



THE Probe

Quarterly Newsletter of the Oregon Public Health Association

Spring 2004

President's message for Public Health Week

Public health outcomes ask personal commitment

BY YOLANDA RUSSELL

Cause, origin, root cause ... stress, Obesity, tobacco ... social justice, environmental justice, health literacy, racism, otherism. As the Oregon Public Health Association celebrates 60 years of public service this year, what legacy will we create for the next generation of public health professionals?

How great it would be to actually eliminate a public health problem like violence or drug abuse. Or to be the first state to increase life expectancy and eliminate health disparities in diabetes or HIV. This is a discussion that started at our conference last fall and will continue throughout this year, in April during Public Health Week, throughout the spring and summer at our regional member meetings, in the fall at our annual members meeting, and at our next conference during Public Health Week 2005.

This year, Public Health Week runs April 5-11. OPHA will celebrate with a morning gathering on Wednesday, April 7, at the Oregon State Building in

Portland, to exhibit efforts to eliminate health disparities.

The more things change, the more they stay the same – almost. When I look at public health information in documents like Healthy People 2010, and the American Public Health Association's

I wonder where the magic wand is that turns knowledge into behavioral change.

Public Health Week fact sheets, I wonder what is missing. Why are so many health outcomes not improving? Why am I reading what seems like the same statistics that I have read for several years? I wonder where the magic wand is that turns knowledge into behavioral change.

I understand that public health is based on the health of groups of people, on identifiable populations, but that is not where behavioral change and improve-

ment in health status occurs. Change and improvement occur at the individual level, and if enough individual people in a group change their behavior to the better, then the health outcomes for the group improve.

In the thirty years that I have worked in educational institutions and health organizations; worked with groups, populations, and communities; the things that I have seen work are relationships, and investment of time and personal commitment. These are also the things that brought many of us to public service.

I want to challenge each of us to take up the call from APHA to "Leave No One Behind" – to make a commitment this year to bring all populations and communities to the highest level of health outcome currently enjoyed by a few. Take up the call that was presented at our fall conference to take a stand for health and wellness in each of our communities. Let's meet or beat the measurements in Healthy People 2010.

We know what to do. Our communities have told us what they need to be healthy. We have but to do it. Let's make solutions, not statistics our legacy.

OPHA Mission

- *Protect and promote the health of all Oregon residents*
- *Educate and support public health workers*
- *Advocate for just and equitable health policies*

INSIDE: Diversity in the health workforce ❖ Health information infrastructure ❖ Immorality of abstinence ❖ OPHA leadership roster ❖ Health impact assessment ❖ And more ...

Health awareness campaigns short on responsive solutions

With the panoply of new appreciation days, and weeks, months, even years and decades dedicated to some cause or special group, conscientious social activists must be worn out by changing buttons so frequently to mount each new campaign. Scanning the list of activities in various states for Public Health Week, April 5-11, shows a multitude of declarations, dissemination of printed information, and events for talking heads, but few activities with discernible outcomes.

The website for the American Public Health Association (www.apha.org) shows two events in Oregon: a gathering for presentations to colleagues on health disparities, including James Mason, newly appointed administrator of the Office of Multicultural Health in the Oregon Department of Human Services; and a gathering to honor public health heroes.

Few states show much more. In Pennsylvania, a full schedule of fairs and meetings also includes several healthy walking tours. Other states sometimes, but rarely, include free preventive health screenings, bike-helmet education with children, and occasional convocations with policymakers to advance specific projects. Otherwise, there are many posters, speakers, awards and introductions. Under the rubric of "real community solutions," APHA lists four accomplishments in 2003, all related to minorities, one to low income, and only two with actual outcomes.

Compare these results to the proposed target. Healthy People 2010 has 28 focus areas and 467 objectives; the average number of health indicators tracked by states is 113. Multiply these numbers by 50 states, or 3,082 counties, or 40,000 zip codes, and the recorded number of activities appears decidedly dismal.

