AGENDA

PUBLIC HEALTH ADVISORY BOARD

October 13, 2022, 3:00-5:30 pm

Join ZoomGov Meeting
https://www.zoomgov.com/j/1602414019?pwd=MWtPYm5YWmxyRnVzZW0vZkpUV0lEdz09

Meeting ID: 160 241 4019
Passcode: 577915
One tap mobile
+16692545252,,1602414019#

Meeting objectives:

- Approve September meeting minutes
- Discuss PHAB subcommittees
- Review Strategic Data Plan subcommittee charter
- Review PHAB charter and bylaws
- Discuss prioritization for public health modernization funding in the 2023-25 biennium

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3:00-3:15 pm	**Welcome, board updates, shared agreements, agenda review** • Welcome, board member introductions (name, pronouns, board role) and icebreaker in the chat: place a public health acronym in the chat • Share group agreements and the Health Equity Review Policy and Procedure • Share update from meeting with Oregon Health Policy Board chairs and staff • Health Care Workforce Needs Assessment update • ACTION: Approve September meeting minutes	Veronica Irvin, PHAB Chair

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3:15-3:45 pm	**Subcommittee updates** • Hear updates from Strategic Data Plan subcommittee • Review Strategic Data Plan subcommittee charter • Hear updates from Accountability Metrics subcommittee	Jackie Leung, Strategic Data Plan Subcommittee; Jeanne Savage, Accountability Metrics Subcommittee
3:45-4:30 pm	**Charter and bylaws discussion** • Discuss the Health Equity Committee's letter to OHPB expressing its commitment to racial equity • Hear update and discuss proposed changes to PHAB's charter • Discuss high level changes to PHAB charter and bylaws • ACTION: Adopt PHAB charter	Bob Dannenhoffer, PHAB member
4:30-4:40 pm	**Break** • Public health acronyms	All
4:40-5:10 pm	**Public health modernization investment prioritization** • Determine PHAB role and recommendations for how to scale the public health modernization budget request • Discuss impact to public health system partners and feedback needed for decision-making	Veronica Irvin, PHAB Chair
5:10-5:20 pm	**Public comment**	Veronica Irvin, PHAB Chair

5:20-5:30 pm	**Next meeting agenda items and adjourn**	Veronica Irvin, PHAB Chair

PUBLIC HEALTH ADVISORY BOARD (PHAB) MEETING MINUTES

September 8, 2022, 3 – 5:30 pm

Attendance

***Board members present*:**

Dr. Veronica Irvin, Dr. Jocelyn Warren, Kelle Little, Dr. Jeanne Savage, Carrie Brogoitti, Dr. Sarah Present, Rachael Banks, Dr. Dean Sidelinger, Bob Dannenhoffer, Dr. Michael Baker, Dr. Ryan Petteway, Jackie Leung, Jawad Khan, Hongcheng Zhao (SDP subcommittee member)

Board members absent:

Nic Powers, Erica Sandoval

***Oregon Health Authority (OHA) staff*:**

Cara Biddlecom, Sara Beaudrault, Tamby Moore, Victoria Demchak, Charina Walker, Mitike Lyons

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3:00-3:20 pm Welcome, board updates, shared agreements and agenda review

Veronica Irvin, *PHAB Chair*

- Welcome, board member introductions and icebreaker: your favorite fall activity
- Share group agreements and the Health Equity Review Policy and Procedure
- Share group agreements and the Health Equity Review Policy and Procedure
- Share update from meeting with Oregon Health Policy Board chairs and staff
- ACTION: Approve September meeting minutes
    - Jeanne Savage proposed motion to approve minutes, Jocelyn Warren second the motion.
- Updates:
    - Recruitment for new PHAB subcommittee members.
    - Public health response to hMPXV and COVID19:
        - Approval of bivalent booster for COVID-19. Available in OR now.
        - Bivalent booster recommended for all of those 12 and up, monovalent only recommended for those under 12.
        - Community spread increasing, pressure on hospitals.

    Monkeypox (hMPXV)

    - Decline in reported new cases. Seeing a slowing in increase of cases, like other states.
    - Mostly affecting people who identify as men, three individuals who were infected identify as women. Other individuals have other identities.
    - Increased vaccine availability for Jynneos. 3rd generation vaccine, intradermal dosing for everyone except children and those with a history of keloid formation.
    - Community advisory group, queer provider group advising on the public health response.

- Messaging – anyone can get hMPXV. Who's being affected right now – mostly men who have sex with men who have multiple partners. Leaning on diff sides of that message depending on the venue. Primarily use "monkeypox" and "hMPXV" or "Monkeypox/ hMPXV" because CDC and WHO use the term monkeypox regularly. Trying to balance.

No identified polio in Oregon (yet).

3:20 – 3:40 pm Subcommittee updates

Veronica Irvin, *Strategic Data Plan*; Jeanne Savage & Jocelyn Warren, *Accountability Metrics*

- Strategic Data Plan Subcommittee (Veronica): Committee was on hiatus. Met in August and working on charter. Hoping to bring charter back to this group after September meeting.
- Accountability Metrics: (Jeanne and Jocelyn)
  - Need agreed-upon key ideas and selection criteria to get to the metrics.
  - Indicators/ process measures are where the work begins.
  - Meeting had CLHO representatives and received robust feedback.
  - Working on connection between indicators and process measures. Indicators have usually been focused on a narrower perspective of health outcomes.
  - Is it the role of PHAB to look at an indicator that's larger, more applicable to areas that PHAB and public health generally doesn't have control. Example: homeownership among communities of color. LPHAs can't control much of that, though it can affect this. Or do we want to look at more narrowly at public health interventions.
  - Do PHAB members want to see the traditional public health indicators or expect to look at the root causes of some of these inequities as an indicator?
  - Communicable Disease subcommittee of CLHO brought up a concern that all LPHAs are resourced appropriately before being held to reductions in disease prevalence. Brought forward measures on how

well-resourced depts were or were not, which is not a measure of what a health department is doing.

