AGENDA

PUBLIC HEALTH ADVISORY BOARD

November 19, 2020, 2:00-3:30 pm

Join ZoomGov Meeting
https://www.zoomgov.com/j/1609326045?pwd=M3hGbmVMZ2RwNm1kYWJhc3Q4Tzh1Zz09

Meeting ID: 160 932 6045
Passcode: 107561

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Meeting objectives:

- Approve October meeting minutes
- Discuss PHAB presentation to the Oregon Health Policy Board and next steps
- Determine PHAB subcommittee structure for 2021
- Discuss COVID-19 response work by local public health authorities

2:00-2:15 pm	**Welcome and agenda review** • ACTION: Approve October meeting minutes • Welcome Sarah Poe • Discuss board transitions	Rebecca Tiel, PHAB Chair
2:15-2:30 pm	**PHAB presentation to Oregon Health Policy Board** • Debrief presentation to Oregon Health Policy Board and next steps	Rebecca Tiel, PHAB Chair David Bangsberg, Oregon Health Policy Board Liaison
2:30-2:45 pm	**PHAB subcommittee structure** • Discuss approach to PHAB subcommittee membership to engage community • Discuss addition of public health data subcommittee	Rebecca Tiel, PHAB Chair
2:45-3:10 pm	**COVD-19 response update** • Discuss response activities to date • Discuss equity in COVID-19 response	Muriel DeLaVergne-Brown, Crook County Public Health Carrie Brogoitti, Center for Human Development

3:10-3:20 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
3:20-3:30 pm	**Public comment**	Rebecca Tiel, PHAB Chair
3:30 pm	**Next meeting agenda items and adjourn** • Discuss canceling December meeting	Rebecca Tiel, PHAB Chair

Public Health Advisory Board (PHAB)
DRAFT October 15, 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, Muriel DeLaVergne-Brown, Rachael Banks, Akiko Saito, Carrie Brogoitti

Board members absent: Dr. Dean Sidelinger, Alejandro Queral

Oregon Health Authority (OHA) staff: Cara Biddlecom, Krasimir Karamfilov, Chris DeMars, Amanda Peden, Kusuma Madamala, Margaret Braun

Members of the public: Jackson Baures (Jackson County), Nancy Goff (Nancy Goff & Associates), Alyshia Macaysa (Macaysa Consulting), Andres Lopez (Coalition of Communities of Color)

Welcome and Agenda Review
Rebecca Tiel

Ms. Tiel welcomed the PHAB to the meeting and reviewed the agenda. She announced that Ms. Rachael Banks would be the new state public health director. For this meeting, Ms. Banks is a voting member with Multnomah County.

- *Approval of September 2020 Minutes*

A quorum was present. Dr. Schwarz moved for approval of the September 17, 2020, meeting minutes. Ms. DeLaVergne-Brown seconded the move. The PHAB approved the meeting minutes unanimously.

Ms. Tiel remarked that there were two important documents in the meeting packet. One was a summary of biennial accomplishments as a result of the Public Health Division's partnership with ODOT (Oregon Department of Transportation). A version of the board had a meeting with the Transportation Commission in 2019, with Dr. Charles Brown giving a presentation on health equity, which is reflected in the summary. The second document is a letter from the Health Equity Committee (HEC) to the Oregon Health Policy Board (OHPB) with recommendations for the COVID-19 response. In terms of next steps, Ms. Biddlecom and Ms. Tiel will be attending the OHPB meeting in November.

Ms. Tiel stated that two areas of interest in the letter were declaring racism as a public health crisis and alignment with the health equity definition. Much of the work around implementing

the health equity definition is within the public health system (i.e., OHA, LPHAs). There is a lot of work to engage with community around decision-making related to COVID-19. One point to continue to talk about is the funding from OHA to community-based organizations through the CARES Act. A third area of interest is a focus on the specific needs of the disability community, Latinx community, and older adults.

Dr. Bangsberg noted that he and Mr. Oscar Arana (Vice Chair, OHPB) were approached by Mr. Derick DuVivier and Ms. Kate Wells (Chair, HEC) to bring their work to OHPB's attention and requested that the OHPB made a recommendation to OHA and/or the Governor. The work is highly aligned with the work of the PHAB. In that discussion, Dr. Bangsberg suggested a joint presentation by the HEC and the PHAB to both endorse this work and ask the OHPB to elevate it by proposing a set of recommendations to the OHA and the Governor, with the hope of getting a letter from the Governor that talks about this as an organizing principle for the state. This would be a great way to reinforce HEC's message and PHAB's message and bring everybody together.

Dr. Bangsberg pointed out that one thing that was not yet in the letter was the inclusion of health systems in HEC's definition of health equity. Every time this comes up at different forums, he reiterates that *health system* is *health system broad*, which includes public health. That is very important to bring out in a more direct way, because health inequities, including racism, operate outside of the healthcare delivery system. This an opportunity for the PHAB to remind people to bring that out. The collective wisdom of the HEC and the PHAB can enhance and shape this letter and the presentation to the OHPB and create something even better.

Ms. Biddlecom asked whether a small group of PHAB members should come together to prepare for responding to the HEC letter and presenting the OHPB with next steps.

Dr. Bangsberg supported Ms. Biddlecom's suggestion to convene a smaller group of PHAB members who tried to identify what was missing in the HEC letter, as well as what could be reframed, reshaped, or presented differently. That would become the presentation to the OHPB and an endorsement of this work. The group can also suggest consideration of 1-3 additional things. He reminded the board that the OHPB met on the first Tuesday of every month.

Ms. Little requested a little more time to read the letter and consult with colleagues about strengthening any of the language related to tribal communities, which had been significantly impacted by COVID-19 in disproportionate and unequal ways across Oregon. That additional time would allow her to respond to the letter and provide more context related to impacts on the American Indian/Alaska Natives community.

Dr. Irvin asked if there would be another meeting of the PHAB health equity workgroup and if others could join the discussion at that subcommittee meeting.

Ms. Tiel supported Dr. Irvin's idea.

Ms. Biddlecom asked if Dr. Savage, Ms. Rippeteau, or Ms. Banks would be willing to review the letter and help to prepare PHAB's response to it between now and the OHPB meeting on November 3, 2020.

Dr. Bangsberg expressed interest in attending the ad-hoc PHAB health equity workgroup meeting so that he could reinforce the messages from that meeting during the OHPB meeting.

Ms. Saito also expressed interest in attending the ad-hoc meeting.

Ms. DeLaVergne-Brown remarked that if the workgroup needed somebody to listen in from the local public health standpoint, in terms of what was happening on the ground, she would be happy to attend the ad-hoc meeting.

Dr. Schwarz commented that due to so many board members attending the ad-hoc meeting, maybe a draft could be sent to all PHAB members before the OHPB meeting, because, when the board met again in November, the OHPB meeting would be in the past. The main problem with the letter is that it is all-encompassing. It is difficult to find places in it to comment. He suggested that Ms. Biddlecom could find 1-3 focus areas where the PHAB could support the work rather than trying to address all issues that are raised in the letter.

Dr. Bangsberg suggested, in terms of digesting the letter, to focus on the first set of bullet points. Those are the specific recommendations to the OHPB, starting at the bottom of page 2 in the letter. The rest is important context.

Health Equity Review Policy and Procedure
Rebecca Tiel, Cara Biddlecom (OHA Staff)

Ms. Tiel stated that since the PHAB met last month, the workgroup met to develop the statement around the public health system commitment to leading with race. That is a new element to the document. The PHAB also presented the draft policy to the Health Equity Committee of the OHPB. The PHAB should look at the statement around leading with race, look at the feedback from the HEC, and then make a motion on the policy and procedure. If this is done, then the PHAB will share the board-approved version with the OHPB for consideration.

Ms. Biddlecom suggested, in terms of process, to focus on leading with race. The workgroup both developed its own language around the PHAB's and the public health system's commitment to leading with race, and also pulled in some great source material in terms of why leading with race was important, as well as intersectionality.

Dr. Schwarz noted that it was an amazing document to read from a public agency.

Dr. Present added that the document was beautifully written.

Ms. Biddlecom remarked that the HEC suggested to include APHA's (American Public Health Association) definition of racism in the document.

Dr. Schwarz suggested that the definition of racism could be placed after the definition of health equity, with the guidance coming afterwards.

Dr. Irvin stated that it was good to have the definition of racism in the document.

Ms. Tiel asked if the intention of including the definition of racism was about the framing of this section or that the definition was more specific to racism rather than saying leading with racial equity.

Ms. Rippeteau answered that it was about including the definition and having a consistent definition that had been broadly used by and adopted across many organizations.

Ms. Biddlecom added that the workgroup didn't define *racism* in the policy and procedure.

Ms. Biddlecom noted that the workgroup discussed which terminology to use, knowing that BIPOC is preferred by some. OHA uses "communities of color and tribal communities". Another term that is used is in Healthier Together Oregon is BIPOC-AI/AN. The workgroup didn't feel that it could make the call on which term to use, recognizing that further discussion was needed.

Dr. Dannenhoffer asked what BIPOC meant.

Ms. Biddlecom explained that it meant Black, Indigenous, and People of Color. AI/AN stands for American Indian and Alaska Native.

Dr. Schwarz remarked that Dr. Dannenhoffer's question made it clear why the board should not use that acronym.

Ms. Saito noted that Ms. Julie Johnson from OHA's tribal affairs recommended using communities of color and tribal community, which the PHAB should use as well.

