AGENDA

PUBLIC HEALTH ADVISORY BOARD

July 23, 2020, 2:00-4:00 pm

Dial: 1-877-873-8017
Access: 767068#

Meeting objectives:

- Approve June meeting minutes
- Discuss racism as a public health crisis
- Determine next steps for updating PHAB Health Equity Review policy and procedure
- Discuss the COVID-19 response
- Approve 2020 Public Health Accountability Metrics Report
- Receive an update from the Incentives and Funding Subcommittee
- Discuss important topics for PHAB members

2:00-2:05 pm	**Welcome and agenda review** • ACTION: Approve June meeting minutes	Rebecca Tiel, PHAB Chair
2:05-2:35 pm	**Leading with race** • Discuss racism as a public health crisis • Discuss next steps for updating PHAB Health Equity Review policy and procedure	Rebecca Tiel, PHAB Chair
2:35-3:00 pm	**COVD-19 response update** • Discuss response activities to date • Review active monitoring strategy • Discuss equity in COVID-19 response	Dean Sidelinger and Lillian Shirley, OHA staff
3:00-3:40 pm	**Review draft 2020 Public Health Accountability Metrics Report** • ACTION: Approve report • Discuss next steps for Accountability Metrics Subcommittee	Kusuma Madamala, Program Design and Evaluation Services

3:40-3:45 pm	**Incentives and Funding Subcommittee Update** • Provide an update on the review of the public health modernization funding formula • ACTION: Approve Funding Principles • ACTION: Approve statement of expectation for use of Funding Principles in funding decisions • ACTION: Approve 2021-23 funding formula	Bob Dannenhoffer, PHAB member
3:45-3:50 pm	**PHAB member discussion** • Discuss key issues that PHAB members should be aware of or should help problem solve on behalf of the public health system	Rebecca Tiel, PHAB Chair
3:50-4:00 pm	**Public comment**	Rebecca Tiel, PHAB Chair
4:00 pm	**Next meeting agenda items and adjourn** • Determine August meeting schedule	Rebecca Tiel, PHAB Chair

bnhPublic Health Advisory Board (PHAB)
DRAFT June 18, 2020
Meeting Minutes

Attendance:

Board members present: Dr. Jeanne Savage, Dr. Eli Schwarz, Kelle Little, Dr. Bob Dannenhoffer, Rebecca Tiel (Chair), Dr. Sarah Present, Dr. Veronica Irvin, Dr. David Bangsberg, Eva Rippeteau, Lillian Shirley (ex-officio), Teri Thalhofer, Muriel DeLaVergne-Brown, Dr. Dean Sidelinger, Akiko Saito, Rachael Banks, Alejandro Queral

Board members absent: Carrie Brogoitti

Oregon Health Authority (OHA) staff: Cara Biddlecom, Danna, Drum, Krasimir Karamfilov

Members of the public: None

Welcome and Agenda Review
Rebecca Tiel

Ms. Tiel welcomed the PHAB to the meeting and invited the board members to take a moment to recognize the power that the PHAB had and should use to move racial equity work ahead in light of the murders of George Floyd, Breonna Taylor and Ahmaud Arbery and the over 1,000 people killed by police each year. There have been longstanding inequities in public health work due to systemic racism and oppression and the PHAB started this work initially with its equity review policy and procedure, the funding formula, the investment in public health modernization being focused on health equity and cultural responsiveness, and the board is by no means finished. She asked if board members had any other thoughts about how the PHAB should shape its work ahead.

Dr. Present remarked that public health had always been rooted in social justice. The PHAB has the ability to talk both about the pandemics right in front of us, like COVID-19, and long-term issues, like racism. For a while, people have been calling on the public health community to name racism as a public health crisis. Many of the public health solutions are geared towards that. The public health community understands the social determinants of health and has been advocating for a long time for more investment and prevention in upstream strategies. Our science and overall approach can be offered to people looking for a different type of investment that divests from downstream and tertiary interventions in criminal justice and other things and reinvest that in the upstream.

Dr. Schwarz stated that he had been very happy and proud that the PHAB had wide-ranging discussions three years ago about health equity and how to include the discussions about

health equity and the different structures in our society in the board's decisions. He had to look at the PHAB health equity review policy and procedure yesterday, because the Health Share board was discussing something very similar. He informed the Health Share board that the PHAB had a document from 2017 but couldn't remember if the document had been updated. He wondered if the present situation required of the PHAB to look at the policy and procedure and see if it was still current and whether it needed changes.

Ms. Tiel agreed and suggested that this could be a future agenda item.

Ms. Thalhofer shared that she had been thinking a lot recently about the benefit her white privilege had given her, and really thinking about sitting back and listening to members of communities of color and not trying to instinctively justify their responses, and just sit in the discomfort of listening. Even when those of us in a position of power, who are white, go out and listen to communities of color, we then want to interpret for them, and say, "We went out and listened to these community-based organizations and they told us X, Y, Z." It's really important that we start to yield the power and not be the ones interpreting the experiences, but letting those communities of color speak for themselves. That's going to take a shift in Oregon. It's not going to be comfortable, because nobody likes to yield power, but we are going to have to sit in our discomfort for quite a while to make a difference. She is ready to do that, and really ask her colleagues, who experience that white privilege, to do it as well.

Ms. Tiel noted that it was really important to recognize that when convening people from the public health perspective, the process was beyond cocreation. As Ms. Thalhofer pointed out, it was about sitting back and listening.

Ms. Tiel informed the PHAB that Ms. Thalhofer was retiring at the end of the month. This is Ms. Thalhofer's last board meeting. She has been on the PHAB since its current iteration and has been a public health leader since before the board was created in statute. She thanked Ms. Thalhofer for her contributions to the board, the public health modernization, and representing her region and the state.

Ms. Thalhofer thanked Ms. Tiel and added that it had really been an honor to be a part of public health modernization and it had been great working with all board members. She will not disappear. She will be listening to the board to see what happens. It's a really exciting time, and she is stepping out with a lot of mixed emotions in the midst of a pandemic, but no time would have been perfect. The thanked the board.

Ms. Biddlecom added that the other retirement (in the fall) during this pandemic, Ms. Lillian Shirley, was shared in an email this morning. The board is very excited for Ms. Shirley and Ms. Thalhofer to be able to spend more time with their loved ones. The PHAB appreciates their dedication to public health for such a long time.

Ms. Shirley shared that she would be around for a couple of more board meetings. As opposed to two months ago, when OHA had a workplan, now we are very stretched in terms of resources, communications, and many other things. But public health has landed on a framework: we know we have to test, investigate, trace, and support. This was a good time for her to bring up her retirement plans and respect both Director Allen and her colleagues with whom she works, to give them some time in this transition. Unlike Ms. Thalhofer, she won't listen (to see what happens).

- *Approval of May 2020 Minutes*

A quorum was present. Ms. Rippeteau moved for approval of the May 21, 2020, meeting minutes. Dr. Present seconded the move. The PHAB approved the meeting minutes unanimously.

COVID-19 Response Update
Dr. Dean Sidelinger, Lillian Shirley, Akiko Saito

Dr. Sidelinger provided an update to the PHAB with the latest COVID-19 developments:

- 148 new cases today; total around 6400; 4 additional deaths
- Oregon continues to have one of the lowest case rates in the country
- Increased cases seen since reopening the state on May 15; workplace outbreaks and congregate care facilities account for most of the increase
- The percentage of cases not traced back to a source is increasing, which indicates community spread
- The weekly surveillance report comes out on Wednesday
- Age group 20-29 has the most cases, due to workplace outbreaks
- The data for Hood River, Polk, and Marion counties, which applied for entering Phase 2, looks good; the data for Multnomah County, which applied for entering Phase 1, looks good
- Seven counties will enforce mandatory face covering guidance: Multnomah, Clackamas, Washington, Marion, Polk, Lincoln, Hood River
- Due to the outbreak in Union County, the county's board of commissioners voted for residents and businesses to revert to Phase 1 to minimize spread
- Traveling around the state is not recommended
- Funds and resources are being directed to LPHAs and community-based organizations (CBOs) to help in the response effort
- The state response is being restructured

Ms. Saito added that the COVID-19 response needed to have a cross-agency unit. It's called COVID Response and Recovery Unit (CRRU). The unit had a footprint in Salem at a Health and

Human Services branch. The agency operation center (AOC) is in Portland. The response effort will continue from the AOC. Some of the work that has come out of CRRU includes work around playbooks. The food production playbook is ready and posted on the OHA website. The farmworker playbook is close to being finalized. The CRRU will lead with health and service equity focus and will be designed to be more nimble and integrated. The CRRU will work over the next 12-24 months.

