

**Public Health Advisory Board (PHAB)**  
**August 15, 2019**  
**Meeting Minutes**

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**Attendance:**

Board members present: Dr. David Bangsberg, Dr. Jeff Luck, Akiko Saito, Dr. Jeanne Savage (by phone), Rebecca Tiel, Teri Thalhofer (by phone), Tricia Mortell, Carrie Brogoitti (by phone), Dr. Bob Dannenhoffer, Dr. Katrina Hedberg, Muriel DeLaVergne-Brown, Eva Rippeteau, Lillian Shirley (ex-officio)

Board members absent: Dr. Eli Schwarz, Alejandro Queral, Kelle Adamek-Little, Dr. Paul Lewis

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

Members of the public: Gary Cobb (Central City Concern)

**Welcome and Agenda Review**

*Rebecca Tiel, PHAB Chair*

Ms. Tiel welcomed the PHAB to the meeting. She introduced herself. The PHAB members introduced themselves.

- Approval of May 2019 Minutes

A quorum was present. Dr. Luck moved for approval of the May 16, 2019, meeting minutes. Dr. Dannenhoffer seconded the move. The PHAB approved the meeting minutes unanimously.

- Debrief of June meeting with Oregon Transportation Commission and Dr. Charles Brown

Ms. Tiel invited the PHAB members to share comments or ask questions about the ODOT meeting in June.

Dr. Dannenhoffer remarked that Dr. Brown was an incredibly good speaker, who brought out the equity and transportation issues.

Dr. Bangsberg stated that although he was not able to attend the meeting, he called out that meeting at the Oregon Transportation Commission meeting as a great example of a bridging discussion across sectors. The OHPB would like to emulate that approach when engaging in social determinants of health, such as the foster care system, the justice system, transportation, and environmental health. He praised the PHAB for having that meeting.

Dr. Luck noted that the meeting exceeded his expectations. The meeting had been in the works for a long time. The equity lens was a just, different, and very thought-provoking aspect.

Ms. Saito added that it was extra special because the PHAB was there for the signing of the bill by Governor Brown.

Ms. Tiel agreed that the signing of the bill was a great surprise.

Ms. Biddlecom remarked that the same sentiment echoed during a debrief with the ODOT staff. They are interested in having the PHAB and ODOT reconvene again in the future and have joint conversations. They would like to get their next director onboarded. That position is in an interim capacity because the most recent ODOT director retired at the end of June. Once they have the leadership in place, we would plan for something together again.

- September Meeting Plans

Ms. Tiel informed the PHAB that OHA has invited the PHAB members to join a bus tour that is led by the Fair Housing Coalition of Oregon, which takes place on September 26, 2019, at 8:00 a.m., departing from the Public State Office Building. OHA has extended the invitation to the leadership of various committees, including the OHPB. The PHAB members are encouraged to attend. It will be an important event for the PHAB to participate in and learn from. PHAB members who are traveling will be reimbursed. If a group of PHAB members decided to attend the bus tour, it might be best to reschedule the monthly PHAB meeting in September for the afternoon of September 26. PHAB members should inform Ms. Biddlecom or Ms. Tiel of their intention to attend by early September.

- PHAB Mini-Retreat at November Meeting

Ms. Tiel shared with the PHAB that the board's November meeting might be used as an opportunity to step back and take a look at the PHAB's future-looking workplan. The board has done a lot of work and its subcommittees have been in place strategically over the last couple of years to plan for an investment, which will be discussed next. The November meeting might be like a mini-retreat, perhaps outside facilitation, so that the PHAB could plan for future years.

Ms. Tiel remarked that the next update was information about the Student Success Act, which was included in the meeting packet, and OHA's role in supporting the Department of Education's implementation of the act. It is a great opportunity for improving outcomes. Education is one of the social determinants of health that the PHAB has been discussing.

Ms. Shirley stated that the OHA was mobilizing around the Student Success Act, which is seen as an amazing opportunity. The document shared with the PHAB members was Patrick Allen's letter to OHA. Part of the reason for sharing the letter was because it is incredibly articulate and very moving. In the letter, Mr. Allen talks about his own participation on his local school district's school board. When Ms. Shirley came to Oregon 20 years ago, the state was in good shape. When Measure 5 passed in 1990, Oregon was one of the top 4 educational systems ranked in the U.S. Now, the state is consistently in the bottom quarter. OHA will be sharing opportunities, as it will work across systems on the state level to bring this work to fruition. We have to have realistic goals. We have to have proven steps for doing the work. It is very exciting for all Oregonians, but especially for children and new parents.

Ms. Tiel noted that the next update was the OHPB committee digest, which includes updates from other policy boards and is on page 44 of the meeting packet. On page 51 in the packet is a screenshot of the Firearm Safety website recently-launched by the Public Health Division.

Ms. Shirley added that it has taken OHA a long time to get the political will to step out front in public health around the issue.

Dr. Hedberg remarked that the website was not about gun control, but about safety and the focus was on that, as well as figuring out what the division's role was. The division has a strong role around data and, looking at the website, a lot of it relates to the data. Eighty percent of the firearm deaths in Oregon are suicide, which is higher than the rest of the country. The website sheds light on what the issue is. At the same time, policy pieces are not neglected. Rather than talking with advocacy, there is a tab on the page for Oregon Firearm Legislation. The tab Resources for Clinicians includes links to firearm associations related to safe storage of weapons and extreme protective service that facilitates the granting of a court order to take away the weapons of depressed people, among other services. Dr. Ali Hamade, the Deputy State Officer, was the brains behind the creation of the website and brought it to fruition. The PHAB members are encouraged to comment and provide suggestions. This website is the beginning and the intention was to start small and grow incrementally. Feedback is needed on the usefulness of the web page and whether the presented information is objective, evidence-based, and policy-focused, while addressing this countrywide public health problem.

### **2019-2021 Public Health Modernization Investment**

*Cara Biddlecom (OHA Staff)*

Ms. Tiel stated that the legislature allocated additional \$10 million to public health modernization for this biennium, in addition to the \$5 million previously allocated, for a total of \$15 million.

Ms. Biddlecom noted that the slides shown were the same slides presented at the last Incentives and Funding Subcommittee meeting on August 9, 2019. It was important to ensure that the work at the local public health authorities (LPHAs) was aligning with the guidance that the PHAB had on the use of funds. The goal for this new investment in public health modernization was to utilize state general funds that had already been in place from the last biennium and position the public health system to achieve the ultimate goal of modernization, which is that all essential public health services are available to every single person in Oregon. All the conversations that have been had to-date around these dollars have used the PHAB's funding principles that have been developed over the years, as well as the PHAB's guidance on how to use funds that came out of the Incentives and Funding Subcommittee at its June meeting. OHA has been able to align the scope of work for LPHAs and the state investment with the public health modernization manual. Going forward, all of that will also leverage the findings from the 2016 public health modernization assessment that each LPHA completed.

Ms. Biddlecom added that this was an opportunity to build on the work that had been started in the last biennium and work towards the future. This is a turning point for public health. How

do we look at our system more critically? How do we figure out how we can have more effectiveness and efficiencies, and keep an eye towards continuing the things that have been built and preparing ourselves for doing all the work that we need to do in the future?

Ms. Biddlecom pointed out that of the \$15 million that was allocated for this biennium, \$10 million was going to LPHAs, \$1.2 million was going to federally-recognized tribes and NARA, and \$3.8 million was going to OHA Public Health Division. The PHD investment is very much aligned with the work that is happening at local and tribal public health authorities. The PHD will be continuing the health equity work that it had started a few years ago in response to the 2016 assessment and also supporting implementation of LPHA health equity plans. Under leadership and organization competencies, PHD has significant amount of resources that will help the whole public health system come together to identify what changes we need to make as a system, state and local. Where are some areas that we need to put systems in place to improve? We'll be building that out together. The PHD will also have resources going into its data collection systems, ensuring that the PHD is collecting the right data and getting it out to communities for decision making in a way that's going to be helpful and drive community health assessments and plans. The PHD will report on the public health accountability metrics and do evaluations. Under communicable disease control and environmental health, the PHD has resources that will provide search capacity to LPHAs, as well as help us think more proactively about acute environmental health threats and how we both identify where those risks are and prepare the public health system, including the LPHAs, to be able to respond to these threats as they come up.