Will we see more for Cover the Uninsured Week, May 10-16? Today, the agenda in Oregon includes a staged press release and a public forum. The official website for the event names two local

contacts: in Portland, Thomas Novick (tnovick@mrsspx.com); and in the Rogue River Valley, Maureen O'Brien (maureen.obrien@gmmb.com).

Portland is listed by CTUW organizers as one of 17 target communities this year. The honor leaves it unspecified whether this means we get more information than anyone else, or we end up fully insured by June.

In February, the office of Oregon Health Policy & Research published an issue brief on "Gaps in Health Insurance," mostly advancing the definitive treatment in the Institute of Medicine's six volumes on the topic over the past few years, concluding in January with a final volume of principles and recommendations. Kaiser Family Foundation (www.kff.org) gives us continuous data updates. In a systematic review of the literature last year, Jack Hadley recommended that we know enough already. The point is to act.

In this light, one has to appreciate the mission statement of the collaborative organization Connecting for Health, mentioned in the article in this issue on health information:

"The purpose of the Collaborative is neither to report nor exhort. It is, simply, to catalyze specific actions on a national basis that will rapidly clear the way for an interconnected, electronic national health information infrastructure."

This statement reflects the current theme of Public Health Week – moving from statistics to solutions. According to the statistics on solutions so far, we have a long way to go.

– TERRY HAMMOND

Alert! *The Probe* seeks section reports

Current activities in the nursing, nutrition, health promotion, and adolescent risky behavior sections deserve regular attention. Section leaders – please consider writing a brief news story for each issue of *The Probe* (see page 7).

You can help us spread the word

Please consider distributing *The Probe* to colleagues and friends interested in Oregon public health. With office technology, the best way to achieve a magazine format is by double-sided copying, with two automated staples on the side.

THE *Probe*

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News published in The Probe aims to provide information. Views expressed in this newsletter do not necessarily represent the views of OPHA members or its board of directors.

Give us your news!

We invite you to send stories, news and graphics. Submission dates:

ISSUE	STORY DEADLINE
Winter	Dec 21
Spring	Mar 21
Summer	Jun 21
Fall	Sep 21

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IOM book review

Diversity initiatives could improve health

BY LESLEY RUSH

Following the recent Supreme Court's decision in the *Grutter v. Bollinger* case – upholding the University of Michigan Law School's admissions policies, and also maintaining that greater diversity promotes educational experience – diversity initiatives in the health professions obtained a new significance.

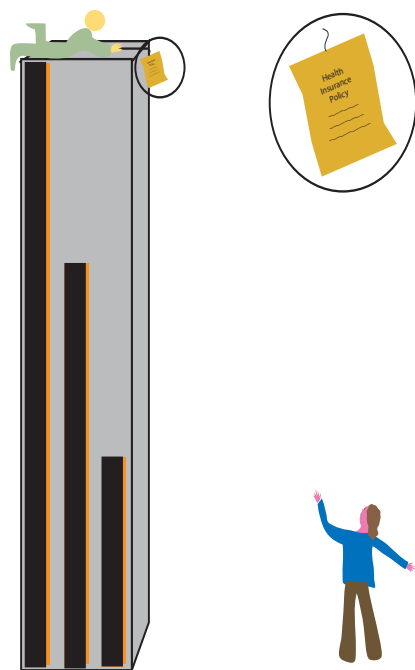
In response to population changes in the United States, showing the number of persons in minority groups increasing, the Institute of Medicine in February published, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*. The report addresses the potential for institutional and policy-level strategies to increase underrepresented minority participation in the health professions. In great detail regarding processes for diversifying the healthcare professions, the report focuses on the overarching question: What benefits does diversity contribute to the larger society?

The IOM report makes a number of recommendations to integrate minority groups into health profession educational institutions, and incisively connects these recommendations to the assertion that a greater number of perspectives and approaches is beneficial, both in academic and professional settings, working with coworkers and patients alike. The committee that produced the report hopes that introducing a stronger minority presence in academic settings will not only improve opportunities for disadvantaged groups, but also allow nonminority students to gain a better understanding of the many differences in people and cultures in our society.

