OREGON PARTNERSHIP MEETING

Thursday, October 11, 2018

Portland State Office Building
800 NE Oregon St. Portland, OR 97232

Members in attendance: Tom Jeanne (for Katrina Hedberg), Frank Franklin, Paul Virtue, Kim Sogge, David Bangsberg, Katie Harris, Jim Rickards, Brian K. Gibbs, Annie Valtierra-Sanchez,

Members on phone: Victoria Warren-Mears, Alicia Ramirez, Rebeckah C. Berry, Laura Williams, Katherine Duarte (for Erin Schulten), Vanessa Mendoza (for Ernesto Fonseca), Kirt Toombs

Members absent: Lee Po Cha, Clarice Amorim Freitas, Cat Livingston, Holden Leung, Kelle Little

Facilitator and Staff: Lisa Ladendorff, NEON, Christy Hudson, OHA-PHD

Meeting Objectives:

- Brainstorm potential strategic issues
- Develop understanding of why an issue is strategic
- Identify strategic issues for community prioritization

Welcome, Introductions and Review of Last Meeting

Members shared reflections from previous meeting. Appreciation for explanation of process for those not involved in the State Health Assessment and the sharing of stories beyond names as an ice breaker.

Proposed process for identifying strategic issues

Group reviewed proposed process for identifying strategic issues. Goal of day is identifying approximately 12 strategic issues. Group will consider criteria (magnitude/severity, disparities and upstream determinants), as well as 3 guiding questions when determining process:

- What issues must be addressed in order to achieve the vision?
- What disparities exist?
- What are the consequences of not addressing the issue?

Responding to the State Health Assessment.

A brief overview of the four assessments completed for the SHA was provided. Then, members were asked to identify notable data points from the SHA. They conducted this exercise via a gallery walk, using the SHA framework. The following data points were identified in each chapter:

Social Determinants

- Institutional racism
- ACEs – among AA, AI/AN, and <100% FPL

- High prevalence of ACEs – especially in many counties
- Extremely high ACEs score for AI/AN w/ 37% of AI/AN Adults having 4 + ACEs
- ACEs: 22.6% and 4+, 31% of 3+. Race/ethnicity disparities among AI/AN.
- 31% of people with 4+ ACEs live at <100% FPL
- Higher rates of childhood abuse in adults that identify as LGB
- Physical and sexual abuse rates among economically disadvantaged LDBT youth
- Youth with 4 or more ACEs are twice as likely to be heavy drinkers
- Safe affordable housing
- People of color experience higher rates of homelessness. AA (9.7%), NA (9.2%), AI/AN (8%), also higher in rural areas
- Language access – lack of access for of interpreters for ASL population
- Affordable housing crisis
- Oregon has the lowest educational outcomes in the country
- High school graduation
- Kindergarten readiness
- Rural educational attainment
- HS graduation rates among AI/AN and AA
- Economic, education, housing, safety and violence, incarceration
- Incarceration
- ACEs by race/ethnicity
- Sexual abuse and income
- LBG youth are at higher risk for intimate partner violence and cyberbullying
- AI/AN experience highest rates of IPV
- 1 in 5 homicides in Oregon in 2015 was result of IPV
- School bullying and violence at home, especially high among LGB teens
- School safety for LGB youth
- 24% of adults and 30% of youth report living with a disability
- 36% of adults with disabilities are more likely to be low income
- 15% of adults with disabilities graduate from college
- 1 in 5 children in Oregon lack access to healthy and safe food, especially communities of color, rural communities, single mothers, renters
- Food insecurity is highest in rural, communities of color, single mothers, and renters
- Food insecurity is getting worse (more census tracks w/ poor access to grocery stores in 2015 since 2013)
- Child food insecurity
- Food insecurity – 22.5% of Oregon's children 18 and younger, 14.2% of Oregon's population
- Food insecurity – Oregon is 44th worst in the country, 17% of people with disabilities have food insecurity, and 22.5% of children < 18 years old
- Livable wage

