

Health Improvement Plan Draft Sept, 2010

“Health starts where we live, work, learn and play”

Introduction

The Oregon Health Policy Board (OHPB) created the Health Improvement Plan Committee and their charter in January 2010. In the charter, the Committee’s stated objective is to “provide leadership, direction and oversight for the development of an Oregon Health Improvement Plan, under the direction of the Oregon Health Policy Board. This plan supports a key OHPB goal to improve the health of all Oregonians by promoting and supporting lifestyle choices that prevent and manage chronic diseases. The plan will outline evidence-based interventions that incorporate policy, systems and environmental approaches to promote population health at the state and community levels. The plan will emphasize a strategy that links population health to the health care delivery system and communities.”

The plan supports the OHPB’s Triple Aim: improve the lifelong health of all Oregonians, increase the quality, reliability and availability of care for all Oregonians, lower or contain the cost of care so it is affordable to everyone. The charter also refers the Committee to the Oregon Health Fund Board’s final report, “Aim High: Building a Healthy Oregon,” (November 2008), particularly in reference to Building Block 4: Stimulate System Innovation and Improvement.

The 26-member Health Improvement Plan (HIP) Committee, representing public and private sector organizations including schools, government, tribes, business, and community leaders, conducted Listening Sessions in eight locations across the state to gather community input. In addition, they reviewed Building Blocks 4 and 5 (Ensure Health Equity) in the 2008 Health Fund Board Report, current statewide plans and reports, national guidelines, and evidence-based and best and promising practices in developing their recommendations. The Committee used the Health Impact Pyramid (from Tom Frieden, A J PH, April 2010) as a guide for prioritizing the most effective actions.

The Health Improvement Plan is organized by three key focus areas. These include: 1) achieving health equity and population health by improving social, economic and environmental factors; 2) preventing chronic diseases with a specific emphasis on reducing obesity and tobacco use; and 3) stimulating public health, community, and health system linkages, innovation and integration.

Achieving Health Equity and Population Health - Health starts where we live, work, learn, and play.

Opportunities for health happen, or don’t happen, long before people need medical care. Nothing will improve health for all of Oregon’s various populations more than being well-educated and employed. State and local policies and funding decisions made by various sectors related to education, employment, housing, transportation, land use, agriculture, economic development, and public safety all have a major impact on health and on the opportunity for all Oregonians to achieve health equity

regardless of income, education, or ethnic background. “Health in all policies” needs to be a goal for Oregon.

Educational attainment is the cornerstone for employment, income level and overall health. Healthy students do learn better, and the public health system can partner with the Department of Education and local school districts to assure Oregon’s students are healthy and able to attain their fullest potential. State and local public health can provide leadership for achieving this goal by developing partnerships, convening and facilitating conversations, building relationships, and, over time, reaching agreement among all sectors at the state and local level on common goals to improve and protect population health. The availability of data to monitor and evaluate health, social, economic and environmental factors for Oregon’s diverse populations will be critical in this effort.

Preventing Chronic Diseases - Medical care for diseases like cancer, heart disease, stroke, diabetes, asthma, and arthritis are the primary contributors to high medical costs. Preventing these diseases from developing and preventing complications for those who have a chronic disease will yield significant cost savings and improve quality of life for Oregonians. Creating conditions where people live, work, learn and play that are tobacco-free and provide access to healthful, affordable choices for foods and beverages, and safe places for daily physical activity will have the highest impact in preventing these chronic diseases and preventing further complications. Oregonians want to be healthy and believe in prevention. The current norms in schools, workplaces, neighborhoods, and communities don’t often make healthy choices easy. Creating environments where these healthy choices are common, affordable, safe, and accessible by all populations can be achieved when all sectors participate in these efforts.

Stimulating public health, community, and health system linkages, innovation and integration - State and local public health agencies play a key leadership role in convening partners across health and social sectors. Public health is working with those partners to assess current conditions supporting health and develop plans for improving health tailored to population needs. A key partner in this effort is area hospitals who are mandated by the 2010 federal Affordable Care to conduct community health assessments. Development of regional health collaboratives responsible for local policy, health improvement planning and priority setting will improve local system integration and development. Working with partners across sectors will maximize the effect of improving health for all populations and force the analysis of existing health services so that resources can be used wisely. Availability of population health and risk factor data by race, ethnicity and economic status tied to clinical, emergency, and hospital data at the community as well as state level will be critical for monitoring success. Accreditation for state and local health departments will bring system improvements through performance management, achievement of standards, collaborative planning and utilization of consistent and relevant health outcomes.