Dr. Sidelinger noted that the focus on health equity was huge in this response. The inequities are seen in communities of color. Some of the disability communities are also overrepresented in the data. OHA is working with OR-OSHA and the Department of Agriculture partners to ensure that there are workplace protections. LPHAs are trying to get outreach in the community to ensure testing occurs where people live from organizations and people that they trust. In terms of data, there is a significant amount of missing data in the negative test results. Some of the data that is there doesn't seem to be accurate. More testing is needed in all these communities, regardless of what the data shows.

Ms. Rippeteau expressed gratitude for using COVID response money for the quarantine and having a lot of support in ensuring that people have financial support for housing, food, and services like childcare. One of the things the community partners are finding is that people don't have access to paid time off. The federal COVID family and medical leave doesn't cover everybody. People who work at places with fewer than 50 and more than 500 employees are no covered. If these people don't have access to paid time off, that's still a barrier for them to feel comfortable taking the time off or coming forward when they are sick. She asked if there was a way for public health to elevate and highlight this issue. It was hoped that this would be covered in the COVID-related special session that is happening next week, but it didn't make the list.

Ms. Shirley agreed with Ms. Rippeteau and recognized that public health was not in control of a lot of these funding streams. It doesn't mean that OHA can't influence the conversation. Some of the work Ms. Saito called out is exactly to see how some of these dollars can be braided. It's an enormous barrier for people to admit that they don't feel good, or if they are contact that they have to be tested. This has become evident in the last 10 days cross communities. It is not easy administratively do make these changes. Mistakes will be made and people will misinterpret some of the work. OHA is changing its understanding of what needs to be done to achieve equity and ensure that Oregonians can achieve their maximum health regardless of who they are and where they live.

Dr. Savage echoed Ms. Rippeteau's gratitude. She solicited some questions from the leaders in the CCO world. One of the biggest questions is about how CCOs and public health can communicate around the work that public health is doing with the contact racing and the coordination of that care. She asked about the best practices for contract tracing going forward

and asked whether the PHAB could suggest best practices for helping the communication between public health and the CCOs.

Ms. Shirley answered that OHA's work with the CCOs and the hospitals was figuring out how to protect their access, capacity and PPE. Right now, OHA is trying to reconcile all these work streams in some places of the state (e.g., Eastern Oregon). In the small counties there, it is all hands on deck for the response, including the hospitals and the CCO. In different parts of the state, people are solving those problems locally themselves. Also, the state has refocused its regional hospital system and regional hospital work with the healthcare system. Now that challenge is in connecting them with both the public health system and the CBOs, as the state moves forward and implements new models for public health. Ultimately, it will protect the population and give better access across the system.

Ms. DeLaVergne-Brown added that in Central Oregon they involved the CCO very quickly. For example, Crook County, Jefferson County, and Wheeler County initiated a conversation about doing a fast clinic during an outbreak with St. Charles Health. The work is a collaborative effort.

Academic COVID-19 Surveillance Studies
David Bangsberg (OHSU-PSU), Javier Nieto (OSU)

Ms. Tiel stated that at the last PHAB meeting, the board asked for an overview of each of the COVID-19 surveillance studies going on in Oregon. Dr. David Bangsberg will share about the Key to Oregon study and Dr. Javier Nieto from OSU will share about the TRACE study.

Dr. Bangsberg explained that the objective and goal of the Key to Oregon study was the understand the prevalence of COVID-19 throughout the state regionally and over time, in order to give OHA and Governor Kate Brown the information they need for evidence-based health policy, as we adapt to rolling back the physical distancing and other interventions that have been so effective. The initial approach to the Key to Oregon study was to invite 150,000 households throughout Oregon with the goal of recruiting 100,000 people. Households are randomly selected throughout the state. Households were oversampled for zip codes where prevalence of underrepresented minorities was greater than 50%. Households were also oversampled if they were in a rural zip code. The individuals who agree to participate are asked to engage in daily symptom monitoring, with the addition of a smart, Bluetooth-enabled thermometer to track symptoms. Individuals who develop symptoms that are consistent with COVID-19 are offered a free COVID-19 test by mail for self-administration.

Dr. Bangsberg added that OHSU was planning to provide testing to up to 10,000 people without symptoms over time to examine the prevalence of asymptomatic COVID-19 infection. Households were invited with a postcard and were provided with a letter. They signed up on the website and provided consent. In the rush to launch the study and provide as much data as possible as Oregon starts to reopen, OHSU made some important mistakes. One of them was

announcing the study before seeking out the input of communities of color and tribal communities. OHSU received a letter from community leaders who addressed that concern. Based on that feedback, OHSU has put additional recruitment and engagement activities on hold until OHSU added new recruitment strategies or changed existing recruitment strategies. Currently, there are 8,600 individuals who have consented and enrolled in the study.

Dr. Savage asked about the process for managing the collected information and the exchange of information between the individual and their PCP (primary care provider).

Dr. Bangsberg answered that the individual results of the COVID tests were reported to the OHA. Each participant has a participant navigator. The navigator will ask the participant whether they have a primary care provider. If an individual is feeling sick, the navigator helps with the hand-off to the clinical care system and their PCP. If they don't have a PCP, OHSU will help them find a new PCP. The positive tests are received by OHA, whose team follows up with contact tracing and works with community health workers, who talk to the participant about home isolation.

Dr. Savage asked if there was something the participants had to sign that said that they agreed to release their information to their PCP.

Dr. Bangsberg answered that it was written in the consent form that all COVID test results would be released to OHA. There is no disclosure to clinical providers unless the participant requests it.

Dr. Schwarz asked how long it would take to recruit 100,000 people.

Dr. Bangsberg answered that it depended on how OHSU adapted, modified, or changed its recruitment strategy based on community engagement. Initially, OHSU planned several reminder mailings for the first collection of 150,000 households. OHSU sent one postcard and one mailing. This resulted in just under 10% of the intended sample. It's quite feasible to recruit 100,000 with reminders and additional sampling over a few months.

Dr. Nieto thanked Dr. Bangsberg for his comments. What Oregon State University is trying to do with its TRACE study is very complimentary to the Key to Oregon study. Similarly to the Key to Oregon study, the TRACE study will examine the prevalence of COVID-19 in the population. The goal is to take a pulse of the state of the epidemic in the population. That's where epidemics occur, not in individual cases. We cannot manage a pandemic in a way that is rigorous and evidence-based without knowing what's happening in the community. That's because there are so many asymptomatic cases. Simply counting the symptomatic cases will not give us a full picture.

Dr. Nieto clarified that TRACE stood for *team-based rapid assessment of coronavirus epidemics*. The study's objectives included estimating the prevalence of COVID-19 infection in a community in near real time, developing a scalable system that can be rapidly deployed in other communities, and harnessing untapped potential in universities to adapt and respond to COVID-19. The sampling strategy is rapid health assessment. Assessment area is identified by political boundaries or sections of specific communities. The area is divided into non-overlapping sections (i.e., clusters). The sampling frame is the list of all clusters. Probability sampling will allow the collection of data that are representative. The field teams will include traditional health workers or other community health workers, as well as OSU students.

Dr. Nieto explained the experience at the doorstep for participants in the study. Once samples are collected, they are brought to a lab for analysis. So far, five date collection sessions have taken place (4 in Corvallis and 1 in Bend), all including 30 neighborhoods. The average participation rate has been 76%. Overall, the prevalence has been very low, but not zero. The estimate of city-wide prevalence is 1 per 100,000 people. The study also tracks coronavirus in municipal wastewater that will serve as an early alert to identify localized spikes. Future sampling sites include Bend (repeat), Marion County (Salem), and Lane County (Eugene).

Dr. Dannenhoffer asked about the neighborhood sampling in Newport for the TRACE study. In Corvallis, where there are not many cases, random sampling makes sense. In Newport, there is going to be a varying variable, depending on which neighborhoods are sampled.

Dr. Nieto answered that the county health department provided OSU with a map of the distribution of the cases. Because the city has uniform distribution of cases, random sampling will be used. The study will reveal the impact of the concentration of cases at a local packing plant on the community.

Dr. Irvin asked Dr. Bangsberg and Dr. Nieto if their respective studies were antibody studies and, if not, would that be something happening in the future.

Dr. Nieto answered that three issues prevented the TRACE study to take that route: (1) antibody testing requires blood samples, which requires for participants to be touched, which necessitates the use of PPE, (2) the antibody tests have been questionable in terms of validity, (3) it is unclear what a positive antibody test means in terms of immunity and how lasting it is. OSU is considering antibody testing for Fall 2020, but only if these issues have been resolved.

