

AGENDA

PUBLIC HEALTH ADVISORY BOARD

April 18, 2019

Portland State Office Building
800 NE Oregon St., Conference room 1A
Portland, OR 97232

Join by webinar: <https://register.gotowebinar.com/rt/4888122320415752707>

Conference line: (877) 873-8017

Access code: 767068

Meeting objectives:

- Update from PHAB subcommittees
- Review Public Health Block Grant progress
- Hear an overview of Health Equity Action Plans from modernization grantees
- Check in on progress on the 2015-2019 State Health Improvement Plan immunization and communicable disease priority areas

2:00-2:10 pm	Welcome and updates <ul style="list-style-type: none">• Approve March meeting minutes• Legislative update	Rebecca Tiel, PHAB Chair
2:10-2:20	Public Health Block Grant <ul style="list-style-type: none">• Review annual progress of grant work plan	Danna Drum, OHA staff
2:20-2:30	Accountability Metrics Subcommittee <ul style="list-style-type: none">• Discuss work of the subcommittee	Muriel DeLavernne-Brown, PHAB member
2:30-2:40	Incentives and Funding Subcommittee <ul style="list-style-type: none">• Discuss work of subcommittee	Akiko Saito, PHAB Member
2:40-3:10	Modernization Grantee Update: Health Equity Action Plans <ul style="list-style-type: none">• Update PHAB progress in the assessment and epidemiology foundational capability	Kim Handloser and Katherine Duarte, Jackson and Klamath counties Katrina Rothenberger, Kristty Polanco and Carla Munns, Marion and Polk counties Heather Kaisner and Jenny Faith, Deschutes, Crook and Jefferson counties

3:10-3:20	Break	
3:20-3:50	Modernization Grantee Update: Health Equity Action Plans (continued)	
3:50-4:50	SHIP Update: Immunization and Communicable disease <ul style="list-style-type: none"> Update on progress in the 2015-2019 State Health Improvement Plan 	Aaron Dunn, Ann Thomas, Tim Menza, OHA staff
4:50-5:00 pm	Public comment	Rebecca Tiel, PHAB Chair
5:00 pm	Adjourn	Rebecca Tiel, PHAB Chair

Public Health Advisory Board (PHAB)

March 21, 2019

DRAFT Meeting Minutes

Attendance:

Board members present: Dr. David Bangsberg, Carrie Brogoitti, Dr. Bob Dannenhoffer, Dr. Katrina Hedberg, Dr. Jeff Luck (by phone), Tricia Mortell, Alejandro Queral, Dr. Jeanne Savage, Teri Thalhofer, Rebecca Tiel.

Board members absent: Kelle Adamek-Little, Muriel DeLaVergne-Brown, Eva Rippeteau, Akiko Saito, Dr. Eli Schwarz.

Oregon Health Authority (OHA) staff: Lillian Shirley (ex-officio), Danna Drum, Sara Beaudrault, Katarina Moseley, Krasimir Karamfilov, Myde Boles, Dr. Ali Hamade, Margie Stanton.

Members of the public: Daneena Scholl (Pacific University).

Welcome and updates

Rebecca Tiel, PHAB Chair

Ms. Tiel welcomed the PHAB and reviewed the agenda for the meeting.

- Approval of February 2019 Minutes

A quorum was present. Dr. Dannenhoffer moved for approval of the February 21, 2019, meeting minutes. Ms. Thalhofer seconded the move. The PHAB approved the meeting minutes unanimously.

- Legislative Update

Ms. Shirley remarked that the legislative session was in full swing. Over 3,000 bills have been introduced. The Health Care Committee has the most bills of any other committee. Many bills have passed, or are pending, and we should feel positive about public health, as we think of the social determinants of health and moving upstream, as well as bills related to the Governor's agenda around climate, carbon, and energy.

Ms. Shirley informed the PHAB that OHA testified on March 20, 2019, before the Senate Committee on Health Care. All presentation slides are available online. The structural slides at the beginning of the presentation are of interest. All OHA divisions had similar templates of slides, such as *How We All Relate to the Oregon Health Policy Board* and *How We All Relate to the Health Evidence Review Commission*. Each division had a slide that showed their external



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advisory groups. The Public Health Division has 57 separate advisory groups. This morning, OHA Director, Patrick Allen, and other OHA staff, gave a presentation about the tobacco tax at a work session.

Ms. Shirley pointed out that public health officials initiated the concept of raising the price of tobacco, which worked into a tobacco tax, which worked into the Governor's picking it up, and so on. While the debate now is around looking at it as a revenue bill and what it is going to fund, it will most prominently fund the gap that remains in the Medicaid bill. We, in public health, should be proud, if we have managed to do that. It is the single most important thing we can do to counter the spread of smoking in our state. It is also the first time we have looked at e-cigarettes and taxing them.

Ms. Shirley recalled that, for example, last year, when we did the public health bill around modernization, and went through the experience with Wallowa county, and when we got to the brink with Douglas county, there was no language in the bill about cases when a county had surrendered its authority to be the local health authority; they can now get it back. There are this type of housekeeping changes in the new public health bills, including changes, such as changing "Local Public Health Departments" to "Local Public Health Authorities." Among the fee bills, the most prominent is the Drinking Water Fee Bill. Over the last several years, the Environmental Protection Agency has reduced its support of states. In Oregon, we had ongoing problems with spreading algal blooms, which threaten our drinking water and agricultural water. There wasn't a lot of discussion about the details at this session, but we will continue to be part of the overall Oregon Health Authority budget.

Ms. Shirley noted that other good things that are happening include the expansion of WIC (Women, Infants, and Children) by expanding the age children are eligible, expanding the time for eligibility of breastfeeding women, and protecting the Farmers Market's use of WIC. In past years, people have complained that no one pays attention public health. That has changed, in a good way. Although people are working very hard, it is good to be working hard, because we know that people understand what our work means to the health of Oregonians.

Accountability Metrics Subcommittee

Myde Boles (OHA staff), Sara Beaudrault (OHA staff)

Ms. Boles introduced herself to the PHAB and welcomed its members to the first annual update of the Accountability Metrics Report. She acknowledged the contributions of the PHAB Accountability Metrics Subcommittee to the report. The subcommittee reviewed multiple iterations of the report and offered suggestions. Acknowledgement is due to all programs and sections in the Oregon Public Health Division that provided the data for the report, especially the staff in the Policy and Partnership team and the office of the Public Health Director for their deep involvement in the production of the report and for their role in keeping all stakeholders connected to the process. Acknowledgement is also due to all local public health officials for



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their contributions to the report. Finally, a special mention to OHA staff member Jaime Madsen, who did all the design and production of the report.

Ms. Boles explained the organization of the report to the PHAB. Although this year's report is like last year's report, we have an additional year of data. The report is organized by the four foundational program areas under Public Health Modernization: communicable disease and control, prevention and health promotion, environmental health, and access to clinical and preventive services.

Ms. Boles informed the PHAB that, with a few exceptions, the baseline year for the report was 2016 in most cases, with the year-one update being 2017. There are benchmarks for each measure. For most measures, the higher or the larger the data, the more desirable it is, relative to beating or exceeding the benchmark. There are some exceptions, indicated on the pages, where it is better when the measure is lower. In the results pages, there are small arrows that indicate lack of improvement from the baseline year. The data reported in the Race/Ethnicity categories do not include Hispanic ethnicity. The data for individuals of Hispanic ethnicity are reported separately. The data do not come from one reporting system, but from a variety of different data systems. The data are reported using the reporting conventions for each public health program that provided the data.

Ms. Boles presented a few highlights from the results. Public health modernization funding in 2017 helped to strengthen the capacity for improving childhood immunization rates. As a result, in 2018, the LPHAs exceeded the 25% benchmark for the Vaccines for Children clinics participating in the quality improvement program AFIX. Gonorrhea rates continue to increase, from 107 per 100,000 in 2016 to 121 per 100,000 in 2017. Despite the increase, Oregon's rate is below the national average of 172 per 100,000. Prescription opioid mortality rates are on the decline. For the first time, the report shows LPHA's involvement in local planning initiatives for active transportation, parks and recreation, and land use. In 2018, more than half of all LPHAs were involved in local initiatives in this area. Lastly, health outcomes vary across racial and ethnic groups. It is important to collect and report data that show where health disparities exist, and where public health can focus its efforts to address these disparities.

Ms. Boles noted that the introduction of the report is similar to the introduction in last year's report, but it provides more information about the context of the report and the data, including some background on public health modernization and how the accountability metrics came to be. The introduction section provides information about local public health funding for public health authorities. The section also includes a table that summarizes all accountability metrics, health outcome measures, and local public health process measures.

Ms. Boles reviewed the data pertaining to childhood immunization. The first outcome measure is *Percent of two-year-olds who received recommended vaccines*. The data source and the sources of the benchmark are indicated on each page of the report. Each year of data is color-

coded. Statewide rates and race/ethnicity rates for each year are shown as a bar chart. A state map with all counties shows how each county measured against the benchmark. Each page also contains footnotes, which are explained in greater detail in the technical appendix.

Dr. Dannenhoffer pointed out that the second footnote on page 10, related to the official childhood vaccination series, is the one chosen for this measure. It is not the official vaccination schedule recommended by ACIP (Advisory Committee on Immunization Practices), which is different than the one in the report.

Ms. Boles continued with the presentation of the data for the health outcome measure *Percent of two-year-olds who received recommended vaccines*. Statewide, immunization rates increased from 66% to 68%. Across the racial groups, the increases from 2016 to 2017 were also small. No county exceeded the benchmark of 80% in 2017. The public health process measure for childhood immunization is *Percent of vaccines for children clinics participating in AFIX*. Data is available for the last two years, 2017 and 2018. Baseline year for this measure is 2017. Each local public health process measure page contains information about local public health funding.

Ms. Tiel asked the PHAB for any questions or comments about the formatting and structure of the report. No PHAB members had comments. Ms. Tiel expressed her liking of the formatting of the report.

Ms. Boles noted that the formatting of the remaining pages in the report is similar to the first two pages. The health outcome measure for gonorrhea is *Gonorrhea incidence rate per 100,000 population*. Data are available from 2016 and 2017. There are clear disparities by race and ethnicity, and an increase in the statewide rate from last year, as mentioned earlier.

Ms. Mortell stated that, although the PHAB has talked about it in the past, this is a glaring example of how this graph could be stigmatizing to the African American community. We have narrative here that explains what are the things that are not because of race or racism, systemic institutional racism, and access to services. It would be great to have language added right here to call that out.

Ms. Boles explained that a lot of that language was included in the Executive Summary on page 4. To the extent possible, there can be notation on page 12 to refer to the paragraphs that reflect that kind of language.

Dr. Dannenhoffer added that it is always hard to show visually when there are some measures that are better when they are lower and better when they are higher. In each of these graphs, the authors of the report have chosen the higher number to be the darker color. In some case, the dark color is a good thing, and in some case, the darker color is a bad thing. This could be confusing for people who are going to be looking at these graphs casually.

Ms. Boles thanked Dr. Dannenhoffer for pointing that out. The graphs were like that last year. People who do color mappings advised the team that the higher and denser the metric, the darker the color should be. It is a formatting thing that, if there is a consensus, it can be done the other way.

Dr. Dannenhoffer remarked that consensus would be hard to get.

Ms. Boles concluded that the graphs would follow the professional recommendation.

Ms. Tiel noted that people might pull out just the graphics without the text. It is hard to get all the notes and framework and everything on a page. It is something for the PHAB members to consider and be mindful about when they are using the information in their own presentations.

Ms. Thalhoffer agreed that people will pull out just the graphics. She expressed worry about the graphs being shown on the news. It would be good if more explanation is included about where the graphic is that is explaining. There are going to be a lot of people who will take out just the graph.

Ms. Boles continued the presentation by reviewing the two local public health process measures for gonorrhea. The first process measure is *Percent of gonorrhea cases that had at least one contact that received treatment*. There is a considerable amount of variation between 2016 and 2017. Statewide, there is an improvement from 13% to 15%. The second process measure is *Percent of gonorrhea case reports with complete priority fields*. Statewide, there is an improvement from 19% to 24%.

Ms. Boles reviewed the health outcome measure *Percent of adults who smoke cigarettes* for adult smoking prevalence. The data for this measure comes from Behavioral Risk Factor Surveillance System survey. Statewide data is based on data collected in 2016 and 2017. Race/ethnicity data is based on data collected during the 2010-2011 and 2015-2016 periods. Statewide, the adult smoking problem has remained stable at 17%. On a county level, there are several counties that are between 0 and 15%, which is the benchmark. The first process measure for adult smoking prevalence is *Percent of population reached by tobacco-free county properties policies*. There was no change statewide from 2015 to 2016. Regardless of whether the policy in place is comprehensive (i.e., all properties) or partial (i.e., some properties), HPCDP (Health Promotion and Chronic Disease Prevention) considers everyone in the county to be covered. The second process measure for adult smoking prevalence is *Percent of population reached by tobacco retail licensure policies*. Two notable changes from 2016 to 2017 are that Benton county increased its reach (i.e., from 26% to 93%) and Klamath county was added. Statewide, the percentage increased from 23% to 26%.

Dr. Luck pointed out that the process measure *Percent of population reached by tobacco-free county properties policies* is more of a Yes/No rather than a 0/100 kind of measure. Has presenting the results as Yes/No been considered?

Ms. Boles responded that, in essence, this is a Yes/No, but the 0/100% reflects the percentage of the population reached, rather than “It is a thing” or “Not a thing.” It can be done either way, but 0/100% reflects that 100% of the population was reached.

Dr. Dannenhoffer remarked that it was misleading to include the partial and the comprehensive policy together. Douglas county is a partial county and it is shown as 100%. It is a little too generous.

Dr. Luck suggested that “Non-partial” or “All” would probably be more useful for a measure like this.

Dr. Dannenhoffer clarified that, in Douglas county, the Public Health Department is smoke-free, but the other departments, such as Department of Corrections, you can smoke outside a jail.

Ms. Thalhofer added that it was the same in Wasco county. The public health campus is tobacco-free by order of the Board of Commissioners, but the rest of them are not and that is not reflected.

Ms. Boles explained that the Health Promotion and Chronic Disease Prevention Section in the Public Health Division recommends this way of reporting. The format can be taken back to them and they can look into modifying it by reflecting non-partial or all. There is a distinction between a tobacco-free policy versus a smoke-free policy, which includes tobacco-free.

Ms. Thalhofer reiterated that that is not reflected in the report as a policy. In Wasco county, the public health campus has been tobacco-free for several years by order of the county commissioners. It is not reflected here. It says that Wasco county is 0%. We have been able to make progress on the health campus and we are trying to show that that would move things along, because it is those little teeny-tiny wins on a local level that we have to get.

Ms. Mortell noted that Douglas county is 100% with exceptions. So if there is something wrong with your data, we need to have a conversation.

Dr. Luck stated that he was struck by what Ms. Thalhofer said, namely, being able to show some steps toward success, even if not all the way there.

Ms. Moseley remarked that getting a public health county campus tobacco-free or smoke-free is not a tiny thing. It is a big accomplishment.

Ms. Tiel added that it is hard to understand what 100% means. There has to be some kind of Yes/No/Maybe, just because looking at the graph, it says that 100% of the county is covered, but it is just the county property. It is hard to read, but it is great progress and work on this piece.

Ms. Brogoitti stated that the situation in Union county is similar. Certain county properties would be tobacco-free, while others aren't. When we are looking at the graph, it looks like we are done, possibly; if we are at 100%, that maybe there isn't more work to do. If we are going to use this as a tool for continuing along in the process, we may want to think about what we are putting on here. I think it's great to be at 100%, and I want to celebrate the accomplishments that we've made, but if this is a tool that we can share with policymakers and say, "Hey, we made this much progress, let's get to a 100," then we might want to think about it.