Although prevention of chronic diseases is our priority, people with diagnosed chronic diseases need support where they live, work, learn, and play, as well as where they receive health care, in order to be good managers of their health. People living with chronic conditions who have the tools to effectively

self-manage their conditions feel an increased sense of efficacy, are more able to follow-through with their health care provider's recommendations, and use fewer high-cost health care services because they are able to prevent or delay complications of their diseases. Establishing and funding systems that effectively link primary care with public health and social service resources and track outcomes is essential to achieving all components of Oregon's triple aim – improving population health, increasing quality and reducing cost.

Goals, Strategies, Actions

Goal I: Achieve health equity and population health by improving social, economic and environmental factors.

Outcome: Increase high school graduation rates and college degrees for populations with disparities

Strategy 1: Target resources to improve student health (pre K-12) to support improved educational outcomes (OHA, ODE)

Action in 1 year:

- Support passage of a “Healthy Schools Act” that establishes student health measures as a part of the education accountability system. (OHA)

Action in 3 years:

- Incorporate health improvement of students and staff as a component in School Improvement Plans (ORS 329) and the implementation of those specific plans. (PHD/LHD/ODE/Local School Districts)
- Expand funding for and access to Head Start, Early Head Start and Migrant Head Start. (Legislature)
- Promote stable housing by prioritizing existing resources to build new, affordable housing and preserve and rehab existing affordable housing to accommodate families who make less than 30% under median income. (Oregon Housing and Community Services)
- Require Health Impact Assessments and plans to remediate identified health impacts for building and transportation school sites and projects in geographic proximity to school sites. (OHA/Legislature)

Metrics: high school graduation rates, 2 and 4-yr college degrees

Return on Investment: Nothing will improve health for all of Oregon's various populations more than being well-educated and employed. Less education predicts higher levels of health risks, such as obesity, substance abuse, and violence. At the same time, good health is associated with academic success. Health risks such as teenage pregnancy, poor dietary choices, inadequate physical activity, physical and emotional abuse, substance abuse, and gang involvement have a significant impact on how well students perform in school.

Educational attainment is directly related to future income of individuals and of the State. In Oregon, on average working-age people who did not complete high school earn \$10,000 less each year than those who graduated high school. The personal implications of this type of wage disparity are many. The implications to the state are also significant. Approximately \$173 million dollars in tax revenue is lost each year due to the decreased earnings of individuals that did not earn a diploma in high school.

There are additional costs incurred to provide social and medical services to Oregonians that did not complete high school. Those who did not complete high school and are over the age of 24 are reported to be in worse health than adults that completed high school. As a result of this health disparity, costs for state supported social and medical programs are higher for this population. For example, Oregon spends more than \$200 million providing Medicaid services to people who did not graduate high school.

Goal II: Prevent chronic diseases by reducing Obesity prevalence, Tobacco use, and Alcohol abuse.

Obesity Outcome: Reduce obesity in children and adults

Strategy 1: Make evidence-based obesity prevention education and weight management support a covered health insurance benefit and widely available to Oregonians.

Action in 1-3 years:

- Make an evidence-based obesity prevention education and weight management health insurance benefit available to DMAP managed care and fee-for-service clients, as well as to PEBB and OEBC members in 2011, and promote its use at workplaces (OHA); and expand availability of this benefit to county and city public employees and health care industry employees in 3 years (county and city agencies, health care settings).

Strategy 2: Reduce consumption of sugar-sweetened beverages

Action in 1-3 years:

- Eliminate the sale of sugar-sweetened beverages in cafeterias, stores and vending machines in 2011 (State agencies, public schools, and universities); and expand the elimination of the sale of sugar-sweetened beverages to other settings in 3 years (County and city agencies, community colleges, tribal agencies, health care facilities).