Another expressed benefit of these initiatives is a possible increase in care for marginalized groups. When minority students go into the workforce, they are more likely than white students to work with underprivileged groups in disadvantaged areas. In effect, putting more diversity in the education system will improve opportunities for professional

care for those with presently limited access. In this way, diversity initiatives could help close the gaps for some health disparities.

In its recommendations to support underrepresented minority groups and their involvement in health professions, the committee proposes that educational institutions develop mission statements that recognize diversity. In the commit-



tee's view, this acknowledgment makes a good start on improving the value of healthcare education.

The effectiveness of each program's mission, and efforts to increase diversity should be assessed. Are the programs attracting diverse applicants? Are the minority students progressing and completing the programs?

Also, Congress should be involved, encouraging diversity by increasing funding under the Public Health Service Act, Titles VII and VIII, which deal with a wide span of issues in education and training of health professionals – and already recognize the value of racial and ethnic diversity. Locally, communities may provide additional support to encourage diversity.

Educational institutions rely heavily on quantitative data to make admission selections. Due to research that shows that minority populations perform lower than white students on standardized tests, the committee proposes the integration of qualitative factors in the admissions process, including the attributes that each candidate could contribute, and compatibility with the mission of the institution.

Additionally, the selection committees for academic programs should include representatives from various culture groups. Conducting training programs about the importance of diversity in the educational sector should be included in the selection committee's responsibilities. This training should extend to include students, faculty, and administrative bodies, so that the climate for diversity is supported on every level.

The first step in this process involves accreditation bodies, which ultimately control policy at educational institutions. The U.S. Department of Education and accreditation bodies at educational institutions should enforce standards of diversity in enrollment and curriculum. This is intended to have a ripple effect. A diverse academic setting will promote appreciation and understanding of the value of diversity in professional settings, and further, in society.

The committee believes that all of its recommendations should be developed with a concern for health and social values. Focusing on outcomes, each institution's diversity initiatives should consistently emerge as part of the overall goal of bettering the healthcare professions, resulting in higher-quality care.

Although disparities are not the focus of the report, the committee believes that diversity initiatives should be designed to target disparities in health care. Defining disparities involves not only racial and ethnic minorities, but also financial and nonfinancial barriers to access and quality care experienced by other people, identified by need rather than color or language.

National leaders in health information

BY TERRY HAMMOND

In a nation with one-fourth of the population functionally illiterate, and another one-fourth semi-literate (and in terms of health care also functionally illiterate), the goal of consumer-choice advocates to provide information online to facilitate smart shopping in health care is not likely to transform the system toward market efficiency.

Paul Ellwood, a founder of managed care, managed competition and consumer choice – and also co-founder of the Foundation for Accountability (FACCT) based in Portland – admitted last year:

“Exaggerated assumptions about the power of consumer financial choices to permanently change provider behavior or the health system’s structure have undermined everyone’s including our attempts at health system reform.”

This marks an important new direction. Further evidence of circumspection appears in the lead article by Len Nichols et al. in the new March/April *Health Affairs*: “Waning confidence in health market forces?” The authors use data from the long-running Community Tracking Study to reveal increasing favor among stakeholders for government intervention in a “market,” which despite valiant efforts to the contrary, remains disorganized and inefficient.

In an interview a few years ago, FACCT President David Lansky said the organization’s long-term future involves getting healthcare consumers to think differently about their role in the care they receive. Probably this statement is too ambitious. As consumers, we are unlikely to want anyone to tell us how to shop for groceries or anything else. Relying on presently unpopular “paternalistic” authority, or word of mouth, or plain negligence to save time are all good options. Really, only our willingness to lay out the cash matters – which is another problem with consumer-choice theory.

Consumers are typically not the primary purchasers. Short of destroying insurance entirely, they are never likely to be.

Still, when we do want to know the ingredients, or comparison shop, then we have to appreciate the laws and organizations that make that information available. This is more in line with FACCT’s actual achievements, and fits with Lansky’s more immediate point, also quoted in the interview:

“Individuals should have access to tools that enable them to make decisions about their future.”

