AGENDA

PUBLIC HEALTH ADVISORY BOARD

March 21, 2019
Portland State Office Building
800 NE Oregon St., Conference room 1B
Portland, OR 97232

Join by webinar: https://register.gotowebinar.com/rt/4888122320415752707
Conference line: (877) 873-8017
Access code: 767068

Meeting objectives:

- Hear an update on behavioral health system changes
- Receive updates on modernization of public health data reporting
- Hear update from subcommittees; approve subcommittee products

2:00-2:15 pm	**Welcome and updates** • Approve February meeting minutes • Legislative update • OHPB Digest	Rebecca Tiel, PHAB Chair
2:15-3:00 pm	**Accountability Metrics Subcommittee** • Review 2019 Public Health Accountability Metrics report **Action:** vote to approve 2019 report	Myde Boles, Program Design and Evaluation Services Sara Beaudrault OHA staff
3:00-3:10 pm	**Break**	
3:10-3:30	**Incentives and Funding Subcommittee** • Discuss work of subcommittee **Action:** vote to approve plan for distributing funding to LPHAs if funding remains flat	Alejandro Quaral, PHAB Member
3:30-3:55	**Modernization Progress Update: Data visualization** • Update PHAB progress in the assessment and epidemiology foundational capability	Ali Hamade, OHA Staff
3:55-4:30 pm	**Update on behavioral health** • Hear an update on behavioral health system changes taking place through OHA's health policy and health systems work	Margie Stanton, OHA Staff
4:30-4:45 pm	**Public comment**	Rebecca Tiel, PHAB Chair

4:45 pm	**Adjourn**	Rebecca Tiel, PHAB Chair

OHPB Committee Digest

PUBLIC HEALTH ADVISORY BOARD, METRICS & SCORING COMMITTEE, HEALTH PLAN QUALITY METRICS COMMITTEE, HEALTH INFORMATION TECHNOLOGY OVERSIGHT COUNCIL, HEALTHCARE WORKFORCE COMMITTEE, HEALTH EQUITY COMMITTEE, PRIMARY CARE COLLABORATIVE, MEDICAID ADVISORY COMMITTEE, STATEWIDE SUPPORTIVE HOUSING WORKGROUP, MEASURING SUCCESS COMMITTEE

Public Health Advisory Board

During the February meeting, Public Health Advisory Board (PHAB) members received an update from Lillian Shirley on CCO 2.0. Director Shirley provided an update on the procurement process. Director Shirley also reviewed each recommendation the board provided to OHPB in February 2018 and described whether and how each recommendation has been included in the next round of CCO contracts.

The Board received a presentation on the 2020-24 State Health Improvement Plan. PHAB provides oversight to OHA Public Health Division on the state health assessment and state health improvement plan. The presentation highlighted feedback provided by nearly 2,500 people across Oregon through an extensive community engagement process. The steering committee for the SHIP used this feedback to select the final set of priorities for the next five-year SHIP. These priorities are:

- Institutional bias
- Adversity, trauma and toxic stress
- Economic drivers of health (including issues related to housing, living wage, food security and transportation)
- Access to equitable, preventive health care
- Behavioral health (including mental health and substance use).

Over the coming months, subcommittees will identify strategies and measures for each priority area and solicit additional feedback from the community. The SHIP will go into effect in January 2020. PHAB will continue to receive regular updates on progress from OHA.
PHAB received updates from its subcommittees.

- The Accountability Metrics subcommittee reviewed a draft of the 2019 Public Health Accountability Metrics Report at its February meeting. PHAB is expected to adopt the report at its March meeting.
- The Incentives and Funding subcommittee reported on initial recommendations for the use of public health modernization funding in 2019-21. This subcommittee will continue to develop recommendations over the coming months.

COMMITTEE WEB SITE: https://www.oregon.gov/oha/ph/About/Pages/ophab.aspx
STAFF POC: Kati Moseley, Katarina.Moseley@dhsoha.state.or.us

Primary Care Payment Reform Collaborative

In February the Collaborative delivered its report on the Primary Care Transformation Initiative ("Initiative") to the Oregon Legislature and OHPB, as mandated by SB 934 (2017). The report included

progress on the Initiative and recommendations on how to achieve the goals of the Initiative. The Collaborative recommended the Initiative focus on the spread of mechanisms to strengthen Oregon's primary care system with an emphasis on innovative payment models supported by a statewide infrastructure. All 46 Collaborative member organizations endorsed the recommendations in the report.

In 2019, the Collaborative will focus on strategies to implement the recommendations. At the January 29 meeting Collaborative members identified and formed the following four workgroups: implementation, technical assistance, evaluation and metrics. The workgroups will convene monthly except during the month the full Collaborative convenes. The next Collaborative meeting is scheduled for April 23, 2019.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx.
COMMITTEE POC: Amy Harris, AMY.HARRIS@dhsoha.state.or.us

Healthcare Workforce Committee

The Healthcare Workforce Committee holds its next meeting on March 6.

Key Items include:

Behavioral Health:
Representatives from the Eugene S. Farley, Jr. Health Policy Center in Colorado will be meeting with the Committee to discuss three key aspects of their years-long work for Oregon around behavioral health: A set of recommended core competencies and standards for behavioral health clinicians, a finalized draft of their statewide behavioral health assessment, and a draft of a behavioral health workforce recruitment and retention plan.

Oral Health:
The Committee will receive an update on OHA's HRSA Oral Health Workforce Grant

Health Care Provider Incentive Program:
The Committee will hear recommendations from its workgroup on use of available money in the Health Care Provider Incentive Program not expected to be spent by June 30, 2019.

