

AGENDA

PUBLIC HEALTH ADVISORY BOARD

October 19, 2017

2:30-5:30 pm

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

Join by [livestream](#)

Conference line: (877) 873-8017

Access code: 767068

Meeting objectives

- Discuss PHAB co-chair positions
- Provide input on tobacco prevention funding for the 2017-19 biennium
- Adopt public health system process measures
- Learn about the Action Plan for Health and discuss relationship to public health objectives

2:30-2:45 pm	Welcome and updates <ul style="list-style-type: none">• Approve September 5 meeting minutes• State Health Assessment	Jeff Luck, PHAB Chair
2:45-3:00 pm	PHAB reappointments and chairs <ul style="list-style-type: none">• Discuss vacancies on the PHAB• Solicit nominees for PHAB chair positions	Jeff Luck, PHAB Chair
3:00-3:25 pm	Tobacco funding update <ul style="list-style-type: none">• Discuss the impact of cuts to the tobacco prevention and education program	Karen Girard, Oregon Health Authority
3:25-3:40 pm	Break	
3:40-4:20 pm	Public Health Accountability Metrics <ul style="list-style-type: none">• Review recommendations for local public health process measures• Adopt process measures	Myde Boles, Oregon Health Authority
4:20-5:00 pm	Oregon Action Plan for Health <ul style="list-style-type: none">• Learn about the Action Plan for Health• Discuss connections between public health modernization, Oregon's State Health Improvement Plan, and the Action Plan for Health	Steph Jarem, Oregon Health Authority David Bangsberg, Oregon Health Policy Board
5:00-5:15 pm	Public comment	

5:15 pm

Adjourn

Jeff Luck,
PHAB chair

Public Health Advisory Board (PHAB)

June 15, 2017

Draft Meeting Minutes

Attendance:

Board members present: David Bangsberg, Muriel DeLaVergne-Brown, Jeff Luck, Diane Hoover, Safina Koreishi, Rebecca Pawlak, Akiko Saito, Eli Schwarz, Lillian Shirley, Teri Thalhofer, and Jennifer Vines

Oregon Health Authority (OHA) staff: Isabelle Barbour, Cara Biddlecom, Sara Beaudrault, Emily Elman, Christy Hudson, Helene Rimberg, and Angela Rowland

Members of the public: Kelly McDonald

Approval of Minutes

A quorum was present.

- Page 2 change \$5 to \$5M
- Page 7 the accountability metrics agenda item at the Metrics and Scoring Committee meeting will be moved to August due to a conflict

The Board unanimously voted to approve the edited May 18, 2017 minutes.

Welcome and updates

-Jeff Luck, PHAB chair

- David Bangsberg, Dean of OHSU-PSU School of Public Health has been appointed as the Oregon Health Policy Board liaison to the PHAB.
- The OHA budget passed out of the joint Ways and Means Human Services Subcommittee. There is a proposed \$5M allocated for public health modernization for the 2017-2019 biennium.
- HB2310 should be scheduled for a hearing in the next few weeks.
- The proposed Public Health Rules Advisory Committee will consist of two workgroups, one for the delegation of local public health authority and subcontracting, and the second workgroup for the local public health funding formula, accountability metrics, and incentives. The workgroup meetings will be held July-August, the committee meetings will be August-September, and the public comment period will be October-November. The rules will go into effect January 2018. PHAB members can participate in this process since they offer valuable expertise.
- Eli inquired on the timeline for the PHAB Accountability Metrics Subcommittee. The next step for the subcommittee is to determine process measures that align with the outcome measures to be selected today, and to identify performance targets.

Subcommittee updates

Incentives and Funding Subcommittee

– Akiko Saito

Akiko provided an overview of the Incentives and Funding Subcommittee meeting held on June 13th. The subcommittee made a decision to continue with the previously proposed funding formula. If the legislature awards under \$5M annually, funds will be allocated to pilot projects. If funds are above \$10M annually it will be fully allocated to all local public health authorities (LPHA) through the funding formula.

The subcommittee suggests moving forward with regional demonstration projects so that all county size bands can participate in modernizing the public health system. The funding focus area was decided with guidance from the Joint Leadership Team (JLT) to specifically look at communicable disease control. There was a discussion about a scoring matrix for the projects that include health equity and community partnerships to ensure other foundational capabilities are utilized as a part of the project. Another recommendation was to build a learning environment by providing technical assistance in support of pilot projects including regularly scheduled conference calls. There was a discussion about ensuring that local public health authorities are supported with technical assistance for grant writing to eliminate any unfair advantage. Additional points could be awarded for creative partnerships.

Accountability Metrics Subcommittee

-Jeff Luck

The May 31st Accountability Metrics Subcommittee meeting discussed the stakeholder survey. The survey gathered input from a number of stakeholders by prioritizing modernization goals in a practical way. The subcommittee identified a recommended list of accountability measures for public health that will be discussed as a part of the following agenda item. The measures should allow an opportunity to collect data from a significant part of the state to show the legislature progress.

Public health accountability metrics

-Myde Boles, Oregon Health Authority

Myde presented the findings from the stakeholder survey and the recommendations for accountability metrics from the Accountability Metrics Subcommittee. She explained the background for the measure selection, which began with a list of outcome metrics proposed by PHD managers for each foundational program, was followed by webinars with the Conference of Local Health Officials (CLHO) and the Conference of Local Environmental Health Supervisors (CLEHS). Following these sessions, PHD launched a public stakeholder survey to obtain additional feedback on the initial list of measures. The survey engaged 201 respondents,

including local public health, coordinated care organizations, PHAB, etc. Twenty-four accountability metrics were included in the survey.

The selection criteria used for each measure includes how it promotes health equity, how it is respectful of local priorities, has transformative potential, its consistent with state and national quality measures, and how feasible it is to measure.

Communicable disease control

The subcommittee recommended *two-year vaccination rate* as the first choice measure and *gonorrhea rate* as the second choice. Although vaccination rates can be out of public health control it does align with its priorities.

David asked about the feasibility of Hepatitis C screening based on laboratory data. Myde said that screening is not a local public health activity and that prevention interventions, such as needle exchange programs, are emerging but not readily available in all areas of the state. Muriel stated the Hepatitis C screening is in the primary care wheelhouse but is an important issue. Lillian reaffirmed the purpose of these measures are for accountability for the entire state. The collection of Hepatitis C surveillance data is in the purview. David mentioned Indiana provides a good example with its statewide needle exchange program. These are important preventable diseases with a plethora of data available. It is an example of a public health emergency.

Safina understood that Hepatitis C wasn't chosen due to the lack of current capacity. Three years from now the infrastructure could be developed and it could be selected as an emerging issue that aligns with modernization. We are looking at capabilities and need to determine the possibility to be accountable at the state and local level for outbreaks.

Muriel commented that drug and alcohol prevention in primary care is integrated into public health work. Her county is looking at needle exchange as a public health responsibility. Jeff mentioned the goal is to identify measures for which health departments can make changes.

Eli anticipated this discussion from the subcommittee. The Metrics and Scoring Committee is in the same situation and has a desire to monitor many measures. Eli suggests that PHAB use the additional measures for monitoring to keep it them close in our minds. If conditions allow, then PHAB can adopt them as metrics rather than discard the ones that aren't selected this year.

Salmonella infections was chosen as a subsequent measure that is not under public health control but the subcommittee instead recommended *secondary Salmonella infections*.

Prevention and health promotion

Adults who smoke cigarettes was ranked as the first choice but the subcommittee preferred a *youth tobacco measure* including electronic cigarettes. There was concern about using a measure from the Oregon Health Teens (OHT) survey since not all Oregon school districts participate.

Opioid mortality ranked second since it is transformative, but the number of cases is small at the local level so the data must be combined over a few years. The subcommittee subsequently ranked *youth who smoke cigarettes*, *youth use of vaping/e-cigarettes*, and *suicide deaths*. The subcommittee recommended removing *adult obesity* and *binge drinking* measures.

David inquired on the subcommittee's discussion between *opioid use* and *suicide*. Teri commented that LPHAs are not getting the funding to work on suicide prevention as it is typically allocated to mental health partners. Lillian said that local public health participates at the local level in suicide coalitions. Oregon is participating in the Zero Suicide initiative through community based organizations and other sectors.

Teri asked who at the state level is responsible for suicide prevention. Lillian stated that the state injury and violence prevention program provides the data and convenes suicide prevention workgroups. The grant money flows through the OHA Health Systems Division for prevention and behavioral health coalitions. Akiko remarked this is a good opportunity to bring in creative partnerships. Muriel is partnering with a hospital in her county to work on suicide prevention.

Rebecca questioned why adult obesity wasn't selected. Myde said that specific measure wasn't ranked highly.

Eli recommends the Board review the PHAB guiding principles for health care and public health collaboration. The practical implications of these measures could be discussed in collaboration with health care partners.

Environmental Health

The *active transportation* measure was ranked first by the subcommittees since it reflect land use planning and transportation planning work. This measures the percent of people who walk, ride a bike, or ride a bus to get to do things. Jeff says transportation is not just an urban issue. Teri commented how Wasco County is suffering from transportation issues due to poor sidewalks.

The *drinking water standards* measure was ranked second. It is more closely tied to health outcomes and is a priority for CLEHS. Lillian stated that Oregon has bypassed national standards so it can be hard to improve. She mentioned that the Public Health Division Strategic

Plan also includes targets for drinking water standards but they still need a policy change as OHA cannot test or certify private wells.

Access to clinical preventative services

The *effective contraceptive use* measure is recommended as the first choice since it aligns with the CCO metric and its priorities. Consider *dental visits for children 0-5, dental sealants in schools, and partner expedited therapy*. If communicable disease control uses the gonorrhea measure, *partner expedited therapy* isn't needed here.

Public health accountability metrics health equity review

Cara provided a summary of how the accountability metrics aligns in the PHAB health equity policy.

- Demonstrates progress
- The metrics require the promotion of health equity per the measure selection criteria
- The metrics do not address individuals but help to understand disparities
- The metrics don't address one area of health inequity over another
- The metrics don't directly address an equitable distribution of power
- The community was engaged through a stakeholder survey with cross-sector partners, transportation, early learning, CCOs, etc.

Eli mentioned there is an overlap with CCO metrics and that a race and ethnicity breakdown should be included. Teri mentioned that CCO data is collected through Medicaid clients and the accountability metrics will be used for the full state population, not just Medicaid.

Eli asked if the Board can work with CDC on small area analysis. Lillian mentioned the 50 largest cities data as a resource, which contains a lot of variables. This is a small piece of information to drive changes to the system and how it is funded and accountable. The challenge is in the analysis. Jeff mentioned there is variation across the state so we will want to see the numbers.

The Board adopted the prioritized accountability measures with a unanimous vote for:

Communicable disease control

1. *Two-year old vaccination rate*
2. *Gonorrhea rate*

Prevention and health promotion

1. *Adults who smoke cigarettes*
2. *Opioid mortality*

Environmental Public Health

1. *Active transportation*

2. *Drinking water measures*

Access to clinical preventative services

1. *Effective contraceptive use*
2. *Dental visits, children 0-5*

Action Item: Jeff will send the approved accountability metrics to the Health Plan Quality Metrics Committee to encourage the use of these measures.

