Multnomah County Public Health Advisory Board Minutes April 2021

Date: Thursday, April 22, 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. Receive updated data on leading causes of death in Multnomah County
2. Elect a new Chair and Vice-Chair to start in July
3. Celebrate with the MCPHAB members whose terms will be ending in July

Members Present: Suzanne Hansche, Becca Brownlee, Hanna Atenafu, Joannie Tang, Cheryl Carter, Maribel Reyes, Bertha Ferran, Daniel Morris, Rebecca Lavelle-Register, Ryan Petteway
Multnomah County Staff: Jessica Guernsey, Nathan Wickstrom, Nicole Buchanan, Adelle Adams, Dr. Frank Franklin, Dr. Jason Thompson, Ebony Clarke

Item/Action	Process	Lead
Welcome, Introductions, Agenda & Minutes Review	• Attendees introduced themselves • Agenda was approved by consensus • Meeting minutes from January were approved by consensus	Becca Brownlee, Hanna Atenafu

Public Comment & Board Sharing	• Thank you to Daniel for stepping up and providing testimony for Public Health Modernization funding to the Ways & Means Committee
	• We made a change to allow for easier testimony going forward
	  o Through the end of this term (end of June), a vote will not be needed for a board member to provide testimony
	  o MCPHAB will need to review the testimony beforehand to make sure there are no objections
		Becca Brownlee, Hanna Atenafu

Updated Leading Causes of Death Data Presentation	• Looking at the magnitude of mortality in Multnomah County
	• Using a standard mortality ratio, comparing White, Non-Hispanic to other races/ethnicities
	  o Looks at the standard mortality ratio within each group
	  o What would the mortality ratio look like if the groups were the same
	• Looked at what kind of impacts we see and years of potential life lost
	  o What kind of parity exists?
	  o Speaks to the risks of death
	• Updated leading causes of death data
	  o Presentation last given in 2018 to MCPHAB
	• Comparisons from the leading causes of death from 2015-2019 with preliminary 2020 death data
	  o Looked at all-cause mortality, cause-specific mortality, years of potential life lost
	• Stepped back from the focus on COVID-19 to refocus on the leading causes of death to capture a broader picture of the health impacts of the pandemic
	• Crude mortality rate:
	  o How many deaths per 100,000 people
	  o Rise of 11.5% in deaths from 2015-2019 to 2020
	  o Similar rates seen in North Portland, but in Mid County and East County we see double digit increases. These areas were already leading in mortality rates.
	• All-cause crude mortality rate:
	  o Increase in mortality seen across the board
	  o BIPOC communities have seen the greatest increase in mortality
	  ▪ Mortality among two or more races saw an 82% increase
	  ▪ Hispanic and Latinx mortality rates increased by 66%
	• Slight uptick in nearly all leading causes of death
	• COVID-19 is the 4th largest leading cause of death -- didn't include that information in the presentation
	• Single digit increases in mortality of 4 of the top 5 causes
	  o Chronic Lower Respiratory Disease (COPD) is the outlier
	  ▪ 15% decrease; this could just be an anomaly
	• Diabetes increase of 16.6%
	• There is no disability status data at this time - there is a push for it with REALD
	• COVID-19 mortality rate is around 48 to 49 per 100,000 population
	• Drug overdoses are included in unintentional injury
	• We use standardized mortality ratios to make apples-to-apples comparisons of mortality
		Dr. Frank Franklin, Dr. Jason Thompson

among BIPOC populations and the White, NH population
    - Controls for variation across racial and ethnic groups in terms of age and gender comparison
- In comparison to the White, NH population, the cancer mortality rate is...
    - 1.1 times greater among Black, NH population
    - 2.3 times greater among Pacific Islander, NH population
    - 1.4 times greater among those identifying with two or more races
- Might want to consider framing class stratification among the White, NH population
    - Misleading in that the poor White population doesn't see itself represented in the data
    - Residential data could be useful
    - The only class measure we have is education, in a small measure
    - We have begun using index of concentration at the extremes to measure economic polarisation
- In comparison to the White, NH population, the heart disease mortality rate is...
    - 1.5 times greater among Black, NH
    - 1.6 times greater among those identifying with two or more races, NH
    - If there are fewer than five events, we will suppress that cell
        - e.g. Pacific Islander, NH population had fewer than 5 deaths - cell size is too small
        - If the standard error is too large, we suppress the estimate
        - Decolonizing data and erasure - if it's removed from the chart, even if it is only 4 deaths
            - Curious about what Dr. Duldulao would say about this
        - The epidemiology team has been engaged to revise these decisions that we follow and find where we need to stick fast and where we need leeway to combat erasure
        - Some jurisdictions say if numerator is 3 or above, some say 10
        - If less than 5, we're also worried about confidentiality
            - We're imposing a worldview about confidentiality; protection is assumed
            - MCPHAB should make a space to discuss data erasure
- In comparison to the White, NH population, the unintentional injury mortality rate is...
    - 1.8 times greater among Black, NH population
    - 2.6 times greater among Native American, NH population
    - Unintentional injury includes drug overdose deaths, firearm fatalities, car crash mortalities
    - REACH program did a traffic safety report presentation to the Board of Health
        - Work coming out of REACH is directly related
- In comparison to the White, NH population, the stroke mortality rate is...
    - 2.2 times greater among Black, NH population
    - 1.5 times greater among Hispanic/Latinx population
    - 1.4 times greater among Asian, NH population
    - 2.2 times greater among those identifying with two or more races, NH
- In comparison to the White, NH population, the diabetes mortality rate is...
    - 4.0 times greater among Black, NH population
        - 3.12 times greater from 2015-2019
    - 1.2 times greater among Hispanic/Latinx population
    - Numbers didn't rise over 5 with Pacific Islander, Native American, and two or more races
- Summarizes the years of potential life lost due to mortality
    - The difference between age at death and life expectancy at that age
    - ex: female life expectancy at 63 is another 22.3 years of life. therefore, the death of a female at age 63 contributes 22.3 years of potential life lost to the calculator
- Quantifies the burden of disease in terms of premature death
    - Increases in years of potential life lost indicate potential increases in death and or increases in premature death
- Years of potential life lost increase is greatest among those who identify with two or more races and Hispanic/Latinx population
    - Numbers increased among all groups
- Greatest burden is in East Portland
    - Rater were similar in North Portland and mostly similar west of the Willamette
    - Mid County had the largest increase
- All-cause mortality has increased significantly in Multnomah County in 2020 vs. the prior 5-year period