FACCT

FOUNDATION FOR ACCOUNTABILITY

This narrower purpose is a more realistic goal, corresponding to the core value of patient-centered care from the Institute of Medicine’s *Crossing the*

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– PAUL ELLWOOD

Quality Chasm. Advocacy for consumer choice remains a prominent feature in FACCT, but counting this a rhetorical failure does not detract from the organization’s notable achievements in applied information technology.

FACCT stakes its fame on providing reliable, scientifically based data on clinical healthcare quality, marketing a variety of survey instruments designed to capture quality data, and also packaging data in interactive report cards designed for easy use by consumers. Milestones recorded on its website (www.facct.org), include adoption of instruments by the National Committee for Quality Assurance, by dozens of states and top companies, and a 2001 endorsement by IOM.

The newest FACCT tool – Compare Your Care – allows patients to compare

their care to several standards: an ideal clinical guideline, and regional and national benchmarks. Users can also access elementary information about their health needs (see demonstration at www.compareyourcare.org).

Additional FACCT projects are underway with Johns Hopkins University for a schizophrenia tool, and with purchasing groups like Leapfrog and “Fortune 100” companies for tools that assist prudent purchasing based on quality.

On the frontier, FACCT is also working with a number of associations and foundations in the development of a personal health record. Achieving any kind of electronic medical record is the typical goal, but FACCT and partners are most concerned to assure interoperability with the patient – so the patient owns the record – thus the distinction between a PHR and an EMR.

Kris Gowen, FACCT’s senior research associate, lists the organization’s current activities with assurance up to the point of the personal health record, where she sighs, confronted by a daunting image

share agenda from Portland offices

of endless details and challenges. In 2003, Healthcare Information and Management Systems Society released a starting model for a standard electronic medical record, just as the federal government announced the same initiative. Further development of the model is on the agenda of the HIMSS summer conference in Las Vegas, June 14-15 (see www.himss.org).

Neighbors unite

A comparison of FACCT to WebMD appears inevitable by the intersection of content related to quality health care, and expertise in electronic information systems. Coincidentally, these two nationally recognized health information specialists also share the same neighborhood, with offices hardly more than a stone's throw away from each other, near Old Town.

Unlike FACCT, WebMD is a for-profit organization, with information focused more on health promotion and management as a saleable product to large companies. The report-card strategy advanced by FACCT is not included. Evidently, simply giving employees access to health information saves money for self-insured companies, regardless of provider profiles for quality selection.

With additional offices in Atlanta and

New York City, WebMD also operates Medscape, the most popular information website for physicians. Survey results reported in the Jan. 23 issue of *Medical Economics* show half the responding physicians use Medscape – many times more than any other resource.

WebMD also uses its electronic skills to transfer claims from providers to purchasers, standardizing the platform for a few cents per claim. According to an insider, the service earns millions of dollars. Presumably, this amount is figured in to the estimated cost savings

WebMD

of \$86.8 billion each year, plus significant quality improvement, once we achieve a standardized electronic health information infrastructure, as calculated recently by the Center for Information Technology Leadership.

David Rowe, local WebMD vice president for product marketing, distinguishes FACCT as an advocacy group, and emphasizes his product's commercial

viability. Contrary to this view, Kris Gowen at FACCT emphasizes her organization's reputation for solid research skills, placing that character first, and "questions how much advocacy we want to do."

The similarity of FACCT and WebMD was recognized by the Markle Foundation, which made them the primary partners in a television and internet feature called "Life on the Line," using information modules from both organizations. The television program aired on Oxygen Network last October. The online feature is still available (www.lifeontheline.webmd.com).

The Markle Foundation is dedicated to advancing information technology, and sponsors a public/private collaboration – Connecting for Health (dot org) – which energetically addresses "the challenges of mobilizing information to improve quality, conduct timely research, empower patients to become full participants in their care, and bolster the public health infrastructure."

Developing a standardized information infrastructure is critical to the advancement of public health as well as health care. The good news here is that we have two information champions, working for the future, onsite.

