

AGENDA

PUBLIC HEALTH ADVISORY BOARD

August 15, 2019 2:00-5:00 pm

Portland State Office Building

800 NE Oregon St.

Conference Room 177

Portland, OR 97232

Join by conference line: 1-877-873-8017

Access code: 767068#

Meeting objectives:

- Learn about 2019-21 legislative investment in public health modernization.
- Discuss CCO 2.0 contract provisions that further advance social determinants of health, health equity and population health.
- Discuss Public Health Division Health Equity Work Group accomplishments and plans.
- Learn about progress within the State Health Improvement Plan suicide prevention priority.
- Adopt public health accountability metric related to opioids for 2019-21.

2:00-2:15 pm

Welcome and agenda review

- ACTION: Approve May meeting minutes
- Debrief June meeting with Oregon Transportation Commission and Charles Brown
- Discuss September meeting plans
- Discuss concept for PHAB mini-retreat at November meeting

Rebecca Tiel,
PHAB Chair

2:15-2:30 pm

2019-21 public health modernization investment

- Discuss investments and process for allocating the \$15 million 2019-21 budget for public health modernization

Cara Biddlecom, OHA staff

2:30-2:40 pm

CCO 2.0 discussion

- Review contractual responsibilities that relate to public health

Cara Biddlecom, OHA staff

2:40-3:10 pm

Public Health Division Health Equity Workgroup

- Discuss Public Health Division Health Equity Workgroup milestones

Victoria Demchak and Tim
Noe, OHA Staff

3:10-3:30 pm

Break

3:30-4:00 pm	State Health Improvement Plan: Suicide Prevention priority	Laura Chisholm, OHA staff
	<ul style="list-style-type: none"> • Discuss progress in implementation of suicide prevention interventions in the State Health Improvement Plan 	
4:00-4:40 pm	Public health accountability metrics for 2019-21	Josh Van OtterLoo and Laura Chisholm, OHA staff
	<ul style="list-style-type: none"> • Discuss proposed changes to the prescription opioid mortality accountability metric • Vote to adopt metric 	
	ACTION: Vote to adopt opioid accountability metric and oral health developmental metric	
4:40-4:55 pm	Public comment	Rebecca Tiel, PHAB Chair
4:55 pm	Adjourn	Rebecca Tiel, PHAB Chair

Public Health Advisory Board (PHAB)

DRAFT May 16, 2019

Meeting Minutes

Please note: The Public Health Advisory Board will not meet to approve the 5/16/2019 minutes until August 2019. Final minutes will be uploaded to PHHS BG MIS once final copy is available.

Attendance:

Board members present: Dr. David Bangsberg, Dr. Jeff Luck, Akiko Saito, Dr. Eli Schwarz, Alejandro Queral, Dr. Jeanne Savage, Rebecca Tiel, Teri Thalhofer, Tricia Mortell

Board members absent: Carrie Brogoitti, Dr. Bob Dannenhoffer, Dr. Katrina Hedberg, Kelle Adamek-Little, Muriel DeLaVergne-Brown, Eva Rippeteau

Oregon Health Authority (OHA) staff: Danna Drum, Sara Beaudrault, Katarina Moseley, Krasimir Karamfilov, Dr. Thomas Jeanne, Monty Schindler

Members of the public: Jocelyn Warren (Lane County), Heather Amrhein (Lane County, by phone)

Welcome and Agenda Review

Rebecca Tiel, PHAB Chair

Ms. Tiel welcomed the PHAB to the meeting. She informed the committee members that Dr. Paul Lewis had been appointed to the PHAB to fill in the health officer seat. He will join the PHAB at the next month's meeting and introduce himself to the PHAB.

Ms. Tiel added that the meeting would begin with an update of the work of the Health Equity Committee (HEC), presented by Ms. Johnson, who is the director of the Office of Equity and Inclusion at OHA.

Ms. Tiel encouraged the board members to think about how the PHAB could learn from the HEC and incorporate insights from the HEC into the PHAB's work, especially aligning the PHAB's health equity policy that the board developed around the work of the committee.

Ms. Tiel introduced herself. The PHAB members introduced themselves.

Health Equity Committee

Leanne Johnson (OHA Staff)



Public Health Advisory Board
Meeting Minutes – May 16, 2019

Ms. Johnson introduced herself to the PHAB. She explained that the Equity and Inclusion Division is one of OHA's seven divisions. Twenty-two people work at the division. These employees cover 18 functions for OHA and the statewide delivery system. Some of the work of the division includes the Regional Health Equity Coalition, healthcare interpreters, internal investigations on discrimination and harassment, and Americans With Disabilities Act work, among others. Nine of the functions are state or federally mandated.

Ms. Johnson remarked that the Health Equity Committee is a committee of the Oregon Health Policy Board (OHPB) and it is managed by the Equity and Inclusion Division. The committee has had a long history. It evolved from the Health Equity Policy Review Committee and the Health Equity Policy Committee. The HEC provides analysis, guidance, and recommendations to the OHPB on policy, including key legislation using an equity lens. A recent example of HEC's work is the support it provided during the implementation of CCO 2.0 from policy to practice.

Ms. Johnson noted that another role of HEC is to provide assessment and actionable recommendations to OHA to achieve health equity goals, including cultural responsiveness. Current projects include the formulation of a definition for *health equity*, the assessment of and advising on OHA's progress toward health equity goals, and the design of a health equity measurement. The HEC also works collaboratively with other OHPB committees and makes recommendations to OHPB. HEC strives to partner with each OHPB committee to develop goals that integrate and advance health equity.

Ms. Johnson stated that the HEC drew from a variety of sources to create a draft definition for *health equity*. Although the Equity and Inclusion Division has used a variety of working definitions throughout the years, there has not been a definition that is adopted across the agency and across all communities. This is HEC's goal right now. A couple of years ago, the Medicaid Advisory Committee formulated an ongoing, consistent definition of *social determinants of health*, and HEC's goal is to do something similar with the definition for *health equity*. The draft of the definition is currently circulating.

Ms. Johnson pointed out that achieving health equity required ongoing collaboration of all sectors to address the equitable distribution or redistribution of resources and power, as well as recognizing and rectifying historical and contemporary injustices. There are social inequities, both historically and currently, that not only created but continue to exacerbate the health disparities that exist within our system.

Ms. Johnson invited the PHAB members to ask questions and to consider what it would mean in their work to recognize and rectify historical and contemporary injustices, and how that would fit into a health equity framework. In terms of the HEC, the committee has two co-chairs and 15 members. The HEC members represent the ethnic, language, and organizational diversity of the residents of Oregon.

Mr. Queral noted that the definition draft parallels the definition the PHAB has been using over the last two years. He praised the work of the HEC to recognize and rectify historical and contemporary injustices and suggested to think about the implications of that. What we need to recognize and rectify is the structures that we have created and put in place that have led to injustices. Injustices are hard to measure, as they are subjective. We need to focus on the system and not necessarily on just the outcome. That's where the collaboration of all sectors is required to change these systems.

Ms. Johnson agreed with Mr. Queral. In part, this is where there might be a departure to some degree. That's why the equity and inclusion discipline formed out of the public health discipline and became its own discipline. It's a paradox. It's both an alignment and conflict. When we talk about injustices and inequities, we could get more specific, because what we are talking about in many respects is the legacy of oppression. Today, the common words we use are *discrimination* and *harassment*, or lack of accommodation when it comes to the Americans with Disability Act. There are very specific actions that do manifest, and those actions have evolved from the injustices of a system and those systems remain inequitable. The question is: How do we get at this from the standpoint of two disciplines that are both aligned and working somewhat independently from a set of principles?

Dr. Luck informed Ms. Johnson that there was another health equity measurement workgroup and Dr. Luck and Dr. Schwarz were a part of. In that group, there were long discussions about definitions. The group chose the word *injustices*. Rather than saying that current inequities relate to past inequities, we now say that inequity in health relates from injustice. It was a deliberate, causal choice of that wording. He asked Ms. Johnson about the process for finalizing the draft definition.

Ms. Johnson answered that the draft definition is being vetted right now with the state, the regional health equity coalitions, and a variety of community-based organizations and other committees. It's headed to the PHAB as well. In terms of timing, the next HEC meeting is in June and the vetting should be completed by that time, so that the HEC can make a decision at the June meeting. That's not a promise.

Ms. Moseley noted that the PHAB received a request from the equity office yesterday. She and Ms. Tiel are finalizing the details on how to get feedback on that from the PHAB and compile them back to Ms. Johnson by the deadline.

Dr. Luck remarked that the State Health Improvement Plan (SHIP) had health equity as a component. He asked what definition of *health equity* would be used for the SHIP and if the plan was to incorporate that definition in the 2020-2024 SHIP.

Ms. Mosely clarified that Dr. Luck was referring to the health equity framework for the SHIP. She explained that the SHIP Steering Committee landed recently a new committee member –

her name is Leanne Johnson – as well as a SHIP subcommittee lead for the institutional bias priority – her name is Leanne Johnson. So, it's tightly aligned.

Ms. Johnson stated that, for her, while a definition was critical, so that we all have words to hang on to and have a shared understanding, it is more about the concepts. One of the concepts that we are starting to get traction around is really calling out the populations specifically that are experiencing inequities related to disparities and then also the historical legacy and the contemporary manifestation of inequities. Those are concepts that should be incorporated. The equity office will not be the health equity police. It's critical that we are working from similar assumptions.

Ms. Thalsofer informed the PHAB that one of her roles is as a member of the Early Learning Council, which has worked with the Oregon Education Investment Board's health equity lens for a long time. When we look at CCO 2.0, so much of the work is around social determinants of health and those are systems that are outside of the health system. Where is the alignment work at the state happening around the definitions of equity? There will be confusion, and people will pick and choose pieces of definitions, as they try to implement work. It would be good if the different agencies in the state worked very closely to make sure the definitions are aligned and don't contradict each other, because, in public health, we are the people who cross systems. Especially with the social determinants work that is so clearly emphasized in CCO 2.0 – whether or not it is clearly defined is up for discussion. It is really important to have coordination across systems.

Ms. Johnson agreed. Regarding CCO 2.0 and the health equity and social determinants of health, those were intentionally connected by Governor Brown, so that this work should align. From the standpoint of social determinants of health, those indeed exist within the discipline of health equity as well. The alignment piece – the Medicaid Advisory Committee coming up with the definition of *social determinants of health* and then the HEC working on a definition for *health equity* – is an alignment of words and concepts. Of course, there is the alignment of work after that, which remains to be seen how it will play out.

Ms. Thalsofer gave an example of her concerns. When she hears her CCO partners in her region talk about social determinants of health work, they are not talking about the systems that need to be improved, like “We need more housing. We need better education. We need more jobs.” She's hearing them speak of “This patient needs a house.” That is going to do nothing unless they are willing to jump in and start advocating for policy change, which the CCOs haven't talked about at all, except around the area of CCO policy. It is not going to move.

Ms. Johnson stated that that might be a conversation for the Oregon Health Policy Board (OHPB). There have been conversations there related to whether we are talking about individuals or systems. We are already talking about systems, but the tricky piece is how that is interpreted. The transformation center, an OHA unit, and the Equity and Inclusion Division are

working very closely. When we move to CCO 2.0 implementation and technical assistance, that piece will be front and center.

Dr. Bangsberg remarked that thanks to the deliberations of the PHAB, it has gotten to the OHPB the importance of looking at how outside [...] in the population and that systems are part of that or would drive that. That's understood in theory, but as CCO 2.0 is rolled out, we have to pay careful attention to how it is implemented.

Dr. Bangsberg asked Dr. Luck if he could share a conversation they had about the metrics committee that is important to the PHAB conversation. It would be essential for the PHAB to communicate to the OHPB the importance of a metric to monitor and move these things forward. There's some serious work to be done despite a recent setback, which can be seen as an opportunity.

Ms. Johnson stated that there was a health equity measurement workgroup that was formed that included representatives from the PHAB, as well as other committees that are with OHPB. The workgroup was charged with developing a health equity measurement. There were five months of deliberation and work, and the health equity measurement workgroup came forward with a measure that related to the utilization of healthcare interpreters. We heard over and over again from the community and community-based organizations that this was an area that was lacking in their care: the need for qualified and certified healthcare interpreters to interpret their primary health information in their primary language.

Ms. Johnson added that after looking at a variety of options, the workgroup moved to designing the measure because it was a strategy. It is not an outcome measure, but it is a measure that measures utilization around an intervention or around a strategy. From the standpoint of culturally responsive care, there is evidence that culturally responsive care needs better outcomes. After receiving feedback from health plan quality metrics, the CCO technical advisory group, Metrics and Scoring, and the CCOs were surveyed around this measure, the measure went for its primary vote before the Health Plan Quality Metrics Committee (HPQMC) and was planned to go to Metrics and Scoring in June, but it was voted down 5:4 at the HPQMC meeting. There will be a debrief with the internal group that worked on the measure from Equity and Inclusion and Health Plan Analytics, and with OHA director Pat Allen, to decide where to go from here.

Dr. Schwarz informed Ms. Johnson that the PHAB has been working on public health modernization for the last two years. In April, the PHAB heard from three partnerships that received modernization grants. All these groups from the various local public health agencies have been working on a variety of health equity projects. It was interesting to hear that people in the field carried out some of the measurements that the PHAB discussed. Maybe the HEC can use this information somehow. Dr. Schwarz was going to suggest it in the metrics committee, because things can be picked out and then converted to a formal measurement.

Dr. Bangsberg pointed out that the incentive measure should have more complete data on race and ethnicity. We can't get there unless we have good data to work with. We need a big, long push to get there. The interpretive measure is a little bit too narrow. We need good data to start with.

Dr. Schwarz admitted that the metrics subcommittee had many discussions about that. The subcommittee was informed that the state was trying to come to grips internally with what to do about the different platforms that don't talk together. This is one of the reasons we can't get proper, real statistics. Dr. Schwarz suggested that Ms. Johnson can push for that, as she is part of OHA.

Dr. Bangsberg suggested that unless money was put behind this effort, it won't get done. If it was easy, it would have been done long time ago.

Ms. Johnson remarked that one of the issues was, and this is just a common dynamic, that when we talk about health equity work and implementing the strategies that move forward, we are talking about a system that has been built up over decades, policies that have been built up over decades. To then say, "Here's a policy. We're going to implement it, because it is a good idea," and try to push that into a system that is not prepared for that answer or solution – it will get kicked back out. It's not just around REAL D and any of those systems. It's around a lot of our work. We saw that with the health equity metric. The system did not accommodate the solution that we created for it.

Dr. Bangsberg added that the data quality problem is an equity problem by itself, and we need to fix that.

Dr. Luck asked Dr. Bangsberg if he was looking for a sense of whether the PHAB feels that having comprehensive and valid race and ethnicity language data is essential for public health and health system transformation.

Dr. Bangsberg confirmed that that was his intention.

Dr. Luck made a motion that the PHAB felt strongly that comprehensive and valid race/ethnicity language and disability data is an essential foundation for public health activities and for health system transformation.

Dr. Savage seconded the motion and stated that, from a CCO perspective, that was absolutely the case. Every time the CCOs do a process improvement project of any kind, there is a look at some angle from health equity. Is it a male/female issue? Is it an ethnicity issue? We use the very limited data that we do get on race and ethnicity and we overlay it with language preference to try to tease out what it is. The PHAB heard a little bit about that last month with

our HPV data. It is the crush. The biggest obstacle we have for doing really good health equity work is that we don't have appropriate data for that. It is because one family of five speakers can be counted as one. It really needs to be fixed on the basic level.

Mr. Queral remarked that this begs the question: What is the barrier to getting better data? Is it a matter of resources? Is it a matter of will? Can we put some concrete ideas on the table? For example, the PHAB feels strongly that the legislature has to fund more of this, or with CCOs, go back to the legislature as advocates to get the resources necessary to be able to collect the data and that those resources to be allocated not only to the CCOs, but to LPHAs.

Dr. Savage stated that it was before the CCOs. It's all done in eligibility. It's all done when a person is applying. All of that data comes to the state and then the state pushes it out to whichever member it is assigned to. All of that data comes directly from the state. CCOs don't have a way of changing it. Any change of that information has to be made with the state. It's all at OHA.

Ms. Mortell noted that LPHAs don't have databases on a lot of things. They don't have systematic databases across all of their counties. For example, they are not on the same level with some of the very large health databases in the healthcare system, such as *EPIC*. For LPHAs, there are infrastructure and resources needs for collecting data.

Ms. Johnson revealed that Dr. Schwarz and Dr. Luck got a report by Dr. Marjorie McGee, assessing the system and showing some of the breaks in the system from the standpoint of where the systems are not speaking to each other and defaults, and how some of the data that got collected does not push through the system appropriately. Dr. McGee should be involved in the conversation, as she did the research.

Dr. Bangsberg asked if the CCOs would do nothing because this was a state problem.

Dr. Savage agreed and added that the CCOs want all that data. That's the only way they can affect change.

Dr. Bangsberg remarked that it's the state's accountability to send the metric. Dr. Savage agreed.

Dr. Schwarz added that it's much easier, because we have 15 CCOs, but only one state.

Dr. Savage clarified that the CCOs can't use all the levels of the data by the time it gets to the clinic, because these members can be assigned a different PCPs, and you can use the database to get all that information from *EPIC* and so forth, but you are still going to miss a large portion of our members who happen to not have care.

Dr. Bangsberg asked what is stopping the CCOs to get their own data, independently.

Ms. Thalsofer stated that they did, through *EPIC*.

Dr. Savage disagreed by clarifying that not every CCO has a health database like Arcadia to collect all the data. The data that CCOs get comes directly from the state.

Dr. Luck clarified that his motion had two purposes: 1) For a health equity measurement in the CCOs. To develop a robust health equity measure, having this REAL D data is an important foundation. 2) Because Ms. Johnson and others are working on approving that data, the purpose of the motion is to put PHAB's support behind the implementation of those measures.

Ms. Johnson thanked Dr. Luck.

Ms. Tiel asked the PHAB to vote on Dr. Luck's recommendation, which would also be communicated to the Oregon Health Policy Board. The recommendation was approved unanimously by the PHAB.

Ms. Tiel added that, early next week, the PHAB would be rolling out the feedback on the specific definition. The work would be done electronically, staff would compile the feedback to the HEC, and, at a future meeting, the PHAB will look at the board documents and see if the PHAB and HEC would want to align, and then have a separate vote on that.

Ms. Tiel thanked Ms. Johnson for her presentation.

PHAB Updates Business

Rebecca Tiel, PHAB Chair

Ms. Tiel reminded the PHAB that the meeting packet contained the OHPB committee digest, which provides details on what the other committees are up to. As mentioned at the April's PHAB meeting, Director Lillian Shirley and Ms. Tiel presented to the OHPB. They did an overview of all the work done over the last year and provided an update on the SHIP.

