

# AGENDA

## **PUBLIC HEALTH ADVISORY BOARD Accountability Metrics Subcommittee**

**May 6, 2019**

**1:00-2:00 pm**

Portland State Office Building, room 918

Conference line: (877) 873-8017

Access code: 767068#

Webinar link: <https://attendee.gotowebinar.com/register/5150607625475124481>

Please do not put your phone on hold – it is better to drop the call and rejoin if needed.

### Meeting Objectives

- Make recommendations for prescription opioid mortality metric
- Discuss purpose and use of accountability metrics and make recommendations

PHAB members: Muriel DeLaVergne-Brown, Eva Rippeteau, Jeanne Savage, Eli Schwarz, Teri Thalhofer

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1:00-1:05 pm	<b>Welcome and introductions</b> <ul style="list-style-type: none"><li>• Approve April 1 minutes</li><li>• Subcommittee member updates</li></ul>	Sara Beaudrault, Oregon Health Authority
1:05-1:35 pm	<b>Prescription opioid mortality metric</b> <ul style="list-style-type: none"><li>• Discuss the current outcome measure and options for alternative outcome measures for 2019-21.</li><li>• Discuss the current process measure for PDMP enrollment and alternative process measures for 2019-21.</li><li>• Make recommendation on 2019-21 outcome measure, for a PHAB vote.</li></ul>	Matt Laidler and Josh Van Otterloo, Oregon Health Authority
1:35-1:50 pm	<b>Purpose and use of public health accountability metrics</b> <ul style="list-style-type: none"><li>• Review legislative requirements for public health accountability metrics</li><li>• Discuss framing for public health accountability in the annual report</li><li>• Discuss how accountability metrics have been incorporated into existing contractual requirements</li><li>• Discuss improvements for the next annual report.</li></ul>	Sara Beaudrault, Oregon Health Authority
1:50-1:55 pm	<b>Subcommittee business</b> <ul style="list-style-type: none"><li>• Decide who will provide subcommittee update at May 16 PHAB meeting</li></ul>	All

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- Next subcommittee meeting is scheduled for Monday, June 3 from 1:00-2:00

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1:55-2:00 pm      **Public comment**

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2:00 pm      **Adjourn**

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## **PUBLIC HEALTH ADVISORY BOARD**

### **DRAFT Accountability Metrics Subcommittee meeting minutes**

**April 1, 2019**

**1:00-2:00 pm**

**PHAB Subcommittee members in attendance:** Jeanne Savage, Eli Schwarz, Muriel DeLaVergne-Brown, Teri Thalhofer

**Oregon Health Authority staff:** Sara Beaudrault, Myde Boles, Kati Moseley, Amy Umphlett, Kelly Hansen, John Putz, Cate Wilcox

#### **Welcome and introductions**

Minutes from the March 4, 2019 meeting were approved.

OHA is making final edits to the 2019 Public Health Accountability Metrics Annual Report, based on the 3/21 discussion at PHAB. It will be released within the next couple weeks. Eli suggested that the subcommittee discuss whether and how this report is useful to public health and other stakeholders, beyond publishing an annual report.

OHA is seeking members to join 2020-24 SHIP subcommittees to develop strategies and measures for each of the five priority areas. OHA is hoping to have someone with measurement expertise, like from the PHAB Accountability Metrics subcommittee, on each of the subcommittees.

#### **Oral health developmental measure**

When PHAB adopted oral health as a developmental measure, the Board requested that the subcommittee revisit the measure in 2019.

Amy and Kelly reviewed current data for the developmental measure, and other oral health measures for children including CCO incentive metrics and the proposed health aspects of kindergarten readiness metric.

Eli asked whether Medicaid claims data is the only data source or if other groups are collecting and reporting data. Kelly reported that Medicaid data is the most complete, can be broken down by demographics and is reported systematically each year.