Ms. Biddlecom remarked that after the Incentives and Funding Subcommittee provided the big scope for how the dollars should be used, the PHD went into a process with the Conference of Local Health Officials (CLHO) to develop the scope of work and the contract between OHA and LPHAs. Taking the feedback of the PHAB members on wanting to continue the good work that had been established in the 2017-2019 biennium and build on that for the future, the decision was made to have, of the \$10 million, \$3 million go out to existing regional partnership work, focusing on the work that had been truly regional in the last biennium. The remaining \$7 million would go out to each LPHA using the PHAB's funding formula.

Ms. Biddlecom stated that some specific criteria went into place around the regional work. OHA wanted to focus knowing that it was less than the approximately \$5.2 million that would need to be allocated to continue what had been done in 2017-2019 but wanted to make sure that OHA was focused on regional work and allow for changes in configurations to partnerships. A new LPHA or partner could drop in or drop out, while keeping the same definition of partnerships, which meant two or more LPHAs and one non-local public health authority partner.

Ms. Biddlecom explained that the PHD and CLHO created a funding model that provides both overall guidance and some requirements, but also allows flexibility. The model is trying to hit a place where these dollars could be used to meet local needs, but also keep the whole state moving together in similar areas and gives us an opportunity to really evaluate the impact of these funds. There will be funding and activities in three areas with menu choices: leadership and governance, health equity and cultural responsiveness, and communicable disease control.

Under leadership and governance, all LPHAs through their funding formula dollars will be required to participate in learning communities. LPHAs can choose from one of the following menu items: developing a plan for full implementation of public health modernization, enhancing partnerships to build a sustainable public health system, implementing workforce development and leadership development initiatives, developing and implementing technology improvements that support effective and efficient public health operations.

Ms. Biddlecom noted that for health equity and cultural responsiveness, many of the LPHAs going into this biennium already have a health equity assessment and action plan that came out of the first round of funding. LPHAs that have not completed an assessment or a plan would have to do them. LPHAs with a completed assessment and plan must implement an activity that mirrors the internal and internal work around partnerships: developing and/or enhancing partnerships, co-creating strategies with communities, staff training/workforce development, collecting and maintaining data that reveal inequities and social conditions that influence health, and workforce diversity. Under communicable disease control, each LPHA must conduct communicable disease control and prevention activities. These activities could vary based on the needs of each jurisdiction. LPHAs must also select one additional menu item: work with partners on communicable disease control prevention, workforce development, and starting to look at how we leverage our systems to address environmental health threats.

Dr. Bangsberg asked if a LPHA uses the funds that had been planned for modernization or health equity, where were the resources to implement the plan? Can a LPHA spend all the money on planning and not have any left over for implementation? Is there an expectation that LPHAs developed a plan in the first biennium and the PHAB identifies funds for them to implement the plan in the second biennium?

Ms. Biddlecom answered that there were two different plans that Dr. Bangsberg mentioned in his question. The first plan was about full implementation of public health modernization. That would be the development of the plan, which would require several biennia to implement, or at least additional biennia to implement. How do we do all of the foundational capabilities and programs since we are focused on three here? As for the health equity plans, most LPHAs developed those in the last biennium. The requirements are to implement strategies, both internally-facing to the public health authorities' workforce and externally-facing.

Ms. DeLaVergne-Brown remarked that when LPHAs talk about implementation, that's when they have to think about their plan for future funding. In her case, Crook County is a small county and its amount per year for all this work is \$39,000. We have to be realistic when we think about the small counties and the list of work and how to get it all done. This is valid for a lot of small counties, not just Crook County. Crook County just finished reaccreditation for public health and it's ahead, but there are a lot of counties that are not that far yet.

Ms. Biddlecom noted that this was the first tribal investment in public health modernization. Through some other work funded by the public health preventative services block grant, some tribes have completed public health modernization assessment. Those that have done the assessment will move into the planning and implementation stage. Those that have not completed an assessment would be able to do that. This is going to be an opt-in. The work now

is to determine which tribe would like to participate in this work and where they are on the spectrum between assessment and implementation.

Ms. Mortell shared that CLHO has had much more time to discuss that than the PHAB. As Ms. DeLaVergne-Brown mentioned, the funding directly to LPHAs is not a large amount. It's a drop in the bucket even for large counties. She reminded the PHAB that an assessment showed \$100 million gap a year and the current funding is \$15 million per biennium. Some great work was done with CLHO and OHA working well together to come up with a plan for work activities that were both structured and moving us together as a system, as well as flexible to meet the needs and resources available at the local level, because it is a very big lift with this little bit of money.

Dr. Bangsberg asked if the funding was a new baseline level commitment that was expected to be ongoing or a one-and-done, in terms of the legislature and how the funding was being discussed.

Ms. Biddlecom answered that the PHD's assumption is that it is a new baseline.

Ms. Shirley stated that she could be more optimistic than that. There was never any question that the \$5 million from the last biennium wouldn't be part of the base funding. It never came up in conversation. There is a lot of support and commitment from the legislature. They are not marching down the road to get us \$200 million. They are marching down the road to get us to think about how we do our work and to get the gaps covered. They are behind us and we are very excited about it. They are very clear that public health needs to be part of other pots of money through other funding streams that have come through, because everyone is now understanding what prevention means. If we are going to solve problems like the system of care, prevention is part of it. Public health in local communities, as well as at the state, is the area that can inform that conversation.

Ms. Tiel commended the Incentives and Funding Subcommittee for preparing the PHAB to be nimble and act on the funding right way. She introduced the next agenda item by reminding the PHAB that in July the OHA announced its decision related to the next round of coordinated care organization contracts. The PHAB provided significant input into the contract development process.

### **CCO 2.0 Discussion**

*Cara Biddlecom (OHA Staff)*

Ms. Biddlecom remarked that the purpose of the discussion was to close the loop with the PHAB. Dating back to November 2017, the PHAB started brainstorming opportunities to better bridge public health and prevention in the next round of CCO contracts. The presentation is to show where some of the CCO work has landed. She showed the PHAB the new CCO 2.0 service delivery map of Oregon. There have been some changes in CCO configurations in service areas. A few areas of the state will now have two CCOs where previously they had one.

Ms. Biddlecom stated that going back to some of the things that have come out of the CCO 2.0 contract process, the pieces that the PHAB discussed over the last year and half were around



including LPHAs in value-based payment strategies, including sharing resources for the public health contribution towards incentive measures, requiring CCOs to develop shared CHAs and CHIPs with LPHAs and hospitals, requiring CCOs to invest in community health improvement plan implementation, and including the Oregon State Public Health Laboratory as an in-network provider for CCOs.

Ms. Biddlecom showed the PHAB the new contract language for the recommendation *Include LPHAs in value-based payment strategies*. CCOs are required to have a written distribution plan for Quality Pool and Challenge Pool earnings. These are dollars that they receive for performance on the incentive metrics. CCOs must have arrangements with participating providers, which include social determinants of health and equity public health partners and others to provide that monetary incentive payment that reflect the Quality Pool program priorities. For example, if a LPHA has been doing work with a CCO on tobacco-free campuses and referrals to tobacco-cessation services, that arrangement would be put in place for the distribution of Quality Pool dollars and opens up the Quality Pool earnings beyond contracted providers.

Ms. Biddlecom showed the new contract language for the recommendation *Require CCOs to develop shared CHAs and CHIPs with LPHAs and hospitals*. The CCO through its Community Advisory Council (CAC) should develop a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP) that both include at least two State Health Improvement Plan (SHIP) priorities and social determinants of health and health equity partners, organizations, counties, traditional health workers, and tribes.

Ms. Mortell asked where in the language was the requirement to include two SHIP priorities. In her view, LPHAs should work with CCOs to have a connection back to local public health, as well as state public health. Where are those connections in the contact language?

Ms. Biddlecom answered that the web links to the specific pages in the contract would be sent to PHAB.

Ms. Biddlecom stated that under the recommendation *Require CCOs to invest in community health improvement plan implementation* CCOs are required to develop a social determinants of health and health equity spending programs plan that aligns with CCO community health improvement plans that are shared with LPHAs and hospitals. A portion of social determinants of health and health equity spending program expenditures must go directly to social determinants of health and equity (SDOH-E) partners for delivery of those programs. CCOs must enter into a contract with a SDOH-E partner to do that.

Ms. Biddlecom showed the new contract language for the recommendation *Include the Oregon State Public Health Laboratory (OSPHL) as an in-network provider for CCOs*. CCOs should include the OSPHL as one of their in-network laboratory providers and should reimburse at the rate of the current Medicaid fee schedule for the date of service.

