AGENDA

PUBLIC HEALTH ADVISORY BOARD

July 21, 2016
2:30-5:30 pm
Portland State Office Building, 800 NE Oregon St., Room 1E, Portland, OR 97232

Conference line: (877) 873-8017
Access code: 767068

Meeting objectives

- Discuss legislative briefing and provide update on other public health modernization activities
- Share information about the work of Public Health Advisory Board Incentives and Funding Subcommittee
- Discuss the process for the development of the public health modernization economic and health outcome report
- Learn about Oregon's State Health Improvement Plan priorities and provide feedback

2:30-2:40 pm	**Welcome** • Approve June 16, 2016 minutes	Jeff Luck, PHAB Chair
2:40-3:10pm	**Public health modernization updates** • Provide update on legislative briefing and other activities since the June PHAB meeting • Discussion	Jeff Luck, PHAB Chair
3:10-3:25 pm	**Public Health Advisory Board Incentives and Funding Subcommittee report**	Akiko Saito, Incentives and Funding Subcommittee
3:25-4:05 pm	**Public health modernization economic and health outcome report** • Review initial report methodology • Discuss framing for report • Review report delivery timeline • Discussion	Myde Boles and David Solet, Program Design and Evaluation Services
4:05-4:15 pm	**Break**	
4:15-5:15 pm	**Oregon's State Health Improvement Plan** • Review the State Health Improvement plan development and implementation process • Discuss health equity interventions • Discuss the tobacco priority area and provide feedback	Katrina Hedberg, Karen Girard and Tim Noe, OHA Public Health Division

5:15-5:30 pm	**Public comment**	
5:30 pm	**Adjourn**	Jeff Luck, PHAB chair

Public Health Advisory Board (PHAB)
June 16, 2016
Portland, OR
Draft Meeting Minutes

Attendance:

Board members present: Carrie Brogoitti, Muriel DeLaVergne-Brown, Silas Halloran-Steiner, Katrina Hedberg, Safina Koreishi, Jeff Luck, Alejandro Queral, Eva Rippeteau, Akiko Saito, Eli Schwarz, Lillian Shirley, Teri Thalhofer, Tricia Tillman, and Jennifer Vines

Board members absent: Prashanti Kaveti

Guest: Zeke Smith, Oregon Health Policy Board

OHA Public Health Division staff: Sara Beaudrault, Cara Biddlecom, Holly Heiberg, Dano Moreno, Angela Rowland

Members of the public: Morgan Cowling, Coalition of Local Health Officials and Charlie Fautin, Benton County Health Department

Changes to the Agenda & Announcements

Jeff introduced the guest attendee, Zeke Smith from the Oregon Health Policy Board.

Akiko gave an update on the recent Cascadia Rising Exercise. She provided a link to a news story about the Cowlitz tribe's work to prepare for a Cascadia event.

Think out loud link:
https://soundcloud.com/thinkoutloudopb/tribes-prepare-for-the-big-one .

Muriel provided an overview of her county's work in the exercise.

Approval of Minutes

A quorum was present. The Board voted to approve the May 19, 2016 minutes and the June 3, 2016 webinar minutes. All members approved the minutes.

Public Health Advisory Board subcommittee reports

– Silas Halloran-Steiner, Incentives and Funding Subcommittee chair

The subcommittee met on June 15th. Under House Bill 3100, the funding formula must include county population, burden of disease, health status, matching funds, and incentives and accountability measures. The subcommittee recommends including additional indicators for racial/ethnic diversity, poverty and limited English proficiency indicators, and is considering additional indicators. Silas stated that there is a tension between adding additional indicators vs. maintaining a simple model. In upcoming meetings, the subcommittee will make recommendations on weighting for each indicator, finalize the indicators, look at county allocations in a hypothetical model, consider incorporating a funding floor and collaborate with the accountability subcommittee regarding how to incentivize funds.

Subcommittee members support including the funding formula framework in the report to Legislative Fiscal Office with the caveat that they will continue to refine the model over the coming months.

Public Health Division has developed a model to demonstrate how the model may work. The subcommittee has requested access to the interactive model for use at the next subcommittee meeting.

Teri noted that this framework looks at 34 LPHAs rather than 36 counties. If there is a funding base for each LPHA, counties may be dis-incentivized to regionalize.

Muriel stated that this model does not look a lot different from how counties are funded now and encouraged the subcommittee to look at sharing, equity and meeting the needs of all Oregonians.

Eli would like more information on the methodology and stated that the Accountability Metrics subcommittee considers County Health Rankings to be an unreliable data source. The Incentives and Funding subcommittee could consider using the base variables instead of County Health Rankings.

Tricia questioned what the expectation for the Board is around decision making for this formula. OHA will submit the framework to Legislative Fiscal Office, with a statement that this represents work to date and will continue to be refined.

Silas proposed the Board could potentially provide the Oregon Health Authority input without a full endorsement until there is more fine-tuning. After the Board takes a formal position then they can work with the Oregon Health Policy Board.

Eli asked if the funding formula will apply to all funds used to support public health modernization or cover the additional gap. Silas responded that the funding formula applies to new money made available through the state to support public health modernization.

The next Public Health Advisory Board Incentives and Subcommittee meeting is on July 12th 2016.

– Eva Rippeteau, Accountability Metrics Subcommittee chair

The Accountability Metrics subcommittee met on June 9th. The bulk of the committee's conversation was around measure selection criteria and what principles should be applied to measure selection. The group prioritized the criteria and principles and added additional principles. At the next meeting the subcommittee will look at existing measures for possible consideration.

Teri stated that the Accountability Metrics subcommittee has removed County Health Rankings as a possible data source. The data can change from year to year and some counties are not ranked.

Silas asked whether the subcommittee is thinking about measures that are most likely to be influenced by local public health activities, as there must be a link.

PHD is developing a matrix with potential health measures and selection criteria to be used at the next subcommittee meeting. Jeff stated that the PHAB subcommittees will need to coordinate data sources and measures. Katrina appreciates that both process and outcome measures are included.

Alejandro asked how the principles will be applied to the metric selection in both process and outcome measures. In particular, he is curious how one measures transformative potential in process and outcome measures and how the measures will account for local priorities.

Eli described the Metrics and Scoring committee's approach to transformative metrics. He suggests a joint meeting of the subcommittees. Alejandro recommends tying the metrics to transformation with the BERK assessment and using the foundational capabilities as a starting point.

Lillian gave an example of transformative potential in some CCO metrics, like the primary care home and team based care metrics. Those metrics allow one to know how people are moving through the system and changes the way one thinks about health care teams. Alignment across sectors is also transformative. Jeff supports the idea of thinking about evaluating transformation in the context of the assessment report and the Board's priorities moving towards implementation.

Silas commented that CCO measures are closely related to health care. Health indicators are tied to the health system and interventions versus trying to move towards population health.

Safina stated that the CCO metrics are the predominant metrics in Oregon and supports the development of another vantage point focusing on population health. For example, food insecurity may fit more appropriately in the public health realm rather than the CCO realm. It will be a benefit to the system and take some burden off of CCOs.

The next Public Health Advisory Board Accountability Metrics Subcommittee meeting with be July 28, 2016.

Public health modernization assessment report and deliverables to Legislative Fiscal Office

Vision Statement

-Holly Heiberg, Public Health Division

Holly presented the draft vision statement and gave an overview of the communications materials under development. The vision statement discusses fairness as a core value and describes how a modern public health system will equip all communities with foundational programs. This is consistent with

approaches recommended through Robert Wood Johnson Foundation, Berkeley Media Studies and from focus groups. The vision statement and communications tools can be tailored to resonate with individual audiences. The statement will include components of the triple aim and quotes from key informants. The next step is to develop case studies.

Eva recommends that the vision statement should discuss equity, not fairness. Things aren't always going to be fair but we can strive to have it equitable. Holly replied that the concept of fairness has been shown to be a plain-speak way to communicate about equity and most communities respond to fairness. Equity can be a little harder for some people to understand. Other subcommittee members also supported using equity instead of fairness.

Muriel recommends that the vision statement clearly articulate what public health is and what it does to protect Oregonians. Teri gave examples from the Early Learning Council and health system transformation of concrete concepts. Jeff summarized that the group feels the vision should explain what public health is to people who are not public health professionals. Safina would like the vision statement to describe what changes from the current system under modernization.

Holly stated that this document will be reviewed with additional stakeholders and updated in the upcoming months. The Coalition of Local Health Officials legislative committee will review this on June 17th.

Akiko stated that these four bullet points that describe core public health work are on par, but emergency preparedness could be added to the first bullet. The bullets are easy to understand, and Akiko suggests making them more prominent.

Jennifer stated that this could be framed around Oregon's investment to health through CCOs. This currently reads that the public health system is broken. Instead, frame the statement in a positive way and show that public health has more work to do and is not finished yet.

Memo to Legislative Fiscal Office

-Lillian Shirley, Public Health Division

Lillian gave an overview of the table comparing public health modernization reports. This table describes the purpose, timeline and content for four reports: public health modernization assessment report, report to Legislative Fiscal Office, report on health outcomes and cost savings, and the statewide public health modernization plan. The report to Legislative Fiscal Office, due by June 30, 2016, contains a recommendation from the Oregon Health Authority for a $30 million baseline investment for 2017-2019.