- *Approval of April 2019 Minutes*

A quorum was present.

Ms. Saito proposed two corrections to the April meeting minutes, one on page 4 and another on page 7.

Dr. Jeanne proposed a correction on pages 22-26 related to the titles of OHA employees Timothy Menza and Ann Thomas. They are both medical doctors.



Public Health Advisory Board
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Dr. Schwarz moved for approval of the April 18, 2019, meeting minutes. Mr. Queral seconded the move. The PHAB approved the meeting minutes unanimously.

- Legislative Update

Ms. Moseley informed that PHAB that there were 45 days left in the legislative session. The revenue forecast came out and the budget work starts. The Public Health Division at OHA did two presentations to the Joint Committee on Ways and Means and the subcommittee on human services. The second phase was completed a couple of weeks ago. It went very well. We continue to provide information on request to the legislative fiscal office and legislators about the priorities of the public health system during this legislative session. There is a clearer picture now about what revenue is available to fund different priorities. OHA's budget will be finalized towards the end of the session. We are in response mode until then. It is at the end of the session that we will know about our different pots of funding.

Ms. Moseley noted that public health modernization would continue an investment in the public health system in Oregon. Governor Brown introduced House Bill 2270, the tobacco tax bill, which included money for public health modernization. However, the funding for modernization was separated from the initial funding vehicle. OHA has been asked by Senator Steiner Hayward to provide additional information on modernization, assuming a \$35 million investment. The document provided to the Senator clarified the importance of public health modernization and contained a refined language and concept on how we talk about moving into this modern practice framework for public health. By the end of the month, OHA will have visited with all the legislators on the Joint Ways and Means Subcommittee on Human Services. Those visits are held at the OHA Director's Office and on director levels.

Ms. Moseley remarked that OHA's universally offered home visiting program proposes to bring together partners to create a system of care for newborns. OHA refined its phase-in approach that it proposed in the policy option package. OHA is proposing to phase-in a universally offered home visiting program over the next three biennia. It would use a model out of North Carolina called Family Connects, which is an evidence-based model, and it provides a vision for public and private partnership where commercial health plans support delivery. It supports rather than replaces some of the more intensive home visiting programs, thus becoming universally offered and using more intensive programs to reach people who need the more intensive interventions.

Ms. Moseley added that OHA also has been working closely with Senator Steiner Hayward on this bill and she has a bill, Senate Bill 526, which is a companion to OHA's policy option package. The policy option package requests funding to create infrastructure to begin the rollout for the Medicaid population and this includes leveraging federal dollars around that. Senate Bill 526 would require coverage for universal home visiting from commercial insurers. When we put

these two together, we get to the universally offered home visiting package. We envision beginning a rollout in five to six communities around the state that are ready to take that on. A steering committee has been convened and staffed by OHA to help identify the criteria for determining if a community is ready to begin implementation. This includes private and public companies, commercial insurers, and CCOs.

Ms. Moseley explained that Senate Bill 27 would replace authority for sanitary survey fees with an annual regulatory fee and generate revenue to restore five positions to the Drinking Water program. As the saying goes in public health, “If we didn’t have clean drinking water, we all will be working on clean drinking water, because we wouldn’t be living long enough to get chronic diseases.” Since 2009, when a budget situation hit the state of Oregon and the country, the Drinking Water Program has lost over 30% of its authorized positions and local partners have not received any increase in funding to match the increase in cost to implement the program. Further erosion of the program at this point becomes an even more serious threat to the public’s health. Senate Bill 27 is in Ways and Means right now, awaiting its next step in its journey to become a law.

Ms. Thalhoffer remarked that although SB 27 would restore positions at the state, she did not hear anything about the money rolling down to the locals, which is being used as a justification for the funding. Is that correct?

Ms. Moseley answered that she had not read SB 27 in a while and she did not remember the specifics of the fee section. She promised to follow up with the PHAB with more on the bill.

Ms. Moseley noted that Senate Bill 28 is OHA’s other marker fees bill. It is for marker fees paid by food, pool, and lodging facilities. These fees haven’t been raised since 2003. The cost of business has increased since then. Statute allows LPHAs to set their own licensing fees based on local need. OHA might only change the statutory marker fee when a county transfers oversight of environmental public health programs to the state. This fixes the transfer problem that OHA has been facing with the Wallowa transfer as well. This bill is also in Ways and Means, which means that it’s sitting there, waiting its next step.

Ms. Moseley shared with the PHAB that one of her favorite bills in this legislative session has been our housekeeping bill, which is Senate Bill 29. This bill is going to have some technical amendments done to it. It is a little bit late in the stage to do that, but we came to realize and were notified that there are some inconsistent references to some specific turn changes in it. We are going to take a little more time to make sure that we got those corrected, so that we aren’t creating a bigger mess when we are trying to do our housekeeping bill. This bill is up for hearing next week on May 23, 2019.

Ms. Moseley stated that Senate Bill 253 clarified the process for local public health authority to be transferred to OHA and the process for a local public health authority to take back that

responsibility from OHA. It is half the reason for Dr. Hedberg's absence today. The bill is scheduled for a hearing this afternoon.

Ms. Moseley provided more information on the tobacco bill, House Bill 2270, which reduces tobacco use and improves population health by raising the price of tobacco, which helps people quit or not start. The bill is sitting in House Revenue awaiting its next steps.

Ms. Moseley explained that House Bill 3063, which proposed to remove nonmedical exemptions from vaccinations for school children, won't be moving forward. OHA will continue to provide information to legislators and be involved in conversations about how to strengthen vaccine rates in the state and the options around that. Senate Bill 978 proposed various firearm safety provisions, including establishing a minimum age of 21 for purchases, how to safely store firearms, reporting of lost and stolen firearms, supervision of minors around firearms, as well as data collection on firearm injury. This is of interest to Public Health, to have better data on those pieces of firearms in our society. This bill will also not be moving forward, and OHA will continue to provide information to legislators and be involved in conversations about firearm safety in Oregon.

Mr. Queral asked if he heard correctly that we were severing the tobacco tax bill from what would fund public health modernization.

Ms. Moseley answered that OHA wasn't doing that. Mr. Queral pointed out that that was what was happening. Ms. Moseley agreed.

Mr. Queral asked if the vehicle for funding public health modernization was known. Will it be \$35 million, as Ms. Moseley stated?

Ms. Moseley answered that OHA was asked by Senator Steiner Hayward to provide additional information on modernization, assuming a \$35 million investment. No additional information is available.

Mr. Queral reminded the PHAB that, as he mentioned at the last PHAB meeting, there are no public health advocates talking about public health modernization. The people who are talking about the tobacco tax, for example, are focusing on that and not really linking it to the public health modernization piece. Although Senator Steiner Hayward is paying attention to this, Mr. Queral remains concerned that there are not enough voices at the capital talking about this. He realizes that the PHAB is limited in what it can do in terms of advocacy, but the PHAB needs to get the word out a little more, especially if there is an opportunity to [...]. That is a pretty exciting and, hopefully, motivating factor.

Ms. Moseley thanked Mr. Queral for his comments. She stated that there was a public hearing day for following the first Ways and Means presentation that public health did and there were

quite a few organizations speaking on behalf of public health and the importance of the overall public health budget and POPs. That work is going on. She remarked that she could talk to Ms. Angela Allbee and ask her more specifically. She could provide an update at the next PHAB meeting on how some of that strategy is being seen.

Ms. Mortell commented that at the CLHO meeting earlier today, there were OHA fact sheets that were helpful to the members, if they need to have one.

Ms. Thalhofer added that there were multiple advocates, including commissioners and local public health administrators at the Ways and Means roadshows. There were quite a few people who came out to those to talk about modernization.

Dr. Bangsberg asked if there would be additional opportunities for public input as there are considerations for a new funding mechanism.

Ms. Moseley answered that she was not aware of any current opportunities.

Dr. Bangsberg pointed out that it would be a shame to let things like public health modernization go unfunded when there is a state revenue surplus. Two hundred dollars in people's pockets is not going to do much for public health.

Mr. Queral remarked that individuals in the top 1% of Oregonians will get a check of around \$14,000.

A few PHAB members could not believe that information. Ms. Tiel asked if they lived in Oregon. Dr. Savage stated that she did not live in Oregon and did not know the discrepancy in the kicker amounts.

Ms. Tiel asked the PHAB members if they had more questions on the legislative update. There were no more questions. She introduced the next presentation by stating that the PHAB is the advisory body for the Block Grant. Ms. Drum had presented a report at a recent PHAB meeting. The new presentation is on the 2019-2020 workplan proposal.

Public Health Grant Block

Danna Drum (OHA staff)

Ms. Drum reminded the PHAB that she presented to the PHAB a couple of months ago, giving highlights of accomplishments with Block Grant coming to-date. Today's presentation will be about the concepts for what OHA is suggesting for the PHAB to propose for the October 2019-September 2020 workplan. This is not a competitive funding that is in federal code. All states and territories get it. The PHAB is the advisory committee which helps to make recommendations regarding the workplan.

Ms. Drum explained that the workplan is tied to Healthy People 2020. OHA uses a couple of public health infrastructure-related Healthy People 2020 objectives. One is related to accreditation and the other to quality improvement. OHA has switched how the information is presented to the PHAB because, over the last few years, OHA has used this funding to continue to advance the work toward a modern public health system. The key points of the presentation are on page 3, which shows the foundational capabilities and the work that would be supported related to those foundational capabilities.

Ms. Drum remarked that the four foundational capabilities are leadership and organizational competencies (L&OC), community partnership development (CPD), policy and planning (P&P), and health equity and cultural responsiveness (HE&CR). There is an overlap among the capabilities in a lot of ways. The overall priority areas would be: continued implementation of our plan for a modern public health system; continuing to build and expand capacity in the four capability areas; supporting national public health accreditation for the LPHAs, tribal health authorities, as well as maintaining OHA's public health accreditation status. Over the next year, OHA will be doing the work towards reaccreditation.

Ms. Drum added that OHA will continue to do quality improvement performance management work through agreements with LPHAs and triannual review, as well as the technical assistance that OHA provides; continue to align our public health system processes and structures to support a modern public health system. OHA has done some work around the triannual review and the program elements. It will continue to do that work by slowly aligning these pieces, moving us more in that direction. OHA will continue to work on the PHD performance system, which OHA is currently implementing. We are doing this in the public health division, as are all divisions.

Ms. Drum noted that OHS will continue to do work on quality improvement with our quality improvement plan and activities, as well as on OHA's strategic plan. It will also support coordinating work across the system and providing ongoing technical assistance across the system. Another area that OHA is focused on is increasing its effective engagement with communities that experience health inequities. OHA's internal health equity group has been doing a lot around this and building capacity and training around how we do our personal, internal work, as well as our organizational work to be more effective in how we approach health equity and our cultural responsiveness with community partners.

Ms. Drum shared that OHA is completing the implementation of and the progress reporting for the 2015-2019 State Health Improvement Plan (SHIP) and completing the development and preparation for the launch of the 2020-2024 SHIP. OHA is also continuing the tribal public health modernization assessment and planning work, which is an area that needs more resources and the Block Grant could be a source for that. The grant has also supported the accountability metrics and, in particular, the local investment, plus the data analysis. OHA

continues to develop and implement a framework by which all the community engagement work and strategic partnerships fit together and move forward.

Ms. Mortell remarked that it sounded like the last point is in theory and development at this point. Is it possible to share more about it with CLHO whether and how it connects back to our local work? We are not always good about connecting the state strategic plans with the local strategic plans. This might be an opportunity to start doing that and the front end of something that's new.

Ms. Drum agreed, and she knew on the community engagement piece, which is a huge part of that work, is work that is coming to either JLT (Joint Leadership Team) or CLHO. It is on OHA's list of work to begin the system conversation about it.

Ms. Drum called the PHAB's attention to the fact that the Oregon Coalition Against Domestic and Sexual Violence would receive the sexual violence prevention dollars that have been set aside. While the coalition will shift how the funding is used, the work to continue to implement sexual violence primary prevention in communities is still going to be the push of the work. How it gets funded will shift, based on their lessons learned.

Ms. Drum explained that when she went back [to the books], there was a slight difference, about \$10,000, in the funding. OHA has to report how it will fund by health objective. There is about \$8,500 more in the accredit public health agency's line and a whopping \$800 more in the quality improvement line. There was error in the indirect costs line, which has almost \$94,000. OHA will have a public hearing on this, as required, on May 29, 2019, at 11:30 a.m. If there is any feedback from the public hearing that is significant, and OHA feels that it should be brought back to the PHAB, OHA would do that. Otherwise, OHA will proceed with submitting, with PHAB's support, the outlined suggestions.

Ms. Tiel commented that the more the work can be organized by modernization capabilities, the better.

Ms. Drum noted that it would be helpful to have an official recommendation from the PHAB for reporting purposes to CDC.

Ms. Tiel asked for a motion on the workplan. Ms. Saito made a motion to approve the workplan as presented. Dr. Schwarz seconded the motion. The PHAB approved the workplan unanimously.

Accountability Metrics Subcommittee

Dr. Jeanne Savage

Dr. Savage informed the PHAB that the Accountability Metrics Subcommittee had a productive meeting on May 6, 2019. The 2019 Public Health Accountability Metrics Annual Report is out. After the report was reviewed by the PHAB at a recent PHAB meeting, the subcommittee was charged to do a review of a couple of these metrics and make some recommendations about whether or not these outcome measures would be maintained or changed. At its last meeting, the subcommittee focused on two outcome measures and one process measure.

Dr. Savage noted that the subcommittee looked at the dental visits for children ages 0-5, which was discussed previously by the subcommittee and then reviewed again. The subcommittee made the recommendation to keep it as a developmental measure and not to put it forward as an accountability measure, because it is too complex and it's not very clear how public health could really be held accountable for the work and what that work could be. Then the subcommittee moved to the prescription opioid mortality outcome measure. There was a lot of data presented that was enlightening to many of the subcommittee members. One takeaway was that fentanyl is now being made illicitly. The metric is called *prescription opioid mortality rate* per 100,000 people and the outcome rate is less than three, but it is specific to prescription opioid. When the subcommittee was discussing how to gather that data, there were some significant limitations to that data. One of the limitations that the presenters mentioned was that now fentanyl is made illicitly and given prescription. It confounds a lot of OHA's data.

Dr. Savage explained that frequently in overdoses, heroin would be mixed with other drugs. It's difficult to know what they are. There may be some prescription drugs mixed in there, but it could also be heroin and methamphetamines and others. There is inconsistency with what's reported. Because there is an increase in illicitly manufactured fentanyl, we are not able to tell which one was illicit and which one was prescribed. The biggest question posed to us was: Do we really want to go forward with this measure, or should we change this measure around whether or not this is a prescription opioid? After the presentation of the data and the limitations, the recommendation was to go with any opioid and see how that's affecting overdose, because teasing out the differences was not helpful. The more helpful data would be for any opioid and how that would affect the rate. The decision was to change the metric to say "any opioid".

Dr. Savage added that she still raised the question as to whether looking at the opioid mortality rate per 100,000 people is really the best outcome to follow. While the subcommittee decided to change it to just "opioid," it didn't confirm that the same outcome would be used. The measure might end there, but more data will be brought to the subcommittee, so it can have a more informed discussion about that. A non-fatal overdose may be a much more valuable endpoint. The subcommittee is going to look into the data. It might be something that, as public health, there may be some clear process measures that could then be put in place to affect that.

Dr. Savage stated that the second thing the subcommittee looked at was the prescription opioid mortality percent of top opioid prescribers enrolled in the PDMP. As it was discussed at the PHAB meeting in March, now that that's required, they wanted the subcommittee to weigh in as a metrics group. The CLHO will make recommendations as well, but they wanted us to discuss if that was really a good process measure to use. The subcommittee's discussion was around the question "If we are not going to use the money to measure whether or not providers are registered for the PDMP, then what kind of process measure would be most helpful in that area?" Measuring rates, whether or not providers go into it, may not be a good spot, because people are getting it from other areas. For preauthorization of opioids, CCOs are required for the PDMP to be in the chart notes and to be reviewed. They are already feeling some pressure from the inability to get the medications. Then there is pressure from the federally qualified health center level as well. Those providers all must get into the PDMP at least once a month. There's money tied to that through a federal push. Do we get on that? Maybe it's helpful to have the pressure come from different areas, or maybe there is something else we can think about as a different process measure.

Ms. Mortell remarked that the discussed process measure felt like a healthcare process measure, not a public health process measure.

Dr. Savage agreed. That's an ongoing discussion and the subcommittee will continue it next month.

Dr. Schwarz noted that one of the interesting things about the accountability metrics is that we are working in an area where there are no national standards. When he was on the Metrics & Scoring Committee, the committee had a reasonable approach in wanting to use metrics from the national quality forum that had been vetted. There are also examples of measures that have been created in Oregon and have been tested and validated in Oregon and ended up on the national quality forum. When he sees an attempt to come up with a metric that doesn't exist anywhere else, but it is necessary to be able to document the healthcare transformation in the state, he is concerned. He and Dr. Luck are on a subcommittee and its accountability metrics have not been presented to the Health Plan Quality Committee, because it's not healthcare. It's public health. Those metrics will not be voted down yet. They would otherwise be voted down because they don't exist on the national quality forum. This schizophrenic approach to our attempt to modernize public health, and health equity would become a very important part of this modernization, and when the discussion is about the accountability metrics, it makes him think of doing something more. The PHAB meeting might be the appropriate place to mention it. We are set back by our own strange, procedural rules that we have put on ourselves in this area.

Ms. Mortell added that one of the things that is different for public health is that process measure and outcomes measures are quite different than healthcare delivery measures. That's why we are struggling. We are being creative in thinking about those. This body of work is a

little bit similar to the transportation metrics that we have developed. One of the process measures that could be considered is *What are the harm-reduction activities happening in a local community?* We could talk about needle exchange and other proven strategies. It may behoove us to try to continue to capture that data in our measurements, because that's what's telling the story of public health being effective and working well in the community.

Dr. Luck shared with the PHAB that he made a connection between Dr. Schwarz's and Ms. Mortell's comments and a conversation he recently had with people from Washington state and Wisconsin about the public health modernization. They went through a list of other states that are working toward implementing a foundational program and capability models, including Kansas, Ohio, Colorado, and California, among others. There are 10 or more states that are implementing either through statute or through recommendation foundational program and capabilities model. The work the subcommittee is doing is potentially really important. Oregon and Washington are out in the front, and the people from Washington say that of those two states, Oregon is in the lead. There are no national standards, but the work the subcommittee is doing, and structuring it very carefully, is something that other states can pick up as they do modernization too.