Dr. Bangsberg answered that no antibody testing had been planned for the Key to Oregon study. Study participants have consented to be approached for additional studies. OHSU anticipates interest in add-on studies in addition to the core study.

Dr. Savage asked whether the test results from the TRACE study went to OHA.

Dr. Nieto answered that the Willamette Toxicology Lab reported to OHA and the local health department. It is conveyed in the informed consent form that both positive and negative cases are reported to the local health department.

Dr. Dannenhoffer noted that in areas with very low prevalence anything other than perfect specificity (i.e., number of false positives) could really make the results difficult. Other studies have reported test specificity as low as 97%. He asked about the specificity of the TRACE study. For example, the Abbott ID has 3.3% false positives or 33 positives in 1000 people.

Dr. Nieto answered that for PCR testing of the person with the virus, the specificity was virtually perfect (i.e., close 100%). The sensitivity is more questionable. The problem is false negatives, which for this test is around 90%.

PHAB Member Discussion
Rebecca Tiel

Ms. Tiel remarked that this was the time for the PHAB to discuss key issues that board members should be aware of or should help problem-solve on behalf of the public health system. It is also time to discuss PHAB member roles and liaison responsibilities. One thing that was expressed was a desire to look at PHAB's health equity policy and procedure. Another was the long-term infrastructure and system changes that go beyond the initial COVID-19 response.

Dr. Savage commented that the CCO community would like to hear the public health strategies going forward, given the increased need for behavioral health. How would the PHAB look at this and help guide the public health response to not only identification, but also any treatment options, looking at how the board would recommend going forward? Another area to look at is decreasing immunization rates. It would be good if the PHAB had a strategy on how to deal with decreased vaccination rates.

Ms. Little stated that decreasing vaccination rates would be an issue for all communities, not just for childhood vaccinations, but also for adult vaccinations. She asked how OHA and the Public Health Division were thinking about flu immunizations in the fall and how the flu related to potential increasing cases of COVID-19. The thinking within the tribal communities is to increase promotion, not just the flu vaccine, as well as other adult vaccinations.

Ms. Drum responded that CDC had been producing more flu vaccine that they had ever had before. OHA was recently notified that it was receiving $1.7 million in supplemental funds related to immunization for the purpose of high-risk populations receiving flu vaccination, because of the concerns related to COVID-19. OHA is in the early stages of figuring out what that will look like. In addition, there will be additional 60,000 flu vaccine doses that OHA will receive as a result of that.

Dr. Irvin requested more updates on the development of the SHIP.

Ms. Rippeteau asked how the board could support resiliency in the workforce and how the PHAB could set up protections for its members and all the people who work with the board members in the public health offices and agencies across the state.

Dr. Savage stated that the board needed to work on the communication and cross-coordination between PCPs, counties, and CCOs, and how to get the information from OHA to the providers who were taking care of those members.

Ms. Biddlecom answered that public health didn't share case information with providers unless it had to do with an individual case. She invited local public health administrators to share more broadly how they are coordinating in the health care setting.

Preventive Health and Health Services Block Grant
Danna Drum

Ms. Drum reminded the PHAB that the Preventive Health and Health Services Block Grant is a noncompetitive grant that was issued to all states and territories to address state and territory determined public health priorities. It's the only flexible funding the state has received from the Centers for Disease Control for public health. By federal law, there is a Block Grant advisory committee and the PHAB serves that role in Oregon. The state gets an allocation every year, based on a formula. A portion of the allocation must be used for rape prevention and victims' services. Currently, the funding goes to the Oregon Coalition Against Domestic and Sexual Violence (OCADSV). The work has to be tied to Health People 2020 objectives. Historically, the Block Grant has been used to support public health infrastructure, including public health modernization. OHA is proposing this year to remove one of the Health People 2020 objectives in the workplan. Some of the work related to public health accreditation doesn't need to continue to be in the Block Grant. In its place, OHA is proposing to use these funds to support the SHIP implementation. The work will be also moved under the quality improvement objective.

Ms. Drum explained that OHA would support SHIP implementation. That includes a staff person who has been funded through this grant to oversee the SHIP work; support for convening of the PartnerSHIP and all partners that come together to provide strategic direction and oversight; support of the community-based organizations that are represented on the PartnerSHIP; provide grants to support SHIP strategy implementation. In addition, OHA is working on a SHIP implementation website, which will be launched soon. Grant funds will also supplement some of the state funds that OHA receives for public health modernization to help support tribal work, as well as local public health training and technical assistance. The total funding is little over $1.1 million, with 86K designated for the OCADSV.

Preventative Health and Health Services Block Grant Public Hearing

Ms. Drum opened the public hearing for the Preventive Health and Health Services Block Grant regarding the proposed workplan concepts for October 1, 2020, through September 30, 2021. She invited members of the public to provide comments on the Block Grant.

There was no public comment.

Ms. Sierra Prior from the Oregon Coalition of Local Health Officials (CLHO) asked for clarification around how OHA's Public Health Division and CLHO worked together on accreditation.

Ms. Drum answered that the accreditation work was done by an OHA staff member who worked with CLHO and the accreditation workgroup. That staff person works with LPHAs and tribes when they need specific documentation from OHA to support their own public health accreditation efforts. There is no financial agreement with CLHO for that work.

Ms. Drum closed the public hearing for the Block Grant.

Public Comment

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

Ms. Jill Lake introduced herself as the director of clinical strategies at the Oregon Health Leadership Council. She read a statement on the communication between public health and the healthcare community regarding COVID-19 patients. She recommended that COVID-19 data from the Orpheus registry was shared with the collective platforms, where cases could be quickly identified and patients could be provided with the assistance they needed from their PCP.

Next Meeting Agenda Items and Adjourn
Rebecca Tiel

Ms. Tiel adjourned the meeting at 3:48 p.m.

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

July 16, 2020
2:00-4:00 p.m.
Join Zoom Meeting
https://zoom.us/j/730818593

Meeting ID: 730 818 593

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Public Health Advisory Board (PHAB)
Accountability Metrics Subcommittee meeting minutes
June 24, 2020
3:00-4:00 p.m.

PHAB members present: Muriel DeLaVergne-Brown, Rebecca Tiel, Eli Schwarz, Jeanne Savage, Eva Rippeteau

PHAB members absent: Teri Thalhofer

Oregon Health Authority (OHA) staff: Sara Beaudrault, Dr. Myde Boles

Welcome and introductions

Sara introduced the meeting. Subcommittee members introduced themselves.

Sara noted that without a quorum, minutes from the February meeting could not be approved.

PHAB Letter of Support for Obesity and Health Equity Metrics

Sara reviewed an updated version of the letter of support PHAB provided to Metrics and Scoring earlier this year for the obesity and health equity metrics. Metrics and Scoring will be making decisions about which metrics to send to Health Plan Quality Metrics Committee at their July meeting. PHD staff have made small updates to the letter and ask whether the subcommittee would support resubmitting the letter.

Rebecca stated that she was fine with the changes.

Muriel agreed.

Eli: reminded the group that OHA had convened a health equity measurement workgroup more than a year ago. The measure developed was presented to the Oregon Health Policy Board, and OHPB did not approve the metric. At that point the workgroup stopped meeting. Eli asked if Sara had additional information to share.

Sara stated that the work continued internally. The measure that has been under development for the better part of the year has been based on the number of language access services provided by a CCO. Sara did not have the specifications to share.

Eli noted that it is hard to define a metric for imprecise and imperfect measurements; it is difficult to define a metric.

Eli gave support for sending the letter.

Sara will accept the track changes and PHD will forward to Metrics and Scoring on PHAB's behalf.

Jeanne stated that from the CCO perspective, there is very much a drive to implement programs to meet metrics, and she appreciates having a health equity measure that allows CCOs to be creative and that also holds them accountable. With the obesity metric, as a PCP this is really hard work. By the time a provider is working with a patient who is obese. They have missed their opportunity. She appreciates the focus on prevention. It is key but hard to get to, to get the basic support to a family to be able to provide healthy food.

Eli said that toward the end of his tenure with Metrics and Scoring, they were discussing disparity-sensitive metrics. He wondered whether trying to develop a measure of health equity itself may not make sense. We know that inequities exist in our society. He noted that we are able to report metrics by race and ethnicity and see where disparities exist, like in the Public Health Accountability Metrics Report. That is a demonstration of health inequities in our country. He wonders whether we are spending way too much time in these discussions when we already can see the disparities in our existing metrics.
Sara said that sets up the next phase of this subcommittees phase of work as well.

