Multnomah County Public Health Advisory Board Minutes December 2021

Date: Thursday, December 16, 2021
Time: 3:30-5:30pm
Purpose: To advise the Public Health Division on several areas of work with a strong focus on ethics in public health practice and developing long-term public health approaches to address the leading causes of death and disability in Multnomah County.
Desired Outcomes:

1. Hear updates from board members
2. Provide input for data discussion
3. Inform OHA's Crisis Care Guidance Advisory Committee process

Members Present: Becca Brownlee, Karen Wells, Tsering Sherpa, Daniel Morris, Arya Morman, Nick Kinder, Maribel Reyes, Ryan Petteway, Laurel Hansen
Multnomah County Staff: Jessica Guernsey, Nathan Wickstrom, Adelle Adams, Jason Thompson
Public: Suzanne Hansche

Item/Action	Process	Lead
Welcome, Introductions, Agenda & Minutes Review	• Attendees introduced themselves and checked in with one another • December 6th meeting minutes were approved by consensus	Maribel Reyes
Public Comment & Board Sharing	• Is there a volunteer to facilitate our January 27th full board meeting? • Crisis Care Guidelines are really hard to wrap my brain around o It is a painful topic	Maribel Reyes

Data Meaning Making Discussion	• Questions to consider during discussion:
	  o What data already collected is most important to you?
	  o What data not collected would be important for the county and communities to know?
	  o What strengths-based data or data showing community resiliency do you feel needs known?
	• Update from Jessica:
	  o We are doing an overhaul of epi and data work:
	  ▪ Undergoing structural changes, thinking through what epi means, decolonizing data, building repositories of storytelling data
	  o A lot of this is funded through PH Modernization work
	  o Partially what we're doing is looking at data in relation to budget
	  o What is the information that we're getting directly from the community and how are we doing meaning making with this data?
	  o Coming to you to ask those transformational data questions
	• Presentation from Jason:
	• When we're looking at quantitative data, it's stark and sobering
	  o Acknowledge that people relate to this data, and want to make room for that pain
	  o Acknowledge the weight of this - these are real people and lives reflected in the data
	• Building off presentation from earlier this year
	• The data covers a year and a half period
	  o None of the data we see will include Delta variant (ends in June 2021)
	• Two-pronged approach:
	  o Shorter term - inform policy and practice to reduce injury
	  o Longer term - inform policy and practice to support the social determinants of health and ease burden of chronic disease
	• 80% of health factors are socially determined
	  o A lot of public health is focused on this
	  o Tobacco 21 (T21) and Vision Zero are examples of policy that impacts the social determinants of health
	  o The numbers show the rationale behind the two-pronged approach
	• Need to address the upstream to impact downstream health
	• Leading Causes of Death
	  o All leading causes show an increase in mortality besides COPD
	  o Greatest increase was seen in unintentional injury
		Dr. Jason Thompson, Jessica Guernsey

- Huge increase in diabetes and liver disease
- Liver disease displaced hypertension in 2021

- Motor vehicle traffic mortality
  - Doubled in Black, Non-Hispanic (NH) population
- Dashes in the presentation don't indicate that no deaths occurred
- All deaths from firearms, not just unintentional, rose substantially
- Unintentional drug poisoning
  - Increases across the board - largest increases seen in BIPOC communities
- Alcohol-related mortality rates
  - Largest increases in Native American, NH communities
- Suicides doubled in Hispanic/Latino/Latinx community
- Standardized mortality ratios
  - Ratio of observed deaths over expected number of deaths
- Mortality is 2.2 times greater among Black, NH population in comparison to White population
  - 2.6 times greater among Hispanic/Native American
- Cancer
  - Pacific Islander population died at 2.3 times the rate of White, NH
- Heart disease
  - 1.7 times greater for Black, NH
  - 1.8 times greater for Pacific Islander, NH
- Unintentional injury mortality rate
  - 1.6 times greater for Black, NH
  - 3.2 times greater among Native American, NH
- Stroke mortality
  - 2.3 times greater in Black community
- Diabetes mortality rate
  - 3.0 times greater in Black, NH population
- Increased mortality among nearly all leading causes
- Greatest increase seen in injury
  - Traffic, firearm, and overdose injury deaths rose
- Inequities in Covid-19 and leading chronic disease mortality have persisted or worsened
- Small numbers question (dashes in slides):
  - Ryan:
    - We're not really talking about estimates since we're talking about actual deaths; we're talking about small numbers
    - Sharing the counts on the slides is not an erasure
  - Jason:
    - It is an estimate because we're using denominator numbers
      - We're assuming that we're correct in the denominator numbers and race attribution
        a. If one is misclassified when there are only 4 people, that's 25% incorrect
      - Over the summer, there was a lot of discussion over what should or shouldn't be released - ended up releasing all data and had some small numbers end up being 100% incorrect
  - Ryan:
    - No sound argument that numerators cannot be shared if we can reliably give the counts
    - I hope that these conversations continue
    - At some point, it makes sense to give people the data back when talking about numerators
    - Decolonize the data
- Data is pulled from vital records from the State
  - Knowing the source of truth is vital
- A lot of data is going to continue coming from vital records data
  - Becca:
    - If we are interested in seeing other data, such as income level, etc., is that possible?
      - Systems change is very difficult
  - We have pushed hard for leading causes of death data, such as education and housing status