Dr. Dannenhoffer pointed out that there has been some concern raised about how the CCOs would deal with the social determinants of health. One of the concerns Douglas County has is

that CCOs deal with this on an individual basis, like they are dealing with most things. They don't work on improving immunization rates, they work on paying for the immunizations. One of the concerns that has been raised by several LPHAs is the way they deal with, for example, housing. They will find a member in need and buy them rent. It's hard to argue with that. The New England Journal of Medicine had an article about how paying for rent for poor people will work. That doesn't really change much. In fact, it sometimes makes things worse, because now they are the deep pockets that can pay for any rent in the community and sometimes make the housing in the community worse. You have the benefit of the individual, who is now of mental illness and who gets housed, versus the fact that it doesn't do anything to help the housing in the community and can actually hurt it. How are we going to balance that? That would be incredibly hard to do from the state level or regulatory level.

Dr. Savage remarked that Dr. Dannenhoffer's comment brought up an excellent point. When we say "they", we are talking about 15 different organizations. If you know one CCO, you know one CCO. This work and contract are trying to lay ground for providing a pathway for CCOs to go forward in a similar way, but they are all going to have differences in how they implement that. When we talk about individual CCOs, maybe we should use the example of how we work in our own area or maybe the ones we know, because in Marion County, CCOs particularly have partnered very well with public health to do a lot of different work. The area of social determinants of health is certainly another area for CCOs to tackle, but we plan on doing that in partnership with Marion County Public Health. CCOs and public health are on a trajectory together. It's been tough in the past, but when we look forward, we need to talk about and frame a picture of working together well and in conjunction. It's not going to be easy in every area, but it shouldn't be generalized for all CCOs, because they are very different.

Dr. Bangsberg commented that the contract language is very exciting, though how it's going to be implemented is a big unknown. The key to success is that you have a community where the LPHA and other community-based organizations have an empowered voice in the community health assessment and in the community health improvement plan, in partnership with the CCOs. The language was not explicit enough in terms of population level of health. We should rely on the LPHAs to have that voice. We need to think outside the clinic, in the environment, in the social determinants of health. The other part of CCO 2.0 is a renewed commitment to transparency and sharing best practices across CCOs. The CCOs should come together to share what they are doing in relation to social determinants of health and going upstream, so the best practices become evident and the CCOs that are slower to respond share their deficit and how they could improve. It's important for CLHO to have an important voice in terms of its partnerships with CCOs and getting feedback as to how partnerships are doing, how they are intervening upstream at the population level, and if there are any hiccups. It's important to speak up and make those known.

Ms. Rippeteau stated that the rulemaking for CCO 2.0 social determinants of health is happening right now. Who from public health is sitting on the Rules Advisory Committee and bringing these concerns to that rulemaking process?

Ms. Biddlecom answered that Ms. Sara Beaudrault was there, presenting on the community health improvement plan component to the Rules Advisory Committee. She is not on the Rules



Advisory Committee. The person who is representing the public health perspective on the Rules Advisory Committee can be found online.

Ms. Rippeteau shared that she was not sure whether the PHAB was having that conversation only within the board or whether other people were carrying the message in that space as well.

Ms. Mortell added that she could not understand the opportunity for input into the rulemaking if there's no public health representation on the committee. Is there an opportunity for the PHAB to weigh in at some point?

Ms. Biddlecom answered that there was always a public comment process with rules. OHA can make sure that that information is shared as well. Broader communication around CCO 2.0 and the RAC processes has been shared because OHA gave all the rosters for the PHAB at that time, when the communications plan was being developed. If that's not the case, Ms. Biddlecom should be notified.

Dr. Dannenhoffer remarked that his comment was not to denigrate the CCOs, because paying for housing for somebody with mental illness is maybe one of the best uses of the money. For CCOs, it would be easiest use of the money and the one with the biggest early returns. You can show that they paid the \$800 for rent and this person had fewer emergency department visits. That's exactly what we are looking to do with the CCOs. It's a very different workload from working with community housing organizations to increase the housing stock in the community. It would be hard to balance that.

Dr. Hedberg answered that, as the PHAB knows, OHA is working on the State Health Improvement Plan (SHIP). Of the five areas in the plan, three of them relate to social determinants of health: institutional bias, toxic stress, and economic drivers. It will take a while to figure out what the strategies are. We will need a lot of input. The purpose of the SHIP is not a plan for public health. It is how we work with partners. We do need people to help pay for housing. We don't need everybody to do everything. What should public health do when it's not the one that builds the house and not the one that pays the rent? Public health has an important role in convening. The SHIP subcommittees will be meeting over the fall. This is an opportunity for synergy. We need CCOs to think about their populations, but also about their individual members. The tide rises all boats.

Ms. DeLaVergne-Brown stated that having been involved with the Central Oregon Health Council (COHC) for many years (COHC was a health council before there were CCOs), getting this amount of work is what Ms. DeLaVergne-Brown has been asking for a long time to be a part of. When the COHC recently presented at its board meeting a pie chart that included public health, she was very excited. Whatever everybody did to give public health a voice with this – it has taken a lot of work and it is incredibly important. On the housing, for the Central Oregon's regional health improvement plan, the partnership had a social determinants of health workgroup that was based on the improvement plan. Out of that workgroup came out a housing group and that group had a ton of people on it from public health and housing. There was some money that went towards it, but it was to help some of those organizations create

those housing opportunities. There are some ways that it is happening where you can create more of a bigger picture than paying for a person's rent.

**Public Health Division Health Equity Workgroup**

*Victoria Demchak (OHA staff), Dr. Tim Noe (OHA staff)*

Dr. Noe introduced himself as the administrator for the Center for Prevention and Health Promotion at the PHD.

Ms. Demchak introduced herself as the health equity coordinator at the PHD.

Dr. Noe reminded the PHAB that back in 2016, the PHD did an assessment related to modernization at the PHD. It assessed itself on its capacity and expertise on the foundational capabilities and programs. The foundational capability *health equity and cultural responsiveness* was ranked fairly low (3 out of 10). The leaders at the PHD saw this as a call for change to try to address this foundational capability. The Future of Public Health Task Force has to be commended for having the foresight to see that health equity is a foundational capability and include it in the public health modernization framework, because the other states doing modernization didn't include it. That was an important impetus to start this work within the public health system in Oregon.

Dr. Noe added that, back in 2017, PHD came to the PHAB and proposed to develop a health equity workgroup. We saw the assessment and the foundational capabilities as a call for change for doing that. The workgroup developed a model that could potentially be used throughout the public health system to try to address the foundational capabilities. The foundational capabilities are the capacity and expertise that the public health system needs in order to successfully and effectively implement the foundational programs. Because of the public health system's reliance on categorical federal grants, the public health system doesn't have the resources it needs to fully resource the capacity and expertise of these foundational capabilities. There was a need to develop a creative solution to trying to address this.

Dr. Noe noted that even though the PHD was thankful for the investment that the legislature had given it in terms of general funds to help it address this need of developing the foundational capabilities, the PHD saw it as its responsibility to try to come up with some creative solutions. One thing that the division did was to develop the health equity workgroup (HEWG). The first order of business was to form the workgroup and pull together a coalition of the willing – the people who are passionate about health equity across the division – and ask them to come together. The workgroup was legitimized by developing a charter, which was reviewed and approved by the executive committee. The workgroup then came up a workplan, developed goals and objectives, formed subcommittees to do the work for the workplan, and developed metrics and outcomes to make sure the work was successful.

Dr. Noe stated that what the workgroup did was a really good model. When we are trying to develop our capacity on the foundational capabilities across the public health system, it's important to gather the resources and capacity that we have from within and pull on the positive core work and passion that we have within the system.

Ms. Demchak confirmed that the HEWG was a coalition of the willing. It is a useful organizing method to pull together individuals from across the PHD, so they can work to fulfill the various and community roles of health equity and cultural responsiveness identified in the modernization manual. They can tap into subject matter expertise and knowledge across the division, as well as other subject-specific knowledge, such as community engagement or workforce diversity, which not all individuals would necessarily have the background in.

Ms. Demchak remarked that the vision for this capability is to ensure equal opportunity to achieve the highest attainable level of health for all populations through policies, programs, and strategies. They respond to the cultural factors that affect health, correct historic injustices borne by certain populations, and prioritize development of strong cultural responsiveness by public health organizations. When we say health equity as a foundational capability, we are really talking about a lot more than just health equity as an outcome. We are talking about the various processes, community-engagement methods, from developing a policy to implementation, that create different kinds of outcomes with communities.