- Ryan shared to think of accountability in tiers – need to have funding and outcomes from LPHAs– propose tiers. Ryan commented "strongly suggest hiring folks with legal epi expertise to systematically examine the policy and regulatory of each Oregon heath jurisdiction and broadly – not just "health", but all policies relevant to health (e.g, tax, land use, housing, education, climate, transportation).
- Jocelyn shared that the political context varies from county to county.

2:40 – 3:40 pm Charter and bylaws Discussion

Bob Dannenhoffer, *Charter and Bylaws workgroup*

- Bob reviewed the Health Equity Committee letter as framing for updates.
- Overall recognition that public health isn't just OHA and LPHAs. Also includes Tribes, regional health equity coalitions and community-based organizations.
- Health equity and organizational priorities have changed. Considering changes in charter, bylaws (to comply with charter) and membership to reflect the representation of the public health system.
- Workgroup will be meeting to complete the charter and bylaws revision and will bring it back to PHAB in October.

3:40 – 4:20 pm Break

Legislative update

Charina Walker and Cynthia Branger Muñoz, *Oregon Health Authority*

Questions/ conversations

- Bob identified that LPHAs want more engagement with the POP on regional resource hospitals for disaster response

- General question – which bills/ POPs address health equity and how?
- Questions about flu vaccination – current age for administration by a pharmacist and other vaccines that can be administered in pharmacies
- Hongcheng commented that there needs to be more staffing and funding for CBOs to build up CBO capacity with longer term planning
- Jocelyn: OHA as a whole agency is asking for a lot, maybe 500 FTE. Of course, OHA won't get all of it, but we need to look at system. LPHAs are really underfunded. Cara shared that for public health modernization, each group of partners proposed their own biennial investment request - $100M for LPHAs, $100M for CBOs, $30M for Tribes and $10M for reproductive health provider network.

4:30 – 4:40 pm Public Health Modernization investment prioritization

- Discussion moved to next month's meeting.

4:40 – 4:50 pm Public Comment
Veronica Irvin, *PHAB Chair*

- No written in comment was submitted

4:50 – 5:00 pm Next meeting agenda items and adjourn
Veronica Irvin, *PHAB Chair*

- October meeting agenda will include proposed changes to the charter and bylaws; accountability metrics discussion; public health modernization POP and scaling
- Next meeting will be Thursday, October 13, from 3 – 5:30 pm.

Meeting adjourned at 5:00 p.m.

PUBLIC HEALTH ADVISORY BOARD
Strategic Data Plan Subcommittee

September 20, 2022
1:00 - 2:00 PM

Subcommittee members present: Veronica Irvin, Hongcheng Zhao, Kelle Little, Dean Sidelinger, Jawad Khan, Rosemarie Hemmings, Jackie Leung

OHA staff: Victoria Demchak, Virginia Luka, Diane Leiva, Cara Biddlecom

Other visitors:

Welcome and introductions
Subcommittee members and staff introduced themselves.

Minutes approval
Meeting minutes were approved with all subcommittee members in favor.

Strategic Data Plan subcommittee charter review and possible approval
The subcommittee discussed the equity and inequity wording within the charter and the original intention of the subcommittee, which is to improve the accuracy and accessibility of public health data so it can be used to promote equity through funding, policy and program decisions. The subcommittee made edits to the charter to reflect strengths-based wording.

Subcommittee members reviewed the updates to the deliverables section of the charter and made some additional changes for clarity and intention to center communities.

Additional clarifying edits were made to the charter.

The subcommittee unanimously approved the revised charter with the edits provided today. The charter will be approved to the Public Health Advisory Board at the October meeting.

Veronica reminded the subcommittee that more changes can still be made to the subcommittee charter and asked for a subcommittee member to present it to the Public Health Advisory Board. Jackie volunteered to present to charter to PHAB and take any additional feedback at the PHAB meeting.

BRFSS and Survey Modernization introduction
This agenda item will be carried over to the October meeting.

Public Comment
No members of the public were present, so no public comment was provided.

Meeting adjourned at 1:58 pm.

Public Health Advisory Board
Strategic Data Plan Subcommittee Charter

I. Background

The Public Health Advisory Board (PHAB) is established by ORS 431.122 as a body that reports to the Oregon Health Policy Board (OHPB). The purpose of the PHAB is to be the accountable body for governmental public health in Oregon.

The role of the PHAB includes:

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

Since 2016, PHAB has established subcommittees that meet on an as-needed basis in order to comply with statutory requirements and complete deliverables. PHAB currently has three subcommittees:

1. **Accountability Metrics Subcommittee**, which reviews existing public health data and metrics to propose biannual updates to public health accountability measures for consideration by the PHAB.
2. **Incentives and Funding Subcommittee**, which develops recommendations on the local public health authority funding formula for consideration by the PHAB.
3. **Strategic Data Plan Subcommittee**, which makes recommendations for a public health system plan for the collection, analysis and reporting of population health data based on community participation.

This charter defines the purpose, scope, and deliverables for the PHAB Strategic Data Plan Subcommittee.

II. Purpose:

In October 2020, PHAB adopted its current Health Equity Review Policy and Procedure, which reflects PHAB's values and a commitment for the public health system to lead with racial and ethnic equity.

Public health data are used to make program, policy, and funding decisions. Public health data, including information on identifying community strengths that serve health equity, are a key part of identifying and eliminating health inequities. A primary function of state public health is to collect and report public health data for these purposes. Public health data are used by

federal, state, local and Tribal public health authorities, health care, researchers, community-based organizations, other government agencies, and community members. Therefore, data must be accurate, accessible, and reflect community values and wisdom.

The PHAB Strategic Data Plan Subcommittee will be responsible for helping to create, through recommendations and feedback from community partners, a strategic data framework. This framework is to establish the parameters of public health data that accurately represents and addresses the vision and mission of our community partners and the Oregon Health Authority Public Health Division.

This subcommittee will build on existing feedback and the knowledge of subcommittee members to develop priorities for public health data systems across the continuum of public health data types. This will include engaging with governmental and community public health partners to review recommendations and the framework. OHA and Public Health will communicate to the Subcommittee what changes they can implement from the framework to establish an implementation timeline. This framework will be incorporated in the foundation of the 2023 State Health Assessment and other data infrastructure projects as the OHA Public Health Division is able.