-Cara Biddlecom, Public Health Division

Cara reviewed the components of the memo for Legislative Fiscal Office and requested Board feedback on whether any key components are missing.

Eli questioned whether the report can be submitted even though the PHAB subcommittees have not completed the funding formula and accountability metrics deliverables. The draft funding formula framework and accountability metrics structure, and the recommendation for a baseline funding amount fulfill the legislative requirements. The report also provides context for the modernization assessment. Tricia requested that the funding formula framework be updated to include decisions made at the most recent subcommittee meeting, and that a caveat be added to the executive summary that this work is still in progress.

Teri asked whether implementing modernizing in waves by LPHA readiness is a requirement in HB 3100. Cara stated that HB 3100 states that Oregon Health Authority may establish different timelines for different local public health authorities for submission of a modernization plan, but there is flexibility for other implementation models.

Cara reviewed the draft public health modernization priorities for 2017-19. Priorities were identified based on findings from the public health modernization assessment.

Eli asked whether Oregon's schools of public health are connected to public health modernization and whether schools will change their curricula. Jeff stated

that the current curricula at his school doesn't teach to the modernization framework and discussions about updating the curricula are occurring. The national body that accredits schools of public health is looking at curricula; a window exists now.

Tricia asked why communicable disease and environmental health were prioritized. These areas focus on managing risk and are areas of strength. The state has underinvested in health promotion. The priorities selected address the largest systemic gaps found in the modernization assessment and in systemic gaps identified during the triennial review process. Teri stated that it may be more difficult to garner support for health promotion, and communicable disease work also contains a prevention aspect. Jennifer stated that the most pressing needs for Health Officers relate to prevention and health promotion and there is a need to align modernization work with the work of CCOs. Safina asked whether, if prevention and health promotion is not identified as a priority, the work will continue to fall to CCOs. She suggested that OHA state that this is a starting point, and selecting some areas as priorities does not mean that work will not be happening in other foundational capability and program areas.

Jeff suggested identifying only two programmatic priorities so as not to dilute the system's ability to make progress with available resources, and suggested environmental health as one priority. Akiko stated that communicable disease, across the board, is underfunded, and unfunded mandates exist. Jeff, Akiko and Silas identified the need to show measurable results in two years.

Tricia requested the word "infrastructure" be removed from this priority: "Infrastructure for emerging public health threats, tailored to local needs".

Jeff recommended that OHA use the public health modernization graphic that lists all foundational capabilities and programs but highlight those that are priorities.

Eli recommended including a table in the report for Legislative Fiscal Office with the leading causes of death in Oregon to demonstrate the impact of chronic diseases. Jeff stated that the report should focus on information from the

modernization assessment. Lillian stated that this report should be framed to support the public health system and not a specific health indicator.

The Board supports this report being submitted to Legislative Fiscal Office by June 30th, with a caveat included that OHA and PHAB will continue to develop pieces of the report over the coming months.

Review public health modernization assessment report
-Annie Saurwein and Michael Hodgins, BERK Consulting

Annie reviewed changes to the modernization assessment report. Annie focused on discussion around summary findings, policy implications, and phasing considerations. The assessment report explains the current level of implementation of each program and capability and the funding needed to reach full implementation.

Annie reviewed the three models for implementation: by LPHA, by foundational capability or program and by allowing local flexibility to address local areas of greatest need.

Subcommittee members asked questions to understand the assumptions that were made for these three models. For example, for the first model, Tricia asked what would happen if all extra small counties were funded first.

Eli asked that a key for the sizes of the local public health authorities from extra-small through extra-large be included.

Eva asked how the second model – funding for specific foundational capabilities and programs – compares with the 2017-19 priorities that have been identified. Cara stated that the priorities selected are focused on specific foundational capabilities and programs but allow some local flexibility.

Katrina stated that the third model may look most effective, but additional implementation costs for this model are not reflected on the graphic. Subcommittee members discussed other concerns for moving these models forward without adequate time to develop the models, align the models with the

funding formula and accountability metrics work, and understand potential implications. Eli proposed that all models should go forward as options. Alejandro stated that these models are "what-ifs" and are not based on concrete information from the assessment. Akiko recommended overlaying these models with the funding formula framework. Silas expressed concern that these models assume a $40M investment, but a $30M baseline is recommended in the report to Legislative Fiscal Office. Differing investments could be confusing to readers.

Tricia requested that the executive summary clearly that this work is still in progress and will continue to evolve. Tricia stated that this report should not move forward. Lillian stated that it is a required deliverable.

Subcommittee members recommended removing the phasing considerations models. The assessment report should focus on findings from the assessment. PHAB can develop phasing considerations over the coming months.

Zeke provided perspective from the Oregon Health Policy Board. The assessment report includes the "what is," and future work for PHAB will be to develop the "what do we do with it." Zeke supports removing the phasing considerations section.

The Board voted to remove the phasing considerations section and fully adopt the Public Health Modernization Assessment Report.

All in Favor.

Jeff commented that this a big step for Oregon. He thanked the Board for their hard work. He made an announcement that there will be a Legislative Briefing on the modernization of public health on July 6th 2016 at the Portland State Office Building.

Public Comment Period

No public comments were made in person or on the phone.

Closing:

Meeting adjourned.

The next Public Health Advisory Board meeting will be held on:

July 21, 2016
2:30pm – 5:30 p.m.
Portland State Office Building
800 NE Oregon St., Room 1E
Portland, OR 97232

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Angela Rowland at (971) 673-2296 Or angela.d.rowland@state.or.us. For more information and meeting recordings please visit the website: healthoregon.gov/phab

Public Health Modernization: What is the health and economic benefit for Oregon?

David Solet & Myde Boles
Program Design and Evaluation Services (PDES)
July 21, 2016

Oregon Health Authority

Today's focus

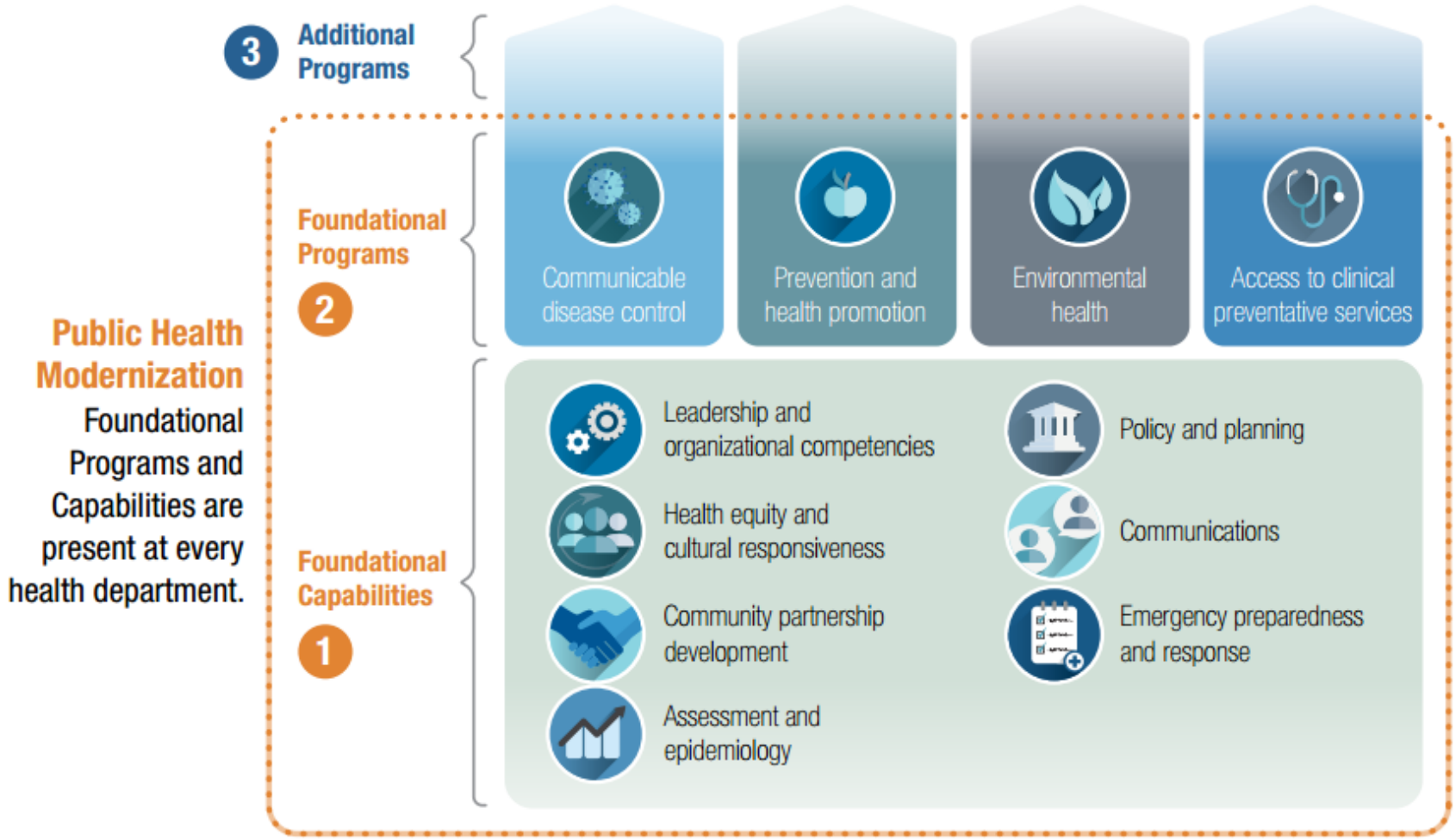
- Method
  - Context
  - Approach
  - Examples
  - Summary