Legislative Update:
The Committee will meet with OHA Government Relations staff to hear an update on health care workforce-related bills in the 2019 legislative session.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/HPA/HP-HCW/Pages/index.aspx
COMMITTEE POC: MARC OVERBECK, Marc.Overbeck@dhsoha.state.or.us

Health Plan Quality Metrics Committee

At the February 14 HPQMC meeting, Jon Collins and Leann Johnson, OHA executive sponsors of the Health Equity Measurement Workgroup, presented the health equity measure concept with a request to bring the finished product back to this committee in March. The short-term goal is

to have a first-step metric available for the CCO incentive program for 2020, while the long-term goal is to develop a more comprehensive approach to tracking equity and disparities that can be eventually incorporated into the same program. The concept focus' on two areas of CCO utilization: traditional health workers and language access.

Also, at this meeting, the committee approved prioritizing a list of measurement gaps for future measure development. That list can be found here: https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Meeting%20Documents/2019-02-Priorities-for-Future-Work-HPQMC.pdf.
Looking ahead to March, the HPQMC will finalize the 2020 Aligned Measure Menu Set at the March 14 meeting.
The next meeting is Thursday March 14, 2019 from 1:00pm – 3:30pm.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/analytics/Pages/Quality-Metrics-Committee.aspx
COMMITTEE POC: Kristin Tehrani, Kristin.Tehrani@dhsoha.state.or.us

Metrics & Scoring Committee

At its meeting in February the Committee heard a presentation from Lisa Bui, OHA's Director of Quality Improvement, on the central role of metrics in quality improvement efforts, and where the CCO Quality Incentive Program fits with other quality improvement efforts by the agency and CCOs. The Committee also began reviewing all 19 current incentive measures, plus five potential new measures under consideration for inclusion in the 2020 incentive measure set. Over the next few months the Committee is reviewing the specifications and performance on these 24 potential measures for 2020, as well as completing informal assessments of each measure against the Committee's measure selection criteria. These reviews will provide the background and initial discussions that will inform the Committee's final decisions about the 2020 measure set, which it will make in June and July 2019. The Committee reviewed the following measures in February: Adolescent well-care visits; Timely postpartum care visits; Patient Centered Primary Care Home Enrollment; and Initiation and engagement in drug and alcohol treatment. The full set of meeting materials is available on the Committee's website (see below).

At its next meeting on 15 March, the Committee will hear updates on development of an evidence-based obesity measure and the State Health Improvement Plan priorities. It will review measures related to oral health (oral evaluation for adults with diabetes and dental sealants for children); kindergarten readiness (preventive dental visits and well-child visits for ages 3-6); and, the weight assessment, nutrition, and activity counseling measure.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx
COMMITTEE POC: Sara Kleinschmit, SARA.KLEINSCHMIT@dhsoha.state.or.us

Health Information Technology Oversight Council

HITOC last met on February 7th. HITOC welcomed its six new members: Bill Bard (retired, consumer), Kacy Burgess (Deschutes County Health Services), Jennifer Clemens, DMD (Capitol Dental Care), Janet Hamilton (Project Access NOW), Anna Jimenez, MD (CareHere), and Bonnie Thompson, Greater Oregon

Behavioral Health, Inc., discussed how best to integrate OHPB's feedback on HITOC's recent report, and finalized HITOC's 2019 workplan. HITOC also reviewed a draft plan for showing Oregon's HIT progress via dashboards and the work planned on that topic in 2019. Finally, HITOC hosted a 90-minute panel on how organizations are using HIT to support work on the social determinants of health. The panelists were Mike Blythe and Ronda Lindley-Bennet of the Regional Health Information Collaborative, Linda Nilsen of Project Access NOW, and Coco Yackley of the Columbia Gorge Health Council. Meeting materials/recording are available here: https://bit.ly/2sGoO4S.

HITOC's next meeting is its annual retreat on April 4, 2019, from 9:00 am – 3:45 pm.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/HPA/OHIT-HITOC/
Committee POC: Francie Nevill, Francie.j.nevill@dhsoha.state.or.us

Medicaid Advisory Committee

The Medicaid Advisory Committee met on January 23rd. The meeting was primarily informational, and the committee received updates and overviews:

- Oregon's quality and metric framework for Medicaid; and
- The State Health Improvement plan and the current process to update the plan for 2020.

The Committee received information on the current stakeholder work to inform the creation of the next 5-year State Health Improvement Plan and expressed interest in using the finalized plan to inform its own work in the future. The committee also received a preview of the 2019 Legislative Session with a discussion focused on OHA-related bills sponsored by the Governor in 2019. The development of the OHA/MAC health-related services guidance (housing-related supports and services) is songoing.

The committee welcomed two new members at the January meeting, but also lost four members to expiring terms as of the end of January. OHA and the Governor's office are currently accepting and reviewing applications to join the Medicaid Advisory Committee and expect to make additional new appointments in the coming months.