Dr. Luck stated that at the Quality & Metrics Committee last week, Dr. Hedberg presented the 2020-2024 SHIP and talked about the domains. There was a discussion in the Quality & Metrics Committee about whether those domains in the SHIP aligned with the modernization priorities and capabilities. They don't seem to be a 1:1 match. The goal of the Quality & Metrics Committee, among other activities, is to align measurement across systems and different levels. It is unclear how the new SHIP framework and modernization line up in a performance measurement sense.

Ms. Tiel remarked that this was a good distinction. The SHIP is more than just the public health system's plan. Are we calling domains *institutional bias* and *economic drivers*? There will be a lot of work underneath each of those areas to determine how we are going to measure success or progress. It's okay that they are not aligned, because that is the overarching state health improvement plan that all systems are working toward. The modernization work is about the governmental public health system.

Ms. Moseley agreed with Ms. Tiel and added that the foundational capabilities and programs of a modern public health is a practice framework for public health. We used to have the ten essential services and now we seven foundational capabilities and the four foundational programs, which are stronger in terms of centering equity and the leadership role of public health. The way the public health system would continue to define its role in the SHIP would be thinking about the delivery of public health in the foundational framework of practice. But the Oregon Department of Transportation (ODOT) doesn't have to do that, or Business Oregon. We don't need to explain modernization to them. It's for them to figure out how they contribute to the SHIP.

Dr. Savage noted that she somewhat agreed with Ms. Moseley. She did believe that the SHIP was the overarching – it's a good name for it – goals for the state. What we've had in healthcare, which is what we have seen, are these individual attempts all over; this isolation of effort and the lack of coordination. The point is that you can have this individual SHIP and then we can have our own community health assessment and we have our own CHIP (Community Health Improvement Plan). We have to make sure that that aligns. When we are looking at that, we are making sure that it is also aligning with the SHIP. We are trying to make sure that the local priorities we find, we can fund, support, and come up with activities that are in alignment with this. While they are not one-on-one the same thing, we can see how our local activities as a CCO, in combination with public health, all fit into the broader plan. That umbrella approach needs to be emphasized and put forward.

Ms. Moseley explained that the SHIP, like the CHIP, is a deliverable of a lot of the public health system. In the public health division, we try to be intentional with this and be community-based and letting the community partnership hold the decision making for the priorities. Then the process, as a deliverable, marks a movement towards planning, that is more representative of that practice framework. They start to align in that regard as well. Because the modern public health framework is a means of doing the work of something like a SHIP.

Dr. Schwarz stated that the SHIP priorities were very conceptual. That makes it harder, or easier, to fight the collaterals. Institutional bias; adversity, trauma, and toxic areas; economic drivers of health; access to equitable preventive healthcare in behavioral health – that's very, very broad. We can fit anything into this. That would be wonderful.

Dr. Schwarz asked Ms. Tiel about the name of the OHA conference to which all PHAB members are invited.

Ms. Tiel responded that it was the Place Matters Conference.

Dr. Schwarz remarked that, as he mentioned at a recent PHAB meeting, when he attended the last AKHA meeting, he could not find any information on public health modernization. Could we not get on the agenda for the next meeting to invite some of the other states that are also doing it and get some kind of a symposium together and look at public health modernization, so we can get a little better informed about what is going on and how we can contribute?

Ms. Mortell noted that OHA staff and CLHO are participants in the Public Health National Center for Innovation. That's the focus of that work. We are in connection with Ohio, Washington, and other new states. Ms. Beaudrault is the only one who can go to the next meeting, coming up soon. She will bring back information and ask pointed questions. We often share materials and the developments of what they've gone through. The answer to the

question “Who is working on metrics?” is that, most likely, some of the states are working on them, and we can ask that question.

Ms. Thalhoffer commented that, in terms of Dr. Savage’s point about CCOs looking for alignment with the SHIP, that’s not explicitly outlined. Not all CCOs are creating CHIPs that align with anything. If you look at local public health accreditation and state public health accreditation, you have to align with something. Most LPHAs draw alignment with the SHIP and also with Healthy People 2020. But the CCO plans don’t require that. This whole tight/loose business that we can’t talk about anymore, but is still in play, has really created kind of a mess, because the looseness isn’t always aligning, and people who have been in it all along, and aren’t waiting for it to be talked about it in a different language, know what they are supposed to do. Dr. Savage’s CCO is saying, “Okay, we have to align.” Other CCOs, where people aren’t as involved, are not aligning. It’s making increased areas of disparity because there is not a requirement that they all align.

Ms. Tiel stated that when CCO 2.0 bill passes, which is House Bill 22*9, it has the requirement that the CCOs and hospitals and local public health – it’s part of the recommendation that the PHAB put forward. When that bill passes, we can do a follow-up here and talk about if there is a role that the PHAB wants to put out in response to that, in terms of implementation and supporting that crossover. That will be a really good tool that we’ll have. The interesting thing when this body proposed that to the OHPB was before the SHIP priorities were set, and now that they are these much more social determinants of health level, it will be interesting to see what comes out of that. Before, when they were tobacco and obesity, it was a lot clearer. The SHIP and how that is this umbrella will be a test for all of us, in terms of how we talk about it, how we measure it. The PHAB – while the SHIP is not the PHAB’s plan, it is everybody’s – can help with that framing and getting it in front of the right people and the right places.

Dr. Bangsberg pointed out that with CCO 2.0, there is an expectation that CCOs will develop a community health improvement plan (CHIP) and that will be developed in collaboration with local health authority and community-based members with a more diverse panel. Is the gap that [...] no action within the SHIP and the community health improvement plan?

Ms. Thalhoffer answered that it doesn’t require alignment. LPHAs that are working on accreditation will require as collaborators that it aligned, but those that aren’t, won’t.

Dr. Savage reminded the PHAB that CCO 2.0 starts in 2020. In the case of Willamette Valley Community Health (WVCH), unfortunately, the CCO is choosing not to go forward in 2020, so there will be one or two possible CCOs in the area. What WVCH has done is communicate with the counties’ public health divisions that WVCH wants to support and get through this process together, so that we set something up. When we find out who is here in September – people get a letter of intent in July, but CCOs don’t get a contract until September and member assignment in October. WVCH reached out to the two possible CCOs and said, “Come, be part

of this. Here's your connection at the county for now. Please call the counties." WVCH is in the process of developing strategies that are aligning with the CHIP and the SHIP. There may be other people who are doing that as well in their areas. Dr. Savage will take this information back to the director's meeting with all CCOs. Maybe they are interested in having a discussion about that. Maybe somebody from public health can come and present to that group and say, "Hey, look, this is what we need. Can we align these areas?" That might be a good crossover connection.

Ms. Tiel remarked that we have seen too that getting the plans aligned isn't the outcome. It's been some really great work in the metro area aligning all the plans. And then, when it comes to making investments, everyone goes back to their own corner and does their own thing. It's continuing and ongoing work. It's like the sandbox play. We are all in the sandbox together, and when it gets to the time to spend the dollars, everyone goes to their corner and plays by themselves. There is going to be a need for some continued work around how those investments can make it into the communities.

LPHA Investments in Local System Capacity

Danna Drum (OHA staff)

Ms. Drum reminded the PHAB that the public health modernization funding formula has a floor, has indicators, has incentives based on the metrics, and incentives for local investment, which we turned into the matching funds piece. While we have not yet had a large enough investment from the legislature for the funding formula to kick in, we have been working towards trying to get fairly accurate baseline data for local investment, so that we have it. When that happens (i.e., when a large enough investment comes), we can plug it into the funding formula and be able to award incentives for local investment.

Ms. Drum pointed out that in fiscal year 2018, OHA collected local government public health investment data from all LPHAs. This was the second year doing this. OHA learned a lot in the first year. Based on lessons learned, OHA worked with local representatives on a technical advisory group to try to get closer to comparing apples to apples. This year's data is more comprehensive than last year's data. OHA also built in a validation process. Monty Schindler, one of OHA's fiscal analysts, did an incredible job around that. There was a lot of interaction with the LPHA partners to make sure that OHA had what it needed and that we were counting the same things. Mr. Schindler had one-on-one conversations with all LPHAs that expressed that they had in-kind support. One of the things we found, as we were talking through this in the technical advisory group, was that everybody had a different definition of what in-kind support was. We wanted to be sure that we were counting that the same way across the board.

Dr. Drum stated that the data in the presented table have been validated. The first column is the population, based on PSU (Portland State University) population estimates. Then we have the reported local expenditures, minus some exclusions, which have been discussed with the

PHAB. This reflects everything a county government has paid for public health in FY 2018, minus the exclusions. Then we have the amount for in-kind support. We totaled the cash, which is the local expenditures, and the in-kind support to arrive at the total local investment and the per capita local investment. The per capita range is quite significant. The lowest is around \$3.50 and the highest is almost \$70.00 per capita. It's all over the map, in terms of what the local investment is.

Ms. Mortell noted that there was another variable here. There is something about population size that we need to describe in some way. Even though the per capita investment is all over the board, it's also publicly about population.

Dr. Drum agreed with Ms. Mortell. To note, the data for Grant Count could not be validated. They did submit the data, but despite multiple efforts, OHA has not been able to validate it. Although it is not reported in the table, it does not mean that there isn't any data. Data cannot be included until it has been validated.

Dr. Schwarz asked if the exclusions include grants received by a county, such as a HRSA grant or a CDC grant.

Ms. Drum answered that this would just be revenue the county has generated from fees and the county general fund. This could include what counties get for third party reimbursement. It would not include any outside funding sources.

Ms. Drum presented a pie chart, which showed the 2018 local governmental public health investment by category. The data in the chart were not validated. They were collected for information purposes. OHA tried to collect the data, as much as possible, along the foundational programs and emergency preparedness. It's not a perfect match, because we needed to account for administrative and other indirect cost. Some of the expenditures cross over multiple areas and we needed to have a way for people to report that. The cross-cutting and leadership category, the green area on the chart, represents the things that could not be assigned to just one category. OHA requested of people to prioritize categories, if they could.

Ms. Drum added that the environmental health piece of the pie includes licensing fees collected by the counties. Those fees are required to support the environmental health work. Most likely, that is an area where we see a high local investment. In terms of the prevention and health promotion category, OHA consistently heard that there was not enough funding for that. At 32%, some of the local investment is going in that category, because of the shortage.

Ms. Mortell asked if that included TCM (Targeted Case Management).

Ms. Drum answered that it did include TCM.

Ms. Mortell remarked that it would be great to have TCM data on the pie chart, when it is including some revenue back in outside of the county [...].

Dr. Savage asked about the definition of TCM.

Ms. Drum explained that TCM stands for Targeted Case Management. It is when a county puts in local funds, such as county general fund, which enables it to draw down the Medicaid match dollars.

Dr. Savage asked about the meaning of the category *Admin & Other Indirect*.

Ms. Drum answered that the category included things like information technology and facilities fees, among others. It varied. With some LPHAs, those expenditures get charged directly to programs. With others, it is an overall fee that is charged to the public health authority. They can't support it out. That's what that category is.

Dr. Schwarz stated that it was a pity that PHAB member Ms. Muriel DeLaVergne-Brown could not attend the meeting. It is very important to understand the variance even across very similar populations. The variance between \$5 and \$70 is almost crazy. It would be good to understand the cultural differences. There must be some explanation for these kinds of things, in terms of commissioners' priorities or population differences or something else. That's one thing. Another thing is that in 2016, the PHAB got a modernization assessment report from BERK Consulting, where they did this fabulous graph with the smallest squares that nobody was able to see what it was. One thing were these three or four different colors which showed the ability to implement public health activities under certain circumstances. The major picture was that most of the counties would be unable to fulfill their public health requirements if something happened. It would be so cool to see this overlaid with that graph. It would be interesting to see if a county that spent \$70 per capita had a much higher probability of being able to fulfill its requirements than a county that spent \$4.00 per capita, or if there is no relationship whatsoever.

Ms. Thalsofer expressed a desire to address the question "Is it culture, or what is it?" She asked Dr. Schwarz if he was in Oregon when Ballot Measure 5 passed.

Dr. Schwarz answered that he was not.

Ms. Thalsofer explained that the way counties could collect revenue based on property taxes was crippled because their property values were held at the levels when that was passed, and they could only increase them by a certain amount. For many counties, because they had another revenue source through timber, they had artificially low property values, but they were held to those. Those counties have continued to struggle over and over. They (i.e., county officials) value public health. They don't have enough money to do anything. Or their county has a lot of federal land in it and they don't get any revenue out of that federal land. Our tax

system in Oregon is a mess. Recently, Representative Daniel Bonham shared with Ms. Thalsofer that the state has an unending ability to collect revenue. They can collect as much as they want. The cities have a fair number of options. Counties are very, very limited in how they can create revenue, but they have a huge amount of responsibility. It's not culture or priority. It is how they do what they are mandated to do with no funding and very limited ability to create funds.

Dr. Drum added that, anecdotally, OHA has been hearing that this has been an extremely difficult budget year for the local public health partners. It would be interesting to look at this this time next year and then the following year and see where we are.

Dr. Luck thanked Ms. Drum for the presentation.

Dr. Savage remarked that it was kind of confusing without an analysis of the difference – how something could be \$3... What is this information going to be used to do?

Ms. Drum explained that the funding formula had a component to it, where OHA could award some matching funds to help incentivize local investment. If a county is at 100% at 159K, that could be plugged into the funding formula, and it wouldn't be a 1:1 match, but you could [...].

Dr. Savage asked if this allowed public health to get more money from the state.

Ms. Tiel explained that we don't want, if there was a big investment from the state in modernization, for a local government to redirect public health dollars to the library or roads. We want to maintain the incentive to fund local public health in whatever little bits that they can. That's part of a broader formula. It's just one input, not the main input.

Ms. Drum agreed and pointed out that it is about not being supplanted. State funds wouldn't be supplanting local investment.

Ms. Mortell stated that the measurement is not how much counties put in right now, but will a county put in the same amount next year, or a higher amount. A county only gets money if it puts in the same amount or a higher amount in the future years, regardless of how much a county is putting in.

Ms. Tiel commented that this practice could be an advocacy tool for administrators to say, "We maintain this. If we get this match, we can have a whole FTE for X role."

Ms. Tiel reminded the PHAB that the board has been getting modernization grantee updates around health equity. Today's presentation is from the Benton/Lane/Lincoln/Linn partnership.

Modernization Grantee Update: Health Equity Action Plans

Jocelyn Warren (Lane County), Heather Amrhein (Lane County)



Public Health Advisory Board
Meeting Minutes – May 16, 2019

Ms. Warren introduced herself as the health administrator from Lane County and, on the phone, she introduced Heather Amrhein, who coordinated the health equity work in the region.

Ms. Amrhein introduced herself as the coordinator of the regional health modernization grant for the Benton/Lane/Lincoln/Linn partnership.

Ms. Warren remarked that she and Ms. Amrhein would share the presentation. She informed that PHAB that the region includes four counties: Benton, Lane, Lincoln, and Linn. The total population of the region is 614, 275 people. The region's goals for the modernization grant include (a) implement regional strategies to address vaccine-preventable diseases, with emphasis on reducing health disparities and fostering health equity, (b) develop and sustain regional "learning laboratory" model, in which the counties developed three pilot projects around different vaccination projects, (c) engage local organization and community members as strategic partners in communicable disease control.

Ms. Warren pointed out that for the regional health equity assessment, the partnership was addressing the inequities that are the result of structural, social, economic, and environmental differences that result in adverse health outcomes and communicable disease-related disparities in the region's populations; not primarily related to vaccination, because that is not necessarily where disparities in communicable disease are seen. The partnership took a much broader perspective on health equity, looking a lot more about region within the counties and some of the disparities seen by region, as well as race/ethnicity, age, and poverty. The partnership acknowledges that one of the big limitations in doing this work is staff capacity for doing health equity work. The counties don't have funding for that. They have a lot of interest and a lot of commitment in the Benton, Linn, and Lincoln region. They have a regional health equity coalition. In Lane County, there is an Equity and Access Advisory Board that is a community of board of county commissioners. There are also health equity committees within health and human services and with each of the divisions that are also working on their own workplans.

Ms. Amrhein stated that the approach the region took in developing health equity plans was to have each county develop their own equity plan, rather than taking a regional approach like it was done with the health equity assessment. This was done for a few reasons. One reason is that each of the counties is starting from a different place when it comes to equity work. Some of the counties, like Benton County, are much farther along than some of the other counties. It made more sense for each county to create its own equity plan. When the partnership looked at the county equity plans, there were strategies that overlapped with each other. All primarily focused on activities to engage underserved communities (i.e., rural, non-English speakers, homeless) to address root causes of disparities. All counties are interested in expanding their collaborations with cross-sector partners across the counties; doing more education and communication with the public; improving their assessment and epidemiology capacity; and

strengthening internal infrastructure. Because of their limited capacity, it is very important that the counties make improvements in staff knowledge, skills, and abilities related to health equity, so that health disparities can be addressed.

Ms. Amrhein explained that in terms of implementing the action plans for equity, there are a few challenges and barriers that keep coming up. One of them is the limited staff capacity and funding for implementing equity plans. Equity work isn't free and cheap. It requires a dedicated staff. It requires funding specifically for the work. This is something that has to be taken into consideration. In Lane County, there is no regional health equity coalition to help with implementing an action plan, like Linn and Benton counties have that resource. There are also varying levels of knowledge, skills, and abilities related to equity work. Even within Lane County, there are some staff who are knowledgeable, other staff who are not very knowledgeable. When we look at the different counties, each county has their own limitations, limited resources, and starting in a different place.

Ms. Amrhein noted that there were a lot of opportunities when it came to equity work and implementing the equity plans that the counties developed. In Lane County, as well as in the other three counties, it was important to align the equity plans that were developed with other local and regional plans and priorities. Each county's community health improvement plan has a strong focus on reducing health disparities and fostering health equity. Equity is a big focus of the county's strategic plan, other internal plans, equity committee work plan, the regional health equity coalition. In Lane County, last year, the Board of Health approved three recommendations related to advancing equity in the county. The county's equity plan helps operationalize those equity recommendations and move them forward. In Lane County, the focus is also on expanding rural engagement opportunities. Good community engagement work has been done in the metro area in Eugene and Springfield. While there are programs and people that have done work in rural communities, there are many opportunities to strengthen the partnerships, engage with communities, and work together on shared outcomes.

Ms. Amrhein asserted that another opportunity is in leveraging partnerships. There are so many community partners that are also focused on reducing health disparities and advancing health equity. Because all have limited resources, it becomes even more important to leverage those partnerships and figure out how they can work together to stretch the dollars that they do have. Lane County and each of the other counties have equity work as a workforce development priority. The stars are aligning to advance the health equity work and use this as a vehicle to reduce health disparities and advance public health modernization.