Accountability and ongoing monitoring will be the responsibility of the PHAB Accountability and Metrics subcommittee.

III. Community-based participation

In this effort, community-based partnerships and Local Public Health Authorities have been identified as purveyors and/or users of public health data. Community members include representatives from the communities of color and tribal communities, people with disabilities, immigrants and refugees as well as representatives from the LGBTQIA2 communities[1].

Additionally, the following entities have been identified for this effort:

- Local public health authorities
- Community-based organizations
- Coordinated care organizations
- Health care providers
- Oregon academic entities
- Other government organizations

Oregon Tribes are also users of public health data, and OHA will engage Tribes in accordance with its Tribal Engagement and Confer Policy on public health data and through the representative of Oregon Tribes on the Public Health Advisory Board. OHA will continue to work

[1] The PHAB Strategic Data Plan Subcommittee is a public meeting and provides a voice to community members and the population at large.

with the Northwest Portland Area Indian Health Board – Tribal Epidemiology Center on Tribal data.

IV. Deliverables and Scope

Deliverables and recommendations shall be provided to the PHAB to report to the Oregon Health Policy Board. Update on deliverables and their status shall be provided quarterly to the PHAB and annually to the OHPB for the life of the committee, starting with the approval of this charter.

OHA's Public Health Division shall inform the committee on the

- Status of developing and implementing recommendations,
- Ongoing data modernization efforts, and
- Inclusion of the recommendations in the State Health Assessment and State Health Improvement Plan.

Deliverables include:

1. Create framework for advancing public health data toward better reflecting Oregon's residents. This framework would include the following:
    - Relevant values and goals for public health data.
    - Generalizable guiding principles on incorporating these values into the continuum of public health data, from data where the Public Health Division has a high degree of authority and control, to those areas where it does not.
    - Principles that guide community leadership and oversight in community engagement and participation.
    - Methods to collaboratively develop surveys and questions with community partners in ways that are sensitive to context, increased validity and precision, context-sensitive interpretation, for increased usability of this data.
    - Inform other PHAB subcommittees in their work regarding data collection, metric development and data interpretation to work toward health equity and data justice. This can be regarding types of public health data collected or processes regarding data.
2. Recommendations for changes to PHAB accountability metrics.
3. Support to other subcommittees, such as the Incentives and Funding committee, to receive population specific data that supports their work toward health equity.
4. Recommendations on how to transform Oregon's public health data systems to center equity and data justice.

Items that are out of scope for this subcommittee:
- Information technology infrastructure
- Recommendations on individual public health data systems or data sets and
- Funding recommendations.

V. Subcommittee member responsibilities

- Regularly attend meetings and communicate with OHA staff to the subcommittee when unable to attend on a regular basis.
- To the extent possible, review meeting materials ahead of time and come prepared to participate in discussions.
- Share relevant information with one's own organization or with other groups as relevant.

Members join either via a public facing selection process for one of (xx) public seats. PHAB members are encouraged to participate in one or more subcommittees of their choosing.

V. Resources

This subcommittee is staffed by the OHA Public Health Division:

- Cara Biddlecom, Deputy Public Health Director and Director of Policy and Partnerships
- Victoria Demchak, Health Equity Coordinator
- Diane Leiva, Public Health Division Data Interoperability Coordinator
- Virginia Luka, Data Justice Policy Analyst

Other leaders, staff, and consultants as requested or needed.

Minutes

draft

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

October 4, 2022
9:00-11:00 am

Subcommittee members present: Jeanne Savage, Kat Mastrangelo, Sarah Present, Ryan Petteway, Cristy Muñoz

Subcommittee members absent: Jocelyn Warren

OHA staff: Sara Beaudrault, Kusuma Madamala, Diane Leiva, Elliott Moon, Ann Thomas, Corinna Hazard

Guest presenters: Tyra Jansson, Nadege Dubuisson, Kathleen Rees

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Welcome and introductions

August meeting minutes were approved with three approvals and two abstentions.

Sara B. reviewed the group agreements and timeline for deliverables.

Framework, measure tiers and metrics selection criteria

- Review proposal for framework and tiers of measures to be included in accountability metrics.
- Review changes to metrics selection criteria
- Come to agreement on framework, measure tiers and metrics selection criteria

Sara B. described updates to the framework and tiers based on the last PHAB discussion.

- The framework still includes process measures for state and local public health authorities, and these are broken into measures of workforce and capacity, and measures of new or changed work resulting from improvements in foundational capabilities. The level of accountability is state and local public health authorities.
- Indicators are still included, looking at priority health issues of concern. The level of accountability is the public health system as a whole.
- Measures of structural determinants look at the policy landscape beyond public health policy to influence policies that contribute to or eliminate health inequities. The level of

accountability could include PHAB, the public health system, other sectors, and elected officials.

Sarah P. said she likes the framework and that it separates out the do-able levels and where the accountability should be.

Kusuma asked whether the concept of tiers includes rank.

Jeanne said she thinks the tiers capture the essence of the most recent PHAB discussion and brings together public health boots-on-the-ground with systemic issues of public health with indicators, and structural determinants with the political and policy level. Jeanne said she does not see tiers as being ranked; rather it is matrixed where it all needs to be done for change to occur.

Ryan agreed that tiers don't need to be ranked. He asked whether indicators are intended to only be outcomes, and are foundational capabilities intended to only reflect services. In order for these practices to change, we need to move away from this older model of public health being about providing services. And if indicators are only about outcomes and not process, there is no way we can change structural determinants. We can track processes but outcomes will take a long time to show change.

Ryan (chat): Re: foundational capabilities and necessity of being explicit about what the status quo entails and requires in terms of antiracism:
https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2020.306137

Sarah P. said that workforce and capacity and foundational capabilities are two parts of public health modernization. She read services as being public health services, which includes data, evaluation and work that is not direct care. She suggested using a word other than services.

Sara B. said she doesn't think indicators need to be health outcomes only. But it may be necessary to communicate what our priorities are. We need to communicate the "why" and what are the issues that communities are experiencing that we hope to improve by changing how we hold ourselves accountable.