Ms. DeLaVergne-Brown agreed with Ms. Saito and asked the board to think about its audience. If the PHAB gets into too much lingo, it confuses things for people. She suggested leaving the language the way it was.

Dr. Savage recalled that when the workgroup met, the idea came up to change the name and use BIPOC, because the communities of color and the BIPOC community were using it. The idea was that while the workgroup understood that the acronym was not necessarily reflective of what OHA wanted and not necessarily in the board's language, the workgroup was listening to what term the community was using, and that was more respectful. The board is trying to write a document that is putting forth racial justice and leading with race and yet it is putting its own language, which the board came up with, versus reflecting what the BIPOC community was telling everybody to use. This should be considered.

Ms. Tiel commented that based on Ms. Saito's comment about the preference of the tribal community, she recommended leaving the language as it was. Both OHA and the PHAB should continue to pose the question and change as advise is received. It shouldn't be up to the PHAB to decide right now.

Dr. Savage pointed out that the workgroup had that discussion. The PHAB could be an avenue to push back to the OHA and say that that was what the board was hearing from the community to use. The PHAB can decide as a group.

Ms. Little added that she was not prepared to make a recommendation today. She wanted to hear what the communities would want with respect to this language. It is a complicated issue for the tribal community. It is not just a racial issue, but also a political and sovereignty issue.

Ms. Tiel stated that the board could put a note in the document that the PHAB would continue to seek consultation and community input, and that the board was not endorsing that specific language, and that the board would make it an objective in its work to continue to get input on how communities wanted to be represented in government documents.

Dr. Savage agreed with Ms. Tiel and added that a living document that was something the board could work with was a really good example.

Ms. Biddlecom remarked that the HEC asked whether this was a policy and procedure or a guidance document because of the accountability piece. Who is accountable to whom when a proposed work product doesn't meet the standards that are set forth in this policy and procedure? What happens if a presenter to the board does not follow the outline of what they need to cover in order to be centering racial equity in their presentation? The board can handle this feedback in a few ways: continue as is, change the document from a policy and procedure to a guidance, or think more about the accountability piece that goes along with it.

Ms. Tiel noted that she liked guidance because of the world she worked in. She was unclear about accountability. If presenters to the board are not addressing racial equity, is it on the PHAB, or is it on the presenters? Because the PHAB has used the document as a policy and

procedure since its inception, and the board will be using it as a living document, maybe it is best to leave it as is and continue to have a conversation around accountability with it.

Ms. Rippeteau appreciated the feedback from the HEC about accountability. It is a question that comes up often with all committees and agencies across the state. If the board needs to move something today, having the asterisk and knowing that it is a living document, how does the board hold itself and the people who come to present to the board accountable? She found old emails about an Early Learning Equity Implementation Committee charge that the PHAB did in 2017 before the Early Learning Council restructured. This wouldn't be a one-for-one guidance document, but it could help inform how the board might build accountability into its work.

Ms. DeLaVergne-Brown added that policies and procedures were used on the local level and changed regularly, depending on new information, new events, and new processes. She always looked at a policy and procedure as a living document. She was fine with the document the way it was.

Dr. Dannenhoffer pointed out that as older white males had tremendously benefited from both male and white privilege, he agreed with everything that had been said.

Ms. Biddlecom noted that the workgroup talked about using this policy and procedure to update the board's charter and bylaws. That is also another vehicle for holding the PHAB accountable to the policies and procedures the board adopts.

Ms. Tiel summarized the changes to the document: (1) include the definition of racism, (2) it is a living document, (3) the board will seek council on how communities want to be represented, (4) the document will remain a procedure, (5) the PHAB will continue to have conversations around how to hold itself and others accountable. She asked for a motion to approve the changes.

Ms. Rippeteau moved for approval of the proposed changes. Ms. DeLaVergne-Brown seconded the move. The PHAB approved the changes unanimously.

COVID-19 Response Update
Jackson Baures (Jackson County)

Mr. Baures introduced himself as the Jackson County public health division manager. He stated that he would provide highlights on the county's COVID-19 outbreaks within the Latinx community. Jackson County brings in several hundred agricultural workers every summer. Based on the 2019 census, the county has 13.5% Hispanic or Latino population.

Mr. Baures added that the county's seasonal agricultural worker weekly outreach started in May. Its purpose was to promote worker safety, encourage testing, and provide supportive

services and resources. To prepare for isolation and quarantine in the event the county had a large agricultural outbreak, the EOC (Emergency Operations Center) set up a facility at the Jackson County Expo with capacity for 40 people. The facility was also used during the wildfires as an evacuation site.

Ms. Baures explained that currently about 40% of the people who tested positive for COVID-19 in Jackson County identified themselves as Hispanic. To help address this, the county brought in a bilingual/bicultural lead as a community-based organization coordinator. In early May, the county convened a communication workgroup to address equity and communication for the Latinx community. This initiative expanded to CBOs and outreach to school districts. The county learned what gaps and questions the Latinx community had and developed public service announcements (PSAs) across TV, radio, Facebook, and print. A school reopening PSA is currently being developed.

Mr. Baures noted that during the wildfires, a large percentage of those who were displaced from the Phoenix-Talent area were Latinx and lower income. After the wildfires, a large number of that population relocated to White City-Eagle Point area. As a result of that, the county worked with Eagle Point school district and Phoenix-Talent school district to provide resources. A testing event was organized, with La Clinica providing the testing. Moving forward, the county is in the planning phase with the Eagle Point school district, OHSU, and Southern Oregon University to have a drive-thru flu clinic in the Eagle Point area and target the Latinx population. This is also part of the county's COVID-19 vaccination planning and preparation efforts.

Dr. Dannenhoffer asked how Jackson County supported language access outside of Spanish.

Mr. Baures answered that the county had Unete, a community-based worker advocacy organization, which was very helpful during the outbreak. The organization handled the translation and interpretation.

Screening for Social Needs Metric Development
Nancy Goff, Chris DeMars (OHA Staff), Amanda Peden (OHA Staff)

Ms. DeMars introduced herself as the director of the Transformation Center and the deputy director of the Delivery Systems Innovation Office at OHA.

Ms. Peden introduced herself as a health policy analyst at the Health Policy & Analytics division at OHA.

Ms. Goff introduced herself as a consultant and former Public Health Division employee.

Ms. DeMars explained that the purpose of the presentation was to share history and context, process, key considerations, and current state of the Social Determinants of Health (SDOH)

Measurement Workgroup, which was currently underway. Additionally, the workgroup would like to hear from the PHAB on key considerations related to social needs screening, especially considerations that the board would like to be raised in a public workgroup. The workgroup is supported by OHA to develop a measure for consideration in the CCO incentive metric program.

Ms. DeMars provided some history on the process, which started in 2015. She explained the difference between social determinants of health and health-related social needs. Social determinants of health are shaped by the social determinants of equity, such as housing availability, access to healthy foods, and income. Health-related social needs are social and economic barriers to an individual's health, such as housing instability and food insecurity.

Ms. DeMars noted that the Metrics and Scoring Committee (MSC) approved an overall social needs screening measurement direction in 2019 that should include social needs screening completion and reporting of data and may include referral data. Oregon is at the forefront of developing social needs screening measure. Only three other states (i.e., RI, MA, NC) are in active development of such a measure or have one implemented.

Ms. DeMars pointed out that the goal of the SDOH Measurement Workgroup was for more CCO members to have their social needs acknowledged and addressed. The objective is to identify a proposed measure concept by December 2020 that incentivizes social needs screening. The measure will be recommended to the Metrics and Scoring Committee and the Health Plan Quality Metrics Committee.

Ms. Peden remarked that while social needs screening and referral was the current focus of this work, it is a long and broader path towards measuring those community-level factors. She reviewed the social needs screening measure development timeline. The project is currently in its early stage of measure development by the workgroup. Measure piloting and testing will take place in 2021 and 2022. The measure will be ready for implementation in 2023.

Ms. Peden added that the guiding principles for the development of the measure concept included equity, alignment, and feasibility. The equity framework is based on the health equity definition adopted by OHPB and OHA. The workgroup has operationalized the definition by developing four strategies: design for the most underserved/marginalized communities, center those screened, encourage equitable/trauma-informed screening practices, align with and support community initiatives. Key considerations for developing a social needs screening measure include who is screened, where are they screened and who screens, how often are people screened, what are they asked about, and how we collect the data.

Ms. Peden posed two questions to the PHAB: (1) When we are asking people about their social needs in the context of CCOs or the health system, what issues or experiences would you like to elevate for workgroup consideration? (2) What is one critical thing you want the workgroup to

keep in mind when developing a social needs screening metric for the CCO Quality Incentive Program?

Ms. DeLaVergne-Brown commented that Crook County was one of the early adopters of doing the program through OHSU. The county had been doing the program in its clinics for 18 months and then COVID-19 happened. Initially tablets were used for the questions, but they were not user-friendly, and the county went back to a paper form. The workgroup should look at what systems will be used and how they will be used. Crook County found the program useful and it did get resources to individuals. Overall, it is a hefty amount of work on the clinic side, especially if the form is not built into the electronic health records system.

Dr. Dannenhoffer stated and he and Dr. Schwarz had been members of the Metrics and Scoring Committee for many years and they really struggled with a social determinants measure because most of the measures were made by commercial insurers, and most of them rewarded an individual for more utilization (e.g., breast cancer screening). To get a truly transformational measure is hard. One of the things that the MSC was concerned was that if people were screened for a social determinant and then the system was not able to meet that, what would that do? For example, if a person went to the pediatrician and they were asked if they were food insecure and they said yes, they were given the number for the food bank, but the food bank didn't have food for them. Will that be retraumatizing every time a person was asked about food insecurity? If people are asked the questions, the system has to be able to do something about it.