Ms. Amrhein explained a slide that showed a flyer from a community event in Lane County in the spring of 2018. Out of this event came the recommendations that were taken to the Lane County's Board of Commissioners, serving as the Board of Health. At that point, the Board of Health approved the recommendations, one being to develop a health equity plan for Lane County and to do more work in engaging underserved communities. Modernization and the

work with the health equity plan the county created to help advance that work is what the Board of Health wants the county to work on. Ms. Amrhein shared with the PHAB some photos from the event last spring, as well as a photo of a Florence coalition Lane County convened to help prevent substance abuse in the west Lane County region.

Ms. Warren invited questions from the PHAB.

Dr. Luck asked if Lane County's health equity plan was in development.

Ms. Warren answered yes. There were recommendations that came out of a series of meetings by the Lane Health Equity Coalition, which is a subcommittee of the regional CHIP coalition. The partners are PeaceHealth, Trillium Community Health Plan, Lane County Public Health, and United Way. A series of meetings took place and the plan got a lot of feedback. The county's Public Health Advisory Committee and the Equity and Access Advisory Board worked together on the recommendations and advanced them to the Board of Commissioners.

Ms. Warren stated that one observation from those meetings was that there was not much representation from the rural areas of Lane County. There was very robust participation from Eugene and Springfield. Before finalizing the plan, people felt that they needed to go out into some of the more outlined areas, and take those recommendations, and see whether they resonated with the folks who lived in those areas first, before saying, "Here's what we are doing for equity," and really getting a sense from other communities whether those recommendations were what they would like to see going forward. What is lacking is dedicated funding for that work. It is frustrating. And then working with the leadership to see if the health department can get half-time funding and repurpose some staff time to leave the outreach to the rural areas. That is the constant challenge. Everybody is really interested and there is a lot of commitment. It's the right time to go to the board and ask for funding, which will be done eventually.

Dr. Schwarz asked what is expected with some of the different challenges from [...] the semi-opened centers to the rural areas.

Ms. Warren answered that she didn't want to prejudge it. She didn't know what it would be. They are very different cultures. There are a lot of different programs out in Cottage Grove, for example, which is south of Eugene and Springfield. There is a lot of engagement in health there. They have their own coalition that works in tandem with the regional CHIP work. They are doing a lot of work locally. They are trying to secure their own primary care clinic. That is going very robustly. Then there is the community in Oak Ridge that has almost zero services. There's one small clinic in Oak Ridge. It's much more difficult to engage people. The thing that engages the community most often is air quality, because they have very, very poor air quality in Oak Ridge. They have woodburning issues and fires. It's the way it is situated geographically that

makes it a challenge. Those two places are radically different from each other and from the Eugene/Springfield area. They have very different wants from public health and the county.

Ms. Saito remarked that, looking at the pictures, it seemed that there were a lot of people in attendance. She asked how the county managed to get people excited to come to that community event and what were some of the recommendations that came out of the meeting that surprised the public health officials.

Ms. Amrhein responded that there were about 200 in attendance at that event in the spring of 2018. It was the fourth event similar to the ones that Lane County Public Health (LCPH) had hosted. The Lane Equity Coalition had been hosting quarterly events, each focused on different topics. The event flyer was sent to all community partners and they shared it in multiple languages. One of the big draws was that LCPH offered free dinner and free information, which made for a very interactive event. So many people had attended past events that they kept sharing information with their friends and families. People are always excited about these events and it seems that the attendance keeps getting higher and higher each time one of these events is held. In Lane County, there aren't any other events like this one, where a person can come to a free event with great information, very action-oriented, network with other people in the community, and it's open to all people. The intention is to reduce the barriers for people to attend. There is also an ESL interpreter who offers a Spanish option.

Ms. Amrhein added that a lot of recommendations came out of that event, and a lot of the work afterwards on behalf of staff was in compiling and organizing the recommendations into categories. One of the first recommendations was for Lane County Board of Commissioners to make a public commitment to advancing health equity and to pass a resolution that articulated a vision for advancing equity in Lane County and the commitment to addressing them. The other big recommendation was to develop a health equity strategic plan that focused on engaging with affected communities and addressing forms of systemic oppression and building organizational capacity. The third recommendation was to institutionalize and embed equity practices, which is a very big strategy. A lot of the work in the next steps would be breaking down those recommendations in bitesize pieces and operationalize them.

Dr. Jeanne pointed out that the framework seems to be regional health equity assessment, but then we have individual counties doing the health equity planning. It seems that the region has a lot of strengths and things in common. Eugene and Corvallis are more common than maybe Eugene and Florence. Is it just administrative factors that cause the planning to be done on the county level? Why isn't the planning for the whole done on the county level?

Ms. Warren answered that there are probably more similarities between Corvallis and Lane County, but Corvallis is not her responsibility. Oak Ridge is. Florence is. One of the things that has come to the fore for LCPH in doing the regional work is that it has drawn some resources away from other places, because LCPH has done AFIX in some of the areas, like Eugene and

Springfield, and then Ms. Amrhein and her team go to Linn County, or go to Lincoln County, or go to Benton County. They have done the work there. It hasn't been a very good thing. It is because Lane County is so big. It's the size of Connecticut. It's very hard for LCPH to make it to all the edges of its own county and that has been something that LCPH has struggled with. There is a perception in the county that LCPH is not responsive to the folks who live in the rural areas. LCPH used to have satellite clinics back in the 1980s. It's been a long time, but people remember that. They remember when the county was in their community and it is not now. That is something that the county is struggling with and must figure out how to respond to. It is absolutely an equity issue.

Ms. Thalsofer remarked that she loved this, but she also realized that LCPH had done the assessment regionally and then decided to plan locally. When she read in the PHAB packed that the Incentives and Funding Subcommittee wanted to continue to strongly incentivize regional work, she very much worried about the PHAB compelling regional work. We've done it. All of our partners have drawn together and done this regional experiment. For some of them it has gone very well around communicable disease, and for others, it's been really, really hard. It's not worked well, because there are 36 local jurisdictions and it's very different. In the Lane/Linn/Benton/Lincoln partnership, we have four counties that are putting a different per capita investment into public health. Those of us doing the work on the ground know how the cross-jurisdictional work will be successful. The PHAB should be very careful about compelling unnatural alignment and let the local partners make those decisions on their own.

Ms. Mortell added that the Washington County partnership wouldn't be doing a regional health equity plan either. The reason is: this is community to community. The goal, as Ms. Warren talked about it, is making a connection with communities in one's county for this work. We will find, as Ms. Thalsofer mentioned, that there are some things and pieces that counties do together and then they pull apart and go back to their community and implement, or work on, the work with their own community. Health equity is one of those.

Ms. Tiel thanked Ms. Warren and Ms. Amrhein and stated that the presentation was a little opposite of the PHAB conversation around partnership with assessments on the CCOs and wanting those to be shared and aligned. But then, some pieces are hyperlocal. Some pieces are regional. It's interesting that we keep the dynamic going. It's exciting.

Incentives and Funding Subcommittee

Akiko Saito

Ms. Saito remarked that the presentation from Ms. Warren and Ms. Amrhein was the perfect segue to this subcommittee update. In terms of Dr. Savage's question from earlier in the meeting about the LPHA investments and local system capacity, we can see on the funding formula model (shown on a slide) that we have a base component and different indicators

within the funding formula, as well as matching and incentive fund components, which had no numbers at the beginning.

Ms. Saito thanked Ms. Drum and Mr. Schindler for attending the last subcommittee's meeting and giving the subcommittee a sneak preview of what they talked about today. We are at that piece, and Ms. Drum's and Mr. Schindler's work has been around figuring out what those numbers are going to be. The subcommittee needed to have a base number that would be used in the future.

Ms. Saito thanked Ms. Thalhofer for her earlier comment. That's why the Incentives and Funding Subcommittee brought the funding formula discussion to the PHAB.

Ms. Saito explained that the subcommittee was charged with looking at how we would recommend spending. The information brought to the PHAB before was that if OHA received up to the \$5 million funding to LPHAs, because, again, we don't know what the actual money is going to be until June 30, 2019. The subcommittee was building scenarios and discussing them. The subcommittee wanted to continue the LPHA partnerships that are currently being funded, because the subcommittee didn't feel that they had enough time to do the work that they were doing. That would help them, as they wouldn't have to go through a RFP process and spend time, but continue that work.

Dr. Schwarz asked if OHA would give the money to the same groups that we have now.

Ms. Saito answered that that was correct. That was what the PHAB discussed as a recommendation at the last PHAB meeting. Looking at funding between \$5-\$10 million, the recommendation was to provide base funding to all LPHAs, as well as use the initial \$5 million to shore off those cross-sectional partnerships that already have been going on. The focus of the last subcommittee meeting was on what to do if the funding for the LPHAs was about \$10 million. The subcommittee wanted to bring this back to the PHAB, because there wasn't enough LPHA representation at the meeting. Ms. Brogoitti was on the phone, but driving, and couldn't participate and give feedback. Dr. Dannenhoffer was out of the country.

Ms. Saito noted that the subcommittee had a couple of questions. If we are looking at funding above \$10 million, what are some of the things that we want to do? As Ms. Thalhofer mentioned, we didn't want to lose the momentum of some of the cross-sectional projects that were happening and also didn't want to deincentivize any cross-jurisdictional partnerships that might be happening if we ended up just doing it fully to the funding formula. The subcommittee discussed that when we initially did the funding formula, we only built in the matching incentives piece. We didn't look at whether we would consider giving some incentives for some cross-jurisdictional partnerships or some really interesting creative systems approaches. For instance, sharing a CD capacity among regions. The subcommittee didn't want to make any major decisions but wanted to have this discussion at the PHAB meeting.

Ms. Saito added that the subcommittee had three questions that it wanted to pose to the PHAB, and specifically to Ms. Mortell and Ms. Thalsofer, as they were the two LPHA representatives at the meeting: (1) If OHA receives a funding amount that results in \$10 million or more allocated to LPHAs, how can we use the funding formula to encourage LPHAs to continue the partnership work, while also allowing flexibility for areas of the state that do not wish to continue the LPHA Partnership or wish to use a different model? (2) How can we use the funding formula to incentivize cross jurisdictional sharing and new service delivery models that strengthen the public health system? (3) If OHA receives a funding amount that results in \$10 million or more allocated to LPHAs, would PHAB consider directing some of those funds to partnerships, cross jurisdictional sharing, and new service delivery models, with the remainder going to all every LPHA through the funding formula?

Ms. Saito stated that, at this point, if we do receive more than \$10 million, the initial idea was that anything above \$10 million would just go out in the funding formula. It wouldn't be kept for the cross-jurisdictional projects.

Dr. Luck drew the attention of the PHAB to a few numbers on a colored Excel slide. His recollection of the subcommittee discussion was that if OHA got up to \$7 million, about just less than \$2 million would be allocated to individual health departments based on the floor level, ranging from 30K for the smallest counties to 90K for the largest counties. That takes about \$2 million, and then continuing full funding through the biennium to the existing partnerships would be about \$5 million. That totals up to about \$7 million. The question the subcommittee wrestled with was: If the total funding went over \$10 million, and we reverted back to the funding formula, would we just distribute all of the \$10 million based on the columns on the table (i.e., floor, plus burden of disease, plus health status, etc.), or would we continue some funding for the regional partnerships and distribute some according to the funding formula? The subcommittee couldn't make a decision without asking the PHAB.

Ms. Thalsofer shared that she felt awkward, because she didn't think she and Ms. Mortell could speak for all of the LPHAs. One of the things that LPHAs have done, which was asked of them in the cross-jurisdictional work, was that they have created stronger relationships with other county partners. If the deliverables stay around CD, epi, and equity, the majority of the partners in the Central Oregon coalition may well say, "Okay, we'll take our county money for this work and we will decide to invest in the team that we've already created." Because that will make sense for us. Because there is economy of scale with all of us tiny little counties. But that would be LPHAs' decision with the LPHA money that comes through the funding formula. Some of other partners who say, "Well, we did this. It didn't exactly work. We want to stay around X, but not Y." They'll be able to take their money and decide what they are going to do with it. The large counties already do a lot of cross-jurisdictional sharing where it makes sense, and the small counties share where it makes sense, and some of the small and large counties share

where it makes sense. The LPHAs have shown over and over again that they can be trusted to make the investments where locally they know that it makes sense for them.

Ms. Thalhoffer added that the funding should be rolled out through the funding formula without moving to other areas until there is a significant increase, and then the LPHAs should be allowed to decide whether to spend it collaboratively or spend it individually, based on how the first 18 months have gone.

Ms. Mortell remarked that we have wrestled with this across the 36 jurisdictions and we all have different opinions, but one of the things is that giving a county \$90,000 for 800,000 population, what can a LPHA do? It won't be able to do anything. We have to get to that significant investment in each county to be able to say that we are modernizing. We've done a project. We've done some good work. We've built relationships. We will continue those relationships. But we do have to figure out how to invest significantly in each of the counties. It could be that the counties decide that a significant investment comes together with sharing. At the CLHO meeting this morning, there was a discussion about whether to do different models, but we don't know if those models work either. We need to learn from others. Talk to Washington state about some of the novel models that they are trying and what's been working and what was the outcome, before we invest in more unknowns.

Ms. Thalhoffer cautioned the PHAB about taking hers and Ms. Mortell's comments as the local public health view point.

Dr. Luck asked if the CLHO was planning to discuss this.

Ms. Mortell answered that the CLHO talked about scheduled webinars to try to gather some information. She asked if the state would be leading those webinars. The CLHO can't lead those because the CLHO is busy in legislation.

Ms. Beaudrault stated that OHA would need to consult with the CLHO on this.

Dr. Schwarz noted that, in a month in a half, we would know what resources we are getting. All the preparatory work is done. We should wait and see what funding we are getting and make a final decision at that stage. We don't want to act on a hypothesis. If we are so close to an actual solution, let's wait. We should know around the next PHAB meeting.

Ms. Thalhoffer informed the PHAB that each of the projects was asked to submit a 3-month workplan and a 3-month budget for bridge funding. The LPHAs are doing what they can until they all know what the funding is. She told her budget committee this year that this was the most made-up budget that she's ever presented. She has no idea what in it will come true and what will not. The budget may need more budget adjustments than they have time for. There is the least tangibility to her LPHA's budget that she ever presented, because there is so much

up in the air. Some of the partners have had to issue layoff notices because of their structures. That's not going to change by a decision by the PHAB today. It's going to change when we know what's coming in the budget.

Ms. Mortell added that we are also having this conversation with tobacco. There is a whole new plan strategy for how Washington County might fund tobacco in the county. She warned her director and the commissioners that she could have significant reductions of staff, but she doesn't know.

Ms. Saito reminded that PHAB that the board was not going to try to make a decision today. There was no vote. The subcommittee wanted to bring this to the PHAB, because it didn't have enough people to discuss this with at its last meeting. Everybody's feedback is appreciated.

Ms. Tiel remarked that the PHAB got a good direction and good guiding principles around the intent of using the funding. There is a lot that we can do after we know for sure. It is clear that the bridge piece is really challenging but considering that the PHAB doesn't have to take an action today, we feel a lot better.

Ms. Thalsofer asked the PHAB to remember the bridge piece, which none of the members really think about until now, when we are getting closer to the end. If we do get \$10 million, we should start to think about when this becomes funding that the LPHAs can count on and get some clarity around that. She told her staff that everything in the financial agreement was always up for grabs. She expects her LPHA to get some money for immunizations and maternal child health and tobacco. We need to start to think about how we can make this the standard of what Oregon does.

Ms. Tiel stated that the intent is to use the funding as infrastructure dollars. When we have the infrastructure dollars, there is a flexibility built into it for LPHAs to implement and maintain. As the PHAB, we understand the system that we are marching towards. We've done a really good job during the last biennium in demonstrating the success of what a little bucket of money can do to bring us the infrastructure and flexibility, but there is still lacking infrastructure. Hopefully, the PHAB has done its job in demonstrating what it can do with a little bit of infrastructure, but the bigger infrastructure dollars are needed.

Public Comment Period

Ms. Tiel asked if members of the public on the phone or in person wanted to provide public comment. No public comment was provided.

Closing

Ms. Tiel thanked the PHAB for their time and adjourned the meeting at 4:47 p.m.



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

**June 20, 2019
12:30-3:00 p.m.
Transportation Building
Room 340 – Steven H. Corey
355 Capital Street NE
Salem, OR 97301**

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Krasimir Karamfilov at (971) 673-2296 or krasimir.karamfilov@state.or.us. For more information and meeting recordings please visit the website: healthoregon.org/phab

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
August 9, 2019
12:00 p.m. – 1:00 p.m.

PHAB members present: Carrie Brogoitti, Akiko Saito, Dr. Bob Dannenhoffer

PHAB members absent: Dr. Jeff Luck, Alejandro Queral

Oregon Health Authority (OHA) staff: Sara Beaudrault, Cara Biddlecom, Krasimir Karamfilov

Welcome, introductions, and updates

Ms. Beaudrault introduced the meeting. She noted that, since the last subcommittee meeting, the legislative session ended with a very positive outcome for public health modernization investments. The focus of today's meeting was to show subcommittee members how the funding for the next biennium would be allocated, based on their collective recommendations.

A quorum was present. Dr. Dannenhoffer made a motion to approve the meeting minutes from the meeting on June 17, 2019. Ms. Brogoitti seconded the motion. The subcommittee approved the meeting minutes unanimously.

Modernization funding for 2019-2021

Ms. Biddlecom reminded the subcommittee that OHA received an additional \$10 million from the Oregon legislature to continue to advance public health modernization in the 2019-2021 biennium. This funding brings the total up to \$15 million. These resources will be used to build on the existing investment from the 2017-2019 biennium and position the public health system to fully achieve the goal of public health modernization, which is to ensure that all public health services are available to every person in Oregon.

Ms. Biddlecom remarked that OHA has been working to frame out what the local public health modernization investment would be, using the PHAB's funding principles and this subcommittee's discussion from the meeting on June 17, 2019. Other major inputs for the budgeting process have been the Public Health Modernization Manual and the 2016 Public Health Modernization Assessment.

Ms. Biddlecom noted that as OHA started to frame out the investments for this biennium, we have been in a place of being able to build on what we had started in 2017 and trying to think systematically about how the public health system can be better positioned to fully implement all of what we want to see for public health modernization in subsequent biennia. OHA has tried to fold some really important work around leadership and governance throughout the funding that OHA is going to be putting out.

Ms. Biddlecom stated that the overall budget is broken out into three categories: \$10 million is going to local public health authorities; \$1.2 million has been allocated to federally-recognized tribes and NARA; \$3.8 millions will be retained by the OHA Public Health Division (PHD). One hundred percent of the Public Health Division investment is going to support the public health system and targeting some important state public health roles that support local and tribal public health, as well as other partners. The target areas include: health equity and cultural responsiveness, leadership and organizational competencies, assessment and epidemiology, and communicable disease control and environmental health.