Amy and Kelly reviewed a spreadsheet of potential measures and data sources PHAB could use, noting that there are few options for a population-based measure, and none meet other PHAB measure selection criteria. All Payer All Claims (APAC) dataset rules passed recently to include dental insurance in APAC. It will take time to get all mandatory reporters in the system and reporting data, so we're still a few years out from being able to use this as a source of utilization data for all children. The 2017 Smile Survey will be released in Spring 2019.

Eli suggests focusing on preventive visits for 0-6 year-olds if the dental sealant measure changes its specifications to exclude 6 year-olds, so this age is not excluded.

Eli stated it is encouraging that there are so many activities occurring to get better data on utilization. He recalled previous conversations about LPHAs having limited influence on this age group. But so much integration and coordination through CCOs is having an effect.

Eli stated it is important to keep the oral health metric to maintain focus and communicate that oral health for 0-5 or 0-6 year-olds is an important thing to think about. As coordination between oral and medical health becomes more firmly founded, maintaining focus through an oral health measure is a way to talk about whole child health. Muriel agreed but noted that access continues to be a problem in many areas of the state. Muriel also stated that public health does have a place in oral health, but the role is not as strong as it is for other accountability metrics. Eli stated that Oregon is at the beginning of a new five-year contract with CCOs that should bring public health and CCOs closer together, with new opportunities.

Muriel and Teri agreed with keeping this measure, either as developmental or as an accountability metric. Jeanne also agreed but needs to understand what public health can do to make a difference before holding LPHAs accountable. Muriel noted the connection to WIC services as a touch point with families with young children, and partnerships with oral health partners in her county. But the direct line is a hard one. Teri stated that she thinks about this in terms of the framework laid out in the Public Health Modernization Manual, which includes broad community-level health promotion interventions that would include oral health. LPHAs are not currently funded to do community-wide health promotion efforts in a big way.

Eli asked about the benchmark for the developmental measure of 48%. He noted that the state has made progress and has met this benchmark, but there are disparities across racial and ethnic groups. Will the benchmark be revised? The PHD oral health program will discuss making a recommendation for an updated benchmark.

Committee members unanimously agreed to recommend that PHAB keep this measure for the next year as a developmental metric.

### **Developing 2019-21 public health accountability metrics**

Sara reviewed specific outcome and process measures that came up during PHAB's 3/21 review of the 2019 Public Health Accountability Metrics Annual Report that warrant discussion by the subcommittee at future meetings.

- Outcome measure for prescription opioid mortality. PHAB noted that, statewide, Oregon met the benchmark, but this does not take into account the broader context for all opioid-related deaths and overdoses. There may be an opportunity to consider a broader outcome measure that looks at all opioid overdose deaths. Muriel stated that while Oregon met the statewide benchmark, many counties

have definitely not met the benchmark. Eli questioned the benchmark of 3 deaths per 100,000 and suggested it should be zero. Eli stated that mortality is the most extreme measure during an epidemic like this, but there may be other ways to look at opioid use or substance use more generally. He noted that as Oregon requires prescribers to limit prescriptions we may be increasing use of illicit drugs unless we put other preventive measures in place. Jeanne state that continuing to follow prescriber enrollment in PDMP as a process measure is not necessary. The State will monitor and enforce this because it is mandatory, and it does not provide useful information. Jeanne is interested in looking at deaths from all opioids, or nonfatal overdoses because that is an area for intervention. If Oregon sees fewer attempts, we'll know we're making a difference. Sara stated that the next step is to bring PHD program staff to an upcoming meeting to discuss the data and possible measures that could be used, and to lead a discussion about whether this subcommittee wants to recommend changes to either the outcome or process measure for 2019-21.