The MAC will meet again on March 20th and will hear more about the Substance Use Disorder waiver currently under development and will discuss an updated version of the HRS Housing Guide also under development.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/hpa/hp-mac/pages/index.aspx
COMMITTEE POC: Tim Sweeney, Timothy.D.Sweeney@dhsoha.state.or.us

Health Equity Committee DRAFT

The Committee invited Ashley Horn, to spend some time with the full committee discussing the goals and objectives that the committee expects to fulfill at this year's HEC Retreat that will take place on March 4th and that Ashley will facilitate.
Last year's retreat was focused on relationship development, for this year's retreat there is the desire review the commitments that were set last year, HEC accomplishments, and build on successes.
HEC would like to accomplish the following: Use the retreat to deepen and strengthen relationships among HEC members and OHA staff; clarify and differentiate roles of HEC members, OHA staff, and other OHA divisions and groups; review commitments from 2018 retreat and progress made to date; address

HEC workgroup structures and expectations; consider workgroup goals and objectives and develop 1-2-year plans.
There was discussion about inviting stakeholders such OHA Director and OHPB liaison to join part of the retreat. The retreat planning committee will work on the plan with retreat facilitator.
HEC had a brief discussion about future OHPB liaison(s) to the Health Equity Committee and the need to potentially change HEC meetings schedule to accommodate their participation was revisited.
HEC workgroups provided their monthly reports, and there was discussion about ensuring retreat incorporates as an objective the development workgroup structures and expectations at the upcoming HEC retreat in March.
Next HEC meeting: Monday, March 4th, 9am – 4pm at Legacy Wellsprings Conference Center, Woodburn, Oregon
COMMITTEE WEBSITE: https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx
COMMITTEE POC: Maria Castro, Maria.Castro@dhsoha.state.or.us

Statewide Supportive Housing Strategy Workgroup

The workgroup's Permanent Supportive Housing Framework and Recommendations report is available online. The report contains recommendations regarding principles to guide permeant supportive housing, recommendations to strengthen cross agency collaboration and coordination, recommendations to expand permeant supportive housing through new and existing housing and service resources and recommendations for training and technical assistance to build permeant supportive housing capacity.

COMMITTEE WEBSITE: http://www.oregon.gov/ohcs/Pages/supportive-housing-workgroup.aspx.
COMMITTTEE POC: Kenny LaPoint, Kenny.LaPoint@oregon.gov

Measuring Success Committee

The Measuring Success Committee of the Early Learning Council met on Wednesday, February 6, from 1-4 at the Early Learning Division. The Committee heard an update on the final recommendations of the Health Aspects of Kindergarten Readiness workgroup. The workgroup will be presenting their incentive metrics package to the Metrics & Scoring Committee this summer for possible implementation in 2020. The Measuring Success Committee will consider two of those metrics (one relating to dental exams and one to well-child visits for young children) for inclusion in the early learning system dashboard for 2020, and two other measures to be developed (follow-up to developmental screening and social-emotional health) for future use.

In addition, the Committee heard from, and continues to follow-up with, several other sector representatives from OHA, DHS, Housing, K-12, and Early Care and Education in an effort to collaborate, use existing and meaningful data, and develop buy-in for shared ownership of the early learning system dashboard. In the upcoming months, the Committee will be completing its initial measure selection process and begin narrowing the potential measures to a manageable set for eventual recommendation to the Early Learning Council.

COMMITTEE WEBSITE: N/A
COMMITTEE POC: Thomas George, Thomas.George@state.or.us

Public Health Advisory Board (PHAB)
February 21, 2019
DRAFT Meeting Minutes

Attendance:

Board members present: Dr. David Bangsberg, Carrie Brogoitti (by phone), Dr. Bob Dannenhoffer, Muriel DeLaVergne-Brown, Dr. Katrina Hedberg, Kelle Little (by phone), Dr. Jeff Luck, Tricia Mortell, Alejandro Queral, Dr. Jeanne Savage, Dr. Eli Schwarz, Teri Thalhofer, Rebecca Tiel

Board members absent: Eva Rippeteau, Akiko Saito

Oregon Health Authority (OHA) staff: Christy Hudson, Katarina Moseley, Lillian Shirley (ex-officio)

Members of the public: None

Welcome and updates
Rebecca Tiel, PHAB Chair

Ms. Tiel welcomed the PHAB and asked the PHAB members to introduce themselves.

- *Approval of January 2019 Minutes*

A quorum was present. Mr. Queral moved for approval of the January 17, 2019, meeting minutes. Dr. Schwarz requested a correction of his last name on page 4. Ms. Tiel seconded the approval. The PHAB approved the meeting minutes unanimously.

- *OHPB Digest*

Dr. Schwarz noted that the digest is done very well and it is helpful in keeping track of the work done by the various subcommittees and workgroups. Ms. Tiel agreed.

Dr. Bangsberg added that the subcommittee discussions are documented well. He invited the PHAB members to speak up during subcommittee meetings so that action items are noticed.

- *Legislative Update*

No legislative update was provided.

Update on CCO 2.0
Rebecca Tiel, PHAB Chair

Ms. Tiel reminded the PHAB that the workplan is a living document and invited the PHAB members to review the workplan and ensure that the changes proposed during the January PHAB meeting have been made.

The PHAB members had no questions or comments about the workplan.

Update of CCO 2.0 RFP
Lillian Shirley

Ms. Shirley provided a disclaimer related to the largest RFA for the largest amount of money the state of Oregon has ever put out to bid. She cautioned the PHAB members about talking to external people about the RFA.

Ms. Shirley explained that recommendations went to the Oregon Health Policy Board about a year ago. What came through the PHAB was a question: Can we require a local public health authority voting member position on the CCO governing board? The answer is no, as that is not in the RFA. Oregon Statute 414627 does require of the CCOs to include representatives of each county government on the community advisory council. It is good to remember that CCOs are not-for-profit or for-profit individual corporations. The Department of Justice did not feel that a private company could be required to have certain board members.