Task force questions structure of health authority

In response to a house bill in the 2003 legislative session that languished in committee upon adjournment, a task force chaired by Reps. Mitch Greenlick and Jeff Kruse is investigating the question whether public health should be moved to an independent department, with a director appointed by the governor. The first meeting of the work group at the state capital building, on March 8, was facilitated by Bruce Goldberg, Oregon Health Policy & Research administrator, and included an array of state and county officials.

Other state functions (like the Employment Department), have been moved to independent status in the past, and other states have made an independent health authority (like Washington). Practical matters discussed at the meeting included the comment that without proper funding, organization hardly matters one way or the other; and Cindy Becker of Administrative Services gave an insightful presentation on challenges to efficiency, observing the fragmentation in electronic data platforms. Reorganization involves information as well as services.

Rep. Greenlick summarized the first meeting with three questions for further action: (1) Does organizational structure matter to state workers in public health? (2) Does it matter to county health workers? (3) What are the results in other states, and what states are models?

Ultimately, these questions refer to outcomes relative to essential public health services, and to the public's health. Anecdotal input is welcome at this point. You can send your answers to Rick Berkobien, legislative committee administrator (rick.berkobien@state.or.us).

NEWS BITES



Terror threatens world health

Among the online resources new or discovered since last issue, the most profound is Third World Traveler (www.thirdworldtraveler.com), featuring a wealth of essays and information “about the state of democracy in America, and about the impact of the policies of the United States government, transnational corporations, international trade and financial institutions, and the corporate media, on war and peace, democracy, civil liberties, free speech, human rights, and social and economic justice in the Third World, and in the United States.”

As 9/11 showed us, confrontation with grave reality is eventually unavoidable. We need to acknowledge the truth that the biggest threat to world health today and in the past half century is heavy bombing, military operations, military hardware, torture and subversion driven by the U.S. government in scores of nations – amounting collectively to a campaign of genocide to secure the “free world” – intent on suppressing movements for democracy, social justice, and national sovereignty. We as public health advocates need to get it straight and pass the word to our neighbors. The face of terror is us.

William Blum – author of *Killing Hope* and *Rogue State*, both documenting the incredible extent of U.S. terror operations – introduces the many quotations on the site, saying: “No matter how paranoid or conspiracy-minded you are, what the government is actually doing is worse than you imagine.”

If we are looking to end health disparities, a principal choice for attention should be the fate of millions around the world who have been maimed, sickened, and killed through our funding and support as citizens. This site helps to raise awareness of today’s world crisis.

Resource directory launched

The Oregon Community Resource Directory (www.OregonCRD.org) puts a new user-friendly face on a handful of

formerly separate databases serving Oregonians and state agencies seeking employment opportunities, social support, and public health services.

Prayer seeks AIDS healing

Publication timing missed the date, but this national event with support from a number of local churches reappears annually. Christian churches with a focus on black communities join in prayer to “break the silence,” and bring awareness and a higher power into the fight against HIV/AIDS (see www.balmingilead.org/programs/weekofprayer2004/founder.asp).

Conference speaks out for sexual minorities

A free conference in Shoreline, Wash., on June 4 – called “Saying It Out Loud” – addresses “alcohol, tobacco, other drugs, mental health and other health issues facing the gay, lesbian, bisexual, transgender and questioning communities.” Keynote speaker: Kate Bornstein. For more information, contact Ira Stallsworth at 206-272-2190 or stallsi@dshs.wa.gov

Audioconference features CV disease in women

George Mensah, MD, and Suzanne Haynes, MD, will give an audioconference on April 14, 10-11 a.m., with online slides and telephone audio, dealing with cardiovascular disease in women. More women than men die from CV disease, and women are 10 times more likely to die from CV disease than from breast cancer. Registration required at the National Conference of State Legislatures website (“meetings” at www.ncsl.org).

Activist girls show nerve

The Girls' Initiative Network, represented on a recent OPHA panel on adolescent risky behavior, announce an upcoming article in the online magazine *Nervy Girl*, focusing on the topic of “teen pressures” (www.girlsinitiativenetwork.org).

New DHS report documents intimate partner violence against women in Oregon

Ten percent of Oregon women ages 20 to 55 years have experienced physical or sexual violence at the hands of their intimate partner during the past five years, a new state Department of Human Services report reveals.