Lillian mentioned an example of using a health equity lens in the case of colorectal cancer. Oregon's public health system has targeted African American men and mortality has decreased due to increased targeted screening. It is compelling to tell this clinical story with a health equity lens through a public health perspective.

Modernization Implementation Planning

-Cara Biddlecom, Oregon Health Authority

Cara provided the Incentives and Funding Subcommittee recommendations for funding regional projects, which include encouraging cross-jurisdictional sharing, targeting communicable disease control, and providing technical assistance. The CLHO-PHD Joint Leadership Team (JLT) reviewed the deliverables in the Public Health Modernization manual to provide recommendations for prioritizing capabilities and programs in specific order:

1. Communicable disease control
2. Health equity and cultural responsiveness
3. Leadership and organizational competencies
4. Assessment and epidemiology (primarily focused on state and regional public health work)
5. Environmental health
6. Emergency preparedness and response

Eli recommended using an adopted communicable disease accountability measure to hone in on communicable disease control. Cara stated that communicable disease risk is different within different areas of the state. Also, the soon to-be-determined state performance measures could help in the next biennium. Teri stated a measure should be chosen that could improve outcomes and is attainable. Muriel mentioned the challenge of reporting communicable diseases and working with partners to screen patients.

Rebecca stated that initial funding could be helpful to get modernization started. She says that Memoranda of Understanding (MOUs) and cross-jurisdictional sharing would be great examples for the legislature to see.

Diane stated that the leadership and organizational competencies work could be cross-jurisdictional sharing agreements. Applications shouldn't use the "jargon of the day" but instead provide specific outcomes.

Akiko stated that it isn't a county project but instead a regional project. A scoring matrix could award more points for health equity and cultural competency work. It is important to get that type of information at the beginning.

Teri stated that all LPHAs can be asked to be involved. This impacts the leadership of every public health administrator. The data on where the disparities are will show where LPHAs need to work together.

Eli stated that a considerable amount of time needs to be allocated to this work. He questions if two years is a reasonable timeline. Any funding allocated this year would be for the two-year biennium only.

Cara commented that it is difficult to have a concrete conversation with information we currently don't have. The funding mechanism should be made available to local jurisdictions as soon as possible after funding is determined by the legislature. She also mentioned the thought that some jurisdictions will have difficulties in hiring the right positions in a timely manner due to workforce shortages.

Action Item: Jeff requested a timeline of the necessary steps to distribute funds by January 2018 at the July PHAB meeting.

David summarized that there isn't enough money to spread across the state to develop competitive requests for proposals for communicable disease control, but proposals could be evaluated based on building leadership capacity and how that capacity could be related to environmental health or emergency preparedness. Teri stated that CLHO is not in favor of the competitive process but rather a collaborative process. The history is that the counties with the most resources tend to be awarded the competitive grants. David asked how to push an idea forward when more than one idea is on the table. Teri stated through consensus. Since the funding is limited it needs to be provided for more than one jurisdiction.

Jeff stated that the criteria must make it clear how this is different than ever done before to set the bar.

Eli stated the need to show legislators that the outcomes are being met. Rebecca stated that this needs to be a new way for doing business and need a collaborative way to push the state forward with limited resources. Teri identified the need to move the system forward. Jeff stated that the direction that PHAB and CLHO are moving are aligning. Cara stated there will be a need to develop infrastructure.

Eli asked if the Incentives and Funding Subcommittee could provide a different formula for less than \$5M. Jeff mentioned that it wouldn't provide adequate resources to hone in on even a narrow set of capabilities.

Jen mentioned absence of the large county representative voice. Lillian stated that the existing Board members should fill in the holes to provide a large county voice. Teri stated that burden of disease has been a part of the considerations. For example, gonorrhea is a large problem in Multnomah County, but the Board is looking at the burden of disease need and not the specific county needs.

Public Comment Period

No public testimony was provided.

Closing

The meeting was adjourned.

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

**July 20, 2017
2:30pm – 5:30 p.m.
Portland State Office Building
800 NE Oregon St., Room 1A
Portland, OR 97232**

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Angela Rowland at (971) 673-2296 or angela.d.rowland@state.or.us. For more information and meeting recordings please visit the website: healthoregon.gov/phab

Public Health Advisory Board (PHAB)

September 5, 2017

Draft Meeting Minutes

Attendance:

Board members present: David Bangsberg, Carrie Brogoitti, Muriel DeLaVergne-Brown, Katrina Hedberg, Safina Koreishi, Jeff Luck, Rebecca Pawlak, Alejandro Queral, Akiko Saito, Eli Schwarz, Lillian Shirley, and Teri Thalhofer

Oregon Health Authority (OHA) staff: Sara Beaudrault, Cara Biddlecom, Danna Drum, Britt Parrott, and Angela Rowland

Guests: Morgan Cowling and Nancy Martin

Approval of Minutes

A quorum was present. The Board approved the May 18, 2017 minutes. The Board made edits to the July 20, 2017 minutes including an update of the attendee list and a correction to a Board member comment. The edited July minutes were approved with all in favor.

Welcome and updates

-Jeff Luck, PHAB chair

Lillian Shirley provided the Oregon Health Authority (OHA) leadership update.

- Patrick Allen is the acting OHA Director.
- Dawn Jagger will be the interim OHA External Relations Director.
- Splitting the OHA CFO/COO position into two positions between Laura Robison and Kristine Kautz.
- Jeremy Vandehey will be the interim Director of the Health Policy and Analytics Division.
- Victoria Demchak has been assisting Jeremy in the Governor's Office and will continue in her role.

Cara Biddlecom provided an update on the State Health Assessment.

- Rebecca and Alejandro sit on the Steering Committee.
- Two subcommittees have been formed to focus on qualitative and quantitative data collection.
- Working to engage non-traditional partners in the process.
- Next Steering Committee meeting will be held on September 11.
- The state health profile indicators are being updated with emphasis on social and structural determinants of health.
- The framework for the state health profile indicators will be revised to follow the public health modernization foundational programs rather than the county health rankings.

- This assessment will form the basis for the next version of the State Health Improvement Plan.

Cara provided an update on the Public Health Modernization rulemaking.

- Rules Advisory Committee met on August 16.
- The next meeting is September 14.
- David Bangsberg, Muriel DeLaVergne-Brown, and Rebecca Pawlak are on the committee.
- These rules will be effective January 1, 2018.

Local public health authority transitions will become a new standing topic as they come available.

The Public Health Modernization Request for Proposals (RFP) was created for local public health authorities. The RFP will be released next week.

Subcommittee updates

-Sara Beaudrault, OHA

Sara provided an update on the Accountability Metrics subcommittee's work last month. There was consensus among subcommittee members to recommend that the existing American Community Survey (ACS) measure (*Percent of commuters who walk, bike, or use public transportation to get to work*) be used now to report on active transportation. Subcommittee members also recommended that, moving forward, PHD pursue opportunities to enhance the Oregon Household Activity Survey (OHAS). This sits nicely with the partnership with Oregon Department of Transportation (ODOT).

Alejandro asked if the OHAS is a one point question or longitudinal survey. Sara stated the recommendation is to move towards a longitudinal survey if more resources come available. Alejandro commented that this needs to be measured over time to provide an accurate picture. Katrina mentioned that the feedback provided from the quantitative State Health Assessment subcommittee discussed this gap in state health indicators and how there is a need for alignment. Muriel questioned if there was discussion of any challenges in rural areas that lack public transportation. Sara stated this is part of phase two to look at all local public health authorities and how they can help support this measure and that it might be very different across the state currently. Eli recommends discussing with ODOT on how to put resources into the OHAS for more valid information.

Action item: Discuss how to add resources to help enhance the OHAS with the Oregon Transportation Commission (OTC) when have joint meeting with the PHAB.

Sara also announced that process measures will come to the Board before the end of the year.

Health Plan Quality Metrics Committee

-Shaun Parkman, OHA

Shaun provided an overview on the Health Plan Quality Metrics committee (HPQMC). In 2015, SB 440 established the committee to align health outcome and quality measures used in Oregon. Specifically, the committee works around health plans that are publicly funded. The committee is a subcommittee of the Oregon Health Policy Board and Jeff Luck is a member. Margaret Smith-Isa is the primary point of contact Margaret.g.smith-isa@state.or.us.

David asked if the PHAB wanted to recommend a population metric for the HPQMC to consider. Shaun doesn't see those types of measures moving forward until next year based on the formal mechanisms and upcoming tight deadlines. David mentioned the importance in timing and alignment with CCO metrics. Public health should have an opportunity to make their suggestions.

Rebecca asked if the same measure is being selected despite that there is a diverse pool of patients being served, including the Oregon Educators Benefit board (OEBB), Medicaid, and Public Employees Benefit Board (PEBB). Shaun stated that the committee is aware of that challenge. Jeff remarked that the HPQMC is determining the details on how to select measures by creating specific criteria and that committee members with a public health viewpoint can help guide these conversations. David proposed taking the PHAB accountability metrics to the committee. Jeff noted that the PHAB accountability metrics have been shared with the HPQMC staff.

Lillian stated that roughly 42% of Oregonians have their insurance paid by public funds therefore it would be a good investment for the state to focus on population health.

Eli asked with the large population served, how it addresses health equity. Shaun indicated that due to the stiff timeline this has not been addressed. Eli stated that rigid criteria and rules potentially harms innovation. Shaun stated that the legislation is fairly specific.

Eli recommended that this committee review any crosswalks of community health assessments in Oregon. David stated that the overarching goal is to help the CCO model by creating incentives to move upstream. The opportunity to put metrics that are reimbursable would be beneficial. Teri Thalhofer stated that CCO metrics have led to more data mining to make the numbers work rather than being focused on changing the actual patient experience.

David made a motion to recommend to the Oregon Health Policy Board that the Health Plan Quality Metrics Committee create a mechanism for PHAB to introduce measure concepts that promote upstream population health and social determinants of health for consideration in a timeline that would allow for such measures to be included in the new CCO contract.

PHAB members want to make sure this informs and captures the CCO model to move upstream and social determinants of health. Muriel seconded. All in favor.

Teri requested that CCOs collaborate with governmental public health on meeting those metrics.

Tobacco prevention evaluation findings

-Shaun Parkman, Oregon Health Authority

The PHAB is responsible for discussing implications of tobacco prevention funding since there was a 2017 budget note added to HB 5006 which brings to the PHAB recommendations of how to apply a \$3.6M loss in tobacco master settlement agreement investment in tobacco prevention. The Incentives and Funding subcommittee will bring a recommendation forward for consideration at the October PHAB meeting.

Shaun presented on the Tobacco Prevention and Education Program (TPEP). TPEP is a comprehensive program including state and community interventions, health communication interventions, surveillance and evaluation, and administration and management. The community interventions base funding is allocated to all counties and Tribes with an additional two competitive grants for local communities. The competitive grants were Strategies for Policy and Environmental Change (SPArC) and Sustainable Relationships for Community Health (SRCH).