Sara B. said that the CLHO communicable disease workgroup proposed an indicator for being prepared to address emerging and seasonal pathogens. This could be an example of an indicator that is more process-focused and not tied to a specific disease.

Sarah P. said that among local health officers, there is a sense that outcomes are important to keep in measures so there is clear evaluation of change over time and to communicate to legislators and the public. Outcomes are important to people. Being prepared is important, but we want to show that we were prepared, and we potentially see this in outcomes. There is a lot of nuance in processes at the local level. Public health struggles to communicate what we actually do. At the last health officer discussion, there was concern about changing the accountability metrics at all.

Ryan said that people are used to seeing an orientation around outcomes, but we can't point to anything that state or local public health does that is causally related to changes in outcomes. The idea of demonstrating need and burden is used to receive funding, and then it becomes the thing that gets tracked and prioritized. But the thing that changes is people coming in and distribution of risk factors. We need to prioritize changes to environments so exposures are modified. How do we frame the metrics to show we made a change to policy or environment that is empirically shown to improve health in the literature, understanding it will take five or ten or more years to show change? Putting outcomes in the design of metrics is faulty logic, and no one will be able to show a change that is causally related to something the LPHA did. The best way to focus on health equity and go upstream is to focus on process measures.

Jeanne said this context was very helpful, and she agreed that metrics have been used to show justification for the public health system.

Kusuma said that these systems are embedded in how things are set up federally, such as the Healthy People framework.

Cristy shared a paper from the Prevention Institute that covers, what works to improve health equity, including social determinants. She said it has been interesting to try to understand the structural drivers and how it affects PHAB's potential recommendations for metrics. The document includes indicators in line with what Ryan shared, including holistic measures that support working across sectors. Full report: https://www.preventioninstitute.org/publications/measuring-what-works-achieve-health-equity-metrics-determinants-health

Jeanne said the diagram on page four was very helpful because it shows the drivers, behaviors and exposures, and then the affect on the medical condition. It shows what Ryan is suggesting, the change is made upstream to affect downstream outcomes. There is room for this to work on all levels. This change requires maintenance of communicable disease work and emphasizing and expanding the work on structural drivers.

Ryan agreed. He suggested that this may be in the best interest of state and local public health departments. Without this, they are being asked to improve outcomes without the social, political and environmental context and changes.

Tyra said that local communicable disease programs are service-based and don't have the resources to provide the necessary services like reaching out to every syphilis case, ensuring partners are treated. We would love to be able to work upstream, but it is outside of the scope of what communicable disease programs are able to do. Sometimes health policy sits in a different area of a health department, so it might make more sense to work with teams responsible for policy.

Ann appreciated the comments made today. She said there are some things that are fundamentally different about communicable disease programs. For example, tobacco prevention programs focus on prevention and policy, but they don't reach every person. Communicable disease programs provide direct services at the same time they are collecting data and making sure that contacts are appropriately monitored and treated. Communicable disease programs are preventing additional

disease through these actions. Ann said there are gaps in the ability to reach everyone, especially among certain populations, such as people who are homeless. She would like to see communicable disease programs held responsible for reaching more people and for doing more community engagement, as we did during the pandemic.

Sarah P. said she thinks about the foundational programs and capabilities, and how we do programmatic work. We are moving toward upstream, policy-focused foundational capabilities, at the detriment of program work. LPHAs struggle to meet statutory needs when the funding comes in for upstream, policy work. There is a disconnect with focusing on policy when the basic workforce and capacity for statutorily required programmatic work isn't there.

Tyra agreed with what Sarah P shared. With upstream work, the work needs to be data-driven. Assessment and epidemiology is a foundational capability that many LPHAs don't have sufficient resources for.

Ryan asked what percentage of LPHA budgets are tied to communicable disease programs.

Tyra responded that it varies by county and described some of the funding mechanisms.

Ryan said that funding is an accountability question. It is a recurring discussion that LPHAs are understaffed and under-resourced. If the budgets aren't adequate, there needs to be a metric that shows this, for example LPHA reports that show percentage of budgets for infectious disease programs compared with local funding for policing. There is power and money being allocated. We won't change the outcomes without changing the political, economic and environmental context. Communicable disease programs are nuanced but if we address structural aspects like housing we are more able to intervene and control infectious disease. This tier structure feels inevitable and necessary. We need to show we're doing the things we need to do with limited resources, and we need to ask questions about why resources are perpetually limited.

Sara B. noted the OHA webpage for state population health indicators which includes YPLL, leading causes of death and other indicators.

Kat asked, is there a corresponding housing accountability metrics workgroup? So these conversations are happening here and not with agencies that have funding for housing?

Ann noted the new Medicaid waiver and wondered whether there is an opportunity for alignment and for public health to support what is measured.

Jeanne said she believes the work of this subcommittee should be informing how that benefit works in every CCO. CCO leaders need to have the same discussion with the same ideas and consistency across issues for where funds go. Jeanne said, regarding collection of more data, at some level we don't need more data. She can tell by looking at geography, factors of poverty, food deserts, she has the data that show the conditions in which poor health outcomes are occurring. We need to focus on movement toward changes and not so much on collection of data.

Cristy said this resonates. From a CBO perspective, data and research are important. But how can metrics help us increase relationships and community engagement as a level of accountability. She is at other tables with other sectors for housing. With large buckets of money coming in she is not seeing that sectors are talking to each other, and she believes public health equity should be a focal point for all bureaus. Governmental entities don't have to do it alone. CBOs are community engagement experts; they know and reflect the community. Instead of trying to increase community engagement capacities within governmental entities, instead they could invest more in local organizations that already have those relationships with community. Cristy agreed with less push for data and more push for community engagement and relationships across sectors and with community partners.

Tyra agreed with Cristy's comments and said that during COVID with better data, LPHAs knew where to focus outreach and which partners to work with to reach those communities.

Sarah P. agreed that there is a lot of data. COVID has also shown us that we also need to work on engagement between public health communicable disease programs and health care delivery systems including insurers, health care and behavioral health providers. The idea of modernization was to put some direct services back in the health care system, but the coordination of services is a barrier to doing public health work and leaves public health scrambling to fill gaps. We need to figure out what the gaps are and how to address them.

