, LCPH chose to increase capacity for the immunization program. LCPH used to offer Immunization services in our East Linn office, but the refrigerator and freezer for that office was not holding the accurate temperatures to ensure vaccine viability. These funds enable Linn County to extend our immunization program again to our East Linn facilities.

We have now purchased and installed the new equipment. We are installing the loggers and connecting the sensaphone. As soon as that has been tested, we will be able to order vaccine and schedule immunization appointments at our Lebanon location. We also purchased a freezer for our Albany location, this will give us extended equipment life to ensure we can continue our immunization program at our Albany location. Funds were also used to purchase power converters and extension cords for our portable vaccine coolers. These will allow us to travel with vaccines or use the coolers as short term storage in case of emergency.

Malheur County Report

ACDP Health Equity Mini-grant Reporting Template 2019
Malheur County Health Department

Data—Who was served with grant funds? Please provide an explanation of the metric you use to determine the community served and amount of people.
We used program process measures, including the number of outreach clinics and health fairs provided, number of individuals reached during health fairs and outreach clinics, number of individuals that received screens/risk counseling and/or testing.

Reflection Narrative—Provide a brief explanation of the program funded and lessons learned. Include goals, outcomes, activities, and desired vs. actual results. Your response to this section will help us understand specific successes or challenges associated with this project.
Our goal: To provide outreach clinics to offer screening/risk counseling and immunizations to at least 250 individuals by through collaboration with our local jail, meal sites, homeless shelters, transitional housing, and recovery centers. We also planned to offer outreach clinics in the more isolated areas of Malheur County.

Jail: We had a plan to go to the jail at least twice a month and screen/test and/or treat inmates. It was originally agreed upon that the jail Lieutenant would collect consents from the inmates at the jail the week prior to our visit, this way we could look up inmate's immunization status and bring vaccines as needed. However, the Lieutenant didn't feel as if she had the time to do this and instead asked us to come to the jail and screen interested individuals for STI testing. This process worked out well because many individuals were interested in receiving screening and testing, and we were able to talk to them about the importance of vaccines and were able to take vaccines back to offer them to those individuals that expressed an interest. I wish we had more staff available and time to commit to the jail as it was a time-consuming process and there was a vast interest. Another challenge that we found was that in order to see inmates, there needed to be two staff present at all times and the jail did not have staff available to help, so we had to provide two nurses for this outreach clinic.

Health Fairs: We felt like attending the health fairs was valuable. We were able to provide education and/or screening to many individuals during our health fairs. We attended 7 health fairs (even though we planned on 6) with 1,062 participants total. We distributed 962 informational packets, screened/counseled 176 participants, and provided testing on site to 7 individuals. It was a challenge getting individuals to agree to onsite testing, but many were interested in screening/counseling and referrals for testing, and we were able to schedule individuals for future screening. We partnered with the immunization coordinator during the community college health fair and were able to offer HPV vaccines at the same time, which we felt was a success.

Homeless shelter: Our hope was to offer screening/testing and counseling at the homeless shelter. Although we weren't able to test any individuals at the site, we were able to provide education and screening to some. One success that we feel proud of is that since this project started, we have had individuals, that identify as homeless, seek screening/testing at our site. They stated that they were either present, or knew someone that was present during our time at the shelter that told them about our services. This project has opened up a unique partnership that we are proud to have with the homeless shelter. We continue to work with them on other projects such as at the meal sites, and will continue to offer screens/tests/treatment and foster relationships with this population.

Recovery Center: We hosted off site clinics at the in-patient recovery center in Malheur County. We had a very successful turn out. Our plan was to schedule approximately 5-6 people per clinic. However, the manager that was helping coordinate this forgot the process and allowed 18 individuals to sign up on the very first clinic scheduled. The struggle was that we had our CD nurse planning to go by herself, but we ended up puling another nurse from our home visiting program to assist (and we didn't account for this, and her time was provided as in-kind). We screened, tested and provided education/risk reduction counseling to 18 people. That doesn't sound like a huge number but getting back to the clinic after an 8-hour day and still having to chart on 18 people and prepare labs to be picked up next day ended up being a 12-hour day, that ran into the next day. This was a huge success but also a challenge. We were more prepared for the next clinic and had pulled someone from our office staff to help with paperwork as well. When we returned the following week, we provided treatment and elicited partner information for those positive tests and were able to provide education and screening as well for new clients. We all agreed this was a successful and fulfilling event and will continue to offer this service if capacity allows.