- Final report in mid-September

Initial project plan

- Goal: estimate benefit of incremental implementation of Foundational Public Health Services (FPHS) in concrete terms of Oregon lives saved and costs averted
- Evidence base: studies linking FPHS spending with health and economic benefits
- Extrapolate benefits of investment in FPHS for Oregon to calculate Return on Investment (ROI)

Conceptual Framework for Governmental Public Health Services



Oregon Health Authority

Initial steps

- Research public health improvement efforts in other states
- Reach out to topic experts and leading researchers
- Conduct literature review of benefit of FPHS

Categories of research related to public health spending outcomes

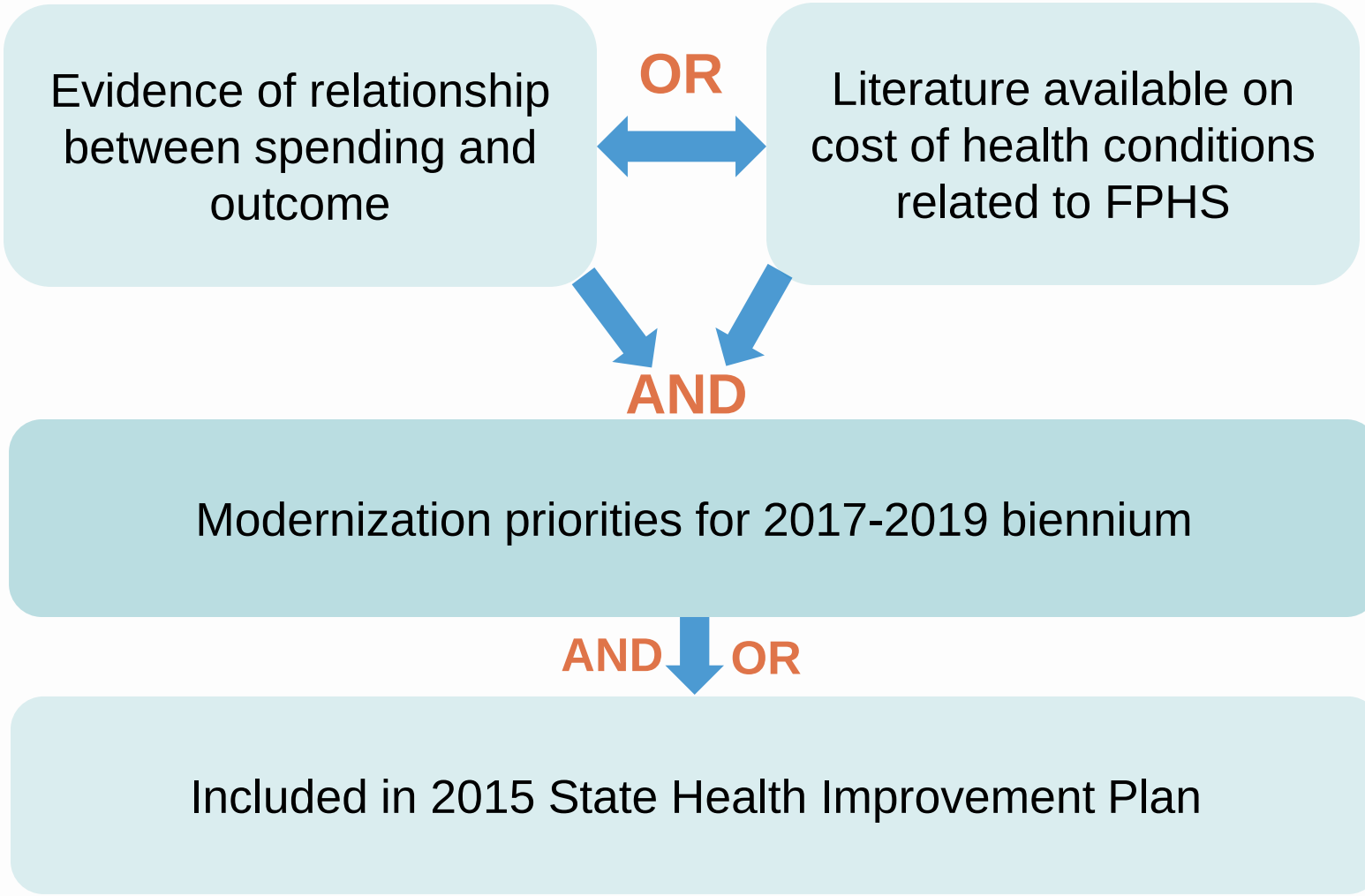
Topic	Strength of evidence	Data sources
Foundational Public Health Services	No peer-reviewed studies	N/A
Total public health spending	Causal or strongly suggestive	U.S. LHD spending and health outcomes California LHD spending and health outcomes
Public health spending in program areas related to FPHS	Mixed; few published studies	U.S. LHD spending and health outcomes
Cost of FPHS-related health conditions	Well documented	U.S. person-level health spending and health status U.S. health outcomes

Revised project plan

- Develop models for Oregon based on findings in the peer-reviewed literature and using local data to estimate economic impact

- Four areas:
  - Impact of overall public health spending
  - Impact of spending in specific program areas related to FPHS (very limited number of studies)
  - Costs of population health conditions related to FPHS Functional Areas
    - Minimum investment needed for positive ROI
    - Cost savings if 10% of conditions was averted
    - Costs and cost savings to Medicaid (if possible)
  - Costs of health inequality

Focus


Evidence of relationship between spending and outcome
OR
Literature available on cost of health conditions related to FPHS
AND
Modernization priorities for 2017-2019 biennium
AND
OR
Included in 2015 State Health Improvement Plan

Topics covered in report

Topic	Type of impact estimate
Overall public health spending and mortality	Public health spending and outcomes
Maternal and child health spending and low birthweight	Public health spending and outcomes
Foodborne illness **S** **F**	Cost of condition Potential ROI of additional increment
Health equity **F**	Cost of condition Potential ROI of additional increment
Obesity and physical inactivity **S**	Cost of condition Potential ROI of additional increment
Tobacco prevention **S**	Cost of condition Potential ROI of additional increment
Diseases of environmental pollution **F**	Oregon cost Costs averted if 10% improvement
Suicide prevention **S**	Cost of condition Costs averted if 10% improvement
Emergency preparedness **F**	TBD

F = FPHS biennial priority

S = State Health Improvement Plan priority

Examples:

- Overall public health spending
- Physical inactivity
- Health inequality

Overall public health spending

Spending on public health is a good investment

- Recent studies
  - Return on investment for public health spending in California county health departments: $67 to $88 for every $1 spent
  - Increase of $10 per capita in public health spending reduced all cause mortality by 9.1/100,000 in California
- Mays (2011):
  - Percent reductions in rates of infant mortality, and deaths from heart disease, diabetes and cancer associated with 10% increase in county public health spending
- Limitations:
  - Studies suggest the benefit of **total** public health spending, but these studies do not concern the benefit of **FPHS** spending specifically
  - Mechanism theorized but not yet shown

Impact of 10% increase in total spending:

Model results for Oregon

- Results of applying Mays model to Oregon:
  - 15 fewer infant deaths
  - 202 fewer heart disease deaths
  - 16 fewer diabetes deaths
  - 88 fewer cancer deaths

Impact of 10% increase in total spending:

Method and model assumptions

Method

- Obtain Oregon number of deaths
  - infant mortality, heart disease, diabetes and cancer
  - 3-year average to increase stability
- Reduced deaths=percent decrease X number of deaths

Assumptions

- Impact in study the same in Oregon

Reference
Mays P and Smith S: "Evidence links increases in public health spending to declines in preventable deaths." Health Aff (Millwood). 2011 August ; 30(8): 1585–1593. doi:10.1377/hlthaff.2011.0196.