Ryan wrote in chat that data is always a part of discourses of power and politics in public health, but only as *potential* tools/instruments of persuasion--always reliant upon action and advocacy to render real. And that's where the accountability part comes in.

Ann agreed and would support measures to improve interview rates. We're not reaching people from populations of concern, like communities of color, people who are houseless or using drugs, people whose primary language is other than English. When we reach people through interviews, we are able to connect people to care and resources. It's not necessarily more data, but reaching more people and making sure we're using data.

Kat raised the CCO quality improvement measure around ER utilization for clients with SPMI. In her community the initial discussion was about who was responsible and how to impact the measure. But they ended up realizing that it required all groups working together to make a difference. Was that a successful CCO measure and did we see the needle move?

Jeanne did not know the answer to that but can look into it.

Cristy asked in chat if LPHAs have forums for community engagement in geographically diverse locations to engage with culturally diverse communities.

Sara B. said the mechanisms for community input are different in different counties, but it is a part of accreditation and all aspects of public health modernization funding. Sara also noted that there is a need to bring a Medicaid 1115 waiver discussion to PHAB. Sara also noted PHAB's responsibilities

toward the State Health Improvement Plan, Healthier Together Oregon and its five priorities. There are connections between these accountability metrics and other areas that PHAB has prioritized.

Sara B. recommended changing the framework with measure tiers to take the indicators out of the middle of the graphic. It should be on the lefthand side if indicators are used for assessing priorities, or on the right-hand side if indicators are used to reflect long-term changes in outcomes. It sounds like there is agreement that the framework should describe work at a spectrum of levels, from programmatic work reflected in process measures to systemic policy work reflected in structural determinants.

Ryan said this is a useful place to start in terms of accountability and equity. Some of the things we're looking at are answerable with the data we have. One issue with equity is when priorities are determined before we look at the data or get community input. Ryan suggested the group workshop one outcome across measure types.

Sara B. proposed the group try this with congenital syphilis.

Ann provided an overview of congenital syphilis. Ten years ago we had 0-1 cases per year, and now it is up to 15-20. While sexually transmitted, much of the increase is driven by increased drug use. There are a lot of behavioral risk factors and social determinants involved.

Sarah P. said that 20 years ago we thought that syphilis was nearly gone in the U.S. but there has been a huge resurgence with behavior changes around sexual activity. The rate of cases among females of child-bearing age, lack of access to reproductive health services, lack of access to appropriate and timely prenatal care, increased use of methamphetamines that correlates with increased sexual behavior risk taking, houselessness and exchanging sex for safety needs like housing and money.

Sara B. noted that both Ann and Sarah talked about drug use, access to health care and behavioral health care, access to prenatal care. There are connections to structural determinants and factors like community wellbeing. If there were an indicator for congenital syphilis, could we demonstrate the core public health work for case investigation, contact tracing, partner treatment, epi trends and use of data in decisions making, community partnerships, etc. Is there a possibility for process measures that would resonate with the subcommittee?

Jeanne said she would defer to public health partners doing the work. They need to feel like they have the ability to make an impact now or potentially in the future. Should the subcommittee be attempting to advance the work with these accountability measures?

Sara B. said it is the role of the CLHO workgroups to come up with what the process measures are or could be, and to bring to the subcommittee for discussion and a recommendation. Sara said these measures should, to some degree, influence the work that happens locally and at the state level, but they also reflect the core work that we want to see in every county in the state. If LPHAs don't have the capacity then we would want to see them building the capacity.

Ryan wondered if it is such a small number, is there enough data to make a determination about a pattern to reveal something about structural processes. If there is a pattern of risks, then we're able to start unpacking the structural things, and they will probably be the same things as for many other outcomes. Hence the significance of focusing on structural determinants.

Sarah P. said when we think about what we do at the local level for congenital syphilis, we have increased funding for case management and incentives for pregnant women. The incentives are not large enough for these individuals to overcome the barriers to getting appropriate care, including drug use and housing. The larger public health system needs to have resources to for the case manager to be able to move the needle.

Ann described the Oregon Nurture program. Twenty-four counties have Prime+ programs with peers with lived experience.

Sarah P. said these programs are critical on the individual level. Ideally, we are also trying to increase screening and treatment at a population so we can prevent disease in general and in people who are pregnant. Public health is struggling to get information out and screening rates when indicated are still low. This is another systems-level place we could improve upon. The LPHA can only do so much in ensuring that providers are screening and have appropriate treatments available.

Tyra said even just having testing and treatment available is a challenge. This is a place where there are disparities among counties. Some provide the services whereas others work through partnerships.

Jeanne said it was helpful to walk through this process to look at a condition at different levels of where work is done and can be held accountable. Will the subcommittee come up with the top things we're working on and come up with measures across them?

Sara B. said yes.

Jeanne asked if other members are on board and whether this will need to go to the Oregon Health Policy Board (OHPB) for approval.

Sara B. said OHPB does not need to approve PHAB metrics, but they are very interested in PHAB's metrics work and how PHAB may use its levers

Jeanne said there is appetite at all levels to have this format, and this could be modeled for metrics happening within the CCO metrics. This is parallel work. Jeanne recommended taking this to the CCO metrics committee and encourage them to use this to hold other groups accountable at the same levels. Jeanne asked whether the next phase is hashing out the priority areas and measures.

Sara B. quickly reviewed the measure areas drafted by the CLHO environmental health work group, including focus on heat-related measures.

Ryan said this is a good example of an outcome, but the reason people seek urgent care vary by reasons public health has no control over. There are interpersonal and community supports to mediate heat impacts. To have a sense of accountability, it would need to work back up to what the state health department and legislators are doing. What's missing is what the measure would look like at the structural determinant level.

Sara B. asked whether subcommittee members are on board with the general direction for measure tiers or if there are concerns. Jeanne noted that the framework and ideas will need to be socialized for how these changes can affect public health. Sarah P. said these are the conversations and movement that should be happening in PHAB. Sarah P. said it will be important to keep an understanding of what local public health can do and be accountable for.

Kat, Ryan and Cristy voiced support.