We are also interested in knowing what changes you might make to improve your program/project/activity and if this project could be carried into the future or replicated.
Ideally, it would be helpful to have additional staffing for this project. We wish we had the capacity to continue to offer off site clinics because we know that there are many barriers to individuals receiving services, and transportation is just one of them. We have learned through this project that If we could just meet people where they are, and offer services, more individuals would use it.

Sharing—Please include any materials created with the grants, such as flyers, posters, brochures, assessment reports, and any relevant handouts. Feel welcome to publicize or share about the impact of this grant so the community can learn about the ways we are working together. We in-turn want to do the same and share the great things you're doing and to publicize the partnership between your organization and our health equity work group. Providing a suitable photo of your program/project/activity that can be shared would be appreciated!
We used different fliers depending on where we were holding clinics. For the Jail, we were able to post fliers throughout the facility to inform inmates about the opportunity and to encourage them to "sign up" prior to the clinic. The following flier we used and added the dates that we planned to host a clinic. We also created a similar flier that we used to share throughout Malheur County, that included a tear off phone number. For the second flier, we focused on agencies and areas where we knew our target population may be:

THE MALHEUR COUNTY HEALTH DEPARTMENT IS OFFERING **FREE** SCREENING/TESTING FOR:

CHLAMYDIA/GONNORHEA

RAPID HIV/SYPHILIS

HEP B/C TESTING

HEP A/B VACCINE

SIGN UP FOR THIS FREE SERVICE!

To learn more, please ask Jail staff.

THE MALHEUR COUNTY HEALTH DEPARTMENT IS OFFERING **FREE** SCREENING/TESTING FOR:

CHLAMYDIA/GONNORHEA

RAPID HIV/SYPHILIS

HEP B/C TESTING

HEP A/B VACCINE

CALL TO SCHEDULE AN APPOINTMENT FOR THIS FREE SERVICE!

541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279	541-889-7279

We also created a consent form to use with agency staff. These were created to allow us to check ALERT prior to the clinic. We used this with some of our off-site clinics:

County of Malheur

HEALTH DEPARTMENT

1108 S.W. 4th Street • Ontario, OR 97914 • (541) 889-7279

The Malheur County Health Department would like to offer you free screening and/or testing for Chlamydia/Gonorrhea, HIV, Syphilis, Hepatitis B/C and immunizations for Hep A/B. If you would be interested in being screened for these services, please sign consent so we can check Oregon State Registry for your past immunizations.

Name (please print): _____ DOB:_____

Signature:_____ Date: _____

*****These consent forms were accompanied by the following letter to agency representatives:**

County of Malheur

HEALTH DEPARTMENT

1108 S.W. 4th Street • Ontario, OR 97914 • (541) 889-7279

May 3, 2019

ATTN: Community Partners,

I have attached a consent letter for any patient's that are interested in having STD, Rapid HIV/Syphilis/Hep B/C testing and Hep A/B vaccine. Please have them read and sign, then please fax back to Malheur County Health Department so we can prepare for a visit for testing/vaccine administration. Our fax number is: 541-889-8468.

We are excited to be able to reach out to those who may not have access to these tests. We would like to start testing as soon as we can and will continue with testing/vaccine until the end of June, 2019.

Thank you for partnering with us, and we look forward to hearing from you.

Tana Waller, RN
Communicable Disease Coordinator
1108 S.W. 4th Street
Ontario, Or. 97914
541-889-7279

We also created sign-up sheets that included the client's name and DOB so we had an idea of how many people to expect, as well as a template for recording the number of participants. In addition to marketing materials, we provided educational handouts (and tracked the number of packets distributed) to clients that included information about the specific diseases we were testing for, risk reduction practices, and CDC recommended testing schedule along with our testing site for future testing.

North Central Public Health Report

North Central Public Health District ACDP Health Equity Mini-grant Report

Jeremy Hawkins

GOAL

The overall goal of this project was to use these grant funds to enhance and expand NCPHD's harm reduction services.