- Raise the price of sugar-sweetened beverages by establishing a \$0.005 per ounce tax in 2011-2013 (increasing to \$0.01 per ounce in 2013). Dedicate a portion of the proceeds to reach recommended funding (\$22 million 2011-13) for comprehensive efforts to reduce obesity and chronic diseases in adults and children including media campaigns and implementation of best and promising practice interventions by counties, regions, tribes, schools, coalitions and community-based organizations. (OHA/Legislature)

Strategy 3: Make healthful food and beverage options widely available in public sector, tribal, health care settings and public schools and universities.

Action in 1-3 years:

- Require that foods and beverages in cafeterias, stores and vending machines meet nutrition standards, and that foods and beverages served at meetings and conferences include healthful options in 2011 (state agencies, public schools and universities); and expand implementation of healthy food and beverage requirements to other settings in 3 years (county and city agencies, community colleges, tribal agencies, health care facilities, private sector workplaces).
- Expand Farm to School and School Gardens and Nutrition Program. (Oregon Dept of Education, Dept of Agriculture, Legislature)
- Supplement the current federal food stamp program with state funds and provide incentives for purchasing healthful foods with state-funded program (OHA, Legislature)
- Fund a Healthy Food Financing Initiative similar to the successful Pennsylvania program (they fund development of grocery stores and corner “healthy food” markets in low-income neighborhoods/“food deserts”) This is now part of a federal program that brings grocery stores and other healthy food retailers to underserved urban and rural areas. It is an initiative of the Dept of Treasury, Agriculture and Health and Human Services. (DHS/ODA, Legislature)
- Reduce the sodium intake of Oregonians by decreasing the sodium in packaged and restaurant foods produced in Oregon by 25% over five years. (Oregon Public Health Division, Department of Agriculture, Oregon State University Food Innovation Food Center, food processors)

Strategy 4: Increase physical activity opportunities in schools, universities, work places and communities

Action in 1-3 years:

- Promote and support active transportation options for employees and students including mass transit, bicycling and walking in 3 years (state agencies, county agencies, schools, health care facilities, city agencies, tribal agencies, colleges, universities, private sector workplaces).
- Promote and support physical activity throughout the work and school day for employees and students including accessible stairs, breaks for stretching, walking meetings, recess, physical

education and after school play time in 3 years (state agencies, county agencies, schools, health care facilities, city agencies, tribal agencies, colleges, universities, private sector workplaces).

- Supplement federal funding with state highway funds dedicated to bicycle and pedestrian facilities to x% and double the amount of state funding allocated to the Safe Routes to School Program. (Oregon Dept of Transportation, Legislature).

Metrics: Obesity (BMI, sugar-sweetened beverage consumption, meet CDC physical activity recommendations)

Return on Investment: One-third of the recent increase in medical costs in Oregon is attributed to obesity. In 2003, estimated medical costs related to obesity in Oregon among adults were \$781 million. Costs in Oregon for treating diabetes are \$1.4 billion/year. CDC estimates that persons who are obese have medical costs that are \$1429 higher than those of normal weight. By reducing obesity and obesity-related chronic diseases like diabetes, Oregon stands to realize a significant return on investment.

Between 1996, the year before the Tobacco Prevention & Education Program was established, and 2006 there was a 22% drop in the prevalence of tobacco use among Oregon adults. If similar effectiveness is achieved in reducing the onset of diabetes (primarily through reducing obesity) over 10 years, an investment in obesity prevention and education would save \$215 million in medical costs from prevented cases of diabetes.

The benefits of establishing health-promoting environments go far beyond reducing the prevalence of obesity and diabetes. Such environments also support treatment and management of diabetes and help reduce its dire complications such as heart disease, blindness, amputations and kidney disease. Likewise, prevention and management of other chronic diseases like hypertension, heart disease, strokes, cancer and arthritis would improve and provide additional savings in health care costs.

Sugar-sweetened beverages are empty calories, a major contributor to the increase in obesity in children and adults. Oregonians consume over 136 million gallons of sugar-sweetened soda each year, equivalent to more than 63 million pounds of excess weight gained in the state. This figure does not include other beverages such as energy drinks and sugar-sweetened fruit drinks. Price increases are being shown to reduce consumption of sugar-sweetened beverages. Raising the price of sugar-sweetened beverages by 10% through taxation is projected to decrease consumption by over 12%. Because sugar-sweetened beverages are one of the main drivers of weight gain in America, taxing these products is an appropriate means for reducing their consumption and funding comprehensive efforts to reduce obesity and related chronic diseases like diabetes.