In SPArC, all grantees passed best-practice tobacco retail policies with more advancements through policy change than non-SPArC counties. For example, Crook County passed a policy that the quit line number must be posted in all tobacco retail outlets.

In SRCH all eight CCOs and 10 local health departments implemented referral systems to the tobacco quit line; formal partnership agreements were secured; and shared projects were created between CCOs and public health.

David asked how the program knows the changes are permanent and after the money is spent it doesn't go back to status quo. Shaun stated that since policies are created they are sustainable.

Muriel stated that her county's TPEP coordinator was doing this work for 20 years. It is very important and effective.

Rebecca stated that with the modernization framework it is important to be nimble and flexible and this program works well to get great outcomes.

Eli asked on the original amount of money provided for these grantees. \$1M for SPARC \$600,000 for SRCH. Katrina mentioned some funds come from state tobacco tax. She also stated that public health works to implement evidence-based control programs.

Jeff read the budget note.

The Oregon Health Authority, in collaboration with the Tobacco Reduction Advisory Committee, shall make recommendations to the Public Health Advisory Board on reductions to the Tobacco Prevention and Education Program, based on the loss of Tobacco Master Settlement Agreement (TMSA) funding, that reflects best practices for tobacco control, to minimize programmatic disruption. The Oregon Health Authority shall report to the Legislature the impact of the loss of TMSA funding to tobacco prevention in Oregon, across state and local programs, health communications, tobacco cessation, and data and evaluation.

Eli stated that if you take money away from one place you will have to get it from another. Tobacco prevalence is one of the accountability metrics, therefore some of the future modernization money could be used for TPEP.

Muriel voiced concerns about how the base TPEP funding has made competitive grants successful. Eli says that one could use health equity strategies as a way to address tobacco across the state. The cost of tobacco due to loss of life could make a case to CCOs and is also CCO incentive measure. In spirit of collaboration perhaps they could use health care funds. Tobacco use prevalence rates among Medicaid members are much higher. Katrina asked what role the Tobacco Reduction Advisory Committee (TRAC) plays. Katrina mentioned that PHAB already prioritized how to spend the initial public health modernization investment for 2017-19.

Karen Girard, the OHA Health Promotion and Chronic Disease Prevention Section Manger, indicated that they are also consulting with the Coalition of Local Health Officials (CLHO), Tribes, and TRAC prior to PHAB and then providing a report to the legislature.

Eli recommended providing a summary on the return of investment. Karen remarked that the bill to increase the age to purchase tobacco to 21 led to incredible pressure to pass with a great statewide effect so the ROI is being tracked. Rebecca stated that the framework for modernization funding pyramid would be a helpful tool that outlines where to put resources in the scale of investment. It is helpful to show how you can succeed with cuts and maintain programs that display positive health outcomes. David stated these TPEP programs are well run and are executed well. If funding can be moved over from the health care system that would be a huge win. Eli would like this to be the Oregon Health Policy Board's task. David agreed that this would require new dollars rather than to scavenge from other public health programs.

Guiding Principles for Public Health and Health Care Collaboration

-Safina Koreishi, PHAB member

Safina provided an overview of her work on health care collaboration with the Columbia Pacific CCO. She created the *Opportunities for partnerships with public health and health care* Venn diagram and shared with the Quality and Health Outcomes Committee, which consists of CCO medical directors, many months ago. The CCO medical directors appreciated the visual interplay between public health and CCOs. More recently, Columbia Pacific CCO brought together their leadership team and three county public health directors to discuss shared priorities with an ease and impact scale to determine focus areas. Immunizations were determined as a shared priority. The group created a collaboration framework to display what is shared work and what is not to reach the goal to increase immunizations for children under two years old and decrease school exclusions.

Lillian is interested in seeing what public health work in this framework fits in the public health modernization foundational capabilities. It would be great to have conversations with the Federally Qualified Health Centers (FQHCs) and local public health authorities regarding what they are responsible for.

Muriel discussed an example in Crook County regarding perinatal care continuum and working with the local CCO on embedding community health workers in the clinics. This helped improved enrollment in WIC. David stated that examples like those should be the types of metrics that get incentivized.

Eli congratulated Safina for pushing the envelope. He will be presenting the *Guiding Principles* with the Metrics and Scoring Committee and the Health Share board.

Cara shared the Columbia Gorge Health Council's suggested edits for the *Guiding Principles* with the Board.

Jeff motioned to adopt the *Guiding Principles* document and it was approved with all in favor.

New PHAB charter template

-Cara Biddlecom, Oregon Health Authority

Cara stated that the Oregon Health Policy Board (OHPB) staff and OHPB committee staff are working to streamline committee processes and procedures. She has shared the PHAB *Guiding Principles* draft with internal OHPB staff.

The PHAB charter has been reformatted for standardization with the only addition from HB 2310 which creates a position on the PHAB for a Tribal member or Tribal member representative.

Jeff made a motion to adopt the new PHAB charter template with all in favor.

Next step is work on PHAB bylaws in October.

Public Comment Period

No public testimony was provided.

Closing

The meeting was adjourned.

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Public Health Advisory Board (PHAB)

Incentives and Funding Subcommittee meeting minutes **DRAFT**

September 22, 2017

1:00-2:00 pm

Welcome and roll call

PHAB members present: Carrie Brogoitti, Muriel DeLaVergne-Brown, Jeff Luck, Akiko Saito, Teri Thalhofer

Oregon Health Authority (OHA) staff: Kirsten Aird, Karen Girard, Luci Longoria, Shaun Parkman, Angela Rowland, Cara Biddlecom

Members of the public: Channa Lindsay

Tobacco Prevention and Education Program funding for 2017-2019

Today's meeting will include a review of the Public Health Division's Tobacco Prevention and Education Program (TPEP) alignment with CDC best practices for tobacco control. There was a decision at this week's CLHO retreat to develop a workgroup of local public health administrators and Public Health Division staff to discuss the impact of the 20% budget reduction to TPEP on local public health programs.

Karen Girard presented the CDC best practices for tobacco control. The CDC provides a roadmap for achieving the best possible outcomes for tobacco control, with recommended funding levels for each state and each component of a comprehensive tobacco control program. Each of these components are necessary to prevent tobacco use. With its current budget, Oregon is defined as a limited reach program. Historically, TPEP has been able to fund all LPHAs, Tribes, and Regional Health Equity Coalitions at the local level. TPEP also funds a mass media campaign, technical assistance, cessation services, surveillance and evaluation, and administration.

Akiko asked if TPEP is tracking the utilization of CCO resources for tobacco prevention that come from the Tobacco Master Settlement agreement and

tobacco tax. Kirsten stated that the state is working on relationship building with CCOs and is not tracking these now.

The state has experienced a 20% decrease in funding and thus will be less able to make reductions in tobacco use. The program uses data and experience to make adjustments to the program to best use resources. The largest portion of the budget is the state and community interventions component. It is vital to have local tobacco prevention programs in order to advance statewide policy.

Shaun and Kirsten discussed how the Sustainable Relationships for Community Health (SRCH) grant brought together CCOs and local public health authorities to improve tobacco prevention at the local level through systems changes. Some CCOs have invested in tobacco prevention media campaigns built off of the state's communications efforts. Muriel commented that depending on the CCO, tobacco prevention work is happening at the local level even without being funded by the SRCH grant. Luci commented on the high level leadership buy-in that has made these partnerships successful.

Karen reviewed the proposed budget structure for 2017-2019. The cessation component has been reduced below the CDC recommended level. State and community interventions are above the CDC recommended level.

Akiko asked about return on investment (ROI) on tobacco control programs. Shaun stated that there is an ROI at the national level but it is hard to determine at the state level. The tobacco industry reports that there is a 1 to 5 ROI for tobacco prevention.

Teri commented that spending less on administrative costs than the CDC recommends doesn't account for the 16% cost allocation. Her health department was not a SRCH or Strategies Policy and Environmental Change (SPaRC) recipient, but CCOs might be getting allocated twice for work they are required to do for the CCO incentive measure. Perhaps CCOs could be allocating that money to LPHAs who have the expertise in tobacco prevention. Kirsten mentioned that communities decided who the fiscal agent should be for SRCH, and the LPHA was the fiscal agent in all but one case. CCOs have provided matching and in-kind resources as a part of the SRCH grant.

Akiko said that the ROI should be a part of the public health message. For a \$2M cut, every \$1 spent there is a \$5 in investment then we are really losing out on \$10M with a \$2M cut.

Jeff asked what proportion of all smokers in Oregon are on Medicaid. Perhaps most tobacco users in Oregon are in CCOs. There are estimates of tobacco use prevalence among Medicaid members, which far exceeds the general population. That fact strengthens the business case that a reduction in tobacco helps the CCOs the most. Teri says there could be an opportunity to include work with CCOs in the TPEP work plans.

Jeff asked what changes there are at the program level. Karen said that \$6.9M will be allocated among LPHAs. There will be a CLHO work group to determine those details in October. The overall budget was reduced by 20% with different funding allocations based on CDC best practices. There was a 4 percentage point increase in the state and community interventions component, and a total of 1% decrease in funding for county health departments.

Akiko is interested in engaging CCOs to help with funding and continue this great work. Muriel stated she already works with the CCO in Central Oregon but there is a need engage with all CCOs.

Teri stated that a reduced investment in local TPEP programs will effect local public health. Teri suggested using a health equity lens since the reduction will influence staffing in rural areas. Luci commented that it would be crucial for the health equity lens to focus on healthy equity outcomes.

Jeff asked whether the entire TPEP budget be reduced by 20% across the board, or whether the first step could be to use ROI data to determine the best areas to fund since some programs reduce tobacco outcomes better than others. Jeff requested a look at line item changes in the proposed budget from 2015-17 and 2017-19.

Teri recommended that local TPEP work plans include work with CCOs.

Public Comment

No public testimony.

TOBACCO PREVENTION & EDUCATION PROGRAM REDUCTIONS COMPARISON

PROGRAM COMPONENT	Data & Evaluation		Statewide & Community Interventions		Health Communications		Cessation		Administration & Management		TOTAL
2015-2017 Budget	\$1,590,015		\$12,023,386		\$2,302,607		\$1,850,000		\$601,142		\$19,686,000 (including cost allocation of \$2,924,825)
2017-2019 Budget	\$1,191,939	Less evaluation projects and less data	\$9,298,055	Less training and technical assistance supports	\$1,586,620	Less paid media and more emphasis on targeted social marketing	\$1,477,932	Increased focus on cessation systems change through partnerships and less quit line services	\$732,744	Three TPEP positions will be left vacant	\$16,300,000 (including cost allocation of \$2,297,766)
Recommended budget target*	9%		62%		11%		12%		6%	Note: New OHA calculations for cost allocation resulted in a reduced cost allocation rate but also added increased costs for levied on programs for facilities, information technology, insurance and tele-communications	
Actual budget target	9%		66%		11%		11%		5%		
Actual change compared to last biennium	-25%		-22.7%	-1.5% decrease to County Community Interventions for a total of \$100,000 decrease -53% decrease to Statewide Interventions for a total of \$2,625,331 decrease	-31%		-20%		+ 18%		

* Recommended budget targets are from the Centers for Disease Control and Prevention Best Practices for Tobacco Control

PUBLIC HEALTH ADVISORY BOARD

DRAFT Accountability Metrics subcommittee meeting minutes

September 26, 2017

PHAB Subcommittee members in attendance: Eva Rippeteau, Eli Schwarz, and Teri Thalhofer, Jennifer Vines

Oregon Health Authority staff: Sara Beaudrault, Cara Biddlecom, Myde Boles, Steve Fiala, Angela Rowland, Amy Umphlett, Suzanne Zane

Members of the public: Jody Daniels, Karen Douglas, Jen Lewis-Goff, Cassandra Leone, and Laura McKeane

Welcome and introductions

The August 23rd, 2017 meeting minutes were approved.