“Intimate partner violence is a significant public health problem,” state epidemiologist Mel Kohn said. “It takes a physical and emotional toll on the women who are harmed, and can have a profound negative effect on children who witness these acts of violence. It undermines the social fabric of our communities.”

The report is based on a survey of 2,962 Oregon women. The prevalence of violence is likely to be higher than the report shows, Kohn said, because women were not asked about their experience over a lifetime.

- At least 1 in 10 Oregon women, aged 20-55 – more than 85,000 women – have experienced intimate partner violence in the past five years, with nearly one-third of the instances in the past 12 months.
- Intimate partner violence results in serious physical injury. Injuries included broken bones, internal injuries, head injuries, and lacerations or knife wounds.
- Less than two-fifths of seriously injured women received medical care.
- Women who experienced intimate partner violence in the past five years reported poorer mental and physical health than other women. They also experienced higher rates of depression, anxiety, post-traumatic stress disorder, suicidal thoughts, and alcohol and drug use.
- Children witnessed 33 percent of intimate partner physical assaults, and 20 percent of sexual assaults.

Kohn said that medical providers are an important part of the solution, but comprehensive, vigorous community involvement is also needed.

The report is available online (www.dhs.state.or.us/publichealth/ipv/index.cfm), or by calling 503-731-4024.

Abstinence threatens moral fiber of youth

Last week, I was handed a copy of an abstinence education catalog. After perusing the merchandise, I discovered a summary chart from Section 510 of Title V in the Social Security Act, established in 1998. Abstinence education programs receive special funding from the U.S. government if they follow mandated regulations as outlined in the act.

Abstinence education programs are intended to teach adolescents of the health gains – psychological, social, and physical – of abstinence. The overarching theme of these programs contends that sexual activity outside the context of marriage is harmful and detrimental to individuals and society.

It is tacit knowledge that the only way to avoid sexually transmitted disease and pregnancy is to avoid sexual activity; but these programs seem to be doing more than teaching that abstaining from sexual activity is a healthy choice. They are advocating a moral choice as well.

The materials in the catalog echo this moral choice. Nearly every item for sale includes a theme such as “true love waits for marriage” or “best sex is in marriage.” Abstinence education programs expand on the belief that every adult will or should get married, and after the vows have been exchanged, sexual activity is perfect and acceptable.

Stating that sexual activity should be reserved for committed, monogamous relationships seems like a fine idea, but insisting on the “for marriage” clause seems a divisive aside for sex education programs. In a nation where the right for same-sex couples to be married is in question, and “marriage” constitutes many different things to different people, the abstinence education programs pose problems.

In my mind, if the goal of these programs is to encourage students to value sexual activity as something we should share only with a most trusted, committed partner, then let’s start thinking about what constitutes healthy relationships and healthy sexuality, and start teaching that to students.

These programs do not address alternatives to abstinence. Apparently you get married or never experience sex – a view that is not only unrealistic, but also blatantly discriminatory.

Even married couples need to be informed about birth control and sexually transmitted diseases. If contraception is included in the curriculum, then students will be doubly prepared to make good decisions; they will know that sexual activity should be reserved for committed relationships, while also being aware of their choices should they find themselves ready for a sexual relationship on other terms.

The United States has the highest teen pregnancy rate in the industrialized world. Title V Section 510 states that “bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society.” Yet this is primarily due to the lack of social services and networks to support people in disadvantaged situations. Abstinence education puts an additional stigma on the struggles that arise for single parents,

because it is morally not supposed to exist.

As the new generation of children reaches school age – and more children have only one parent – it is important to not make them feel like burdens to their families and society. Their challenges should be addressed in a way that encourages them to succeed, and also encourages pride and responsibility in their parents.

Students should learn about critical thinking and decisionmaking in school. The goal of education should be to equip students with the information and skills to go into the world and make sound choices. By neglecting to provide students with the vast amount of information and perspectives available about healthy sexuality, these programs hurt students, not only because they present a single side to a controversy, but also because they neglect to give students the full range of perspectives on moral responsibility, to decide for themselves the appropriate person, time, and way to engage in a sexual relationship.