Ms. Demchak pointed out that the workgroup's composition was all staff: staff-led and staff-managed. She is the chair and there is a co-chair from the acute communicable disease and prevention section. The members range from across the PHD. There is a small core and large group of affiliate members. The purpose of the workgroup is to lead the PHD to advance the health equity and cultural responsiveness capability. When we look at the organizational chart, the workgroup is trying to achieve this purpose in a variety of ways. The HEWG responds and reports to the PHD's executive team. The group has its steering committee and much of its work happens through individual subcommittees that are subject-specific. They are a mixture of ad-hoc committees. Those are the two standing committees that are providing support.

Ms. Demchak stated that the Gatherings and Communications Committee continued to develop capacity-building educational activities and communicating them to the PHD. The HEWG sees capacity-building as central to developing a shared language and shared goals for health equity and cultural responsiveness across OHA staff. Trauma and resilience are something the HEWG is working to understand better both for OHA staff and for the individuals whose lives we affect. The Community Engagement and Workforce Diversity committees came up with recommendations that the HEWG submitted to the executive team.

Ms. Demchak noted that although not all PHAB members were on the board in January 2017 when the HEWG last presented, it's important to have a line from that presentation. At that time, the HEWG presented to the PHAB a draft charter and some draft goals. The final three goals are in the current workplan. The HEWG is planning the goals for the next two years now. They are very similar. The HEWG is trying to continue with building capacity, knowledge development, and shared language. The second goal is about the organizational structures, policies and systems to advance health equity, diversity, and cultural responsiveness. The third goal is about co-creating objectives, metrics, and strategies to build a diverse workforce. A focus on community-engagement will be added to the next round.

Ms. Demchak added that the other line she wanted to draw was that the HEWG's presentation was analogous to some of the presentations the PHAB had seen over the last several months. The PHAB has been hearing from other LPHAs and partnerships about their health equity and cultural responsiveness work. The HEWG organizes its work in a similar way.

Ms. Demchak reviewed the work the HEWG had done in the past. The work falls into three categories: developing frameworks and structures for the work, tools and systems that can be shared, and projects that are used to engage staff throughout the PHD. Sometimes the projects can create tools and systems. It is anticipated that the HEWG's workforce diversity recommendations and community engagement recommendations are projects that the HEWG is working closely with the executive team on, which would then create different tools and systems that affect the whole division. The HEWG's responsibility for them is to develop and propose, and then support implementation whenever the HEWG is able.

Ms. Demchak explained that one thing that the HEWG found to be very helpful was to look back and ground the work in public health modernization. The vision and essential component for this capability are linked to first-degree drivers, second-degree drivers, constraints, and goals. The goals will be updated for the next round of the workplan. When the HEWG tries to affect change, the focus is on the second-degree drivers and managing the constraints. The constraints are modifiable, and the HEWG will be working on modifying them, but frequently the HEWG is working through the second-degree drivers to try to achieve the first-degree drivers that move the public health system closer to modernization.

Ms. DeLaVergne-Brown expressed hope that, while moving down this path, that community outreach would be included. One of the things that Crook County learned was doing its own health equity assessment of its staff and then doing an assessment of community partners. Then the county met with the community partners and presented the assessment results to them as actionable items for Crook County to do. The community partners provided rich information on how Crook County Public Health (CCPH) did around health equity and how they would like to be involved. They wanted to be involved a lot more in program planning, among other things. The community partners assessment gave CCPH a distinctly different view than if the CCPH did the assessment only internally.

Dr. Noe responded that there were a lot of things that were beginning to coalesce around community engagement. The health equity subcommittee on community engagement has developed principles and values for community engagement that have been adopted by the executive committee at the PHD. The HEWG will be rolling out a new communications plan and develop some expectations around the programs for community engagement, trying to ensure that we have meaningful community engagement, one that has shared leadership, shared responsibilities, shared resources, and shared power. In the performance management system at OHA, one of the key core operating processes is community engagement. There are a number of measures and metrics around community engagement that will be a part of OHA's performance management system. The OHA, in conjunction with the Office of Equity and Inclusion (OEI), has developed a community engagement plan related to OHA's strategic plan that will be used throughout the OHA as a guide for community engagement. The OHA is working toward that. The thought about talking to community has always been on the back of

HEWG's mind. The internal structural development has been the key focus of the HEWG, because it had to be done.

Ms. DeLaVergne-Brown added that community engagement was a big part of accreditation.

Ms. Mortell stated that she might share some that information at the CLHO Retreat, and the Oregon Public Health Association would really like the detail, but if the PHD has adopted these principles and is beginning to implement them, it would be great to share these concrete tools across the system.

Dr. Noe agreed with Ms. Mortell. That is the plan.

Ms. Tiel remarked that the membership of her organization, Oregon Association of Hospitals and Health Systems (OAHHS), is made of very large institutions and health systems. The OAHHS is trying to figure out how to support some of its members in achieving their health equity goals. Thinking about the OHA and the PHD as an institution that has systems in place that may prohibit health equity, does the HEWG have better success working in those structures, or is the HEWG working to dismantle structures? The OAHHS members could be huge systems, both literally and figuratively, and sometimes they are finding that the structures within their systems are doing more harm than good in terms of the goals they want achieve. What has been the approach of the HEWG – to embed itself in those structures or to dismantle them?

Ms. Demchak answered that the OHA might not be as large a system as some of the hospitals and health systems. One of the things the HEWG is trying to do at OHA is identify barriers and then make proposals to work with our leadership to manage or change those barriers. Some of those are being looked at through the greater modernization change plan. This is not the only effort. The HEWG is not asking what are the structures that keep us from achieving health equity. It's looking at the structures that keep us from being the state version of the modern public state system that we want to be. Those structures are probably interlaced.

Ms. Demchak explained that one of the things that is challenging about saying, "We have this committee and we did these things and then we had this impact," is that the impact is variable. Some of it is a mix of culture change and process changes. There are the ones where we can see a clear change, but there are more subtle changes that can be seen throughout the PHD. Some of the places where the HEWG sees the most significant change is that our attitude toward the SHIP and the way that we work with communities over the course of this last year has been profoundly different than previous cycles of the SHIP. That is part of the HEWG's work in adopting the framework of modernization and then working to uphold the values that are embedded in modernization, including health equity and cultural responsiveness.

Ms. Demchak added that the HEWG's work on workforce diversity has increased the awareness of the need for accessibility and trauma-informed practices. Efforts are made to engage with staff in a different way. The HEWG created new setup initiatives on increasing the diversity of PHD boards and committees. When the PHD works with the public and there are opportunities to engage the public, how is it tracking diversity, how is it reaching out to different groups, and then how is it identifying that the PHD is more successful in that? The HEWG is also using the

health equity work as a model for division culture change efforts that align with modernization as well. This kind of networked model is one of the ones that the PHD is using as a method for possible change. This also comes up in other section- and project-specific projects. The PHD now has section health equity groups that are adapting health equity and cultural responsiveness to their own programs. For example, the acute communicable disease and prevention program created a Real-D training that is in part leveraging modernization and also responding to LPHAs and their needs. It is also responding to PHD's internal work to have a Real-D policy for tracking race, ethnicity, language, and disability across the populations.

Ms. Demchak remarked that moving forward, the HEWG would continue its HR capacity-building efforts; continue identifying how we develop linkages between health equity and cultural responsiveness, or trauma-informed work, both in the populations we serve and the PHD staff; coordinating work across the division; identifying the resources dedicated to health equity; supporting progress and projects on workforce diversity throughout the division; increasing meaningful community engagement. These initiatives are prioritized and not done all at once. The HEWG is a small group that tries to leverage a mix of passion and engagement. The passion of its members drives the prioritization of initiatives.

Ms. Demchak stated that when the HEWG reviewed the health equity assessment plans from the LPHAs that submitted them, it was clear that different partnerships found different themes. They found regional and local components. Some of them were very focused regionally. Some of them had regional and local compliments. Some of them were almost exclusively focused locally. LPHA partnerships were very cognizant and we were very clear where they saw points of leveraging and shared goals across a region or where they did not, given their different populations. There was a range of resources and capabilities in the different areas. The plans responded to the partnerships' strengths and needs. The range was broad and indicative of the local control and local focus.

Ms. DeLaVergne-Brown pointed out that it would be important for LPHAs implementing health equity plans to have a way to share tools and processes. The next steps related to implementing the health equity plans are written from a statewide perspective. We are a system. It is important to let go of that.

Dr. Bangsberg praised the way the SHIP was shaping out and noted that there has been a concern at the OHPB about lack of progress in coming up with equity measures. The chair of the OHPB wrote a letter to the Quality and Metrics Committee requesting progress on this, because if it's not measured, it's not incentivized, or it won't happen.