Ms. Boles explained that the health outcome measure for prescription opioid mortality is *Prescription opioid mortality rate per 100,000 population*. There has been a decline over time. The data is presented in 5-year averages (i.e., 2012-2016, 2013-2017). There are a lot of county data that is not presented here, because of small numbers.

Dr. Bangsberg expressed a concern with prescription opioid mortality's health outcome measure. If the data for prescription opioid mortality rate does not include fentanyl and heroin, it looks like we've made progress. However, it may be true that people are switching from prescription opioids to non-prescription opioids and overall mortality is going up. We could be patting ourselves on the back when the problem is getting worse.

Ms. Boles agreed that this has been a continuing concern with these data.

Dr. Bangsberg wondered how we would message that. Because, if this report goes up to the legislature, or a public forum, and we say, "We made good progress. We are all done..."

Ms. Shirley interjected by stating that on March 20, 2019, we got the legislature. We have a very clear graph of five different categories, including separating out illegal substances, such as fentanyl and methamphetamines from others. This is the problem with this report and the feedback to Ms. Boles. If the PHAB wants to change things like "partial," it should be clear that this is what the PHAB did. All Ms. Boles is doing is collect the data and giving it back to the PHAB the way you decided that you wanted to look at the accountability metrics. We are agnostic about what they are. Maybe we could reflect on what we were asking for. When we had the conversations around this with Ms. Mortell and others, people were very nervous about metrics. We spent a lot of time in the accountability and metrics committee. We are more comfortable with them now. Maybe, what we can do, if we accept or not accept this report, is to make some further course corrections. We could do that if the PHAB agreed to it and gave direction.

Dr. Bangsberg asked about the overall mortality from the opioids.

Ms. Shirley answered that everything is going down, except methamphetamines and fentanyl.

Ms. Boles stated that she could forward the chart to Dr. Bangsberg.

Dr. Bangsberg added that it warrants some further discussion, as it is such an important issue. If we are making progress, we should celebrate it and export that progress to other states. If we are not making progress with overall mortality, we can pay close attention to it.

Ms. Boles remarked that, in terms of the timeline, after the accountability and metrics subcommittee completes this cycle of the report, it will be looking at updating and changing measures. That is slated for next month – to begin that conversation.

Ms. Tiel reminded the PHAB that it needs to vote and take action on this version of the report without substantial changes and give the committee some things to consider for the next report.

Ms. Boles reviewed prescription opioid mortality's process measure *Percent of top opioid prescribers enrolled in PDMP (Prescription Drug Monitoring Program)*. There are two data collection points: the end of 2016 and the end of 2017. In most of the counties, the percentage of top opioid prescribers enrolled in PDMP has gone down. It maybe in anticipation of the fact that by July 2018, by statute, 100% of all prescribers are urged to enroll in PDMP. As of July 1, 2018, all prescribers were enrolled.

Ms. Mortell asked if providers had to enroll annually. Why did this measure go down? Did we get more providers and they didn't sign up?

Dr. Hedberg responded that the answer is no. Providers enroll once, but we are getting new people who are getting licensed. It is not an annual thing.

Ms. Shirley added that the signing up for PDMP didn't used to be mandatory. It just became mandatory.

Ms. Mortell noted that it seemed weird that the measure went down just in anticipation of "I have to do it next year."

Dr. Dannenhoffer clarified that the data would be correct. What happens is that the top prescribers change. The top prescribers are different people each year, as well as new prescribers come in. For example, in Douglas County, it seems that we have new VA (Veterans

Administration) prescribers every week, and they are frequently top prescribers. The data is correct.

Ms. Queral remarked that this requires an explanation, because, in some ways, it leads us to miss the bigger picture, which is: *How many counties and local health authorities are actually going backwards?* It's not *How many are reaching the benchmark?* but *How many are going in the wrong direction?*

Ms. Mortell stated that we need to go back to the metrics committee, because, as the law changes, this is another measure we need to rethink.

Ms. Tiel suggested to put that task on the to-do list and for Dr. Hedberg to check the data.

Dr. Hedberg promised to check the data, because, what doesn't quite make sense is not that it wouldn't have occasional drop, but for every single one – something is a little off.

Ms. Boles said that she checked this. Starting in January, the numbers went back up again. It could be an end-of-the-year phenomenon. It is not clear. The subcommittee checked and double-checked and right after this, it went right back up. Sharply. It is just an artifact of the point in time we collected these data.

A few PHAB members proposed to change the time of the data collection for the next report.

Dr. Savage noted that one of things to remember is that metrics change. Something that may have been really important a year and a half ago and we start following – it changes, and we don't see it as very useful. That is very useful information. The fact that this data is not very helpful tells that we go back next year and say, "We not going to follow this as it is." What we need to do as a group is to acknowledge that this has happened, this is what's coming out of it. If there is something we can take forward, to use, to go for it – great, we will. If not, then the metrics committee will consider it and probably not bring it back as a useful metric. Once again, the process is useful. We shouldn't we bogged down in every little detail.

Ms. Boles continued to review the results for active transportation in the environmental health area. The health outcome measure, *Percent of commuters who walk, bike, and use public transportation to get to work*, has not changed between 2016 and 2017. The data comes from the U.S. Census Bureau American Community Survey. The local public health process measure is new, added last year. It is a measure that shows the LPHAs' participation in leadership or planning initiatives related to active transportation, parks and recreation, or land use. The data were obtained from a survey sent to the LPHAs. We have 17 counties out of 29 responding, and a few counties not included in the denominator, because they either did not respond to the survey or indicated that they were not eligible, due to lack of planning initiatives or anything happening.

Dr. Dannenhoffer stated that the results are totally backwards. Three counties that he knew about – Grant, Multnomah, and Douglas – were all Yeses and they are noted as Nos in the report. Lake county is indicated as having planning, when they it did not.

Ms. Tiel remarked that the report will be changed to reflect that.

Ms. Thalsofer added that when we look at Wasco county's data, and see that Sherman and Gilliam counties had 8% and 9% of people who said that they walked to work or to active transportation, does anybody know how that question is asked? Because this means that they walked out of the ranch house to the barn. There's nowhere for those people to walk. In reality, the towns are very small.

Ms. Boles admitted that she did not know how the survey question was asked. Ms. Thalsofer expressed a desire to see the question, because it was astounding to her.

Ms. Shirley pointed out that that (i.e., walking from the ranch to the barn) would be the correct answer. Dr. Luck noted that the farmers should get credit for that. Ms. Thalsofer clarified that not everybody works on their farm, but a lot of people work on a farm.

Ms. Boles apologized for the error.

Dr. Hedberg clarified that the measure said "percent of commuters." If you are a farmer, you may not consider yourself a commuter, and you would be ruled out of this. This is for people who consider themselves a commuter, and the measure is what percent of those people commute. We used to ask questions about leisure time and physical activity. And people were, "I'm a walker, or I'm a fisherman, and I'm going to do whatever when I come home and get on the exercise cycle. I don't think so." The measure is more relevant for certain populations than it is for others. My guess is that this is "Do you commute to work? Yes or No." It's not about walking from your home office into the living room and back.

Ms. Boles presented the next section of metrics in the environment health area – drinking water. There is no substantial change between 2016 and 2017. The health outcome measure, *Percent of community water systems meeting health-based standards*, is approximately the same. It did exceed the benchmark of 92% slightly. There are three process measures related to this metric: *Percent of water systems surveys completed*, *percent of water quality alert responses*, and *Percent of priority non-compliers resolved*. All those measures are roughly the same as they were last year.

Ms. Boles reviewed the health outcome measure related to effective contraceptive use, *Percent to women at risk of unintended pregnancy who use effective methods of contraception*. We only have statewide data for 2017, which is approximately the same as 2016. The process

measure is *Annual strategic plan that identifies gaps, barriers, and opportunities for improving access to effective contraceptive use*. In 2018, which is the baseline year for this measure, there are no counties or LPHAs that provided a strategic plan. However, the LPHAs are making progress in this area. They are engaged in a lot of other activities, such as developing collaborative relationships, conducting needs assessments, and other activities that will lead to their developing a strategic plan in the near future.

Ms. Thalsofer added that this is contingent on Title X funding not going away.

Ms. Mortell remarked that this process measure needs some explanation, as it looks like the counties didn't do their work.

Ms. Boles explained that there are notes on the page, as well as a technical appendix, and this page can be fleshed out a little bit more.

Dr. Dannenhoffer recommended to suppress the page, because, for example, Douglas county had a strategic plan, which, probably, does not meet anybody else's guidelines. To suggest that there is not a single LPHA in the state that met this measure suggests that it wasn't a useful measure. It is a useful measure for the future, but it would be better to suppress this page for the year.

Ms. Thalsofer shared a discussion of the accountability and metrics committee. When we got the funding for that program element (i.e., when the Title 10 funding changed), we were given a menu of choices of what we can do with that funding as a LPHA. A strategic plan was one of those choices. Nobody chose it. At the time, none of us made the connection that not choosing that strategic plan would then reflect that that was the process measure that had been chosen. On the committee, we recognize that there was a miss there. It's not a department strategic plan. It is specifically around reproductive health. Most of us didn't choose to do that. For example, in Wasco county's public health department, we wanted to build relationships with partners to try to increase access. Suppressing the page sounds right, because it does look like LPHAs didn't do work. LPHAs are all out there doing work.

Dr. Luck suggested that if we suppressed the page for effective contraceptive use, with which he agreed, a box could be put on the previous page, saying "process measure is coming, and data will be reported next year."

Most PHAB members nodded in agreement. Ms. Mortell asked whether the PHAB needed a full agreement, if members asked for changes to the report.

Ms. Tiel responded that the PHAB would vote at the end of the presentation on the two suggested changes.

Ms. Boles concluded the presentation with the section dental visits children aged 0-5, with the developmental metric *Percent of children age 0-5 with any dental visit*. The data for this measure is Medicaid-only data, not statewide data. There have been some changes from 2016 to 2017 in the positive direction. The rest of the report includes a technical appendix, which has a lot of explanatory notes, associated with each measure, as well as data tables.

Ms. Tiel summarized the changes to the report: (a) on the active transportation measure, flipping the results to reflect accurate information, (b) on the effective contraceptive use measure, suppressing a page and making a note that results will be reported in the next annual report. Any other conversations or ideas around changes to metrics or broader explanation that's needed will be shared with the subcommittee for its consideration in planning next year's report.

Dr. Dannenhoffer reminded the PHAB that changes should be made to the official immunization schedule, because it is incorrect.

Ms. Tiel agreed to add the change to the list of changes.

Dr. Hedberg commented that, first, she would go and check the data for the PDMP. Regardless of whether it has to do with December, instead of November or January, we don't the message to get across that we are going in the wrong direction. The program had one PDMP platform, and then they were sort of on hold, because they were transferring. That might be part of it. We need to figure out why. The fact that everybody is doing this – it doesn't make sense. Second, which is probably for the committee, on page 28, drinking water: this isn't useful. A hundred percent of the counties are doing this process measure all the time. It is terrific that they are doing it, but it doesn't really help us figure out what direction we are trying to move around accountability. It looks like this measure can go in only one direction. These ought to be directions that we are trying to improve and get better. This clearly is not going to help get that message across. If these data are correct, we still need an explanation for why this happened, because it doesn't make an intuitive sense.

Dr. Dannenhoffer made a motion for the approval of the report. Ms. Queral seconded the motion.

Ms. Tiel concluded that the PHAB is adopting the report with three changes and other considerations.

Dr. Hedberg suggested to put page 22 on hold until she went to check the PDMP results.

Ms. Thalhoffer noted that Dr. Hedberg doesn't need to check the data today. If she sees that it is an error, or an artifact in the data, the PHAB accepts that they will add the correction to the report appropriately.

Ms. Tiel asked the PHAB to vote on the report. The report was approved by most PHAB members. Dr. Luck opposed the approval of the report. No PHAB member abstained from voting.

Ms. Tiel congratulated the PHAB for approving the report, as it is a great action and a great deliverable for the PHAB.

Dr. Luck remarked that he was on a phone call with colleagues from Washington State earlier today. They were talking about accountability metrics and the colleagues said that Oregon's report was really good and very detailed. He congratulated everybody who worked on the report.

Dr. Bangsberg asked Ms. Tiel to dispense with her usual efficiency in managing the agenda for the remainder of the meeting, so the meeting could go as long as possible, maybe until 5:30 p.m. or 6:00 p.m. The reason to ask is because Dr. Hedberg is retiring. The PHAB must savor every minute it had with Dr. Hedberg, and thank her, and give her due appreciation for her great public health work and service in Oregon. The PHAB applauded.

Dr. Hedberg thanked the PHAB, stating that she was not leaving yet, as the beginning of June was the official time. She will stay on board for some transitions. She enjoyed very much being a part of the PHAB. She appreciated the applause but didn't think that she would necessarily like staying extra hours at the end of the day.

Ms. Tiel thanked Dr. Hedberg and adjourned the meeting for a 10-minute break.

Incentives and Funding Subcommittee

Alejandro Queral

Ms. Tiel announced that Dr. Hedberg would take a minute to explain the PDMP data from the accountability report.

Dr. Hedberg gave each PHAB member a copy of a chart depicting a PDMP Measure. She remarked that the data came from the Opioid Data Dashboard. The chart shows, by quarter, the number of people who are enrolled in the PDMP. This isn't quite the same as the top prescribers. The chart shows a steady increase and then there is a dip in the fourth quarter of 2017. One of the things that happened was that they moved to a new platform and no one was being enrolled for a period, and then the new platform switched over and a law was passed. Part of the reason that you don't continue to see a blip and then the same regression line, but an abrupt increase, was the law. People were supposed to be enrolled at the end of the second quarter of 2018. The line on the chart topped out, or it started to do that, and, most likely, we will see the same line as we did before. There was a sharp increase, and all the people who

weren't enrolled and should have been enrolled signed up, and now it will level off and continue with the people who are retiring, plus the new folks.

Dr. Hedberg proposed, as a decision, to compare the third quarter of 2016 with the third quarter of 2017, rather than the fourth quarter, which is where we saw that fall off. We would see the last point, where, if not all, most counties would be going in the right direction. If we then compare the third quarter of 2017 with the third quarter of 2018, we would see an even bigger increase. The data aren't really reflecting what's happening, but there has been a huge push to do this. If we put in the report that it is going in the wrong way, it does not message that we have a new and improved platform, but rather that things aren't working or whatever. Hopefully, it is not lying with data. It is actually being more truthful, as the one data point that was picked was not reflective.

Ms. Tiel thanked Dr. Hedberg for the update, calling it a culmination of age, technology, policy, behavior, and everything. A wonderful update.

Dr. Bangsberg suggested that the motion should include the update.

Ms. Tiel confirmed that the motion covered the update. She turned over the forum to the Incentives and Funding Subcommittee for their update.

Mr. Queral informed the PHAB that the Incentives and Funding Subcommittee met on March 12, 2019. The subcommittee had a good conversation, much of which was a revisit of the discussion it had the previous month (i.e., February). One of the things the subcommittee is asking the PHAB to do today is to take a vote on a recommendation that the subcommittee brought last month, in terms of how to spend the existing or anticipated \$5 million dollars that have been included in the Governor's budget. The recommendation was to stay the course, in terms of the grants going to the LPHAs not to go through a new RFP process. Part of the reasoning was that, for that amount of money, there was no point in creating a new process that would burden unnecessarily the local health departments.