Ms. Shirley added that the recommendation was that there would be a CCO voting member position on the local public health advisory committee when there was such a committee in a jurisdiction. That was not included in the RFA, because that is a decision of each local jurisdiction. The serve requirement that the PHAB requested was that LPHAs are compensated for public health contributions towards incentive measures. This has been partially addressed in the RFA and the contract does require CCOs to demonstrate and report on the amount and quality of their pool dollars that are being distributed to the public health and non-clinical providers. That information will be collected, reported, and publicly posted annually.

Ms. Shirley noted that this aligned with one of the goals of the Oregon Health Policy Board (OHPB), namely, asking for increased transparency. That was one of the initiatives to address that, as well as to align the CCO incentive measures with population health priorities to a feasible extent. The OHA believes that the CCOs made progress on that. Recommendation 3 does encourage the adoption of social determinants of health, health equity, and population health incentive measures. The RFAs will be scored on how well any given organization demonstrates that that is part of their plan. Policy work committees, including the PHAB, Accountability Metrics Subcommittee, Metrics and Scoring, and Health Plan Quality Metrics

Committee routinely consult on population health priorities during measure selection processes.

Ms. Shirley pointed out that another wish by the PHAB was to require CCOs to develop shared community health assessments and community health improvement plans with LPHAs and hospitals and require the use of community health assessment and community health improvement planning tools that meet the requirements for LPHAs and hospitals. In the RFA, the answer is yes. The contract requires CCOs to work with LPHAs, nonprofit hospitals, and other CCOs that share a portion of the service area. This is beyond the distribution of a governmental jurisdiction. Some counties had multiple CCOs and they had to come to the table around those priorities. In addition, with the federally recognized tribes in the service areas, CCOs have to include their prioritization and assessments in their final plans. The RFA does require applicants to provide information on current relationships, so the CCOs have to demonstrate that being a CCO is not only aspirational. They have to demonstrate and document their current relationships with the entities in their service area. The RFA also asks the CCOs to identify gaps in those relationships and they will be scored on having plans to address those gaps prior to any awards that are given. Beginning in 2020, after we have had some history of concrete documentation of how we can evaluate these relationships, the CCOs will be required to report the activities they have undertaken annually.

Ms. Shirley remarked that per the PHAB requirement for CCOs to invest in shared community improvement plan implementation, OHA feels that this is in the RFA. The implementation of House Bill 4018 requires CCOs to spend a portion of their net surplus on health disparities and social determinants of health, which includes spending on population health priorities. In the interim, the Oregon Health Policy Board requested that there was a standing committee for health equity, which is a new committee that will be also monitoring CCOs' implementation.

Ms. Shirley stated that there was nothing in the RFA around public health emergencies, such as participating in regional health coalitions. This is because CCOs do not provide services. The regional health coalitions are made up of hospital systems and provider groups. Most of the emergency preparedness work that goes on is directly to that and, a CCO, as a paying entity, is not involved in that planning.

Dr. Schwarz asked how the application would be scored. This is typically stated in a table that indicates the points that each section could receive. There was nothing like that in the RFA. Also, if a CCO applies to operate in a new area, how can it document its relationships with the new community?

Ms. Shirley responded that even if a CCO tries to operate in a new area, it is possible that the CCO has relationships through the providers. In terms of scoring, there are criteria, which will be shared with the PHAB as soon as they become available.

Ms. Tiel clarified that it is a request for application process, not a request for proposal process. Any entity that meets the requirements of the application gets to be awarded. It is more of a Pass-Fail than scoring.

Dr. Savage noted that there are a couple of places on the OHA's website where the RFA contracting section can be viewed. Under CCO 2.0 Reference Documents, there are two documents: RFA Community Engagement Plan Required Components and RFA Community Engagement Plan Required Tables. These documents explain the relationships that CCOs have to develop, even if they don't have them now, when they apply in the RFA. The CCOs have to invest in and document those relationships to get their RFA in.

Dr. Luck asked about the next steps after the Pass-Fail stage. Do entities that pass the RFA get to start negotiating with the OHA about becoming a CCO, or is there another process?

Ms. Tiel responded that the applications are due on April 22, 2019. Prior to that date, organizations have been submitting letters of intent and staking territory. The applications will be reviewed after April 22 until July. There will be public process and the organizations will have to do presentations in their communities.

Ms. Mortell expressed an appreciation of the conversation about other avenues for the important components of what LPHAs would like to do between public health and the health care system. For example, on the meningococcal vaccines – even though the language is not as strong as LPHAs would like, it is a starting point to continue building these relationships stronger and work through the internal systems to be stronger too.

Dr. Savage pointed out that during conversations with the medical directors of different CCOs, there is a discussion about local public health and the benefits and value of the public health system. There is a big appetite amongst the medical directors to have those relationships and to support each other. Everybody understands that nobody can do it by themselves. The medical directors are looking forward to building those relationships, if they don't currently have them. There is a system in how the money is given to LPHAs, and governed, in terms of how LPHAs then spread the money amongst contracts. The hard part about making more relationships isn't the desire to do it. It is the difficulty in trying to balance the money given to PCP and spread it through different areas.

Ms. DeLaVergne-Brown remarked that February 20, 2019, was Exclusion Day (i.e., all children who were not up-to-date or complete on their immunizations were excluded from their school or child care facility). While some communities have more providers, other communities, such as Crook County, have a few providers and they are booked a month and half out. It is impossible for children to get in for the immunizations. The system is built, but in many parts of the state access is still restricted. In Crook Country, the providers stayed open and, with the help of extra nurses, they took care of the children and sent them back to school.