Focusing prevention efforts and providing weight management benefits for the 850,000 OHA covered lives (OHP, PEBB, OEBC) will enable significant savings to accrue directly to the state budget.

Tobacco Outcome: Reduce tobacco use and exposure

Strategy 1: Create tobacco-free environments

Action in 1-3 years:

- Adopt and implement tobacco-free campus policies in 2011 (state agencies, addictions and mental health facilities contracting with OHA); and expand implementation of tobacco-free campus policies to other settings in 3 years. (County agencies, community colleges, universities, hospitals, city agencies, tribal agencies, private sector worksites and multi-tenant office properties)
- Adopt and implement smoke-free policies for all public multiunit-housing settings in 2011. (County/regional health departments, public housing authorities)

Strategy 2: Reduce tobacco use

Action in 1-3 years:

- Assure that evidence-based tobacco cessation health insurance benefits are available and promoted to DMAP managed care and fee-for-service clients, as well as to PEBB and OEGB members in 2011. (OHA)
- Raise the price of tobacco by increasing the cigarette tax by \$1, and by a proportionate amount on other tobacco products, and dedicate 10% (\$40 million) to comprehensive efforts to reduce tobacco use and exposure in adults and children, including implementation of best practice interventions by counties, regions, tribes, schools, coalitions and community-based organizations immediately (OHA/Legislature); continue to increase the tobacco tax and dedicate a portion of the proceeds to expand effective efforts to reduce tobacco use and exposure in adults and children, until the CDC recommended level of funding for tobacco control in Oregon is reached. (OHA/Legislature)

Strategy 3: Counter pro-tobacco influences

Action in 1-3 years:

- Ban free sampling of tobacco products, tobacco coupon redemption, and other tobacco price reduction strategies in. (County/regional health departments, OHA/Legislature)
- Require tobacco prevention messages at the point-of-sale, such as Quit Line or hardhitting graphic warnings. (County/regional health departments, tribes, OHA/Legislature)
- Require tobacco retailers to obtain a license before selling tobacco in the state of Oregon to monitor, implement, and enforce local, state, and federal laws regulating tobacco sales, marketing, and promotions. (County/regional health departments, tribes, OHA/Legislature)

- Require that tobacco education and cessation materials be given “equal time” in tobacco retail stores, such that anti-tobacco marketing materials take up the same amount of space as tobacco advertising and promotional materials including “powerwall” displays. (County/regional health departments, tribes, OHA/Legislature)

Metrics: Tobacco use and exposure

Return on Investment: Increasing the cost of tobacco is a proven practice for reducing tobacco use in youth and adults. Oregon’s current tobacco tax is below the national average, making it easier for youth to begin using tobacco and more difficult for tobacco users to quit. Oregon’s low tobacco tax rate, unchanged since 2004, also limits funds available for tobacco prevention and other important state services. Without an on-going substantial and dedicated source of funding, the relentless efforts of the tobacco industry to recruit new smokers and promote tobacco use will overcome current tobacco prevention efforts.

Tobacco use continues to be the leading cause of illness and premature death in Oregon. For each one percentage point decline in adult and youth smoking rates, Oregon can expect to see 28,400 fewer adult smokers, 460 fewer pregnant smokers, and 2,000 fewer high school smokers. This will result in a \$269.8 million reduction to future health care costs from adult smoking declines and a \$148.8 million reduction in future health costs from youth smoking declines.

Focusing prevention efforts and providing evidence-based cessation benefits for the 850,000 OHA covered lives (OHP, PEBB, OEBC) will enable significant savings to accrue directly to the state budget. For every dollar Oregon spends on providing tobacco cessation treatments, it has an average potential return on investment of \$1.32.