Dr. Present noted that it would be beneficial to have some sort of a feedback loop to see whether the organization doing the screening had the resources. What should be followed is how successful is the linkage. The feedback loop will show how successful the linkage was in meeting needs. This will provide information on existing gaps versus overall need.

Dr. Schwarz pointed out that Dr. Dannenhoffer's and Dr. Present's comments captured some of the real challenges with social needs screening. The metrics and scoring system is not set up to measure feedback. It is essentially collecting information either from claims data or electronic healthcare forms. The PHAB discussed food insecurity in the past mostly because, at the time, there was a very bad definition and bad evidence for food insecurity. He wasn't sure how the data would be collected. He asked if the metric would be like ESTER? In the past, Oregon used metrics that were approved by the National Quality Forum. He asked if the intention of the workgroup was to trailblaze the development of this measure and have the rest of states follow.

Ms. DeMars answered in the positive. A National Committee for Quality Assurance (NCQA) representative had been participating with OHA in providing pro bono guidance and input.

Ms. Peden added that NCQA had been participating in the expanded planning team and would continue participating in the public workgroup as a formal advisor. The organization has an interest in this area, but there is no movement for a nationally standardized metric at this point. If the board members are interested, the workgroup could send them summary materials that describe four measure concepts: measure based on EHR (electronic health records) data collection, measure based on claims data, and two broader measures that allow for a variety of data sources.

Ms. Rippeteau asked if it was possible to have an open-ended question in the measure. For example, *What would a perfect day look like for you?* It's not just *What do you need?* It's giving people an opportunity to give a narrative that would describe what they need. The follow-up question could be asked from that. This would also get to the question about re-traumatization, if a person had been referred to a service before and the need was not met. It would help the person receiving services to drive the conversation and allow them to explain how they might have been frustrated through previous interactions. On the food security, pediatricians ask a food security question every time during well-child check-ups. The way the question is asked is open-ended.

Dr. Bangsberg expressed excitement for this work going forward. He offered two suggestions for the workgroup's consideration. When the CCO 2.0 framework started, there wasn't much specificity about what CCOs would do. What the CCOs are doing could inform the measurement strategy. He asked if there was a way to bring the CCOs together and see what was working and what was not working to inform the measurement strategy.

Ms. DeMars answered that the workgroup was looking for CCO input through various channels. There is some CCO representation on the public workgroup. The MSC has three CCO members. The measure will be going to a pilot phase, if the MSC approves the initial concept, which will bring in more input.

Ms. Goff noted that the workgroup spent the first two months of this project doing interviews and surveys with key stakeholders, which was now an environmental scan. It describes interviews with partners from OHA, community-based organizations that are doing a screening, and key health systems, as well as a survey of all CCOs and their current screening practices.

Dr. Bangsberg suggested that, in terms of measurement, the target population should not be only people at risk and CCO members, but the entire population, including people who were not CCO members. This could be a really important role for local public health authorities to do the measurement. What is measured are social determinants of health of the population writ large rather than CCO members. Some disparities are going to exist outside of CCO members. This gets to Dr. Dannenhoffer's question about measuring something about which nothing can be done. If the workgroup were to go to a global measuring strategy, it would get to that concern.

Dr. Bangsberg also suggested to leverage the CCOs as convening bodies for the social determinants of health that operate outside the healthcare delivery system. If CCOs are bringing people together to advocate for more affordable housing, better pre-K education, and anti-racism initiatives, that could be, in the long run, the most powerful public health initiative – to reach out to the whole population and forces outside of the healthcare system, even though half the measure and the feedback may not be as precise in terms of time, intervention, and impact.

Dr. Schwarz asked if the measure would be included in the accountability metrics.

Dr. Bangsberg answered that there should be an incentive to improve population health. It would be a reach incentive. It is important to have a reach incentive for a CCO and try to use things in terms of convening and advocacy. It would be a new, innovative, and somewhat controversial measure, but OHA at large is doing initiatives such as anti-racism, leading with race, social determinants of health, and the public health system is really innovating, and this is another way to innovate just a bit further.

Dr. Savage added that, as a CCO representative, she thought this work was fantastic. Bringing it to a measure and something for accountability is a must. When thinking about going forward and what the workgroup would pick and analyze when looking at the social determinants of health, the goal of the PHAB is leading with race. The board needs to ensure that there is a clear message in the measure that the focus is not only on inequities but leading with race. The difference Oregon public health wants to make is, first and foremost, in the communities of color and tribal communities. That has to be stated outright. That's where the biggest difference needs to be made. She suggested for the workgroup to keep that in mind as it looked at the different measures. If the REAL-D data from providers was incorporated with the data from OHA, the workgroup may be able to provide a better way of measuring and create a feedback loop, with race and equity as the main focus.

Public Health Survey Modernization

Alyshia Macaysa, Andres Lopez, Kusuma Madamala (OHA Staff), Margaret Braun (OHA Staff)

Ms. Tiel reminded the board that in the fall of 2019 the board heard about some investments that had been made with public health modernization resources in how the system gathered survey data. The board discussed in the past the problems and limitations of using just the BRFSS (Behavioral Risk Factor Surveillance System) or standard surveys, as they don't give a full picture. The Program Design and Evaluation Services (PDES) has been engaging with the Latinx, Black/African American, American Indian/Alaska Native and Pacific Islander communities and thinking about public health data. This work can help to inform PHAB's strategies around addressing root causes of issues.

Dr. Madamala introduced Dr. Andres Lopez, director of research at the Coalition of Communities of Color (CCC), OHA researcher Dr. Margaret Braun and her project partner Alyshia Macaysa. She provided an overview of the survey modernization project. The Public Health Division has relied heavily on the BRFSS for surveying adults in Oregon, around 8000-9000 adults per year, using a telephone survey. Every few years, a racial and ethnic oversample is conducted to ensure that OHA has sufficient numbers of participants from communities of color for analyses. The current challenges of the BRFSS is that it is expensive, it is long, it lacks estimates for smaller geographic areas, it raises concerns about representativeness and validity of data, it lacks community engagement, and it lacks data for Pacific Islander communities.

Dr. Madamala added that the public health modernization framework was used to identify a new approach, using the four foundational capabilities: assessment and epidemiology, health equity and cultural responsiveness, community partnership development, and policy and planning. Instead of conducting the usual BRFSS racial and ethnic oversample, the team combined 4 years of standard BRFSS data for analysis for communities of color, collaborated with communities, and identified innovative statistical and survey methods. It also did extensive partnership building between October 2019 and March 2020 to develop the project team. Latinx and Black/African American project teams are comprised of 4-5 individuals from community-based organizations and researchers. The team partnered with the Northwest Portland Area Indian Health Board to identify and lead the American Indian/Alaska Native project team.

Dr. Lopez stated that communities of color had been hit the hardest during the COVID-19 pandemic and the recent political uprising. They are fed up with the same responses and lack of accountability and they demand systemic change. The team is thinking of using the data to allow communities of color to frame how mainstream data fails to represent them, connect available mainstream data to the data driven by the communities, help local and regional entities with supplemental data collection strategies, and let communities lead the discussion on data needs.

Dr. Madamala remarked that each Latinx and Black/African American project team met three times virtually. Prior to the first meeting, the core team provided the project teams with all variables for each of the data sets for both BRFSS and the Oregon Healthy Teens survey and asked them what they wanted to learn about and what analyses they wanted to see. Prior to the second meeting, the core team send the project teams the results of those analyses and asked them to what degree these results resonated with what they knew of their community. Before the third meeting, the core team asked the project teams in what ways they currently engaged with their community during COVID-19 and what would be some promising practices for engagement. The priority of the third meeting was to discuss the gaps in the data that the project teams had identified.

Dr. Lopez noted that the teams identified structural problems in the survey design that focused more on programmatic and less of community-centered needs. Examples of the limitations of data quality include construct validity and data relevancy. A gap in the healthcare access questions in BRFSS is that the questions don't provide a structural understanding of what prevents people from accessing healthcare. Aside from cost and coverage questions, questions need to include what is keeping members of these communities from going to the doctor. Examples: *Do you know how to use health care coverage? Do you know what you are covered for?* The system needs a better way of capturing contextual and structural realities.

Dr. Madamala highlighted a few lessons learned: partner with communities and share the data discovery process, explore alternative ways of collecting data that communities find relevant, don't let the "small numbers" argument get in the way of sharing data with communities, ask for translation feedback to refine the question text to better reflect the intention of the questions. Additional lessons pertain to the scientific integrity, which gets compromised without community engagement. Questions should be designed in a way that results in data that is actionable and drives community program policy change. Communities should be engaged at every step of the process, from question design to data reporting.

Dr. Braun pointed out that there was extremely low Pacific Islander response to the BRFSS (i.e., 106 people). For the collaboration with the Pacific Islander communities, the core team couldn't start with an analysis of multiple years of BRFSS data. Using BRFSS is not the correct approach to collect data from this diverse community. This work is referred to as Pacific Islander Data Modernization (PDIM).