Subcommittee updates

- Eli recently presented at the Metrics and Scoring committee meeting regarding the public health accountability metrics. More than half of the public health accountability metrics align with priorities for CCOs or early learning hubs. Eli highlighted Columbia Pacific CCO's collaborative process with local public health around childhood immunizations. Sara will send the presentation out to the subcommittee.
- OHA will present the public health accountability metrics at the Health Plan Quality Metrics Committee in November.
- OHA will share information about obesity metrics at the October Metrics and Scoring Committee meeting and the November Health Plan Quality Metrics Committee meeting.

Dental visits for 0-5 year olds

Amy Umphlett, Suzanne Zane and Kelly Hanson presented on the *dental visits for 0-5 year olds* public health accountability metric. Child dental visits are measured in various ways, all of which have limitations and none of which meet the selection criteria established by PHAB. The OHA Public Health Division's Oral health Program compiled available measures and recommended two measures for the PHAB Accountability Metrics subcommittee to consider. Whatever measure is selected will be used to begin reporting on *dental visits for 0-5 year olds* in 2018.

1. “Children aged 0-5 with a dental visit in the previous year”. The data source is Medicaid claims data. Data for this measure can be updated annually and may allow for breakdowns by county and by race and ethnicity. However, the existing data source only includes the Medicaid population; therefore this is not a true population measure.
2. “Has your two year-old ever been to a dentist or a dental clinic? The data source is the PRAMS-2 survey. PRAMS-2 is not limited to the Medicaid population. There are limitations to being about to report data by county or by race/ethnicity due to sample size. Also it is limited to 0-2 year olds.

Eli mentioned the tension around total population and Medicaid population. The Metrics and Scoring committee looks at Medicaid data and PHAB looks at population data. He recommends talking with public health colleagues to get feedback on using a measure that only looks at a portion of the population.

Eva inquired if PRAMS includes socio-economic data or what type of insurance they have. To offer a comparison, she asked if there’s a possibility to ask dental insurance companies to offer data for privately insured 0-5 year olds.

OHA has a cross-agency oral health team that is developing a dashboard. The measure is selected by PHAB will be included on the dashboard.

Eventually there may be an opportunity to pull information from the All Payer/All Claims system, which would not be limited to Medicaid claims. But that is at least a few years away.

PHAB members discussed looking at dental sealants instead of dental visits.

Although we are limited in measures that are available now, Amy requested feedback on whether PHAB members are most interested in measuring dental visits, preventive dental visits, or preventive oral health services in medical or dental settings.

Teri stated we should be explicit when taking a recommendation forward that this is the best measure we have currently.

OHA staff will add this to the November subcommittee agenda and will bring data using the two recommended measures to inform the discussion.

Local Public Health Process measures

Steve Fiala presented the local public health process measures developed by Public Health Division and local public health staff. These measures are intended to show the core work of local public health to meet the accountability metrics.

Recommended immunization measure: *% of clinics [that serve populations experiencing disparities] that participate in the Assessment, Feedback, Incentives and*

eXchange (AFIX) program. AFIX is a quality improvement tool for clinics that are enrolled in the Vaccines for Children Program.

- Evidence-based intervention for increasing childhood immunization rates
- Has the potential to build or enhance partnerships
- Aligns with CCO strategies
- Expand state and local partnerships

Teri stated that the CCOs need to participate and be held accountable for working with public health on this shared priority.

OHA provides technical assistance with CCOs on the AFIX intervention.

LPHAs could approach this measure a number of ways, including partnership with CCOs or the PHA Immunization Program to increase local clinics participation. Eli stated we need to have ways to show where success is happening.

All local public health departments receive immunization funding through a program element, although there are no required activities connected to promoting AFIX within the local health care provider community.

Recommended gonorrhea measures:

1. *% of gonorrhea cases that had at least one contact that received treatment*
2. *% of gonorrhea case reports with complete 'priority' fields*
3. *Number of community-based organizations/partners engaged by LPHA to decrease gonorrhea rates*

These three recommended measures should be narrowed down to one or two.

Eva asked if #1 is chosen will it set up LPHAs up for failure since many LPHAs don't have adequate resources. Jen said that Multnomah County is unable to follow through on all gonorrhea cases.

Sara stated that we should focus on what the "right" work is to achieve improved outcomes, even if health departments don't have adequate resources now. This will highlight where to direct the resources we have now and new resources coming into the system.

Jen recommended *FTEs per # of gonorrhea cases* that could reflect burden and infrastructure.

Eva mentioned that #3 could be hard to accomplish since public health departments do not have control over what community-based organizations do.

Teri noted that OHA has eliminated Disease Investigation Specialist positions that had provided support to local public health.

Recommended tobacco measure: *% of community members reached by local policies that restrict tobacco industry influence in retail environment.*

Teri stated this is difficult to do in some communities.

Eli suggests that the measure be simplified.

Cara reminded the subcommittee that all of these measures offer a starting place based on where each LPHAs are today; each LPHA can make incremental improvements toward benchmarks set for each individual county.

CLHO will review and provide feedback on these local public health process measures next week.

Sara asked that this subcommittee meet again before the October 19 PHAB meeting to continue reviewing local public health process measures. PHAB is set to vote on local public health process measures on October 19.

Public comment

Public comment was not requested.

Adjournment

The meeting was adjourned.

The next Accountability Metrics Subcommittee meeting is scheduled for:

October 13, 2017 from 1-3pm.

Public Health Advisory Board (PHAB)

DRAFT Accountability Metrics Subcommittee meeting minutes

October 13, 2017

1:00-3:00 pm

Welcome and roll call

PHAB members present: Muriel DeLaVergne-Brown, Eva Rippeteau, Eli Schwarz, Jennifer Vines

Oregon Health Authority (OHA) staff: Sara Beaudrault, Steven Fiala

One correction was noted for the September 26 meeting minutes. Jennifer Vines attended and should be added to the list of PHAB members who were present. Minutes were approved with this change.

Subcommittee updates

No updates were provided.

Local public health process measures

Sara provided an overview of the purpose for establishing local public health process measures for each of the accountability metrics adopted by PHAB in June. Local public health process measures will bring attention to the unique and essential work of public health departments to make improvements in the accountability metrics. The purpose is to emphasize the work that will move the system forward, in part to emphasize the need for sufficient funding to do this work.

The purpose for today's meeting is to review and provide feedback on process measures that have been recommended by OHA, and to provide approval to take recommended measures to PHAB for a vote on October 19. Local public health administrators and health officers reviewed and provided feedback on these measures during a webinar on October 3, and by submitting written comments following the webinar.

A matrix showing recommended process measures, rationale, data sources, current funding, examples of activities to meet the measure and feedback from local public health officials is available in the 10/13 meeting materials. A summary of recommended process measures is included on page 7-8 of these minutes.

Communicable disease control

Two year-old vaccination rates: The subcommittee discussed the measure recommended by OHA, for the percent of clinics [that serve populations experiencing vaccination disparities] that participate in the Assessment, Feedback, Incentives and eXchange (AFIX) program.

Muriel described Central Oregon's approach to implementing AFIX with health care providers and noted that vaccination rates are going up. Eli questioned how public health and CCOs could work together on this shared metric and suggested that it be tied to the PHAB *Guiding Principles for Public Health and Health Care Collaboration*. Muriel described Central Oregon Health Council's involvement. Muriel also noted that often health care providers receive incentive payments when a CCO meets incentives metrics, but not public health. This needs to be looked at as a systems issue.

Decision: The subcommittee approved recommending this measure to PHAB.

Gonorrhea rates: OHA presented four process measures that have been discussed by local public health officials and staff. These need to be narrowed down to 1-2 process measures.

The subcommittee discussed the process measure for # of FTE trained and employed to conduct gonorrhea case management. Eli suggested that collecting FTE as a baseline should be done for all local public health authorities (LPHAs). He suggested that it be collected but not be used as a metric. Muriel stated there is a need for consistent, standardized training. She stated that we have consistently gone backwards in our resources to support staff training. Training should be a state/local partnership, and training should be looked at for all local public health process measures.

Sara stated that OHA recommends the first two process measures. The purpose for increasing FTE would be to conduct the activities for these two measures.

Decision: The subcommittee approved recommending process measure #1 and #2 (related to treating contacts and completing priority fields on case reports) to PHAB.

Access to clinical preventive services

Effective contraceptive use: The subcommittee discussed two proposed process measures. Assuring access to clinical preventive services is a new area for public health; as such, these process measures focus on working with local partners to complete an assessment of access to effective contraceptives, and working with local partners to develop a plan to address barriers.

Jen expressed concern that many of the recommended process measures require participation from CCOs, so these measures are not owned solely by public health. Eli stated this is a challenge of two systems coming together to focus on improving care for vulnerable populations. Eli noted that effective contraceptive use is also a CCO incentive measure, and this should be included in the rationale. Muriel stated that public health can have ownership of the assurance function but not the provision of care. She also stated that LPHAs should not be required to serve as convener for local assessments and plans; in some instances they may be participants rather than conveners.

Decision: The subcommittee approved recommending the process measure for developing local policy plans or strategies for increasing access to effective contraceptives to PHAB.

Dental visits for 0-5 year olds: The subcommittee reviewed three proposed process measures.

Eli expressed reservations with the proposed process measures. He noted that few LPHAs provide dental services, and access among dental providers for this age group is limited in many areas of the state. Therefore, establishing a process

measure to increase referrals may be unsuccessful if no organizations are able to accept the referrals. Muriel agreed. Eli also stated the process measures are too weak to make any real changes. For example, training can be provided, but that doesn't mean it will be acted upon.

Eli shared state and national data on dental care activity for Medicaid-enrolled children. He stated that more exploration of the data that are currently available is needed before selecting measures and offered suggestions for venues through which this could happen.

Decision: Eli made a motion not to adopt a process measure for dental visits for 0-5 year olds. Instead the subcommittee should continue to assess data that are available and explore public health roles and functions to increase dental visits for this population. Muriel seconded the motion, and all subcommittee members were in favor.

Prevention and health promotion

Adults who smoke cigarettes: The subcommittee discussed the measure recommended by OHA, for the percent of community members reached by local tobacco retail or smoke-free policies.

Muriel stated that flexibility is needed at the local level, in part due to local politics that make it very challenging for some areas to pass ordinances. However, all LPHAs can make progress.