Impact of 10% increase in total spending:

Modeled Oregon estimate

Cause of death	Reduction with 10% increase in spending	Number of deaths (2011-2013 average)	Estimated annual reduction in number of deaths*
Infant death	6.85%	225	15
Heart disease	3.22%	6,274	202
Diabetes	1.44%	1,116	16
Cancer	1.13%	7,776	88

*for heart disease, diabetes and cancer, assumes equivalent decrease in deaths in each of 11 age groups used for age-adjustment

Physical inactivity

Annual health care cost of physical inactivity in Oregon:

Model results for Oregon

- Estimated Oregon annual cost: $1.3 billion
- Estimated Oregon annual Medicaid cost: $360 million
- Potential for ROI for additional increment funding
  - Minimum improvement needed for positive ROI:
    - 0.12% of health care cost of physical inactivity saved
    - 0.10% of health care cost of physical inactivity in Medicaid saved
  - ROI if costs are reduced by 1%
    - Overall: $8 for every $1 spent
    - Medicaid: $10 for every $1 spent

Annual health care cost of physical inactivity in Oregon:

Sources

- 3 levels
  - Complete physical inactivity (sedentary) (**SED**)
  - Inadequate physical activity (**IPA**)
  - Physically active (meets CDC guidelines) (**PA**)
- Per capita direct health care spending difference for SED and IPA compared to PA
- Data for national estimate
  - Medical Expenditure Panel Survey (MEPS): National random survey of individual's medical expenditures and health status
- Data for local model
  - Oregon BRFSS
  - Oregon Medicaid BRFSS
  - BERK assessment

Reference
Carson SA et al: "Inadequate physical activity and health care expenditures in the United States." Progress in Cardiovascular Diseases 57 (2015) 315–323.

Annual health care cost of physical inactivity in Oregon:

Model Assumptions

- Per capita costs of physical inactivity in Oregon the same as U.S.
- Per capita costs of physical inactivity in Medicaid population are the same as overall per capita costs
- 90% of health care costs in Medicaid population are paid by Medicaid, with 10% out-of-pocket

Annual health care cost of physical inactivity in Oregon:

Modeled Oregon estimate

PA status	Per capita cost (2012$)	Per capita cost (2015$)	Oregon prevalence (adult %)	Number of adults	Population medical costs
SED	$1437	$1499	19%	566,000	$850 M
IPA	$713	$744	20%	611,000	$450 M
Total Oregon costs of physical inactivity……..					$1.3 B
Medicaid costs of physical inactivity……..					$360 M

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Annual health care cost of physical inactivity in Oregon:

Potential for ROI

PA status	Additional increment	Additional increment % of costs	Costs averted if 1% increase in PA	Increment ROI if 1% increase in PA
SED	$800,000			
IPA	$800,000			
All inactive	$1,600,000	0.12%	$13.0 M	8 to 1
Medicaid	$351,500*	0.10%	$3.6 M	10 to 1

*Assuming proportional additional increment to Medicaid-covered. 22% of the adult population is on Medicaid.

Health inequality

Annual cost of health inequality in Oregon:

Results

- The estimated direct and indirect cost of health inequality in Oregon is $1.3 billion
- Potential for ROI for additional increment funding:
  - Minimum improvement needed for positive ROI: 0.4%
  - If costs are reduced by 1%: $3 for every $1 spent

Annual cost of health inequality in Oregon:

Sources

- National cost savings if every racial/ethnic group had health outcomes equal to the racial/ethnic group with the best health outcomes
  - Direct medical costs
  - Indirect medical costs (lost workdays)
  - Premature death (economic value of statistical life)
- Data: MEPS, National Vital Statistics Reports, U.S. Census

Reference
LaVeist TA, Gaskin D and Richard P: "Estimating the economic burden of racial health inequalities in the United States." International Journal of Health Services (2011) 41(2) pp. 231–238.

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Annual cost of health inequality in Oregon:

Assumptions and limitation

Assumptions: Oregon and the U.S. are the same for:

- Per capita direct and indirect costs for each race/ethnicity group
- Demographics (age, gender, education, health status, income, etc.) within each race/ethnicity group
- Inequalities by race for health status, morbidity and mortality

Limitation: National inequality costs for Native Hawaiians and Pacific Islanders, American Indian/Alaska Natives and people of more than one race were not calculated in the LaVeist paper so Oregon costs can't be estimated. Inequalities in these groups are often large and would likely add to the Oregon result.

Annual cost of health inequality in Oregon:

US, 2008$, 2003 to 2006 total, in billions

Type of cost	Race/ethnicity: African American	Asian	Hispanic	Total
Direct	$135.9	$11.4	$82.0	$229.4
Indirect: Illness	$36.6	$0.1	$13.7	$50.3
Indirect: Death	$746.2	<$0.1	$211.3	$957.5
Indirect (illness + death)	$782.8	$0.1	$225.0	$1,007.9
Total, direct + indirect	$918.7	$11.5	$307.0	$1,237.3

Annual cost of health inequality in Oregon:

Ratio of OR/US population by race

Race/ethnicity	Oregon population	U.S. population	Ratio (%)
Black/African American	73,459	39,925,949	0.18%
Asian	172,298	17,416,714	0.99%
Hispanic/Latino	511,901	56,592,793	0.90%

Next steps:

- Multiply race-specific costs by ratio of OR/US population to get Oregon costs
- Inflate Oregon costs to 2015$
- Divide costs by 4 to obtain annual average costs
- Multiply by 1,000 to report costs in millions

Annual cost of health inequality in Oregon:

Oregon, 2015$, annual average

Type of cost	Race/ethnicity: African American, Asian and Hispanic/Latino combined Total (in millions)
Direct	$316
Indirect: Illness	$53
Indirect: Death	$904
Indirect (illness + death)	$957
Total, direct + indirect	$1,273

National inequality costs for Native Hawaiians and Pacific Islanders, American Indian/Alaska Natives and people of more than one race were not calculated in the LaVeist paper so Oregon costs can't be estimated. Inequalities in these groups are often large and would likely add to the total.

Annual cost of health inequality in Oregon:

Potential for ROI

Additional increment	Additional increment % of costs	Costs averted if 1% decrease in health inequality costs	Increment ROI if 1% decrease in health inequality costs
$5 M	0.4%	$13 M	3 to 1

*

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Limitations of modeling

- Assumptions need to be transparent
- Assumptions may not be met
- Variability in results not calculated
- Our best estimate based on national studies and available data

Summary

- Direct evidence of FPHS benefit does not yet exist
- Indirect supporting evidence of FPHS in:
  - Total public health spending
  - Public health spending in program areas
  - Cost of health conditions and opportunity for cost savings
- Focus on biennial FPHS priorities and SHIP priorities
- Measures:
- Method examples:
  - Total public health spending and mortality reductions
  - Cost of physical inactivity overall and to Medicaid/ROI potential
  - Cost of health inequality/ROI potential
- Estimated Oregon costs of physical inactivity and health inequality are large
- Minimum improvement needed for positive ROI is small

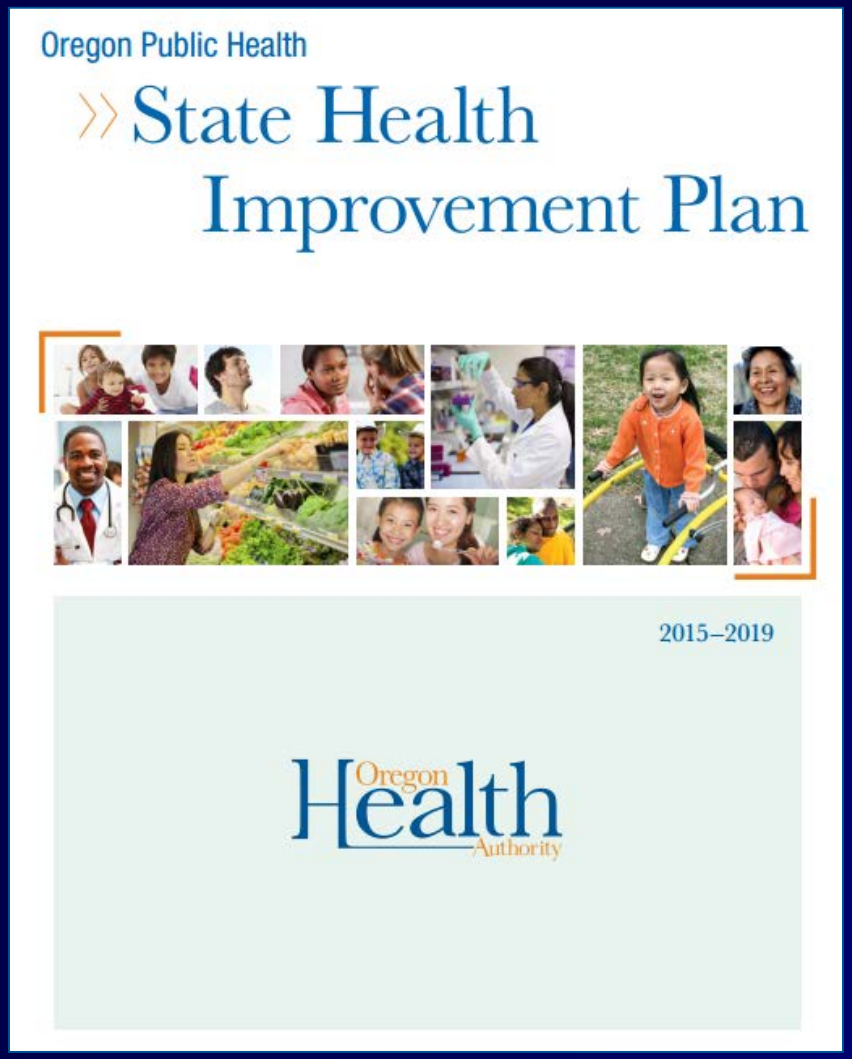
Questions?