Ms. Biddlecom explained that under health equity and cultural responsiveness, the PHD will use funding to retain a short-term health equity coordinator position that helped the health equity efforts at the PHD. The position will support implementation of the health equity plans at the local level going forward. Under leadership and organizational competencies, the PHD investment includes support for learning collaboratives that both LPHAs and PHD will co-participate in to figure out how to advance public health modernization and identify the structures needed to move forward in subsequent biennia. Under assessment and epidemiology, a large section of the PHD investment is going to data collection and reporting, including different ways to make data accessible and more easily used by partners at the local level. The PHD will also invest in the evaluation of the use of these funds and collect and report accountability metrics, which the PHD is legislatively required to do. Under communicable disease control and environmental health, the PHD will hire an additional position to help provide surge capacity to LPHAs on communicable disease control issues, as well as a new staff role that will be able to help identify and work with communities to look at environmental health threats and be a bridge between acute environmental health impacts on health and how we monitor and plan for those using our communicable disease control and preparedness systems.

Dr. Dannenhoffer asked what the additional staff at the PHD would be. Are people who are currently there going to be transferred to this program, or will the division hire new people? What is the plan?

Ms. Biddlecom answered that of the three positions she specifically mentioned, one has been in a limited-duration capacity since 2018. It's the health equity coordinator position. The other two positions under communicable disease control and environmental health will be new and people have not been recruited yet.

Dr. Dannenhoffer remarked that, looking at the money, those hiring expenses would not come close to \$3.8 million. Are there other kinds of expenses there?

Ms. Biddlecom asked if Dr. Dannenhoffer meant under communicable disease control and environmental health.

Dr. Dannenhoffer clarified that he meant under anything. The overall story is that the \$3.8 million that the subcommittee budgeted was for so many FTEs and so much programmatic stuff. Do we have that kind of budget set out?

Ms. Biddlecom answered that the PHD will share more details on positions and contracts when the information is available. The PHD is also in the process of finalizing its budget, just like LPHAs will be doing in the coming months.

Dr. Dannenhoffer stated that from a county point of view, where they have to do the budget down to the penny, and the local public health people don't get to see what the state is spending, it seems a little bit incongruous. The PHD can do itself a great favor by publishing its budget, just like LPHAs need to publish their budgets.

Ms. Biddlecom answered that the PHD would get more detail out as the budget is finalized.

Ms. Beaudrault noted that in terms of connecting the funding to the work of this subcommittee, the funding will go out according to the PHAB recommendations for use of funding. For funds to the LPHAs, we hit the \$10 million threshold, which kicks on the funding formula. The subcommittee discussed funding at this level at a couple of different meetings, thinking about how to continue to support the regional partnerships, as well as get funding out to all LPHAs through the funding formula. Upon the subcommittee's request, we heard feedback provided by local public health administrators at the meeting in June. As soon as legislative session wrapped up on June 30, 2019, OHA started working with the Joint Leadership Team, which is comprised of CLHO executive leadership and PHD leadership, to take these recommendations and start operationalizing them.

Ms. Beaudrault added that the Joint Leadership Team developed a process and timeline for implementing PHAB's guidance and, ultimately, decided to allocate \$3 million of the \$10 million available to LPHAs for regional partnerships, with the remaining \$7 million allocated to LPHAs through the funding formula. Some of the things that the Joint Leadership Team used to make that decision included looking at the budgets for the regional partnerships and trying to understand the nature of the regional work and the most successful aspects that they wanted to see funded, reviewing the evaluation to understand successes and challenges in the regional partnership model, as well as going back to the information that's been provided by local administrators about what they see as the successes and the work that needs to continue.

Ms. Beaudrault remarked that, in terms of the \$3 million, funds are available and funding to existing regional partnerships will be prioritized. OHA understands that some regional partnerships might want to change configurations by either adding new counties, possibly some counties would step out of the partnership. There is possibility that we'll see some new regional partnerships interested in funding as well.

Ms. Saito stated that the \$3 million is for the biennium, which comes to \$1.5 million per year. That's a little bit different than what LPHAs have had. How will this determination be across the board? Will each regional partnership get the same percentage it got before? Does the subcommittee need to help in making that decision?

Ms. Beaudrault answered that the Joint Leadership Team looked at the budgets for the regional partnerships and parsed out what within these budgets is truly regional work, and what was work that went out through that model but was really work sitting within an individual county. They were able to narrow in on this \$3 million by doing that. Three million is a good target to hit, in terms of continuing the truly regional aspects of the work that happened in the last biennium.

Ms. Saito asked if the Joint Leadership Team had already decided where that money is going to go for the different partnerships.

Ms. Beaudrault answered that the Joint Leadership Team had not decided. Regional partnerships will submit proposals telling OHA what they want to do and give an estimated budget later in August. That would allow OHA to see how close it is to hitting the \$3 million mark. In terms of the work, the requirements are largely not changing for the regional partnerships. The funding requirements that were in place are mostly the same and will allow the regional partnerships to continue what they put into play and allow the work to evolve and progress. One thing we'll expect to see is that the partnerships implement components of the health equity plans that were developed in the previous biennium.

Ms. Beaudrault showed a slide of the distribution of the \$7 million funding going out to individual LPHAs based on the funding formula. This is a big deal. The subcommittee has been working on the formula since 2016 and the formula is being used for the first time in 2019. The funding formula breaks counties into groups, based on population size. This gives an idea of the range of funding that different county population size bands will receive. We built the funding formula to keep the floor funding in place. Those floors were set by this subcommittee a couple of years ago with an expectation that not dropping lower than these floors gives each county something that they can be working from.

Ms. Beaudrault pointed out that in terms of the required work for all LPHAs, the requirements will be bucketed into three areas. Communicable disease control and health equity and cultural responsiveness are not new. This gives LPHAs that have been participating in regional partnerships, or will, an opportunity to think about how the work within their own county connects with the regional efforts. There could be some nice synergies there. Leadership and governance was the body of work Ms. Biddlecom was referring to earlier around some system-wide planning work, understanding that the legislature's expectation is to see that we are using this investment to make some sustainable system changes over the course of the biennium and strategically using funds to do the planning work for full implementation of public health modernization over time. While LPHAs will have requirements to be doing this work, the state

is also using funds to support this work. We are hoping this sets us up for some nice opportunities to think about the work that needs to happen locally, as well as what we can all be working on together statewide.

Ms. Beaudrault noted that, considering the funding formula, the extra small counties and small counties are receiving a fairly small amount of funding for the biennium compared with the extra-large counties. That was a concern of this subcommittee to think about whether the funding through the funding formula was equitable for all LPHAs. That's another question that the Joint Leadership Team has been thinking about. Their recommendation was to build the structure for the funding requirements for LPHAs around a menu concept, where instead of every LPHA having the exact same requirements and doing the exact same work, the menu concept will allow LPHAs to select objectives and strategies that are most relevant to the needs and priorities within their own county, and then to tailor their work plans to the level of work that makes sense for the level of funding that they are receiving.

Ms. Saito wondered if the menu options leadership and governance and health equity and cultural responsiveness were foundational capabilities and communicable disease control was a foundational program, where was emergency preparedness? Are we trying to mix and match, or are we trying to focus on foundational capabilities first and then programs? It seems odd to have two capabilities and one program.

Ms. Beaudrault responded that the team hadn't thought about it in that way. Leadership and governance is not the entire foundational capability around leadership and organizational competencies, although it is very similar. One thing we have learned is that even though we list out foundational capabilities like this, the reality is that the foundational capabilities are interconnected, and we are not doing health equity without doing the community partnership work and, similarly, we are not doing communicable disease planning work without bringing in emergency preparedness.

Ms. Saito noted that she would love to see that called out and have CD as part of that. If we put leadership and governance, health equity and cultural responsiveness, and emergency preparedness, that covers communicable disease control, as well as environmental health. It leaves the menu more open for people to do stuff. The emergency preparedness section at PHD doesn't get any general funds, and at the local level they are not getting general funds for emergency preparedness either, which includes CD.

Ms. Beaudrault explained that all LPHAs are required to participate in learning communities focused on governance. OHA doesn't have all the details about what it would look like to be doing local or statewide work focused on governance. We will be having those conversations with the Joint Leadership Team and local administrators over the coming weeks and months to identify the areas that we want to focus on collectively. Under the menu items for leadership and governance, each LPHA will choose from one of the buckets of work: planning for full implementation of public health modernization (i.e., thinking about the infrastructure to make

sure that the foundational capabilities are solidly in place that can be applied to any emerging threats or population health priorities), developing or enhancing partnerships to build a sustainable public system (i.e., healthcare and all sectors that are part of a public health system); implementing workforce and leadership development initiatives; developing and implementing technology improvements. LPHAs are not expected to do all of this work, but to select one area that is most relevant to a county's needs and priorities.

Ms. Beaudrault remarked that in terms of health equity and cultural responsiveness, most LPHAs that participated in a regional partnership had completed a health equity assessment and have an action plan. The work will be around implementing those action plans. The action plans that the regional partnerships developed are very robust. Some of them include very large bodies of work that will happen over an extended period of time. The requirement here will be for LPHAs to select specific areas of their health equity action plans that they want to prioritize with funding. Based on feedback from the Joint Leadership Team this week, the requirement will be to make sure there is at least one objective focusing on work that happens within the health department (e.g., staff training, workforce development around health equity, policy development), as well as work happening external to the health department (e.g., partnerships, working directly with communities, doing things differently with public health data to make sure that it is available to groups within the community that need to use it).

Dr. Dannenhoffer asked that in building these community partnerships, some of the partnerships are very specific on an equity issue or a housing issue, but some a bit broader. Is this requirement going to give counties the ability to be a bit broader? For example, there is a group in Douglas County that does housing and nursing among other things – will this be broad or narrow to communicable disease and health equity?

Ms. Beaudrault answered that this would be broader. The Joint Leadership Team wanted OHA to make sure that it gives LPHAs the exact level of flexibility that Dr. Dannenhoffer was talking about.

Dr. Dannenhoffer added that it was important to call it out because, in small communities, people are usually doing a bunch of things at once.

Ms. Beaudrault stated that for LPHAs that didn't have an assessment and action plan, that would be their focus for the first year or so of funding. Then they will move into implementing the plan for the remainder of the funding period. For communicable disease control, each LPHA will need to have an objective in their workplan around conducting jurisdiction-specific communicable disease control or prevention activities with a focus on developing infrastructure. This involves looking at the communicable disease needs and priorities and identifying a need to focus on. The overarching focus is on developing infrastructure. Selecting communicable disease needs gives an anchor for the work, but the intention is to be developing the partnerships, or doing the systems development work to prepare each LPHA to have stronger infrastructure around communicable disease control and response. Additional menu

items here are around working with partners, workforce development, and utilizing communicable diseases investigation and emergency preparedness systems to begin planning for environmental health threats.

Ms. Beaudrault noted that in terms of the funding for the tribes, OHA is working with tribal partners now to develop a concept for how funding will be used and what their priorities are for that funding. We anticipate that some funds will be used to support tribes that have not completed a tribal modernization assessment to complete an assessment, and then begin working on planning based on their assessment results. For tribes that have completed an assessment, OHA will likely be supporting them to make updates and start doing the planning work and implement. We anticipate that there may be some contractual work as well to support the federally recognized tribes and NARA in doing that work.

Ms. Saito asked if any of the tribal public health funds for doing the modernization assessment would come from the state pot.

Ms. Beaudrault answered that the funds would come from the tribal pot of \$1.2 million.

Ms. Saito reiterated having the communicable disease control bucket be emergency preparedness with having still the same menu options. It would bring us up to a more system-level approach. The goal is to build the foundational capabilities first and have them solid and then the programs underneath.

Ms. Beaudrault shared that, for her, one of the biggest learnings over the last couple of years has been how to lead with the foundational capabilities. She asked the subcommittee members whether the funding approach was consistent with the direction the subcommittee provided and what level and type of information the members would like to be brought back to the subcommittee when it reconvened.

Dr. Dannenhoffer admitted that the division of the funding was slightly different than what he thought. He thought that more funding would go to the LPHAs, less to the regional partnerships, so that the LPHAs would use their own staff to do this work. He understood that the split had to be made somewhere.

Ms. Saito pointed out that the Joint Leadership Team was most likely part of that discussion and they must have felt comfortable with that split, which made Ms. Saito feel comfortable because many people talked about it.

Subcommittee business

Ms. Beaudrault informed the subcommittee that the PHAB has a meeting on August 15, 2019. Ms. Biddlecom will do an overview of the legislative investment for the full board. There is no

need for a subcommittee update unless the subcommittee members would like to provide something specific from the subcommittee.

Ms. Saito remarked that the Incentives and Funding Subcommittee has been a great subcommittee. That would be her update.

Dr. Dannenhoffer seconded Ms. Saito's remark.

Ms. Beaudrault agreed that it was a pleasure to work with the subcommittee. There have been some challenging conversations this year, but she hoped the subcommittee members were happy with where things landed. The positive is that, going into the next session, all signs point to continued support for public health modernization and additional funding. The legislative session ended with a very positive outlook. That is exciting.

Ms. Beaudrault added that unless there were other needs, this subcommittee was on hiatus for the next few months. Sneak preview for PHAB later this fall, there will be an opportunity to think about the subcommittees and what they want to be working on to get into the system change work and have some exciting bodies work on their horizons. Subcommittee members are encouraged to start thinking about things that they would like to see the subcommittee engage in moving forward.

Public comment

Ms. Beaudrault invited members of the public to ask questions and provide testimony.

There was no public comment.

Closing

Ms. Beaudrault adjourned the meeting at 12:42 p.m.

OHPB Committee Digest

PUBLIC HEALTH ADVISORY BOARD, METRICS & SCORING COMMITTEE, HEALTH PLAN QUALITY METRICS COMMITTEE, HEALTH INFORMATION TECHNOLOGY OVERSIGHT COUNCIL, HEALTHCARE WORKFORCE COMMITTEE, HEALTH EQUITY COMMITTEE, PRIMARY CARE COLLABORATIVE, MEDICAID ADVISORY COMMITTEE, STATEWIDE SUPPORTIVE HOUSING WORKGROUP, MEASURING SUCCESS COMMITTEE

Public Health Advisory Board

In June, the Public Health Advisory Board held its meeting in conjunction with the Oregon Transportation Commission, at the Commission's invitation. The meeting focused on a conversation between the Board and the Commission discussing the intersection of transportation, public health, and social equity. The workshop was facilitated by Charles Brown, a national leader in the intersections of health, social equity, and transportation.

Transportation is essential to quality of life and the economic health of our state. The public's health (population health) is shaped by social determinants of health, including experience of adversity, trauma and toxic stress; institutional bias; access to stable housing; living wage jobs and having enough healthy food to eat. The work ODOT leads in Oregon connects people with the resources and opportunities they need to find meaningful work, keep their children in school, and access enough healthy food while maintaining stable housing and supporting people to increase their physical activity. The work contributes to Oregon's population health goals. ODOT and OHA-PHD have a signed memorandum of understanding that structures the work done between the two agencies.

The boards discussed that data from both the health and transportation spheres describes severe and persistent disparities in health outcomes, and access to best-practice transportation infrastructure – things like complete streets and accessible sidewalks. The Board and the Commission agreed to look more closely at how we measure the outcomes of our partnership, and the co-work that the agencies undertake and seek to address these disparities through our memorandum of understanding.

The Chair of the OTC, Tammy Baney, the PHAB Chair, Rebecca Tiel, requested that ODOT and OHA-PHD staff develop a set of suggestions for how the Board and the Commission can pursue work together, as well as a proposed cadence and purpose of ongoing dialogue between the Board and the Commission.

COMMITTEE WEB SITE: <https://www.oregon.gov/oha/ph/About/Pages/ophab.aspx>
STAFF POC: Kati Moseley, Katarina.Moseley@dhs.oha.state.or.us

Primary Care Payment Reform Collaborative

In July, the Primary Care Payment Reform Collaborative convened to discuss the next steps in the Primary Care Transformation Initiative. Lisa Dulsky Watkins, from the Milbank Memorial Fund provided a federal perspective on the future of primary care payment reform at the federal level. Additionally, Jeannette Taylor, from OHA provided highlights of legislation from the recent session impacting the work of the Collaborative.

OHA staff presented a draft workplan for the committee's input, and staff will be making revisions based on the feedback.

The Metrics, Technical Assistance, and Implementation workgroups provided updates of their work and received recommendations from Collaborative members to further advance their efforts.

The workgroups will continue to convene monthly except during the month the full Collaborative convenes. The next Primary Care Payment Reform Collaborative meeting will take place on October 8th, 2019, from 9am to Noon in Portland.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx>.

COMMITTEE POC: Susan El-Mansy, SUSAN.A.EL-MANSY@dhsoha.state.or.us

Healthcare Workforce Committee

The Healthcare Workforce Committee met on July 10. Key Items of note:

OHPB Updates:

Brenda Johnson provided an update on Board activity from June and July –including work on the Children's Healthcare Model and the Health Plan Quality Metrics Committee's process measures for 2020. Brenda noted that the July meeting was held in Pendleton and included a visit to Yellowhawk Clinic.

Primary Care Office Updates:

Marc Overbeck shared that 11 new sites were certified to become part of the National Health Service Corps, bringing the total in Oregon to over 350 whose clinicians may participate in federal loan repayment and scholarships. Many of the new sites offer Substance Use Disorder (SUD) treatment and will be able to participate in the new SUD Loan Repayment Program. Marc and his office are continuing to work on provider updates for the 99 Community Health Centers, Rural Health Clinics and Tribal Clinics whose HPSA scores will change later this year.

Presentation on Health Care Provider Incentive Program:

Joe Sullivan provided a summary of accomplishments and impacts of the first 18 months of the Health Care Provider Incentive Program, which began January 2, 2018. 83 providers have received loan repayment, including nearly 50 physical health professionals and 20 mental health professionals. Joe reported that primary care provider FTE has increased in six of the 16 lowest quartile service areas since the start of the program. It is estimated that more than 115 additional FTE years are able to be supported through these funds over the next three-year period. OHA will come back to the Board in October with further recommendations for allocating funds in the new biennium.

Presentation on HOWTO Grant Program:

Shelly Ziegler of OHSU provided an update on activity and results of the first year of the HOWT Grant Program, which OHSU is administering for the OHPB and OHA. Four projects are underway and an additional six have been funded to begin later this year.

Legislative Update:

Jeff Scroggin provided a session wrap-up for the Committee and led a discussion regarding workforce-related legislation and other major topics of the 2019 Legislature.