Dr. Hedberg admitted that that was one of the challenges with the SHIP subcommittees, ensuring that we had metric experts. When there aren't a lot of new data sources, we end up measuring what we have data on, and sometimes it is not as meaningful as we would like. When it comes to the SHIP and those groups, the PHD would love to have more involvement from academic partners that might know who was a measurement expert. We really need help in figuring out how to measure. Health equity is an important part of both the SHIP and the public health modernization work.



Dr. Dannenhoffer shared that when he was the chair of the metrics committee when it started, they looked deeply for an equity measure. There were national experts trying to find any state that was using an equity measure, but they couldn't find one. There were several proposals locally to create one, but creating measures has lots of troubles associated with it. It is shocking that no state has figured it out, but we do need to put some effort into getting a measure, because what doesn't get measured, it doesn't get paid attention to. The data about the difference in life expectancy by zip code has been so elegantly simple and so striking.

Dr. Luck reminded the PHAB that, in June, he mentioned to the board that the Health Equity Measurement Workgroup had proposed a very limited scope but concrete health equity measure to the Health Plan Quality Metrics Committee, but it was not approved. It was tremendously disappointing. OHA staff are stepping back and trying to reflect on where to go next. He asked Dr. Bangsberg if the letter from the OHPB to the Quality Metrics Committee after that vote.

Dr. Bangsberg answered that the letter was within the last couple of weeks. It was largely living by that need to go back and not start again and make more progress.

Dr. Luck remarked that the Quality and Metrics Committee did not meet in August. Probably they'll discuss it in their next meeting. He asked if there was a health equity workgroup at the OHA level and if there was coordination between that group and PHD's HEWG. The Health Plan Quality Metrics Committee is mostly focused on health equity for the Oregon Health Plan (OHP) members. Is the work of the HEWG consistent with or reinforcing what's being done in the Medicaid side and the behavioral health side of OHA, so everybody is working toward the same goal?

Dr. Noe responded that there was a not health equity group across OHA, but there is a social determinants of health workgroup focused on social determinants of health through health system transformation. Within the new performance management system, there is an outcome that is intended to address health equity. There are several core processes and measures that are directed to health equity across the OHA that will be measure and tracked. That's one way of aligning. There are two different tiers of the performance management system. OHA feeds information to the first tier, which feeds information to the outcomes. There are a lot of improvements to be made around how we coalesce around addressing health equity from a systems perspective and both PHD and OHA working together to do that.

Ms. Shirley agreed with Dr. Noe and added that PHD had been struggling with this for a number of years. The payment side of Medicaid has not been struggling with the broader issues. It has led to things like the changes in the CCO contracts. That being said, there is a system-wide, not just Medicaid, effort by OHA trying to do this work across the system. There are many pieces of the OHA beyond Medicaid including the State Hospital. This work is being replicated. In a lot of ways, they are looking to the work PHD started. Part of OHA's goal in doing this is to make OHA's performance management system and outcomes very robust and concrete around these areas, but also to look at how we do our own work internally. We know that a lot of the barriers to us getting done what needs to be done are of our own creation.

Ms. Shirley shared that going through this work, together, is part of what we hope to do to be able to also expand. Is this the way we do the other foundational capabilities, not programmatically necessary, but leadership and governance and foundational capabilities? Is this the way to take these broader concepts and have them dictate how we do our work and how we hold ourselves accountable across the traditional public health programmatic silos? This is really changing the practice of public health. OHA is trying to be as thoughtful and as honest as we move forward but double ourselves accountable for making these changes. The work that Ms. Demchak has led, and the committee, with Dr. Noe being the executive sponsor, is really how PHD is trying to roll it out and not have it become this quarter's reporting data, but really have it change the way we, as public health professionals, think about doing our work.

Dr. Noe remarked that in terms of the model he mentioned for addressing the foundational capabilities, one thing that the HEWG noticed was that health equity and cultural responsiveness cannot be addressed without addressing community partnership development, or without addressing communications. There is so much intersectionality between the foundational capabilities that when you start trying to work on one, you work on them all simultaneously and try to build their capacity. In terms of community engagement, at the state level, we have realized that on a programmatic level we have done very well with engaging the community on programmatic issues. Statewide initiatives, such as the SHIP, are developing models to do that well. But then we have a higher level, the public health system, for which we need to get community engagement. OHA has not figured out that piece.

Ms. Mortell stated that as CLHO and the local public health authorities are working on health equity, work we often need to do within our own communities, but there is one area that we should be thinking about being much more collaborative and that's workforce training and development. All LPHAs are out there trying to figure out what are some good resources, what are some training modules, what are some ways to build affinity groups. We can do better at putting this all together across our system.

Dr. Luck encouraged the HEWG to work as much as possible across OHA, because (a) everybody in the PHD has a population focus, while other divisions might have a different focus, and (b) any health equity program is focused on improving the health of the least advantaged people in Oregon. Since the Medicaid expansion, most of those people are OHP members. The HEWG should think beyond the silo and bring its perspective across OHA.

Dr. Noe appreciated Dr. Luck's comments and remarked that the de Beaumont Foundation recently released an announcement about a new program they were implementing called Research to Action, where they are working with state health departments on building their recruitment and retention of the public health workforce. PHD applied and was selected to participate in this program. PHD has a design team that's a part of it, for which PHD wants to ask several public health authority members to sit on the design team with PHD to attend webinars and to learn from training that the de Beaumont Foundation will be offering. This would be a good opportunity for us to coalesce around the workforce issue and get some training around it.

## **State Health Improvement Plan: Suicide Prevention Priority**

*Dr. Laura Chisholm (OHA staff)*

Dr. Chisholm introduced herself as the section manager for the Injury & Violence Prevention Program (IVPP) at PHD, doing work on suicide prevention from the public health side. The program has funding from the Garrett Lee Smith Memorial Suicide Prevention Program, which is a federal grant. The IVPP has had this grant for three 5-year cycles and was just awarded the grant for the fourth time. The IVPP also has a general fund that supports the FTE for a suicide prevention coordinator. The IVPP works closely with the Adolescent Health Program and school-based health center programs. The IVPP also works closely with the Health Systems Division, who also have FTE for suicide prevention.

Dr. Chisholm reviewed the key questions: (a) How do we ensure suicide prevention is woven into the new SHIP priorities (i.e., institutional bias; adversity, trauma, and toxic stress; economic drivers of health; access to equitable preventive health care; behavioral health)? (b) How can we more effectively engage populations at highest risk (e.g., Native Americans, older white men, veterans)? The funding of the IVPP in public health is focused on youth suicide prevention. While the work is focused on systems approaches that will help to benefit in many cases the entire population along a lifespan, it is focused on youth. There are quite a few youth-specific efforts going on. (c) How can suicide prevention tie in with efforts on opioid, alcohol, and other drug use as well as other aspects of the overdose syndemic? The IVPP is thinking about the confluence of suicidality and overdose and a wide variety of other issues that all have come together.

Dr. Chisholm stated that the rate of suicide is moving in the wrong direction. Suicide is one of the leading causes of death in Oregon. It's the second leading cause of death among younger Oregonians, aged 10 to 34, and eighth leading cause of death among all Oregonians (data from 2017). Oregon is losing 830-840 people by suicide each year. The state lost 825 people in 2017. The Oregon suicide rate of 19.0 for 100,000 people is almost 36% higher than the national average. Speaking of youth suicide prevention, youth suicide is of tremendous concern. One of the challenges with the way the funding is right now, there is a huge focus on youth suicide. While it is important and any suicide is one too many, suicides of people under 25 in Oregon account for about 13% of the total suicides. If we are focusing on youth suicides, we are missing a huge area of the population.

Dr. Chisholm explained that the highest suicide rates are among males aged 85 and older. We have these two growing areas of the population where the rates are increasing quickly: one is in youth and the other is in elders. They have been continuing to increase over the past 20 years nationwide. The increases in Oregon are driven by the rates of the younger and older populations. It is a little bit of an unusual epidemic from the public health side when looking at racial and ethnic disparities, because older white males are at highest risk, as well as Non-Hispanic American/Indian/Native Alaskan. Veterans constitute about 8% of the total population, but they account for about 21% of the total suicides in Oregon. Both male and female veterans have higher suicide rates than non-veterans. This is a place where we want to do some thinking related to how we can move forward, using the groundwork that IVP has with youth suicide prevention and focus on the veteran area.