- Muriel suggests that the subcommittee not make too many changes to the measure set because we're not far enough along in the process. Eli agreed and stated that the Metrics and Scoring committee only changes measures when there are changes in standards or when all CCOs meet a benchmark.
- Other process measures just need some clean-up for how data are collected or reported, but these changes will not require changes to the measure itself. We'll bring PHD program staff into upcoming subcommittee meetings to talk about the feasibility of making the changes that PHAB discussed.
- Teri stated that there is a disconnect between how PHAB is looking at what accountability metrics are about and how OHA programs are using them. Teri has the understanding that we are not a fully modernized system and none of our work is fully funded at state or local level. But OHA programs are making changes in Program Elements with a real emphasis on all the work needing to be toward accountability metrics. In many ways PHAB chose these metrics because they're being measured and can be reported. Teri suggested that accountability metrics, what they mean and what they should be driving, be discussed at PHAB. The metrics should show that some metrics don't move because we're not funded. Muriel agrees that there is a disconnect between PHAB's intention, LPHA funding and what OHA is pushing through contracts. Sara stated that the Accountability Metrics subcommittee can revisit the purpose of accountability metrics, with a separate conversation between OHA and LPHAs about contracts. Eli noted that measures do not in any way reflect the breadth of what LPHAs are doing and stated that the Accountability Metrics subcommittee was meant to be parallel to the PHAB subcommittee that would make decisions about how to use \$200 million. But we've only seen \$5 million of those so far. Jeanne agreed and suggested that measures could be considered developmental unless you have clear processes in place to make a difference. Other measures we could follow, get the data, and use it to pressure CCOs and the community to work together.

Muriel stated that modernization is about rising all boats and helping health departments, but she's seeing more barriers.

**Subcommittee business**

Muriel will provide the subcommittee update on April 18.

The next Accountability Metrics Subcommittee meeting is scheduled for May 6 from 1:00-2:00.

**Public comment**

No public comment was provided.

**Adjournment**

The meeting was adjourned.

DRAFT

**PHAB Accountability Metrics subcommittee**

**Public Health Accountability Metrics – 2019-21 measures for review**

**April 1, 2019**

**Background:** On March 21, 2019 the Public Health Advisory Board adopted the 2019 Public Health Accountability Metrics Annual Report. PHAB requested that the Accountability Metrics subcommittee review the following measures before finalizing the 2019-21 measure set.

Measure	Outcome or process measure	Notes from March 21 PHAB discussion	Next steps
Dental visits for children aged 0-5 <b>Subcommittee recommendation: No change for 2019-21; keep as developmental measure</b>	Outcome	Need to determine whether available data sources meet the criteria to move this from a developmental to an accountability metric.	<b>Decision requires PHAB approval</b>
Prescription opioid mortality	Outcome	Oregon met the benchmark of three deaths per 100,000 in 2017. PHAB should consider changes to this metric to reflect the broader context of illicit opioid deaths and overdoses not resulting in deaths.	<b>Decision requires PHAB approval</b>
Prescription opioid mortality: Percent of top opioid prescribers enrolled in the Prescription Drug Monitoring Program (PDMP)	Process	Since 2018, Oregon law requires all opioid prescribers to be enrolled in the PDMP. Measure no longer provides useful information.	OHA and CLHO will make recommendations to the subcommittee
Adult smoking prevalence: Percent of population reached by tobacco-free county properties policies	Process	LPHAs met the benchmark for comprehensive (all properties) or partial (some properties) tobacco-free county properties. Consider changing what is reported to differentiate comprehensive and partial policies.	OHA and CLHO will discuss whether to make this change
Active transportation: LPHA participation in leadership or planning initiatives related to	Process	The measure should reflect LPHA participation in implementation, in addition to planning.	OHA and CLHO will revise measure data collection

active transportation, parks and recreation or land use			
Drinking water: Percent of water system surveys completed, and Percent of priority non-compliers resolved	Process	Both measures are at close to 100%. Consider changing what is measured and reported.	OHA and CLHO will make recommendations to the subcommittee
Effective contraceptive use: Annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use	Process	Need to develop a new data collection mechanism.	OHA and CLHO will revise measure data collection