Dr. Bangsberg provided comments on the process of things that went well and things that could be improved for CCO 3.0. What went well were the discussions at the PHAB meetings that were brought to the OHPB. The conversations with the CCOs showed that some of the work is being done, in terms of true partnerships with LPHAs. That made it into the 46 policies that were approved. OHA did the contracting language, which went for public comment. After public comment closed on a Friday or Monday, nobody could talk about it during the OHPB meeting the following Tuesday. Some of the reasons for why this couldn't be done, like having LPHAs on the board and requiring the contract, is that it put the LPHAs in veto power. They didn't want to work with a CCO that wouldn't be eligible for contract. Although that seems like a sensible reason, it was not what the PHAB intended. The PHAB wanted to encourage a partnership and it has put in a stronger language to encourage that partnership.

Dr. Bangsberg concluded that the lesson here for CCO 3.0 is that the step between developing the policy and the contract language is a very complicated step. There are unanticipated blocks that the PHAB didn't think of, or the OHPB didn't think of, that are recognized in the final drafting of the contract. It would be nice to have an iterative step somewhere in the process. For CCO 3.0, it would be good to read the contract, then touch base with OHA, and see if there are other ways to do the contract language. This way, we could be 90 percent of the way there.

Ms. Thalhofer asked Ms. Shirley and Dr. Bangsberg if it was intended for the geographic boundaries to change every five years.

Ms. Shirley responded that it isn't an intention to do that. There's nothing to stop that from happening.

2020-2024 State Health Improvement Plan
Christy Hudson

Ms. Tiel reminded the PHAB that the PartnerSHIP is a group that has been coming together at the community-based steering committee for developing the next state improvement plan. The group convened on February 12, 2019, to finalize the priorities. This is important to the PHAB because this work falls into the public health block grant and the PHAB is the advisory committee to that group.

Ms. Shirley noted that Ms. Hudson has done an amazing job. She has been a public health warrior around this and deserves credit for that.

Ms. Hudson thanked Ms. Shirley and shared with the PHAB that OHA just completed a significant community engagement effort and this presentation would be about what we heard and learned from communities. The last time Ms. Hudson presented to the PHAB was after the PartnerSHIP had its second meeting at which the partners were tasked with identifying 12

issues that they harvested out of data that OHA had put out in the State Health Assessment and the State Health Indicators. The communities landed on 14 issues. Because we couldn't have 14 priorities, we asked the communities for additional feedback and to further prioritize these issues.

Ms. Hudson stated that there were three avenues for getting input: (1) Online survey in English and Spanish, (2) Mini-grants to community-based organizations, (3) Other community forums (e.g., letters, emails, comments on Twitter and Facebook). Over 2,500 people provided feedback. The sample was racially representative, more women than men responded, people will less education were underrepresented, disability and LGBTQ community was represented, areas outside of the I-5 corridor were represented, and youth voice (under 18) was not present.

A PHAB member asked whether the 2,500 participants were known, to which Ms. Hudson answered that the survey was anonymous. In the OHA survey, participants were directed to sign up for a SHIP listserve, so that OHA could stay in touch with them. For individuals who engaged through the community-based organizations, OHA intentionally made their contracts go through the end of September. This aligned with the block grant, which funds that work, but we also wanted a mechanism to ensure that we had a communication route back to communities. Part of their contract is ensuring that communication gets back to individuals who participated.

Ms. Hudson presented a summary of the data collected from seven communities: Eastern Oregon Center for Independent Living (150 participants), Micronesian Islander Community (65 participants), Northwest Portland Area Indian Health Board (215 participants), Q Center (219 participants), Self-Enhancement Incorporated (54 participants), Next Door (137 participants), Unite Oregon (164 participants). In terms of priorities, the top five included housing (77%), mental health care (69%), adversity, trauma, and stress (55%), living wage (48%), substance abuse (44%), and access to care (42%).

Dr. Schwarz asked if Ms. Hudson could unpack the category Access to Care. Ms. Hudson responded that when these issues came out of the PartnerSHIP, OHA asked the organizations what they meant by "access to care." There was a short description in the survey about what it was meant by "access to care," which included access to medical care and oral health care. This category was separate from Mental Health Care. The PartnerSHIP really wanted to look at Mental Health Care as a separate category from Access to Care.

Ms. Hudson added that other topics that were important to the community participants included education, transportation, older adults, social cohesion, chronic pain, oral health, social services, and vaccinations. In terms of priorities by education (high school diploma, GED, or less than high school), 91 participants indicated the top five priorities, plus food insecurity. For priorities by sexual orientation, 332 participants indicated the top five priorities, plus institutional bias. For priorities by youth, 17 participants indicated climate change, suicide, and

institutional bias as three of the top six priorities. Interestingly, American Indian/Alaska Natives (65 participants) indicated adversity, trauma, and stress at their top priority (68%).

Ms. Hudson summarized that based on this feedback, the PartnerSHIP identified five 2020-204 priorities: (1) institutional bias, (2) adversity, trauma, and toxic stress, (3) economic drivers of health (i.e., housing, living wage, food insecurity, transportation), (4) access to equitable, preventive health care, (5) behavior health (including mental health and substance use).

Dr. Schwarz asked if the economic drivers were the social determinants of health. Ms. Hudson responded that social determinants also include environmental health and education, among others. Dr. Bangberg added that the economic drivers are a subset of the social determinants of health. Dr. Schwarz noted that, for him, social determinants of health are very conceptual unless the concept is broken down by the actual issues. This is what the participants have reported. Education, for example, is not listed anywhere. This means the people do not think that education is a barrier.