Ms. Macaysa explained that the Pacific Islander Data Project (PIDP) was a collaboration with Dr. Aileen Duldulao. That happened after years of advocacy from the community. The community was undercounted in the 2010 census. The ultimate goal of the PIDP with Multnomah County was to collect relevant data through community-based and action-oriented approach and tell the story of what it meant to be a Pacific Islander in Oregon. Two key conclusions from the PIDP data were that the data was not reliable and not relevant.

Dr. Braun added that the PIDP will be utilizing the Prevention Institute's THRIVE framework and tool.

Ms. Macaysa pointed out that the goal of using the THRIVE tool was to look at the community rather than the individual level of analysis. The onus must be on systems and institutions to look at how the structural racism that is embedded in the system drives people away from the health behaviors that are culturally embedded and natural to them. The THRIVE framework looks at 12 social determinants of health under three broad categories: people, place, and equitable opportunity. One of the core components to doing this work is not just creating this assessment tool and reframing how to the tell the stories about health inequities, but to engage community members to become trained community research workers.

Ms. Macaysa remarked that there would be six people trained as community research workers. They will be cofacilitating the data collection and data assessment workshops with the core team. They will be the first point of contact when community members have a question about the assessment that they will be accessing online. The project kickoff will take place on November 21, 2020. Any involvement and any input provided by Pacific Islanders will be paid. CBOs will recruit community members and host data collection workshops in early 2021.

Dr. Braun stated that this work centered the Pacific Islander community to lead this work. The core team has been able to engage weekly despite the pandemic and other competing projects. There is enthusiasm for the work among the boarder community. The draft budget for the work was recently solidified and scopes of work for CBOs and CRWs have been drafted. Relationships and engagement are built-in through the team members.

Ms. Tiel expressed excitement about this work and added that she couldn't think of a better use of the modernization work. The surveillance system in the state is antiquated and burdensome for users to get work done. This is not a one-time research project. The goal is to update the system, so that there is ongoing data collection and ongoing community engagement.

Dr. Schwarz asked about the size of the Pacific Islander community in the state.

Dr. Braun answered that the size was unknown. Any official count, such as the U.S. Census, undercounts the population.

Ms. Macaysa added that the 2010 census data showed around 4,000 members, but Pacific Islander leaders stated that that number was maybe half of the population in Oregon.

Dr. Schwarz noted that it sounded like the core team was converting a regular surveillance program to a community-based participatory research project. He asked about the sustainability of the project. The BRFSS is a program that runs on the CDC. This project would need a considerable and ongoing financial commitment from somebody. He asked if the state was willing to put that kind of funding into this project.

Ms. Macaysa answered that the state already put significant investments into BRFSS. It is known that it doesn't work for specific communities, especially for Pacific Islanders and Black/African American communities. The hope is to demonstrate through this work the importance to reinvest those dollars into community-led work.

Dr. Lopez added there were larger efforts for more sustainable community data collection. At the CCC, the research justice institute is going after a lot of large grants, having a lot of discussions with foundations, and engaging a lot of people for a more sustainable model. The

goal is to crowd-source data that is owned by community for community and have more sustainable practices. The work will begin with the training community on data justice and then find meaningful ways to communicate how storytelling and other community-driven strategies can be packaged in a way that is meaningful for government to make decisions. The work also involves working with communities to help them communicate their knowledge, power, and solutions in an impactful way.

Ms. Macaysa pointed out that the way data were reported out for Pacific Islanders right now was not sustainable. There are only three people in Oregon, including her, who know Pacific Islander data on an intimate level. That's why Dr. Lopez said that a community researcher model was needed. Quite a bit of history must be undone, because even during COVID-19 response efforts, a lot of local public health authorities across the country have said that they couldn't increase investment in the Pacific Islander community because it was too statistically insignificant.

Ms. Tiel commented that the small-numbers argument was a fascinating community insight. There is an assumption from the public health system that reporting insignificant numbers could do harm in some way. Using language like *insignificant* or *unreliable* is harmful from a public health systems perspective.

Ms. Biddlecom explained that the PHAB would be preparing to look at the public health accountability metrics for the next go-around. This is a great time to figure out the data that the system collects, how institutions are holding themselves accountable, how to ensure that the right data sources are available to do the work, and how the work lines up with the goals of Healthier Together Oregon and the policy and procedure the PHAB just adopted. This has been designed to take this biennium and look critically at the data collection and reporting system, so that the system can change how it works.

PHAB Member Discussion
Rebecca Tiel

Ms. Rippeteau shared that she was talking to somebody whose mother was a refugee and needed to be evaluated during the wildfires. It triggered trauma and memories about having to leave her home quickly decades prior. It would be great to coordinate with emergency management and other partners that respond to evaluation needs and figure out how to make these response efforts trauma-informed in the future.

Ms. Tiel agreed that some debriefing around emergency response needed to happen at some point in the future.

Public Comment

Ms. Biddlecom invited members of the public to provide comments or ask questions.

Dr. Kevin Parks at the Allergy and Asthma Center of Southern California sent the following public comment prior to the meeting:

"The topic of return to in-person learning has been vigorously debated since the beginning of lockdowns last spring. As a physician, spouse of a teacher, and parent of publicly-schooled children, I have the opportunity to view the current remote learning process from multiple angles. As I discuss school with patients and their parents in the clinic, see my wife struggle to connect with students in her online Spanish classes, and help my own kids navigate technology, I realize the data on distance learning don't look positive.

Students are falling behind. The education gap is widening. Vital social services are lacking for vulnerable children. Students need more than academics -- they need nutritious meals; access to healthcare; a stable and competent adult who can screen them for abuse and neglect; and role models to whom they can look for guidance. For the majority of our students, this only occurs at school.

Risk assessment is key to pandemic decisions. Public health officials, government leaders, education system leaders, and front line healthcare workers must consider risk outside our respective domains. Measurement of risk across domains is key to good medicine. If a treatment reduces risk of a heart attack but increases risk of liver failure, we use tests to screen for liver damage; or employ an alternative treatment strategy.

Relative risk assessment should be applied in the context of pandemic policy. Early decisions were made with limited preparation, foundational data, or prior experience. When businesses and schools closed in March, we were beginning to learn about the behavior of SARS-CoV2, the virus responsible for COVID-19 illness. The news from Northern Italy, New York City, Spain, and other large population centers was terrifying. The experience in these centers was initially applied to policy-making in disparate groups.

Seven months into our response in this country, we know more.

1. Children are less likely to become infected than adults; and infection is almost uniformly mild or asymptomatic in children and adolescents.
2. Children and adolescents are less likely to transmit the virus to adults outside their own home.
3. Super-spreader events account for most large outbreaks; and such events tend to be large gatherings, indoors, without masks, involving high minute ventilation activities (singing, yelling, exercise) in close proximity. Examples of such events include concerts, indoor sporting events, bars or dance clubs involving large crowds without physical distancing.

4. Testing, isolation, and contact tracing are effective strategies to control outbreaks in micropopulations such as manufacturing facilities, universities, care homes, and health care facilities.
5. Physical spacing, masks, and sanitation strategies are effective means of reducing transmission in the indoor environment, including schools.

An educated analysis of current data does not suggest that children cannot infect adults -- they can. The data do not suggest that reopening schools for in-person learning will have no effect on community transmission. However, results from Europe and several US states are reassuring. Transmission in schools is manageable with modifications in attendance guidelines; good testing, isolation, and contact tracing; and continuous data analysis with nimble policy changes. Jackson County Health and Human Services and our 2 hospital systems have made tremendous progress in this area over the past 3 months.

SARS-CoV2 vaccine development is progressing at an unprecedented pace, a truly remarkable collaboration in drug development aided by the National Institute for Allergy and Infectious Diseases. Like most new vaccines, initial data suggest significant barriers to broad community vaccination efforts. Most experts estimate that about 60% natural plus vaccine-generated immunity is needed to achieve "herd effect". In typical years, less than 50% of Americans receive the influenza vaccine despite demonstrable safety, low cost, and widespread availability. We cannot assume that the necessary portion of the population will be willing or able to receive a coronavirus vaccine before resuming in-person learning for students. If we wait, we will lose a generation of vulnerable children.

In a recent article from the non-partisan Economist "*Let Them Learn: the risks of keeping schools closed far outweighs the benefits,*" editors offer a clear warning:

"Education is the surest path out of poverty. Depriving children of it will doom them to poorer, shorter, less fulfilling lives. The World Bank estimates that five months of school closures would cut lifetime earnings for the children who are affected by $10trn in today's money, equivalent to 7% of current annual GDP."

Good science points toward a policy change. The Oregon Health Authority metrics for return to in-person learning must be revised to weigh the relative risk of adverse outcomes for children against the risk of SARS-CoV2 transmission."

Next Meeting Agenda Items and Adjourn
Rebecca Tiel

Ms. Tiel remarked that in the interim before the next meeting, the PHAB will convene to discuss a response to the HEC letter and to prepare for the OHPB meeting on November 3, 2020.

Ms. Tiel adjourned the meeting at 4:23 p.m.

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

November 19, 2020
2:00-4:00 p.m.
ZoomGov

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Krasimir Karamfilov at (971) 673-2296 or krasimir.karamfilov@state.or.us. For more information and meeting recordings please visit the website: healthoregon.org/phab

DRAFT

Public Health Advisory Board

Health Equity Recommendations

Rebecca Tiel, PHAB Chair

David Bangsberg, OHPB Chair & PHAB Liaison

Cara Biddlecom, Deputy Public Health Director

Thank you to the Health Equity Committee

The members of the Public Health Advisory Board (PHAB) are grateful to the Health Equity Committee (HEC) for preparing the letter to the Oregon Health Policy Board.