Environmental Health

- 18% of Oregon adults report being exposed to secondhand smoke
- 21% of households living with a severe housing related health problem
- Air quality, forestry wildfire management
- Safe drinking water

- Natural/human causes hazards – potential for greatest impact on vulnerable populations
- Wildfire mitigation

Prevention & Health Promotion

- Opioid overdose death rates for AI/AN
- 22% of attempted suicide by 11th graders, girls & LGB youth
- Tobacco remains #1 contributor to preventable death in Oregon – high degree of disparities
- Tobacco use among < 100% FPL
- High rates of tobacco use in e-cigarettes, disparities by gender, sexual orientation, income and disability
- Mental distress among <100% FPL and high ACEs
- Mental health and hopelessness among LGB youth, up to 62% of LBG girls!
- Disparities in sexual health among youth of color, LGB youth, rural and with disabilities
- Opioid related death rate – 12.4% of AI/AN, 8.4% white, 8.4% African American
- Chronic abseentism (missing more than 10% of school year) due to poor physical or mental health, poverty, lack of transportation and other family issues. AI and AN have lowest graduation rate
- Oregon is third highest in the country for deaths related to alcohol
- Fluoride and sealants
- Untreated dental pain in children as #1 reason for poor educational performance
- Overdose
- Behavioral health and incarceration
- Suicide rates
- Alcohol disparities by number of ACEs
- Adults reporting mental distress by number of ACEs
- Physical and mental health by income
- 10th highest for drug overdose, alcohol and suicide
- Nutrition/physical activity/health education in rural parts of the state
- Firearm deaths by race
- Chronic conditions by income
- High % of women breastfeeding does not seem to be impacting obesity rates
- Diabetes deaths by race/ethnicity
- Suicide rate compared to US – disparities by race/ethnicity
- Obesity – 8th graders receiving free or reduced price lunch
- Need for health education to improve nutrition
- Obesity prevalence among Oregon adults has risen quickly in the past 2 decade – 11% to 29%
- Obesity – risk factor for high blood pressure, high cholesterol, diabetes, heart disease, and cancer. Certain race/ethnicity groups disproportionately impacted
- Obesity = increased risk for diabetes Fighting obesity would help get to root cause of type 2 diabetes
- 2x as many people have diabetes today as compared to 1990
- Teen pregnancy rates and race/ethnicity disparities
- Equivalent firearm deaths in Oregon (compared to US) – but Oregon has highest suicide rates in the country
- LGB youth suicide
- Suicide rates in frontier/rural communities
- Suicide – among AI/AN, whites and children who have experienced sexual abuse

- Suicide
- Mental health among 11th graders – teen suicide
- Firearm safety regulations
- Increasing suicide attempts and completions. Particularly among people with disabilities, males and LGB
- Obesity and diabetes – injury, cancer and heart disease
- Sexual abuse among 11th graders is more likely to increase suicide attempts. 19% of victims of sexual abuse attempted suicide
- Suicide – high rates among whites, AI/AN. Disparities by geography, LGB, sexual abuse survivors and disability
- LGB youth are more likely to have attempted suicide in the past year
- Mental health/behavioral health – LGB stats are alarming
- People in poverty are 2x more likely to report frequent mental distress
- LGB youth are at higher risk for a number of poor mental health indicators
- LGB youth at higher risk for poor mental health
- MCH disparities – infant death by race/ethnicity – highest among AA and AI/AN. Almost 2x higher than others.
- Infant deaths by race/ethnicity
- Adults living with low income report more frequent mental distress
- "most comprehensive sex ed curriculum in the country" – but why high STD rates?