Other:

The Committee adopted a Conflict of Interest Policy for its members which is aligned with the Board Policy.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/HPA/HP-HCW/Pages/index.aspx>

COMMITTEE POC: MARC OVERBECK, Marc.Overbeck@dhsoha.state.or.us

Health Plan Quality Metrics Committee

At the July 11 meeting, the Health Plan Quality Metrics Committee (HPQMC) continued to focus on committee level-setting over the summer months (June-August). The July meeting was dedicated to committee orientation for new and returning members. Orientation included a general overview of HPQMC and essential committee materials, an overview of the primary stakeholders, and roles and responsibilities related to public meetings and public officials.

In the coming months, the committee will formally engage with its primary stakeholders with the purpose of enhancing collaborative opportunities and aligning priorities through measurement. The primary stakeholders are: Oregon Health Policy Board, Metrics and Scoring Committee, Public Employees Benefit Board, and Oregon Educators Benefit Board.

- August: Discussion with Oregon Health Policy Board and begin review of current measure selection criteria
- September: Measure users feedback panel, begin review of stepped (on-deck) measures, nomination of chair and vice-chair

The next meeting is Thursday, August 8, 2019 from 1:00pm – 3:30pm. To hear a recording of the meeting, visit the committee's website.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/analytics/Pages/Quality-Metrics-Committee.aspx>

COMMITTEE POC: Kristin Tehrani, Kristin.Tehrani@dhsoha.state.or.us

Metrics & Scoring Committee

At its July 19th meeting, the Metrics & Scoring Committee finalized the list of health care quality measures that will be included in the 2020 CCO Quality Incentive Program. These metrics will be the first set of pay-for performance measures included in the new CCO contracts beginning January 2020. The Committee chose to reduce the number of measures included in the program from 19 to 13. This included retiring 10 of the measures currently included in the program and adding four new claims-based measures.

Nine of the 10 retired measures are included in Oregon's Medicaid Demonstration agreement with the Centers for Medicare & Medicaid Services, and as such, the Oregon Health Authority continue to track and publicly report performance on these measures to ensure Oregon Health Plan members continue to receive high quality care.

Two of the new measures are part of a multi-year strategy focused on the health sector's role in preparing children for kindergarten (well-child visits for children ages 3-6 and preventive dental visits for ages 1-5). The other new

measures focus on immunizations for adolescents and ensuring those newly diagnosed with substance use disorders are able to access treatment.

This follows a six month process of reviewing the specifications and performance history of current and potential new incentive measures, evaluation of these measures against the Committee's [measure selection](#) and [retirement](#) criteria, and consideration of [recommendations](#) from the Oregon Health Authority, [direction from Governor Kate Brown](#), and public input in the form of a [stakeholder survey](#) and a significant amount of public testimony. The Committee will spend the next two months identifying targets for each of the measures included in the 2020 incentive measure set.

The full list of 2020 incentive measures is available [here](#), and information on the Metrics & Scoring Committee, including past meeting materials and copies of written public testimony, is available [here](#).

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>
COMMITTEE POC: Sara Kleinschmit, SARA.KLEINSCHMIT@dhs.oha.state.or.us

Health Information Technology Oversight Council

The Health Information Technology Oversight Council (HITOC) will be meeting on August 1, 2019. HITOC will hear brief updates on CCO 2.0, discuss next steps with its Strategic Plan for Health IT and Health Information Exchange, and discuss membership. HITOC will also cover the following in-depth topics:

HIT Commons Report

The HIT Commons is a shared public/private governance model designed to accelerate and advance Health Information Technology adoption and use across the state. It is co-sponsored by Oregon Health Leadership Council and OHA and responsible for overseeing two major initiatives: Oregon EDie/PreManage and Oregon Prescription Drug Monitoring Program (PDMP) Integration. The report is expected to focus on HIT Commons' maturity, challenges, and accomplishments.

Social Determinants of Health Update

HITOC will hear an update on the HIT Commons' exploration of an Oregon Community Information Exchange model, which could help connect health and social services to address the social determinants of health. The HIT Commons has been assessing the Oregon environment and share an update on its efforts. OHA will also provide a very brief update on OHA's ongoing social determinants of health work, with a more extended update to follow in a future meeting.

Behavioral Health Health IT Workgroup Report

HITOC will hear an update on the draft Behavioral Health Health IT Work Plan, including a draft timeline, based on recommendations from behavioral health representatives in HITOC's Behavioral Health Health IT Workgroup. HITOC chartered the group following OHA's Behavioral Health Health IT Scan, which was conducted by OHA's Office of Health IT in 2017 to gain a better understanding of the health IT landscape among behavioral health organizations, including their adoption and use of electronic health records (EHRs) and health information exchange (HIE).

Oregon Provider Directory Update

HITOC will hear an update on the upcoming launch of the Oregon Provider Directory (OPD) and watch a demonstration. The OPD is part of the Oregon Health IT Program, which is operated by OHA's Office of Health IT, with oversight by HITOC. OPD will give providers, hospitals, payers, Medicaid coordinated care

organizations (CCOs), and others in health care a single, trusted place to find and connect with providers. It will support care coordination, health information exchange, administrative efficiencies, and serve as a resource for health analytics.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/HPA/OHIT-HITOC/>
Committee POC: Francie Nevill, Francie.j.nevill@dhsosha.state.or.us

Medicaid Advisory Committee

The Medicaid Advisory Committee held a retreat on July 24 in Salem to welcome four new members, get acquainted, develop a shared understanding of the purpose and goals of the MAC, and begin strategy development and action planning for the next two years. The committee also heard presentations from Sarah Dobra and Ellen Pinney of the Ombuds Program; and met with Steve Allen, OHA's new Behavioral Health Director.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/hpa/hp-mac/pages/index.aspx>
COMMITTEE POC: Tim Sweeney, Timothy.D.Sweeney@dhsosha.state.or.us

Health Equity Committee

May meeting minutes were approved unanimously. There was no HEC meeting in June, but workgroups use that time to develop drafts of the work plan that would be presented in July.

Lori Kelley, OHA Social Determinants of Health Manager (HSD), presented an update on **the Housing Health-Related Service (HRS) Guide for CCOs**. In May, a draft version of the guide was circulated among the Health Equity members for feedback from a health equity perspective.

The HEC requested the addition of context around the role gentrification and displacement play in the housing crisis and associated health status. Definitions were added to appendices, and the impact of displacement and gentrification on health status was directly noted in the report

HEC requested more clarity around bridging gaps between existing funding streams for housing issues experienced specifically by disabled populations. Language around bridging benefits already covered by DHS and current Medicaid included was added with the caveat that HRS could not cover services already within a Medicaid plan.

HEC raised concerns about running detailed systems through CCOs instead of elevating and funding community partners to do the work directly. Since CCOs have ultimate decision authority on how and when to utilize HRS OHA cannot mandate what they fund and by what mechanism. However, these concerns were shared directly with the Transformation Center to consider within Technical Assistance and administration of the program. Draft of the Housing HRS Guidance Document will be finalized on July 15th.

The Policy, Capacity/Technical Assistance, and Recruitment workgroups provided an overview of their draft work plans. The full committee provided feedback. Work on the proposals will continue offline, and each group will have the opportunity to present a final work plan version in the following months.

The Recruitment workgroup presented a **final set of candidates** to fill the two HEC seats that were vacant and two more that opened due to member resignations. The candidates that were brought forward for approval included:

- Ashley Harding, Tribal Health Project Director, Umatilla County.
- Kate Wells, Director, Wellness and Community Health Strategy, Deschutes County.
- Deb Morrow, Real State Administrator, Clatsop County.
- Rakesh Gadde, Dentist, Klamath County.

The candidate slate was approved unanimously, and the next step is to present it to OHPB in their August meeting for confirmation.

The meeting also included a health equity definition work session. The window to provide feedback closed on July 5th. Several organizations and community members had the opportunity to weigh in on the definition. A smaller group of HEC member will reconvene offline with the mission of finalizing a draft definition and presenting it to the full committee at the August meeting. The expectation is that a final version of the definition will be approved and potentially resented in front of OHPB in September.

COMMITTEE WEB SITE: <https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx>

STAFF POC: Maria Elena Castro maria.castro@state.or.us

Statewide Supportive Housing Strategy Workgroup

The Statewide Supportive Housing Strategy Workgroups (SSHSW) Recommendations have been incorporated into the Oregon Housing and Community Services (OHCS) Five-Year Statewide Housing Plan (appendices document), released on February 11th, 2019. The report contains recommendations regarding principles to guide permanent supportive housing, recommendations to strengthen cross agency collaboration and coordination, recommendations to expand permanent supportive housing through new and existing housing and service resources and recommendations for training and technical assistance to build permanent supportive housing capacity.

OHCS Statewide Housing Plan: <https://www.oregon.gov/ohcs/pages/oshp.aspx>

COMMITTEE POC: Kenny LaPoint, Kenny.LaPoint@oregon.gov

Measuring Success Committee

The Measuring Success Committee of the Early Learning Council met on May 1. The committee completed its process of reviewing the proposed early learning system measures by mapping them across seven identified developmental domains, five sectors, and nine objectives of early learning system strategic plan, *Raise Up Oregon*. The committee determined that the proposed measures adequately covered the intended areas.

Over the course of the summer, staff will continue to document specific details of the measures and conduct a review to determine whether data can be analyzed by racial/ethnic groups. In addition, the ELD will consult with external stakeholders to conduct an equity review of the measures to determine potential bias in the measures. Further, a small workgroup will work in collaboration with OHA on the revision of the PRAMS-2 to

incorporate additional early learning system items. The committee is planning on submitting the measure set to the Early Learning Council in October for consideration.

COMMITTEE WEBSITE: N/A

COMMITTEE POC: Thomas George, Thomas.George@state.or.us

Firearm Safety

Injury and Violence Prevention

Falls Prevention for Older Adults

Firearm Safety

Keeping Children Safe

Prescription Drug Monitoring Program

Suicide Prevention

Contact Us

Public Health's Role

The Oregon Health Authority (OHA), through its [Injury and Violence Prevention section](#) in the Public Health Division, works to **prevent firearm-related deaths and injuries**, including suicide. The Public Health Division does this through data collection and tracking, and by collaborating with community, tribal, local, state, and federal partners.

Learn More



[Firearm Safety Tips](#)



[Firearm Data](#)



[Oregon Firearm Legislation](#)



[Resources For Clinicians](#)



[Additional Resources](#)



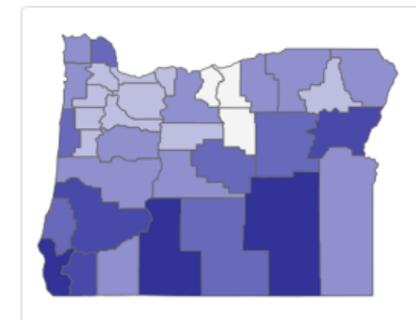
Crisis Lines

National Suicide Prevention Lifeline

1-800-273-8255

Featured Data

Firearm fatality rates vary by county, age group and intent.



2017 Firearm death rates by county

[\[View details\]](#)



2019-21 public health modernization investment



PUBLIC HEALTH DIVISION

Office of the State Public Health Director

Goals, objectives and inputs for the work

- Goal: Utilize state general funds to build on existing investment while positioning the public health system to ensure that all essential public health services are available to every person in Oregon.
- Inputs
 - Public Health Advisory Board (PHAB) funding principles
 - PHAB guidance on use of funds, June 2019
 - Public Health Modernization Manual
 - 2016 Public Health Modernization Assessment

\$15 million investment in public health modernization

- Continue and leverage the work that started in the 2017-19 biennium.
- Additional resources to continue putting public health modernization into practice and build a *public health system* for the future.

\$15M public health modernization legislatively-approved budget, 2019-21

- Funding to local public health authorities: \$10M
- Funding to federally-recognized tribes and NARA: \$1.2M
- Funding to the OHA Public Health Division: \$3.8M

OHA Public Health Division investment

- Targets the following areas:
 - Health equity and cultural responsiveness: Implements policy initiatives within PHD and implementation of LPHA health equity plans
 - Leadership and organizational competencies: Provides co-learning opportunities for PHD and LPHAs to identify new business models that advance public health modernization
 - Assessment and epidemiology: Expands data collection and reporting capacity, including data visualization; funds program evaluation and collection and reporting of public health accountability metrics
 - Communicable disease control and environmental health: Provides technical assistance to LPHAs and leverages the communicable disease response system to monitor and respond to environmental health threats

Local public health modernization investment

- \$3 million will be used to continue funding Regional Partnerships.
 - Funds will support regional positions, contracts, partnerships, and infrastructure that includes and benefits all counties.
 - Existing Regional Partnerships will be prioritized.
 - Existing Regional Partnerships can change configurations, and new Partnerships can also request funding.
 - The same definition of Regional Partnerships from 2017-19 will apply (two or more LPHAs and one partner).
- The remaining \$7 million will be allocated to each LPHA through the public health modernization LPHA funding formula.

Public health modernization investment to all LPHAs

- Includes requirements and menu options in three areas:
 - Leadership and governance
 - Health equity and cultural responsiveness
 - Communicable disease control

Leadership and Governance

- All LPHAs are required to participate in learning communities focused on governance.
- LPHAs must choose from one of the following menu items:
 - Developing a plan for full implementation of public health modernization
 - Developing and/or enhancing partnerships to build a sustainable public health system
 - Implementing workforce and leadership development initiatives
 - Developing and implementing technology improvements that support effective and efficient public health operations

Health Equity & Cultural Responsiveness

- Each LPHA must complete a health equity assessment and action plan.
- If the LPHA has already completed an assessment but does not have a plan, they must complete the action plan and select one additional menu item.
- If the LPHA has already completed an assessment and plan, they must select one or more additional menu items.
- LPHAs that have completed the health equity assessment may choose from the following:
 - Developing and/or enhancing partnerships
 - Co-creating strategies with communities
 - Staff training/workforce development
 - Collecting and maintaining data that reveal inequities and social conditions that influence health
 - Workforce diversity

Communicable Disease Control

- Each LPHA must conduct jurisdiction-specific communicable disease control and prevention activities, with focus on developing infrastructure.
- Each LPHA must select one additional menu item:
 - Work with partners on communicable disease control prevention
 - Workforce development
 - Utilizing communicable disease investigation and emergency preparedness systems to begin planning for environmental health threats

Tribal public health modernization investment

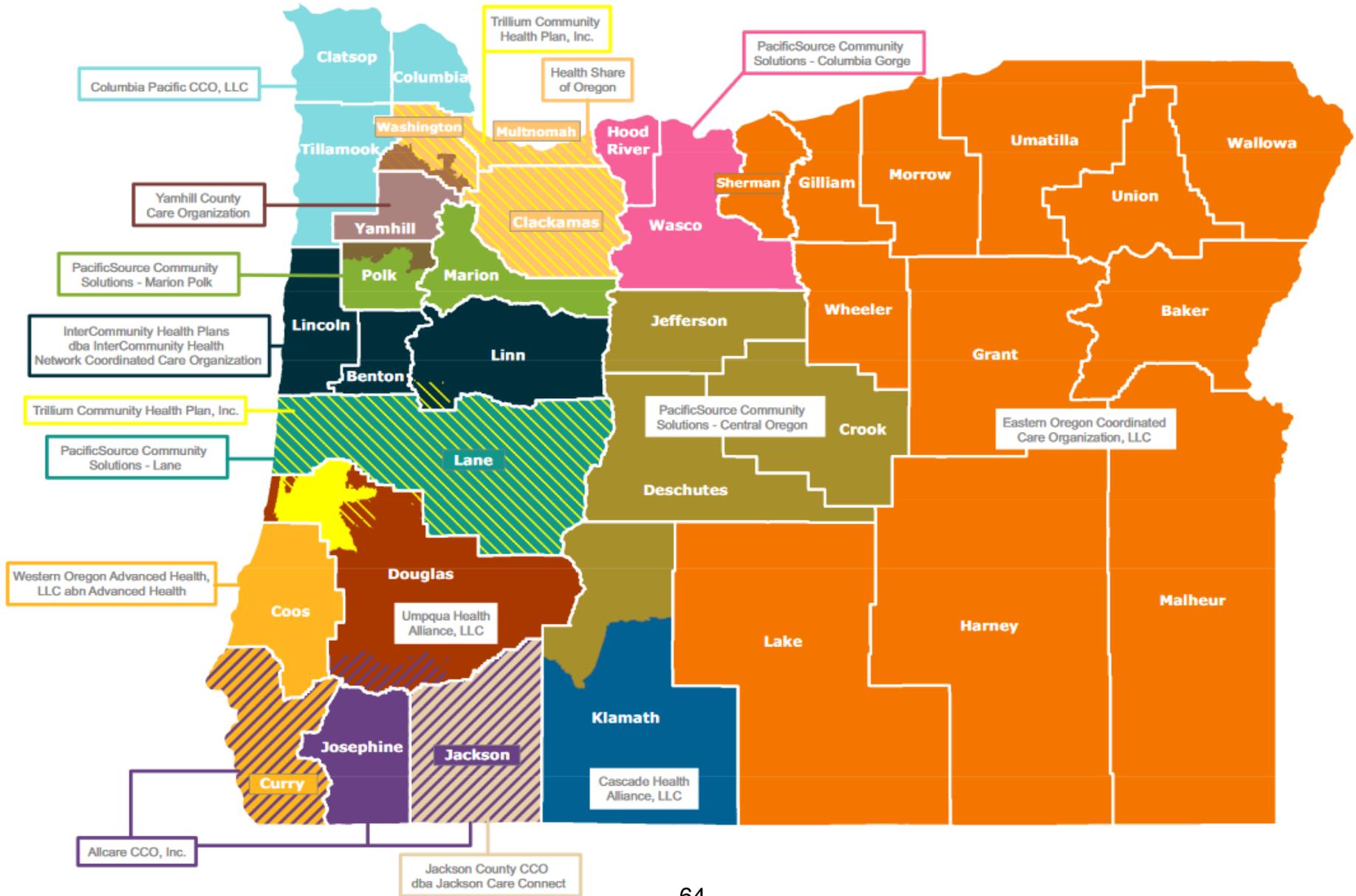
- Will support tribes that have not completed a public health modernization assessment in doing so, and moving towards planning.
- Will support tribes that have completed a public health modernization assessment in updating those and moving towards planning and implementation.
- Goal is to bring tribes that would like to be a part of public health modernization to the point of implementation by the end of the biennium.
- Collaborating with a tribal work group to develop scope of work and funding model

CCO 2.0 update



PUBLIC HEALTH DIVISION Office of
the State Public Health Director

Coordinated Care Organization 2.0 Service Areas



CCO 2.0 policy alignment with PHAB 2018 recommendations

- Include LPHAs in value-based payment strategies, including sharing payments for public health contribution toward incentive measures.
- Require CCOs to develop shared CHAs and CHIPs with LPHAs and hospitals.
- Require CCOs to invest in community health improvement plan implementation.
- Include the Oregon State Public Health Laboratory as an in-network provider for CCOs. (not a CCO 2.0 policy recommendation, but included in the 2020 CCO contract)

Include LPHAs in value-based payment strategies

New contractual requirements:

- *Contractor shall create a written distribution plan for Quality Pool and Challenge Pool earnings (that includes an overview of the methodology and information to help participating providers understand how they may qualify for payments). The distribution plan must be made publicly available. (Contract Exhibit B, Part 10)*
- *Contractor must offer correlative arrangements with Participating Providers (including Social Determinants of Health and Equity partners, public health partners, and other Health-Related services Providers as appropriate), providing monetary incentive payment arrangements with Providers that reflect priorities which align with the Quality Pool program for achieving the outcome and quality objectives.*

Require CCOs to develop shared CHAs and CHPs with LPHAs and hospitals

The Contractor, through its CAC, shall adopt a CHA and a CHP with responsibilities identified in OAR 410-141-3145 and in compliance with ORS 414.627 and ORS 414.626. This includes, but is not limited to developing a CHA and CHP that:

(3) Includes in the CHP at least two State Health Improvement Plan (SHIP) priorities, based on local need and the statewide strategies being implemented;

(4) Includes SDOH-HE partners and organizations, counties, THWs, and tribes in development of the CHA and CHP;

Require CCOs to invest in community health improvement plan implementation

Social determinants of health and equity spending programs plan must align with CCO community health improvement plans that are shared with local public health authorities and hospitals. (Exhibit K)

A portion of social determinants of health and equity spending program expenditures must go directly to SDOH-E partners for the delivery of services or programs, policy, systems change or any of these. CCO must enter into a contract with each SDOH-E partner.