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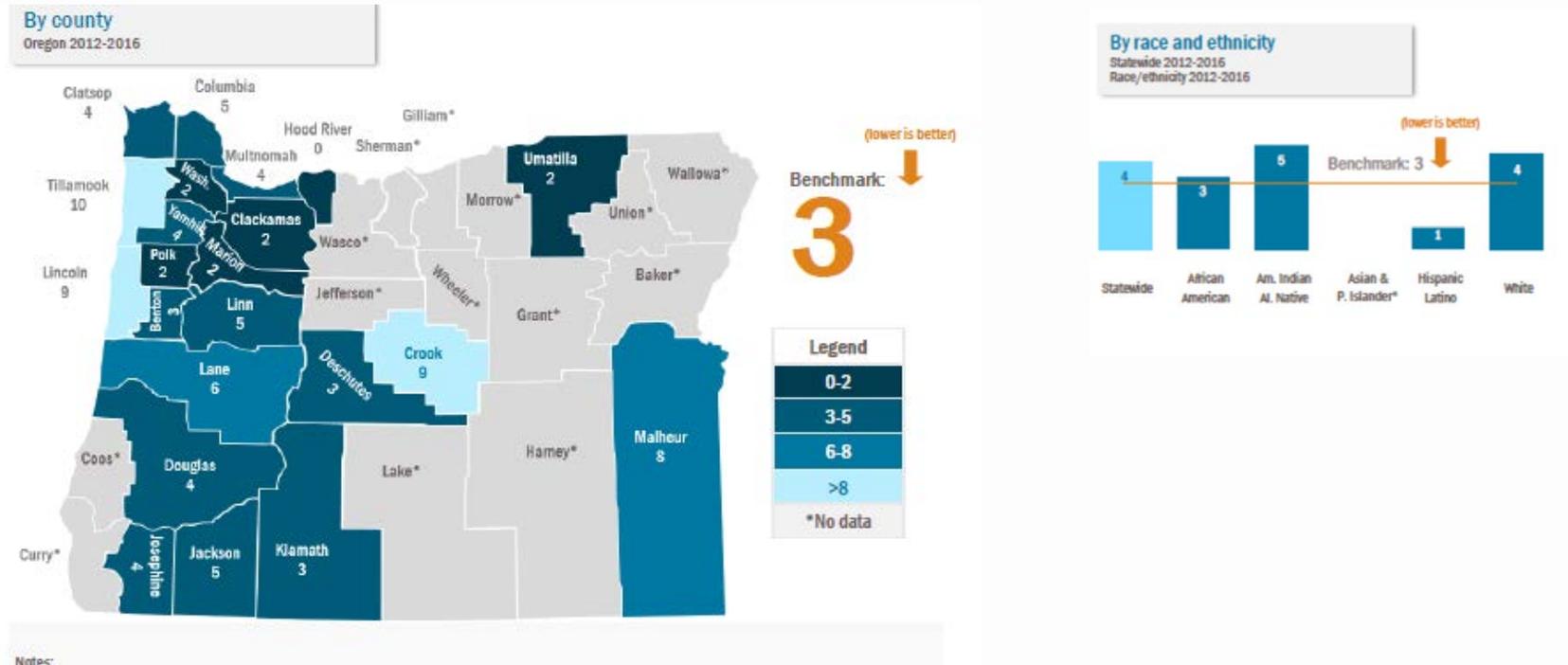
The logo for the Oregon Health Authority. The word "Oregon" is in a smaller, orange, serif font. The word "Health" is in a large, dark blue, serif font. The word "Authority" is in a smaller, orange, serif font, positioned below "Health".

# Oregon Health Authority

Injury & Violence Prevention Program  
Public Health Division

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# Prescription opioid mortality rate per 100,000 population