Access to Clinical Preventive Services

- Shortage of dental providers (and # of them that accept Medicaid)
- 45th in the country for % of children 19-35 who are fully vaccinated
- Vaccine herd immunity
- Mental distress: 23% of adults who live at 100% of FPL and 23% of adults with 4 or more ACEs.
- Access to mental health care for adults and adolescents
- Mental health treatment access in rural areas
- Psychiatric/mental health provider ratios- lack of access in rural/frontier areas.
- There are significant disparities in population to provider ratios by geographic region within Oregon.
- Pediatric providers for children with severe and persistent mental illness
- Lesbian, gay and bisexual (LGB) youth are much more likely to have unmet mental health care needs
- LGB youth lack access to mental health care
- Health literacy – low across US generally, lower among elders, people of color (POC), less than high school/GED, non-native English speakers, etc.
- Uninsured rates – 11% among Latinos, 9.1% among AI/AN
- Only 6.2% of children/adults are uninsured (A good thing!)
- State/federal restrictions on telemedicine
- Health literacy levels?
- Provider shortages create significant disparity across parts of Oregon
- Undocumented residents, adjudication charges for receiving health care

Communicable Disease

- Third highest prevalence for Hep C. in the nation
- Safe sex protection – condoms/dental dams

- Low flu vaccination rates (43%)
- Gonorrhea rates
- Rate of syphilis infection in 2016 was nearly 5x the 2010 rate.
- Risk of new HIV infections among men who have sex with men, African Americans and Latinos
- HIV among African Americans – high rates of new HIV infections
- Men who have sex with men are at increased risk of HIV infection

Group reflected on data points that were pulled out as notable:

- Focus on social determinants and prevention and health promotion resonated with what is heard in the community.
- Observation that not many issues within Environmental Health were called out. Might be due to limitations data set.
- Noticed that untreated dental pain in children was not highlighted – important given connection to chronic abseentism and other adverse health outcomes.
- Observation that members were going for the root causes, e.g. tobacco, toxic stress, etc.
- Dr. Gibbs asked group to consider who is listening to the PartnerSHIP and this work – noting that there is a desire to aspire to social capital however we live in a capitalist society. Disparities are a reflection of this. We attempt to do work upstream but we're working in a chasm.
- Areas related to living wage and economic development have been noted. An example of a CHIP where living wage had been identified as a priority - albeit with limited impact. CCOs will be required to invest 1% of their budget into social determinants – priorities and strategies which will ideally be aligned with the SHIP.
- Dr. Gibbs further commented that he observes a schizophrenia occurring. Although the SHA highlights to some degree impact of institutional racism and classism, systems remain oppressive in policy and practice. We spend a lot of time addressing the crumbs around the plate (disparities), but not the heart of the issue (institutional and systemic oppression). We talk about the fact that it exists, but we allow for gentrification, incarceration, poor k-12 education, etc. to persist. Capitalism is a driver in this.

Brainstorm potential strategic issues

Members were then asked to nominate 2 strategic issues they wanted to move forward. No duplication of issues was allowed. Members identified the following issues for further discussion:

- Safe, affordable housing
- Unplanned pregnancy
- ACEs, trauma and toxic stress
- Obesity
- Racial equity in health
- Access to care
- Suicide
- Provider shortages
- Access to health resources for LGBTQ
- STIs
- Segregation and social cohesion
- Living wage
- School safety
- ACEs and toxic stress in 2 year olds, people of color and low income as a predeterminant of kindergarten readiness
- Aging population
- Institutional racism
- Health literacy
- Pre-natal care
- Access to mental health care
- Cancer
- Incarceration
- Oral health

- Culturally responsive/respective care
- Data availability for AI/AN
- Disparities in tobacco
- Unconscious bias across all state agencies
- Data availability for LGBTQ
- Food insecurity
- Firearms
- Crisis mental health system
- Substance use (drugs and alcohol)
- Language access
- Violence
- Sexual assault
- Climate change
- Immunization

Discussion followed regarding these issues:

- Regarding the question made prior to the break about who is listening, Lisa commented that this question seems to be about systems of oppression and how far upstream can we go to address those.
- Paul reflected that even a priority addressing living wage, is still working within a capitalist, profit-driven society that will ensure everyone has just enough to keep people from marching in the streets. Much of what we're doing is just enough to keep people comfortable. I feel like we've spent the past two years pushing for the SODH, but we've really been settling.
- Brian continued that we have a great audience, we've collected a lot of data, that people are rallying around concepts. There are also systems in play that enable us to gather, to contemplate, and to organize for incremental changes. Not addressing the real determinants called capitalism is complicit and enables us to have this discussion. A lot of people benefit from it, but if we're really serious about it – and taking an urgent approach to it- the room and space would look different and no one organization would own it. The people who are most impacted would be sitting around the table. We're saying ouch – but people are behind bars and in graves. For the audience we have, are we really engaging education, foster care, incarceration and pathways to, mental health, etc. around the table? If that's not represented here, then who is listening? Would this process look different if the other systems were involved – in an effort to undo system silos.
- There also seems to be a related question about who is speaking?
- Regional health equity coalition includes representation from a variety of sectors that interact with the public – which is resulting in a shift towards policy and systems change. As a convener, we're able to look at the social determinants from a number of different angles. If we don't look at this differently, we're going to continue to do band aid work.
- Observation that ensuring the voices of people most impacted by disparities is included in this process is critical, and that it is on the PartnerSHIP to figure out how to meaningfully bring their voices to this conversation.
- In the SHA – despite best effort to hear community voices, most participants in that process were white, educated women.
- Christy reminded group that community engagement will be a significant undertaken starting in November: mini-grants, surveys and open invitation to other groups wanting to submit feedback.
- Question about who has the final say in the priorities and what about if community groups don't agree with the issues. Final decisions rest with the PartnerSHIP.
- To some degree, decisions will also be data driven, but limitations in data – especially for marginalized communities such as Q+ need to be taken into consideration.
- This also ties into the conversation from the first meeting regarding evidence base and for whom?
- Victoria shared that for example, the NPAIHB spends a lot of time correcting misclassed race and ethnicity information. There's also a larger question about who is the expert? Is it the state or the community?

- Frank shared that he doesn't think it's an either/or – but a both/and. It doesn't need to be an argument about whose expertise is more important – but how are they complementary?
- David reflected that we're talking through a health lens about systems of oppression that live outside the health sector. How do we connect those two? How do we make the Oregon Health Authority and CCOs accountable to reach out to these other sectors that are causing much of the problem. It's pushing some discomfort among state systems and that's great. Public health is the convening body and needs to be accountable to bringing these sectors together. It's on us to use our power and influence to bring other people to the table.
- Christy shared some information regarding subcommittee structure and makeup of the PartnerSHIP. While MAPP frameworks recommend that cross-sector partners be included in this group – PHD decided to hold off on that involvement to ensure that decisions about the priorities were grounded in the voices of marginalized communities (versus already defined sectors based on participation in the PartnerSHIP). That being said – when the PartnerSHIP reconvenes in February to determine the subcommittees, they'll also be asked to identify additional partners for the subcommittees which will include people from cross-sector agencies. Some of this relationship is already in place either at the programmatic level or division level via MOU. Priorities will inform where the PHD should seek other MOUs.
- Lisa observed that the action item rising out of this conversation is that the PartnerSHIP will determine formation of the subcommittees. This includes who is involved, where meetings are held and who is facilitating.

Lunch

Public comment

Two people provided public comment:

Scott Bonhoffer, member of the public. Accessible, comfortable, usable care would be his number one priority. Safe and affordable housing would be his second priority.
Kirk: The Oregon Center on Brain Injury and Training at University of Oregon received a grant from the Administration of Community Living labeled as a Traumatic Brain Injury State Partnership Grant 2018-2021 . Goal is to improve Oregon's capacity to provide coordinated services and support to people with TBI and their families across the life span.