Sara B. asked how subcommittee members want to move forward with identifying measures. Sara proposed that the CLHO workgroups could develop proposals for priority issues and have some conversations with the subcommittee about process measures and structural determinants.

Sarah P. said the CLHO workgroups have already brought things to the subcommittee, and this could be a starting place within the context provided by PHAB.

Sara B. agreed and said the committees are well-prepared to bring proposals to the subcommittee.

Ryan said he doesn't know the process for CLHO workgroups to determine priorities. This work is not separate from other commitments to equity, antiracism and social justice. Whatever the outcomes or priorities, they need to be arrived at through a process that considers equity, antiracism and social justice.

Subcommittee business

- Jeanne volunteered to provide the subcommittee update at the October 21 PHAB meeting.
- Next subcommittee meeting scheduled for October 21 from 12:00-2:00. Most, but not all, members are available to attend.

Public comment

Carissa Bishop with Access Care Anywhere. She brought attention to her comments in the chat. She encourages use of the social ecological model in terms of identifying levers. She sees an opportunity for alignment with CCO metrics and encourages PHAB to find ways to align with other committees and boards.

Carissa provided the following links.
https://pubmed.ncbi.nlm.nih.gov/26082170/

https://www.cdc.gov/nccdphp/dnpao/health-equity/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fnccdphp%2Fdnpao%2Fstate-local-programs%2Fhealth-equity%2Fframing-the-issue.html
https://www.frontiersin.org/articles/10.3389/fpubh.2020.00131/full

Meeting was adjourned

Public health accountability metrics Measure tiers			
Indicators (assessment)	Public health process measures Public health data, partnerships and policy (assurance)		Structural determinants of health (policy development)
Health outcomes and reduced differences among populations *What are priority health issues that are of concern to communities throughout Oregon?*	LPHA workforce and capacity *Do public health authorities have the capacity and expertise to address priority health issues?*	Foundational capabilities *Are public health authorities better able to provide core public health functions within their community?*	Policy landscape and interventions *How are policies contributing to or eliminating root causes of health inequities?*
Level of accountability: Public health system	Level of accountability: OHA and LPHAs	Level of accountability: OHA and LPHAs	Level of accountability: PHAB, public health system, other sectors and state/local elected officials

Public health accountability metrics Environmental health – Extreme heat and health (example only)			
Indicators (assessment)	Public health process measures Public health data, partnerships and policy (assurance)		Structural determinants of health (policy development)
Health outcomes and reduced differences among populations	LPHA workforce and capacity	Foundational capabilities	Policy landscape and interventions
Heat-related emergency department and urgent care visits Extreme weather-related hospitalizations/deaths	LPHA staff trained in using climate and health-related data	# Collaborations with other agencies for data and monitoring efforts # local jurisdictional plans that include heating and cooling interventions at individual and community level	Policy supports for renters, MSFW and others for accessing and using cooling options in homes Climate ready homes and affordable housing

Public Health Advisory Board, October 2022 PHAB proposed updates

I. Authority

The Public Health Advisory Board (PHAB) is established by ORS 431.122 as a body that reports to the Oregon Health Policy Board (OHPB). PHAB performs its work in accordance with its Health Equity Review Policy and Procedure https://www.oregon.gov/oha/PH/ABOUT/Documents/phab/PHAB-health-equity.pdf.

The purpose of the PHAB is to advise and make recommendations for governmental public health in Oregon. The role of the PHAB includes:

- A commitment to leading intentionally with racial equity to facilitate public health outcomes.
- A commitment to health equity for all people as defined in OHPB's health equity definition.
- Alignment of public health priorities with available resources.
- Analysis and communication of what is at risk when there is a failure to invest resources in public health.
- Guidance for Oregon Health Authority, Public Health Division strategic initiatives, including the State Health Assessment and State Health Improvement Plan.
- Support and alignment for local governmental strategic initiatives.
- Connect, convene and align LPHAs, Tribes, CBOs and other partners to maximize strengths across the public health system and serve community-identified needs.
- Support for state and local public health accreditation and public health modernization.

This charter defines the objectives, responsibilities, and scope of activities of the PHAB.

The charter will be reviewed no less than annually to ensure that the work of the PHAB is aligned with statute and the OHPB's strategic direction.

II. Definitions

Governmental public health system: A network of state and local public health authorities and government-to-government relationships with federally recognized Tribes. In Oregon's decentralized public health system, local and Tribal governments have authority over many public health functions to ensure the health and well-being of every person in their jurisdictions.

Public health system: A broad array of governmental public health authorities and partners working collectively to improve health through interventions that reach every person in Oregon with a focus on those experiencing health inequities. Partners include but are not limited to community-based organizations, regional health equity coalitions, health care and behavioral health providers, public safety agencies, faith-based institutions, schools, environmental agencies,

and the business sector.

Community-based organizations (CBO): Non-governmental organizations that provide community-informed, culturally and linguistically responsive services to improve the community's health and well-being. CBOs often provide services intended to reach those experiencing a disproportionate impact of health risks and disease. Within this charter, CBOs is used to refer to community-based organizations that currently are or in the future may be funded by OHA.

III. Deliverables

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

PHAB Duties per ORS 431.123	PHAB Objectives
a. Make recommendations to the OHPB on the development of statewide public health policies and goals.	• Have knowledge of OHPB agendas and priorities. • Create opportunities to align with OHPB priorities and elevate recommendations to OHPB • Participate in and provide guidance for Oregon's State Health Assessment. • Regularly review state public health data to identify ongoing and emerging health issues. • Provide recommendations to OHPB on policies needed to address priority public health issues, including the social determinants of health, per PHAB's health equity review policy and procedure.
b. Make recommendations to the OHPB on how other statewide priorities, such as the provision of early learning services and the delivery of health care services, affect and are affected by statewide public health policies and goals.	• Regularly review health system transformation priorities. • Recommend how health system transformation priorities and statewide public health goals can best be aligned. • Identify opportunities for public health to support health system transformation priorities. • Identify opportunities for health care delivery system to support statewide public health goals.