Eli noted that reducing tobacco use prevalence is also a CCO incentive measure, and this should be included in the rationale.

Decision: The subcommittee approved recommending this measure to PHAB.

Opioid overdose prevention: The subcommittee discussed two process measures related to Prescription Drug Monitoring Program (PDMP) top prescribers.

Eli asked for a definition of top prescriber and whether it includes all provider types, including dentists.

A subcommittee member noted the written comment from a local health administrator that being enrolled in PDMP does not mean a top prescriber uses the system. Sara will send the link to the Prescribing and Overdose Data Dashboard for Oregon. There is a tab for PDMP data that allows users to run queries based on top prescriber enrollment and use.

Muriel stated there should be a state law requiring PDMP enrollment and training in order to get a DEA license.

Decision: The subcommittee approved recommending one process measure – the percent of top prescribers enrolled in PDMP – to PHAB.

Environmental health

Active transportation: The subcommittee discussed two process measures for active transportation.

This is an emerging area for public health and few health departments are working in this area now. Muriel stated that interest from transportation and planning for working with public health seems to be increasing. Eli stated if there is interest from both sides, it is important to highlight this as a metric.

The subcommittee recommended changing the second proposed process measure (to give presentations to local decision makers on active transportation barriers and promising policy solutions) to an activity that could be implemented to meet the first measure proposed measure (to ensure local public health seats on transportation or planning governing or leadership boards).

Decision: The subcommittee approved recommending one process measure – the number of active transportation partner governing or leadership boards with LPHA representation – to PHAB.

Drinking water services: The existing program element for drinking water services includes three performance measures for LPHAs. The state and local Drinking Water Services workgroup recommends using all three of these performance measures and to not develop any new measures at this time.

Decision: The subcommittee approved recommending the three established performance measures to PHAB.

Subcommittee business

Myde Boles from Program Design and Evaluation Services will present these recommendations for a vote at the October 19 PHAB meeting. No separate subcommittee update is needed.

The current plan for the November meeting is to bring an outline for the public health accountability metrics report that will be published in 2018 to solicit feedback from the subcommittee. The subcommittee will continue its discussion about dental measures at an upcoming meeting.

Public testimony

No public testimony.

Adjournment

The meeting was adjourned.

The next Accountability Metrics subcommittee meeting is scheduled for:

November 22 from 1:00-2:00 pm

Public health accountability metrics: Local public health process measure recommendations

Public Health Advisory Board
October 19, 2017



PUBLIC HEALTH DIVISION
Office of the State Public Health Director

Purpose for today's presentation

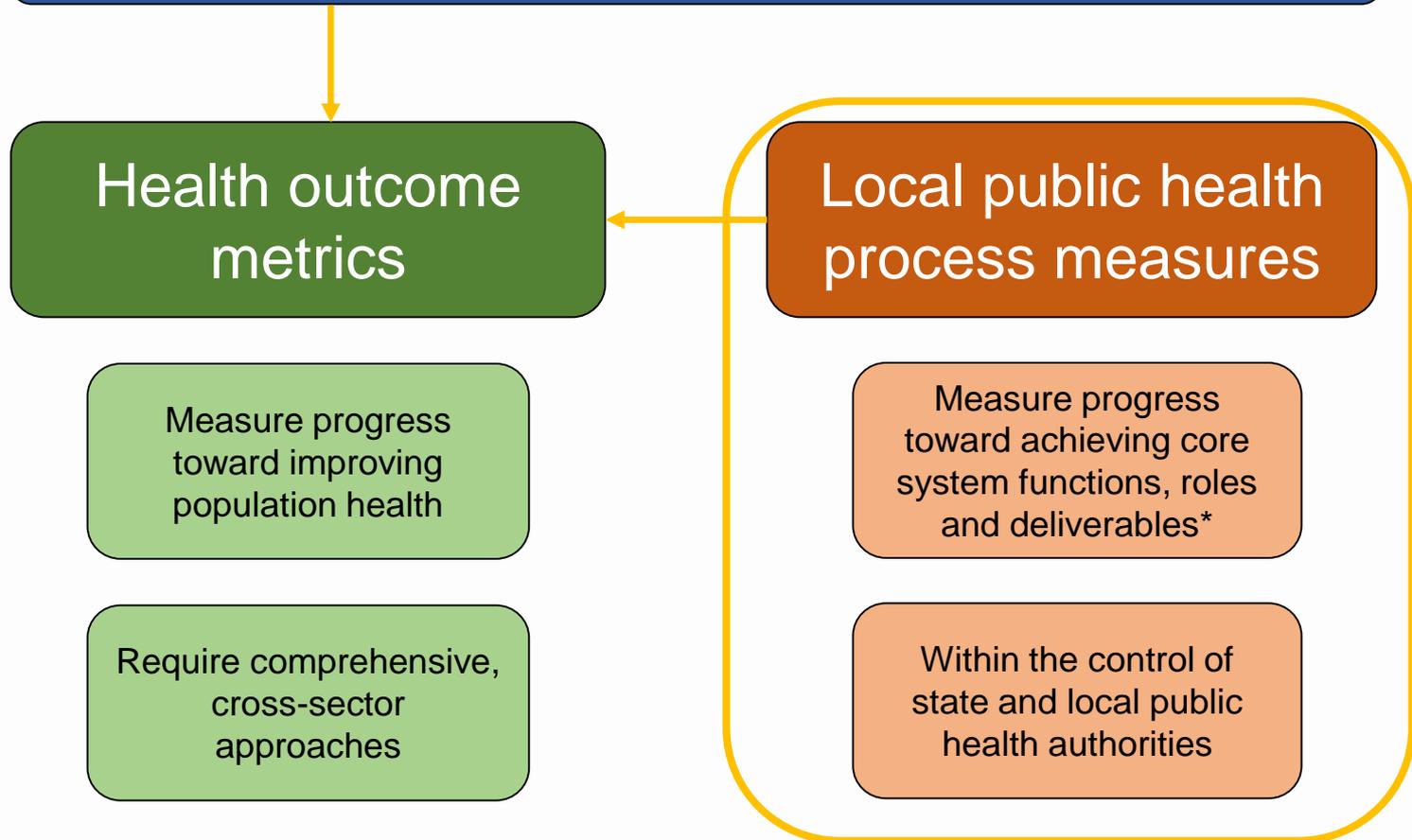
- Review process measures recommended by the PHAB accountability metrics subcommittee
- Vote to adopt process measures

Public health accountability metrics

Communicable Disease Control <ul style="list-style-type: none">- Two-year old immunization rates*- Gonorrhea rates	Prevention and Health Promotion <ul style="list-style-type: none">- Adults who smoke cigarettes*- Opioid overdose deaths*
Environmental Health <ul style="list-style-type: none">- Active transportation- Drinking water standards	Access to Clinical Preventive Services <ul style="list-style-type: none">- Effective contraceptive use*- Dental visits, 0-5 year olds*

* Aligns with CCO or early learning priority

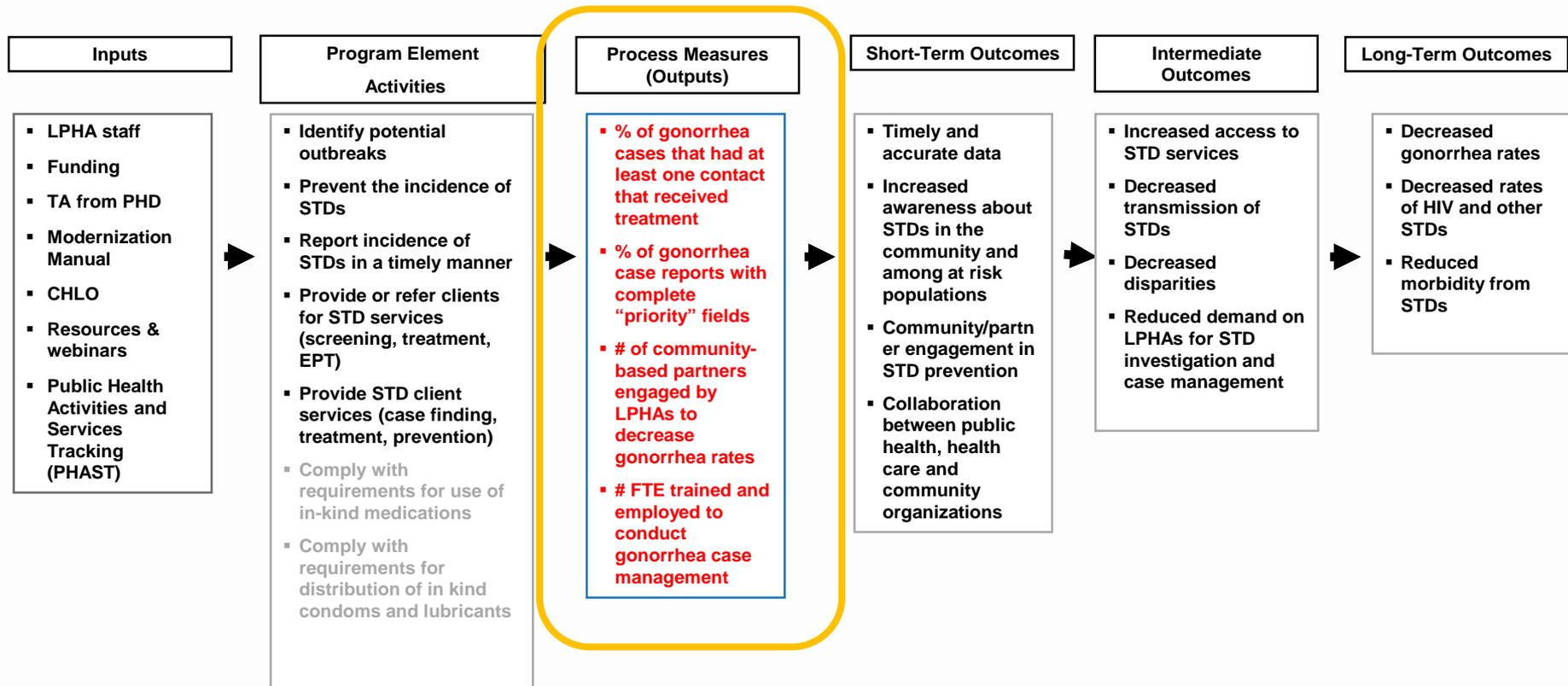
Public health accountability metrics



* Core system functions, roles and deliverables are listed in the Public Health Modernization Manual

Logic model - example

Gonorrhea rates



Steps for identifying and selecting process measures

- July – September 2017
- CLHO committees developed set of process measures
 - Healthy Families, Healthy Communities, Communicable Disease, including state and local subject matter experts
 - Reviewed existing measure sets and deliverables in Public Health Modernization Manual
- CHLO reviewed measures recommended by committees and proposed limited set of measures to PHAB accountability metrics subcommittee
- PHAB accountability metrics subcommittee
 - Reviewed and discussed merits of proposed process measures
 - Recommend 1 to 3 process measures for each public health accountability metric for consideration by PHAB