Alcohol Outcome: Reduce Alcohol Abuse

Strategy 1: Reduce alcohol abuse by increasing the beer tax in Oregon to the national average and index it to inflation and dedicate a portion of the proceeds to comprehensive efforts to reduce alcohol abuse. (Legislature)

Action in 1-3 years:

- Raise the price of beer by raising the current 8 cents per gallon tax to 16 cents in 2011-2013. Dedicate a portion of the proceeds to provide funding for comprehensive efforts to reduce economic burden of alcohol abuse (estimated at \$3.2 billion per year, more than eight times the amount of tax revenue from alcohol). (Legislature)
- Implement a target media campaign and evidence-based community alcohol abuse prevention interventions towards high-risk and vulnerable populations such as youth, and communities with high prevalence of alcohol abuse. (OHA/Legislature)

Metrics: Alcohol abuse

Return on Investment: A 2010 report to the Governor indicated that alcohol abuse costs Oregon's economy \$3.2 billion per year, more than eight times the amount of tax revenue from alcohol sales. Much of these costs are borne by Oregon's system of health care and social service agencies. The future does not look promising in this area as the number of Oregon 8th graders who have had a drink in the past 30 days is twice the national average. Today, more than 1 in every 20 youth aged 12 to 17 abuses alcohol or is alcohol dependent. According to a report by the Oregon State Epidemiological Outcomes Workgroup, there has been a worsening trend in Oregon regarding alcohol-induced death and Potential Years of Life Lost (PYLL). Blood alcohol levels over the legal limit are present in one-third of Oregon's traffic crashes. Alcohol is the most widely used addictive substance in Oregon.

The return on this investment would be lower levels of alcohol related damage in our society, and increased funding to cover the costs of damage that does occur. Because the cost of alcohol abuse to Oregon's economy is \$3.2 billion annually, a substantial return could be gained by reducing consumption, especially in youth. The actual amount in financial terms needs to be determined by an economic and health analyses assessing the unique contribution of beer and other malt beverages, estimating the potential drop in consumption given tax increase, and estimating the savings in health care and social service agencies. However, the 2010 report to the Governor has indicated that "prevention and recovery programs are very cost effective".

Goal III: Stimulate public health, community, and health system linkages, innovation and integration that increase coordination and reduce duplication.

Outcome: Implementation of integrated and coordinated community-based initiatives to reduce chronic diseases and improve population health

Strategy 1: Increase the effectiveness and efficiency of Oregon's public health system

Action in 1 year:

- Coordinate funding and programs available through federal health reform that would contribute to establishing systemic integration between primary care homes, public health, mental health, and other ancillary health services (dental, vision) and social services such as public health nurse home visiting, community health workers, community health teams. (OHA)
- Collaborate with local (non-profit) hospitals to conduct community health assessments, develop local coordinated and integrated health improvement plans focused on reducing obesity, tobacco use and exposure and chronic disease prevention and management and evaluate the results. (County/regional health departments, tribes, hospitals, key stakeholders)

- Create regional “health collaboratives” that track and are responsible for local policy, health improvement planning, priority setting, system development, financial investment and health outcomes. (County/regional health departments, tribes, health systems, clinics and hospitals, and other key stakeholders)
- Establish adequate data systems to collect, manage, and analyze public health performance measures and quality improvement processes including demographic data on race, ethnicity, income and education level. (PHD, county/regional health departments, tribal health authorities)

Action in 3 years:

- Increase public health capacity statewide by the state and all county/regional health departments seeking accreditation that will assure implementation of community health assessments and health improvement plans. (PHD, county/regional health departments)
- Assure that data systems support collection and analysis of population health improvement measures including demographic data on race, ethnicity, income and education level, and tie them to clinical, emergency and hospital data through state and regional HIEs. (OHA)

Strategy 2: Establish and fund systemic integration between patient-centered medical care homes* and community-based public health and social services resources to support chronic disease prevention and management. **term meant to capture the range of settings in which individuals receive care.*

Action in 1 year:

- Establish pilots to develop, test, and evaluate “community health team” models that coordinate, navigate, integrate and track patient referrals and outcomes between primary care homes, public health and social services. (OHA)
- Require that pilot programs and funding be targeted to Oregon populations that are most vulnerable and have the greatest disparities due to income, race, ethnicity, and/or geographic region. (OHA)

Action in 3 years:

- Establish a mechanism to measure the savings resulting from implementing chronic disease health prevention benefits associated with the Health Improvement Plan and redirect the savings for further expansion of OHP and funding of proven intervention strategies. (OHA/DMAP/PEBB)
- Bring to scale programs that demonstrate improved health outcomes through successful coordination, navigation, integration and evaluation of patient referrals and outcomes between primary care homes, public health and social services. (OHA)

Strategy 3: Establish and fund systemic and collaborative community-based chronic disease management programs that target conditions that have high-risk and costs associated with each negative health event.