c. Make recommendations to strengthen foundational capabilities and programs for governmental public health and other public health programs and activities	• Provide representation and participate in the administrative rulemaking process when appropriate. • Provide recommendations on updates to the Public Health Modernization Manual as needed. • Make recommendations on the roles and responsibilities of partners, including LPHAs, Tribes, CBOs, OHA and others to the governmental public health system
d. Make recommendations to the OHPB on the adoption and updating of the statewide public health modernization assessment. e. Make recommendations to the OHPB on updates to and ongoing development of and any modification to the statewide public health modernization plan.	• Make recommendations and updates to the OHPB on processes/procedures for updating the statewide public health modernization assessment. • Perform ongoing evaluation, review and recommendations toward system performance • Update the public health modernization plan as needed based on capacity. • Use assessment findings to inform PHAB priorities.
f. Establish accountability metrics for the purpose of evaluating the progress of the Oregon Health Authority (OHA), ~~and~~ local public	• Establish public health accountability metrics as a core set of metrics. For example, across any program there would be relevant metrics related to access or reach. • Use a menu of metrics, with organizations working in these areas eligible to receive incentives.

health authorities in achieving statewide public health goals.	

g. Make recommendations to the Oregon Health Authority (OHA) and the OHPB on the development of and any modification to plans developed for the distribution of funds to local public health authorities, and the total cost to local public health authorities of implementing the foundational capabilities programs.	• Identify effective mechanisms for funding the foundational capabilities and programs. • Develop recommendations for how the OHA shall distribute funds to local public health authorities and community-based organizations. Continue to evaluate and update funding recommendations. • Follow Tribal Consultation policy on funding to federally recognized Tribes and the Urban Indian Health Program. • Review the Public Health Modernization Assessment report for estimates on the total cost for implementation of the foundational capabilities and programs. (completed, 2016)
h. Make recommendations to the Oregon Health Policy Board on the incorporation and use of accountability metrics by the Oregon Health Authority to encourage the effective and equitable provision of public health services by local public health authorities,	• Develop and update public health accountability metrics. • Provide recommendations for the application of accountability measures to incentive payments as a part of the local public health authority funding formula. • Make recommendations regarding the extension of metrics and use of incentive metrics, including CBOs funded by OHA, federally recognized Tribes and the Urban Indian Health Program, if approved through Tribal Consultation Policy. • Consider public health system's integration as it relates to achievement of accountability metrics.
i. Make recommendations to the OHPB on the incorporation and use of incentives by the OHA to encourage the effective and equitable provision of public health services by local public health authorities.	• Develop models to incentivize investment in and equitable provision of public health services across Oregon. • Solicit feedback on incentive models.

j. Provide support to local public health authorities in developing local plans to apply the foundational capabilities and implement the foundational programs for governmental public health.	• Provide support and vision for local modernization plans, and ensure collaboration with CLHO. • Provide support and vision for Tribal planning as requested by Tribes through the Tribal Consultation process. • Develop a strategy for PHAB to support vision and strategies for working with LPHAs on local modernization plans. •
k. Monitor the progress of local public health authorities in meeting statewide public health goals, including employing the foundational capabilities and implementing the foundational programs for governmental public health.	• Provide guidance and accountability for Oregon's State Health Improvement Plan by receiving quarterly updates and providing feedback for improvement. • Provide support and guidance for local public health authorities in the pursuit of statewide public health goals. • Provide guidance and accountability for the statewide public health modernization plan. • Develop accountability measures for state and local health departments.

l. Assist the OHA in seeking funding, including in the form of federal grants, for the implementation of public health modernization.	• Provide letters of support and guidance on federal grant applications, as applicable. • Educate federal partners on public health modernization. • Explore and recommend ways to expand sustainable funding for state and local public health and community health.
m. Assist the OHA in coordinating and collaborating with federal agencies.	• Identify opportunities to coordinate and leverage federal opportunities. • Provide guidance on work with federal agencies.

Additionally, the Public Health Advisory Board is responsible for the following duties which are not specified in ORS 431.123:

Duties	**PHAB Objectives**
a. Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters.	• Provide guidance and recommendations on statewide public health issues and public health policy.
b. Act as formal advisory committee for Oregon's Preventive Health and Health Services Block Grant.	• Review and provide feedback on the Preventive Health and Health Services Block Grant work plan priorities.
c. Provide guidance for the implementation of health equity initiatives across the public health system by leading with racial equity..	• Receive progress reports and provide feedback to the Public Health Division Health Equity Committee. • Provide direction to the OHA Public Health Division on health equity initiatives. • Participate in ongoing learning and continuing education to support PHAB priorities and initiatives • Participate in collaborative health equity efforts.

IV. Dependencies

PHAB has established three subcommittees that meet on an as-needed basis in order to comply with statutory requirements and support PHAB priorities and initiatives:

1. Accountability Metrics Subcommittee, which reviews existing public health data and metrics to propose biannual updates to public health accountability measures for consideration by the PHAB.
2. Incentives and Funding Subcommittee, which develops recommendations on the local public health authority funding formula for consideration by the PHAB.
3. Strategic Data Plan Subcommittee, which provides recommendations and develops a framework for modernization of public health data in the state of Oregon.

PHAB shall operate under the guidance of the OHPB.

V. Resources

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

PHAB Executive Sponsor: Rachael Banks, Public Health Director, Oregon Health Authority, Public Health Division

Staff Contact: Cara Biddlecom, Oregon Health Authority, Public Health Division

PUBLIC HEALTH ADVISORY BOARD BYLAWS
~~**November 2017**~~**September 2022**

ARTICLE I
The Committee and its Members
The Public Health Advisory Board (PHAB) is established by ORS 431.122 for the purpose of advising and making recommendations to the Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB).

The PHAB consists of the following 14 members appointed by the Governor.

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

Governor-appointed members serve four-year terms and are eligible for reappointment. Members serve at the pleasure of the Governor.