Two year old vaccination rates

Recommended measure: Percent of Vaccines for Children clinics [that serve populations experiencing vaccination disparities] that participate in Assessment, Feedback, Incentives and eXchange (AFIX) program

Rationale:

- An evidence-based intervention for increasing childhood immunization rates
- Has the potential to build or enhance partnerships with health care providers and the local CCO(s)
- Aligns with strategies used by some CCOs to increase childhood immunization rates
- Requires collaboration between state and local public health

Data source: CDC's Provider Education Assessment and Reporting (PEAR) system

Gonorrhea rates

Recommended measures:

1. Percent of gonorrhea cases that had at least one contact that received treatment
2. Percent of gonorrhea case reports with complete priority fields (pregnancy status, HIV, most recent test date/status, gender of sex partners, proper treatment of gonorrhea)

Rationale:

- Treating cases is an evidence-based intervention for stopping gonorrhea transmission
- Consistent with existing activities under the Program Element (i.e., state funding of local public health)
- Ensures complete data to identify disparities and target interventions

Data source: Oregon Public Health Epi User System (ORPHEUS)

Adults who smoke cigarettes

Recommended measure: Percent of community members reached by local [tobacco retail or smoke-free] policies

Rationale:

- Aligns with CDC tobacco prevention best practices
- Policy change is one of the strongest levers for reducing tobacco consumption
- Aligns with CCO metric
- Measure can be flexible to address policy differences across counties

Data sources:

- Local Tobacco Prevention and Education Program grantee reporting
- PHD Health Promotion and Chronic Disease Prevention Policy Database

Opioid overdose deaths

Recommended measure: Percent of top prescribers enrolled in the Prescription Drug Monitoring Program (PDMP)

Rationale:

- Consistent with existing activities under the Program Element (for selected areas of the state only)
- PDMP is a tool used by all states to promote safer prescribing practices
- Represents area for state and local partnership
- Existing mechanism for data collection

Data sources:

- Prescription Drug Monitoring Program (PDMP)

Active transportation

Recommended measure: Number of active transportation partner governing or leadership boards with LPHA representation

Rationale:

- For many health departments, partnerships with local transportation or planning is an emerging area. These proposed process measures document progress toward establishing partnerships
- Aligns with PHAB “Guiding Principles for Public Health and Health Care Collaboration” document

Data sources:

- LPHA reporting

Drinking water standards

Recommended measures:

1. Number of water systems surveys completed
2. Number of water quality alert responses
3. Number of priority non-compliers resolved

Rationale:

- These are included in the existing Program Element, but capacity to make improvements is limited
- Existing mechanism for data collection

Data sources:

- Public Water System database

Effective contraceptive use

Recommended measure: Number of local policy strategies for increasing access to effective contraceptives

Rationale:

- Aligns with Public Health Modernization Manual core system functions for assuring access to clinical preventive services
- LPHA may serve as convener of community partners and stakeholders
- Strong equity component
- Aligns with CCO incentive metric

Data sources:

- LPHA reporting

Dental visits among children ages 0-5 years

Recommended measure: Do not adopt a local public health measure at this time

Rationale: Continue to explore public health roles and functions to increase dental visits for 0-5 year olds

Accountability metrics timeline

Activity	Timeline
Identify population health outcome metrics	March-May
Conduct stakeholder survey	April-May
Adopt health outcome metrics	June
Identify and adopt local public health process measures	July-October
Establish data collection mechanisms	October-November
Collect baseline data	November-December
Publish first accountability metrics report	2018

Public Health Advisory Board

Summary of local public health process measure recommendations

October 19, 2017

	Public Health Accountability Metric	Local public health process measures
Communicable disease control	Two-year-old vaccination rates	PHAB Accountability Metrics subcommittee Recommendation: 1. Percent of Vaccines for Children clinics [that serve populations experiencing vaccination disparities] that participate in the Assessment, Feedback, Incentives and eXchange (AFIX) program.
	Gonorrhea rates	PHAB Accountability Metrics subcommittee Recommendation: 1. Percent of gonorrhea cases that had at least one contact that received treatment 2. Percent of gonorrhea case reports with complete “priority” fields Additional measures considered: 3. Number of community-based organizations (CBOs) / partners engaged by LPHA to decrease gonorrhea rates 4. # of FTE trained and employed to conduct gonorrhea case management
Prevention and Health Promotion	Adults who smoke cigarettes	PHAB Accountability Metrics subcommittee recommendation: 1. Percent of community members reached by local [tobacco retail/smoke free] policies
	Opioid overdose deaths	PHAB Accountability Metrics subcommittee recommendation: 1. Percent of top prescribers enrolled in the Prescription Drug Monitoring Program (PDMP) Additional measures considered: 2. Percent of top prescribers who completed opioid overdose prevention trainings
Environmental Health	Active transportation	PHAB Accountability Metrics subcommittee recommendation: 1. Number of active transportation partner governing or leadership boards with LPHA representation Additional measures considered: 2. Number of presentations to local decision makers on active transportation barriers and evidence-based ore promising transportation policies
	Drinking water standards	PHAB Accountability Metrics subcommittee recommendations: 1. Number of water systems surveys completed 2. Number of water quality alert responses 3. Number of priority non-compliers (PNCs) resolved
Access to	Effective contraceptive use	PHAB Accountability Metrics subcommittee recommendation: 1. Number of local policy strategies for increasing access to effective contraceptives

		<p>Additional measures considered:</p> <p>2. Number of local assessments conducted to identify barriers to accessing effective contraceptives.</p>
	<p>Dental visits among children ages 0-5 years</p>	<p>PHAB Accountability Metrics subcommittee recommendation:</p> <p>Do not adopt a local public health process measure at this time. Continue to explore public health roles and functions to increase dental visits for 0-5 year olds.</p> <p>Measures considered</p> <ol style="list-style-type: none"> 1. Percent of dental referrals made for LPHA 0-5 year old clients 2. Percent of WIC, home visiting and health department medical staff (if applicable) who have completed the “First Tooth” and/or “Maternity Teeth for Two” trainings 3. Number of “First Tooth” and/or “Maternity Teeth for Two” trainings delivered to health and dental care providers

Public Health Advisory Board
 Local public health process measure recommendations
 October 19, 2017



Purpose:

Local public health process measures will be used to bring attention to the core work that each health department must do to make improvements for each accountability metric. These recommendations are those that are believed to be most likely to move the public health system forward toward achieving the public health accountability metrics. Work will be ongoing to ensure LPHAs have funding to conduct the activities that will allow each health department to meet these process measures.

Timeline:

From July-September 2017 CLHO committees developed recommendations for local public health process measures for each public health accountability metric. The committees, which include state and local subject matter experts, reviewed existing measure sets and the Public Health Modernization Manual to inform these recommendations.

The PHAB Accountability Metrics subcommittee approved the recommended measures on October 13, 2017.

Outcome Metric	Process Measure	Rationale	Data Source	Existing Funding	What activities could be used to meet the process measure?	Local health administrator and health officer and PHAB subcommittee feedback
Communicable Disease Control						
Two-year-old vaccination rates	PHAB Accountability Metrics subcommittee recommendation: 1. Percent of Vaccines for Children (VFC) clinics [that serve populations experiencing vaccination disparities] that participate in the	<ul style="list-style-type: none"> An evidence-based intervention for increasing childhood immunization rates Has the potential to build or enhance partnerships with health care providers and the local CCO(s) Aligns with strategies used by some CCOs to increase childhood immunization rates Requires collaboration between state and local public health 	CDC’s Provider Education Assessment and Reporting (PEAR) system Example data: To date in 2017, 9% of VFC clinics have participated in AFIX.	All LPHAs receive funding through Program Element (PE) 43, Immunization Services. There is no specific Procedural and Operational Requirement to implement an AFIX program with local health care providers, but LPHAs	LPHAs could increase the % of clinics that participate in AFIX by: <ul style="list-style-type: none"> Promoting AFIX to local clinics and facilitating contact with the OHA Immunization Program Partnering with the CCO to promote AFIX 	Clarified that this measure is for AFIX with health care clinics in the county, not LHD clinics. Suggestion to measure that LHD offers or encourages participation, rather than measuring participation.

Outcome Metric	Process Measure	Rationale	Data Source	Existing Funding	What activities could be used to meet the process measure?	Local health administrator and health officer and PHAB subcommittee feedback
	<p>Assessment, Feedback, Incentives and eXchange (AFIX) program.</p>	<ul style="list-style-type: none"> • There is an established mechanism for data collection and reporting 		<p>are required to design and implement two educational or outreach activities</p>	<ul style="list-style-type: none"> • Attending AFIX visits with OHA Immunization Program staff • Conducting AFIX visits and reporting information to OHA Immunization Program 	<p>Not an easy sell with health care providers.</p> <p>No direct control over health care provider participation.</p> <p>One administrator stated that her county and surrounding counties have been doing AFIX visits with local providers. They now have champions, and there is a lot of enthusiasm among the provider community.</p> <p>One administrator expressed support for using AFIX as the measure. She stated she would like to do this and suggests a corresponding state measure on technical assistance offered to counties.</p> <p>PHAB subcommittee:</p> <ul style="list-style-type: none"> • Need to use this as an opportunity to work

Outcome Metric	Process Measure	Rationale	Data Source	Existing Funding	What activities could be used to meet the process measure?	Local health administrator and health officer and PHAB subcommittee feedback
						<p>with CCOs on shared metric; tie to Guiding Principles.</p> <ul style="list-style-type: none"> Encourages a bigger systems discussion about how public health is included in CCO incentives to providers for meeting metrics.
Gonorrhea rates	<p>PHAB Accountability Metrics subcommittee recommendation:</p> <p>1. Percent of gonorrhea cases that had at least one contact that received treatment</p> <p>PHAB Accountability Metrics subcommittee recommendation:</p> <p>2. Percent of gonorrhea case reports with complete “priority” fields</p> <p>(Currently these fields are: pregnancy status, HIV status/date of most recent test, gender of sex)</p>	<ul style="list-style-type: none"> Treating cases is evidence-based intervention for stopping the chain of gonorrhea transmission. Consistent with existing activities under the Program Element, but in most counties capacity for case finding and treatment is limited There is an established mechanism for data collection and reporting <ul style="list-style-type: none"> Measures quality of data collection/systems Ensures complete data to identify where disparities exist and to inform targeted interventions Consistent with existing activities under the Program Element, but in most counties capacity to complete priority fields is limited There is an established mechanism for data collection and reporting 	Oregon Public Health Epi User System (ORPHEUS)	<p>All LPHAs receive funding through PE 10 for Sexually Transmitted Disease (STD) Case Management Services.</p> <p>The LPHA bears primary responsibility for identifying outbreaks and reporting the incidence of reportable STDs in a timely manner. The LPHA must provide STD client services including case finding, treatment and prevention activities to the extent that local resources permit.</p>	<p>Provide education and follow up to health care providers for areas like expedited partner therapy.</p> <p>Expand capacity within the health department for contact tracing.</p> <p>Provide education to health care providers for areas like collecting information for priority fields or proper treatment of gonorrhea.</p> <p>Expand capacity within the health department for collecting and entering priority field data.</p>	<p>How would we put meaning to #3 and #4?</p> <p>Suggestion to expand #3 beyond CBOs to include medical providers, and non-traditional and other partners besides PCP (corrections, tribes, urgent cares).</p> <p>#4 intended to reflect huge differences in disease rates among counties, in terms of case load.</p> <p>One health administrator supports #1 and thinks it could influence #3 and #4.</p>