PROPOSED OUTCOMES

Originally, the proposed outcomes were: 1) Purchase three community sharps disposal containers & associated materials (decals and inner containers) to collect and dispose of injection drug equipment, and 2) additional funding would be used to pay for additional sharps disposal pickups or for marketing harm reduction services, and a small amount of the funds would go to personnel time.

ACTIVITIES

We began by seeking quotes for community sharps kiosks from companies that were recommended by staff at OHA and Multnomah County. After finding one with a model we liked in our price range, we went ahead and ordered 3 wall-mounted kiosks and two 20-packs of inner disposable sharps containers at the beginning of June 2019.

Next we sought a quote from our sharps disposal service on how much it would cost to increase the frequency of our pickups. We currently only get pickups once per quarter (4/year), but the remaining funds were not enough to increase the frequency of our pickups in a meaningful way. We discussed the backup plan of using the remaining funds for marketing activities, but decided it wasn't feasible given the short turnaround of the grant funding period.

Ultimately we decided to use the remaining funds to purchase 18 two-packs of NARCAN. It ended up being a good way to make sure the funds were spent down before the deadline, and also still enhance our harm reduction services.

DESIRED vs. ACTUAL RESULTS

We received the sharps kiosks on 7/30/19, a little later than we had anticipated.

Notwithstanding the delay, we are moving forward with the program by evaluating potential locations for the kiosks, and garnering support from partner agencies. So far, we have received endorsements from the North Wasco County Parks & Rec District, which owns and manages most of the city parks in The Dalles, and both the Wasco County Sheriff's Department, and City of The Dalles Police Department. The Parks & Rec department has already agreed to let us put a kiosk up at any of their properties. However, our current first choice is a park that is owned by the City of The Dalles (Lewis and Clark Festival Park), and will likely require approval from the City Manager and/or the City Council. We're still exploring options for Sherman and Gilliam counties, though likely candidates include the Biggs Junction truck stop at the intersection of I-84 and Highway 97 in Sherman County, and the waterfront park in Arlington in Gilliam County.

As mentioned previously, our original intent was to use leftover funds towards increasing our sharps pickups, or marketing our harm reduction services, neither of which panned out. Instead we used the funds to purchase 18 NARCAN kits.

After several meetings with the medical staff at Northern Oregon Regional Correctional facility (NORCOR), the jail has agreed to help us use the kits to create a pilot program of sorts to get naloxone into the hands of people who use opioids or who have close friends or family who do as they are released from jail. Participants will be recruited by the jail medical staff as part of a health screening that is given during the booking process. They'll be asked a few targeted questions regarding their drug use behaviors, and willingness to receive or administer NARCAN. If they agree to participate, they will receive brief training on administering NARCAN, and receive one kit along with information on preventing drug overdose upon being released from jail. Participants will also agree to receive a communication from the health department in the future to assess for usage of the NARCAN. We hope to use data gathered from this limited pilot program as evidence to support further funding and expansion of the program if it is successful.

We are currently in the process of working out the details of participant recruitment and what questions they will be asked, along with creating an MOU between the jail and NCPHD.

Data

These funds were used to fund two separate projects under NCPHD's harm reduction program. The target population for this grant was people who use illicit drugs, particularly opioids. Both programs are currently in the development phase, so there isn't currently any data to share, though both should eventually generate data that will be useful for informing future efforts. For example, data from these projects may be used to support implementation of a syringe exchange program in Wasco County, or to continue and expand the NARCAN program with NORCOR.

Some data were used in the process of deciding what to use the grant funds for. The Oregon Health Authority's Opioid Data Dashboard shows that Wasco County was in the top five among Oregon counties for rate of drug overdose hospitalizations for all drugs in 2017 (the most current year available). For heroin or other opioids specifically, our counties have some of the lowest rates of overdose hospitalization.[1] However, we know that people are often poly-substance users, or fluctuate back and forth between multiple substances depending on what is available at the time. Anecdotally, interviews with both the director of North Wasco Parks & Rec and a Sheriff's deputy from Wasco County revealed that their agencies find used injection equipment both at our local parks and in the community at large.