Ms. Hudson explained that education was not one of the original 14 priorities. It did come up in the comments. Education was brought in as an issue for consideration with the PartnerSHIP last week. The structure of the subcommittees that are going to be stood up to inform the strategies that get developed will include representation from Department of Education. We will likely see education threaded throughout as a factor that will be involved. Education might appear as a factor when the economic drivers of heath are discussed.

Ms. Thalhofer remarked that she is a member of the Early Learning Council, and the council just released the state strategic plan for early learning system, called Raising Up Oregon. The plan is cross-walked with several plans, including the Oregon Health Authority's and the Governor's priorities. The similarities between the plans are huge. The issues that impact how we prepare kids for school are the same as the PartnerSHIP priorities. Education has become a subset of the chaos families have to live through. We have gotten so far down on the hierarchy of needs that things that we used to take for granted, such as housing and living wage, are gone. Families can't think about education because it is the next step.

Ms. Thalhofer added that it is sad to see this happen to working families in our lifetime. We have lost a middle class that worked hard and had prosperity. We are at the point where families are trying to get housed and they can't think about education yet. We have taken a giant step backwards.

Dr. Dannenhoffer praised the process for collecting the feedback. However, compared to the last SHIP, none of the eight priorities in the last SHIP made it into the new SHIP and none of the new SHIP priorities were in the last SHIP. It will be interesting, in retrospect, 20 years from now, to know which one was more correct, the previous one or this one. The last plan also had very specific bullets underneath it, such as improve immunization rates. With the new priorities, we

could be having a harder time getting the directly measurable bullets underneath. The list of the new priorities looks a bit simplistic, which could be a better way to go, but it will be interesting to see how we get there.

Ms. Hudson explained that the new priorities are grounded in the community voice and that they will get us in the right direction. These priorities also align with some other efforts, such as Governor Brown's policy priorities, as well as with the priorities in the recent Trust For America's Health report Promoting Health and Cost Control in States.

Ms. Hudson concluded that subcommittees are being formed with PartnerSHIP members, subject matter experts, cross-sector partners (i.e., partner state agencies), and people with lived experience. The groups will start convening later this Spring and will continue working until early next year. They will identify strategies, measures, and action steps, as well as solicit additional feedback from the community later this summer.

Dr. Schwarz commented that there have been other PHAB presentations, which showed what people were dying of, and how long people lived, and how the life-expectancy has come down in America due to various factors. In the Australian model just presented, life expectancy and mortality rates at the top. These are more objective metrics, which would say something about the health of the community from a more objective point of view. The question is: How do we get intentions and wish lists aligned with the problems as they are documented by the epidemiological data?

Ms. Shirley pointed out that the State Health Improvement Plan is our direction. The priorities do not reflect what people want. It is felt need rooted in the community. The priorities give us a way to organize our work and figure out the priorities that are driving us to change those outcomes that we obtain with our regular, epidemiology metrics. Epidemiology tells us what is happening. These priorities are helping us think through what we can do about what is happening. We should include this for any further presentations. This is aligned with the Early Learning Council's strategic directions. In terms of socializing this particular process, which is a Public Health best practice, we are trying to get people to understand that this is a state health improvement plan. It is not a public health department improvement plan. We still have all our outcomes and measures and business practices for which we are still accountable.

Ms. Thalhofer remarked that she saw the presented priorities as the subjective part of the plan. Epidemiological data is needed to support this subjective work before an assessment is made. Data that backs this up is most likely available at the Public Health division and other community partners. This information must be part of the plan, because we know that tobacco usage and obesity are still killing lots of Oregonians and we can frame them under the new priorities. We need to continue pointing that out with the data we know about what is harming Oregonians and how that is happening.

Dr. Luck suggested that the PHAB should reconsider the proposed Health Equity framework. The Health Equity Committee agreed on using a framework developed by the Robert Wood Johnson Foundation that talks about historic inequities leading to health disparities. Perhaps the SHIP should look at that framework as a way to align its work with what OHA is doing and what the federal government is doing. While the concepts are similar, the more we can have shared health equity concepts and definitions, the better our chance at realizing Ms. Shirley's vision of this being a state plan that everybody works toward.

Incentives and Funding Subcommittee
Alejandro Queral

Mr. Queral informed the PHAB of the subcommittee's discussion during its meeting on February 12, 2019. At the center of the discussion was a question: How do we move forward with the available funding for Public Health Modernization investments for 2019-2021, if funding remains at the $5 million level ($3.9 million to LPHAs)? Dr. Dannenhoffer proposed to continue as before for the start of the new biennium. If additional funding is available through new tobacco tax revenue or increased General Fund investment, a new structure should be developed to account for the additional money. During the subcommittee meeting, Dr. Dannenhoffer suggested three principles of the funding: 1) to encourage regionalization, 2) to fill gaps in funding so personnel is not lost, and 3) to fund successful projects that have great promise for the future.

Ms. Thalhofer suggested that there needs to be some evaluation of how those county-to-county cross-jurisdictional relationships have worked. These cross-jurisdictional relationships can be country-to-CCO, country-to-FQHC. It may work better if the jurisdictions are not LPHA-to-LPHA, but LPHA-to-something-else. That may be more applicable in some areas than it is in others. We should not force one model across the state because it is square peg-round hole.

Ms. Mortell echoed Ms. Thalhofer's remarks by noting that it is regional approaches, or regional projects, or regional configurations. The regional in epidemiology is different than cross-jurisdictional sharing of everything. The principle of regionalization is a principle of regional approaches, or regional systems, or centers of excellence.