Improving the Health of Oregonians: Directing the SHIP

Katrina Hedberg, MD, MPH
Health Officer & State Epidemiologist

Oregon Health Authority

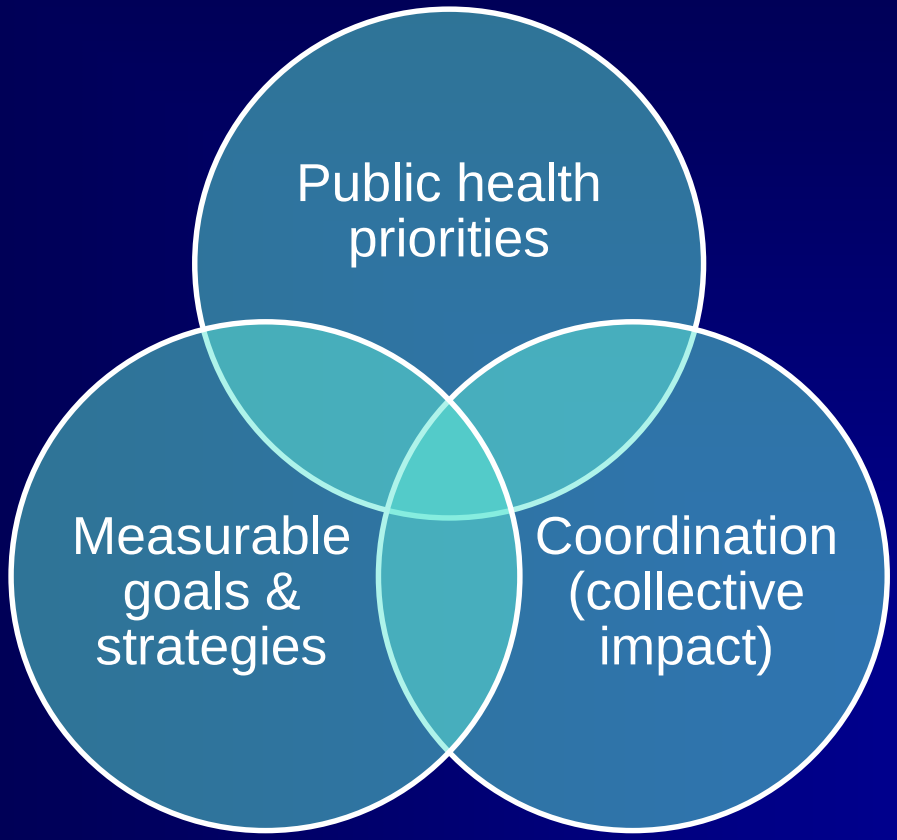
July 21, 2016



- The Public Health Division has oversight of the SHIP and is accountable to the Public Health Advisory Board
- The SHIP meets requirements for accreditation

Oregon's State Health Improvement Plan (SHIP)

Goal: Improve the health of all people in Oregon by 2020



SHIP priorities

- Prevent and reduce tobacco use
- Slow the increase of obesity
- Improve oral health
- Reduce harms associated with substance use
- Prevent deaths from suicide
- Improve immunization rates
- Protect the population from communicable disease

SHIP priorities

- Informed by data and stakeholder input
- Met at least one of the following criteria

A leading cause of death	Not improving over time
Poor national ranking	Winnable battle

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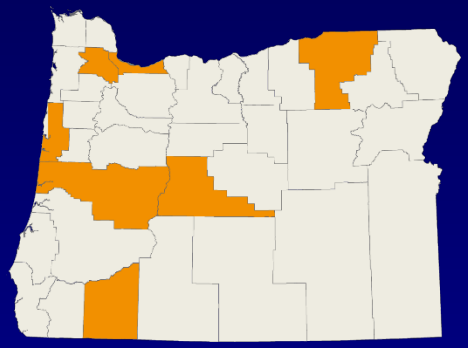
Building the SHIP

- 2013: Oregon's first SHIP released
- 2014: Additional input obtained through community engagement sessions in seven counties



- 2015: Updated SHIP released
  - Incorporates stakeholder input
  - Addresses health system transformation

Sailing the SHIP

- Implement SHIP interventions addressing:
  - Population health
  - Health systems
  - Health equity
- Track progress toward 2020 targets

Sailing the SHIP

- Engage stakeholders to further progress
  - Public Health Advisory Board
  - Public Health Division staff
  - Local health departments
  - News media
  - State agencies
  - State legislators
  - Health systems
  - Public health advocates and practitioners
  - The public and other external partners

For more information

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Prevent and Reduce Tobacco Use

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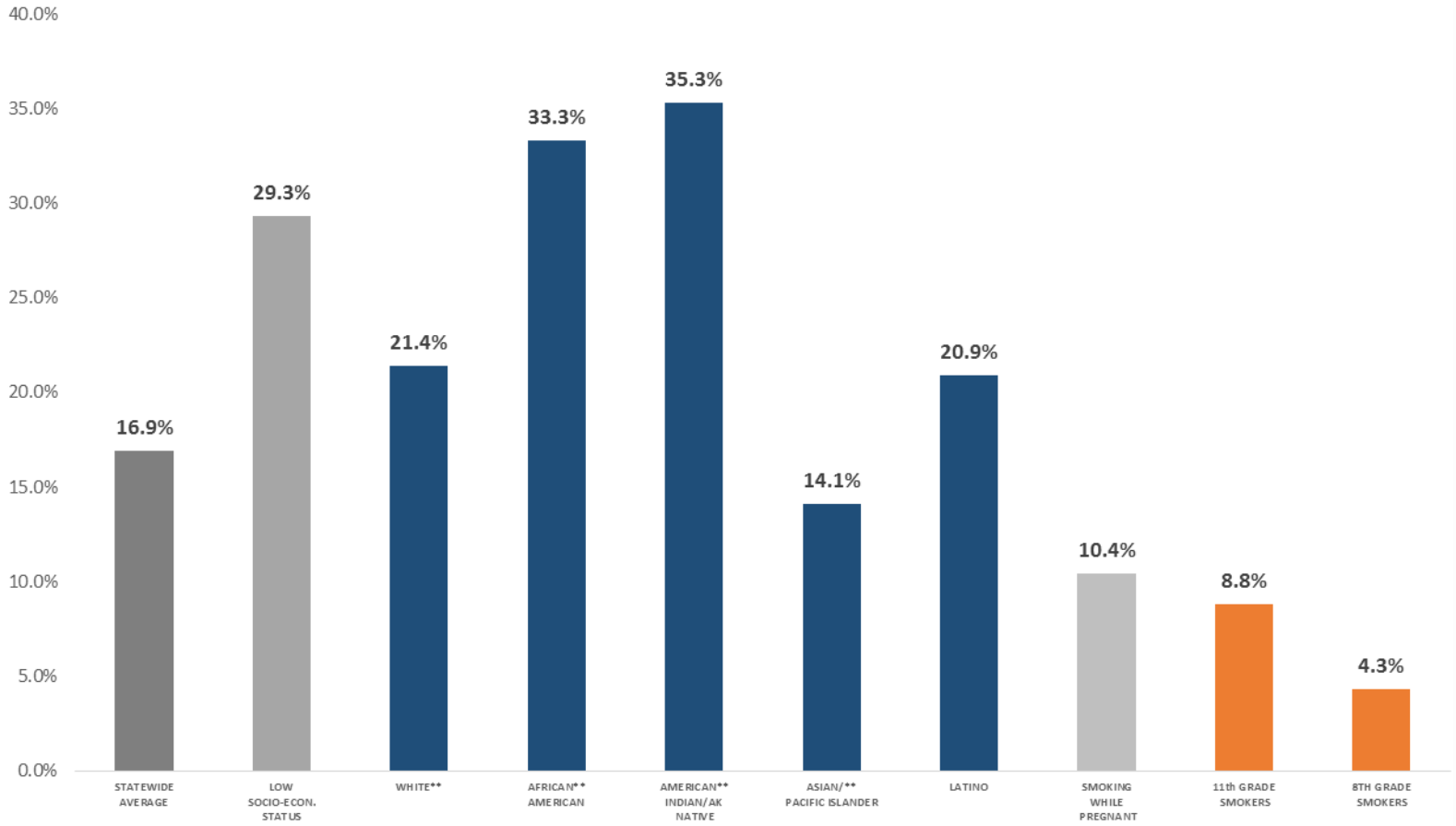
Oregon Health Authority

HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION
Public Health Division

Percentage of adult Oregonians who smoke among selected groups



*Household income less than $15,000/year. **Non-Latino

Oregon Behavioral Risk Factor Surveillance System (2014 & Race Oversample 2010-2011); Oregon Healthy Teens Survey (2015)