	▪ We aren't the data stewards, so we don't collect the data ▪ Hard to convince external stakeholders to collect data ▪ REALD is mandated by law now ● Issue is getting it into the data system so that they transfer to us ● While we can now get to our own spots in our data system, where other organizations store their REALD data in the system is completely different a. Data have the ability to be collected, but we have to rely on the data stewards ● What is the data in mostly Black/Latinx communities - are mortality rates better due to resiliency? o Collecting this data shouldn't be so difficult - communities were neglected when building the systems o Does the State want this? ▪ Their full intention is to move more towards a community-centered approach ▪ Trying to move in a direction to keep data and move deeper, so that it's not just for surveillance ● Is there a possibility to link data? o We do link birth and death records o Approved linking for APAC data o Social security administration linkages are very far off ● Karen: o Is there any background on how, if, attention (culturally sensitive - education of) was/is focused on the "survivors" who could provide information/data on the demographics/background of their deceased family member - to the implied/implicit importance of providing such information to better inform - thus improve health outcomes? ● Jason: o I am not sure what the training practices are for the Vital Records team who collects the data from the data sources (for the demographics of the deceased, this is usually the funeral director). While there may be a training program that the Oregon Health Authority uses for funeral directors, I'm not familiar with it. Here is a link to the description of how deaths are recorded by care providers. Improvements in data quality would need to work with physicians (for cause of death) and funeral directors (for demographics).	
Crisis Care Guidance Advisory Committee	● Chief Medical Officer for the Oregon Health Authority Dana Hargunani provided an update to MCPHAB on Oregon's Crisis Care Guidance ● Background: o September of 2020, OHA made a decision to no longer rely on its crisis care guidance, due to concerns that it would exacerbate health inequities o They are now working to pull together an advisory committee o Last fall, we knew we needed to have something in place, so we created a set of principles ▪ It was not the process we had intended ▪ Since then, there have been ongoing conversations around what the structure would look like and what decisions would be guided by ● Advisory committee: o Hoping to set it up in the upcoming week o Trying to ensure a different representation on this committee ▪ Typically they are primarily, if not all, healthcare representation ▪ Want to make sure we have broader community participation ▪ Seeking applicants across the state who have lived experience, live with disabilities, come from a variety of backgrounds o Hoping first to revisit the principles, recognizing that we were unable to engage in a full approach/process when creating them o Within the first 3-6 months, we will look at ways to ensure that the principles are operationalized ▪ What are the norms and expectations in terms of transparency and communication o Dana will share the opportunity when it comes out o There is never a good time for this committee; want to acknowledge that we are	Dana Hargunani

learning more about Omicron, which will pose a challenge for us
    - Omicron is creating a sense of urgency and tension
    - News and data is very concerning - overpowering Delta, which had overwhelmed health systems
    - The tension between responding to real-time issues with trying to create an inclusive process is challenging
- Questions:
    - Arya:
        - How will you care for the BIPOC employees? Is there going to be room for BIPOC leadership?
            - In the midst of trying to hire facilitators and staff for the committee
            - We have resources internally and externally to provide support due to the stress this will involve
        - We're always having to resolve problems when we didn't create them
            - Need to teach others how to unlearn some of the things that have gotten us to this point
                a. Thinking of a train the trainer model so that BIPOC leaders aren't responsible for every aspect of success
                b. How can we get everyone collectively involved in this responsibility?
                c. Thinking through long-term solutions
    - Ryan:
        - Who has power/control/votes on the committee? Will antiracist training/expertise be required? Who are the ethicists and what are their professional obligations?
        - Principles document contradicts itself
        - How is power determined on the committee?
    - Arya:
        - Need to have an in-depth conversations with healthcare providers and define the points of power before putting out a broad call for community members to join the advisory committee
            - Every member needs to have that equity training
            - Need for more BIPOC leadership
            - When you're looking at the roles being developed, let's look at who is doing the planning right now
            - Need to go back to the drawing board - let's not just jump into it and have to redo the guidance
                a. Another advisory board will not solve the community's problems
                    - Keep going in the same cycles
    - There is urgency at this moment with the continued stressors of Omicron to create guidance quickly
    - Ryan:
        - Which hospital/care systems will be a part of/party to the updated guideline? Do they receive OHA funding? Can that be leveraged to deepen commitments to equity in application of guidelines? Is there a policy (or policy conversation going on) to more expressly compel some level of uniform use, via incentive or penalty? What about data-is there an audit system in development to collect/compile who is "scored" how and where (care systems and geographic specificity)?
        - Will the committee have a legal/team support?
        - Over a year and a half into conversation - moving way too slow
        - What I'm really feeling is that we can find folks - we're going to have to have something in place I imagine
            - There are times when you just have to get something done
            - If we do not explicitly create antiracist guidelines, more White folks are going to benefit first
            - If we don't have folks on the committee with teeth on it, it's not worth creating
            - It's going to take teeth, with legal support and prioritization of BIPOC communities
            - Follow the science

	a. The default is going to benefit whiteness o Is there a requirement for equity and inclusion training for white leadership? o BIPOC leadership need support o Arya: ▪ A lot of dollars went to health systems, who just hired people in specific roles and didn't directly address racism ● We're missing the count of all who are impacted by the work ● We need to look and follow where the health equity dollars went ● Let's get the community involved completely - go directly to community partners and give to the frontline organizations a. Need to create those partnerships b. Need to think about the long-term training situation c. Let's set it up so that we have cohorts d. Making community-led partnerships is a part of crisis care guidance o Karen: ▪ Although we are in crisis mode (and the dial is being turned up as we speak) I'm still hearing too many "I don't know, we haven't thought of this?" Like why not? This is more of a comment, not so much a question in need of response. Thanks. ● Dana's email address is dana.hargunani@dhsoha.state.or.us **Action:** ● Dana will share the crisis care guidance advisory committee information with MCPHAB when it comes out	
Wrap-up and Meeting Evaluation	● Meeting adjourned at 5:32pm	Maribel Reyes