PHAB is committed to being a partner in advancing equity across Oregon's public health system in ongoing partnership with the HEC and OHPB.

PHAB membership – ORS 431.122

- (1) state public health employee
- (4) local public health administrators
- (1) local health officer
- (1) representative of the Conference of Local Health Officials
- (1) individual who represents a federally-recognized tribe
- (1) CCO representative
- (1) non-CCO health care representative
- (1) representative of academia
- (1) public health metrics expert
- (1) representatives of public health employees
- (1) at-large
- (3) non-voting, ex-officio members: Public Health Director, Public Health Officer, OHPB representative

PHAB's ongoing commitment to health equity

- Health equity assessments and action plans (ongoing)
- Public health modernization funding formula (updated 2020)
- Healthier Together Oregon - State Health Improvement Plan (launched September 2020)
  - Healthier Together Oregon vision: Oregon will be a place where health and wellbeing are achieved across the lifespan for people of all races, ethnicities, disabilities, genders, sexual orientations, socioeconomic status, nationalities and geographic locations.
- PHAB health equity review policy and procedure (updated October 2020)
  - Grounded in OHPB health equity definition
  - Public health system commitment to lead with race
- Public health accountability metrics (to be updated 2021)
- Ongoing learning to ground PHAB in equity and leading with race

Declare racism a public health crisis

- PHAB fully supports declaring racism a public health crisis
- This strategy is included in Healthier Together Oregon in the equity and justice implementation area

Use health equity definition to center COVID-19 response on equity

- For the COVID-19 response, the public health system can:
  - Facilitate co-creation of equity action plan strategies
  - Develop/continue meaningful community engagement, especially with community-based and culturally-specific organizations
  - Continuously improve language access and timeliness of translations
  - Bring community partners into the ongoing response structure at the local level to move from input and consultation to co-creation and power sharing

- There has and will be enduring equity challenges before and after COVID-19. The public health system can:
  - Co-create and implement equity strategies across the public health system
  - Implement workforce diversity recruitment and retention strategies
  - Implement strategies included in Healthier Together Oregon
  - Update public health accountability metrics to center equity

Equity Action Plan

- PHAB supports developing an Equity Action Plan that is co-created with community and allows for meaningful community engagement and power sharing
- PHAB recommends looking at the system as a whole and lining up with Healthier Together Oregon
  - Inequities that have been perpetuated as a result of systemic racism, injustices and oppression
  - Secondary and tertiary impacts of COVID-19, and beyond COVID-19
    - Opioid overdoses
    - Behavioral health
    - Sexually transmitted infections
    - Unemployment
    - Houselessness
    - Educational outcomes

Discussion and contact information

healthoregon.org/phab

healthiertogetheroregon.org

cara.m.biddlecom@state.or.us
(971) 673-2284

Public Health
Prevent. Promote. Protect.

CROOK COUNTY HEALTH DEPARTMENT

COVID-19 RESPONSE IN CROOK COUNTY PRESENTED TO OREGON HEALTH ADVISORY BOARD NOVEMBER 19, 2020

MURIEL DELAVERGNE-BROWN, RN, BSC, MPH
PUBLIC HEALTH DIRECTOR

- How we created the infrastructure in Crook County to directly work with and support communities experiencing COVID-19 Disparities?
- ***ORGANIZE THE TEAM!***

CROOK COUNTY HEALTH DEPARTMENT

CROOK COUNTY DEMOGRAPHICS (2019 CENSUS ESTIMATE)

- Population: 24,404
- Hispanic/Latino: 7.6%
- White Alone: 94.7%
- With a Disability under 65: 15.5%
- Median household income: $44,524
- Persons in Poverty 12.9%
- Individuals 65 and over: 25.2%
- Outside of traditional employers of city, county, and school district industries include wood products, data centers, warehouse and transportation, trucking, healthcare, and government land management.

DESCHUTES COUNTY

CROOK COUNTY Serving You EST. 1882

JEFFERSON COUNTY OREGON

CROOK COUNTY HEALTH DEPARTMENT Serving You

INCIDENT COMMAND

St. Charles HEALTH SYSTEM

Central Oregon Emergency Information Network

REGIONAL LEADERSHIP

CITY OF PRINEVILLE OREGON

SHERIFF STATE OF OREGON CROOK COUNTY 1859

Crook County School District where students dream, learn & succeed

Mosaic Medical

CENTRAL OREGON DISABILITY SUPPORT NETWORK

DAWNS House Directly Assisting Women Newly Sober

Latino COMMUNITY ASSOCIATION

CENTRAL OREGON thrive CONNECTING INDIVIDUAL NEEDS TO COMMUNITY RESOURCES

CBO's

PARTNERS

ACCREDITED HEALTH DEPARTMENT PUBLIC HEALTH ACCREDITATION BOARD PHAB Advancing public health performance

REPORTS AND SITUATION REPORTS

Crook County

Wednesday, July 8, 2020

Situational Status Report (SitRep #15)

A weekly COVID-19 report for community partners
Prepared by
Crook County Public Health Department

Incident: Crook County COVID-19 ORES#2020-0584

Health and Medical Situation Status Report (SSR#15); 5 pages

New or updated information is identified in blue.

Go to https://co.crook.or.us/health for previous Situational Status Reports.

Report Period: A recap through July 7th; Continued Weekly

Incident Manager: Muriel DeLaVergne-Brown, Health & Human Services Director
-Work Phone: 541-416-1980
-Cell: 541-233-8534
-Email: mdelavergnebrown@h.co.crook.or.us
PIO: Vicky Ryan, Public Health Preparedness Coordinator
-Work Phone: 541-323-2467
-Work Cell: 541-233-8504
-Email: vryan@h.co.crook.or.us
Operations Chief: Jo McCabe, Clinical Nursing Supervisor
-Work Phone: 541-447-5165
-Email: jmccabe@h.co.crook.or.us
Planning Chief: Katie Plumb, Health & Human Services Deputy Director
-Work Cell: 541-233-9177
-Email: kplumb@h.co.crook.or.us

Activation Level: Crook County Health Department EOC is currently activated.

General Objectives for the Incident:

1. Monitor public information needs and develop accurate and timely messaging in coordination with Deschutes, Jefferson, and COEIN.
2. Provide Surveillance, investigation and monitoring of suspect and confirmed cases of COVID-19 within Crook County.
3. Support the logistical needs of hospital, health clinics, first responders, and critical services in coordination with Emergency Management.
4. Provide accurate situational awareness to support operational and policy decisions for Crook County as well as offices and departments within the county.
5. Support planning efforts.
6. Develop plans to increase medical capacity with regional partners and provide for the safety of responders and medical personnel.

07/13/20 - 07/19/20

0800 – 1700

COVID-19 (Novel Coronavirus) Daily Situation Update

June 29, 2020

COVID-19 Updates for Today:

- Since Friday's situation update, Oregon Health Authority reports that total case counts:
  - Increased by 1 in Crook County (10)
  - Increased by 13 in Deschutes County (172)
  - Increased by 9 in Jefferson County (100)
- Since Friday's situation update, Oregon Health Authority reports that total COVID-19 case counts in Oregon increased by 667, bringing the total number of known cases statewide to 8,485. Since Friday's situation update, statewide COVID-19 deaths have increased by 2, bringing the total number of COVID-19 deaths in Oregon to 204.
- CDC reports there are >2.5 million cases of COVID-19 in the United States.
- Worldwide case counts are >10 million.

COVID-19 Situation in Central Oregon

(Click here for source: Oregon Health Authority Situation in Oregon)

Data as of 6/29/20, 12:01AM Pacific Time

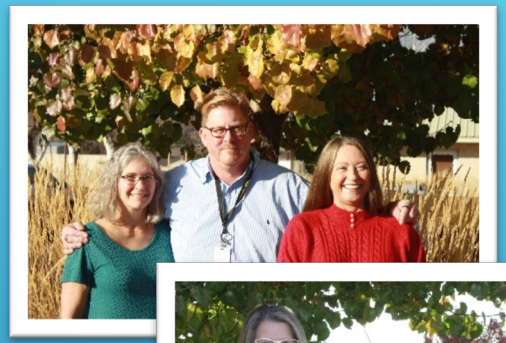
Central Oregon COVID-19 Cases:
- 10 in Crook County
- 172 in Deschutes County
- 100 in Jefferson County

Central Oregon COVID-19 Deaths:
- 0 in Crook County
- 0 in Deschutes County
- 0 in Jefferson County

The chart below shows the number of new COVID-19 cases reported from Crook, Deschutes, and Jefferson County each calendar week beginning the week of 3/9/20-3/15/20 (when the first cases were reported in Central Oregon).

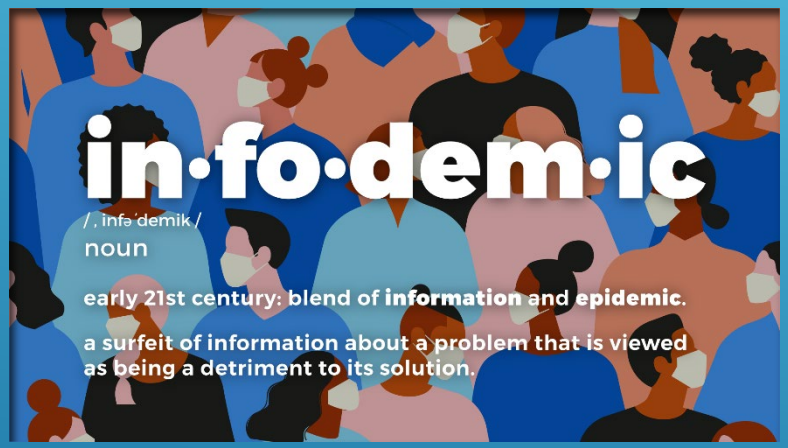
Data for this week is not yet shown. This chart will be updated **weekly** to show the number of new COVID-19 cases that were reported each week in Central Oregon.