2020 Public Health Accountability Metrics Report Review

Myde reviewed the final draft of the report. She noted that it will have OHA branding before it is final. The report is in two pieces: the report and the technical supplement that includes data tables, footnotes, measure specifications and all the technical information.

The executive summary focuses on the two communicable disease measures because that has been the focus of modernization funding. Immunization rates have continued to improve. Gonorrhea rates also continues to rise, with continuing disparities by race and ethnicity, in particular for Black/African Americans. OHA also included context about COVID-19 and how it may have an impact on future reports.

The introductory section reflects some of the comments from the subcommittee in terms of language and framing for the framework, health equity and funding. Myde acknowledged her colleague in PDES for the design work on the report and the input from a new graphics designer graduate from OSU, who also helped with some design features.

Muriel stated that she likes the design. It is more inviting.

The data pages include a key finding and some contextual information and for every health outcome measure a url to where people can find more information from the Public Health Division program. Details about measurement are in the technical appendix.

Eli appreciates the changes and thinks the display of racial and ethnic disparities is great. He also appreciated that the report starts with a description of outcome and process measures, as not everyone knows. Where would be send people to get more contextual information?

Sara responded that that is why OHA included links to the PHD program pages as the best source for information. The link is the last callout on each outcome page.

Myde reviewed the format for the process measure pages. This year we are highlighting the foundational capabilities that are used for the process measure and a description of what OHA does to support this process measure. This format is repeated for every process measure in the report. For the immunization pages, "AFIX" has been changed to "IQIP," for Immunization Quality Improvement for Providers Program.

Jeanne asked why these numbers and percentages fluctuate.

Myde replied that this is a measure of number of clinics.

Muriel described that Central Oregon has a grant to work with clinics and encourage clinics to participate in IQIP. If a county doesn't have funding or the ability to do that, you may not be having those meetings with clinics. She noted that state public health staff also do these visits.

Myde reminded the group that the technical appendix shows the numbers, in addition to the percentages. Small numbers can also cause fluctuations.

Sara noted that a lot of counties used initial modernization funding to support AFIX immunization work. When we look across the state and we've met the benchmark, more than 1 in 4 clinics participating in IQIP.

Muriel said if you want to improve immunization rates, you need to make sure there are staff to do this work. There is no other funding for this work.

Myde moved to the gonorrhea pages. As in previous years, there are large disparities in gonorrhea rates, especially for Black/African Americans. The report includes 2019 data.

Eli asked how this report gets distributed.

Myde stated it will be available on the OHA website and will be distributed to various groups.

Eli suggested that the report should be seen by minority communities who are reflected in this report. He noted that they are doing so for oral health.

Myde reviewed the two process measures for gonorrhea. Statewide the first process measure has slightly gone down since 2017. For the second process measure for case reports with completed priority fields, there has been little variation, decreasing slightly in 2019.

Jeanne asked about the process measure for treating gonorrhea contacts. When an individual receives treatment at a clinic, does the state contact the original case and then do contact tracing?

Myde described the data in Orpheus.

Muriel said for this measure it can be challenging to get people to name contacts, which is one issue. Sometimes they make contact but people don't come in for treatment. Staff work really hard at this. For the second process measure on entering data, her staff are running weekly reports to make sure people are entering all the data fields. They do the same thing for COVID. They try to get demographics on all communicable disease.

Jeanne noted that she is no longer able to treat contacts along with patients, which is a lost opportunity.

Rebecca reiterated that the report looks good from a design aspect and how the data is presented. She appreciates the call outs and thinks it will help the viewer to show the big picture understanding of the issue.

Eli asked why there is only an outcome measure for opioid mortality.

Myde reminded the committee that PHAB changed the measure from prescription opioid to all opioid mortality. The process measure used to be for PDMP enrollment, but a law was passed in 2018 that requires participation.

Jeanne asked whether the group has talked about metrics for the next biennium.

Sara stated that PHAB made a decision to not make significant changes to the set of metrics in 2019. However, Sara expects that this subcommittee will come together during this fall to consider changes for the next biennium. Some things that are in play are the new State Health Improvement Plan and whether PHAB sees opportunities to line up with some of the indicators in the SHIP, COVID-19, and whether the metrics can be used to address health inequities.

Jeanne stated that she was in awe of how outcomes are so racially divided. She thought about the judicial system and how it may play into health disparities and overall health of minority populations. In the next biennium could we get a public health and judicial measure that looks at racial and ethnic disparities in the judicial system.

Rebecca agreed and said the SHIP will be so important. Rebecca stated that she believes this needs to be an ongoing topic at PHAB meetings with space carved out to talk about PHAB's work related to race. Should PHAB move toward declaring racism a public health crisis. Rebecca will talk with OHA staff about it.

Jeanne and Muriel expressed support for this.

Rebecca stated this issue can be addressed as a public health issue through assessment, what is the policy framework, what is the advocacy strategy.

Eli stated that we live in a state where the Black population is 2% of the population, lower than the national rate, and nonetheless we have extreme disparities.

Rebecca stated that she will bring this to her next agenda planning call with OHA staff.

Myde asked for final feedback on the report.

Subcommittee members expressed support for the report.

Sara confirmed that subcommittee members support this going to the full board for review and approval. Subcommittee members all voiced support.

Myde let subcommittee members know that she is retiring at the end of the month, and Kusuma Madamala will be leading this work moving forward.

Subcommittee business

Sara discussed subcommittee business. There is no need for an update from a subcommittee member in July since the board will do a full review of the report. There are no additional meetings scheduled, but we will plan for meeting this fall to discuss changes to metrics and how PHAB can use metrics to address health inequities.

Public comment

Sara called for public comment. No members of the public provided public comment.

Closing

Sara adjourned the meeting.

2020 Public Health Accountability Metrics Annual Report
Health equity review
July 2020

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

1. How is the work product, report or deliverable different from the current status?
   The Public Health Accountability Metrics Annual Report is intended to measure progress toward achieving health improvements through a modern public health system. The Public Health Advisory Board is responsible for establishing the metrics and overseeing the development of the annual report. This report displays health outcome data by race and ethnicity, which is consistent with many public health reports and the State Population Health Indicators.

2. What health disparities exist among which groups? Which health disparities does the work product, report or deliverable aim to eliminate?
   This report shows health disparities, primarily those related to race, ethnicity and geography, across eight outcome measures.

3. How does the work product, report or deliverable support individuals in reaching their full health potential?
   Individuals are not the target audience for this report, and the report does not provide strategies or solutions for improvements.

4. Which source of health inequity does the work product, report or deliverable address (social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?
   This report does not address health inequities.

5. How does the work product, report or deliverable ensure equitable distribution of resources and power?
   This report does not ensure equitable distribution of power.

6. How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?
   The community was not engaged in the selection of metrics or development of the annual report, including how data on racial and ethnic disparities are displayed. Some

local public health administrators and PHAB members have expressed that the presentation of racial and ethnic disparities may be stigmatizing and may be misinterpreted by some readers of the report. OHA and the PHAB Accountability Metrics subcommittee have attempted to make limited improvements through modifications to how data are presented and providing some contextual information explaining the role of historical and contemporary injustices in health disparities. The PHAB Accountability Metrics report has recommended further action to make improvements for subsequent reports, including working with communities experiencing health disparities.

7. How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?
   Currently engagement with other sectors is limited. OHA has worked with Oregon Department of Transportation on the active transportation measure.

8. How will data be used to monitor the impact on health equity resulting from this work product, report or deliverable?
9. Ongoing measurement across years will demonstrate whether public health interventions are effectively eliminating health disparities and highlight for PHAB and other stakeholders and leaders where progress is not being made.

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
July 6, 2020
1:00 p.m. – 2:00 p.m.

PHAB members present: Dr. Bob Dannenhoffer, Akiko Saito, Veronica Irvin
PHAB members absent: Carrie Brogoitti, Alejandro Queral
Oregon Health Authority (OHA) staff: Sara Beaudrault

Welcome, introductions, and updates

Sara introduced the meeting. The subcommittee members introduced themselves.

A quorum was present. February meeting minutes were approved.

Sara reminded subcommittee members that their main deliverable is the public health modernization funding formula. This was due to be submitted to Legislative Fiscal Office through the Public Health Modernization Funding Report in June, but OHA received an extension until September. More broadly this subcommittee's work is to advise OHA on how to use public health funding in a way that gets us to outcomes.