- All-cause mortality has risen across all racial and ethnic groups
- Mortality rates for 9 out of the 10 leading causes of death have shown an uptick in 2020 vs the prior 5-year period
- The inequities separating the White, NH and BIPOC populations in Multnomah County remain significant and appear to widen for many of the leading causes of death
- We haven't looked at wildfire smoke on CV and respiratory-related deaths
- Recognizing the role that chronic stress plays in contributing to a lot of these chronic diseases, I'm curious to see next year's data to help determine how much we can attribute to the pandemic at large
    - We know who has historically felt the accumulated effects of chronic stress most acutely, and 2020 has set the bar higher
        - We could expect to see uptick in numbers next year with cancer or diabetes because we aren't catching them earlier due to hesitancy to reach out to providers
        - Would expect to see an even greater impact down the line due to lack of contact
- So many of those other contributing factors to chronic disease (e.g. employment).are out of the purview of the Health Department. In terms of HD priorities, do these give any direction of where to focus? Are there some things in which we recognize the historic inequalities we're familiar with that are turned up due to COVID, but we would expect them to settle down to previous rates? Or are there any other things that give insight into program prioritization going forward?
    - We were already looking at some of the data - e.g. REACH traffic report
    - Chair Kafoury released our budget, which was positive news for prioritizing public health
        - Some of the Board of Health's initial prioritization falls into unintentional injury and violence prevention
        - The levers for these system issues fall over multiple areas
        - We know the intersection of the issues - redistribution of power and wealth, which are long-game issues
        - Some of the work is starting to move quickly
            - We are pleased about the budget, as it keeps the work we've been putting forward intact
- One of the things we learned and that is jumping off the page is that it would behoove us to think that these issues do fall into our lane
    - We've done ourselves a disservice in saying that that goes beyond the scope of public health - we have to assert ourselves to say that it is in our lane
- We're seeing a privatization push, where hospital systems are taking on pieces of what the PHD has traditionally done
    - e.g. contact tracing workforce - can we put them to work in another area afterwards? How do we build on our work to make a stronger public health system?
    - We are looking at much of that, and some of it we're already doing. It's a careful balance
    - There's confusion around public health foundational investment (modernization) need
    - Hoping that systems investments keep moving forward - community organizations cannot ramp up without investment, and we could not have done this work without help from community partners
- 2015-2019 data - any greater area designation? Which parts of the county are experiencing the greatest impacts?
    - There have been numerous conversations around what is most meaningful to people on the ground
    - We've used the PUMAs because they can overlap with Commissioner's districts
        - Haven't tried finer granularity over 10 years
    - Considering idea of asymmetric mapping to address the issue of small numbers
    - Considering using quintiles rather than using census tracts so that they may not be contiguous tracks or neighborhoods
        - Would be able to look at most racially economic and segregated folks
- Did Infant or maternal mortality rates go up?
    - Don't have those numbers right now
    - When you're looking at a more detailed analysis from CDC, you'll have mortality rates by age. We have not run those numbers yet

Action Items:

- The epi team will circle back for MCPHAB input on erasure and decolonizing data for community input

	● The epi team will share the presentation and subset data when it is finalized ● Send a link to the REACH traffic safety report	

Chair and Vice-Chair Elections	● Hanna received 3 nominations for Chair via the nomination form
	  o Becca received 1 nomination, but would like to step down and serve in an advisor role as the past Chair
	● **Hanna was nominated as Chair, starting in July**
	  o Her nomination was seconded
	  o There was consensus to nominate Hanna as Chair
	● This will stay on the agenda for upcoming meetings
	Action Items:
	● Determine who would like to step in to Vice-Chair role in July
		Becca Brownlee, Hanna Atenafu

Celebration for Board Members with terms ending in July	● Bertha, Rebecca and Suzanne reflected on their time on MCPHAB and shared their experiences ● Board members expressed gratitude for their years of service	All
Wrap-up and Meeting Evaluation	● Meeting adjourned at 5:28pm	Becca Brownlee, Hanna Atenafu