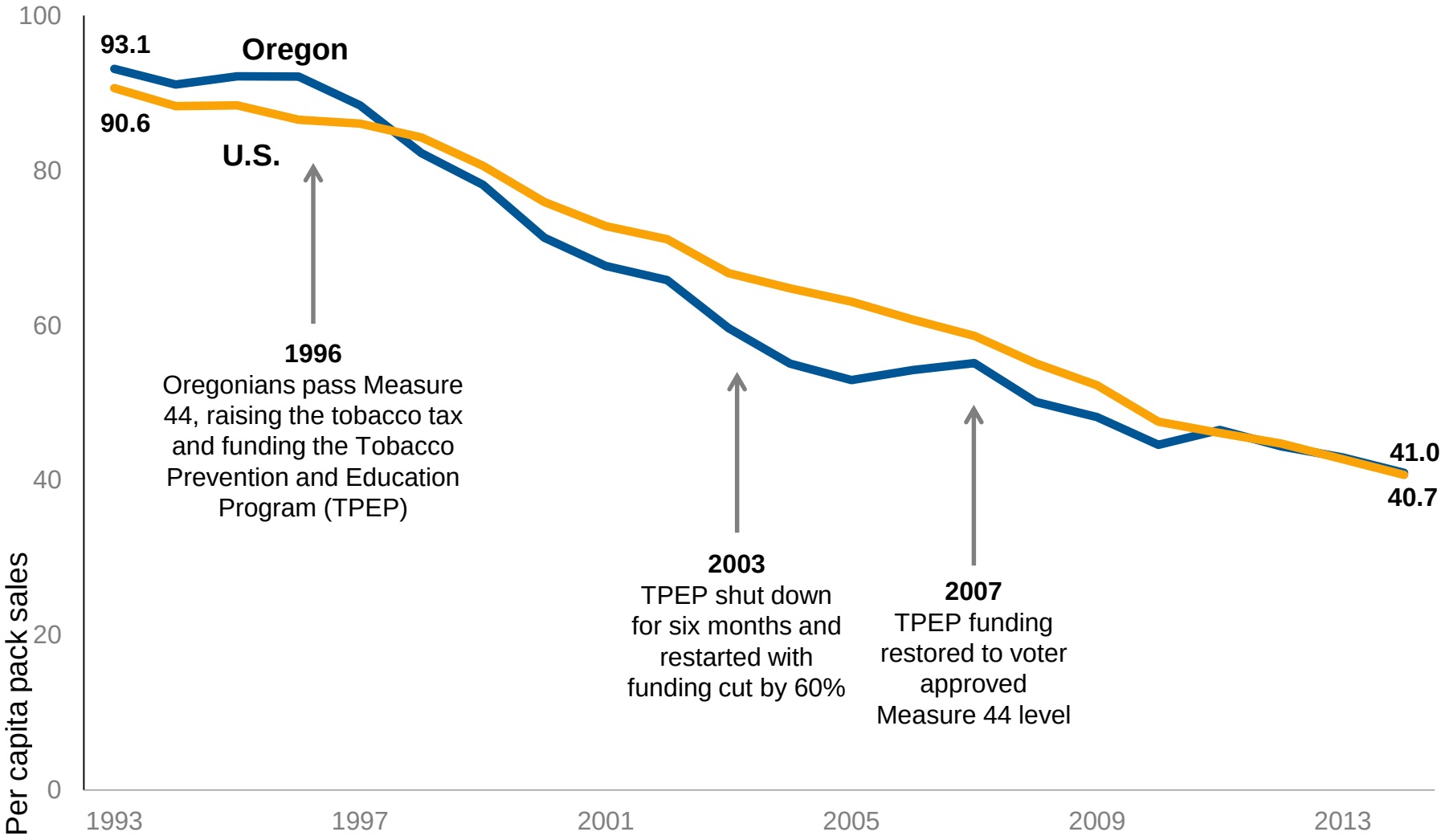
Tobacco targets

By June 2019:

1. Adult smoking prevalence will be reduced to **15 percent**. 16.1% in 2014
2. Smoking prevalence among 11th graders will be **7.5 percent**. 8.8% in 2015
3. Smoking prevalence among 8th graders will be **2 percent**. 4.3% in 2015
4. **Fewer than 38 packs** of cigarettes per capita will be sold in Oregon each year. 40.7 packs in 2014

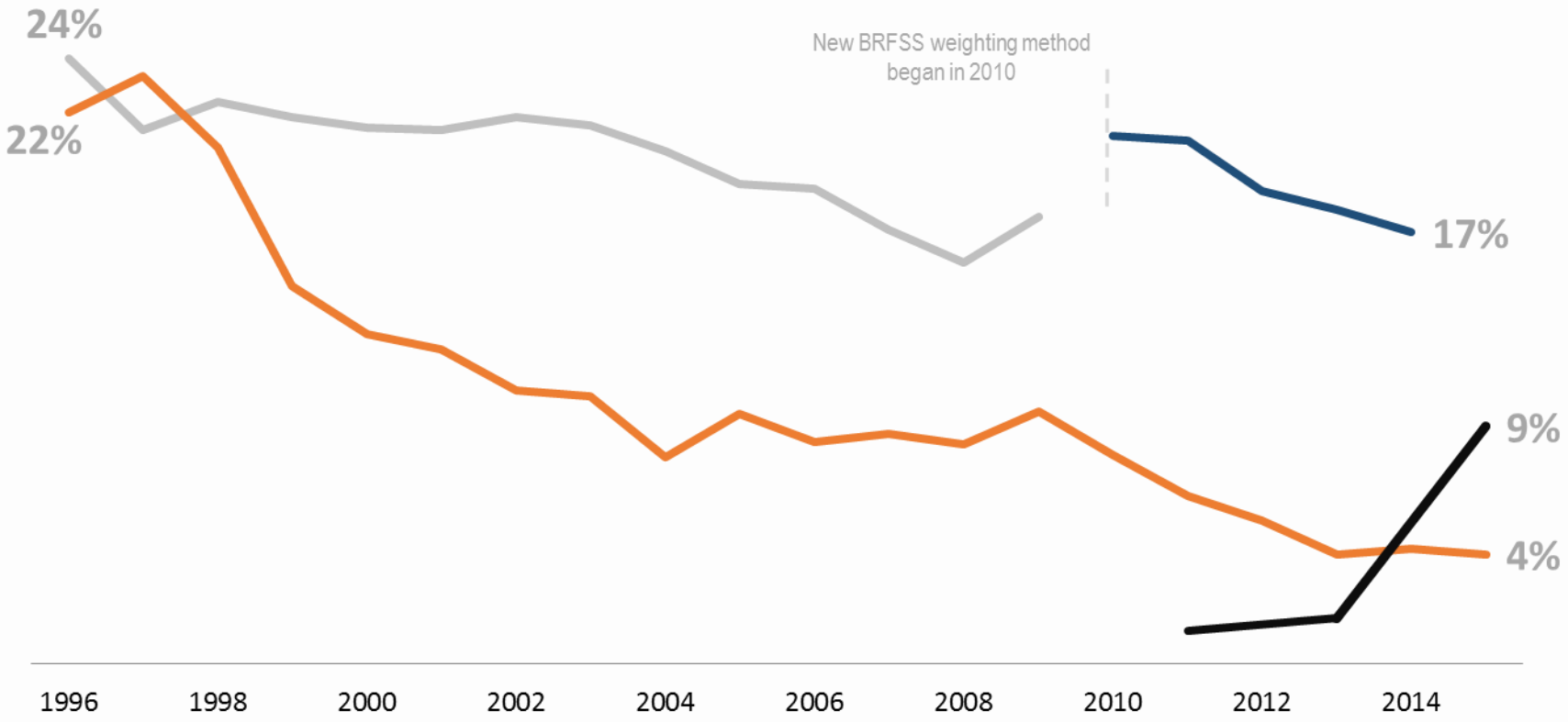
Oregon Health Authority

Per capita cigarette pack sales in Oregon and the United States, Fiscal Year 1993−2014



Source: Orzechowski and Walker (2014). The Tax Burden on Tobacco.