PHAB Funding Principles

Sara reminded the group that the funding principles were originally developed by PHAB in 2018 and are not meant to be limited to funding for public health modernization. PHAB reviewed these in January, and the subcommittee reviewed them in February. Through both discussions, no significant changes were made, and neither the board nor the subcommittee recommended prioritizing some principles over others. OHA is asking the subcommittee for one final review before it goes to PHAB for a vote.

Bob stated that he has no further changes.

Akiko and Veronica agreed.

Sara reminded the subcommittee that it had made a recommendation for PHAB to develop an expectation that would go to the Conference of Local Health Officials and OHA for the funding principles to be used in funding discussions. Sara reviewed a draft letter and asked whether it meets what the subcommittee expected.

Bob stated that one thing he has learned during the COVID pandemic is that the impact of seasonal workers is big, and in Douglas County their risk of disease is about ten times higher than the rest of the population. He is not suggesting changes now, but PHAB could consider including seasonal workers as an indicator in the funding formula.

Veronica asked whether there are certain areas where the funding principles are not being used and whether the letter should be more prescriptive to address those areas.

Sara replied that it is not that individual LPHAs are not adhering to the principles. But for every funding stream that goes from OHA to LPHAs, the conversation and decision-making process is different. This letter clarifies that the funding principles should be part of all discussions and decision-making about funding. It does not mean that funds will always be allocated the same way, but that state and local public health are using the funding principles to guide decision-making.

Bob stated that operationally it would make sense to start with the public health modernization funding formula, and if it doesn't work, then a different funding formula could be used. But one would need to state why it wasn't used.

Akiko stated that her program has Program Element 12 for preparedness and response, and they have tried to use the public health modernization funding formula for the past two years. But the committee that makes recommendations for this funding formula has opted to go with the same funding formula used in the past, which is base plus population. Is this a default funding formula we would have? How would we operationalize this or put more teeth into the letter?

Sara stated that the modernization funding formula is not meant to be used until we reach a level of about $10 million going out to LPHAs. PHAB made a decision to use the funding formula at the $7 million level. The conversation about the amounts that would go to base versus indicators funding, for example, would always need to be discussed.

Akiko asked if this letter is to the OHA-PHD and CLHO Joint Leadership Team. Akiko stated that the preparedness funding is always way below $10 million, and they have stuck with the base plus population because LPHAs need the base to be able to run the program.

Sara asked whether the subcommittee is interested in explicitly stating in the letter that committees should consider using the public health modernization funding formula?

Bob said that sounded reasonable.

Akiko said an additional bullet would be great. Akiko said it would be good to look at this funding formula across the board.

Sara confirmed that this will go to PHAB in July. Ultimately Rebecca would sign and submit this.

2021-23 public health modernization funding formula

Sara stated that she will share information about how the public health modernization funding formula has been used for distributing COVID funding and share results from a survey conducted of local public health administrators in February, and then will ask whether the subcommittee would like to discuss changes to the funding formula for 2021-23.

Sara reviewed the current funding formula and how it works. A portion of available funding is distributed through a different funding mechanism to regional partnerships. LPHAs are not required to participate in a regional partnership. In 2019 a number of LPHAs moved some of their local funding to their regional partnership, mostly in Eastern Oregon.

Sara reviewed how the funding formula has been used to distribute federal CARES Act COVID funding to LPHAs. Sara stated that this is a good place to pause and acknowledge that this funding formula really works and can be applied to other funding streams. This is a big accomplishment of this subcommittee.

Bob stated this is working well. He stated that one thing we'll need to look at is the county contribution to public health, as it will go down as a result of this pandemic. Bob stated that the background of the formula has been really important. For example, limited English proficiency has been a real challenge. Douglas has had a number of outbreaks among seasonal workers who have limited English proficiency, and it has been a challenge to get workers who can provide language access.

Sara stated that part of the CARES Act funding is also going to fund regions.

Bob stated that the only challenge is that these funds do not fund the same regions as the modernization funding, which has been a hiccup.

Sara introduced the survey that was conducted of LPHAs in February, at the request of this subcommittee. The two areas the survey explored were:

1. The effect of distribution of 2019-21 public health modernization funding to LPHAs across county size bands, and
2. 2019-21 allocation of funds to regional partnerships.

In all, 22 of 33 LPHAs completed the survey. The breakdown was as follows:

- 11 of 19 small and extra-small counties;
- 4 of 7 medium counties;
- 7 of 7 large and extra-large counties.

Sara read the first question, “The total amount of funding my LPHA received through the funding formula (for both floor funding and indicators) was enough to conduct the work included in the Program Element 51”. Counties were evenly split between agreeing and disagreeing, with one county strongly disagreeing. Small/extra-small were more likely to disagree, and large/extra-large were more likely to agree. Sara noted that most of the comments were less about changing the work and more about needing more funding.

Bob stated that this wasn’t shocking. Small or extra-small counties would have received less funding, perhaps not even enough to fund an FTE, for the same body of work. You end up with one person being responsible for three or four programs that they’re doing.

Veronica recalls this issue coming up at the retreat.

Sara read the second question, “For the 2021-23 funding formula, I would like PHAB to…” The responses were to keep the proportion of funds across floor and indicators the same, increase the proportion of funds allocated to the floor, or increase the proportion of funds allocated to indicators. Not surprisingly, extra-small, small and medium counties favored increasing funding to the floor, and large and extra-large counties favored increasing funding to the indicators.

Veronica asked about the indicators. She asked whether the indicators are the percentage within their county or how their county contributes to the whole state. Sara replied that it is within their county.

Bob stated that we are learning through COVID that small counties really struggle. They have small staff to begin with. When they have outbreaks, they have large outbreaks that quickly overwhelm their capacity. If we’ve ever had a call for regionalization, this is it.

Sara read the third question, “If a similar amount of funding is available in 2021-23, I recommend that PHAB…” Options included retaining the current split across funding to LPHAs (approximately two-thirds of available funding) and regional partnerships (approximately one-third of available funding). Most respondents favored retaining the current split, closely followed by increasing funding to individual LPHAs.

Bob stated that this contradicts what he just said, but the only thing counties are doing regionally now are the modernization projects, and modernization regional work is still really clunky.

Akiko called attention to a comment that states that regional approaches are critical to communicable disease work. Akiko noted that there may be some areas that are better suited to regional approaches whereas others require a local flavor.

Sara noted that we will continue to learn more about where regional approaches work throughout the COVID response in terms of surge capacity and outbreaks.

Akiko noted it will be interesting to hear Veronica's take from an academic perspective on COVID and how it applies to the work we're doing with modernization, in terms of what we're learning about the successes of the public health system and where we could improve.

Veronica noted that as we've seen in small counties that go from no cases to a large outbreak that pushes the county to capacity, that's what we've also seen with environmental exposures or contaminations. There's less infrastructure, and when there is an outbreak usually other counties or the state step in.

Veronica stated that in terms of the survey results about regional funding, she noted the comments stating that if a county finds regional approaches to be useful, then they should use their own funding. She noted comments about regional funding being too prescriptive and it may depend on the situation.

Sara agreed that there were multiple comments that OHA shouldn't force regional approaches on LPHAs. From OHA's perspective, this is not forced on LPHAs. They have the option to participate or not. Sara noted that from an LPHA perspective, it is probably hard to say no and not take advantage of those funds when they are available.

Sara read the fourth question, "If additional funding is available in 2021-23, how could PHAB improve funding for regional partnerships, cross-jurisdictional sharing, or other shared service delivery models?" There was support for building incentives into the funding formula for regional partnerships versus it feel required.

Veronica stated that people tend to be favorable toward regional partnerships, but there could be more incentives or more options.

Sara replied that there are opportunities to improve the model. Sara noted a comment about regional partnerships adding value to local work.

Sara read the fifth question, "My LPHA and other LPHAs that participate in my regional partnership have…" with a list of options a respondent could select. More LPHAs have planned for expanding or maintaining their partnership than have discussed dissolving the partnership.

Bob stated that there has been a fair amount of turnover in his region, with two of three administrators being replaced. This leaves the partnership a little bit up in the air.

Sara stated that these regional partnerships were designed with flexibility to change partnership configuration or take on other sharing models other than regional partnerships. But even two years in people are very tied to what's been put in place and it is hard to change.

Veronica asked about regional partnerships for very large counties.

Sara said that, at least in the Portland-metro area, the three counties work together closely all the time because they share a population. The funding supports some structure for their collaborations.

Sara drew the subcommittee's attention to the additional comments survey respondents provided to PHAB.