Mr. Queral pointed out that the minutes reflect the bulk of the discussion. Part of that includes a conversation around what the PHAB would recommend if we did get the anticipated dollars coming out of increased tobacco taxes. Part of the amount allocated to OHA would be towards tobacco prevention and another part would be towards public health modernization. The line that cuts through both conversations is: How do we allocate those dollars in a way that it is about public health modernization and not just problem implementation? It is reflected in the minutes that the subcommittee has a realization that LPHAs are doing both: they are working to develop and implement programs and, in doing so, they are increasing, and building on, the foundational capabilities. The same framework would work as we are moving toward a recommendation, perhaps within the next couple of meetings, in terms of how to allocate those resources that are coming from the tobacco tax, in a way that frames the tobacco

prevention education program as a process for creating, or building, the foundational capabilities around prevention, which is one of our foundational capabilities in the modernization plan.

Ms. Queral noted that today's vote is straight forward and asked the PHAB members to open their packets to the page where the recommendation was written. The recommendation concerns the distribution of the funds, if the funding remains at \$5 million: (1) continue the LPHA partnerships that are currently funded, (2) avoid a RFP process and take steps to minimize funding disruptions, (3) allow LPHAs that we not involved in the 2017-2019 biennium to join an existing group, (4) use funding to advance local/regional systems for Communicable Disease Control and Health Equity and Cultural Responsiveness.

Ms. Queral invited the PHAB members to add anything that the subcommittee might have missed and bring it to the attention of the PHAB.

The PHAB members did not have any comments. Mr. Queral suggested for the PHAB to make a motion to approve the recommendation. Ms. Tiel agreed.

Dr. Dannenhoffer made a motion to approve the recommendation. Ms. Tiel asked the PHAB for questions or comments.

Ms. Mortell asked about the nature of the conversation regarding LPHAs joining existing groups. Also, as discussed in today's CLHO meeting, there is probably another change that the three counties that are currently in assessment phase would move to implementation phase.

Dr. Dannenhoffer answered that those were not part of this meeting. In terms of how counties would come in and how counties in the first phase would move to the second, there was not a specific discussion at the committee meeting. This needs to be clarified.

Ms. Thalhoffer addressed the PHAB members who are not local public health administrators with the point that this is not flat funding for the work. You will take 18 months of funding and spread it over 24, and when we add those counties in, it will change the population amounts and that will change the allocations to each of them. When we move one grantee from planning to implementation, that will also change. This will be a significant reduction in the work for each of the collaboratives that have been formed. It is important to be really explicit about that. It is not the same work. It is going to be a significant decrease.

Mr. Queral added that the other element that it is going to be a variable to consider is, if indeed the tobacco tax passes and there is that funding available, the funding is going to be during a very short period of time – for the last part of the biennium. That will also have an impact, in terms of how those dollars are distributed and how those dollars are used, which should be

part of our conversation. CLHO's recommendations on that front would be really helpful, as the committee meets again.

Dr. Savage addressed Ms. Thalsofer by starting that, as a non-public health administrator, she considered "decreases work" a good thing. Does decreasing work mean that it gives less funding to those people, so they are not able to do the work because they don't have the funding?

Ms. Thalsofer responded by giving an example with the four current employees in the Eastern Oregon Modernization Collaborative. With this amount of money, spread over 24 months, the staff cannot be supported. There will be no materials and services. The work requirements will have to be scaled back.

Dr. Savage asked how many LPHAs are interested in joining an existing group.

Dr. Dannenhoffer answered that there were just two.

Dr. Savage reasoned that those two LPHAs would increase the population and decrease the funding to the ones that are currently being funded.

Ms. Thalsofer clarified that it may switch, as some LPHAs may move higher.

Ms. Mortell reminded the PHAB that, if the top category is 700K, it may not. If, for example, a county is brought into the Washington county area with no additional funding, the funding for every group member will go down.

Ms. Moseley addressed a comment made by Mr. Queral regarding the distribution of the funds by stating that we are working and talking with CLHO about how to get the details of that piece worked out.

Ms. Tiel added that the perspective of non-LPHA folks is valuable. These are four guiding principles that are proposed by the subcommittee for PHAB's consideration. These four principles are solid. The considerations brought up by Dr. Savage, Ms. Thalsofer, and Ms. Mortell fit under them.

Dr. Savage noted that we don't want to pit one LPHA against another. But with limited funding, it is difficult. Is there any way that is in place now, when you look at what different LPHAs are doing, to choose to fund LPHAs based on their outcome and what they provided in the quality of the work that they have done?

Mr. Queral remarked that part of the idea is to avoid, at this stage, because the funding is so minimal, those additional processes that would require additional efforts from LPHAs, thus

distracting them from the goals that they have established. For this to be successful, we need a much higher level of funding. While that level of funding is not reaching a certain threshold, then maybe that threshold is reached once the tobacco taxes are allocated towards public health modernization. The recommendation and philosophy is let's make it as simple as possible to not lose the momentum and not create additional burdens that are going to exist anyway because of the increased amount of time that they have to spend those dollars and the other considerations that turn up.

Ms. Mortell admitted that she didn't remember the survey details, but it is difficult. We want all LPHAs to be supported. We are a team. In the surveying of our locals, the majority said, "At this level, we can't add, because we are already going down."

Ms. Shirley asked Ms. Mortell to clarify what can't be added.

Ms. Mortell answered that she meant two additional counties or move the counties that are not currently full funded into the pot. In her view, that was what the local majority discussed.

Ms. Shirley pointed out that what we are getting at right now is the recommendation of the PHAB.

Ms. Mortell responded that she wanted to share some background.

Ms. Tiel recapped that the PHAB subcommittee is recommending allowing the joining of LPHAs to existing groups. What the definition of "allow" is and how that will get worked out would be a conversation outside of the PHAB. We still have a motion on the table related to these four elements.

Dr. Dannenhoffer remarked that the discussion was "to add." It didn't say "to add immediately," or "to add right off," and it didn't say "to allow." The subcommittee recognized that there are a lot of details and it didn't want to get into the details. That is a contractual relationship that the state will need to figure out.

Dr. Savage suggested to change the wording to "allow LPHAs that were not involved to be considered for joining the existing groups." Otherwise, we are asking people like her, who don't know about the history, to come in and say it's okay, when they don't know one way or the other whether that is a good idea. They can abstain, which is fine, and let that decision be made by people who understand it a little better. It is not clear which way the PHAB would have them go on that.

Mr. Queral did not see a big difference in changing the wording, which sounds similar. Ultimately, it is a local decision, in terms of what that relationship is between the jurisdictions and their contractual relationship with the state. Both languages allow for that.

Dr. Hedberg asked which were the LPHAs that were not involved before.

A few PHAB members answered that it was Yamhill and Josephine counties.

Ms. Tiel suggested that the PHAB should strive to not have anyone abstain from this vote, as it is really important. From an access perspective, we, as PHAB, don't want to limit access to doing this work, understanding that there are complexities. From a value of us as PHAB, we would not want to create or vote on something that is denying access to something, but allowing it, and then letting the partners, CLHO, and the state to work through that. This is mostly for non-LPHA folks to make sure that we feel comfortable taking this.

Ms. Tiel reiterated that the PHAB had a motion on the table to adopt this for the bubble funding. She asked for a second on the motion and asked if an edit should be made.

Dr. Savage noted that an edit was fine, as she understood better now. She was not understanding what that meant. It sounds more of a philosophical recommendation and the actual details will be worked out on a local level. That is fine, as long as it is not mandated that that has to happen. She now understood 100% what she was asked, and she felt comfortable as it was written.

Ms. Tiel asked the PHAB for other comments or questions. There were none. She proposed a vote for moving forward with the subcommittee's recommendation on funds remaining at \$5 million dollars. The PHAB approved the recommendation unanimously.

Ms. Tiel asked who seconded the motion. Dr. Savage answered that she did. No PHAB members opposed the recommendation or abstained from voting. Ms. Tiel thanked the subcommittee, pointing out that this work in particular has a lot of complexity and predicting and planning for the unknown future.

Ms. Tiel prefaced the next presentation on data visualization by stating that we have gotten a lot of updates on the portion of the 2017-2019 investment that has gone to local public health, but a portion of that that stayed at the state level supported improving our population data collection and analysis through the public health division. This is our opportunity to hear more about that work related to the assessment and epidemiology capability.

Modernization Progress Update: Data Visualization

Dr. Ali Hamade (OHA staff)

Dr. Hamade introduced himself to the PHAB. He is Dr. Hedberg's deputy, one of the deputy state epidemiologists, and chief science officer for the Center for Health Protection. He has been an OHA employee for five months. Improving on public health modernization data access



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and visualization was one of the first tasks he was assigned to do. It is a useful topic that would help facilitate access to and visualization of data that we have, as well as data from our partners. This task is a group effort, with people working on it in different divisions.

Dr. Hamade noted that, looking at the modernization framework, we can see that data access and visualization fits into all foundational programs and foundational capabilities to varying degrees. We need data for OHA's purposes, for sharing with partners, LPHAs, the media, or whoever might need those data.

Dr. Hamade asked the PHAB member to keep thinking about what questions they might have for the data visualization team. Is the team missing any data access and data visualization strategies? Do PHAB members have any feedback on the plan or strategy that the team has? Do PHAB members see any underlying biases in the plan for data visualization? It is important to keep a critical and analytical lens during the presentation.

Dr. Hamade explained that interactive data visualization is the goal for all data sets. This will enable data representations on a graph, table, or map, with the ability to change variables and link multiple media. Instead of having thick and heavy PDF reports, we can go to a website and see all the different parameters we want. It saves people time and staff time.

Dr. Hamade remarked that data access and visualization fits into the assessment and epidemiology capability activities for both Oregon state and LPHAs. This involves: (a) data collection and electronic information systems, (b) data access, analysis, and use, (c) conduct and use community and statewide health assessments, and (d) infectious disease related assessment.

Dr. Hamade highlighted the aims of the data visualization initiative: (a) data access, (b) faster evidence-based planning (i.e., data is at one's fingertips and it doesn't need any expertise to manipulate the data), (c) staff time savings and capacity increase, and (d) interoperability of systems (i.e., data can be better standardized). These aims benefit state agencies, LPHAs, tribes, policy-makers, community-based organizations, advocates, and media, among others.

Dr. Hamade presented an example of interactive data visualization from the Opioid Data Dashboard. It was a graph of the statewide drug prescribing and overdoses. Types of drugs can be added to and removed from the graph, as well as other parameters. The OR Epi people have used it to create nice dashboards.

Dr. Hamade discussed the science behind data visualization. It starts with platforms and tools (e.g., SQL, data warehouses, data marts) and proceeds through methods and algorithms (e.g., linear regression, random forests), data analysis by statisticians or quants, and creation of visualizations and dashboards. Based on that, we can use those data to develop insights and

strategies. It is not just analysis of data and dumping those data into a software. It is a much more complex system.

Dr. Hamade informed the PHAB of the data visualization priorities: (a) vital records (e.g., birth and death data), (b) reportable conditions (e.g., ORPHEUS, OSCaR), (c) survey data (e.g., BRFSS, OHT, PRAMS I/II), (d) service delivery (e.g., Alerts IIS, Oregon Trauma Recovery), (e) environmental and regulatory (e.g., safe water drinking information system), (f) emergency preparedness and response (e.g., ESSENCE).

Dr. Hamade explained that the performance of the data visualization team will be measured by a performance measure that includes four benchmarks, which will be implemented going forward: (a) developing a data visualization plan that includes maintenance of the data, (b) ensuring that visualization and database software are available and that staff are trained to use them, (c) creating the back-end database or, with completed projects, data is updated on schedule, (d) creating and publishing data visualization. The different dataset owners would get partial credit for advancing through those steps.

Dr. Hamade remarked that the data visualization team is working on developing a plan template that will be used by the different data owners. The plan will include items on partner engagement. For example, how to best share data with LPHAs, tribes, and others, especially making sure that the data are useful to partners and being respectful of partners' needs. The plan will also include items on evaluation of the data and continuous quality improvement.

Dr. Hamade thanked the PHAB and asked to feedback or suggestions on the plan.

Dr. Dannenhoffer stated that he was a huge fan of data visualization and praised the plan. In his opinion, data visualization products are incredibly hard to translate, if they are to be translated to another language. Thinking about the accountability report we saw today, which was about visualization of metrics, is that going to be available in Spanish as it is? That is going to be an incredible, hard job. Second, when we work on written things, we have readability statistics, so we are trying to get down to the sixth-grade level. Is there any other way to do that on data? Some of these reports are very hard to follow. None of the stuff we saw today could be brought down to the sixth-grade level. Do we have the analogy to readability statistics, and how are we going to deal with other languages?

Dr. Hamade responded that the team has discussed briefly these issues, but they haven't been thought out fully. It is something that should be taken into consideration. It may not be feasible for all datasets. That would be a lot of work. We don't know how useful it would be for the different audiences. It is definitely something that the team should consider. It could be something that comes out of reaching out to partners, LPHAs, tribes, and different entities. Hopefully, that could better inform our process. In terms of readability, Dr. Hamade was not sure if it was currently done and what standards existed. The team is looking into disability

issues, trying to remove issues related to colorblindness, but readability will definitely be made part of the plan. Those are things to discuss and get feedback from partners.

Dr. Hedberg commented that, looking at all the different audiences, one size doesn't fit all. People have to be a little data savvy to go the data dashboard now. She hoped the PHAB was impressed by how quickly she got the PDMP data. She went upstairs, got the data, snipped, pasted, and she was back down in five minutes. The PHAB is very different because they know how to use the tool. Is this a tool that the general public will spend a lot of time on? Most likely, no. We have talked that (a) depending on the platform, you are allowed to put in a text box or language, which is part of the interpretation (e.g., it's going up or down), and (b) we will continue to develop, for example, program factsheets. This is an important tool.

A fire emergency interrupted the meeting. The PHAB evaluated the building. Upon returning to the room, Ms. Tiel thanked Dr. Hamade for the presentation and recommended to the PHAB to follow up with an email, if any members had questions about data visualization. It was great to see an innovative and non-silowy thing that state is using and has invested in.

Ms. Tiel introduced the next agenda item by stating that it is related to behavior health. Behavior health and access to quality care is critical in its core to the OHA's broader mission. It is becoming a reoccurring priority raised by community members during the state health improvement process and through the CCO 2.0 process, in which we are actively engaged as a board. This is a session for the PHAB to learn what the OHA is doing related to behavioral health from the Health Systems Division.

Update on Behavioral Health

Margie Stanton (OHA staff)

Ms. Stanton introduced herself to the PHAB. She works at OHA and her supervisor is OHA director Pat Allen. He likes to say that he is new and knows a little bit about behavioral health. If that is the case, Ms. Stanton is newer and knows littler. The PHAB appreciated Ms. Stanton's humor.

Ms. Stanton expressed a delight to be at the PHAB meeting and to share with the board a little bit about OHA's work on behavioral health. Her presentation was shared over a week ago with the Ways and Means Committee. The Health Systems Division, where Ms. Stanton works, is where we have, reporting, the behavior health director, as well as the Medicaid director. We both sit on the cabinet of the executive committee that reports directly to Pat Allen. Many people ask why we have the Medicaid director and the behavioral health director reporting through a division called Health Systems Division. It is because we need that coordination and care, as well as we need the coordination of funds that are necessary to cover the benefits associated with taking care of the care. Many people don't realize that when we talk about

behavioral health, the funds that we use to take care of behavioral health – many of those funds come from Medicaid.