Outcome Metric	Process Measure	Rationale	Data Source	Existing Funding	What activities could be used to meet the process measure?	Local health administrator and health officer and PHAB subcommittee feedback
	partners, proper treatment of gonorrhea)					
	3. Number of community-based organizations (CBOs) / partners engaged by LPHA to decrease gonorrhea rates	<ul style="list-style-type: none"> Represents new approach in most areas of the state to reduce gonorrhea rates 	LPHA reporting ¹	None	Use PHAB <i>Guiding Principles for Public Health and Health Care Collaboration</i> document to build robust partnerships	PHAB subcommittee: <ul style="list-style-type: none"> Recommends collecting information on FTE for all areas, although it doesn't need to be a metric A statewide approach to training needs to be developed
	4. # of FTE trained and employed to conduct gonorrhea case management	<ul style="list-style-type: none"> Indication of local capacity to protect health and prevent the spread of disease There may be national standards for number of case management FTE for population size 	LPHA reporting	None	Work with Board to meet standards for case management FTE.	
Prevention and Health Promotion						
Adults who smoke cigarettes	PHAB Accountability Metrics subcommittee recommendation: <ol style="list-style-type: none"> Percent of community members reached by local [tobacco retail/smoke free] policies 	<ul style="list-style-type: none"> Aligns with CDC tobacco prevention best practices Policy change is one of the strongest levers for reducing tobacco consumption There is an established mechanism for data collection and reporting Alignment with CCO metric Measure can be designed to be flexible to address differences in feasibility of passing tobacco policy among counties 	Local Tobacco Prevention and Education Program grantee reporting OHA Health Promotion and Chronic Disease Prevention section Policy Database Example data: Tobacco retail license policy in County X – 2016: 29% (only unincorporated county)	All LPHAs receive funding through PE 13 for Tobacco Prevention and Education, which includes creating tobacco-free environments and countering pro-tobacco influences.	Implement Procedural and Operational Requirements in Program Element. Apply communications and community partnership development to make progress toward policy change.	Why adult focus for accountability metric? Suggestion for % of multi-family housing units that have adopted smoke free policies or % of incorporated jurisdictions that have adopted at least one smoke free policy beyond the 10' requirement.

¹ For areas where no established data collection system exists, each LPHA would be responsible for creating and supporting an internal mechanism to collect the data.

Outcome Metric	Process Measure	Rationale	Data Source	Existing Funding	What activities could be used to meet the process measure?	Local health administrator and health officer and PHAB subcommittee feedback
			2017: 93% (unincorporated county + city that is a population center)			PHAB subcommittee: <ul style="list-style-type: none"> Measure needs to be designed to be flexible for local differences in feasibility of passing tobacco policy
Opioid overdose deaths	<p>PHAB Accountability Metrics subcommittee recommendation:</p> <p>1. Percent of top prescribers enrolled in the Prescription Drug Monitoring Program (PDMP)</p> <p>A top prescriber is one of the top 4,000 prescribers of controlled substances in the state.</p>	<ul style="list-style-type: none"> Consistent with existing activities under the Program Element; however, only some regions of the state are currently funded through the Program Element PDMP is a tool used by almost all states to promote safer prescribing practices Represents area for state and local partnership. The Public Health Division collects data and makes data available, and LPHAs are responsible for increasing enrollment among local provider communities. Existing mechanism for data collection and reporting. 	OHA Prescription Drug Monitoring Program (PDMP) <p>Example data: Q1 2017: The percent of top prescribers enrolled in PDMP by county ranged from 50-100%</p>	<p>Some LPHAs receive funding through PE 27 for Prescription Drug Overdose Prevention.</p> <p>The PE includes requirements to promote prescriber enrollment in the PDMP.</p>	Implement requirements in the Program Element. Promote awareness about the PDMP and share regional data about local prescribing practices.	<p>One administrator stated that just because a provider has registered for PDMP doesn't mean they use it.</p> <p>There was agreement from a second health administrator who also stated she is fine with the measure.</p> <p>What will help clinics is helping them implement internal procedures around refills.</p>
	<p>2. Percent of top prescribers who completed opioid overdose prevention trainings</p>	<ul style="list-style-type: none"> LPHAs would work with providers and other stakeholders to understand local training needs and make trainings available 	LPHA reporting	<p>Some LPHAs receive funding through PE 27 for Prescription Drug Overdose Prevention.</p> <p>The PE includes requirements to build or</p>	Assess local training needs, coordinate to provide training or bring trainers to the region.	<p>No feedback on #2.</p> <p>PHAB subcommittee:</p> <ul style="list-style-type: none"> Could required enrollment in PDMP and required training be enacted as a state

Outcome Metric	Process Measure	Rationale	Data Source	Existing Funding	What activities could be used to meet the process measure?	Local health administrator and health officer and PHAB subcommittee feedback
				strengthen community partnerships and strengthen local prescription drug overdose networks and systems, which may include training		law in order to get a DEA license?
Environmental Health						
Active transportation	<p>PHAB Accountability Metrics subcommittee recommendation:</p> <ol style="list-style-type: none"> Number of active transportation partner governing or leadership boards with LPHA representation 	<ul style="list-style-type: none"> For many health departments, partnerships with local transportation or planning is an emerging area. These proposed process measures document progress toward establishing partnerships Aligns with PHAB <i>Guiding Principles for Public Health and Health Care Collaboration</i> document 	LPHA reporting	None	<p>Use PHAB <i>Guiding Principles for Public Health and Health Care Collaboration</i> document to build partnerships with local transportation or planning departments</p> <p>Seek opportunities to raise awareness about the connections between transportation policy and health.</p> <p>Seek opportunities to make presentations to local decision makers on active transportation barriers and evidence-based or promising transportation policies.</p>	<p>Would state provide TA for giving presentations?</p> <p>Governing boards are often elected officials or others above health administrators or directors. Would a LPHA get credit if a commissioner is on a board?</p> <p>#2- difficult to get in the door.</p> <p>No funding, no capacity or knowledge about this work.</p> <p>PHAB subcommittee:</p> <ul style="list-style-type: none"> There is interest from transportation and planning; it is

Outcome Metric	Process Measure	Rationale	Data Source	Existing Funding	What activities could be used to meet the process measure?	Local health administrator and health officer and PHAB subcommittee feedback
						important to highlight this work as a metric to continue to gain momentum.
Drinking water standards	<p>PHAB Accountability Metrics subcommittee recommendation: (adopt all 3 measures)</p> <ol style="list-style-type: none"> 1. Number of water systems surveys completed 2. Number of water quality alert responses 3. Number of priority non-compliers (PNCs) resolved 	<ul style="list-style-type: none"> • These three process measures are included in the existing Program Element, but capacity to make improvements in these areas is limited. • Existing mechanism for data collection and reporting 	Public Water System database, OHA Drinking Water Services Program	All LPHAs funded through PE 50 for Safe Drinking Water Programs	Implement Procedural and Operational Requirements in the Program Element	<p>Health administrator who sits on the SDW workgroup stated that these measures capture the work that’s being done and covers a host of nuances under each of the three measures.</p> <p>Why not a %?</p>
Access to Clinical Preventive Services						
Effective contraceptive use	<p>PHAB Accountability Metrics subcommittee recommendation:</p> <ol style="list-style-type: none"> 1. Number of local policy strategies for increasing access to effective contraceptives. 	<ul style="list-style-type: none"> • Aligns with Public Health Modernization Manual core system functions for assuring access to clinical preventive services • LPHA may serve as convener of community partners and stakeholders • Strong equity component • Aligns with CCO incentive metric 	LPHA reporting	All LPHAs funded through PE 41 for Reproductive Health Programs. Program Element under revision.	<p>With partners and stakeholders, lead or contribute to developing a local plan or local strategies for increasing access.</p> <p>Policies will address disparities in access, and involve community partners in planning and implementation</p>	<p>Are more assessments better?</p> <p>One health admin expressed preference for #2. Can do a lot of assessments and do nothing. A plan is moving in the direction of doing something.</p> <p>Should include “at least every 5 years” to align</p>

Outcome Metric	Process Measure	Rationale	Data Source	Existing Funding	What activities could be used to meet the process measure?	Local health administrator and health officer and PHAB subcommittee feedback
	<p>2. Number of local assessments conducted to identify barriers to accessing effective contraceptives.</p>	<ul style="list-style-type: none"> Aligns with Public Health Modernization Manual core system functions for assuring access to clinical preventive services LPHA may serve as convener of community partners and stakeholders Strong equity component 	LPHA reporting	All LPHAs funded through PE 41 for Reproductive Health Programs. Program Element under revision.	<p>A policy strategy is a document that identifies and guides the strategic policy priorities and policy goals for the LPHA and can align with other local public health plans (e.g., CHIP)</p> <p>Work with partners and stakeholders to implement strategies, develop shared governance or secure funding for implementation.</p> <p>With partners and stakeholders, lead or contribute to efforts to assess access barriers.</p> <p>Local assessments will identify populations experiencing disparities and involve community partners in planning and implementation.</p>	<p>with accreditation standards. Not sure why there would be multiple assessments.</p> <p>PHAB subcommittee:</p> <ul style="list-style-type: none"> Concern that many process measures are reliant on participation from the health care sectors. Public health does not have full control over meeting the measure. This is the challenge of two systems trying to work together toward shared goals and improving care for vulnerable populations. Public health assurance role
<p>PHAB Accountability Metrics subcommittee recommendation: Do not adopt a local public health process measure at this time. Continue to explore public health roles and functions to increase dental visits for 0-5 year olds</p>						

Outcome Metric	Process Measure	Rationale	Data Source	Existing Funding	What activities could be used to meet the process measure?	Local health administrator and health officer and PHAB subcommittee feedback
Dental visits among children ages 0-5 years	1. Percent of dental referrals made for LPHA 0-5 year old clients	<ul style="list-style-type: none"> • Creating and implementing referral systems is likely to get children in for dental visit • Some LPHAs are developing referral systems with existing Title V funding; this could be expanded to other counties • However, this process measure may only capture clients who receive services at the health department 	LPHA reporting	<p>All LPHAs funded through PE 42 for Title V Maternal, Child and Adolescent Health (MCAH) Services.</p> <p>LPHAs select an area of focus with Title V funds. Currently some have selected oral health.</p>	<p>LPHA could use different mechanisms to increase referrals by partnering with WIC, home visiting programs, FQHCs or schools.</p> <p>LPHAs could work toward closed loop referral systems</p>	<p>#2- virtually impossible to get in the door, a really big hurdle. (A second admin agrees- often get five minutes, have to prioritize what is discussed)</p> <p>Referrals are good but consumers get frustrated when referrals are made with no ability to follow through.</p>
	2. Percent of WIC, home visiting and health department medical staff (if applicable) who have completed the “First Tooth” and/or “Maternity Teeth for Two” trainings	<ul style="list-style-type: none"> • Recommended by local public health administrator • Ensures LPHA staff who have contact with mothers and children have basic oral health training 	LPHA reporting		LPHA could convene these groups to make trainings available	<p>A local early learning hub is developing a child health referral system, and there has been a lot of resistance. Creation of a referral system is a tough sell.</p>
	3. Number of “First Tooth” and/or “Maternity Teeth for Two” trainings delivered to health and dental care providers	<ul style="list-style-type: none"> • Integrates oral health into medical community • Increases likelihood that providers (medical and dental) will conduct assessments and screenings, provide preventive care and anticipatory guidance, and make referrals 	LPHA reporting		<p>Partner with CCO or DCO to assess local need for trainings</p> <p>Partner with CCO or DCO to provide trainings</p>	<p>#1 Since public health is moving away from direct services, we’d expect the number to decrease. Makes the most sense to attach this to WIC or home visiting; CCOs should capture the % of kids who received a</p>