Include the Oregon State Public Health Laboratory as an in-network provider for CCOs

- *Contractor shall include the OSPHL as one of the in-network laboratory Providers in their networks. Contractor shall reimburse the OSPHL for communicable disease testing Laboratory Services provided for Enrolled Members at the rate of the current Medicaid fee schedule for the date of service. (Contract Exhibit B, Part 4)*

Public Health Division Health Equity Work Group

Tim Noe,
Victoria Demchak



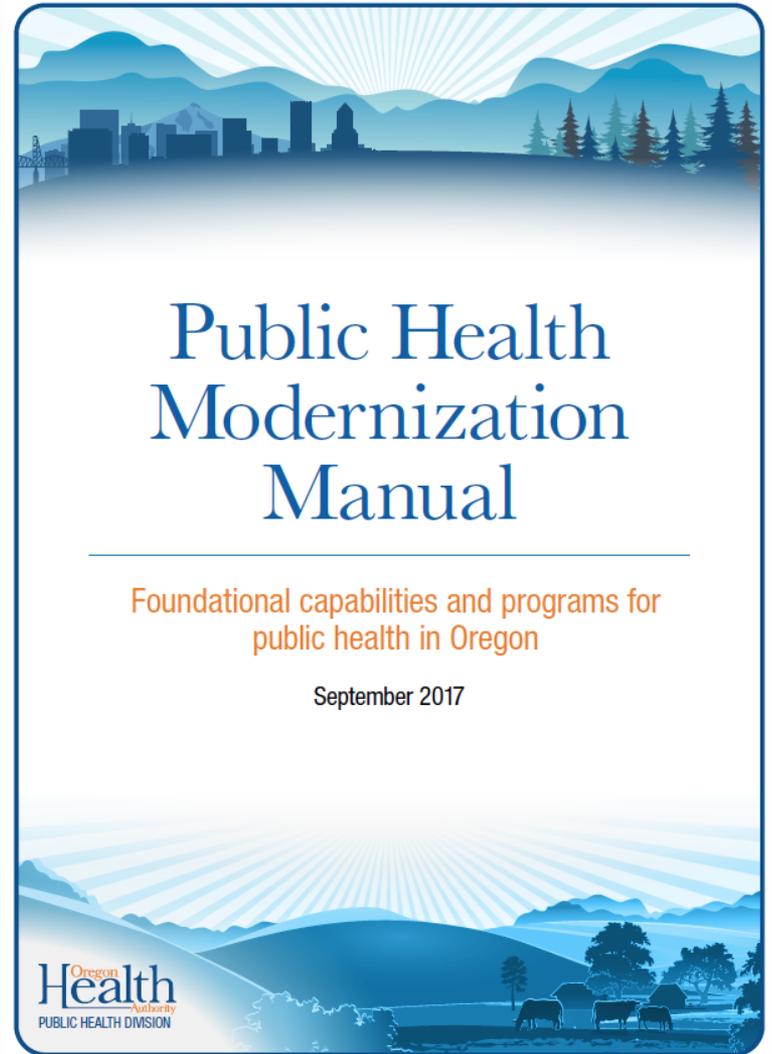
Overview

1. The PHD Health Equity Work Group
 - What we've done
 - What we're preparing to do
2. Investing in health equity this biennium
3. Discussion

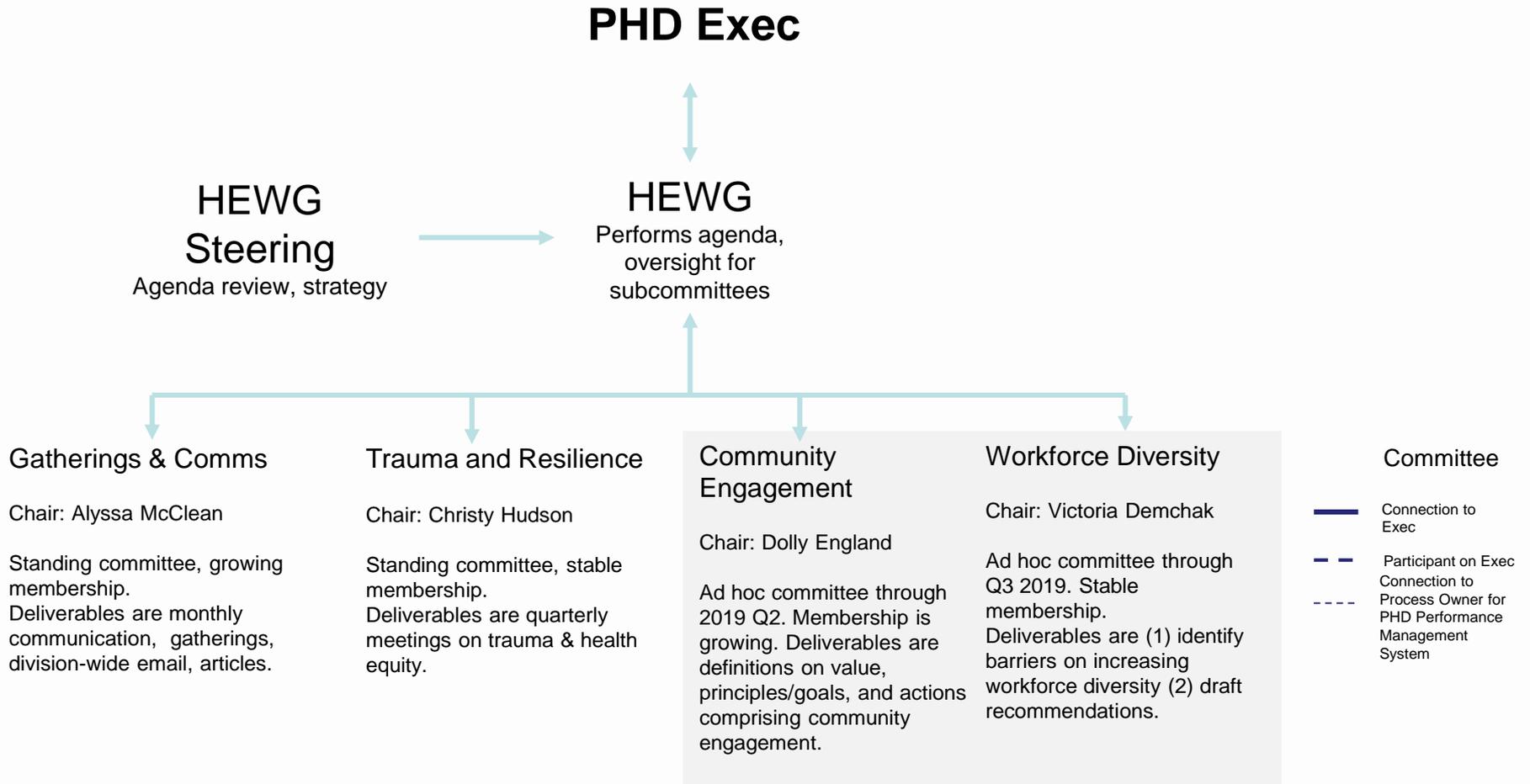
1. HEWG



Members Purpose



How we fit



Our work on health equity and cultural responsiveness

Last presented to this group in January 2017.

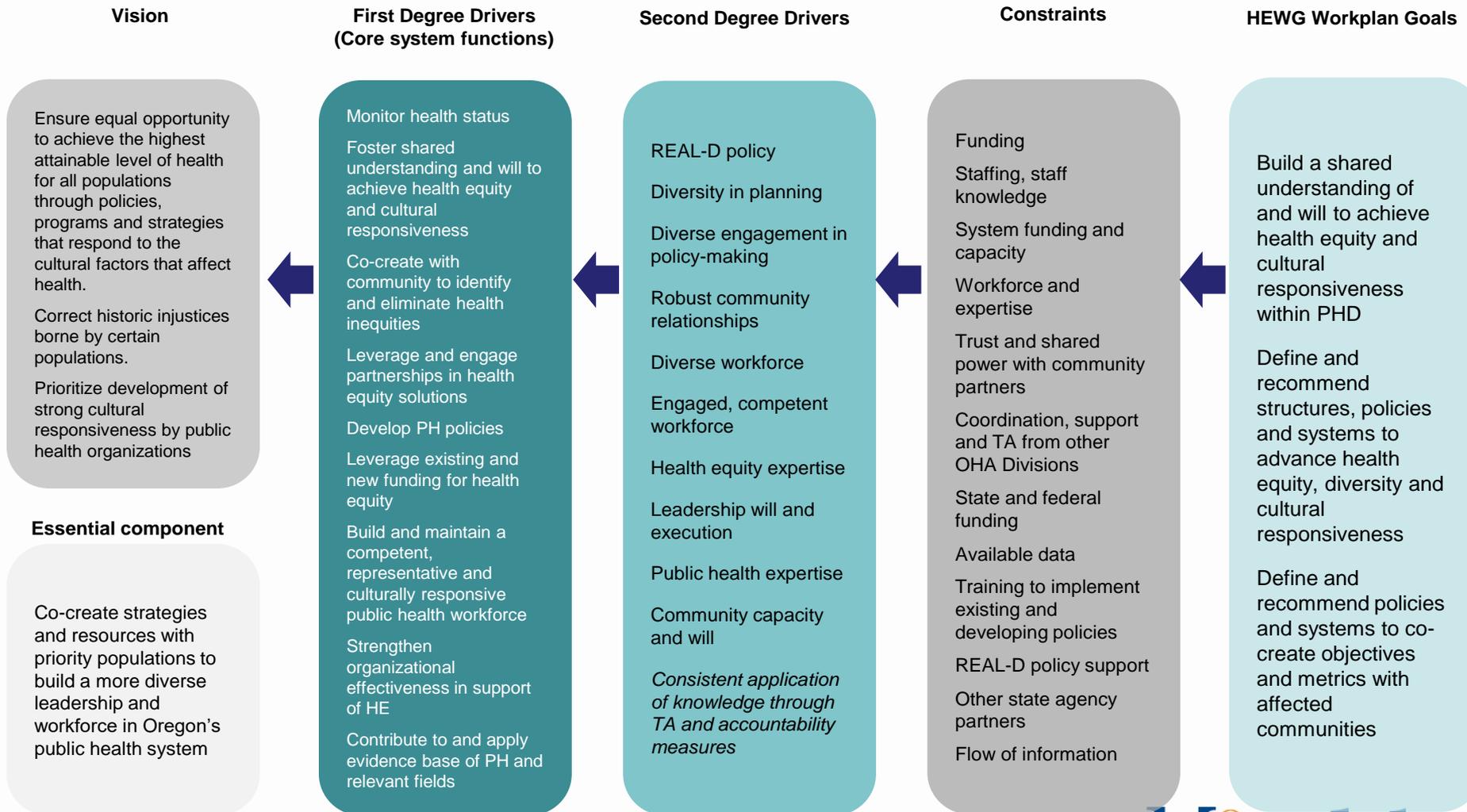
Goals:

1. Foster shared understanding and will to achieve health equity and cultural responsiveness in the division
2. Institutionalize necessary organizational structures, policies and systems to advance health equity, diversity and cultural responsiveness
3. Will recommend a plan to division leadership to co-create objectives, metrics and strategies for building a diverse workforce

Our work on health equity and cultural responsiveness: Past

- **Developing frameworks and structures for our work**
 - Charter
 - Workplan 2017-19 and 19-21.
- **Tools and systems**
 - [SDOH explainer video](#)
 - Inventory of SDOH measures
 - Communications channels on health equity work
- **Projects**
 - Monthly educational sessions, “Gatherings”
 - Quarterly forums on trauma-informed practices at the division
 - Recommendations on workforce diversity and community engagement

Driver Diagram: Health Equity Work Group (2018-19)



Outcomes so far

- SHIP process changes
- Increased awareness of the need for accessibility, workforce diversity, and trauma-informed practices throughout the division
- Increased practice of engaging community members and community organizations
- Focus on increasing the diversity of the division's board and commission members
- A model for division culture change efforts
- Other section and project specific projects

Our work on Health Equity and Cultural Responsiveness: Up next

- Develop and program ongoing educational opportunities for staff to learn and share (Gatherings)
- Identify linkages between health equity and cultural responsiveness with trauma-informed work
- Coordinate work across the division and recognize advances happening across the division
- Identify and track resources dedicated to health equity
- Support progress and projects on workforce diversity throughout the division
- Increase meaningful community engagement by recommending guidelines and building on successes

2. System health equity scope

Health Equity Plans

- Each LPHA must complete a health equity assessment and action plan.
- LPHAs that have completed the health equity assessment may choose from the following:
 - Developing and/or enhancing partnerships
 - Co-creating strategies with communities
 - Staff training/workforce development
 - Collecting and maintaining data that reveal inequities and social conditions that influence health
 - Workforce diversity

Discussion

2015-2019 State Health Improvement Plan

Prevent deaths from suicide



OFFICE OF THE STATE PUBLIC HEALTH DIRECTOR
Public Health Division

Key Questions

- How do we ensure suicide prevention is woven into the new SHIP priorities?
- How can we more effectively engage populations at highest risk: Native Americans, older white men, veterans?
- How can suicide prevention tie in with efforts on opioid, alcohol and other drug use as well as other aspects of the overdose syndemic?

Suicide

Priority Targets

Measure	Baseline	2017	2018* (preliminary)	2020 Target	Data Source
Rate of suicide	18.7 (2014)	19.0 (2017)	20.1	16.0 per 100,000	CDC WISQRS
Suicide attempts among 8 th graders	7.9% (2013)	8.7% (2017)	NA	7%	Oregon Healthy Teens Survey

*2018 Preliminary Data: Crude rate 20.1 (2017: 19.9). Oregon Healthy Teen Survey data conducted in odd years.

Point #1

Suicide rates continue to move in the wrong direction.

Suicide rates have increased among all age groups over the past 20 years. Since 2011, rate increases were mainly among youth aged 10 to 24 and older adults aged 65 years and older.

Non-Hispanic white (19.8) and Non-Hispanic American/Indian/Native Alaskan (19.3) have higher rates of suicide than other races and people with Hispanic ethnicity.

Non-Hispanic white males (31) have the highest suicide rate among all races/ethnicity.

Point #2

Currently there is limited public health capacity or funding to comprehensively address the problem of suicide.

There have been significant investments in youth prevention (10-24 years of age) in recent years.

Point #3

What policies can make a difference?

Directly addressing suicide through the healthcare system.

Firearm safety work is needed for significant movement. More than half of people who died by suicide were due to firearm injury. Suicides accounted for 82% of total firearm deaths in Oregon.

Key Questions

- How do we ensure suicide prevention is woven into the new SHIP priorities?
- How can we more effectively engage populations at highest risk: Native Americans, older white men, veterans?
- How can suicide prevention tie in with efforts on opioid, alcohol and other drug use as well as other aspects of the overdose syndemic?

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Public Health Accountability Metrics



Background

- When PHAB adopted the 2019 Public Health Accountability Metrics Annual Report, PHAB asked the subcommittee to consider two changes to outcome measures for the 2019-21 measure set:
 - Prescription opioid mortality
 - Dental visits for children ages 0-5

Public Health Accountability Metrics

Annual Report
March 2019



Rationale for PHAB's request to the subcommittee

- Prescription opioid mortality
 - Oregon met the benchmark of three deaths per 100,000 in 2017. However, Oregon has a long way to go in addressing the opioid crisis and this metric should be considered within the broader context.
 - Measuring provider enrollment in PDMP through the related process measure is no longer relevant since a law was passed in 2018 that requires enrollment.
- Dental visits for children ages 0-5
 - Need to determine whether available data sources meet the criteria to move this from a developmental metric to an accountability metric.