Ms. Stanton presented a slide called “the honeycomb slide,” which depicted 13 hexagons and described the state of behavioral health in Oregon. She pointed out that (a) suicide is the second leading cause of death for young adults in Oregon, (b) only 50% of adults in Oregon who received mental health services were satisfied with their services. This is interesting, because when we do the surveys for physical health and we talk about coordinated care in Oregon, the survey results come back and we get 90% are satisfied with the care that they are receiving, while here, we are getting 50%. And that is those who are receiving care. Think about how many are not even receiving access to care. The many things on the slide tell you what we are talking about when we talk about behavioral health in the state.

Ms. Stanton explained that behavioral health is where we live, work, and learn. We want all Oregonians to receive personal-centric services. We want them to have support for their needs wherever they live, work, and learn. We are talking about providing universal home visits. We are talking about having services in the schools. We are talking about the type of care in the homes where people don’t need to be in residential facilities. We want people to be able to stay in their communities and have access to the same type of services that they are receiving in residential facilities. We find that when people are able to get the services in the communities where they can have to support from peers and family members, the outcomes are much better than when they have to leave those communities. The challenge is that we don’t have a lot of those service in those communities. In many cases, people have to leave the state to find the support for those services.

Ms. Stanton stressed that we have got to do a lot more in the State of Oregon. Although Pat Allen and Ms. Stanton might have limited knowledge about behavioral health, the good news is that, when we were talking to the Ways and Means Committee, we also announced that we had hired a behavioral health director – someone who has quite a bit of experience in this area – and we are quite excited about the fact that this person, Steve Allen, will be joining us at the end of April.

Ms. Stanton noted that the behavioral health vision addresses providing universal home visits after birth, expanding middle health access in schools, invest in suicide intervention and prevention, providing intensive in-home behavioral health services for kids, provide access to behavioral health services in the right place at the right time. We want to improve mental health outcomes through supportive housing, invest in more connected behavioral systems, expand community services in mental health illness, as well as misdemeanors. We have quite a few of our mental health patients staying at the state hospital. They don’t need to be there, other than the fact that there is nowhere else for them. We are not able to get the systems that they need unless they commit some type of action that gets them locked up. Then the system

has nowhere to put them, other than to keep them in jail, or to send them to the state hospital, because the different communities don't have the services to offer them.

Ms. Stanton reviewed the elements of behavioral health services: (a) prevention, (b) intervention, (c) treatment, (d) case management, (e) maintenance and recovery support. In terms of spending, and contrary to popular belief that we don't spend money for behavioral health, we anticipate to spend over \$3 billion in the 2019-2021 biennium.

Ms. Shirley pointed out that the little purple line at the top of the bars for the past four biennia is the spending for prevention.

Mr. Queral asked for clarification because he was looking at the same line and was trying to understand. Does it mean that none of these other programs and none of these other dollars go to prevention at all? On the graph, the spending is broken down by who the source of funding is, but then we have prevention. Does this actually reflect the amount of dollars invested in prevention?

Ms. Stanton answered that Mr. Queral's statement was correct. There is quite a bit of money spent in many areas having to do with behavioral health. Over \$3 billion dollars is anticipated to be spent. We would like to spend more money on prevention, and we'll see more of what the strategies are along those lines. Maybe that will give you some ideas of what the plans are. Let me share more about the successes along those lines and maybe that will give you an idea about why we want to invest more in the schools and in early childhood, because that's what will make the difference about the future; and why we will be spending less on care in the state hospital and on emergency room treatment. Because if we do more of those things in the schools, we'll have less suicides and attempted suicides and people looking for these services out of state. That is the key.

Ms. Stanton stated that, in terms of strategies, we want to do more in those areas to address some of those serious things. When we are talking about behavioral health, it is not one of those things that you can pinpoint and be done. It is something that is chronic. It lasts a lifetime. We have to invest in a system of care and support, and we have to invest in programs. Not only do we have to be there at the right time and the right place, but we have to be there to support that individual for a lifetime. We have to build that group of care in that community and be ready to receive support no matter how many times a person would last. This is very important, especially when it comes to... If a person is using, they are sober one minute and they are not the next, we can't kick them out of... That can't be the answer. Or we can't deny them housing, because housing so important to a person's recovery. Things like that are involved in the success of one's health, and how they make those connections.

Ms. Stanton added that success is increased availability of services. These are the things that have worked for us. These are the things that we want to invest in for the future, for us to have

the prevention that we are talking about. Permanent supportive housing is another success. Our agency will not only make best efforts in reference to the care, but we will partner with other agencies and provide funding to apply that type of support. Success is also increased capacity in rural Oregon in reference to behavioral health. We have quite a few programs for Oregon's tribes that can be customized with the different groups, based on whatever the needs are and make sure that they are culturally specific. We try to remove barriers for tribal behavioral health and meet the specific needs of our clients. In relation to suicide, when we have those programs in the schools, it makes a huge difference. Public health can do a lot in this area and have.

Ms. Stanton noted that success is parent-child interaction therapy. For those not familiar with this therapy, it is the one where the parent wears an earpiece and the therapist talks to the parent and coaches them how to interact with the children. This is prevention. We work with them when they are young and we don't have the problems later in life. It is amazing how many things can be prevented by doing this in the early ages (ages 2-6), as far as behaviors are concerned. Every parent can use this.

Ms. Stanton showed a slide with an embedded YouTube [video](#), in support of success as keeping families together through recovery. The video is very moving, and it is about families. This is prevention. These are young couples who have kids, and they are talking about that they were hopeless, and how the work we did with them saved their families.

Dr. Dannenhoffer remarked that, in terms of "rights," you don't have right treatment at the right place at the right time, because some people are getting incorrect treatment. They are getting lower level of treatment than they would otherwise need. Other people are getting higher level of treatment than they probably need.

Ms. Stanton stated that one of the things the Health Systems Division is working on is just that challenge – making sure that we have adequate space criteria around what's needed. It is very important. That has not been available to us so much. That is one of the areas where we are making the investment going forward.

Dr. Dannenhoffer gave an example that in a four-county area, including Douglas county, there is no child psychiatrist. That is crazy.

Ms. Tiel informed the PHAB that the video cannot be played because there were no speakers in the room to listen to it. The link will be sent out to the PHAB members.

Dr. Hedberg commented that what is a little bit difficult with behavioral health is when we think about primary prevention versus what's prevention through screening and treatment and being intergenerational. She did not dispute that much less is spent on prevention, but there might be a way to talk about it that we are preventing the future generations with those types of

interventions. We say, at least in public health, “Don’t start smoking,” and for people who started, “Quit.” It is a little bit different with behavioral health issues.

Ms. Stanton explained that the big challenge, when we talk about treatment, is that it’s not like physical health where you know the moment. With behavioral health, the challenge is recognizing that you need treatment. Where is that moment? When someone recognizes that they need treatment, they must have access to it. It has to be right then and there.

Ms. Stanton highlighted the behavioral health challenges: (a) Urgency for intensive children’s services: When we recognize an issue, it can’t be at the crisis moment. Because when it is at the crisis moment, it is almost too late. Keeping children close to home is important, because it’s more than one person at that point. If you have to pull someone out of the family, the impact is more than one individual. It’s an entire family that’s being impacted. (b) Unmet mental health need in school age youth: Everything that’s going on – the surveys are telling us that it’s unmet. The teens and children are telling us that we are not meeting their needs. It’s hard to understand it. We are not understanding what they are talking about, if we are not able to get at it. Somehow, we have got to fit into these schools and find out. It is unclear if it the peers, or how we are going to get this information, but they are clearly telling us that the emotional help, the need is not being met. (c) Suicide rate above the national rate: Oregon is not doing well. (d) Aid and assist: This is the situation about taking up state hospital beds. The people who need those beds can’t get them, because we have people there who have nowhere else to go. (e) Integration of behavioral health: The coordinating care situation is not happening. We have done a lot of work on CCO 2.0 to try to address this and get better outcomes.

Ms. Tiel thanked Ms. Stanton and invited the PHAB to ask questions and provide comments, encouraging the PHAB members to think about how the behavioral health system and its work align with some of the wording around the foundational capabilities and infrastructure.

Ms. Queral commented that the second bullet point on the slide about urgency for intensive children’s services (i.e., children with complex needs and their families need better access to community services) is really critical. As we think about what those community services are, we are also thinking about how we can ensure that those parents can actually take time off from work, so that they can attend to their children who are in crisis. That’s a part of how we address this set of challenges. The Oregon Health Authority should weigh in on that.

Ms. Queral added that another piece that is important to understand about the suicide rates is how we compare to the rest of the country when it comes to investments. What does the distribution of those investments in other states look like? We need to understand that it is part of the driver for what appears to be an important difference in terms of those rates.

Ms. Stanton answered that the Health Systems Division does have a policy in its budget this biennium to get the resources to address that. There was a study done that provided a plan and

foundations that needed to be put in place in reference to some of the work that was done from the study. We are looking to put that plan in place, both for the children and the adults. That's part of the package that we have on the table now in the budget. Hopefully, it will get approved and that would help the situation.

Dr. Hedberg noted that suicide is extremely complicated and that these data are absolutely right. It turns out that the states that had the highest suicide rate are on the west coast – Alaska, Oregon, Montana. In contrast to the rest of the country, 80% of our gun deaths are suicide deaths. The rest of the country, it is 60%. It is not just as simple as met or unmet mental health needs. A big part of it culture. It is also access to lethal means. In the last legislative session, there was a bill that talked about a restraining order for people who had guns, for family members to take the gun away when they were in a crisis. This is no safe for adults. Youth are a little bit different. It is very hard to link this directly to research, because the situation is so complicated. That's potentially part of it, in access to behavioral health services. It might also be, and that's the reason to have better integration, that there are a lot of men who won't necessarily go to see a psychiatrist. We get care from a primary care provider. We need to make sure to bring up these issues, so there isn't this chasm between what we need for behavioral health and physical health, but that the whole person is addressed. Per lethal means, we want to present more data about that, because, most likely, it's the gun deaths that make the western state higher than other parts of the country.

Ms. Thalhoffer remarked that at the Oregon Public Health Association conference this year, there was a presentation from Means Matters. The research shows that it is very much about access to a lethal means. When they asked people who had survived an attempt how long they had been planning their suicide, it was somewhere in the range of 8 to 10 seconds before they attempted. So, you have a gun, and you have ammunition, and you attempted. The likelihood that it is going to be accessible is high. There is a program that was created and has been available in Deschutes county and Umatilla county that was created with gun owners. Because it is not about taking guns away; it's about raising awareness among gun owners. Those of us in eastern Oregon know this – it's about gun owners understanding that that access puts their families and friends at risk. Ms. Thalhoffer would love to do the program in Wasco county, but there is no money to implement it. Her nephew is a police officer in town and she has great access to law enforcement, but the county has no funding to implement a program like that.

Ms. Tiel responded to Ms. Queral's comment about parents taking time off from work by stating that it reminded her of the State Health Improvement Plan (SHIP) and the economic drivers, such as a living wage and a job, that are important for this work. She wondered how we would implement and take our SHIP process and share it with the partners, with the Health Systems Division, and talk about that in a statewide capacity.

Ms. Mortell commented that we continue to hear concerns from partners at school-based house centers regarding continued increase of mental health service needs in school-based

house centers. She met recently with two of Washington county's school districts that are combined. One of the things that is so typical about our work is silos and not working well together. How do we bring funding, and bring people together, and talk about the work we are doing around things like a good behavior game and other resiliency building factors, to the mental health services at school through the community? It's not connected. We are not working well enough together to get as far as we can get. We were brainstorming: Could we do some kind of a forum and bring everyone together? Everyone's starting pilots – a pilot here, a pilot there. If we could think what is successful and how we could fund a broadest sweep across the whole community, we could get so much farther.

Ms. Stanton stated that Ms. Mortell's comment was interesting, because that was what the coordinated care model was all about. We provide funding for the coordinated care model to do just those types of things and building more into their incentive program. That's why we have put in the value-based payment system for them. With CCO 2.0, a piece of that has to do with community base. When they submit [an application], they work with their community to talk about how they come up with their proposals and their plans to represent their community. The thing with their schools is part of their whole process. It's not uncommon for them to work with their counties and their schools on those types of things.

Ms. Thalsofer apologized for what she was about to say. That sounds great on paper. That is not what is happening on the ground. Whatever the CCOs are writing in their reports might be lovely, but on the ground, they are just another silo that we have to bang on the door to try to get into. And they are a piece. They are worried about the Medicaid population. We have said it many times that they are supposed to help the whole population. They don't. They are worried about their population. In the community of Wasco county, they are just another billing mechanism. It's another silo. We can do much better with the huge amount of public funds that are being spent on these efforts. On the ground, it is not happening the way the reports are coming out that they are saying they are doing it. It is just very, very difficult to work. For example, Ms. Thalsofer's workload has increased four-fold since CCO 1.0, with no additional funding. They are not funding local efforts. They are not funding local coordination. It's just become another silo that we have to work with. The county partners can say if it's been the same for them, but can do much better, and really work across community, and that's not happening in many, many cases.

Ms. Mortell pointed out that focus of the CCOs is on the adult population than on the children's population.

Dr. Savage noted that, as the CCOs representative, she has discussed this with Ms. Thalsofer. It is very different around the state. The CCO's experience, from Dr. Savage's perspective, is very different in Marion and Polk counties. The CCOs have a very good relationship and have been funding at the table with these community investments and community partnerships. If you ask our local public health [official], Katrina, and other local public health [official] in Polk county,

her name is Christy, they will tell you that the CCOs are very much active and at the table. It is not to the level that it should be. That is definitely true. It is like what happened at the very beginning – you put a bunch of people in a room together, and they may not know how to interact, or how to like one another, or how to play in the sandbox. To throw them there without guidance was probably not the best way to start. There are willing partners in the CCO world. We just have to get those partners spread all across the state.

Ms. Moseley expressed a hope to tie this up and come back to what she hoped this conversation would be for the PHAB – thinking about alignment of the public health system around behavioral health. The reason for keeping this in the forefront is that we are hearing – at least at OHA and through our community engagement around the SHIP, CCO 2.0, and other efforts – that behavioral health and the priority that communities want to place on figuring out how to make this, from a human’s perspective, cohesive and meeting them as a full person and, from a system’s perspective, a real system that supports around this component of our health that we call behavioral health. How do we have that conversation as broadly as possible within OHA? Because the communities are coming to us, over and over again, saying, “We need to do better on this. We need more from the state on this.” All of us, on state and local level, want to deliver on that.

Ms. Moseley added that that was the impetus of her bringing this to the PHAB meeting. It has been a good conversation. She is very hopeful, if possible too hopeful, that the new SHIP will help carry that throughout the state, both because it is more grounded in community engagement than what the Public Health Division has recently achieved in the past, but also because it is just a loud and clear priority for all communities around the state to raise us and to get our systems working better. The PHAB is part of our public health and our health care system as well. That’s why Ms. Mosely wanted to bring this conversation to the meeting for this kind of thoughtful conversation. She hoped the PHAB members kept these things in mind as we are moving forward, talking about all the other components of the public health system that we talk about in this group.

Ms. Tiel thanked Ms. Moseley, as well as Ms. Stanton for coming to the meeting.

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 4:44 p.m.