Sara asked whether the subcommittee would like to discuss changes to the funding formula, including funding for regional partnerships, or leave it as is to submit to Legislative Fiscal Office. Sara reminded members that during the first half of next year, they will have a large role in advising OHA on how funds awarded for 2021-23 are allocated. What we see in the survey results are clear support for continuing to support regional partnerships. There is less support for expanding the model, but clear support for continuing. A lot of the comments provided with the survey are about how funds are used, and less about how the funds are distributed, with some comments about how to shift from using modernization dollars programmatically to building infrastructure.

Veronica noted the burden on small counties and asked, if there is not an opportunity to increase the floor funding, is there an opportunity to reduce the requirements for those counties.

Sara replied that state and local public health discussed that in 2019 and ultimately didn't get there. We need to think about that within the context of ensuring that every person in the state has access to the same level of public health protections.

Akiko stated that she appreciated Bob pointing out seasonal farm works and commercial fishing as pieces of health equity. Other than that, she appreciated today's conversation.

Bob does not have other changes to recommend.

Sara stated we could discuss a seasonal farmworker indicator, but other than that she is not hearing of other changes needed. She asked if subcommittee members would like to add seasonal farmworkers now.

Bob recommended no changes now, but that seasonal farmworkers should be considered in the next revisions.

Veronica agreed with Bob. She asked whether we need to get into the details of requirements and the extent of partnerships at this point.

Sara replied that much of that work will happen next winter, and that much of the detail of the contractual requirements sits with local and state public health. In terms of incentivizing regional partnerships, Sara is not sure how to get there. This could be a topic for the next big

overhaul. She suggested that LPHAs who participate in regional partnerships could have increased floor funding, because there are added costs to participating in regional partnerships.

Veronica stated that evaluation results may also inform these future discussions.

Sara confirmed that PHAB will be asked to vote to approve the funding formula with no changes, and including ongoing funding for regional partnerships.

Subcommittee business

Sara stated that there are no additional subcommittee meetings scheduled at this time. The subcommittee will start meeting again late this year or early next year as we start going into Legislative Session.

Sara asked who would like to provide the subcommittee update at the July Meeting.

Bob agreed to provide the update.

Public comment

Sara invited members of the public to ask questions and provide comments.

There was no public comment.

Closing

Sara ended the call.

Public Health Advisory Board
Funding principles for state and local public health authorities
~~**February 15, 2018**~~**Updated February 2020**

The Public Health Advisory Board recognizes that funding for foundational capabilities and programs is limited, but innovations can maximize the benefit of available resources. These funding principles are designed to apply to the public health system, which means state and local public health authorities in Oregon. These funding principles can be applied to increases or decreases in public health funding.

Public health system approach to foundational programs

1. Ensure that public health services are available to every person in Oregon, whether they are provided by an individual local public health authority, a tribal health authority, through cross-jurisdictional sharing arrangements, and/or by the Oregon Health Authority.

2. Align funding with burden of disease, risk, and state and community health assessment and plan priorities, while minimizing the impact to public health infrastructure when resources are redirected.

3. Use funding to advance health equity in Oregon, which ~~may~~ includes directing funds to areas of the state experiencing a disproportionate burden of disease or where health disparities exist.

4. Use funding to incentivize changes to the public health system intended to increase efficiency and improve health outcomes, which may include cross-jurisdictional sharing.

5. Align public health work and funding to ~~coordinate~~ leverage resources with health care, education and other sectors to achieve health outcomes.

Transparency across the public health system

6. Acknowledge how the public health system works to achieve outcomes, and direct funding to close the identified gaps across the system in all governmental public health authorities.

7. Improve transparency about funded work across the public health system and scale work to available funding.

Commented [BS1]: PHAB I&F subcommittee discussed removing the "may" but recommends keeping it.

To: Coalition of Local Health Officials Executive Committee
Oregon Health Authority, Public Health Division Executive Leadership

From: Rebecca Tiel, PHAB Chair

Date:

In 2018, Oregon's Public Health Advisory Board (PHAB) developed a set of funding principles, which were established to guide decisions for maximizing public health funding to eliminate health disparities and improve health outcomes.

PHAB acknowledges significant challenges to public health funding, including insufficient funds to fully address many population health priorities and categorical, siloed funding streams. However, Oregon's public health system is uniquely positioned to address these and other challenges by thoughtfully and strategically making decisions to maximize the benefit of available resources to achieve desired outcomes.

It is PHAB's expectation that Oregon Health Authority and Conference of Local Health Officials will take the following steps during processes to make decisions about the distribution of funds to local public health authorities:

1. Consider using the public health modernization funding formula. If a different funding formula is used, the decision-making body should provide a rationale for this decision.
2. Use the set of funding principles to make decisions about how public health funding is allocated. These principles do not dictate any single solution for allocating public health funding, but the same set of principles should be applied to the decision-making process. This could include:
    - Reviewing funding principles when funding formulas are being changed, and coming to agreement on which funding principles are most relevant to the work to be completed with available funding;

- Including a statement with each finalized funding formula for which funding principles were prioritized;
- Using funding principles to support discussions about how to maximize resources across multiple funding streams.

Respectfully,

PHAB Chair

Public health modernization LPHA funding formula - FINAL
2019-21 biennium
August, 2019