Dental visits for children ages 0-5

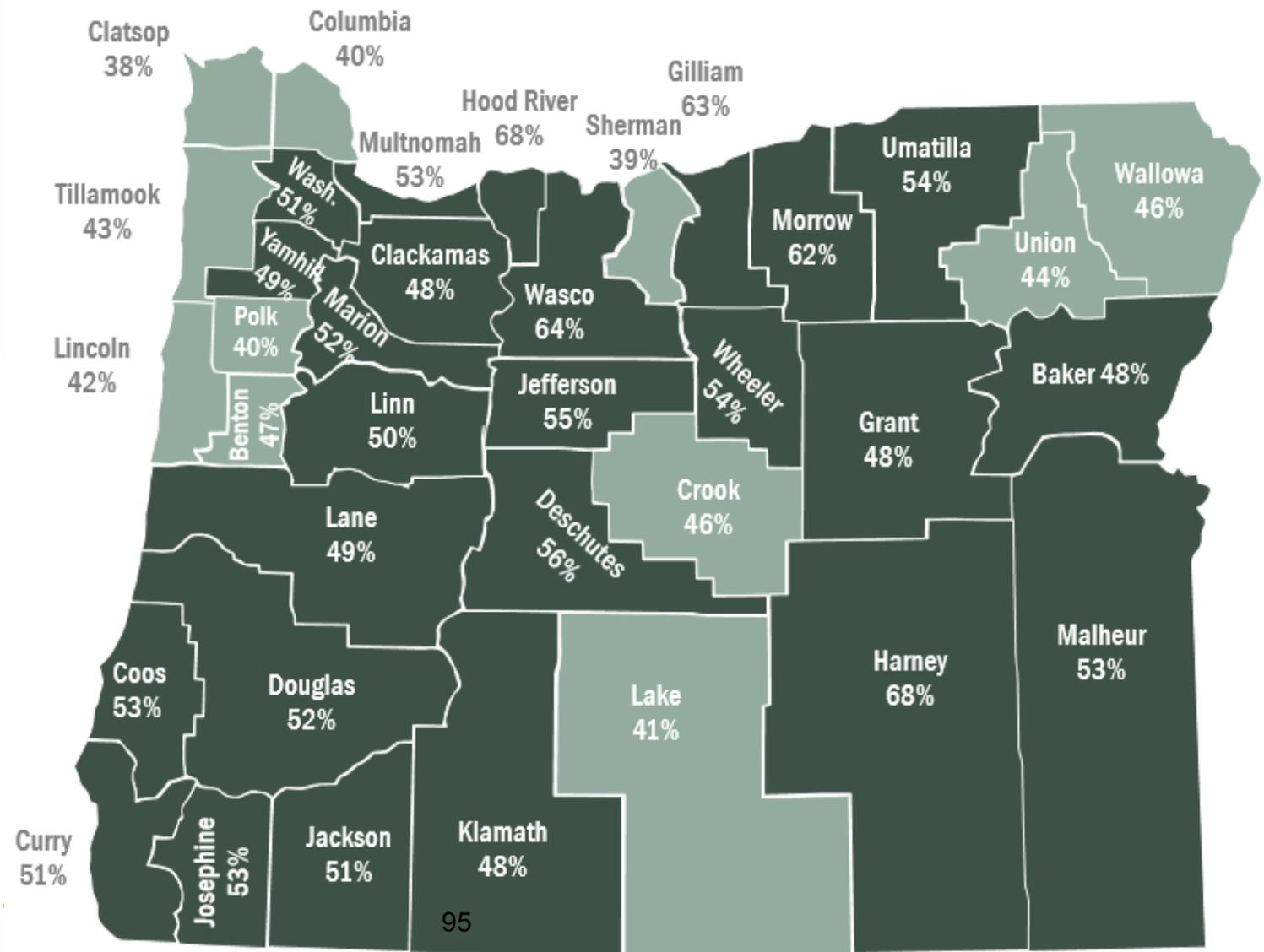
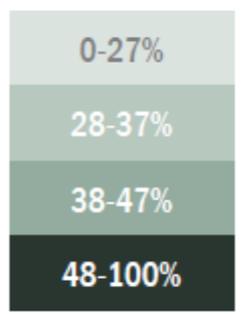
Percent of children age 0-5 with any dental visit

Medicaid
Claims Data
2017

Benchmark:

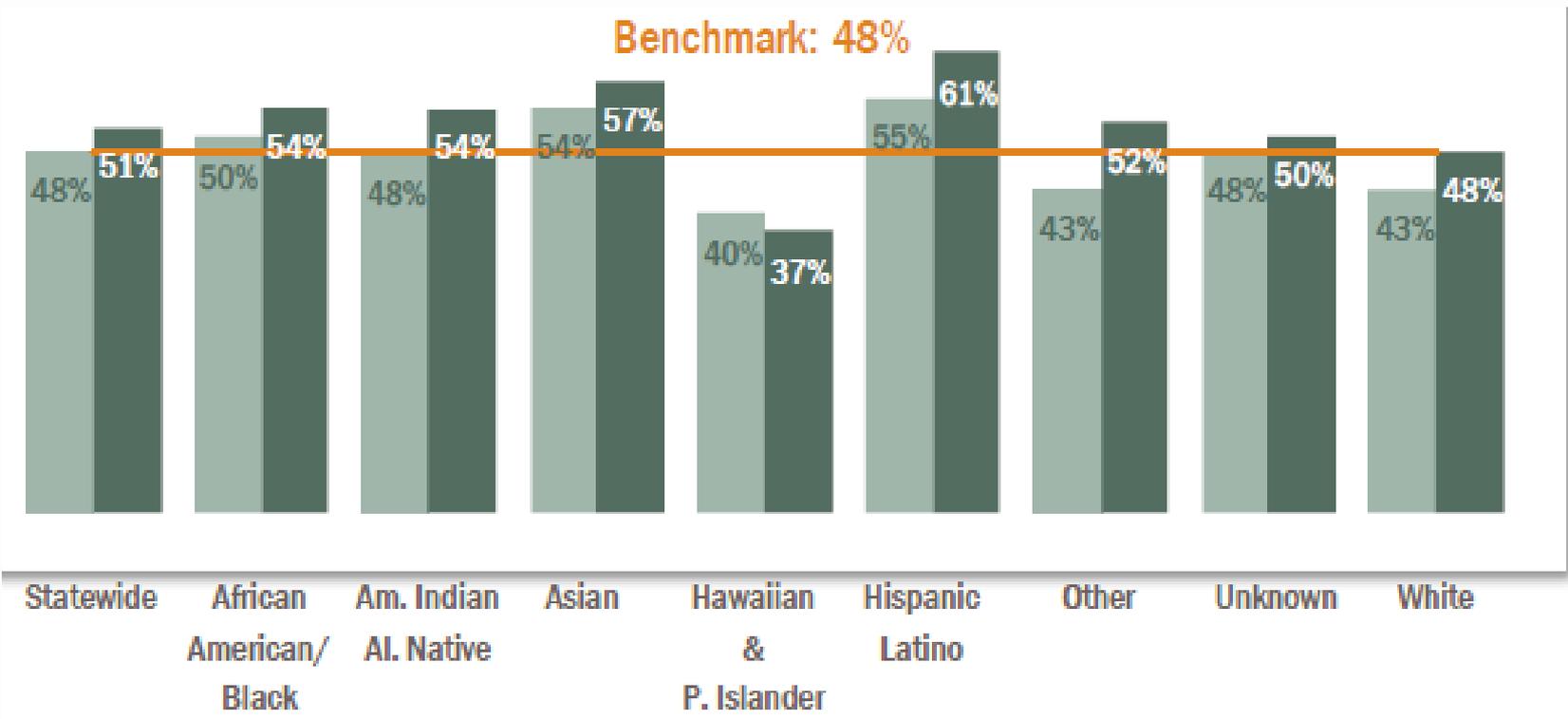
48%

Legend



Percent of children age 0-5 with any dental visit

By Race/Ethnicity
 Oregon Medicaid ● 2016 ● 2017



Benchmark is based on SHIP 2020 target



Subcommittee discussion and recommendation

- Reviewed other potential data sources and measures for childhood oral health, but none met selection criteria requirements at this time.
- Better integration and coordination through CCOs will result in better utilization data in the future.
- The subcommittee unanimously voted to keep this measure as a developmental metric for 2019-21.

Health Outcome Metric: All Opioid Mortality



Prescription Opioid Mortality

Health Outcome Measure

Prescription opioid mortality rate per 100,000 population

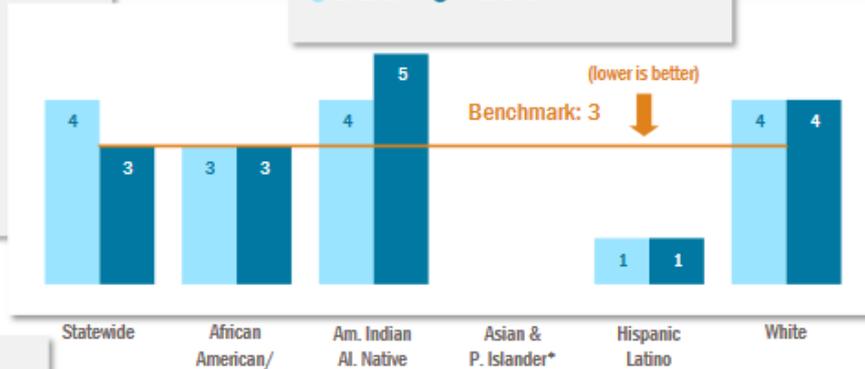
Foundational program area: Prevention and Health Promotion

Data source: Oregon Vital Events Registration System (OVERS)

Benchmark source: Less than 3/100,000, Oregon State Health Improvement Plan (SHIP) 2020 target

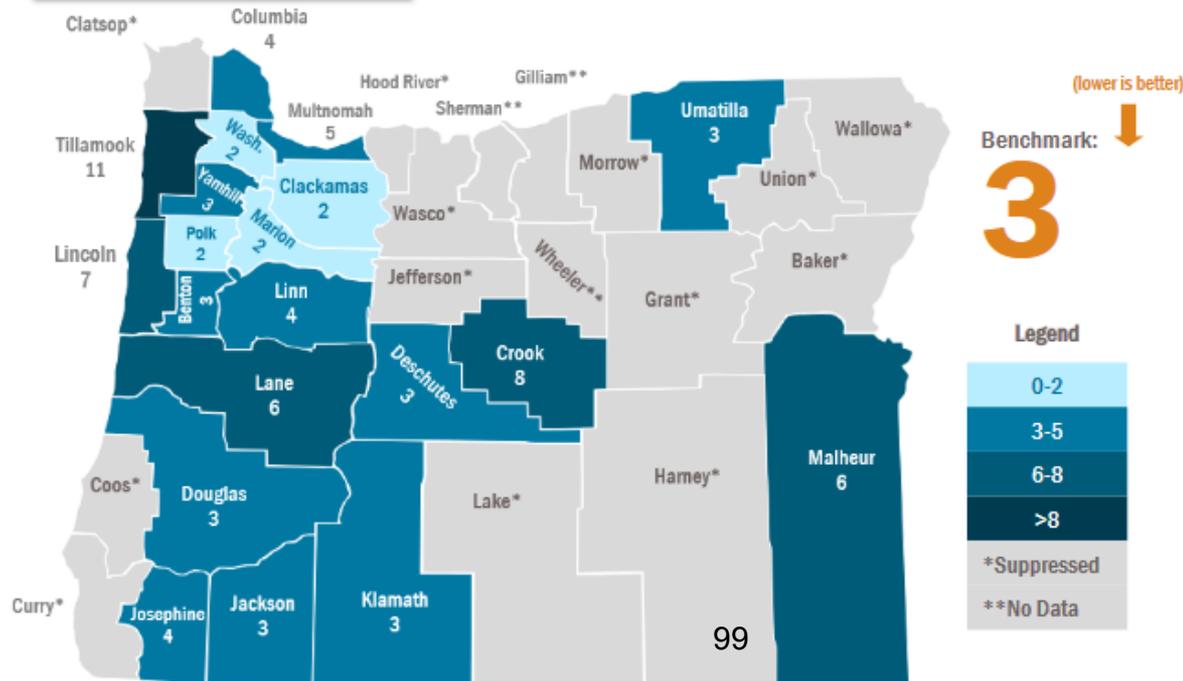
By race and ethnicity

● 2012-2016 ● 2013-2017

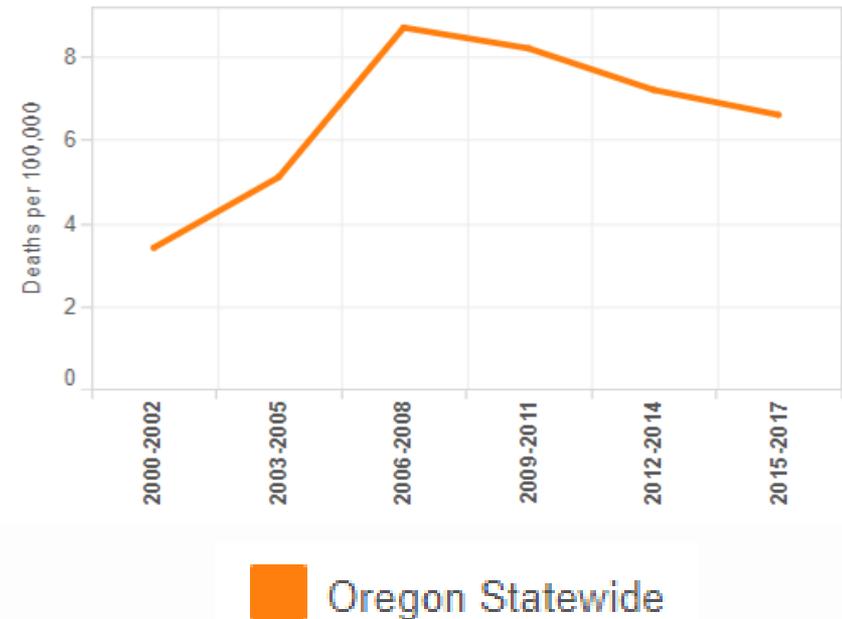
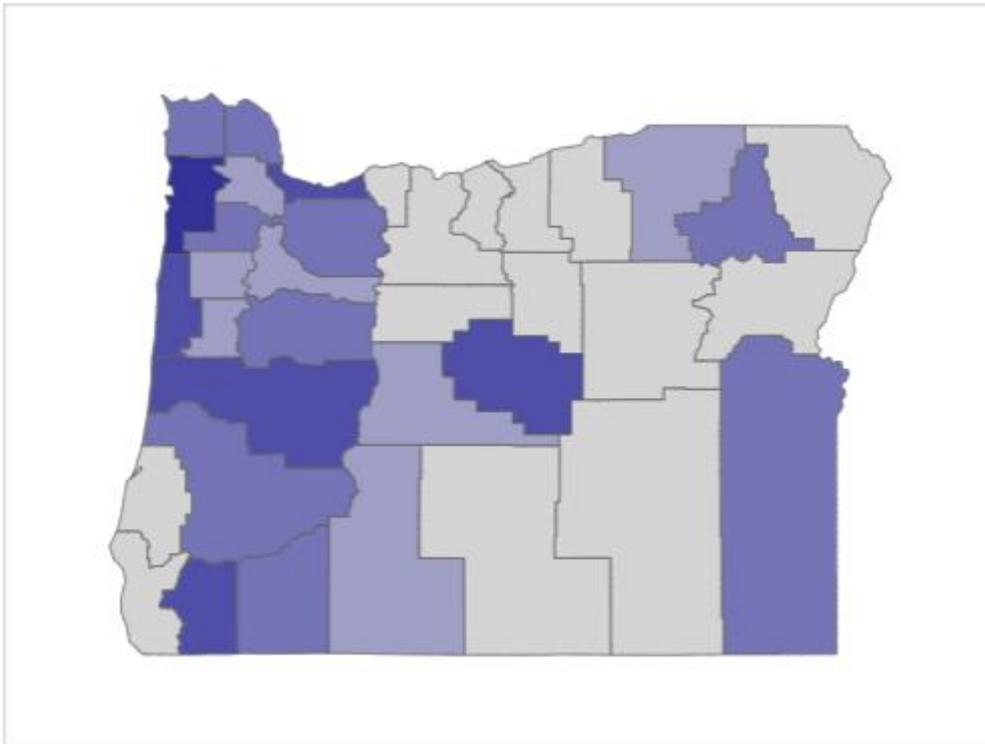


By county

Oregon 2013-2017



All opioid overdose mortality rate per 100,000 population



Data source

- Oregon Vital Events Registration System (OVERS)
- County rates
 - Numerator: The number of prescription opioid poisoning deaths in a 5-year period among Oregon residents (that died in Oregon)
 - Denominator: state population, county populations
- Race/ethnicity rates
 - Numerator: The number of prescription opioid poisoning deaths in a 5-year period by race/ethnicity among Oregon residents (that died in Oregon)
 - Denominator: state population by race/ethnicity

Classifying opioid poisoning deaths

- Requires an underlying cause of death code (e.g. poisoning by narcotics) + at least one “T code” among contributing causes of death
- T Codes: T40.0 = opium, T40.1 = heroin, T40.2 = other opioids, T40.3 = methadone, T40.4 = other synthetic narcotics
- Intent: unintentional, undetermined, suicide, homicide
- Poisoning vs “drug related” (diseases precipitated by drugs)
- Polypharmacy

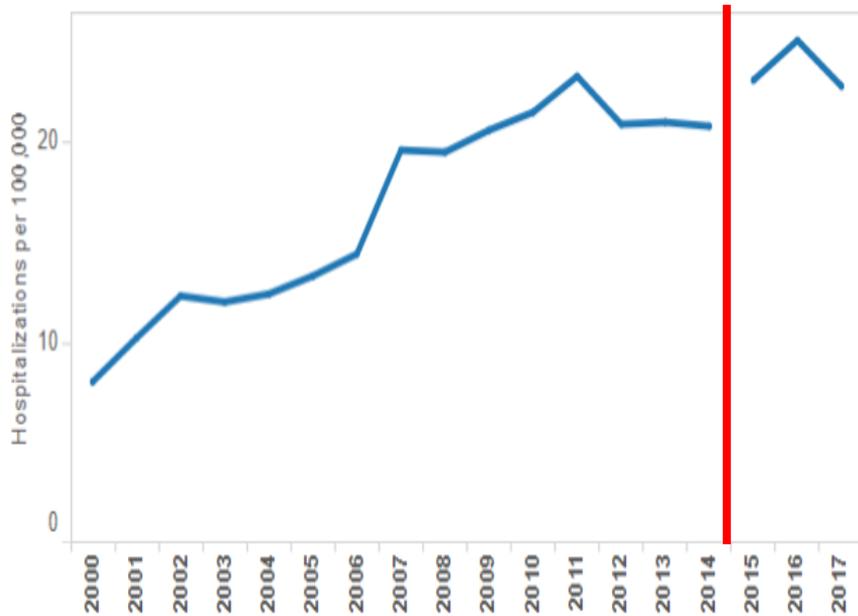
Limitations

- Aggregation due to small counts (e.g. 2012-2016 average annual rate), but better than previous measure (only prescription)
- Does not include deaths out of state
- Coded data:
 - Polypharmacy
 - Poisoning vs “drug-related”
 - Less limitations than previous measure (only prescription)

Alternatives

- Hospital discharge
 - Emergency department visits
 - Not available currently, but perhaps in future
 - Syndromic surveillance (ESSENCE)
 - More limitations, case definition problematic
-
- All of these track the same underlying exposure (drug use)

Hospital Discharge



Limitations

- ICD9 to ICD10-CM changeover mid-2015
 - Rates not comparable
 - Cannot separate intent between coding change
 - Primary diagnosis vs any diagnosis
 - Limited time for aggregation due to small counts
- Requires inpatient medically attended event
 - Illegal drugs less likely to stay inpatient
- Historical race data inaccuracies
- Needs aggregation due to small counts

Recommendation

- “All opioid” instead of “prescription opioid”
- Mortality rather than hospitalization
- Use measures already available

- If PHAB chooses hospitalization
 - Start 2016 forward
 - ICD10-CM consistency
 - Use only recent race / ethnicity data