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



Public Health Advisory Board
Meeting Minutes – March 21, 2019

**April 18, 2019
2:00-5:00 p.m.
Portland State Office Building
800 NE Oregon St Room 1B
Portland, OR 97232**

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



April 2019

Preventive Health & Health Services Block Grant – Fact Sheet

Background

- Non-competitive grant issued to all states and territories to address state/territory determined public health priorities.
- The Public Health Advisory Board (PHAB) is designated as the Block Grant Advisory Committee which makes recommendations regarding the development and implementation of the work plan.
- Federal code states that a portion of the allocation (pre-determined) be used for rape prevention and victim services. This funding currently goes to the Oregon Coalition Against Domestic and Sexual Violence.
- Work plan must be tied to Healthy People 2020 objectives. Oregon has historically used the block grant to support infrastructure. Healthy People 2020 objectives in the 2018-19 work plan:
 - *Public health infrastructure (PHI-16. Increase the proportion of Tribal, State and local public health agencies that have implemented an agency-wide quality improvement process.)*
 - *Accredited public health agencies (PHI-17. Increase the proportion of Tribal, State and local public health agencies that are accredited.)*
 - *Sexual Violence (IVP-40. Reduce sexual violence.)*

Funding

- For October 2018 – September 2019 work plan, funding is \$1,202,991 with \$85,660 allocated for sexual assault prevention and services.
- Oregon's overall goal has been to support ongoing planning for and implementation of Public Health Modernization foundational capabilities, so all Oregonians have access to the basic public health protections to prevent disease, injury and death.

PHHS Block Grant Supported Accomplishments - 2018

- Implementation of the statewide Public Health Modernization Plan
 - Public health accountability metrics and process measures were developed and analyzed with an annual report issued.

- Tribal public health modernization assessment data and reports were finalized for three federally-recognized tribes and the Northwest Portland Area Indian Health Board.
- Fiscal year 2018 local investment financial data were collected from local public health authorities to support matching funds component of public health modernization funding formula.
- Training and technical assistance was provided on newly revised Oregon Administrative Rules for public health modernization implementation.
- Foundational programs and capabilities information was integrated into local public health authority intergovernmental agreement scopes of work and compliance review tools.
- The OHA-PHD Health Equity Work Group developed charter, work plan and shared understanding of health equity as a basis for supporting implementation of the health equity and cultural responsiveness public health modernization foundational capability.
 - OHA-PHD staff listening sessions were held to identify highest priorities for policy interventions, strategies, and policy and practice changes required to improve division workforce diversity and inclusion.
- Local and tribal training, technical assistance and coordination
 - Fourteen compliance reviews were conducted with local public health authorities.
 - A resource guide for local public health authorities exploring alternative structures and models for delivering public health services was produced.
 - Intensive technical assistance and coordination was provided with local public health authorities seeking to transfer responsibilities to state or to implement alternative models.
 - Two public health partner orientations were held to orient new staff of partner organizations to OHA-PHD.
 - Financial support was provided for Conference of Local Health Officials meeting coordination.
 - Formal tribal consultations were held in preparation for a fish consumption advisory for water bodies on which some Tribes have treaty rights.
 - A new OHA Tribal Consultation Policy was implemented within the Public Health Division.
 - Consultation was provided to PHD programs seeking to expand their work with federally-recognized tribes.
- State health assessment and improvement plan (SHA and SHIP)
 - The new state health assessment was completed using a community engagement best practices model.
 - Planning for 2020-2024 State Health Improvement Plan commenced as included mini-grants to community-based organizations serving and/or representing communities experiencing health disparities to gather input on next SHIP priorities.

- Public health accreditation
 - A monthly local and tribal public health accreditation work group was convened in partnership with Conference of Local Health Officials.
 - The annual report to maintain OHA-PHD national public health accreditation was completed.
- A new OHA Performance System was implemented within the Public Health Division, including a division-specific fundamentals map and performance measures.
- Workforce development
 - Workforce development opportunities with a focus on mentorship and community partnership development were offered to OHA-PHD staff.
 - Significant increases in manager and new employee completion of core curriculum courses, including new employee orientation, were achieved.
 - The OHA-PHD annual all-staff meeting and fall forum sessions were conducted.
 - Over 80 online learning opportunities aligned with public health modernization foundational capabilities were made available to state, tribal and local public health authority staff.
 - An Oregon Public Health Association annual conference sponsorship was funded.
- Sexual violence primary prevention
 - El Programa Hispano was funded to identify and implement culturally-specific sexual violence primary prevention with Latinx youth.
 - Mini-grants were awarded to 12 community-based organizations to build-capacity for culturally-specific sexual violence primary prevention.

Next Steps for 2019-20 Work Plan Development

- Funding allocation for October 2019 – September 2020: \$1,123,160 (\$85,660 for sexual assault prevention and services)
- Draft 2019-20 proposed work plan concepts (April-May 2019)
- Hold public hearing on proposed work plan concepts. (May 13, 2019, 1:00 p.m., PSOB Room 915)
- Share proposed work plan concepts and any comments received at public hearing with PHAB for final recommendation. (May 16, 2019 PHAB meeting)
- Submit final work plan to Centers for Disease Control and Prevention. (early June 2019)

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

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
April 9, 2019
1:00 p.m. - 2:00 p.m.

PHAB members present: Carrie Brogoitti, Dr. Jeff Luck, Alejandro Queral, Akiko Saito, Dr. Bob Dannenhoffer

PHAB members absent: None

Oregon Health Authority (OHA) staff: Sara Beaudrault, Katarina Moseley, Danna Drum, Krasimir Karamfilov

Welcome, introductions, and updates

Ms. Beaudrault introduced the meeting and thanked everybody for joining. She apologized for not having the meeting materials posted online and assured the subcommittee that the materials would be posted as soon as possible after the meeting.

Ms. Saito introduced herself and invited meeting attendees and the subcommittee members on the phone to introduce themselves.

A quorum was present. Ms. Saito asked the subcommittee members to review the meeting minutes from March 12, 2019, before the subcommittee approved the minutes.

Ms. Saito asked if the subcommittee would entertain a motion to approve the meeting minutes. Dr. Dannenhoffer made a motion to approve the meeting minutes. Dr. Luck seconded the motion. The subcommittee approved the meeting minutes unanimously.

Dr. Dannenhoffer expressed appreciation for the quick preparation and distribution of the meeting minutes. Ms. Saito agreed with Dr. Dannenhoffer and added that the meeting minutes were detailed.

LPHA funding between \$5-10 million – planning scenario

Ms. Beaudrault followed up on the work the subcommittee did during its last meeting to formalize the recommendations for use of the \$5 million in funding, with \$3.9 million going to LPHAs, if we have the same level of funding in the next biennium. Because of the work the subcommittee did, OHA has been able to put plans in place to ensure that funds go out to the eight LPHA partnerships that are funded now in July and not go through a RFP process. There should be very little or no interruption in funding out to those groups. OHA will continue to provide updates.

Dr. Dannenhoffer pointed out that because the funding is spread over 24 months rather than over 19 months, it is a monthly decrease of \$5,000/\$6,000 per month for the plans, which would most likely result in reductions of personnel in most of the programs.

Ms. Saito asked Ms. Beaudrault if she had heard from any of the partnerships whether that was a concern.

Ms. Beaudrault remarked that LPHAs have expressed that concern through the Conference of Local Health Officials (CLHO). Some of the partnerships can absorb the reduction in funding more easily because they had spent funds on up-front costs that they would not necessarily need in the next biennium. For other partnerships, it is not how they used their funding, so it is a real impact.

Ms. Beaudrault guided the subcommittee members to page 11 of the packet, displaying the funding pyramid and funding levels. Until now, the subcommittee has been talking about the very top of the pyramid, up to \$5 million in funding to local public health authorities (LPHA)s. Today the subcommittee will take it down to the next tier, between \$5 and \$10 million in funding to LPHAs. This is just planning for if OHA ends up with additional General Fund investment at the end of Legislative Session. Funding to LPHAs is a portion of total funding for public health modernization.

Ms. Beaudrault called the subcommittee's attention to page 10 of the packet, listing the funding priorities that the Public Health Advisory Board (PHAB) developed in 2018. She emphasized the first four priorities as being relevant to the discussion:

- (a) Ensure that public health services are available to every person in Oregon, whether they are provided by an individual local public health authority, through cross-jurisdictional sharing arrangements, and/or by the Oregon Health Authority.
- (b) Align funding with burden of disease, risk, and state and community health assessment and plan priorities, while minimizing the impact to public health infrastructure when resources are redirected.
- (c) Use funding to advance health equity in Oregon, which may include directing funds to areas of the state experiencing a disproportionate burden of disease or where health disparities exist.
- (d) Use funding to incentivize changes to the public health system intended to increase efficiency and improve health outcomes, which may include cross-jurisdictional sharing.

Ms. Beaudrault noted that the text on the pyramid for funding between \$5-\$10 million was vetted by the Conference of Local Health Officials (CLHO) last year and states that if LPHAs are to receive between \$5 and \$10 million, then all LPHAs would receive floor funding through the base component of the local public health funding formula. This is the part of the funding formula that gives all counties some funds to work with, based on their county size. The base funds range from \$30,000 for the extra small counties up to \$90,000 for the extra large counties. The remainder of funds would be distributed through grants to LPHA projects or partnerships. The text says that it would be connected with the partnerships that were established with current funding, but there is some flexibility to how PHAB would recommend those additional funds are used.

Ms. Beaudrault added that, looking at it a different way, if there were between \$5-\$10 million for LPHAs, this is how the funding would break down: (a) The eight LPHA partnerships that are funded now would receive \$3.9 million, (b) The base funding to each LPHA totals to \$1.845 million, (c) Remainder funds that could be available. Different ideas have been voiced about how the remainder funds could be used, both in this subcommittee and in CLHO conversations. Possible

funding avenues include: (a) additional funding to LPHA partnerships, (b) new partnerships that did not meet the criteria for currently-funded LPHA partnerships (e.g., a county that wants to form a partnership with a tribe, or a CCO, or a different entity, but not with other LPHAs), (c) cross-jurisdictional service delivery models (e.g., Washington state's new service delivery models, where one county plays a role of providing foundational public health services for other counties). Other ideas might be directly related to the funding principles.

Ms. Saito commented that one of the things to consider, based on Dr. Dannenhoffer's remark about the potential decrease of funding to the partnerships, is whether the first part of the funds over \$5 million could be used to make those partnerships whole, so that the funding is there for the 24 months, and then decide on the remainder funds to do base funding, and so on. The idea was to put the money in these pilot projects, so that they could really show us what could be done and be a model project for everything else.

Dr. Luck asked how much it would cost to fully bring the partnerships back up to the same monthly level.

Dr. Dannenhoffer answered that it could cost about \$1.2 million.

Ms. Saito asked the subcommittee members if they had thoughts on bringing the partnerships whole first and then deciding on the remainder of the funds.

Dr. Dannenhoffer noted that, speaking as somebody from Douglas County who is the fiduciary for one of the projects, this would be his choice, although he is conflicted. The disadvantage of all this is that public health people come on to do projects and having to be uncertain about their continued employment is really, really, really a negative. It is such a stressor to the programs, when the two people who work on this program don't know if they are going to have jobs starting in July. That is enormously stressful.

Ms. Brogoitti remarked that even before Ms. Saito asked the question, her initial reaction was that we probably should look at using some of these funds to fill in the gaps that the partnerships will be experiencing over the next year, given the change in the funding period and the change in the number of partnerships that are getting funded. The other piece of that is thinking about how we can use those partnerships to continue expanding upon the work they are doing now. Are there natural jumping-off points to expand the scope of the capabilities and priorities we are focusing on, given the infrastructure that we have already established?

Ms. Brogoitti stated that she also would want to put value on creating space for new partnerships and new opportunities. One of her concerns that she has had all along, and continues to have, is that we would continue funding the same partnerships and that would not give us space to open it up to new things. She would like to hold both, if that is possible.

Dr. Luck agreed with Ms. Brogoitti and Dr. Dannenhoffer that bringing the existing partnerships back up to their current funding level was a good place to start.

Mr. Queral seconded Dr. Luck's remarks, pointing out that Dr. Dannenhoffer and Ms. Brogoitti had a much better sense of what was needed, and it was consistent with what the subcommittee had discussed in the past.

Ms. Saito summarized the discussion by noting that the subcommittee is suggesting that before we do the remainder of the funds, we would bring the existing partnerships up to full capacity. From there on, we would do the base funding. Then we still need to decide on, if we have even more money, which is a good problem to have, the three suggested choices or some other choices the subcommittee members might propose.

Ms. Beaudrault clarified the math, using Dr. Dannenhoffer's number of needing an additional \$1.2 million to bring the LPHA partnerships whole. That would be just over \$5 million, plus the \$1.845 million in base bunding. That takes us up to about \$7 million dollars, earmarked to go to LPHAs. We are now talking about remaining funds, above the \$7 million. The options listed under remaining funds do not necessarily need to be mutually exclusive. It is likely that OHA would need to do an RFP for these options, so it is clear where we open things up to new models, new partnerships, new opportunities to do things differently, as Ms. Brogoitti mentioned.

Ms. Moseley asked if the pyramid is the LPHA allocation of what we would assume would be more funding.

Ms. Beaudrault answered that that was correct. The pyramid shows funding to LPHAs within a broader funding level.

Ms. Saito reiterated that the funding between \$5-\$10 million would be utilized for the LPHA partnerships to bring them whole, which would be an additional \$1.2 million. Then we would take base funding to LPHAs, which ranges from 30K to 90K. The remainder of up to \$10 million would be about \$3 million, which would be done in an RFP process, which would include all potential options.

Ms. Mosely pointed out that, considering the math related to the \$5-\$10 million range, if the funding is below \$7 million, that is not achievable.

Ms. Saito remarked that if the funding is at \$7 million, we would not have the remainder RFP process. If it is at \$5 million, we would have the LPHA partnerships becoming whole.

Dr. Dannenhoffer liked this proposal.

Dr. Luck asked if the proposal was for the first \$7 million or for the last \$3 million.

Ms. Saito answered that the proposal is for the total \$10 million, while Ms. Moseley's question concerned funding of \$7 million or less. At \$7 million, we would bring the current LPHA partnerships to a holistic number, and then using the base funding to the LPHAs in the range from 30K to 90K. We would not be doing the extra \$3 million RFP process.

Ms. Queral agreed that the proposal made sense.

Ms. Saito added that with funding at just \$5 million, we would just be funding the LPHA partnerships as a holistic number.

Dr. Luck agreed with the proposal.

Ms. Saito stated that the subcommittee members were in agreement on how funds would be allocated to LPHAs if somewhere between \$5-10 million is allocated to LPHAs. Funds would be used in this order:

1. Increase funding to the eight LPHA partnerships so that the funding level matches current funding for a full 24-month period (approximately \$5.1 million).
2. Provide base funding to all LPHAs (\$1.845 million)
3. Any remaining funds distributed through RFP for new partnerships, CJS service delivery models, or additional funding for existing LPHA partnerships.

Ms. Beaudrault called the subcommittee's attention to page 13 of the meeting packet, showing the purpose and goals of funding in the three different buckets. For the LPHA partnerships, the purpose of funding is the creation of regional systems for communicable disease control and elimination of health disparities. Another thing these partnerships are achieving is setting in place new infrastructure that was not there before; sustainable infrastructure built around policies that are in place, and shared staffing. We are hoping to get feedback on the purpose of providing base funding to each LPHA, which would help us craft our planning work. Some ideas include (a) increase local capacity to improve accountability metrics for the communicable disease process measures (i.e., improving two-year-old immunization rates, decreasing rates of gonorrhea), (b) implement local components of health equity action plan, and (c) increase local capacity to participate more fully in the regional partnership, which could include contributing some local funds to the broader partnership.