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

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

Date approved: ~~November 17, 2017~~

Commented [VD(1]: Comment: is this where we identify how we want to increase interactions and describe the relationship we want with the OHPB? Could be added to liaison role or elsewhere

Could include:
-Requesting quarterly updates from OHPB
-Clear communication between two boards

Commented [VD(2]: Adding other roles, say individuals with lived or professional experience, would require a change to statute. Roles to consider inclusion include:
-RHECs, which may include people with lived experience
-CBO representative(s), maybe metro and non-metro?
-Individuals who receive public health services

Members are entitled to travel reimbursement per OHA policy and are not entitled to any other compensation.

Members who wish to resign from the PHAB must submit a formal resignation letter. Members who no longer meet the statutory criteria of their position must resign from the PHAB upon notification of this change.

If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

ARTICLE II

Committee Officers and Duties

PHAB shall elect one~~two~~ of its voting members to serve as the chair ~~and vice chair~~. Elections shall take place ~~no later than January of~~within the first quarter of each even-numbered year and must follow the requirements for elections in Oregon's Public Meetings Law, ORS 192.610-192.690. Oregon's Public Meetings Law does not allow any election procedure other than a public vote made at a PHAB meeting where a quorum is present.

The chair ~~and vice chair~~ shall serve a two-year term~~s~~. The chair ~~and vice chair are~~is eligible for one additional two-year reappointment.

If the chair were to vacate their position before their term is complete, ~~the vice chair shall become the new chair to~~a chair election will take place to complete the term. ~~If a vice chair is unable to serve, or if the vice chair position becomes vacant, then a new election is held to complete the remainder of the vacant term(s).~~

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

Should the PHAB chair not be available to facilitate a meeting, the PHAB chair shall identify a voting member to facilitate the meeting in their place.

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

Both the PHAB chair ~~and vice chair~~ shall work with OHA Public Health Division staff to develop agendas and materials for PHAB meetings. The PHAB chair shall solicit future agenda items from members at each meeting.

ARTICLE III

Committee Members and Duties

Members are expected to attend regular meetings and are encouraged to join at least one subcommittee.

Absences of more than 20% of scheduled meetings that do not involve family medical leave may be reviewed.

Date approved: ~~November 17, 2017~~

Commented [VD(3]: This changed in the 2021 legislative session with the new board and committee compensation policy which exempts anyone who meets a certain income level or is a government employee. Note to add citation to follow this compensation policy in HB 2992

Commented [VD(4]: Reflect current practice, "shall inform chair in writing" or staff, as it may be?

Commented [VD(5]: Create space for an outside or alternative facilitator (concern about this being reasonable).

Commented [VD(6]: Pending alignment with HEC recommendations to fold in practices related to inclusion, anti-racism and anti-oppressive practices.

Commented [BCM7]: Comment from Veronica: Do PHAB members want to be required to join at least one subcommittee?

In order to maintain the transparency and integrity of the PHAB and its individual members, PHAB members must comply with the PHAB Conflict of Interest policy as articulated in this section, understanding that many voting members have a direct tie to governmental public health or other stakeholders in Oregon.

All PHAB members must complete a standard Conflict of Interest Disclosure Form. PHAB members shall make disclosures of conflicts at the time of appointment and at any time thereafter where there are material employment or other changes that would warrant updating the form.

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

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

Members must complete required Boards and Commissions training as prescribed by the Governor's Office.

PHAB members shall utilize regular meetings to propose future agenda items.

ARTICLE IV

Committee and Subcommittee Meetings

PHAB meetings are called by the order of the chair ~~or vice chair~~, if serving as the meeting facilitator. A majority of voting members constitutes a quorum for the conduct of business.

Commented [BCM8]: From Veronica: Should group agreements that PHAB has been using be added here?

PHAB shall conduct its business in conformity with Oregon's Public Meetings Law, ORS 192.610-192.690. All meetings will be available by conference call, and when possible also by either webinar or by livestream.

The PHAB strives to conduct its business through discussion and consensus. The chair ~~or vice chair~~ may institute processes to enable further decision making and move the work of the group forward.

Voting members may propose and vote on motions. The chair ~~and vice chair~~ will use the current version of Robert's Rules of Order to facilitate all motions. Votes may be made ~~by~~ in-person, webinar or by telephone. Votes cannot be made by proxy, by mail or by email prior to the meeting. All official PHAB action is recorded in meeting minutes.

Commented [VD(9]: Should this be more specific to versions? Concern that some members would appreciate greater clarity.

However, we review and adopt bylaws infrequently.

Meeting materials and agendas will be distributed one week in advance by email by OHA staff and will be posted online at www.healthoregon.org/phab.

ARTICLE V

Amendments to the Bylaws

Bylaws will be reviewed annually. Any updates to the bylaws or charter will be approved through a formal vote by PHAB members followed by an approval by the Oregon Health Policy Board.~~s.~~

Date approved: ~~November 17, 2017~~

Public Health Modernization Policy Option Package (POP)

October 13, 2022

Oregon Health Authority

PHAB guidance on POP priorities

- Investments in 2023-25 will accelerate work toward health equity for communities of color, Tribal communities, immigrant and refugee communities, LGBTQIA+ communities, people living in rural Oregon, people with low income and other groups that experience intersecting oppressions.
- This includes:
  - Ensuring an adequate workforce and building on lessons learned from the COVID-19 pandemic to respond to and mitigate emerging public health threats;
  - Investing in antiracist governmental and community public health initiatives that engage Oregonians directly;
  - Investing in the development and retention of a public health workforce that is representative of and from the community served; and
  - Broad implementation of public health modernization across the Oregon public health system.

POP development process

- After receiving PHAB's guidance on the framework for POP development, OHA convened existing networks of partners to further detail out each investment:

1. LPHAs through the Conference of Local Health Officials
2. Tribes through group and individual consultation with Tribal Health Directors and the Northwest Portland Area Indian Health Board
3. CBOs through the CBO Advisory Committee
4. OHA through Public Health Division Executive Leadership, OHA leadership and shared services (technology, contracts, financial services, etc.)

*Each group above developed their own budget priorities based on guidance from PHAB. The POP reflects the total sum of all requests.

Options for scaling

- PHAB can propose any of the following or other options for how to scale the public health modernization POP.
  - Request that all investments are scaled proportionally
  - Request that each group scale their own investments, with specific guidance from PHAB
  - Identify priorities for scaling across the public health system