THE TEAM – EVERYONE BEFORE COVID-19 AND MASKS



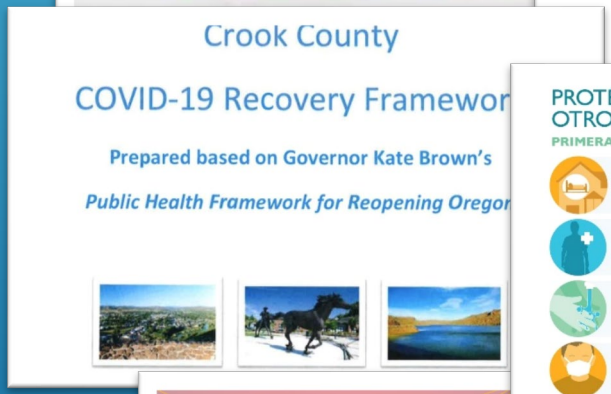
- Case Investigation – OHA Guidelines
- Contact Monitoring
- Wrap Around Services - bilingual
- Facilitation of testing approvals
- Communication/Liaisons/Regional
- Respond to public calls
- Hired bilingual staff and nurse

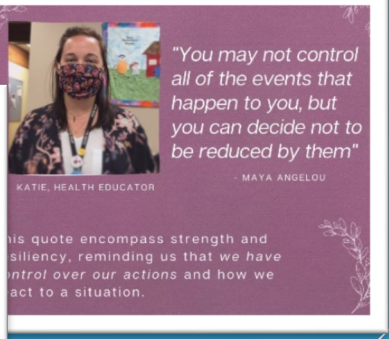
THE COMMUNITY LIAISONS

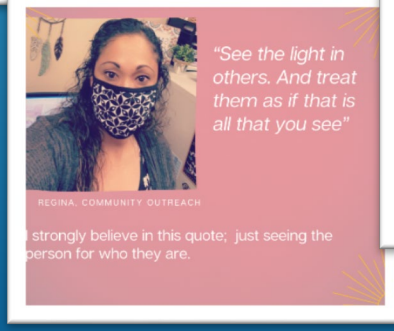


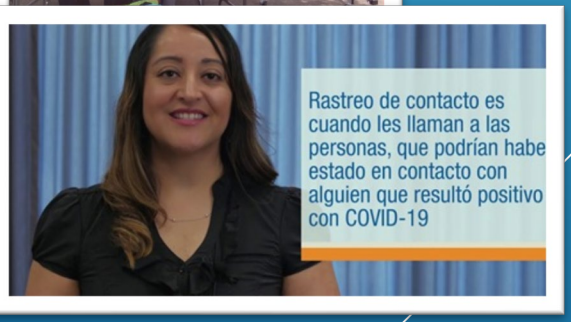
- Communication Team – PIO
- EMS/Hospital/Medical
- Businesses, Chamber
- Schools, Daycare
- Long-term Care
- County Court/City
- Faith-Based Network
- Environmental Health

EXAMPLES OF THE WORK





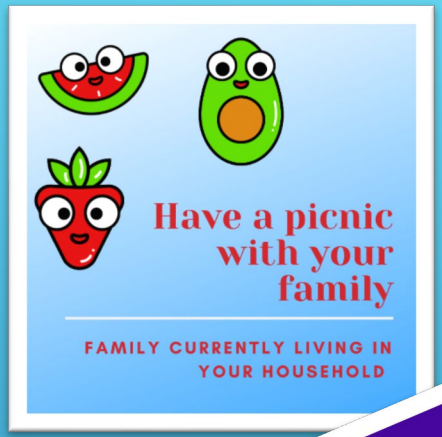




SUPPORTS FOR THE COMMUNITY

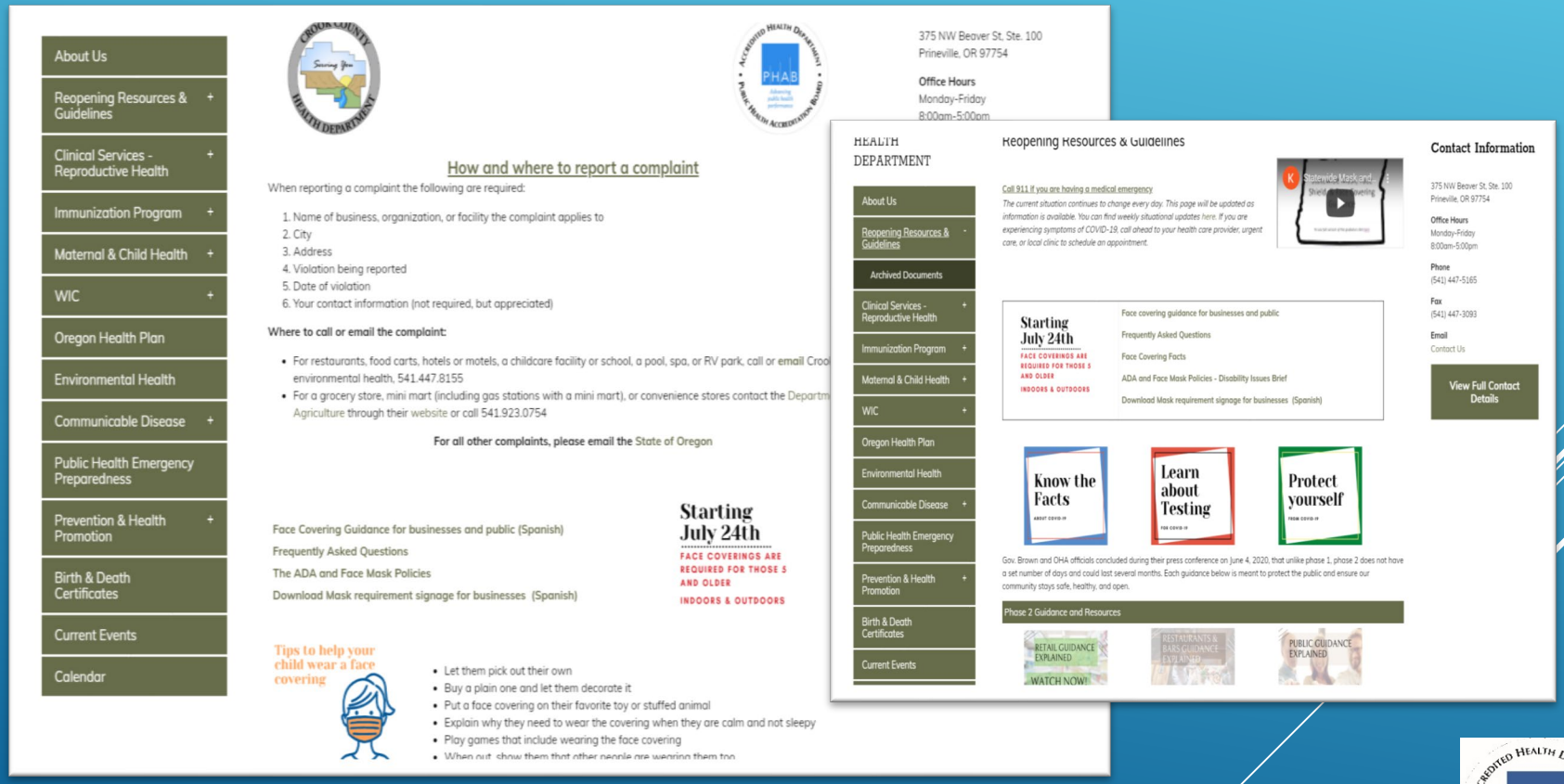
- Community Grants through the Chamber
- Drive Through Food Distribution Event at the Fairgrounds

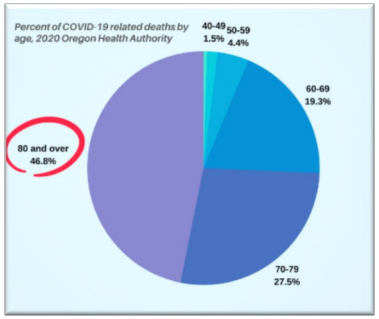
MESSAGING

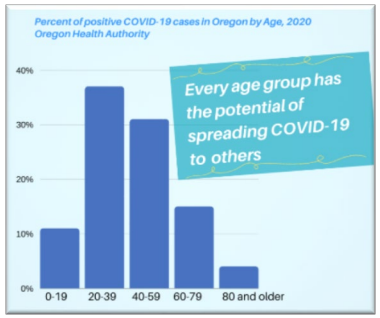


Three W's
Wear a face covering
Watch your distance
Wash your hands

REOPENING CROOK COUNTY ENFORCEMENT CHALLENGES

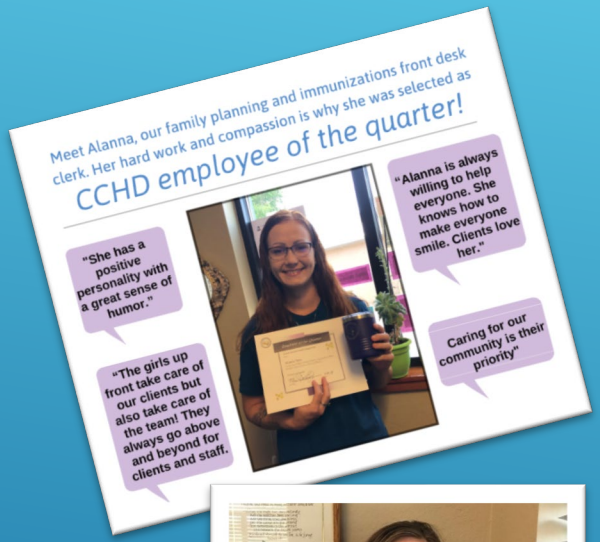






WE CREATED VIDEOS FOR EDUCATION AND RE-OPENING DIRECTIONS IN ENGLISH AND SPANISH

STAFF CARE



Exercise June of 2019

Microsoft Teams
Nothing can stop a team.