Cigarette Smoking Prevalence, Oregon, 1996 - 2015



Sources: Behavioral Risk Factor Surveillance System
Oregon Healthy Teens

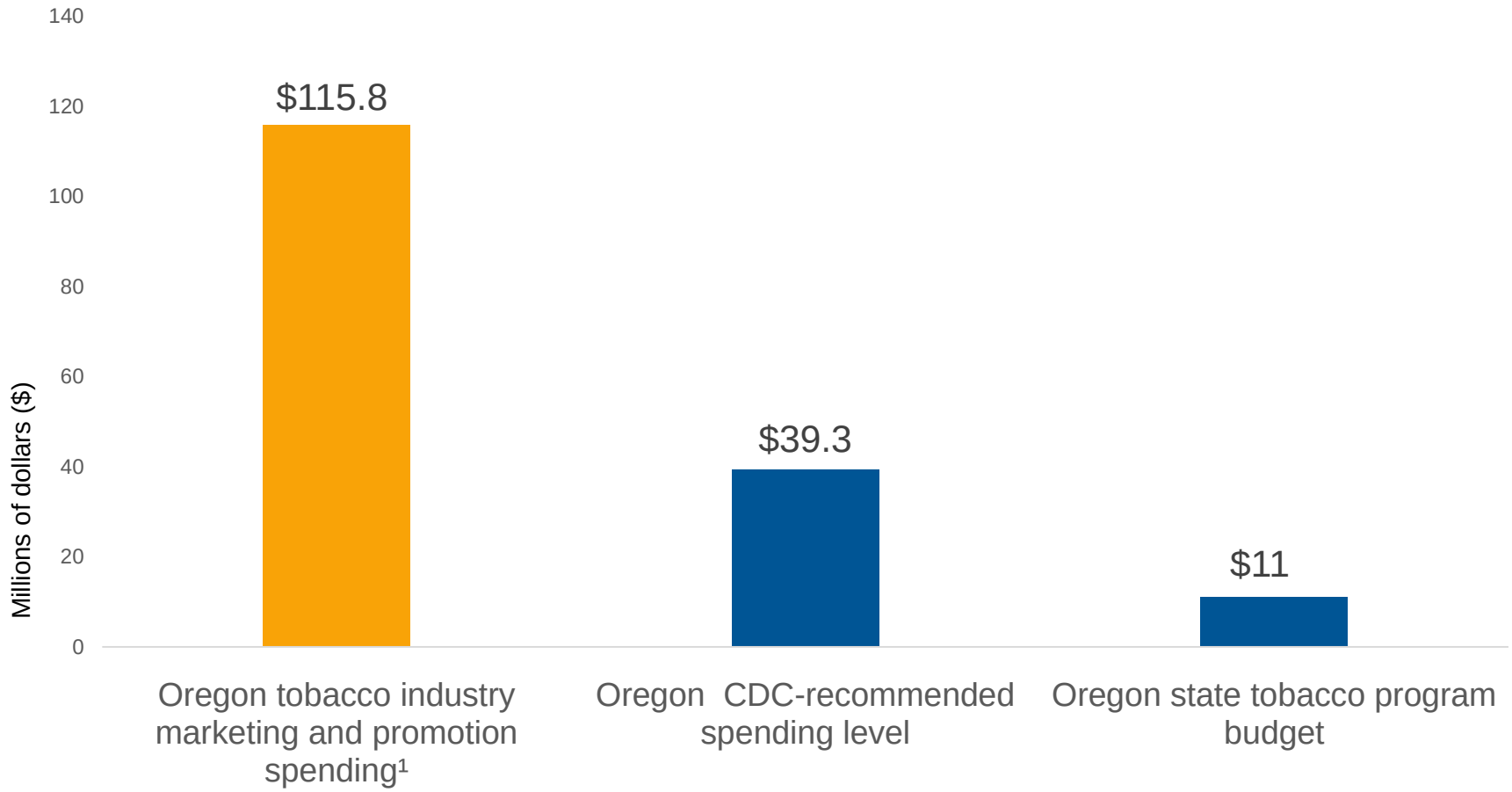
Oregon Health Authority

Addiction

- Addiction to tobacco starts during childhood
  - Half of current and former adult smokers surveyed in Oregon responded that they started smoking before they turned 18.[1]
  - 90% of adult smokers began while in their teens; and two-thirds become regular, daily smokers before they reach the age of 19.[2]
- Most people want to quit
  - 3 out of 4 smokers surveyed in Oregon report they want to quit, and more than half report attempting to quit during the past year.

1. Behavioral Risk Factor Surveillance System (2014).
2. SAMHSA, Calculated based on data in 2013 *National Survey on Drug Use and Health*.; See also, HHS, *Preventing Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General*, 2012. HHS, *Youth and Tobacco: Preventing Tobacco Use among Young People: A Report of the Surgeon General*, 1994, http://profiles.nlm.nih.gov/NN/B/C/F/T/_/nnbcft.pdf (pg 49).

Tobacco industry is outspending prevention efforts in Oregon

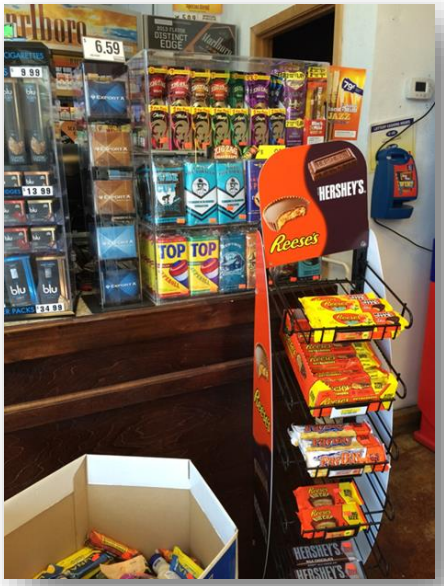


Sources: [1]Calculation based on CTFK state specific figures (2012), Federal Trade Commission Report (2013), and Best Practices for Comprehensive Tobacco Control Programs (2014).

SWEET

CHEAP

EASY TO GET



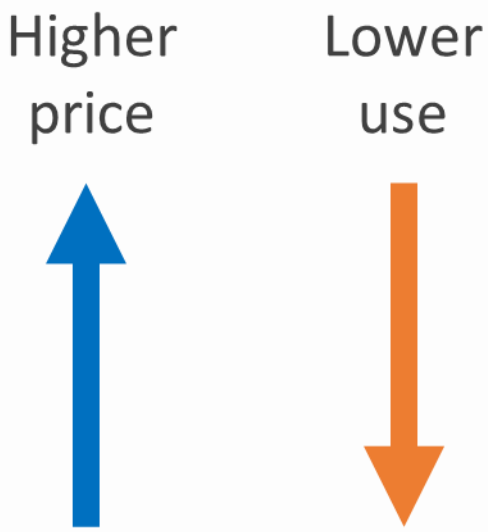
The Surgeon General's Report on *Preventing Tobacco Use Among Youth and Young Adults* concluded that, "Advertising and promotional activities by tobacco companies have been shown to cause the onset and continuation of smoking among adolescents and young adults."

SHIP Tobacco Priority Areas

- Raise the price of tobacco
- Transform the retail environment
  - Increase the age to purchase tobacco products to 21
  - Establish Tobacco Retail Licensure Systems
- Expand Tobacco Free Environments
  - Cross Agency Health Improvement Project (CAHIP)
  - Indoor Clean Air Act Expansion
- Support Health System Transformation

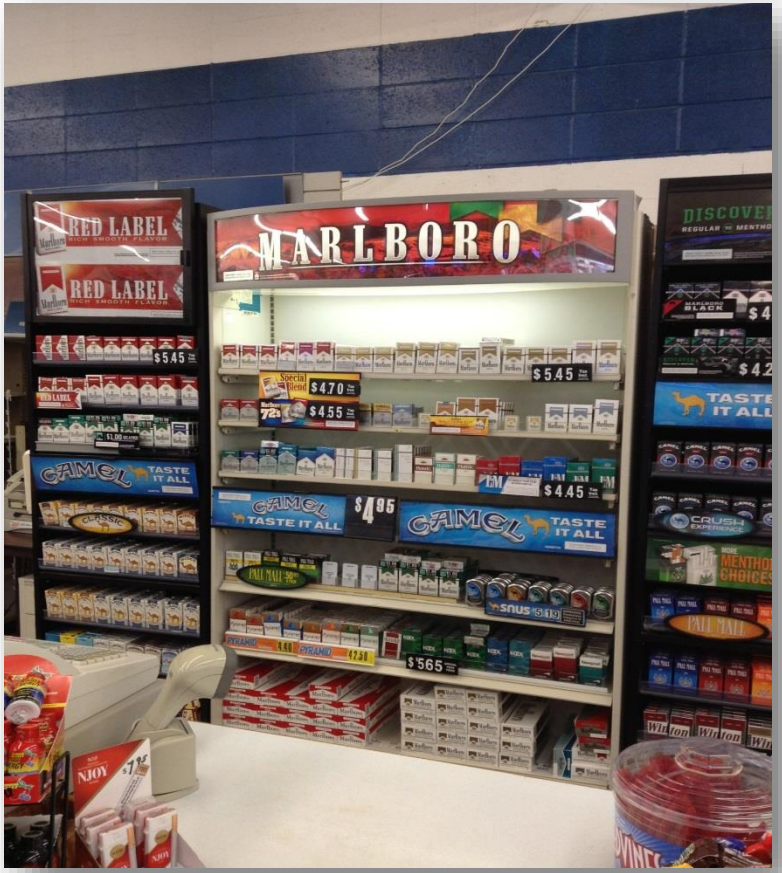
Increase the Price of Tobacco

Increased prices of tobacco and nicotine products result in **decreased use**



Transform the Retail Environment

- Increase the age to purchase tobacco products to 21
- Establish tobacco retail licensure systems
- Implement other retail prevention policies such as prohibiting or restricting:
  - flavored products
  - free sampling
  - tobacco coupon redemption
  - proximity to schools
  - tobacco sales at pharmacies



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Expand Tobacco-Free Environments

- Expand Indoor Clean Air Act (ICAA) to increase protections for secondhand smoke among low-income and service industry employees.
- Advance policies that establish tobacco-free city agencies or other regional governments.
- Advance policies that establish tobacco-free outdoor venues such as parks and fairgrounds.
- Include prohibition of inhalant delivery systems in the policies.