Action in 3 years:

- Make evidence-based chronic disease self-management and targeted case management interventions widely available in communities and reimbursed by OHA for DMAP managed care and fee-for-service clients, as well as PEBB and OEGB members. (OHA)
- Make evidence-based group exercise and falls prevention programs widely available and affordable in all counties and all tribal communities. (OHA/PHD, county/regional health departments and Area Agencies on Aging, tribal agencies)
- Make evidence-based chronic disease programs widely available and affordable in multiple venues in all counties. (OHA/DMAP/PHD, county/regional health departments and Area Agencies on Aging, tribal agencies, health plans)
- Provide reimbursement for evidence-based home-based multi-trigger, multi-component interventions with an environmental focus for people with asthma available through targeted case management programs in all local health departments and tribal health authorities in Oregon. (OHA/DMAP/PHD, county/regional health departments, tribal agencies)

Metrics: community assessments done in collaboration with local health departments and hospitals, health collaboratives established and tracking health outcomes, state/local health departments applying for accreditation, participation in evidence-based chronic disease self-management programs, hospital readmissions and preventable emergency department utilization

Return on Investment: A focus on community health assessment and community health improvement plans resulting from inter-related community collaborations that include public health, hospitals and community based organizations, will focus community interventions on identified needs and will be embraced by the community because they are driven at the local level. The collaborations with population based public health measures and decreased hospitalization use will reduce costs and focus on primary prevention. A public health system focused on utilization of prevention and meaningful outcome measures will assure the focus on prevention at the community level. The return on investment is well documented by Trust for America's Health. Healthy people spend less on medical care. Investing \$10 per person annually in community programs that increase physical activity, improve nutrition, and prevent smoking could save Oregon more than \$193 million in the next five years.

Persons living with chronic conditions who have the tools to effectively self-manage their conditions feel an increased sense of efficacy, are more able to follow-through with their health care provider's recommendations, and use fewer high-cost health care services. A recent OSU report on Oregon's evidence-based Living Well program estimates the following five-year effects if only 5% (78,300) of eligible Oregonians were to participate in the program: 2,138 quality adjusted life years gained, 11,119

avoided ED visits saving \$13 million, 55,593 avoided hospital days saving \$130 million. Evidence based healthy homes programs improve overall quality of life and productivity, specifically improving asthma symptoms and reducing the number of school days missed due to asthma. The Community Guide for Preventive Services found that healthy homes programs with a combination of minor or moderate environmental remediation with an educational component provide good value for the resources invested and have benefit-cost ratios ranging from 5.3 to 14.0.

HIP Committee Recommendations to OHA/DMAP

Enroll all eligible tribal members onto the Oregon Health Plan outside of the lottery system because of 100% federal reimbursement.

DMAP purchased health care benefits for managed care and fee-for-service clients should reimburse:

- evidence-based tobacco cessation that meets US Preventive Services Task Force recommendation
- evidence-based chronic disease self-management programs such as Living Well
- evidence-based weight management programs such as Weight Watchers
- diabetes daily glucose testing supplies
- lactation-related durable medical equipment and lactation specialists to provide lactation services
- evidence-based home-based multi-trigger, multi-component interventions with an environmental focus for people with asthma

HIP Committee Recommendations to other HPB Committees

Health Information Technology Oversight Council (HITOC)

- Require public health participation on Health Information Exchange initiatives.
- Require county level demographic data (income, race/ethnicity, education) that supports identification of populations vulnerable to chronic disease disparities and chronic disease risk factors.

