

## Public Health Advisory Board (PHAB)

May 16, 2019

### Meeting Minutes

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#### **Attendance:**

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

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

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

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

#### **Welcome and Agenda Review**

*Rebecca Tiel, PHAB Chair*

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

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

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

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

#### **Health Equity Committee**

*Leanne Johnson (OHA Staff)*

Ms. Johnson introduced herself to the PHAB. She explained that the Equity and Inclusion Division is one of OHA's seven divisions. Twenty-two people work at the division. These employees cover 18 functions for OHA and the statewide delivery system. Some of the work of the division includes the Regional Health Equity Coalition, healthcare interpreters, internal



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investigations on discrimination and harassment, and Americans With Disabilities Act work, among others. Nine of the functions are state or federally mandated.

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

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

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

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

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

Mr. Queral noted that the definition draft parallels the definition the PHAB has been using over the last two years. He praised the work of the HEC to recognize and rectify historical and contemporary injustices and suggested to think about the implications of that. What we need to recognize and rectify is the structures that we have created and put in place that have led to

injustices. Injustices are hard to measure, as they are subjective. We need to focus on the system and not necessarily on just the outcome. That's where the collaboration of all sectors is required to change these systems.

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

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

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

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

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

Ms. Mosely clarified that Dr. Luck was referring to the health equity framework for the SHIP. She explained that the SHIP Steering Committee landed recently a new committee member – her name is Leanne Johnson – as well as a SHIP subcommittee lead for the institutional bias priority – her name is Leanne Johnson. So, it's tightly aligned.

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

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

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

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

Ms. Johnson stated that that might be a conversation for the Oregon Health Policy Board (OHPB). There have been conversations there related to whether we are talking about individuals or systems. We are already talking about systems, but the tricky piece is how that is interpreted. The transformation center, an OHA unit, and the Equity and Inclusion Division are working very closely. When we move to CCO 2.0 implementation and technical assistance, that piece will be front and center.

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

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

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

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

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

Dr. Bangsberg pointed out that the incentive measure should have more complete data on race and ethnicity. We can't get there unless we have good data to work with. We need a big, long

push to get there. The interpretive measure is a little bit too narrow. We need good data to start with.

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

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

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

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

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

Dr. Bangsberg confirmed that that was his intention.

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

Dr. Savage seconded the motion and stated that, from a CCO perspective, that was absolutely the case. Every time the CCOs do a process improvement project of any kind, there is a look at some angle from health equity. Is it a male/female issue? Is it an ethnicity issue? We use the very limited data that we do get on race and ethnicity and we overlay it with language preference to try to tease out what it is. The PHAB heard a little bit about that last month with our HPV data. It is the crush. The biggest obstacle we have for doing really good health equity work is that we don't have appropriate data for that. It is because one family of five speakers can be counted as one. It really needs to be fixed on the basic level.

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms. Johnson thanked Dr. Luck.

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

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

Ms. Tiel thanked Ms. Johnson for her presentation.

### **PHAB Updates Business**

*Rebecca Tiel, PHAB Chair*

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

- *Approval of April 2019 Minutes*

A quorum was present.

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

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

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



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- Legislative Update

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

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

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

Ms. Moseley added that OHA also has been working closely with Senator Steiner Hayward on this bill and she has a bill, Senate Bill 526, which is a companion to OHA's policy option package. The policy option package requests funding to create infrastructure to begin the rollout for the Medicaid population and this includes leveraging federal dollars around that. Senate Bill 526 would require coverage for universal home visiting from commercial insurers. When we put these two together, we get to the universally offered home visiting package. We envision beginning a rollout in five to six communities around the state that are ready to take that on. A steering committee has been convened and staffed by OHA to help identify the criteria for

determining if a community is ready to begin implementation. This includes private and public companies, commercial insurers, and CCOs.

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

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

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

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

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

Ms. Moseley stated that Senate Bill 253 clarified the process for local public health authority to be transferred to OHA and the process for a local public health authority to take back that responsibility from OHA. It is half the reason for Dr. Hedberg’s absence today. The bill is scheduled for a hearing this afternoon.

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

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

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

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

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

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

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

Ms. Moseley thanked Mr. Queral for his comments. She stated that there was a public hearing day for following the first Ways and Means presentation that public health did and there were quite a few organizations speaking on behalf of public health and the importance of the overall public health budget and POPs. That work is going on. She remarked that she could talk to Ms.

Angela Allbee and ask her more specifically. She could provide an update at the next PHAB meeting on how some of that strategy is being seen.

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

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

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

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

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

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

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

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

### **Public Health Grant Block**

*Danna Drum (OHA staff)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Accountability Metrics Subcommittee**

*Dr. Jeanne Savage*



Public Health Advisory Board  
Meeting Minutes – May 16, 2019

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **LPHA Investments in Local System Capacity**

*Danna Drum (OHA staff)*

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

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

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

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

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

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

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

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

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

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

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

Ms. Drum answered that it did include TCM.

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

Dr. Savage asked about the definition of TCM.

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

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

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

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

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

Dr. Schwarz answered that he was not.

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

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

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

Dr. Luck thanked Ms. Drum for the presentation.

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

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

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

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

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

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

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

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

**Modernization Grantee Update: Health Equity Action Plans**

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



Public Health Advisory Board  
Meeting Minutes – May 16, 2019

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

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

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

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

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

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

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

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

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

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

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

Ms. Warren invited questions from the PHAB.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Incentives and Funding Subcommittee**

*Akiko Saito*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Public Comment Period**

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

### **Closing**

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



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

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

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