- 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
  
- 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

# Data source

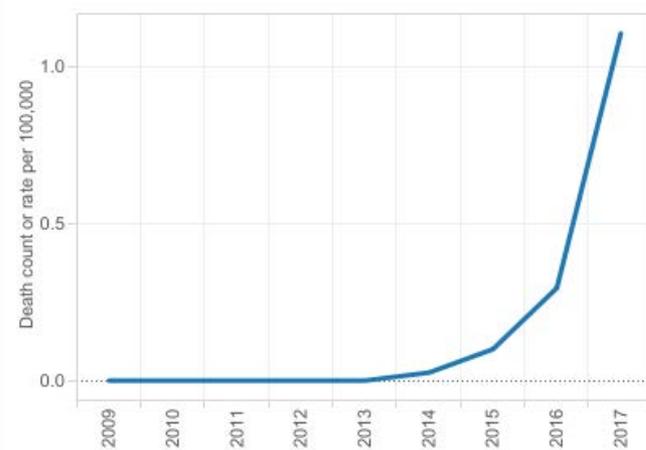
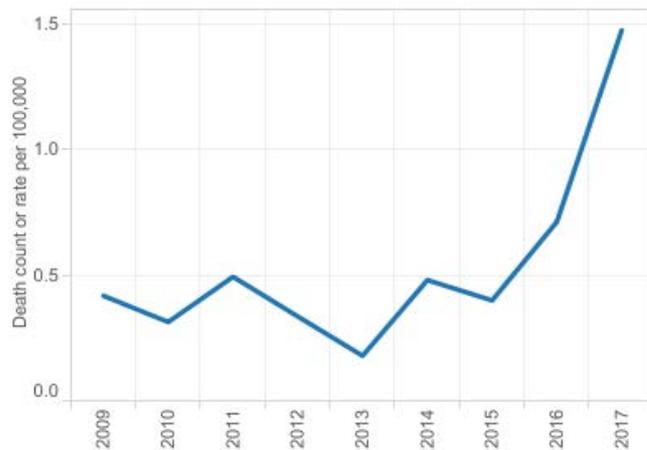
- Limitations:
  - Aggregation due to small counts (e.g. 2012-2016 average annual rate)
  - Does not include deaths out of state
  - Coded data:
    - Aggregates some drugs (e.g. “other opioids”) into general categories but specifies others (e.g. “heroin”)
    - No “prescription” vs “illicit” category
  - Classification affected by changes in drug use and overdose (e.g. fentanyl is both an illicitly manufactured and prescribed substance)

# Classifying opioid poisoning deaths

- Requires an underlying cause of death code (e.g. accidental 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

# Non-pharmaceutical fentanyl and analogs

- Fentanyl and analogs (e.g. 3-methyl fentanyl, 4-ANPP, butyryl fentanyl, furanyl fentanyl, U-47700, 4-methoxy-butyryl, MT-45, carfentanil, etc.)
- Fentanyl (all) mortality rate (unintentional and undetermined deaths) vs fentanyl analog deaths (below)



# Classifying “prescription” opioid deaths

- Former: other opioids + methadone + other synthetic narcotics
- New: other opioids + methadone
- Excluding “other synthetic narcotics” excludes illicit fentanyl, but also excludes prescription fentanyl and drugs such as tramadol.

# Options

- Continue using limited definition of “prescription opioids” (i.e. minus synthetics)
- Classify by general ICD-10 code (i.e. “other opioids”, “methadone”, “other synthetic narcotics”, etc.)
- Any opioid
- All intents vs “accidental” overdose (unintentional and undetermined)

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# Prescription Opioid Mortality Accountability Metric



# Current Process Measure

	Current Specifications
<b>Measure</b>	Percent of top prescribers enrolled in PDMP
<b>Definitions</b>	Top prescribers defined as the top 4000 prescribers of all controlled substances by number of controlled substance fills.
<b>Benchmark</b>	95%