Total biennial funds available to LPHAs through the funding formula = $7 million

		Base component								Matching and Incentive fund components		Total county allocation				
County Group	Population[1]	Floor	Burden of Disease[2]	Health Status[3]	Race/ Ethnicity[4]	Poverty 150% FPL[4]	Rurality[5]	Education[4]	Limited English Proficiency[4]	Matching Funds	Incentives	Total Award	Award Percentage	% of Total Population	Award Per Capita	Avg Award Per Capita
Wheeler	1,450	$ 30,000	$ 292	$ 543	$ 138	$ 202	$ 1,588	$ 107	$ 5	$ -	$ -	$ 32,876	0.5%	0.0%	$ 22.67	
Wallowa	7,175	$ 30,000	$ 1,751	$ 1,076	$ 411	$ 725	$ 7,858	$ 530	$ 223	$ -	$ -	$ 42,576	0.6%	0.2%	$ 5.93	
Harney	7,380	$ 30,000	$ 2,492	$ 2,394	$ 846	$ 947	$ 3,581	$ 791	$ 511	$ -	$ -	$ 41,561	0.6%	0.2%	$ 5.63	
Grant	7,400	$ 30,000	$ 1,527	$ 1,661	$ 527	$ 797	$ 8,105	$ 786	$ 282	$ -	$ -	$ 43,684	0.6%	0.2%	$ 5.90	
Lake	8,115	$ 30,000	$ 2,172	$ 1,316	$ 1,043	$ 1,228	$ 5,626	$ 1,292	$ 505	$ -	$ -	$ 43,183	0.6%	0.2%	$ 5.32	
Morrow	11,885	$ 30,000	$ 2,449	$ 3,609	$ 4,055	$ 1,370	$ 5,975	$ 3,055	$ 6,496	$ -	$ -	$ 57,010	0.8%	0.3%	$ 4.80	
Baker	16,765	$ 30,000	$ 4,308	$ 2,719	$ 1,295	$ 1,905	$ 7,528	$ 1,727	$ 754	$ -	$ -	$ 50,237	0.7%	0.4%	$ 3.00	$ 5.17
Crook	22,710	$ 45,000	$ 5,711	$ 6,592	$ 2,287	$ 2,857	$ 11,939	$ 2,860	$ 943	$ -	$ -	$ 78,189	1.1%	0.5%	$ 3.44	
Curry	22,915	$ 45,000	$ 7,925	$ 6,624	$ 2,626	$ 2,642	$ 9,713	$ 2,409	$ 1,110	$ -	$ -	$ 78,048	1.1%	0.5%	$ 3.41	
Jefferson	23,560	$ 45,000	$ 6,835	$ 5,431	$ 8,140	$ 3,201	$ 16,282	$ 3,507	$ 4,157	$ -	$ -	$ 92,552	1.3%	0.6%	$ 3.93	
Hood River	25,310	$ 45,000	$ 4,092	$ 6,112	$ 7,866	$ 2,547	$ 14,470	$ 5,374	$ 13,834	$ -	$ -	$ 99,295	1.4%	0.6%	$ 3.92	
Tillamook	26,395	$ 45,000	$ 6,762	$ 6,245	$ 3,506	$ 2,855	$ 20,121	$ 2,775	$ 2,648	$ -	$ -	$ 89,912	1.3%	0.6%	$ 3.41	
Union	26,885	$ 45,000	$ 6,215	$ 4,722	$ 2,497	$ 3,619	$ 12,397	$ 2,043	$ 1,581	$ -	$ -	$ 78,073	1.1%	0.6%	$ 2.90	
Gilliam, Sherman, Wasco	30,970	$ 105,000	$ 8,070	$ 5,930	$ 6,184	$ 3,151	$ 14,077	$ 4,250	$ 6,106	$ -	$ -	$ 152,768	2.2%	0.7%	$ 4.93	
Malheur	31,925	$ 45,000	$ 7,354	$ 11,175	$ 10,615	$ 5,113	$ 16,923	$ 6,280	$ 9,277	$ -	$ -	$ 111,737	1.6%	0.8%	$ 3.50	
Clatsop	39,200	$ 45,000	$ 10,524	$ 7,410	$ 4,764	$ 4,027	$ 16,744	$ 3,468	$ 3,661	$ -	$ -	$ 95,600	1.4%	0.9%	$ 2.44	
Lincoln	48,210	$ 45,000	$ 15,049	$ 12,112	$ 7,157	$ 6,125	$ 19,853	$ 5,319	$ 4,169	$ -	$ -	$ 114,785	1.6%	1.1%	$ 2.38	
Columbia	51,900	$ 45,000	$ 11,869	$ 12,217	$ 4,911	$ 4,809	$ 24,784	$ 5,132	$ 2,514	$ -	$ -	$ 111,235	1.6%	1.2%	$ 2.14	
Coos	63,275	$ 45,000	$ 19,268	$ 16,978	$ 7,910	$ 8,278	$ 26,612	$ 6,915	$ 3,283	$ -	$ -	$ 134,243	1.9%	1.5%	$ 2.12	
Klamath	67,960	$ 45,000	$ 19,971	$ 17,820	$ 12,567	$ 9,346	$ 27,987	$ 8,913	$ 7,523	$ -	$ -	$ 149,126	2.1%	1.6%	$ 2.19	$ 2.88
Umatilla	80,765	$ 60,000	$ 17,350	$ 21,671	$ 23,138	$ 10,058	$ 25,741	$ 15,131	$ 29,336	$ -	$ -	$ 202,425	2.9%	1.9%	$ 2.51	
Polk	82,100	$ 60,000	$ 15,355	$ 14,519	$ 15,039	$ 8,262	$ 17,894	$ 7,947	$ 14,484	$ -	$ -	$ 153,500	2.2%	2.0%	$ 1.87	
Josephine	86,395	$ 60,000	$ 26,611	$ 20,126	$ 9,450	$ 12,498	$ 42,580	$ 9,801	$ 3,885	$ -	$ -	$ 184,952	2.6%	2.1%	$ 2.14	
Benton	93,590	$ 60,000	$ 12,962	$ 16,209	$ 15,194	$ 11,498	$ 19,271	$ 4,481	$ 13,598	$ -	$ -	$ 153,211	2.2%	2.2%	$ 1.64	
Yamhill	107,415	$ 60,000	$ 20,129	$ 25,022	$ 20,888	$ 9,954	$ 26,588	$ 13,081	$ 20,065	$ -	$ -	$ 195,727	2.8%	2.6%	$ 1.82	
Douglas	111,735	$ 60,000	$ 34,639	$ 31,888	$ 11,252	$ 12,931	$ 50,419	$ 12,327	$ 4,638	$ -	$ -	$ 218,095	3.1%	2.7%	$ 1.95	
Linn	125,575	$ 60,000	$ 28,856	$ 28,946	$ 15,589	$ 14,374	$ 43,461	$ 12,809	$ 9,122	$ -	$ -	$ 213,158	3.0%	3.0%	$ 1.70	$ 1.84
Deschutes	188,980	$ 75,000	$ 33,149	$ 26,275	$ 20,180	$ 16,006	$ 57,126	$ 12,785	$ 13,728	$ -	$ -	$ 254,249	3.6%	4.5%	$ 1.35	
Jackson	219,200	$ 75,000	$ 52,080	$ 49,191	$ 34,824	$ 25,275	$ 48,255	$ 24,412	$ 25,023	$ -	$ -	$ 334,061	4.8%	5.2%	$ 1.52	
Marion	344,035	$ 75,000	$ 68,536	$ 82,241	$ 100,653	$ 40,535	$ 49,361	$ 54,070	$ 128,532	$ -	$ -	$ 598,927	8.6%	8.2%	$ 1.74	
Lane	375,120	$ 90,000	$ 80,869	$ 73,659	$ 56,665	$ 45,770	$ 71,898	$ 33,187	$ 33,739	$ -	$ -	$ 485,786	6.9%	8.9%	$ 1.30	$ 1.48
Clackamas	419,425	$ 90,000	$ 74,842	$ 75,197	$ 62,993	$ 26,028	$ 83,146	$ 29,685	$ 60,938	$ -	$ -	$ 502,829	7.2%	10.0%	$ 1.20	
Washington	606,280	$ 90,000	$ 83,945	$ 98,345	$ 173,166	$ 44,487	$ 37,185	$ 54,900	$ 190,854	$ -	$ -	$ 772,881	11.0%	14.5%	$ 1.27	
Multnomah	813,300	$ 90,000	$ 162,706	$ 160,691	$ 208,288	$ 84,912	$ 11,580	$ 76,185	$ 239,142	$ -	$ -	$ 1,033,506	14.8%	19.4%	$ 1.27	$ 1.26
Total	**4,195,300**	**$ 1,860,000**	**$ 856,667**	**$ 856,667**	**$ 856,667**	**$ 428,333**	**$ 856,667**	**$ 428,333**	**$ 856,667**	$ -	$ -	**$ 7,000,000**	**100.0%**	**100.0%**	**$ 1.67**	**$ 1.67**

[1] Source: Portland State University Certified Population estimate July 1, 2018
[2] Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon death certificate data, 2012-2016.
[3] Source: Quality of life: Good or excellent health, 2012-2015.
[4] Source: American Community Survey population 5-year estimate, 2013-2017.
[5] Source: U.S. Census Bureau, Population estimates,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,(	above 375,000

Public health funding principles, and public health modernization funding formula
Health equity review
July 2020

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

1. How is the work product, report or deliverable different from the current status?
   Funding principles: PHAB originally developed the funding principles in 2018. The funding principles provide guidance to state and local public health officials for maximizing the impact of public health funding to achieve outcomes. Among the set of funding principles, one prioritizes aligning funding with health disparities, and one prioritizes aligning funding with burden of disease.

   Funding formula: The public health modernization funding formula distributes funds to LPHAs based on floor payments based on county population, and a set of demographic and socioeconomic indicators that measure the diversity and burden of disease within the county.

2. What health disparities exist among which groups? Which health disparities does the work product, report or deliverable aim to eliminate?
   Neither of these two deliverables highlight disparities among certain groups. Both are intended to leverage public health funding to eliminate health disparities, but they do not target specific disparities.

3. How does the work product, report or deliverable support individuals in reaching their full health potential?
   Both deliverables are intended to leverage public health funding to eliminate health disparities. Both deliverables support LPHAs to identify and act on the health disparities that are prominent among their community.

4. Which source of health inequity does the work product, report or deliverable address (social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?
   The funding principles address equitable availability of public health services across the state, burden of disease and risk, and disproportionate burden of disease and health disparities. The principles call attention to incentivizing changes in the public health

system to achieve improvements, and leveraging public health resources with resources coming from other sectors, like education.

The funding formula includes indicators for burden of disease, health status, racial and ethnic diversity, socioeconomic status, rurality, education, and limited English proficiency. The funding formula directs a higher proportion of funding to counties that rank higher on these indicators.

5. How does the work product, report or deliverable ensure equitable distribution of resources and power?
   These deliverables provide leverage for distributing public health funding to areas of the state with greater health disparities and poorer health outcomes.

6. How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?
   The community was not engaged in the development of these deliverables.

7. How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?
   One of the funding principles directs public health to leverage resources from other sectors to achieve improved health outcomes.

8. How will data be used to monitor the impact on health equity resulting from this work product, report or deliverable?
   The funding principles hold state and local public health accountable to ensuring that health equity is at the forefront of funding decisions. The funding formula provides a tool that can be applied public health funding streams to direct funding to counties based on health disparities and burden of disease.