Mr. Queral stated that the conversation highlights the importance of having some amount of dollars available for an assessment of the different models. Not to compare them necessarily against each other, but to understand where the partnerships are leading to real success. The assessment will help us explain why certain models are working better than others.

Dr. Schwarz asked when we will know how much funding we get from the legislature. A few PHAB members responded that we will know in July.

Ms. Moseley added that the subcommittee should be contemplating the best directions to go, based on what happens in the next three months. If we are looking at having a very large investment come through in the last six months of the biennium, what is the best way to prepare the system to succeed in using that toward outcomes.

Mr. Queral responded that the answer is yes. The subcommittee is approaching it by looking at different scenarios and how to prepare for those two alternatives.

Accountability Metrics Subcommittee
Teri Thalhofer

Ms. Thalhofer informed the PHAB that the subcommittee met on February 13, 2019. It reviewed a draft of the public health accountability metrics report. The subcommittee gave some input on what it would like to see in the executive summary. The subcommittee also went through each of the outcomes and process measures and gave input and asked for clarification. The report was reviewed at the CHLO meeting this morning. The report will be presented to the PHAB in March.

Dr. Schwarz asked about CHLO's comments.

Ms. Thalhofer stated that the CHLO gave extensive feedback on the report. The important thing to remember is that even though this report is prepared for the legislature, the modernization funding is not yet reflected in the data that the subcommittee was able to put in the report. The changes in outcome metrics are not a reflection of the investment of the legislature. Overall, the report shows that public health is making a difference, but we cannot say that it is because of the investment. Although the report is for the legislature, most of the local public health administrators are using it with local commissioners and CCO partners, among others. The users of the report must be well-versed in what the report is saying and how to talk about things, such as gonorrhea rates going up, because we are discovering more of it. We are still having providers in our communities that are surprised that gonorrhea is back. It takes some education to bring people up to speed.

Public Comment Period

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

Closing

Ms. Tiel thanked the PHAB for their time and adjourned the meeting.

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

March 21, 2019
2:00-5:00 p.m.
Portland State Office Building
800 NE Oregon St Room 1B
Portland, OR 97232

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

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics Subcommittee meeting minutes

March 4, 2019
1:00-2:00 pm

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

Oregon Health Authority staff: Sara Beaudrault, Myde Boles, Sara Kleinschmit

Guest presenter: Will Brake, Chair of CCO Metrics and Scoring Committee

Welcome and introductions

Minutes from the February 13, 2019 meeting were approved.

Discussion with Metrics and Scoring on using metrics to achieve health improvements

Sara Kleinschmit and Will Brake provided an overview of the CCO Quality Incentive Program. Metrics are one piece of the overall accountability structure for CCOs. The CCO Metrics and Scoring Committee selects CCO incentive measures from the measure menu created by the Health Plan Quality Metrics Committee. The Metrics and Scoring Committee is committed to using incentive measures to improve health through health system transformation and cross-sector collaboration. Sara and Will highlighted some measures under consideration for the 2020 measure set, including health aspects of kindergarten readiness, initiation and engagement in drug and alcohol treatment, adolescent immunizations, and a health equity measure that is currently under development. Sara and Will also reviewed developmental measurement areas including kindergarten readiness, an evidence-based obesity measure, and a social determinants of health measure.

Eli noted the challenge of developing and using measures that are not part of a validated measure set like NQF. He mentioned use of measure selection criteria and opportunities to line up with the State Health Improvement Plan or other policies and priorities.

Muriel requested additional information on the Health Aspects of Kindergarten Readiness measure that's under consideration for the CCO 2020 measure set.

Jeanne asked about an evidence-based obesity measure and interventions to address obesity. Sara stated that the Health Evidence Review Commission has published multisector interventions for prevention and treatment of obesity, which are policy and community-based interventions that CCOs can use.

Jeanne stated that CHP priorities in her area of the state include housing and behavioral health. Eli stated that there is a bias toward physical health in the CCO metrics set. Jeanne stated that when topics like housing and behavioral health are not reflected in the CCO incentive measure set, it is challenging to incentivize or pay behavioral health providers for their work. There is an opportunity to do more.

The group ran out of time for further discussion. We will schedule a follow up meeting between PHAB Accountability Metrics subcommittee members and Will Brake and Sara Kleinschmit.

2019 Public Health Accountability Metrics Report

Myde reviewed changes to the Executive Summary and Introduction sections of the report. Subcommittee members made a recommendation for PHAB to review and hold a vote to approve the report at the March meeting.

Subcommittee business

Myde will present the 2019 report at the March 21 PHAB meeting. There's no need for a subcommittee member to provide an update at the March meeting.

The next meeting is scheduled for Monday, April 1 from 1:00-2:00.

Public comment

No public comment was provided.

Adjournment

The meeting was adjourned.

The next Accountability Metrics Subcommittee meeting is scheduled for March 4 from 1:00-2:00.

DRAFT

Public Health Accountability Metrics

Annual Report
March 2019






Oregon Health Authority

About this Report

Welcome to Oregon Health Authority's Public Health Accountability Metrics Annual Report.

Public health accountability metrics bring attention to Oregon's health priorities and the tireless work of the public health system to achieve better outcomes. In June 2017, Oregon's Public Health Advisory Board established a set of accountability metrics to track progress toward population health goals in a modern public health system. Accountability metrics are one way Oregon's public health system demonstrates it is improving health and effectively using public dollars. These metrics show where Oregon is making progress, as well as help identify where new approaches and focus are needed.

This report fulfills statutory requirements under ORS 431.139 for reporting on public health accountability metrics.