Ms. Beaudrault added that the remaining funds would likely go out through an RFP. Some ideas for the purpose and goals of that money include (a) address gaps in modernization assessment, (b) increase capacity for foundational capability, (c) consider projects or proposals that would have the largest impact on population, (d) address some of the other funding priorities, such as using funding to address health equity or targeting it to areas that have higher burden of disease, (e) prioritize proposals that focus on specific communicable diseases or that address some of the gaps around assessment and epidemiology, such as creating new ways of reporting and making disease data available to communities.

Ms. Beaudrault remarked that it would be helpful if the subcommittee members shared any initial thought they might have around these purposes, or what they would want to see OHA driving toward with funding in each of the three buckets. The feedback would be helpful for planning the requirements OHA would be putting in place around the different buckets of funding.

Dr. Dannenhoffer noted that if we were going to do an RFP, one of the deliverables has to be a toolkit or something that others could use. For example, let's say that there was a project to improve the use of social media to help fight our current battle with gonorrhea. Let's say Multnomah County got that grant, the outcome should be that they teach the rest of the counties how to go ahead and do that.

Dr. Dannenhoffer added that one of the concerns he had from the current project was that stuff that was learned in the other seven areas (i.e., partnerships) would ever be presented to the rest of the partnerships in a way that they could use it. That would be incredible useful for everybody.

Ms. Beaudrault endorsed Dr. Dannenhoffer's suggestion, in terms of being clear that we are not looking at these as one-off projects, but as potentially effective models that can be replicated across the state.

Dr. Luck liked that as criteria. We identified communicable disease, assessment and epidemiology, emergency preparedness, and health equity as priorities above other capabilities and programs, but within that group, we didn't identify any relative priorities. Thinking about broader applicability beyond the boundaries of the initial grant might be a way to help choose within that set.

Ms. Saito shared her liking of the idea of a learning network, with the partnerships having an opportunity to share learning, even if somebody came up with a curriculum like *Train the Trainer*, or something similar that will enable the partnerships to share information across the state. This could be a potential deliverable for both the base funding and the remaining funds.

Ms. Queral asked what this RFP would look like. If it is base funding for all LPHAs, we should be thinking about the most fundamentally basic RFP approach. The criteria should not necessarily be about which is the best project, but, in the spirit of what Dr. Dannenhoffer suggested, what it is that you can bring to the rest of public health across the state. That may be one element of what's in it. In essence, we are saying that we are going to provide some funds towards your base funding on this, and the RFP is giving the health authority an opportunity to articulate what's going to happen with those dollars. Billing it as an RFP makes it sound as if it is competitive, in a sense of competing against each other, or competing to be the best project, as opposed to getting the money for what would be a foundational component of something that they are intending to do in the context of modernization.

Ms. Saito clarified that the base funding for each LPHA (i.e., \$1.845 million) would not be an RFP. That money would just go out based on what we had agreed upon, which was 30K for extra small counties and up to 90K for the larger counties. The RFP process would only be on those remaining funds, which, at this point, we are only looking at between \$0-\$3 million.

Ms. Saito asked the subcommittee if everyone was in agreement with the generalized approach to the base funding and the suggested options.

Ms. Beaudrault reiterated that the options are not mutually exclusive. We could put something in place so that a LPHA could choose to work on any of the options. There might be other things that we are not thinking of yet, but it would be helpful to hear if the subcommittee thinks any of these are more or less important, and if there are any that you really want to see us emphasizing.

Ms. Saito stated that she liked the option *Implement health equity action plan* as a potential priority. It is one of the foundational capabilities and it is also important to lead with health equity. It seems that that could be done with smaller amount of funds.

Ms. Moseley wondered why that would not be in the \$3.9 million tier.

Ms. Beaudrault confirmed that it was. With the \$3.9 million, the next phase for the eight funded partnerships is that they will be focusing on implementing those plans. This would give each LPHA some funds to do some specific and targeted work in their own county that might not happen through the broader partnership. It is just driving to more money, more focus.

Dr. Luck commented that these are good guidelines, but with the relatively small amount of money, we should not be too restrictive, but rather let the different health departments decide how they want to spend that money within these goals of communicable disease, health equity, and partnership participation.

Mr. Queral agreed with Dr. Luck and remarked that we need to be clear and specific about what we mean by each of these options, considering that it is a limited amount of money. In terms of communicable diseases, we can certainly provide some guidance that would facilitate that. In other words, it would be helpful if there are ways in which the OHA can support the LPHAs. In terms of the health equity action plan, considering the amount of money that these grants would carry, it seems that it would be useful to have the health departments outline the priorities within that plan. Expecting them to be able to implement a full plan that includes outreach in partnership development with other organizations and providers may be a bit difficult. There should be enough flexibility for prioritizing and doing those priorities well, as supposed to trying to implement a full plan.

Ms. Beaudrault remarked that it is a similar question for the remaining funds. We have talked about a few different things: increasing capacity for foundational capabilities in any of the work; making sure that it is scalable; thinking back to the funding principles and looking for proposals that build on assessment and epidemiology capacity, or focused on specific areas with burden of disease, or focused on interventions around improving health equity. These are some different options for what we would be trying to achieve with that remaining bucket of funding, if it were to become available.

Ms. Beaudrault asked the subcommittee members if anything in particular resonated for them, or if there was anything that seems less important, or anything that they wanted OHA to be prioritizing as the subcommittee thought through this.

Ms. Saito noted that it would be nice to keep it open, as there was not a lot of money in the remaining funds. It seems that the subcommittee is talking about with those remaining funds to have some kind of a deliverable around what could be used for other partners to do. It builds the learning network piece of it.

Ms. Saito asked the subcommittee members if they were fine with what was written in the additional piece around the deliverables that are resource-oriented.

Dr. Luck remarked that that generally sounded fine to him.

Subcommittee business

Ms. Saito stated that she would provide a subcommittee update at the PHAB meeting on April 18, 2019. She asked Ms. Brogoitti if she would be available to chair the May 14, 2019, subcommittee meeting.

Ms. Brogoitti remarked that she may not be available.

Ms. Beaudrault mentioned that the chairs have gone in alphabetical order and we can skip ahead and see if Dr. Dannenhoffer would be willing to chair the meeting in May.

Ms. Brogoitti thanked for the accommodation.

Ms. Saito noted that in the spirit of Mr. Queral chairing two meetings in a row, if Dr. Dannenhoffer can't chair the meeting, Ms. Saito would be happy to chair another meeting.

Ms. Beaudrault added that, in terms of the agenda for next month, usually Dr. Dannenhoffer or Ms. Brogoitti provides an update from the subcommittee to CLHO and sometimes has additional feedback to bring back. We will have an opportunity to bring back to the subcommittee any additional feedback from CLHO on what we have been talking about today, before we finalize the recommendations at that funding level. Also next month, Danna Drum will be here to talk about fiscal year 2018 LPHA expenditures reporting. This connects to the subcommittee's work around coming up with a mechanism for awarding matching funds for when we get to that funding level. It is an opportunity to look at last year's expenditures reporting and then think about how that fits in with the model for matching funds.

Public comment

Ms. Saito invited members of the public to ask questions and provide comments.

There was no public comment.

Closing

Ms. Saito adjourned the meeting at 1:45 p.m.

The next Public Health Advisory Board Incentives and Funding subcommittee meeting will be held on May 14, 2019, at 1:00 p.m.

Public Health Advisory Board Meeting

April 18, 2019

JACKSON – KLAMATH COUNTIES

REGIONAL MODERNIZATION GRANT



JACKSON COUNTY
Health & Human Services



Objectives

- Reduce hepatitis C rate
- Reduce rates of STIs
- Raise HPV vaccination rate for cancer prevention
- Health equity and cultural responsiveness

Targeted Populations

- M/F, 13-17 yrs old
- M/F, 18-45 yrs old
- Illicit and intravenous drug users (IDU) and their partners
- Men who have sex with men (MSM)
- Latinx
- Klamath Tribes



JACKSON COUNTY
Health & Human Services



Engagement of Community Partners

- Key informant interviews
- Listening sessions
- American Indian and Alaska Native community members
- Tribal Youth Council
- Southern Oregon Health Equity Coalition (SO Health-E)
- KCPH and JCPH community partner agencies



JACKSON COUNTY
Health & Human Services



Assessment Outcome Summary

- Root causes of health disparities include *poverty, trauma, institutional racism, lack of health literacy, and lack of support*
- Partnerships required for addressing *proximal (needle sharing, risky sex behaviors) and root causes*
- Strengthen **internal capacity** to address **health equity**

Addressing Root Causes

- **Open dialogue** with at risk and marginalized community members
- **Open dialogue** with health and social service professionals
- Sustain and expand partnerships addressing health inequities and social determinants of health
- *Outcomes include -*
 - *Identifying appropriate and actionable steps for reducing communicable disease risk in high risk community members*
 - *Engagement in multi-sector efforts to address housing, behavioral health, trauma, and health outcomes*

Increase Staff Capacity

- **Implement staff training** plan including **workshops, written material, targeted activities**
- Collaborate with SO Health-E and other *equity and inclusion* community organizations and members
- Outcomes include *providing public health services that are effective, equitable, understandable, respectful, and responsive*

Setting the Stage for Success

Strategies –

- Continue the *momentum* of 2017-2019 funding cycle
- Fit within organizational capacity
- Foster *partnerships within and across counties*
- Build upon current programs
- Emphasize *equitable culturally responsive programs and systems*



JACKSON COUNTY
Health & Human Services



Questions?



JACKSON COUNTY
Health & Human Services



A Modern Approach to Controlling STDs in the Willamette Valley

CARLA MUNNS, WILLAMETTE VALLEY COMMUNITY HEALTH

KATRINA ROTHENBERGER, MARION COUNTY HEALTH & HUMAN SERVICES

KRISTTY POLANCO, POLK COUNTY PUBLIC HEALTH

Public Health Modernization: Statewide Objectives



- Develop a modern communicable disease control system
- Emphasize elimination of health disparities
- Establish new systems for local public health service delivery
- Increase accountability for health outcomes

Marion & Polk Region



Marion County + Polk County + Willamette Valley Community Health

Regional Modernization Project Goals:

- Implement regional communicable disease control strategies which aim to eliminate health disparities
- Stop the increase of STIs (chlamydia, gonorrhea and syphilis)
- Increase HPV Vaccination Rates

Population by Age Group, 2015



Marion and Polk County Health Status Report 2017

Marion/Polk Modernization Project

Year 1 Accomplishments:

- Developed policies describing regional relationships between partners (MC, PC, WVCH)
- Convened a communicable disease task force – meets monthly
- Developed a regional health equity action plan
- Increased provider knowledge of best practices for testing and treatment of CT and GC in Marion and Polk Counties
- Increasing adequate treatment:
 - Increased gonorrhea case and contact finding capacity in Polk County
 - Increasing adequate gonorrhea treatment in Polk County
 - Maintained or improved rate of adequate gonorrhea treatment in Marion County
 - Improve HPV vaccine administration rates in Marion and Polk Counties

Aligning Practices & Priorities

- Sharing best practices – AETC training series (5 locations)
- Listening sessions among disproportionately affected populations
- WVCH clinic-specific data & outreach to increase HPV vaccinations and reduce gender and geographic disparities
- Mobile screening and treatment van for STIs and reproductive health
- Increasing community support for a regional Syringe Exchange Program

Community Readiness Assessment

Marion & Polk Readiness for Change Results

<u>Dimension</u>	<u>Readiness Level & Stage (Results)</u>	<u>Stage Description</u>
Community Climate	2 - Denial/Resistance	At least some community members recognize that sexually transmitted infections are a concern, but there is little recognition that it might be occurring locally.
Community Knowledge of the Efforts	3 - Vague Awareness	Most feel that there is local concern, but there is no immediate motivation to do anything about it.
Leadership	3 - Vague Awareness	
Community Knowledge about the Issue	3 - Vague Awareness	
Resources Related to the Issue	3 - Vague Awareness	
Existing Community Efforts	6 - Initiation	Enough information is available to justify efforts. Activities are underway.

Action Plan



- Created a communication plan that is culturally responsive to the community's needs
 - Utilizing Spanish radio stations for Latinx communities
 - Collaborative Facebook live sessions (English, Spanish)
- Creating authentic partnerships with local community agencies
- Creating awareness of STDs through posters, flyers, brochures
- Presentation to stakeholders regarding readiness results

Engagement of Partners

- Maintained a working relationship regionally between the regional CCO and both public health agencies
- Partners at the CD taskforce created strategies and currently sharing the work
 - Ex: Willamette University conducting a listening session
- Continue to recruit communities of color and marginalized populations for CD taskforce

Policies and Strategies

- MCHHS has posted employment recruitment for Bilingual candidate for emergency preparedness
- Beginning the work to collaborate with Willamette University and local school boards to discuss policy change regarding sex education curriculum
- Created a regional policy for treatment of Gonorrhea

Modernization Future Work Plan

- ❑ MCHHS to conduct BARHII Organizational Self-Assessment
- ❑ Utilize both organizational self-assessment to identify regional inequities to look at policies
- ❑ Continue to convene a communicable disease coalition in conjunction with the Early Intervention and Outreach (EOI) grant
 - Create, implement and monitor work plan to improve health disparities around gonorrhea, Chlamydia, syphilis, HIV, and to increase HPV vaccination rates
- ❑ By June 30th 2019 – develop and implement a regional health equity action plan to improve practices and implement policies to reduce communicable disease control-related disparities
- ❑ Improve HPV vaccine administration rates among VFC providers in Marion and Polk Counties
- ❑ Utilize our health equity lens in all aspects of PH work
- ❑ Be culturally and linguistically responsive to diverse health needs
- ❑ Creating authentic outreach/partnerships

Partnership Opportunities with CCOs

- **CCO commitment to health equity, LPH partnerships, and our shared community**
 - Population health: beyond WVCH enrollment, community members with high SDoH are CCO focus
 - Upstream approach: ensure women of child-bearing age are healthy = healthy babies
 - Data-driven population health management- strategic priority due to rising trend
- **Community Health Improvement Plan**
 - Prenatal care/reproductive care
- **Quality Incentive Metrics strategies**
 - Early contraceptive use
 - Adolescent well child checks
- **Contractual requirements**
 - Health equity and disparities
 - Evidence-based guidelines





CARLA MUNNS, WILLAMETTE VALLEY COMMUNITY HEALTH

KATRINA ROTHENBERGER, MARION COUNTY HEALTH & HUMAN SERVICES

KRISTTY POLANCO, POLK COUNTY PUBLIC HEALTH

Central Oregon Public Health Partnership

Oregon Public Health Advisory Board Meeting

April 18, 2019

Jenny Faith	Central Oregon Tri-County Epidemiologist
Heather Kaisner	Deschutes County Public Health Manager
Muriel DeLaVergne-Brown	Crook County Public Health Administrator

Health equity assessment components

Analysis of local data

- Demographics of region
- Populations vulnerable to communicable diseases and outbreaks

Internal staff assessment (BAR-HII)

- Internal staff survey
 - Crook County: 20/24 staff (83%)
 - Deschutes County: 65/76 staff (86%)
 - Jefferson County: 19/19 staff (100%)
- Internal staff and leadership focus groups

External partner assessment (BAR-HII)

- 118 respondents total
 - Crook County: 24 respondents
 - Deschutes County: 34 respondents
 - Jefferson County: 34 respondents
 - Tri-County: 16 respondents
- Multiple sectors represented:
 - Community-based organizations
 - Academic institutions/schools
 - Private sector businesses
 - Tribes
 - Others

Highlighted results

Tri-county analysis of local data:

- Long term care facilities (LTCF) experience a high burden of communicable disease outbreaks
 - Nearly 60% of all outbreaks in tri-county area occur in LTCF
 - Influenza vaccination among skilled nursing facility staff lower in Central Oregon than in Oregon
 - Proportion of older adults higher in Central Oregon than in Oregon

Translating results into action

- Prioritize LTCF prevention activities
- Improve equity data and communication through epidemiology activities and reports

Deschutes County Health Services

Infection Prevention 101

Kari Coe, RN BSN
Infection Prevention Nurse II
Deschutes County Public Health



1

Central Oregon Public Health Quarterly

Communicable Disease Update for Crook, Deschutes, and Jefferson Counties
2018: Quarter 1

24/7 Communicable Disease reporting lines: Crook County 541-447-5165, Deschutes County 541-322-4118, Jefferson County 541-475-4456

2017 Communicable Diseases Year-in-Review
The table below summarizes 2017 case counts and estimated rates for select reportable communicable diseases with Central Oregon regional case counts of 5 or higher.