# Percent of Top Prescribers Enrolled in PDMP



- As of 4/1/2019, 94.2% of top prescribers are enrolled in PDMP

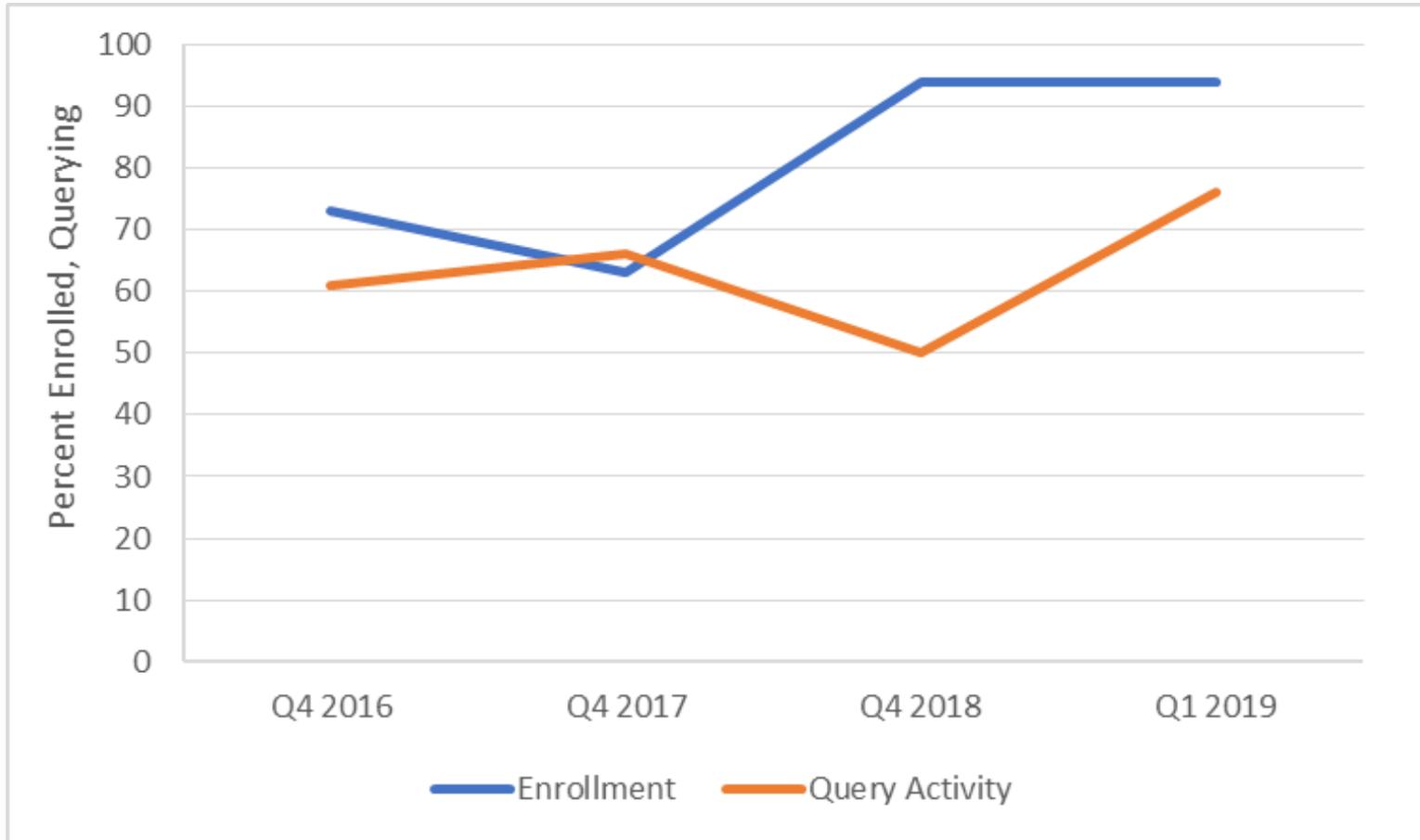
# Data source

- Oregon Prescription Drug Monitoring Program
- County rates
  - Numerator: The number of top prescribers enrolled in the PDMP
  - Denominator: Number of top prescribers in state or county as defined by DEA registration
- Race/ethnicity rates
  - Not applicable

# Limitations

- 2018 mandate for all prescribers to enroll
- County rates may be unstable due to small numbers
- Local health departments are no longer funded to increase PDMP enrollment
- Only addresses the legal prescribed opioids
- Only addresses enrollment, not system use
- Prescriber address is based on DEA license registration, which is not regularly updated.