Dr. Chisholm pointed out that currently there was limited public health capacity or funding to comprehensively address the problem of suicide. The IVPP has done a huge amount of work with very little resources. Because the IVPP has some general fund, it can push most of the grant money out to the counties. The IVPP supports youth suicide prevention coordinators and coalitions in five counties: Deschutes, Jackson, Josephine, Umatilla, and Washington. The IVPP will continue to support those five grantees for the next year, which is Year 1 of the new 5-year grant. This is the status quo with the grantees through August 2020. During that time, the IVPP will be working with the AOCMHP and CLHO to identify new grantees.

Dr. Chisholm noted that those grants support gatekeeper trainings, which are trainings of lay bystanders in identifying people with high risk of suicide and helping them to stay safe and get the support that they need to continue to stay safe, as well as a lot of clinical training. Last year this time, we talked about Zero Suicide, which is the quality improvement program for healthcare organizations. We had a very successful Zero Suicide academy last year in Oregon. There was space for only 18 systems. A national team came out to do a 2-day training. The IVPP has been working to support those systems in continuing their suicide prevention efforts. Right now, it's mainly hospitals and behavioral health systems. One of the issues the IVPP needs to solve is the CCOs. A lot of great work is already happening in CCOs, there is a challenge with metrics. Suicide prevention has not been one of the highest priorities with the CCOs. The IVPP is hoping to change that in the next few years.

Dr. Chisholm stated that IVPP's counterparts in the Health Systems Division have an FTE and they created a youth suicide intervention prevention plan five years ago. That plan is up for renewal in 2020. The IVPP also created the Oregon Alliance to Prevent Suicide, which has grown quite strong over the last year. They have bylaws and active members, who did a lot of advocacy work this year. This legislative session was huge for suicide prevention. There is a \$10 million policy option package that was passed to support implementation of the state youth suicide prevention plan. That includes another FTE that will go to the Health Systems Division. There is going to be an adult suicide prevention coordinator as well, plus funding to support youth suicide prevention in schools. There is also the Student Success Act, which is going to provide a strong opportunity for IVPP to partner with youth suicide prevention advocates and individuals who are doing work in schools around the state. OHA's Director, Patrick Allen, has already put together a group to think about how PHD can help to support the work of the Department of Education, as it is implementing the Student Success Act.

Dr. Chisholm remarked that in thinking about policies, one of IVPP's major areas of focus is directly addressing suicide through the healthcare system. We know that a very significant portion of people who attempt or complete a suicide had had a connection to a healthcare system recently. We know there are still many potential opportunities to connect with people with resources. The Zero Suicide initiative is focusing there. The IVPP is also connecting with the people who are working on the metrics and measures for the behavioral health package for CCO 2.0 and easing into the CCO work for suicide prevention. House Bill 3090 requires hospitals to provide a referral, a safety plan, and a follow-up for people experiencing mental health crisis at the emergency department, or who are admitted patients.

Dr. Chisholm added that one of the things the IVPP has done for firearms safety throughout the year, with Dr. Hedberg helping to lead the initiative, was to think about the connection between firearms and suicide. Ms. Shirley and Dr. Hedberg have been very supportive in helping IVPP identify their role. The PHD recently put up a Firearm Safety website. There is firearms safety information on it and a lot of good data. It's a great start for the PHD to be putting data and resources out there. The public health role for firearms safety is getting the evidence out and providing resources and good quality data.

Dr. Hedberg pointed out that 82% of firearm death were suicides, but a little over half of the suicides were by a firearm, so there were other means. If means matter, what's the suicide method by age group? We know, for example, that most veterans have been trained in using a firearm. Frequently, veterans who are coming back from war zones have depression and post-traumatic stress disorder (PTSD). Some of the risk factors might vary by age groups. Depression is a key one for everyone, but the behavior may be slightly different when we talk about older adults and when we hear about the murder-suicide aspect. She asked if the IVP has done the means by age group.

Dr. Chisholm confirmed that the IVPP had that data.

Dr. Hedberg added that young women often attempt suicide more, but it is often by less lethal means, such as taking overdose of some pills or another that might not be particularly lethal. Whereas, when one has a gun, it is very impulsive, depending on how one uses it, most people don't survive an attempted suicide with a gun.

Dr. Chisholm revealed that the IVPP was expecting to receive a federal grant for emergency department non-fatal suicide attempt data systems development. The grant is about \$185K per year, but it will support a position that will work with PHD's ESSENCE (Emergency Syndromic Surveillance System). CDC will be funding 10 sites across the nation to help them compile a project to really dial in the queries that are used with the ESSENCE data system that comes out of emergency rooms; to really dial in the sensitivity and specificity of the data, so that we can get quality information about suicide attempts. It will be fantastic if that happens, because, as Dr. Hedberg mentioned, it's a 10-1 attempt-to-completion ratio. It's going to be really helpful to have that data to help the IVP focus its prevention efforts in a much more specific way.

Ms. DeLaVergne-Brown noted that depending on the hospital system and their community benefit – St. Charles Hospital (in Bend, OR) chose suicide as one of their areas – one of the things that the hospital does for Crook County that helps support some of the work is that Crook County Public Health has a staff person who trains on the Mental Health First Aid and the QPR. When a person attends one of the classes, St. Charles Hospital pays Crook County Public Health. That may be a way that other counties can work with their hospital systems around some community benefit dollars to help in that. St. Charles Hospital has been incredibly supportive of that.

Ms. Rippeteau asked Dr. Chisholm to elaborate on the \$10 million for the youth suicide prevention and the plan around that and adult suicide prevention.

Dr. Chisholm answered that there will be quite a bit of funding for programming to support youth suicide prevention specifically, as well as the Sources of Strength program in schools, the postvention training CONNECT, tribal mini-grants, and about \$50K for Oregon's Child Fatality Review. The adult suicide prevention position will be to create an adult suicide prevention plan, similar to the one the IVP has for youth.

Dr. Luck asked if there was any data on how many of the 840 people who commit suicide per year were members of the Oregon Health Plan (OHP).

Dr. Hedberg answered that the PHD needs to look at that data. The answer, most likely, is: a disproportionate number. That's something very important to the PHD. In thinking about the risk factors we talked about—veterans, depression—we also need to consider whether or not some of those factors are related to financial issues or health issues, among others. The percentage is quite high.

Dr. Luck added that in terms of getting CCOs engaged in suicide prevention, having data on suicide completions and attempts who are members of CCOs, and then breaking it down by CCO, could potentially be a way to create a performance metric that could be put forward to the Quality and Metrics Committee.

Dr. Hedberg agreed with Dr. Luck that measuring suicide completions and attempts by CCOs was important. The difficult part is the data source. One of things PHD has is the embedded client system, where PHD can link Medicaid with death certificates, but it's not as easy as it sounds. Most death certificates don't say what insurance the person had. PHD could probably get that information, but not necessarily by CCO, unless there was an incentive method of some sort.

Dr. Savage stated that it was a great idea and a great place for CCOs to collaborate with public health and especially on the data. If CCOs could get their own data and combine them with public health data, that would be fantastic.

Dr. Luck asked if there were any other states that had successful public health suicide prevention efforts.

Dr. Bangsberg answered that Massachusetts' approach to firearm safety has been very successful, reducing completed suicides related to firearms and overall suicide.

Dr. Chisholm added that New Hampshire also has an excellent program.

Dr. Hedberg reiterated that Oregon was one of the higher states in the country in suicide death rates. All of the western states are. Everybody should agree that we don't want to have these types of deaths or "accidental injuries from firearms". Having a conversation is important. New Hampshire may have higher firearm ownership than Oregon, but otherwise, it's the states in the west. These are the ones Oregon has been trying to look to.



Dr. Chisholm remarked that Colorado has done [Man Therapy](#), which is about men speaking to men about struggles and suicide. It's humorous and informative.

Dr. Dannenhoffer stated that he sits on the Douglas County Traffic Safety Commission and they have observed an increasing number of deaths from very unusual circumstances – single vehicle accidents, people walking on the freeway. These are deaths that get written as motor vehicle deaths, but are quite likely suicides. The suicide numbers for Oregon may be undercounted.