WHAT'S NEXT AND HOW DOES THIS WORK ALIGN WITH FUTURE GOALS?

- Continuing the day to day work
- Messaging
- Coordinate additional testing high risk
- Planning for Influenza clinics and COVID-19 Clinics
- Continue to work with schools for reopening
- FUTURE GOALS
  - Finish Strategic Plan, Health Equity, QI
  - Completed Public Health Reaccreditation In June of 2020
  - Ongoing training of staff

Drive Through

Influenza Vaccination Clinic/COVID-19 Testing – Nov. 14th, 2020
200 flu shots/20 COVID Tests

WEBSITE:

https://co.crook.or.us/health

Muriel DeLaVergne-Brown, RN, BSc, MPH

Public Health Director (Incident Commander for Event)

mdelavergnebrown@h.co.crook.or.us

QUESTIONS?

UNION COUNTY COVID-19 RESPONSE

PRESENTED TO THE OREGON PUBLIC HEALTH ADVISORY BOARD

CARRIE BROGOITTI, PUBLIC HEALTH ADMINISTRATOR

NOVEMBER 2020

BACKGROUND

- Union County Population

Population estimates, July 1, 2019, (V2019)	26,835
Race and Hispanic Origin	
White alone, percent	92.6%
Black or African American alone, percent (a)	0.8%
American Indian and Alaska Native alone, percent (a)	1.3%
Asian alone, percent (a)	1.3%
Native Hawaiian and Other Pacific Islander alone, percent (a)	1.3%
Two or More Races, percent	2.7%
Hispanic or Latino, percent (b)	5.2%
White alone, not Hispanic or Latino, percent	88.2%

COVID-19 UNION COUNTY TIMELINE

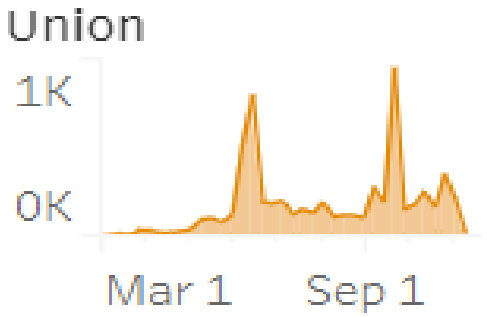
December 2019 Started tracking national and international activity.

March 2nd Stood up Incident Command at CHD Public Health (**Longest Incident in CHD History)**

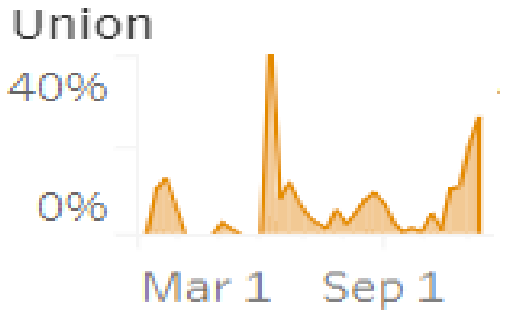
March 19th First Case

June 2020 Two linked cases led to testing event that confirmed large outbreak

Persons Tested



Positivity



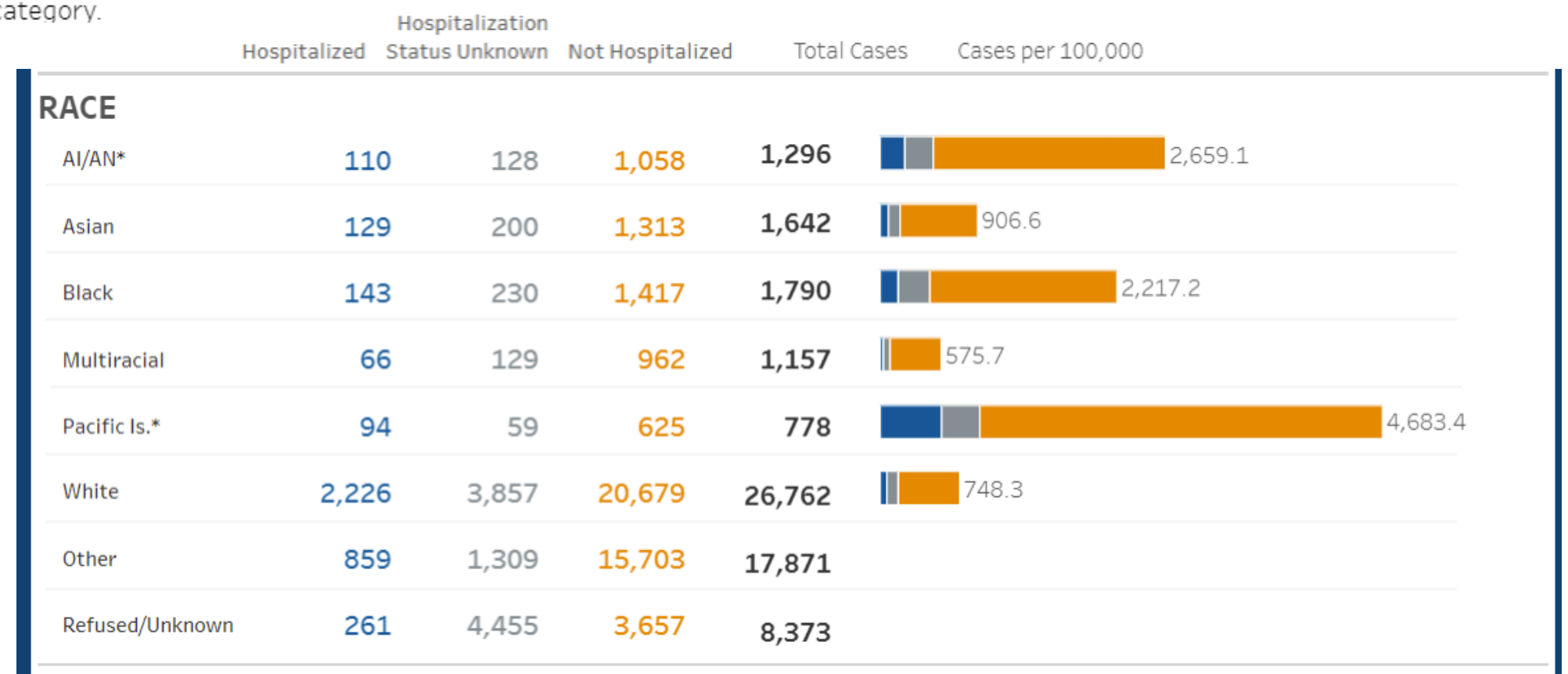
Testing Outcomes by County

	Case Count per 100,000	Deaths (%)	Positive Tests (%)	Negative Tests (%)	Test Count per 100,000
All	1,408.5	1%	6%	94%	22,989.4
Malheur	6,933.9	2%	24%	76%	28,659.7
Umatilla	4,869.4	1%	18%	82%	25,612.4
Morrow	4,707.1	1%	20%	80%	22,912.6
Jefferson	3,053.4	2%	10%	90%	29,523.5
Union	2,347.2	0%	9%	91%	24,060.2

OREGON'S COVID-19 CASE RATES

Oregon's COVID-19 Case Rates by Demographic Group

This dashboard shows the case rates per 100,000 people and the total number of reported COVID-19 cases in Oregon broken out by sex, age group, race, and ethnicity. Use the toggle below to see how many COVID-19 cases in each demographic group were ever hospitalized for their illness and how many have died from their illness. Hover over a bar to see the exact number of cases in each category and the percentage of total cases that fall in that category.