# Top Prescriber Enrollment vs Use



\*Querying percent is of those with a PDMP account

# Options

- Keep the current metric
  - Or tweak to include all prescribers
- Change PDMP metric
  - Capture querying activity
- Change the metric
  - Access to treatment services
  - Access to harm reduction

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# Purpose and use of accountability metrics



# Legislative requirements for accountability metrics (ORS 431)

- ORS 431.115: OHA shall use accountability metrics to encourage the effective and equitable provision of public health services by LPHAs.
- ORS 431.123: PHAB shall establish accountability metrics for the purpose of evaluating the progress of OHA and LPHAs in achieving statewide public health goals.
- ORS 431.123: PHAB shall make recommendations to OHPB on the use of accountability metrics to encourage the effective and equitable provision of public health services by LPHAs.
- ORS 431.139: OHA shall submit to Legislative Fiscal Office a report on... the progress of LPHAs in meeting accountability metrics.
- ORS 431.380: OHA shall adopt by rule incentives and a process for identifying, updating and applying accountability metrics.

# Report introduction: framing for accountability metrics

- **Public health funding for accountability metrics**
- **Purpose of the report**
- **Outcome and process measures**

Outcome: Reflect population health priorities for the public health system.

Process: Reflect the core functions of an LPHA to make improvements in each outcome measure.

# Introduction

## Background

Since 2013 Oregon has been working to modernize how it improves the public's health. A modern public health system operates efficiently to achieve goals and is set up to provide critical protections for every person in the state. Through focusing on prevention, public health lessens the impact of health threats on people's lives and saves money by lowering demand for costly health care interventions. A strong and effective public health system is essential for achieving Oregon's triple aim of better health, better care and lower health care costs.

Efforts to modernize the public health system have been driven by Oregon's legislature, which has passed related laws in the last three sessions. In the 2015 and 2017 sessions, the legislature enacted laws to use public health accountability metrics to track the progress of state and local public health authorities to meet population health goals, and to use these metrics to incentivize the effective and equitable provision of public health services (Oregon Revised Statute 431.115).

## Public health funding for accountability metrics

The Oregon Health Authority (OHA) and local public health authorities (LPHAs) are funded to implement programs for some, but not all, public health accountability metrics. State and federal funding often provides partial funding for local programs, with the remainder provided through county general funds or other sources.

LPHAs receive funding from the Oregon Health Authority through contracts for categorical public health programs. This report includes information about whether LPHAs currently receive funding to support achievement of each local public health process measure.

In 2017 the Legislature made a \$5 million investment to modernize the governmental public health system. OHA distributed the majority of these funds to LPHAs to develop and implement regional strategies for communicable disease control.

Moving forward state and local public health authorities will continue to look for opportunities to align existing funding with public health accountability metrics, while also seeking opportunities for new funding.

# Introduction

## Purpose of this report

This reports increases understanding of Oregon's current status on population health priorities. This report is not a report card for Oregon's public health system or any individual public health authority.

### Reporting by race and ethnicity

Where possible, data are reported by race/ethnicity. Differences in rates across racial and ethnic groups occur because of generations-long social, economic and environmental injustices that result in poor health. These injustices have a greater influence on health outcomes than biological or genetic factors or individual choices.

Public health authorities have a responsibility to address the social conditions and correct historical and contemporary injustices that undermine health. One way the public health system begins to do this is by collecting and reporting data that show where health disparities exist and the underlying causes for why certain racial and ethnic groups experience poor health.

Annual public health accountability metrics reports help to achieve the following core roles of the public health system<sup>1</sup>:

1. Collect and maintain data that reveal inequities in the distribution of disease and the social conditions that influence health;
2. Identify population subgroups characterized by an excess burden of adverse health or socioeconomic outcomes; and
3. Make data and reports available to partners and stakeholders and other groups.

Data showing health disparities supports affected communities and public health authorities to co-create the solutions that will begin to correct historical and social injustices so that all people in Oregon can reach their full health potential.

<sup>1</sup> Oregon Health Authority 2017). Public Health Modernization Manual. Available at: [https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public\\_health\\_modernization\\_manual.pdf](https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf).