Voting and discussion

A first round of voting took place. Each member had 20 votes. They could vote for one issue no more than 5 times.

The following summarizes the votes received for each issue. The group agreed to look at issues getting 8 or more votes.

- **Safe, affordable housing (18)**
- Unplanned pregnancy (5)
- **ACEs, trauma and toxic stress (20)**
- **Obesity (17)**
- Racial equity in health (6)
- **Access to care (8)**
- **Suicide (8)**
- Provider shortages (6)

- Access to health resources for LGBTQ (1)
- STIs (5)
- Segregation and social cohesion (7)
- **Living wage (8)**
- School safety (3)
- ACEs and toxic stress in 2 year olds, people of color and low income as a predeterminant of kindergarten readiness (5)
- Aging population (0)
- Institutional racism (4)
- Health literacy (2)
- Pre-natal care (1)
- **Access to mental health care (17)**
- Cancer (3)
- **Incarceration (10)**
- Oral health (7)
- Culturally responsive/respective care (4)
- Data availability for AI/AN (0)
- **Disparities in tobacco (9)**
- **Unconscious bias across all state agencies (14)**
- Data availability for LGBTQ (6)
- **Food insecurity (8)**
- Firearms (7)
- Crisis mental health system (7)
- **Substance use (drugs and alcohol) (10)**
- Language access (1)
- **Violence (10)**
- Sexual assault (5)
- **Climate change (8)**
- Immunization (7)

Discussion about the issues followed – What is your general reaction to the issues identified? Do they align with vision and values?

- Concern about leaving data availability for LGBTQ+, and other marginalized communities off the list. How should data limitations be handled?
- Concern voiced about feasibility of forcing people to collect data – how does this work out to a strategy?
- Do we want to add a broad strategic issue regarding data availability for populations experiencing disparity?
- In the current SHIP, across the seven priorities there are three cross-cutting strategies: population interventions, health system interventions, and health equity interventions. Within the health equity interventions there are strategies that are addressing data limitations. Within the chosen priorities, we could address data limitations as a strategy.
- Culturally responsive care wasn't identified as a strategic issue – this is critical for many, especially LGBTQ communities.
- Once priorities are identified – PartnerSHIP can direct subcommittees to ensure communities experiencing disparities are specifically addressed based on data within each priority.
- Proposal to include diabetes and chronic illness to diabetes. Question about why these should be included and collapsed? What about chronic illness as the primary strategic issues– that includes obesity and diabetes. Observation that this creates a lumping vs splitting problem – where specific focus of obesity might get lost if items are lumped under chronic illness. Lumping obesity and diabetes is problematic for people with type 1 diabetes. Proposal to use chronic illnesses related to obesity. Concern about changing the structure of the issue for possible implications of impacting votes. For example, if we had collapsed all the LGBT related issues into one, we likely would have enough votes to move that forward as an issue. If staying with obesity, diabetes could be addressed as a strategy – this

is how it's addressed in the current SHIP. PartnerSHIP voted to keep obesity as the strategic issue. Food insecurity and ACEs are also correlated with obesity.

- Recommendation to bring back unplanned pregnancy prevention on to the strategic issue – given contribution to ACEs, ability to work, reliance on social services, etc. Although important, group agreed the issue did not get enough votes.
- What about issues related to structural determinants? Most of these don't seem to be about root causes, but rather intermediary determinants Does unconscious bias across all state agencies cover the issue? Suggestion made to reword as systemic unconscious bias across all private and public entities as bias extends beyond state agencies. Victoria noted she was abstaining from vote due to political designation of American Indians. Membership agreed by vote.
- Question regarding the role of public health system in addressing these areas – particularly the social determinants of health. What is role for Public Health system in addressing the social determinants. Public Health can be the convening body and data collector to talk about the linkage between root causes, proximal causes, and secondary causes. Public Health is the chief health strategist for the state. What are the levers within OHA to move this work, e.g. CCOs and Executive Order for Workplace Wellness. This will be an important consideration for the subcommittees and the charge that the PartnerSHIP carriers into those groups. For example, strategies could be related to convening cross sector partners for action.