RACE	Hospitalized	Hospitalization Status Unknown	Not Hospitalized	Total Cases	Cases per 100,000
AI/AN*	110	128	1,058	1,296	2,659.1
Asian	129	200	1,313	1,642	906.6
Black	143	230	1,417	1,790	2,217.2
Multiracial	66	129	962	1,157	575.7
Pacific Is.*	94	59	625	778	4,683.4
White	2,226	3,857	20,679	26,762	748.3
Other	859	1,309	15,703	17,871	
Refused/Unknown	261	4,455	3,657	8,373	

UNION COUNTY COVID-19 RESPONSE

Collaboration and Co-Creation related to Contact Tracing, Wraparound Services, and Education/Outreach

- Community Based Organizations (CBOs) integrated into Incident Command structure
- Participate in regular meetings for planning and decisions related to contact tracing, wraparound services, outreach and education activities and with broader community stakeholders

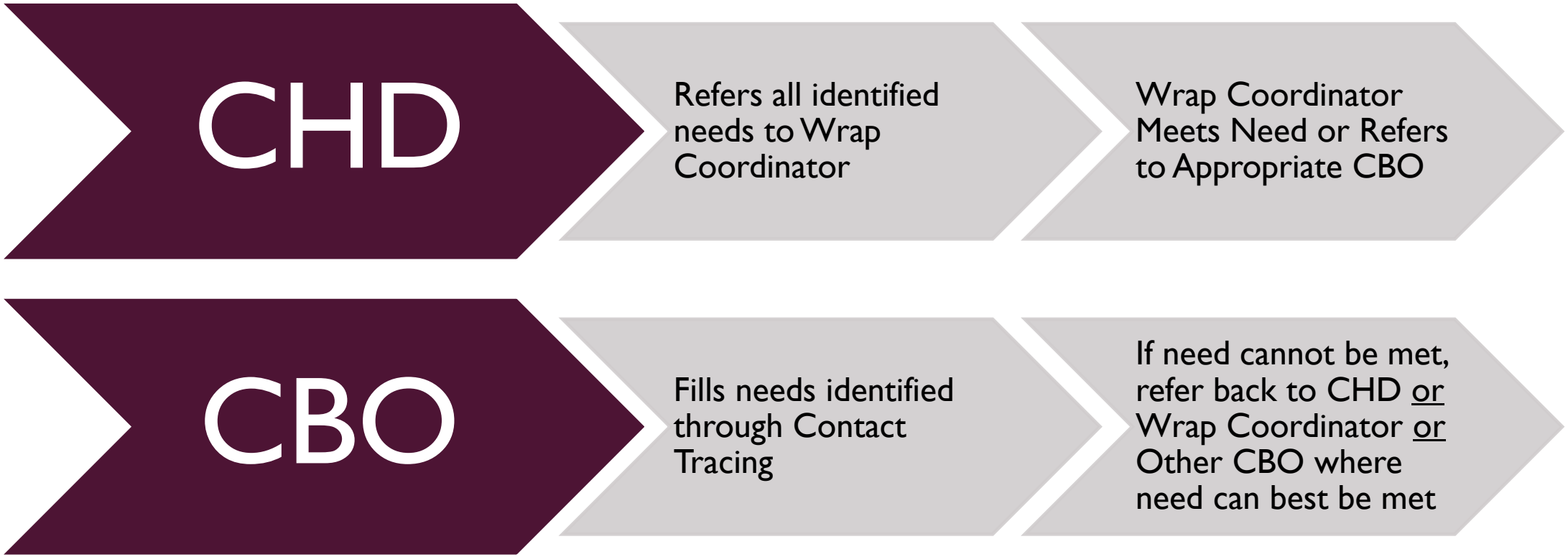
CONTACT TRACING

- CBOs funded to do contact tracing are now onboard and we are assigning as many contacts as they are able to manage.
- CBOs can provided wrap services to the contacts traced, or send them back to CHD or to another CBO if there is another CBO that can better address language/cultural needs.

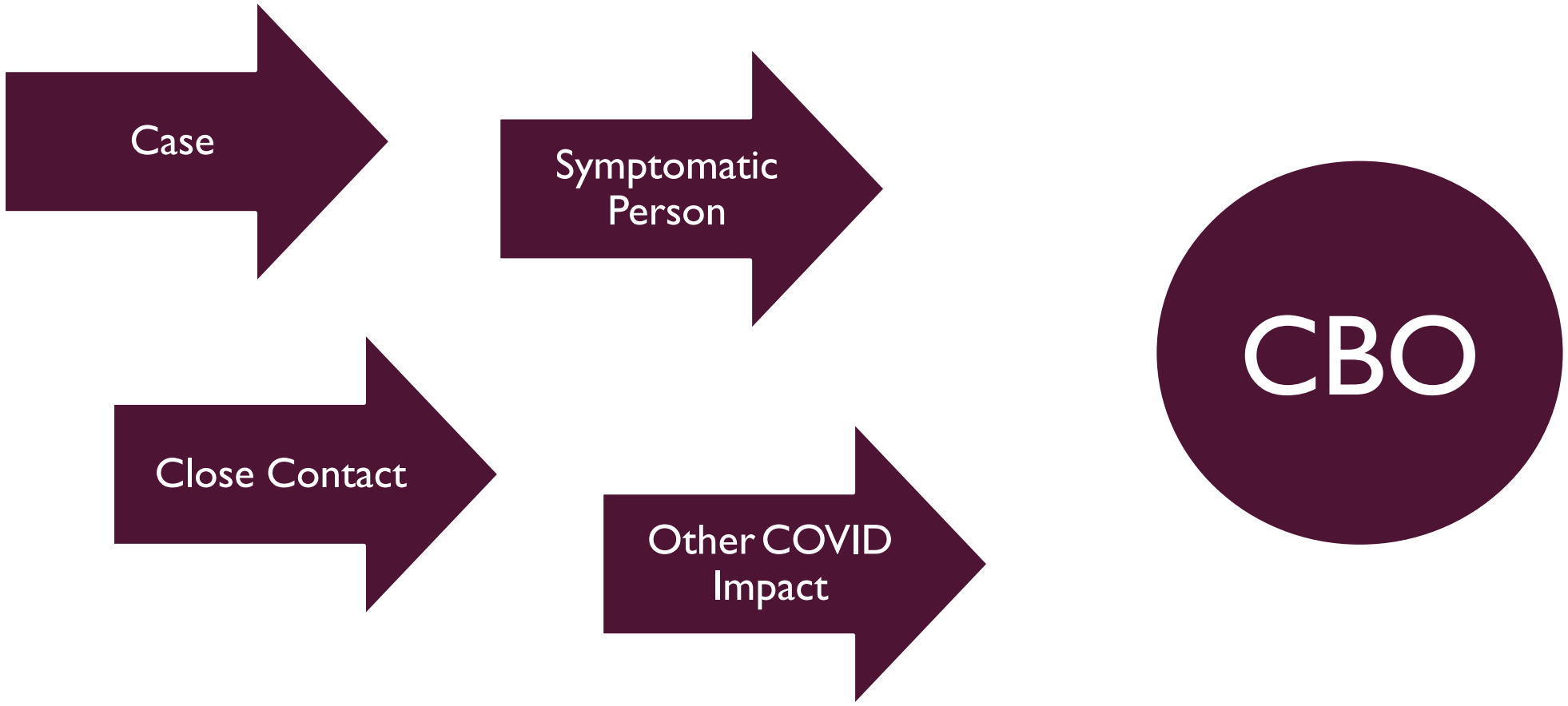
WRAP SERVICES

- Wrap Services Identified DURING Investigation/Contact Tracing:
  - Connect people with the CBO that can best meet their needs or refer to Wrap Services Coordinator
- Weekly "Wrap Operations" meetings bring partners together to collaborate and address issues/gaps in response effort.
- Reverse Referrals have been critical to addressing needs

WRAP SERVICES WORKFLOW
INVESTIGATION & CONTACT TRACING



WRAP SERVICES WORKFLOW
REVERSE REFERRAL



COMMUNITY EDUCATION AND OUTREACH

- Currently hosting a weekly communication and coordination workgroup with our funded and non-funded CBOs. The purpose is to provide a platform for communication/messaging coordination and strategies that are most responsive and resonant to the needs of people of color, people with disabilities, people who are houseless, individuals with substance use disorder, immigrant and refugee communities, faith communities, undocumented communities and farm workers, people experiencing mental health issues, older adults and LGBTQIA+ communities in order to ensure the success of community engagement, social services, and wraparound supports.
- Working closely with these trusted community organizations helps accomplish mutually beneficial outreach and education objectives. Many of these organizations are trusted, have long standing relationships, and provide vital services to an extremely broad and diverse network of individuals in our community. Working with their trusted voice and integrating into their services has been essential in reaching some of our most vulnerable community members.

COMMUNITY BASED ORGANIZATIONS (CBOS)

- Building Healthy Families (W) – English, Spanish
- COFA Alliance National Network (CANN) (CT, W, OE) – English, Marshallese, Chuukese, Palauans, Pohnpeians, Kosraeans, Yapese
- Chinese Friendship Association of Portland (OE) – English, Mandarin, Cantonese Chinese, Japanese, Korean, Vietnamese, Hindi, Cambodian, Thai, Filipino
- Eastern Oregon Center for Independent Living (CT, W, OE) – English, Spanish, ASL, Braille
- Euvalcree (CT, W, OE) – English, Spanish, Mam
- Micronesian Islander Community (CT, W, OE) – English, Marshallese, Chuukese, Palauan
- Northeast Oregon Network (CT, W, OE) – Spanish, English
- Oregon Marshallese Community Association (CT, W, OE) – Marshallese, English

Ayuda en español: (541) 910-0336

Help in Marshallese: (541) 910-6308

Help in Chuukese: (541) 910-6312

Help in Pohnpeian: (541) 910-6265

Help in Palauan: (541) 910-4346

CT = Contact Tracing, W = Wraparound, OE = Outreach and Education

RELIGIOUS COMMUNITY PARTNERSHIPS

- Currently participating in a monthly faith leadership meeting.
- Meeting privately with faith leaders from numerous different churches.
- Worked closely with OHA Faith Liaison Team.

NEXT STEPS

- Efforts to create equitable distribution or redistribution of resources and power must continue. These are small steps that are just beginning to set a foundation.
- Direct involvement of affected communities as partners and leaders in change efforts takes trust building due to historical injustices. This will be ongoing work that takes time.