### **Public Health Accountability Metrics for 2019-2021**

*Josh Van Otterloo (OHA staff), Dr. Myde Boles (OHA Staff), Dr. Laura Chisholm (OHA staff)*

Dr. Boles introduced herself as a senior research scientist at PHD's Program Design and Evaluation Services. As a recap, back in Spring 2019, when the PHAB adopted the 2019 metrics, there was a request for the Accountability Metrics Subcommittee to review and consider changes to two of the outcome measures. The first one was the Prescription Opioid Mortality measure and the other was the Dental Visits for Children Age 0-5. At the time, it was thought that because the benchmark for the prescription opioid mortality metric had been met for 2017, there was some discussion possibly considering the broader context of the opioid crisis and a different type of metric that might better represent that. The process measure associated with that outcome measure, Enrollment in the Prescription Drug Monitoring Program, is no longer relevant because the law has been tasked that requires enrollment in that. The reason for reconsidering the Dental Visits measure was because it was put forward as a developmental metric and there was the idea if it should stay a developmental metric and if there were any updates to the data that might transition it from a developmental to an accountability metric.

Dr. Boles pointed out that the data for the percent of children aged 0-5 with any dental visit comes from Medicaid claims data. It's not a state-by-population-based measure. The benchmark is 48%. Most counties in Oregon met the benchmark in 2017. The benchmark is based on the SHIP 2020 target. In looking at the subpopulations, most ethnic/racial group also met or exceeded the benchmark.

Dr. Boles remarked that the Accountability Metrics Subcommittee reviewed the dental outcome measure and looked at the availability of other potential data sources to measure childhood oral health. There are no other good measures other than Medicaid claims data at this time.

Ms. Rippeteau shared that as a mom ready to send her kid to kindergarten, one of the forms she had to submit was proof that her child had had a dental screening, signed by a dentist and sent back to the school. She wondered if there was a way to partner with schools to get more information about kids who have received dental care.

Dr. Hedberg answered that the Dental Visits metric was for children aged 0-5. We have the Smile Survey, or we have screenings that happen in schools. The survey doesn't happen every year. It happens every five years. OHA has tried in the past to get data from the enrollee forms

used in school screenings, but it has had a very hard time. The attempt was to do it for children with diabetes to look at prevalence, but it's very difficult data to access at schools.

Dr. Boles added that there were some other survey data, such as the PRAMS 2 data and the National Survey on Children's Health, but those have a variety of other issues related to the appropriate population or how often those data are being collected. Dental Claims has been now added to the All Payroll Claims database. However, dental visits for children aged 0-5 has yet to be reliably added to the database. Given all these considerations about available data, and in conjunction with the fact that it's still believed that this measure is very important to continue to track, the subcommittee unanimously voted to keep the measure as a developmental metric for the 2019-2021 accountability metric cycle.

Dr. Hedberg noted that oral health would no longer be a part of the SHIP. In terms of where the benchmark comes from, the benchmark is low (less than 50%) and almost every county is meeting it or moving in the right direction. Even if the measure is developmental, we need to pick a new benchmark, something that says, "We are moving in the right direction," but the whole state shouldn't be dark green, like "We're doing great," when it's basically only slightly more than half of the kids.

Ms. Mortell noted that that was the reason for her asking about the national standard. Is it Health People 2020? Is it somewhere else? Why does it fit for Oregon?

Dr. Boles answered that the oral health program folks were investigating, and she would turn in another potential level for the measure. It's under consideration.

Mr. Van Otterloo introduced himself as an epidemiologist at the Prescription Drug Monitoring Program (PDMP), which is a part of the Injury, Violence, and Prevention Program. The prescription opioid mortality metric was the previous metric which was 3 prescription opioid overdose deaths for 100,000. Due to changing overdose death patterns, as well as some other things, the recommendation of the subcommittee was to move to all opioid overdose mortality rate for 100,000. The data source is the Vital Events Registration System (OVERS), which is death certificates. The county rates are calculated by dividing a numerator (i.e., the number of prescription opioid poisoning deaths in a 5-year period among Oregon residents who dies in Oregon) by a denominator (i.e., state population or county population). This rate can be further broken down by race and ethnicity, with the numerator being the number of prescription opioid poisoning deaths in a 5-year period by race/ethnicity among Oregon residents and the denominator being the state population by race/ethnicity.

Mr. Van Otterloo noted that in terms of classifying opioid poisoning deaths, death certificate data were coded and required an underlying cause of death code (e.g., poisoning by narcotics), plus at least one T-code among contributing causes of death. The T codes for all opioids are: T40.0 – opium, T40.1 – heroin, T40.2 – other opioids, T40.3 – methadone, T40.4 – other synthetic narcotics. The T40.4 code has gotten complicated with fentanyl. Previously, it used to be entirely prescription, but now fentanyl dominates the T40.4 code, mostly illicit. Calling it "prescription" is mislabeling. The recommendation was to keep intent on all deaths unintentional, undetermined, suicide, and homicide. This code captures poisoning deaths

rather than drug-related deaths. If someone has a disease and uses drugs, such as Hepatitis C and HIV, and they die of that, it's not going to be counted. What counts are chemical poisonings due to drugs. Another thing to consider is polypharmacy. Things have gotten more complicated in the last couple of years when looking at the death certificate data. It's not one drug, one death. There are often quite a few drugs. Trying to say that something is a prescription overdose death versus a heroin overdose death is more complicated. It's maybe both.

Mr. Van Otterloo explained that there were some limitations to the data. The limitations are very similar to the prescription drug overdose limitations. The PDMP has to aggregate the data due to small counts. It won't out the one person who died due to overdose in Curry County. That's why some counties would either have suppressed rates or a 5-year time period. Another limitation of the data is that the PDMP doesn't receive the death data for Oregonians who died out of state. This is not the majority of the cases, but it's a known limitation of the data. Limitations related to coded data include polypharmacy and poisoning versus drug-related deaths. The all opioid metric has less limitations than the previous measure (i.e., prescription drug overdose).

Mr. Van Otterloo remarked that the Accountability Metrics Subcommittee asked for some alternatives to death as it seemed that that's the top of the pyramid. The PDMP came up with three lower ones: hospital discharge, emergency department visits, and syndromic surveillance. These alternatives do have some limitations and they all track the same underlying exposure (i.e., drug use). The PDMP is going to talk more about hospital discharge as it thinks that it's probably the best option. Emergency department visits is not currently available. It's been one of things the PDMP has wanted to get into, but it has not been able to. In terms of syndromic surveillance (ESSENCE), it is emergency department visits, but it's not coded data. It all based on primary impression or what they show up to, and it's hard to create a case definition for overdose, as overdose can present a whole bunch of different things.

Mr. Van Otterloo stated that the biggest limitation with hospital discharge was that hospital discharge data changed its coding from ICD9 to ICD10-CM in mid-2015. The PDMP made graphs that showed a dramatic increase in all overdose inpatient hospitalizations. The codes pre-2015 and post-2015 are not comparable. Everyone wants to compare that gap for PDMP, but, as an epidemiologist, Mr. Van Otterloo recommends doing it with caution, which means, "Don't do it." It's hard to compare intent (i.e., undetermined, unintentional, suicide, homicide) because of the rate change. When one dives into the hospitalization data, it gets messier. Since the coding changed in 2015, that gives the PDMP a limited amount of time to aggregate. The small counts issue in some of the less populous counties is still there, but a 5-year aggregation cannot be done. The data can be aggregated only back to 2016.

Mr. Van Otterloo added that another limitation of the data is that it requires an inpatient medically attended event. The PDMP has a good handle on deaths, because people die and medical examiners can do an investigation on all the deaths in Oregon, whereas the hospital discharge data undercounts a lot of the illicit drugs. When running the numbers, the heroin hospitalizations are lower than expected, because they maybe don't make it to an inpatient medically intended event. They might leave against doctor's advice, or not get inpatient, or die before they get there. There are also some historical race data inaccuracies. The farther back

we go, the race data gets worse. If the PDMP went with this type of measure, the time period would not go back too far. The last data limitation is the need for aggregation across years due to small counts.

Mr. Van Otterloo stated that the PDMP recommendation was to do “all opioid” instead of “prescription opioid,” stay with mortality rather than hospitalization, and use measures that are already available. If the PHAB chooses to go with hospitalization data, the recommendation is to start with 2016 forward. This will allow for ICD10-CM consistency and the use of recent race/ethnicity data.

Dr. Bangsberg pointed out that all opioid deaths are going down, but hospitalization is going up. He asked Mr. Van Otterloo if the underlying trends were true with hospitalizations going up and overall deaths going down, recognizing all the caveats appropriately discussed about the hospitalization data.

Mr. Van Otterloo answered that the longer-term trend before the changeover was real.