# Introduction

## Framework for public health accountability metrics

The Public Health Advisory Board (PHAB) adopted measures to track progress toward achieving population health goals through a modern public health system. The collection of health outcome and local public health process measures, defined below, are collectively referred to as public health accountability metrics. Measures are shown in Table 1.

Health outcome measures reflect population health priorities for the public health system. Making improvements on the health outcome measures will require long-term focus and must include other sectors.

Local public health process measures reflect the core functions of a local public health authority to make improvements in each health outcome measure. Local public health process measures capture the work that each local public health authority must do in order to move the needle on the health outcome measures.

Developmental metrics reflect population health priorities but for which comprehensive public health strategies are yet to be determined. These health outcome measures will be tracked and reported but will not be incentivized.

Measures in this report are reported under foundational program areas of a modern public health system:



**Communicable Disease Control**



**Prevention and Health Promotion**



**Environmental Health**



**Access to Clinical Preventive Services**

Table 1. Public Health Accountability and Developmental Metrics

**PART 1: ACCOUNTABILITY METRICS**

Health Outcome Measure	Local Public Health Process Measures		
 <b>Communicable Disease Control</b>			
Percent of two-year olds who received recommended vaccines	Percent of Vaccines for Children clinics that participate in the Assessment, Feedback, Incentives and eXchange (AFIX) program		
Gonorrhea incidence rate per 100,000 population	Percent of gonorrhea cases that had at least one contact that received treatment	Percent of gonorrhea case reports with complete priority fields	
 <b>Prevention and Health Promotion</b>			
Percent of adults who smoke cigarettes	Percent of population reached by tobacco-free county properties policies	Percent of population reached by tobacco retail licensure policies	
Prescription opioid mortality rate per 100,000 population	Percent of top opioid prescribers enrolled in the Prescription Drug Monitoring Program (PDMP) Database		
 <b>Environmental Health</b>			
Percent of commuters who walk, bike, or use public transportation to get to work	Local public health authority participation in leadership or planning initiatives related to active transportation, parks and recreation, or land use		
Percent of community water systems meeting health-based standards	Percent of water systems surveys completed	Percent of water quality alert responses	Percent of priority non-compliers resolved
 <b>Access to Clinical Preventive Services</b>			
Percent of women at risk of unintended pregnancy who use effective methods of contraception	Annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use		

**PART 2: DEVELOPMENTAL METRICS**

Health Outcome Measure	Local Public Health Process Measure		
 <b>Access to Clinical Preventive Services</b>			
Percent of children age 0-5 with any dental visit	Not applicable		

# Introduction

## Sources for population health data

The public health system uses data from different sources to track health outcomes, including vital statistics, reportable disease monitoring, and surveys, among others. The variety of data sources, methods used to report data, and time periods for reporting present challenges to making comparisons across accountability metrics.

Each accountability metric should be looked at individually, and comparisons between metrics should not be made to understand differences in population health outcomes of interest.

## Technical details about health outcome and process measures

This report provides the first annual update to the Baseline Report, March 2018. The baseline year for data is 2016 unless otherwise specified. Benchmarks are presented for each measure. For most measures, the higher or larger the data, the more desirable relative to meeting or exceeding the benchmark. Measures where lower or smaller data points relative to the benchmark are desirable, are indicated with “lower is better” on the chart. Arrows on local public health process measures pages indicate where there was a lack of improvement from baseline year to the following year. Race categories of African American, American Indian & Alaska Native, Asian, Pacific Islander, and White do not include individuals of Hispanic ethnicity. Data for individuals of Hispanic ethnicity are presented separately. Data sources, data collection methods, measure specification, and additional technical information are described in detail in the Technical Appendix.

# Accountability metrics in Program Elements

- In 2018, Program Elements updated to reference related accountability metrics.
  - Makes connection between required work and desired outcomes.
  - Funding is not tied to improved metrics.
- [Link to Program Elements](#)

# Subcommittee business

- Decide who will give subcommittee update at May 16 PHAB meeting
- The next subcommittee meeting is scheduled for June 3 from 1:00-2:00

# Public comment

**Adjourn**