Reportable Disease or Condition	Oregon		Crook Co.		Deschutes Co.		Jefferson Co.	
	Case count	Rate per 100,000 population	Case count	Rate per 100,000 population	Case count	Rate per 100,000 population	Case count	Rate per 100,000 population
Campylobacteriosis	1,059	25.6	14	63.3	67	36.6	7	30.2
Chlamydia	18,723	452.1	91	411.7	675	369.0	161	694.3
Cryptosporidium	274	6.6	<5	--	10	5.5	<5	--
E. Coli (STEC)	211	5.1	<5	--	12	6.6	<5	--
Giardiasis	339	8.2	<5	--	17	9.3	<5	--
Gonorrhea	5,039	121.7	14	62.3	65	35.5	49	211.3
Hepatitis B (Chronic)	492	11.9	<5	--	8	4.4	<5	--
Hepatitis C (Chronic)	6,007	145.1	37	167.4	232	126.8	62	267.4
Elevated Blood Lead Level	975	23.5	<5	--	15	8.2	<5	--
Salmonellosis (non-typhoidal)	483	11.7	<5	--	14	7.7	<5	--
Shigellosis	122	2.9	<5	--	<5	--	<5	--
Syphilis	861	20.8	<5	--	11	6.0	<5	--
Vibriosis	32	0.8	<5	--	9	4.9	<5	--
Yersiniosis	48	1.2	<5	--	5	2.7	<5	--

Case counts include both confirmed and presumptive cases. Case counts are preliminary as of February 1, 2018. When case counts are <5, county-level data is suppressed and county-level rates are unreliable. Rates calculated using 2017 mid-year population estimates from the Population Research Center at Portland State University.

- #### Central Oregon Year-in-Review Highlights
- The total number of chlamydia and gonorrhea cases in Central Oregon increased by 21.2% and 33.3%, respectively, since 2016.
 - The highest number of chlamydia and gonorrhea cases in Central Oregon were in Deschutes County; however, the largest rates of chlamydia and gonorrhea cases per 100,000 population were in Jefferson County. (Details can be found on the next page.)
 - Giardiasis cases (n=24) decreased 36.8% from 2016 (n=38).
 - Salmonellosis cases (n=17) decreased 32% from 2016 (n=25).
 - The number of cases of cryptosporidium, chronic hepatitis C, and syphilis in 2017 were similar to the number of cases in 2016.

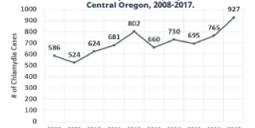
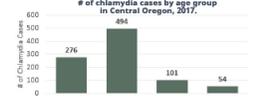
Disease Spotlight: Chlamydia

Chlamydia cases are on the rise in Central Oregon.
The increase in cases over time is partially due to our increase in population; however, rates of chlamydia (# of cases per population size) peaked in 2017 (466.2 cases per 100,000 population for the Central Oregon region).

In 2017, the largest number of cases in Central Oregon were in Deschutes County (675), followed by Jefferson County (161) and Crook County (91).

Of the three Central Oregon counties, Jefferson County had the highest rate of chlamydia in 2017 (694.3 per 100,000 population), followed by Crook County (411.7 per 100,000 population) and Deschutes County (369.0 per 100,000 population).

Chlamydia affects young adults and females the most.
Most (53%) chlamydia cases in Central Oregon in 2017 were among those aged 20-29. Most (88%) cases were female.

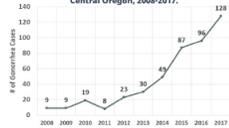
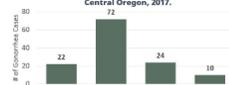
Disease Spotlight: Gonorrhea

The number of annual gonorrhea cases has rapidly increased in Central Oregon.
Gonorrhea rates have increased from 3.5 per 100,000 population in 2008 to 56.1 per 100,000 population in 2017 in the Central Oregon region. Rates have more than doubled since 2014.

In 2017, the largest number of cases seen in Central Oregon were in Deschutes County (65), followed by Jefferson County (49) and Crook County (14).

Of the three Central Oregon counties, Jefferson County had the highest rate of gonorrhea in 2017 (211.3 per 100,000 population), followed by Crook County (63.3 per 100,000 population) and Deschutes County (35.5 per 100,000 population).

Gonorrhea affects young adults and males the most.
Most (55%) gonorrhea cases in Central Oregon in 2017 were among those aged 20-29. Slightly more than half (55%) of all cases were male.

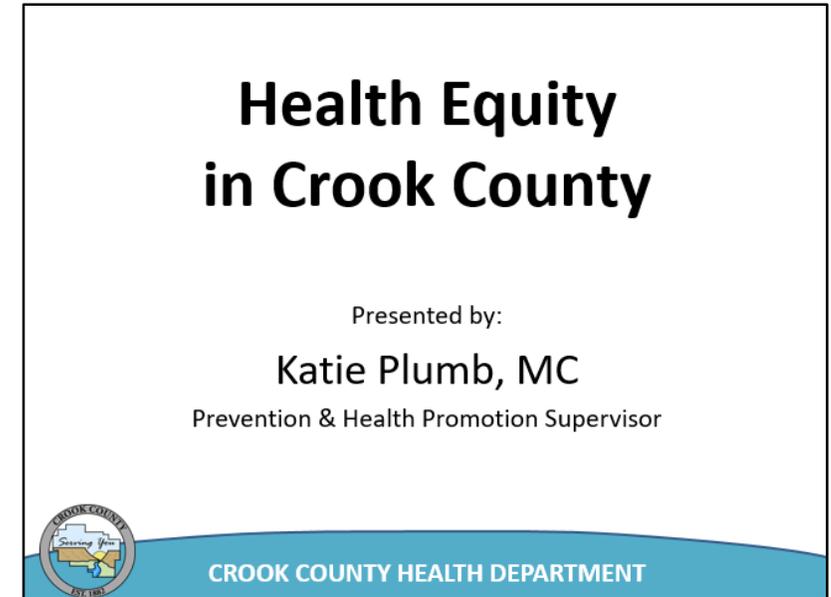



- #### Why are STD cases increasing in Central Oregon?
- Sex is more readily available and anonymous, partially due to dating apps. This makes tracking and partner notification more difficult.
 - Use of condoms has decreased.
 - Infections are spreading more readily and into populations not traditionally affected by STDs.
 - We have become better at detecting cases. This is due to many factors including changes in national screening guidelines, more sensitive tests, and increased access to healthcare services, including STD services.
 - Our local health departments have experienced decreased funding for STD services.
- #### What can be done to slow or stop the increase?
- Providers make STD screening and timely treatment a standard part of medical care, especially for pregnant women, MSM, and young adults.
 - Local health departments: increase prevention efforts through targeted outreach and messaging, and use innovative methods to conduct partner services.
 - Everyone: talk openly about STDs, get tested regularly, and reduce risk by using condoms or practicing mutual monogamy if sexually active.

Highlighted action plan activities

Internal and External equity assessments:

- **All three counties:** better incorporate health equity into staff training, strategic planning, policies and procedures
- **Crook County:** incorporate assessment data in health equity presentation to partners
- **Deschutes County:** incorporate/model equity concepts in day-to-day operations and project planning
- **Jefferson County:** incorporate health equity training and concepts into staff onboarding procedures



Moving Forward

- Repeat health equity assessment every four years and use data to inform regional health improvement plan and agency strategic plans
- Prioritize equity-focused data and communication: e.g., epidemiology reports, communicable disease fact sheets, website, and other external communications
- Continue LTCF prevention work with a focus on vulnerable older adults
- Increase focus on STD equity data and prevention activities
- Work with partners to identify additional needs

State Health Improvement Plan

Improve immunization rates and
protect the population from
communicable disease



OFFICE OF THE STATE PUBLIC HEALTH DIRECTOR
Public Health Division

Improve immunization rates



Key Questions

1. How does our public health work change if the level of measles activity seen this year becomes normal?
2. With the legislative activity related to immunization school requirements this year (HB3063), what do your providers and populations need to hear from us?

Priority Targets

Measure	Baseline	Current Data	2020 Target	Data Source
Immunization rate among two year olds	60% (2014)	68% (2018)	80%	ALERT IIS
HPV vaccination rates among youth	28% (2014)	46.4% (2018)	80%	ALERT IIS
Seasonal flu vaccination	42% (2014)	45% (2018)	70%	ALERT IIS

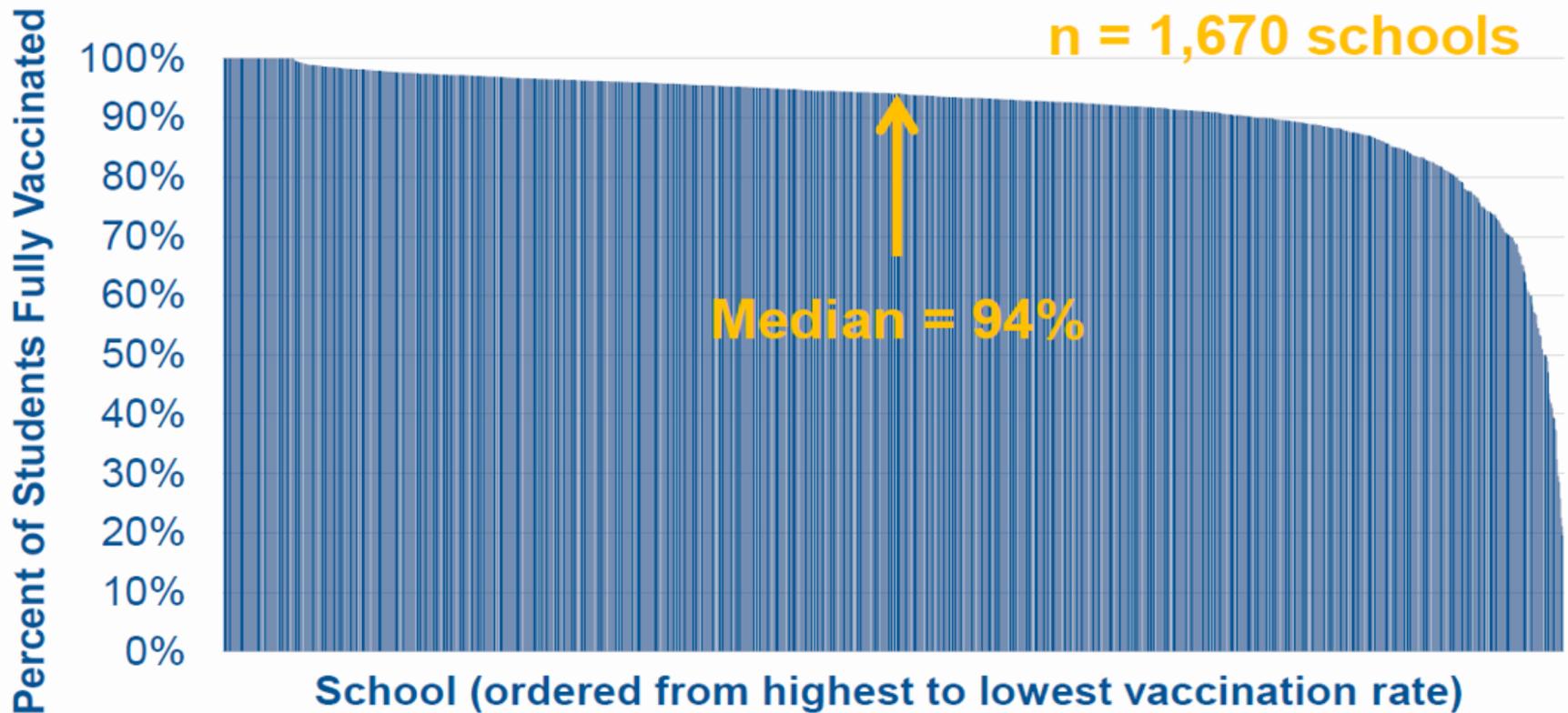
Point #1 Childhood Immunization rates are improving

Oregon Immunization Rates

	2014	2015	2016	2017
Two-Year-Olds^a Up-to-Date Rate^b				
4:3:1:3:3:1:4 ^c	60%	64%	66%	68%
4:3:1:3:3:1 ^d	66%	68%	70%	72%
4 doses DTaP	76%	77%	78%	80%
3 doses IPV	87%	88%	89%	89%
1 dose MMR	87%	89%	88%	88%
3 doses Hib	87%	87%	88%	88%
3 doses HepB	82%	83%	85%	85%
1 dose Varicella	85%	86%	86%	87%
4 doses PCV	72%	75%	76%	77%
1 dose HepA	86%	87%	87%	87%
2-3 doses Rotavirus	65%	67%	68%	70%
1 dose Flu (in most recent season)	55%	52%	54%	55%

Point #2 Improving rates can hide at risk communities

Vaccine completion rates by school, Grades K-12, 2018



Feedback & Discussion

1. How does our public health work change if the level of measles activity seen this year becomes normal?
2. With the legislative activity related to immunization school requirements this year (HB3063), what do your providers and populations need to hear from us?

Contact information

Aaron Dunn

Oregon Immunization Program Manager

Public Health Division

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Protect the population from communicable disease



Key Questions

- How do we leverage policy, health systems and public health to decrease infections among people who use drugs?
- How do we bring all stakeholders to the table for a unified response to the syndemic of substance use and infectious diseases?
- How can we increase funding for surveillance, primary prevention, screening and linkage to care for HIV, HCV, and STI?