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Expand Tobacco-Free Environments

Tobacco-Free Executive Order

- Increase the number of DHS and OHA mental and behavioral health service providers that adopt tobacco-free campus policies, adopt tobacco-free contracting rules and refer clients and employees who smoke to evidence-based cessation services.

Next Steps

- Giving facilities consistent messages about the policy.
- Exploring options for providing on-site NRT.
- Convening additional tobacco-free policy implementation trainings for providers, staff and administrators.

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Support Health System Transformation

Create incentives for private and public health plans and health care providers to prevent and reduce tobacco use.

Cigarette Smoking Prevalence Measure

Measure Components

1. Meet minimum benefit requirements (cessation benefit floor);

2. Submit EHR-based cigarette smoking and tobacco prevalence data according to data submission requirements;

3. Meet benchmark or improvement target established by the OHA Metrics & Scoring Committee

HERC Updated Guidance – Cessation Benefits

Prioritized List of Health Services
As Implemented January 1, 2016

GUIDELINE NOTE 4, TOBACCO DEPENDENCE

Line 5

Pharmacotherapy and behavioral counseling are included on this line, alone or in combination, for at least 2 quit attempts per year. A minimum of four counseling sessions of at least 10 minutes each (group or individual, telephonic or in person) are included for each quit attempt. More intensive interventions and group therapy are likely to be the most effective behavioral interventions. **Inclusion on this line follows the minimum standard criteria as defined in the Oregon Public Health Division "Standard Tobacco Cessation Coverage "(based on the Patient Protection and Affordable Care Act)**, available here: https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/pubs.aspx

New Section!
Multi-Sector Interventions

Prioritized List Coverage Limitations

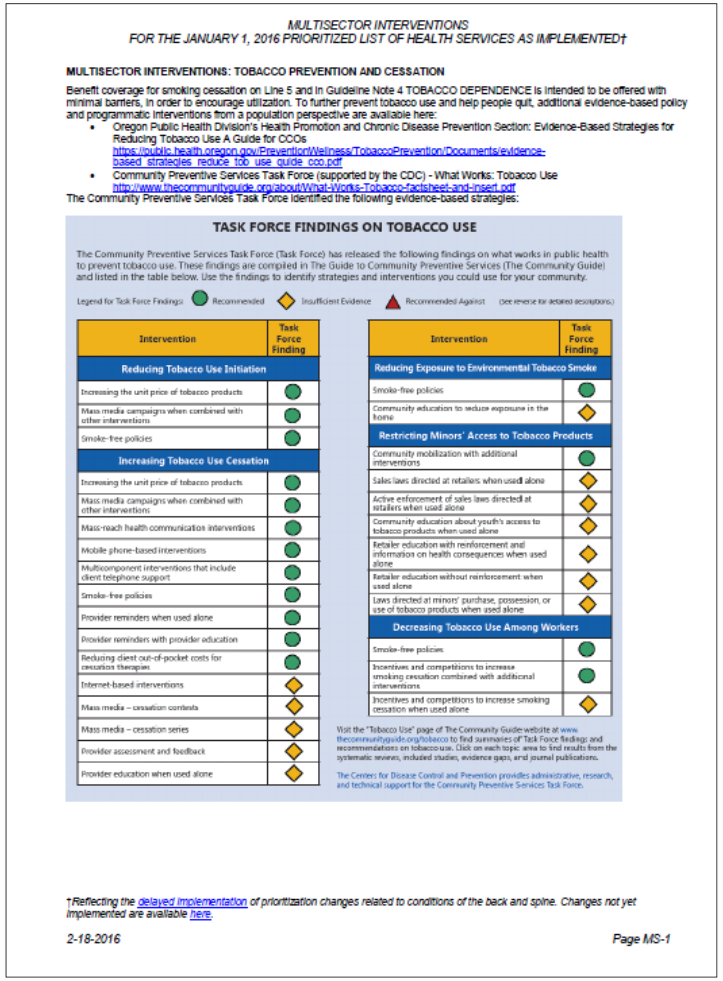
- Many effective services do fit within the current constructs (condition-treatment)

- No place on the Prioritized List to address interventions that fall outside of clinical-coding-based encounters.

New Multi-Sector Interventions Section

- HPCDP: Evidence-Based Strategies for Reducing Tobacco Use A Guide for CCOs

- Community Preventive Services Task Force (supported by the CDC)



MULTISECTOR INTERVENTIONS
FOR THE JANUARY 1, 2016 PRIORITIZED LIST OF HEALTH SERVICES AS IMPLEMENTED†

MULTISECTOR INTERVENTIONS: TOBACCO PREVENTION AND CESSATION

Benefit coverage for smoking cessation on Line 5 and in Guideline Note 4 TOBACCO DEPENDENCE is intended to be offered with minimal barriers, in order to encourage utilization. To further prevent tobacco use and help people quit, additional evidence-based policy and programmatic interventions from a population perspective are available here:

- Oregon Public Health Division's Health Promotion and Chronic Disease Prevention Section: Evidence-Based Strategies for Reducing Tobacco Use A Guide for CCOs https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/evidence-based_strategies_reduce_tob_use_guide_cco.pdf
- Community Preventive Services Task Force (supported by the CDC) - What Works: Tobacco Use http://www.thecommunityguide.org/about/What-Works-Tobacco-factsheet-and-insert.pdf

The Community Preventive Services Task Force identified the following evidence-based strategies:

TASK FORCE FINDINGS ON TOBACCO USE

The Community Preventive Services Task Force (Task Force) has released the following findings on what works in public health to prevent tobacco use. These findings are compiled in The Guide to Community Preventive Services (The Community Guide) and listed in the table below. Use the findings to identify strategies and interventions you could use for your community.

Legend for Task Force Findings: Recommended; Insufficient Evidence; Recommended Against (see reverse for detailed descriptions)

Intervention	Task Force Finding
Reducing Tobacco Use Initiation	
Increasing the unit price of tobacco products	Recommended
Mass media campaigns when combined with other interventions	Recommended
Smoke-free policies	Recommended
Increasing Tobacco Use Cessation	
Increasing the unit price of tobacco products	Recommended
Mass media campaigns when combined with other interventions	Recommended
Mass-reach health communication interventions	Recommended
Mobile phone-based interventions	Recommended
Multicomponent interventions that include client telephone support	Recommended
Smoke-free policies	Recommended
Provider reminders when used alone	Recommended
Provider reminders with provider education	Recommended
Reducing client out-of-pocket costs for cessation therapies	Recommended
Internet-based interventions	Insufficient Evidence
Mass media – cessation contests	Insufficient Evidence
Mass media – cessation series	Insufficient Evidence
Provider assessment and feedback	Insufficient Evidence
Provider education when used alone	Insufficient Evidence

Intervention	Task Force Finding
Reducing Exposure to Environmental Tobacco Smoke	
Smoke-free policies	Recommended
Community education to reduce exposure in the home	Insufficient Evidence
Restricting Minors' Access to Tobacco Products	
Community mobilization with additional interventions	Recommended
Sales laws directed at retailers when used alone	Insufficient Evidence
Active enforcement of sales laws directed at retailers when used alone	Insufficient Evidence
Community education about youth's access to tobacco products when used alone	Insufficient Evidence
Retailer education with reinforcement and information on health consequences when used alone	Insufficient Evidence
Retailer education without reinforcement when used alone	Insufficient Evidence
Laws directed at minors' purchase, possession, or use of tobacco products when used alone	Insufficient Evidence
Decreasing Tobacco Use Among Workers	
Smoke-free policies	Recommended
Incentives and competitions to increase smoking cessation combined with additional interventions	Recommended
Incentives and competitions to increase smoking cessation when used alone	Insufficient Evidence

Visit the "Tobacco Use" page of The Community Guide website at www.thecommunityguide.org/tobacco to find summaries of Task Force findings and recommendations on tobacco use. Click on each topic area to find results from the systematic reviews, included studies, evidence gaps, and journal publications.

The Centers for Disease Control and Prevention provides administrative, research, and technical support for the Community Preventive Services Task Force.

†Reflecting the delayed implementation of prioritization changes related to conditions of the back and spine. Changes not yet implemented are available here.

2-18-2016 *Page MS-1*

Sustainable Relationship for Community Health (SRCH)

Reduce Tobacco Prevalence

Convenes CCOs, local public health, clinics, program delivery organizations to…

- Engage leaders and decision makers
- Plan systems-based approaches across organizational boundaries
- Pilot new systems
- Track progress and make improvements

SRCH Process and Outcomes

SRCH participants will:

- **Identify** people in need of cessation services

  Refer people to services

  Feed back status information (closed loop referral)

  Use **data** to:

  - Track progress
  - Track patient outcomes
  - Continue to improve systems

- Develop and implement formal commitments (MOUs, data sharing agreements) to reinforce collaboration and a long-term commitment to improving community health.

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