- Create Health Information Exchanges and fund data collaborations that support HIP metrics and indicators for all populations including demographics and qualitative data that support assessment and improvement of health equity.
- Assure that Health Information Exchanges include a wide range of health measures for use at the county/regional level including income, education, race/ethnicity, health risks (tobacco use, BMI, physical activity, sugar sweetened beverage and fruit/vegetable consumption at a minimum), clinical services, and emergency and hospitalization data, so that outcomes and return on investment of interventions can be measured for all populations including those most vulnerable to chronic diseases and risk factors.

Public Employers Health Purchasing Committee

Organize OHA services such that full integration of mental health, addictions, oral and physical health care is achieved.

OHA purchased health care benefits reimburse:

- evidence-based tobacco cessation that meets US Preventive Services Task Force recommendation
- evidence-based chronic disease self-management programs such as Living Well
- evidence-based weight management programs such as Weight Watchers
- diabetes daily glucose testing supplies
- lactation-related durable medical equipment and lactation specialists to provide lactation services
- nutrition consultation with a registered dietitian and physical activity consultation with a certified exercise physiologist, and consider other medical and surgical treatment options following evidence-based reviews
- asthma trigger reduction incentives
- health care benefits provided by all employers include tobacco cessation, lactation services and equipment, preventive screenings, chronic disease self-management, mental health, addictions and dental care.

Health Incentives and Outcomes Committee

- Integrate the Chronic Care Model into the medical home model
- Establish referral and care coordination systems between medical/behavioral health homes and community services and resources

- Insurers provide coverage for tobacco cessation, lactation services and equipment, preventive screenings, chronic disease self-management, mental health, addictions and dental care
- Insurers reimburse for evidence-based chronic disease self-management programs (e.g. Living Well, Asthma Home Visits)
- Standardized clinical practices are established for chronic disease prevention, such as BMI calculations, oral health screening, tobacco use prevention and cessation
- Health care providers provide screening and anticipatory guidance for adolescents recommended by the Guidelines for Health Supervision for Adolescents (Bright Futures by AAP and DHHS), such as BMI, lipid screening, tobacco use and cessation, social-emotional health, and alcohol and drug use
- Give all birthing hospitals two years to receive *Baby Friendly* designation/certification. After this period, have all births paid through state public funds, i.e. Oregon Health Plan, Public Employee Benefits Board (PEBB), and Oregon Educator Benefits Board (OEBB) pay a differential reimbursement rate for births/deliveries at certified *Baby Friendly* Oregon hospitals. (Lower reimbursement for non-certified hospitals and higher for certified *Baby Friendly* hospitals.)
- Collect and make available emergency transport, emergency department, and hospitalization data
- Disseminate Childhood Hunger Coalition’s “Childhood Hunger” toolkits and CME training to pediatric and family practice providers across Oregon, including local resources to refer those with food insecurities
- Family planning services include preconception health assessment and education to prevent chronic diseases in future generations

Healthcare Workforce Committee

- Develop a required standard or competency for health professional licensing/certification that includes preventive practices about physical activity, nutrition, breastfeeding, oral health, mental health, and healthy and safe home environments
- Develop and implement a PH internship program for high school and college students in local and state public health agencies.
- Workforce needs for a fully functioning, robust public health system in Oregon include the following (from Oregon State University and Conference of Local Health Officials, CLHO):
 - Oregon needs an accredited school of public health to train and retain a high functioning public health workforce. Establishing a school/college of public health at one or more

universities is a critical step if Oregon is to produce the estimated 240 graduates per year that it will need.

- Many among the workforce lack public health training and are not well prepared to conduct population based approaches, which is the heart of the profession. Oregon needs to establish and offer continuing education and certification opportunities for the current public health workforce.
- o The use of community health worker programs is a strategy that has been demonstrated to be effective at reducing the disparities of care that occur within the context of health care delivery (referenced from the Oregon Health Fund Board report, Building Block 5, Ensure Health Equity for All, November 2008). Oregon should explore the following:
 - Providing direct reimbursement for Community Health Workers (CHWs) for publicly-sponsored health programs.
 - The Oregon Health Authority, in coordination with the Oregon Healthcare Workforce Institute and other groups builds a culturally competent workforce that reflects the diversity of Oregonians.
 - The Legislature supports Community Health Worker programs that recruit and train members of underserved communities to provide culturally and linguistically competent health services within that community.