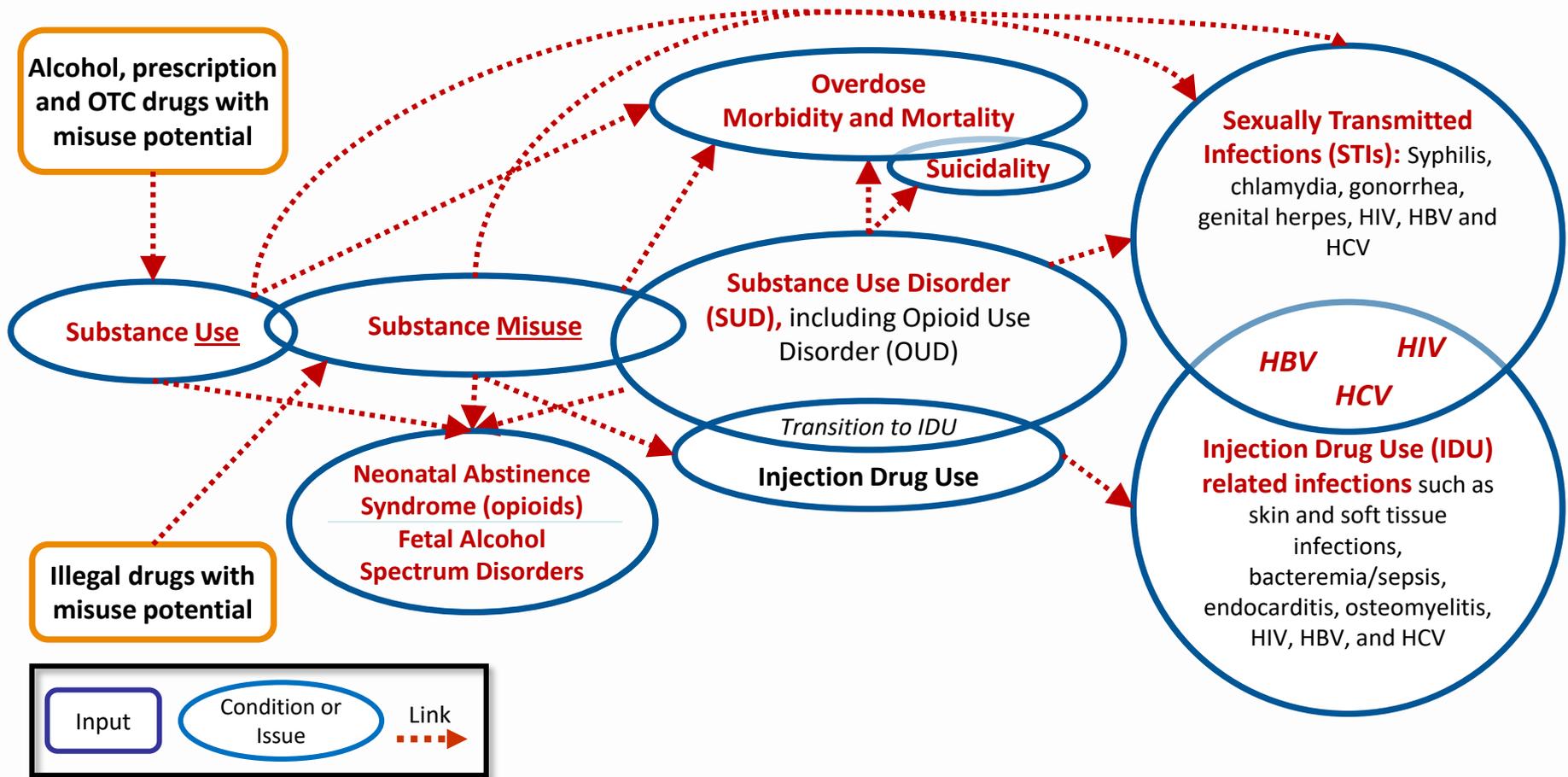
Priority Targets

Measure	Baseline (per 100,000)	Current Data (per 100,000)	2020 Target	Data Source
Syphilis incidence (rate per 100,000)	10.4 (2014)	13.5 (2017)	11.1	ORPHEUS
Gonorrhea incidence (rate per 100,000)	57.9 (2014)	121.3 (2017)	72	ORPHEUS
HIV incidence (rate per 100,000)	6.0 (2014)	4.8 (2017)	4.5	ORPHEUS
HIV Viral Suppression	68% (2014)	75% (2017)	90%	ORPHEUS
Tuberculosis incidence (rate per 100,000)	1.9 (2014)	1.7 (2017)	1.4	ORPHEUS

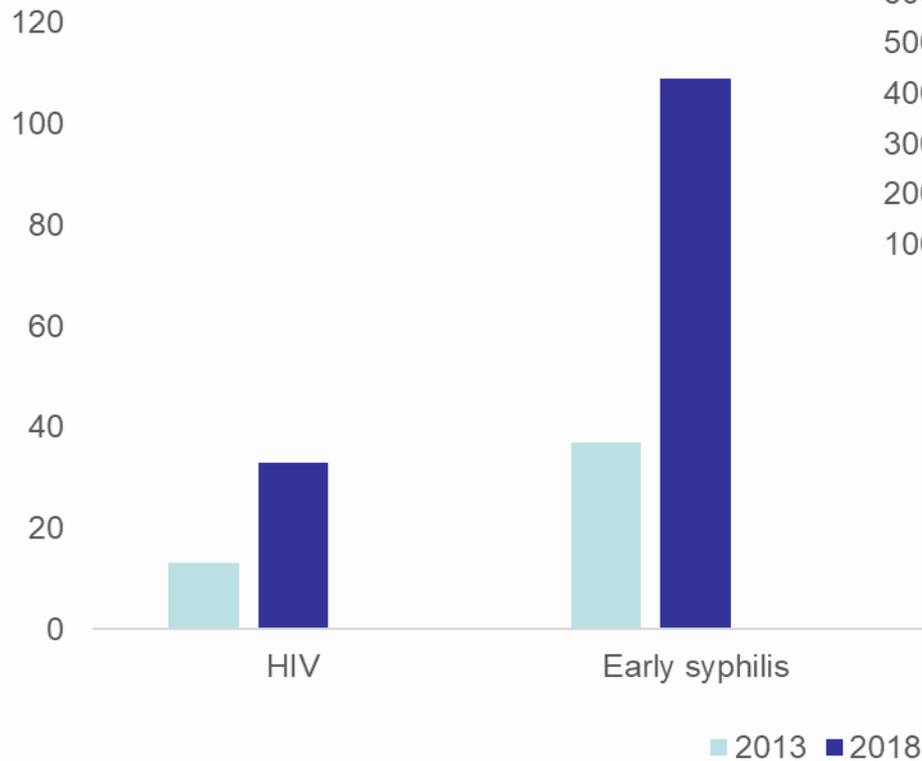
Priority Targets

Measure	Baseline	Current Data	2020 Target	Data Source
HCV Mortality	8.4 deaths/100,000 (2014)	9.3 deaths/100,000 (2017)	6.0 deaths/100,000	Center for Health Statistics

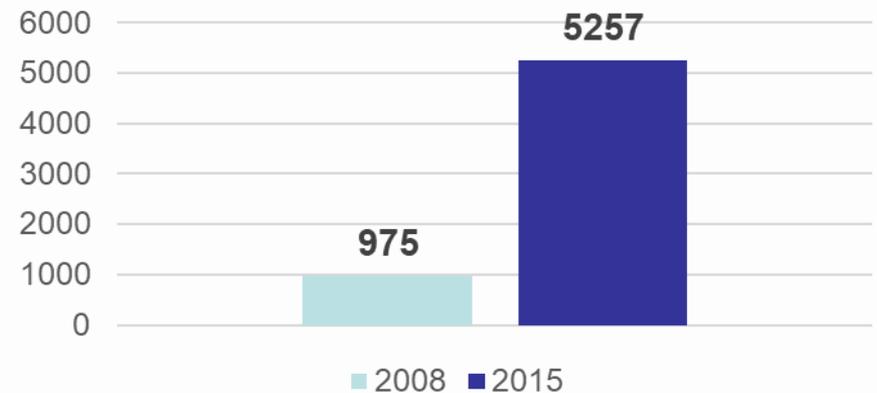
Point 1: Syndemic Model



Point 2: Numbers of cases related to injection drug use, selected infectious diseases, Oregon, 2013 vs 2018

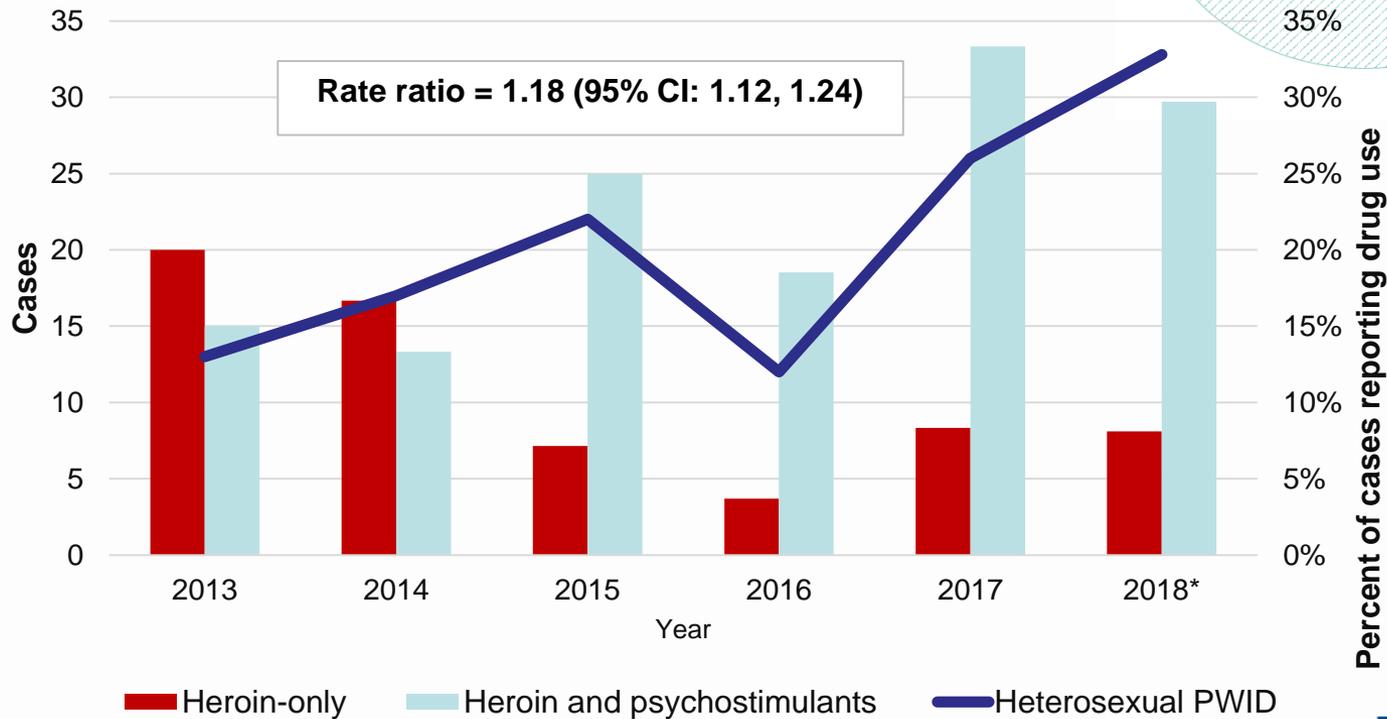
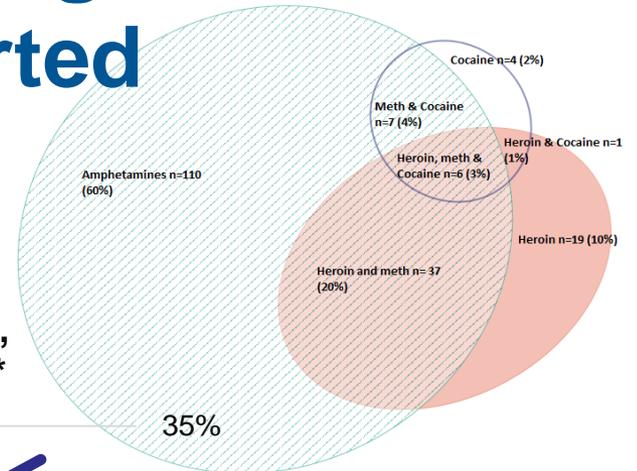


Hospitalizations for bacterial infections related to IDU



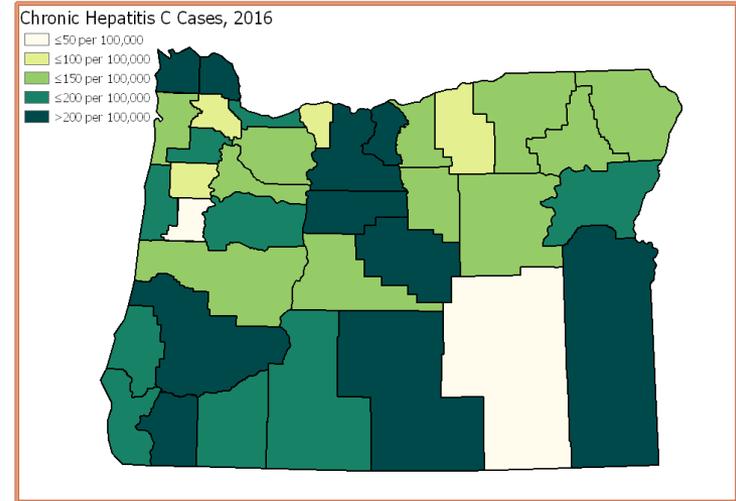
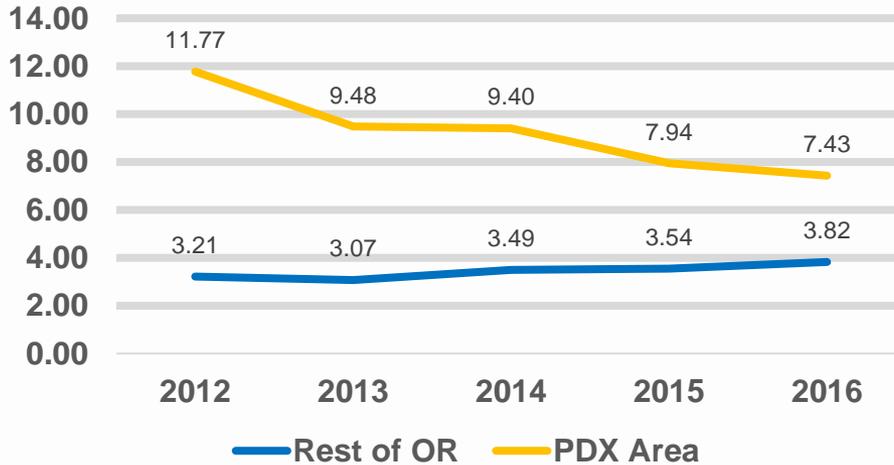
Point 3: HIV diagnoses among heterosexual PWID by reported substance use

HIV diagnoses among persons who inject drugs, Oregon 2013–2018, adjusted for reporting delay*



Point 4: The syndemic affects rural Oregon

Rates of New HIV Diagnoses



Cases of early syphilis among women who inject drugs, by area, Oregon, 2013-2018



What can be done? Can PHAB help?...

Law & Policy



- Eliminate insurance co-pays or charges for STD screening, diagnosis or treatment
- Fund Sexual Health clinics, Wound Care clinics and Syringe Service Programs (SSPs)
- Expand screening, diagnostic and treatment roles for pharmacists, nurses, medical assistants
- Require jail health services to implement opt-out HIV, STI, and Hepatitis C screening, opt-out Hepatitis A and B vaccinations and linkage to care, SUD treatment and community services for people detained
- Modernize text and social media policies to support prevention messages on-line

Health Systems



- Implement routine sexual history collection
- Increase screening in key populations and groups with infection risk
- Facilitate expedited partner therapy for gonorrhea
- Integrate infectious diseases related work into the substance use disorder and opioid responses
- Increase use of community health workers and peers to reach out, support, screen and link people who use drugs and are disengaged back into social services, medical care and SUD treatment
- Use community health workers and peers to support SUD, HIV, STI and HCV treatment engagement

Public Health



- Use a syndemic approach to prevent and mitigate communicable diseases associated with substance use
- Develop public health response to the substance use related infections that are most common and most costly
- Implement expedited partner therapy for gonorrhea
- Pilot on-demand prevention and treatment program: Buprenorphine, PrEP, HIV and Hep C
- Increase partner notification services using alternative methods

Key Questions

- How do we leverage policy, health systems and public health to decrease infections among people who use drugs?
- How do we bring all stakeholders to the table for a unified response to the syndemic of substance use and infectious diseases?
- How can we increase funding for surveillance, primary prevention, screening and linkage to care for HIV, HCV, and STI?

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