Final strategic issues

The group considered the final issues. This is the list that would go to the mini-grantees and the communities at large. Do these reflect our values?

- ACEs/ALEs, toxic stress and trauma
- Safe, affordable housing
- Systemic ~~unconscious~~ bias across all public/private entities
- Living wage
- Food insecurity
- Incarceration
- Climate change
- Violence
- Tobacco
- Obesity
- Substance use
- Access to mental health care
- Access to care
- Suicide

- Regarding ACEs, trauma and toxic stress: Do these overlap or are we trying to lump too much here? Intergenerational trauma may be more accurate. Adverse childhood experiences relate to both children and adults. Proposal to include adverse lifehood experiences to indicate traumas that occur after childhood and throughout the lifespan. Do we want to remove trauma? PTSD as an adult, for example, is very different from ACEs which has far greater downstream effects. Important to not lose focus on adversity experienced in childhood. Recommendation to leave wordsmithing for now as

community conversation may likely help to inform where the strategic issue lands. Adverse lifehood experiences also captures experience of racism, and systemic oppression. PartnerSHIP voted to add.

- How do ACEs/toxic stress differ from violence? Violence is included in ACEs/ALEs to some extent. School safety and gun regulation may also be considered part of the violent picture. Would those be considered a trauma? In favor of keeping violence as separate due to compelling data related to bullying/sexual violence among youth. What would be a finer point on the split? Sexual violence could be captured here. As well as systemic violence, community, familial, etc. The difference or similarities between these two areas could also benefit by being informed by the community. There are many forms of violence and different interpretations of this issue based on the community.
- Can substance use be linked with chronic pain? It feels like that limits our exploration of substance use as it's not related to all substances. Agreement to not add chronic pain at this level – but could be something that is brought in via strategies. We'll see if and where this comes up with the community.
- Access to mental health care: Is this too specific to access and doesn't leave room for prevention and education? Agreement that stigma is a critical part of this conversation. However – access to mental health care is the primary concern of the community. Proposal to just use mental health – and address the access concerns in the more general "access to care" issue. Data shows us the biggest issue is specific to access – and stigma, transportation, cultural providers, etc. could be addressed in strategies.
- Proposal to remove "unconscious" from bias issue. Recommendation to call out both explicit and unconscious bias in context. PartnerSHIP agrees.
- Are access to mental health care and access to care too similar? Care is everything that is not mental/behavioral health. Mental health care would be very specific to mental health issues.
- Can we modify climate change to be environmental health and climate change? Environmental health is more broad in terms of air/water quality. Context will help paint the connection between climate change and health impacts.

Meeting evaluation

The group conducted a +/delta evaluation of the meeting.

+
+/Delta evaluation works – Recommendations were incorporated into meeting
Smartboard worked well for remote participation
Lunch was delicious
Mini-grantees appreciated being invited to meeting

Delta
Troubles with Skype – many reported getting kicked off and having to call back in. Suggestion to use Zoom for future technology
It was hard to see faces
Need name tags for all attendees including guests and core team members
Make sure information/process from meeting is shared with mini-grantees
Update meeting location in calendar invite
Make sure front desk knows were meetings are being held.

Next steps

The PartnerSHIP will meet again in February. A doodle poll will be sent soon to identify a time that works best. Between now and the next meeting in February, these issues will be put out to communities for prioritization. Partnership members are invited to support this effort by: sharing online surveys with networks, supporting activities implemented by mini-grantees, and inviting community groups to share feedback in other ways suitable to them. The OHA-PHD core group will compile context and data around each of the issues for the community and PartnerSHIP members will be asked to provide feedback on these materials. Core group members would be interested in attending any community events and are happy to help as needed.