Public health funding actions

ACTION: Approve Funding Principles

ACTION: Approve statement of expectation for use of Funding Principles in funding decisions

ACTION: Approve 2021-23 funding formula, which includes:

- Public health modernization funds distributed to LPHAs through allocation to floor funding and indicators; and
- Some funds directed to regional partnerships or other shared service models

From:	turn-around@indra.com
To:	publichealth.policy@state.or.us
Subject:	for: Public Health Advisory Board members
Date:	Tuesday, July 7, 2020 7:11:26 AM
Attachments:	Conclusions - 2 review articles.docx ATT00001.htm

I will be out of the State on 7/16 and thus cannot "attend" your meeting and comment at that time.
Kindly forward this "comment" to the Public Health Advisory Board members.

I fully understand that the Coronavirus is a serious present public health issue!
AND, **we have another major, widespread Public Health Issue which is not getting the serious attention it is due, and Health Departments are not even being invited into the conversation!**

These two scientific literature review articles can best describe the situation - if you would just even read the CONCLUSIONS (attached for your convenience) and use the links to look at their lists of scientific references, you might begin to realize that there is an almost unbelievable public health threat looming - and there is still time to avert it!
(see the three webiste links below!) If after looking these over you agree and need to understand further how the State can protect citizens, look through the three websites below (or call me).

5G WIRELESS TELECOMMUNICATIONS EXPANSION: PUBLIC HEALTH AND ENVIRONMENTAL IMPLICATIONS.

Russell, C.L. Environmental Research 165:484-495 (2018).

https://zero5g.com/wp-content/uploads/2018/07/5-G-wireless-telecommunications-expansion-Public-health-and-environmental-implications-Cindy-L.-russell.pdf

TOWARDS 5G COMMUNICATION SYSTEMS: ARE THERE HEALTH IMPLICATIONS?

Ciaula, AD. International Journal of Hygiene and Environmental Health 367-375 (2018).

http://www.elektrosmog.voxo.eu/video/Towards%205G%20-%20Potential%20Health%20Effects.pdf

I refer you to these websites for more science and action information:
ehtrust.org
americansforresponsibletech.org
5Gspaceappeal.org

For your ease, I attach the CONCLUSIONS to the two article above below.

May I also point out that a research study showing the impact of the high frequency millimeter band of 5G unearthed from NASA files shows clearly that *this radiation lays the ground in humans for opportunistic infections,* and there is an association between the places of the worst coronavirus outbreaks (e.g. Wuhan; that cruise ship, NYC) and the very recent widespread installation of 5G radiation.

Your involvement is critical.
This involves nothing less than involuntary radiation of the mass public with a known … and I am not exaggerating here … killer (e.g. via cancer, antibiotic-resistant infections, and more).

PLEASE look into this and you will be astounded, and frightened. It takes courage to face this squarely.

With great concern,
Dr. Sha'ana Fineberg
Williams, Oregon

5G WIRELESS TELECOMMUNICATIONS EXPANSION: PUBLIC HEALTH AND ENVIRONMENTAL IMPLICATIONS.

Russell, C.L. Environmental Research 165:484-495 (2018).

Conclusion

Although 5G technology may have many unimagined uses and benefits, it is also increasingly clear that significant negative consequences to human health and ecosystems could occur if it is widely adopted. Current radiofrequncy radiation wavelengths we are exposed to appear to act as a toxin to biological systems. A moratorium on the deployment of 5G is warranted, along with development of independent health and environmental advisory boards that include independent scientists who research biological effects and exposure levels of radiofrequency radiation. Sound regulatory policy regarding current and future telecommunications initiative will require more careful as- sessment of risks to human health, environmental health, public safety, privacy, security and social consequences. Public health regulations need to be updated to match appropriate independent science with the adoption of biologically based exposure standards prior to further deployment of 4G or 5G technology.

Considering the current science, lack of relevant exposure standards based on known biological effects and data gaps in research, we need to reduce our exposure to RF EMR where ever technically feasible. Laws or policies which restrict the full integrity of science and the scientific community with regards to health and environmental effects of wireless technologies or other toxic exposures should be changed to enable unbiased, objective and precautionary science to drive necessary public policies and regulation. Climate change, fracking, toxic emissions and microwave radiation from wireless devices all have something in common with smoking. There is much denial and confusion about health and environmental risks, along with industry insistence for absolute proof before regulatory action occurs (Frentzel-Beyme, 1994; MichaelsMichaels, 2008). There are many lessons we have not learned with the introduction of novel substances, which later became precarious environmental pollutants by not heeding warning signs from scientists (Gee, 2009). The threats of these common pollutants continue to weigh heavily on the health and wellbeing of our nation. We now accept them as the price of progress. If we do not take precautions but wait for unquestioned proof of harm will it be too late at that point for some or all of us?

https://zero5g.com/wp-content/uploads/2018/07/5-G-wireless-telecommunications-expansion-Public-health-and-environmental-implications-Cindy-L.-russell.pdf

TOWARDS 5G COMMUNICATION SYSTEMS: ARE THERE HEALTH IMPLICATIONS? Ciaula, AD. International Journal of Hygiene and Environmental Health 367-375 (2018).

Conclusions

Evidences about the biological properties of RF-EMF are progressively accumulating and, although they are in some case still preliminary or controversial, clearly point to the existence of multi-level interactions between high-frequency EMF and biological systems, and to the possibility of oncologic and non-oncologic (mainly reproductive, metabolic, neurologic, microbiologic) effects.

Biological effects have also been recorded at exposure levels below the regulatory limits, leading to growing doubts about the real safety of the currently employed ICNIRP standards (Habauzit et al., 2014; Redmayne, 2016; Starkey, 2016).

Particular concerns derive from the wide (and rapidly increasing) density of wireless devices and antennas (also in view of the forthcoming 5G networks), from the increased susceptibility to RF- EMF in children (Meo et al., 2015; Redmayne, 2016; Redmayne and Johansson, 2015; Sangun et al., 2015), and from the effects of RF-EMF at a cellular and molecular level, in particular regarding the ability to promote oxidative processes (Friedman et al., 2007; Kazemi et al., 2015; Kesari and Behari, 2012), DNA damage (Duan et al., 2015; Solek et al., 2017), alterations of gene expression (Chen et al., 2014; Habauzit et al., 2014; Kim et al., 2017a; Le Quement et al., 2012; Le Quement et al., 2014; Lin et al., 2016; Millenbaugh et al., 2008; Soubere Mahamoud et al., 2016) and to influence the development of stem cells (Chen et al., 2014; Eghlidospour et al., 2017; Shahbazi-Gahrouei et al., 2016).

Epigenetic mechanisms modulating gene expression following exposure to environmental toxics are frequently involved in the pathogenesis of a number of chronic diseases, mainly in the case of early exposures determining developmental effects and the onset of chronic diseases later during life (Bianco-Miotto et al., 2017; Bird, 2007; Di Ciaula and Portincasa, 2014). Of note, the epigenome seems also to have a relevant role following RF-EMF exposure, which is able to produce micro-RNA modulation (Dasdag et al., 2015a, b), chromatin remodeling and alterations of DNA repairing processes (Belyaev et al., 2009; Markova et al., 2005) and to affect the DNA methylation pattern (Mokarram et al., 2017).

Further experimental and epidemiologic studies are urgently needed in order to better and fully explore the health effects caused in humans by the exposure to generic or specific (i.e. MMW) RF- EMF frequencies in different age groups and with increasing exposure density.

However, underestimating the relevance of available results (in particular those from in vitro and animal models) do not appear to be ethically acceptable since, as has been observed reasoning in terms of primary prevention, it “is equivalent to accepting that a potential hazardous effect of an environmental agent can be assessed only a posteriori, after the agent has had time to cause its harmful effects”(Tomatis, 2002).
Results already available should be sufficient to invoke the respect of the precautionary principle (Hau et al., 2014; Lo, 2009) considering the large number of subjects involved in this form of environmental exposure and classifiable as “vulnerable” (Bracken-Roche et al., 2017), and possible interactions between multiple and heterogeneous exposures, overcoming the single- pollutant approach with the measurement of the absorbed internal dose of multiple pollutants (the concept of exposome (Wild, 2012)).
In the respect of the WHO principle “health in all policies”, the development of new RF-EMF communication networks should be paralleled by adequate and active involvement of public institutions operating in the field of environmental health, by a revision of the existing exposure limits and by policies aimed to reduce the level of risk in the exposed population.
On the other hand, an adequate knowledge of pathophysiological mechanisms linking RF-EMF exposure to health risk should also be useful in the current clinical practice, in particular in consideration of evidences pointing to the role of extrinsic factors as heavy contributors to cancer risk (Wu et al., 2016) and to the progressive epidemiological growth of noncommunicable diseases (Pruss-Ustun et al., 2017).
http://www.elektrosmog.voxo.eu/video/Towards%205G%20-%20Potential%20Health%20Effects.pdf