Outcome Metric	Process Measure	Rationale	Data Source	Existing Funding	What activities could be used to meet the process measure?	Local health administrator and health officer and PHAB subcommittee feedback
		<ul style="list-style-type: none"> • These trainings are available through the Oregon Oral Health Coalition 				<p>dental referral from those service providers</p> <p>#2 This is a service provided by a DCO, so public health measure should be to get them to do it. E.g., at least one meeting with the DCO about provision of this training to providers if it is not already happening.</p> <p>Suggestions: % of WIC and home visiting direct services staff who have completed the First Tooth and/or Maternity Teeth for Two training</p> <p>PHAB subcommittee:</p> <ul style="list-style-type: none"> • Recommended measures too weak to lead to results • Significant access issues exist even if referrals are made • Training is important but that doesn't mean it's acted upon

Outcome Metric	Process Measure	Rationale	Data Source	Existing Funding	What activities could be used to meet the process measure?	Local health administrator and health officer and PHAB subcommittee feedback
						<ul style="list-style-type: none"> • Need to review available data and continue to develop the public health roles and functions

Public Health Advisory Board
Public health accountability metrics
Local public health process measures health equity review
October 19, 2017

1. How is the work product, report or deliverable different from the current status?

Local public health authorities (LPHAs) have a unique and essential role to meet the public health accountability metrics adopted by the Public Health Advisory Board (PHAB) in June 2017. Local public health process measures will be used to bring attention to the activities and outputs of each LPHA that will lead to corresponding improvements in the accountability metrics.

2. What health disparities exist among which groups? Which health disparities does the work product, report or deliverable aim to eliminate?

Nearly all the public health accountability metrics adopted by PHAB focus on areas where health disparities exist. The local public health process measures emphasize the work that public health departments are doing or will do to reduce these disparities.

3. How does the work product, report or deliverable support individuals in reaching their full health potential?

Public health accountability metrics and local public health process measures do not directly support individuals to reach their full potential.

However, public health accountability metrics and local public health process measures will increase visibility and understanding of the health disparities that exist for the areas that are measured and will bring attention to the population health interventions that are needed to reduce disparities. This information will be useful to state and local public health authorities, partners and policy makers in planning interventions and the allocation of resources to reduce disparities.

4. Which source of health inequity does the work product, report or deliverable address (social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?

The set of local public health process measures do not specifically address one source of health inequity.

5. How does the work product, report or deliverable ensure equitable distribution of resources and power?

This is not directly addressed by local public health process measures.

6. How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?

The community was not engaged in the development of local public health process measures. This work was informed by state and local public health leadership and staff, and by members of the Public Health Advisory Board.

Local public health process measures will impact the community as public health resources are used to support the activities LPHAs need to conduct in order to meet the process measures.

7. How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?

A number of these process measures metrics will require coordination with cross-sector partners. In addition to the health care system, other sectors may include transportation, planning and early learning.

8. How will data be used to monitor the impact on health equity resulting from this work product, report or deliverable?

OHA will publish an initial public health accountability metrics baseline report in 2018. Subsequent reports will be issued on a regular basis as a mechanism to monitor progress.

The public health modernization funding formula includes a component for performance-based payments to local public health authorities. While the mechanism for awarding performance-based payments has not yet been developed, it is understood that these payments will be based on achievement of public health authority process measures that support achievement of the public health accountability metrics.

The public health modernization funding formula includes indicators for equity and social determinants of health.

OHPB Action Plan for Health 2017-2019 “Refresh”

Presentation to the PHAB
October 19, 2017

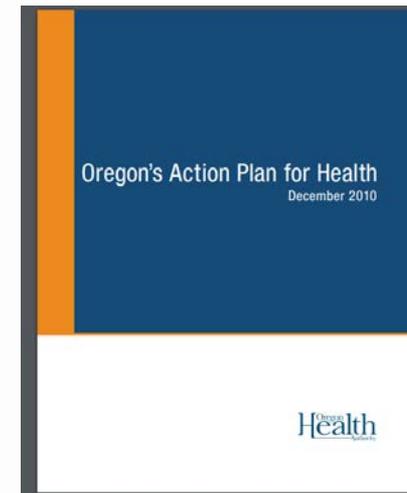
Dr. David Bangsberg, OHPB member
Steph Jarem, OHA policy analyst



HEALTH POLICY AND ANALYTICS DIVISION
Office of Health Policy

History of the Action Plan for Health

- Created in 2009-2010, with input from hundreds of stakeholders
- Served as the comprehensive health reform plan for Oregon
- Guided by Oregon's Triple Aim:
 - Better health
 - Better care
 - Lower costs
- Established a strong vision
- <https://www.oregon.gov/oha/action-plan/rpt-2010.pdf>



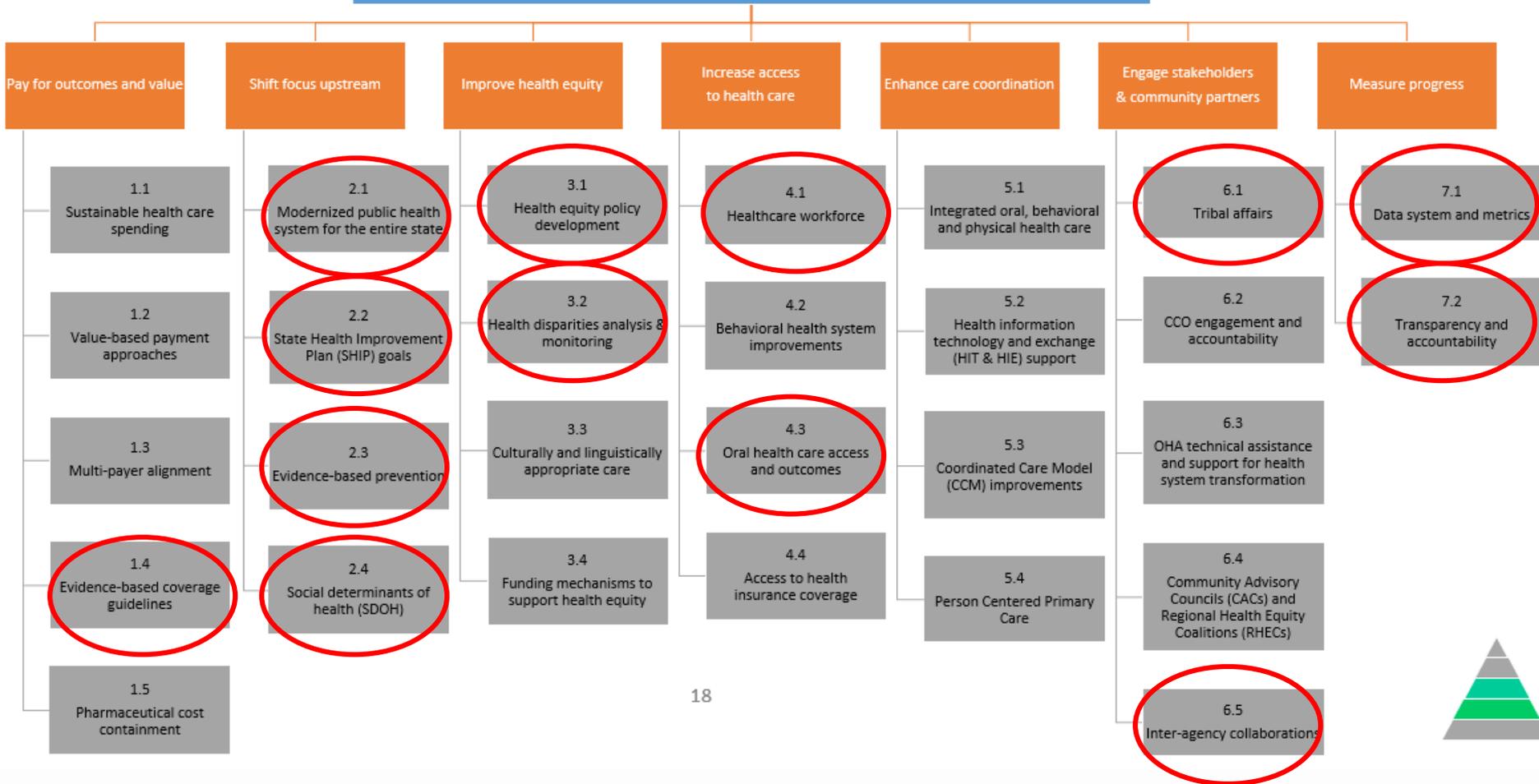
High-level Plan for Refresh

- After 5 years of health system transformation, Oregon is moving beyond initial implementation phase
- Need to establish a roadmap for continued innovation, building upon best practices, evidence, data, and stakeholders' experience
- Build upon and update original Action Plan for Health framework

Framework of Action Plan



Action Plan for Health 2017



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Key Actions

- The true “work” of the Action Plan
- Work has been prioritized at OHA
- List is dynamic and still in draft form – update due January 2018

Focus Area 2.1 - Modernized public health system for the entire state		
2.1a	Implement 14 strategies in the Statewide Public Health Modernization Plan. A modernized public health system will allow each community to determine how public health services will be provided within the context of the local health system in order to achieve improved health for all community members.	PHAB
2.1b	Integrate Health Equity across all public health related foundational areas	PHAB
Focus Area 2.2 - State Health Improvement Plan (SHIP) goals		
2.2a	Implement work plans for the seven identified SHIP priorities to make significant change in public health outcomes for all Oregonians	PHAB

Next steps

- Development of a dashboard/report that includes:
 - Action
 - Status of action (e.g., in development, launched, in progress, halted)
 - Selections:
 - Highlighted achievements
 - Areas of concern
 - Policy opportunities
- Alignment with CCO 2.0

Questions for the PHAB

- Any additional detail from the public health perspective that should be captured through internal tracking or the dashboard?
- How would the PHAB like to be updated on this work?

(Enter) DEPARTMENT (ALL CAPS)
(Enter) Division or Office (Mixed Case)

Questions?

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HEALTH POLICY AND ANALYTICS DIVISION

Office of Health Policy