– LESLEY RUSH

Adolescent Risky Behavior section becomes active part of OPHA

In summer 2003, the proposed Adolescent Risky Behavior section received enough members to be recognized as an official section of OPHA. The section sponsored two sessions at the OPHA fall conference.

One session focused on background information regarding patterns of risky behavior, including results from the annual Oregon Youth Health Survey, plus data on adolescent access to care, risk factors for youth living with disabilities, learning disabilities of youth who engage in juvenile-delinquent acts, and access to health care for youth in custody of the Oregon Youth Authority.

The second session featured a panel by 12 high school students discussing their views on risky behavior and how to

prevent such behavior. Out of these discussions, section members decided to pursue a varied action agenda for the year.

Subsequent meetings have featured discussions of (a) a pilot project where youth help adults to communicate better with their adolescent children, (b) a policy on adolescent risky behavior to submit for APHA approval, and (c) updating the Adolescent Risky Behavior Legislative Handbook to distribute in time for the 2005 Oregon legislative session.

The section meets on the second Monday of each month, 4-5 p.m., in the State Office Building. Interested persons are invited to contact section chair, Katie Riley (katie_riley@comcast.net) to receive meeting notices and minutes. All are invited to attend.

Nexus: OPHA announces leadership for 2004

The new OPHA leadership roster is now available, good through 2004. Some positions continue into later years. Publishing the names and contact information for persons in the four sections, and the board of directors, may facilitate participation and networking for our coming year of accomplishments. *Excelsior.*

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World report

Health impact assessment targets inequalities

BY TERRY HAMMOND

Health impact assessment is a new concept, derived from earlier experience with environmental impact assessments; and also derived from the growing attention to health promotion through evidence-based public policy. British Columbia gave the concept its first governmental endorsement in 1991.

The practice of HIA is now widespread in Canada. Other Commonwealth countries (United Kingdom, Australia, New Zealand) quickly adopted it.

In 1998, the Acheson Report in the UK made its principal recommendation to the national government "that as part of health impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities." This statement recognizes health impact as a standard for public policy.

HIA was officially adopted in the European Union through the Amsterdam Treaty, taking effect in 1999, with Article 152 stating: "A high level of human health protection shall be ensured in the definition and implementation of all

Community policies and activities."

HIA is also strong in Thailand. In its agenda for health system reform since 2000, the Thai government is concentrating on health promotion rather than medical care. About 20 HIA case studies have already been conducted.

The coincidence of HIA with the recent enactment of national health insurance in Thailand reflects the experience in other countries. Evidently, the government only truly has a vested interest in public health once it takes responsibility to pay for medical care.

HIA is virtually absent in the USA. The Minnesota Department of Public Health provides an excellent annotated

bibliography and review of the literature online, indicating interest in the topic.

Intersectoral relationships with stakeholders, and cooperation among state agencies are both essential. Community participation is often promoted by activist researchers, but it is too expensive and time-consuming for rapid assessment schedules. In the policy process, timing is of utmost importance. Community participation is appropriate when there is a direct and personal community interest.

The movement for health indicators (as in Healthy People 2010) is different, representing policy activism with a "health needs assessment." Community participation there is important to prioritize choices for action.

HIA analysts must closely monitor policy developments and be prepared to respond rapidly. Ideal timing in HIA relies upon monitoring, networking, authority to intervene, and access to policymakers during the window of opportunity between vague ideas, definite proposals, and official draft.

The best incremental strategy for instituting HIA probably involves piggy-backing on established procedures for environmental impact assessment, and combining social dimensions into a concept of "human impact."

2004 Health Disparities Symposium, April 15-16

"Neighborhood and Place"

Keynote address:

George Kaplan, president, Society for Epidemiologic Research

Plenary session:

Ana Diez-Roux, an expert on neighborhood research

Location: University of Washington campus, Seattle, rooms TBA.

For more information, contact Syd Fredrickson (sydf@u.washington.edu).

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