Dr. Hedberg remarked that in term of the measures, we have to figure out what is being measured. For somebody to die, they have to overdose and not be rescued, which results in a death. Both of these interventions are happening at the local level. We know from other diseases as well that if you are homeless, you are more likely to be hospitalized with a disease. If you are well-housed and you have medical care, you can manage the disease at home. Hospitalization is tricky in who gets to be hospitalized. We are also aware that if somebody’s overdosed, dies, and is rescued with naloxone, they don’t want to go to the hospital. They don’t necessarily want to go in recovery. They might refuse, they might be overdose-rescued and not be hospitalized. Hospitalization is also sensitive to type of insurance, among many other factors. We need to recognize that we are working on making sure that people are addressing some of the social determinants (i.e., the reason people are using drugs in the first place) and increasing access to naloxone. OHA has been working hard on both of these strategies.

Dr. Bangsberg noted that if OHA had access to EMS data, that data were more approximate.

Dr. Hedberg answered that OHA had access to EMS data, but the question was if OHA had EMS data related to overdoses.

Mr. Van Otterloo confirmed that OHA had access to EMS naloxone administrations. It’s not a complete census of all EMS runs in the state. It only started on January 1, 2019, that all EMS transport agencies have to report to the system. The PDMP is working on getting everybody reporting into the EMS reporting system.

Dr. Hedberg noted that some of the rural counties didn’t have EMS. It might be law enforcement. Does law enforcement report to the EMS system? Isn’t it the EMS providers?

Ms. DeLaVergne-Brown explained that it was challenging getting the data sometimes. Crook County just asked for the data for a report. They had to dig to get it from them.

Dr. Dannenhoffer stated that this was a very problematic measure for many reasons. The hospital discharge data is problematic, because it misses death in the field, something the PHAB cares deeply about. The switch from ICD9 to ICD10-CM was very problematic, because it both chopped and combined different data sources. Anybody who does research using ICD9 and ICD10-CM shakes their head, just the way PDMP does. The hospital discharge data is poor data. The mortality data is problematic for a lot of reasons. If we are expecting 2 per 100,000, but we are in Curry County that has 20,000 people, we will statistically have one every couple of years. In a year where Curry County has one, the rate will be terrible, and in a year with zero, the rate will look great. That's hard when a county has less than 100,000 people, as half of the counties in the state have.

Dr. Dannenhoffer added that the last issue with mortality is that mortality for seniors from drug overdose is tremendously underreported. Hospitalizations for seniors for drug problems are what one would expect – they use drugs at a higher rate and have a lot of hospitalizations – but they almost never die from them. There are missing deaths in that group and the number is significant. The drug overdose numbers are small and it's hard to use as an accountability metrics. Do we say to Curry County, "You've done a great job for the three years, then the year you had one [overdose death] you've done a terrible job?". It's hard.

Mr. Van Otterloo remarked that the PDMP tries to lump 5-year rates together. On the colored map of the counties in the state, the light-colored counties don't have that color because the mortality rate is low, but because the rate is extremely volatile. The number for most of the gray-colored counties is probably a suppressed number. They've had less than five overdoses in that 5-year period.

Ms. Tiel thanked Mr. Van Otterloo for laying out the pros and cons of both alternatives. As with most of these metrics, we are choosing and working with the best that we have.

Ms. Rippeteau asked that as we are making efforts to get more people trained in recognizing overdoses and provide training in using naloxone if there were going to be expectations around reporting using it and how that work would fit into this conversation.

Dr. Hedberg answered that naloxone was now reportable to PDMP, but it's unclear if the reporting is good. A lot of the distribution that comes to social service agencies is not reported. If somebody is given the drug by law enforcement and refuses to go anywhere, there's no way to capture those data.

Ms. Tiel reminded the PHAB that the action the board needed to take pertained to (a) keeping the oral health metric as a developmental metric for the next report, and (b) transitioning to an all opioid mortality metric from the prescription mortality metric.

Ms. DeLaVergne-Brown moved for approval of the two recommendations. Dr. Dannenhoffer seconded the move. Ms. Tiel asked the PHAB for comments.

Dr. Savage commented that she was trying to figure out how public health was affecting this measure and what exactly we are being measured on as public health. The interventions that

she sees being made are much more around medication assisted treatment (MAT) and getting it into rural areas. She wondered if there was a way to take this discussion back to the Accountability Metrics Subcommittee and rework the metric. It might be more valuable for the PHAB to focus on whether we are getting people into treatment versus opioid mortality, although that is very important, obviously. She wondered if we were affecting opioid mortality by getting people into treatment in public health. That's what it should be measured.

Dr. Hedberg answered that people across OHA and partners have been working for several years now on an opioid initiative. MAT is one of the four legs of the four-legged stool. The other has to do with improving non-opioid pain management. OHA has been working with Medicaid to have an alternative treatment. MAT plus naloxone is one of them, as well as community-based interventions like prescribing guidelines. There are very strong coalitions that are happening in regions throughout the state. It's a unique, multi-pronged approach. We need people who are addicted and into treatment; we also need naloxone rescue; we need to make sure people are not taking the drugs in the first place and working with the health system. Dr. Hedberg understood that this wasn't a great metric, but she wasn't sure the metric ought to be Access to naloxone as a public health metric.

Ms. Mortell wholeheartedly agreed with Dr. Hedberg. Harm reduction is not just about getting people into treatment. It's a much broader conversation. If the PHAB went with that metric, it would be a very limiting metric for our harm reduction efforts.

Ms. Tiel stated that if the PHAB adopted this as an accountability metric, then a process measure would need to be updated. That gets exactly at what the PHAB members had described of what then is the process metric that would be measuring for on the local level. That would be the next step. She reminded the board that it had a motion and a second for the approval of the oral health developmental metric and the revised opioid metric.

The PHAB voted on the recommendations. The recommendations were approved with a majority. Dr. Savage voted against the adoption of the recommendations.

### **Public Comment**

Ms. Tiel informed the PHAB that Gary Cobb from Central City Concern had signed up for public comment.

Mr. Cobb remarked that this was his first time at a PHAB meeting. He enjoyed the discussion very much. His family had been affected by suicide and opioid addiction. He introduced himself as the community outreach coordinator at Central City Concern. He came to the meeting at the urging of another member of the community to talk about quality of care. This topic fits into the PHAB discussion because it is an equity conversation.

Mr. Cobb explained that quality of care is symptom relief with the goal of improving quality of life for both the patient living with serious ailments and their family. Quality of care is provided in the home environment where the patient resides and helps prevent frequent emergency department visits and readmissions to a hospital. By discussing values, setting clear goals



through individualized care, care coordination, and proactively managing symptoms, quality of care has been shown to significantly lower health care costs while improving quality of life. Quality of care will provide a stable environment in which to manage health and connect individuals he services that support relationships with health care providers; meet the needs of individuals with complex health needs by providing intensive primary care. It will include social work, behavioral health support, and clinical pharmacy, significantly improving patient quality of life and lowering symptom burdens; improve the quality of care; reduce unnecessary utilization in the cost curve through net savings due to avoidance of preventable crises.

Mr. Cobb stated that there was a gap in the health care system. Individuals can access relevant and appropriate care for both curing disease and disorders and hospice care for their life support. Community members who are in between these two levels of care often struggle to find the appropriate level of support. People experiencing homelessness are especially vulnerable to this disconnect and end up with increased utilization of emergency and hospital service while experiencing high level of rapid deterioration compared to people who are housed. All members of the community will benefit from filling this gap in our healthcare system. This is the right thing to do. Our communities have a responsibility to ensure our healthcare systems are complete, person-centered, and they meet the needs of our most vulnerable members.

Mr. Cobb noted that he has spent almost 18 years of being in service to the community in various roles. For five years he did direct hospital and street outreach. He has worked with too many people who, due to their complex needs, end up in a hospital, and then he would get a call that so-and-so was there and by the time he got to them, they had already been discharged. Then he would get a call from the coroner's office and the situation would repeat.

Mr. Cobb added that, in reality, this isn't a legislative fix. The fiscal component is only \$150K, which was calculated by the legislative fiscal office. This is something OHA can do. OHA can pull a lever or push a button and make this happen. The homeless population is aging and it's getting more complex. This would certainly be a help with the cost curve and provide folks with dignity. It's hard to imagine what it must be, in a person's last moments of life, to die on the street. It's not acceptable. We can do a better job, including Central City Concern, to participate in that preparedness.

Dr. Bangsberg thanked Mr. Cobb for his great work at Central City Concern.

### **Closing**

Ms. Tiel thanked the PHAB for their time and adjourned the meeting at 4:46 p.m.

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

**September 19, 2019  
2:00-5:00 p.m.  
Public State Office Building  
Room 177  
800 NE Oregon Street  
Portland, OR 97232**

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)