With regards to the NARCAN pilot program, several studies have shown that jail inmates that use opioids are at significantly elevated risk for opioid overdose death upon being released from jail, presumably due to diminished tolerance while incarcerated. One such study from North Carolina that was published in the September 2018 edition of the American Journal of Public Health found that over a 16 year period from 2000-2015, former inmates who identified as opioid users were 40 times more likely to die of overdose within two weeks of being released compared with NC residents. When examining the type of opioid used, inmates who were heroin users were found to be 74 times more likely to die of overdose within two weeks of being released.[2]

Attachments

Figure 1. Community sharps kiosk with associated materials

Figure 2. One NARCAN Kit

Citations

1. Prescribing and Overdose Data for Oregon. (n.d.). Retrieved July 30, 2019, from https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/data.aspx
2. Ranapurwala, S. I., Shanahan, M. E., Alexandridis, A. A., Proescholdbell, S. K., Naumann, R. B., Edwards, D., Jr., & Marshall, S. W. (2018). Opioid Overdose Mortality Among Former North Carolina Inmates: 2000-2015. American Journal of Public Health,108(9), 1105-1264, 1207-1213.

Washington County Report

ACDP Health Equity Mini-grant Reporting – Washington County Public Health Rapid Testing and Response to Persons Unstably Housed in Washington County.

Data

Washington County Public Health (WCPH) was glad to be able to use this grant to expand our ability for outreach testing to a sub population in our community that remains difficult to reach. Current estimates from the Point of Time federal survey put the number of un-housed persons in Washington County at 500 on any given day. This number does not account for those persons that are unstably housed, exchanging drugs or sex for housing, or "couch surfing". We also know that injection and illicit drug use, mental illness and minority stigma play a crucial role in limiting both housing stability and access to preventive health services. The transient nature of seeking shelter means that county borders remain invisible and persons move throughout the metro region regularly, making the ability to accurately count numbers difficult. 25% of persons accessing syringe exchange services at Outside In report a connection to Washington County. Persons who are housed in the Washington County Jail and the Community Corrections program are often released with drug and other minor offenses back into the community with no fixed address to return to. It is with the above knowledge coupled with increase rate of syphilis, HIV and Hepatitis C in persons who inject drugs WCPH determined the need to expand testing services into the field. To reach persons where they are at, decrease barriers to testing and improve referral services to a marginalized population in Washington County is a key component of our grant.

Reflection Narrative:

Grant funds where used to purchase 300 rapid tests to use in field testing operations beginning in July. Control solutions, lancets and three at Home HIV tests for contacts to HIV that may refuse testing in any place other then home setting.

The rapid point of care tests includes Hepatitis C, Syphilis and HIV test kits. WCPH has purchased and outfitted a testing van that includes two private testing rooms and supplies to complete testing, referral and education to persons in nontraditional settings through separate grant funding. The van will travel to homeless camps and a consistent location on a weekly basis to provide testing services, syphilis treatment and syringe exchange services to decrease the burden of disease in this vulnerable population.

We just acquired the kits at the end of June and have just begun outreach testing. So far, the schedule includes Project Homeless Connect on July 19th. This event will include testing services as well as vaccine administration of Hepatitis A vaccine to persons unstably housed. We are also scheduled for Virginia Garcia Cornelius Health Fair and Neighborhood Health Center Health fair, both of which serve a large number of minority residents and their families.

Starting in September, and with the permission of the City of Hillsboro Parks and Recs, we will be stationed weekly at Dairy Creek Park. Here we will provide rapid testing services, vaccine administration and syringe exchange. The purchase of rapid tests through this grant will allow us to treat syphilis infections, provide HIV wrap around services for persons newly infected with HIV and referral services for persons with Hepatitis C. Vaccine administration for Hep A and minimal would care will also be available. A public health nurse as well as contracted syringe exchange peer navigators will be co-located on the van.

Sharing:
We currently do not have flyers but will be creating them in the next few weeks. The following photos are of the van that has been active this summer at testing events. So far, we have been working hard doing outreach and education to Hillsboro Police, Washington County sheriffs dept., mental and behavioral health providers, peer recovery mentors and Community Corrections staff to gain support for our work. We will be contracting with a CBO to provide peer lead syringe exchange along side the public health nurse at field sites early September.