For questions or comments about this report, or to request this publication in another format or language, please contact the Oregon Health Authority, Office of the State Public Health Director at:

(971) 673-1222 or PublicHealth.Policy@state.or.us

Table of Contents

The Oregon Health Authority, Public Health Division acknowledges the tremendous work of the Public Health Advisory Board, and specifically members of the Accountability Metrics subcommittee, for establishing and updating accountability metrics for Oregon's public health system. Subcommittee members reviewed hundreds of potential measures over the course of nearly two years to arrive at a set of measures that reflect Oregon's population health priorities and the important work of the governmental public health system. Thank you!

Executive Summary

Oregon's public health system is changing how it prevents disease and protects and promotes health. A modern public health system ensures critical public health protections are in place for every person in Oregon, that the public health system is prepared and has the right resources to address emerging health threats, and that the public health system is engaged daily to eliminate health disparities.

Public health accountability metrics are one way Oregon's public health system demonstrates it is improving health and effectively using public dollars through a modern public health system. Established by the Public Health Advisory Board in 2017, public health accountability metrics reflect population health priorities for public health programs and highlight the daily work of local public health authorities (LPHAs) to achieve population health goals.

The 2019 Public Health Accountability Metrics Annual Report provides an in-depth look at how Oregon's public health system is doing today compared to a year ago on key health issues like childhood immunization, tobacco use and prescription opioid mortality, and access to clean drinking water. Key findings from the report include:

- **The 2017 legislative investment in public health modernization is strengthening capacity for improving childhood immunization rates.** Immunization quality improvement programs are a proven strategy for improving childhood immunization rates. Many LPHAs are using public health modernization funding to strengthen partnerships with health care providers for immunization quality improvement. As a result of increased local capacity and strong state-local partnerships, in 2018 LPHAs exceeded the 25% benchmark for the percent of Vaccines for Children clinics participating in the Assessment, Feedback, Incentives, and eXchange (AFIX) quality improvement program, increasing from 14% to 28% in a single year.
- **Rates of gonorrhea continue to increase at an alarming rate, from 107 per 100,000 in 2016 to 121 per 100,000 in 2017.** Oregon, like much of the nation, continues to experience an alarming increase in gonorrhea cases; however, it's rate is still below the 2017 national rate of 172 per 100,000. A sufficiently-resourced public health system, working with the health care system, has the tools to control and prevent the spread of gonorrhea. State and local public health authorities identify where cases are occurring and make sure both the infected individuals and their partners are properly treated. Some LPHAs are using public health modernization funding for interventions to increase capacity for gonorrhea case tracking and case management, and there were modest improvements in these processes from 2016 to 2017. Any additional improvements resulting from the investment will be reflected in next year's report.
- **Prescription opioid mortality rates are on the decline.** This report shows an overall improvement in the rate of prescription opioid deaths, with Oregon meeting the statewide benchmark of three deaths per 100,000 population in 2017. While we recognize this success, Oregon has a long way to go in solving the opioid crisis. This improvement must be considered within the broader context of illicit opioid deaths and overdoses not resulting in death.

Executive Summary

- **Public health brings health considerations to the forefront in land use and transportation planning.** Communicating about health effects of land use and transportation planning and supporting strategies that promote health is an emerging area for a modern public health system. For the first time, this report shows LPHA involvement in local planning initiatives for active transportation, parks and recreation and land use. In 2018 more than half of LPHAs were involved in local initiatives, ensuring that health is a consideration in local land use and transportation planning.
- **Health outcomes vary across racial and ethnic groups.** Wherever possible, this report displays rates by race and ethnicity, and for many health outcomes disparities exist across racial and ethnic groups. Between 2016 and 2017, gonorrhea rates increased for almost every racial and ethnic group, but the rate of increase was highest among Native Hawaiians/Pacific Islanders and American Indians/ Alaskan Natives. And while this year's report shows that adult smoking prevalence decreased for all racial and ethnic groups, rates of tobacco use remain higher for African Americans and American Indians/Alaskan Natives.

  Differences in rates across racial and ethnic groups occur because of generations-long social, economic and environmental injustices that result in poor health. These injustices have a greater influence on health outcomes than biological or genetic factors or individual choices. Public health authorities have a responsibility to address the social conditions and correct historical and contemporary injustices that undermine health. One way the public health system begins to do this is by collecting and reporting data that show where health disparities exist and the underlying causes for why certain racial and ethnic groups experience poorer health.

Oregon is committed to being a state where health is within reach for everyone. A modern public health system that works daily to prevent disease, protect and promote health, and eliminate the root causes of health disparities is essential for achieving Oregon's vision.

Moving forward, annual reports will provide the public health system and its partners and stakeholders the information that is needed to understand where Oregon is making progress toward lifelong health for all, and where new approaches and additional focus are needed.

Introduction

Background

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

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

Public health funding for accountability metrics

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

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

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

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

Introduction

Purpose of this report

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

Reporting by race and ethnicity

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

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

Annual public health accountability metrics reports help to achieve the following core roles of the public health system[1]:

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

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

[1] Oregon Health Authority 2017). Public Health Modernization Manual. Available at: https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf.

Introduction

Framework for public health accountability metrics

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

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

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

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

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

Communicable Disease Control

Prevention and Health Promotion

Environmental Health

Access to Clinical Preventive Services

Table 1. Public Health Accountability and Developmental Metrics

PART 1: ACCOUNTABILITY METRICS

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

PART 2: DEVELOPMENTAL METRICS

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

Introduction

Sources for population health data

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

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

Technical details about health outcome and process measures

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

DRAFT

Childhood Immunization

Health Outcome Measure

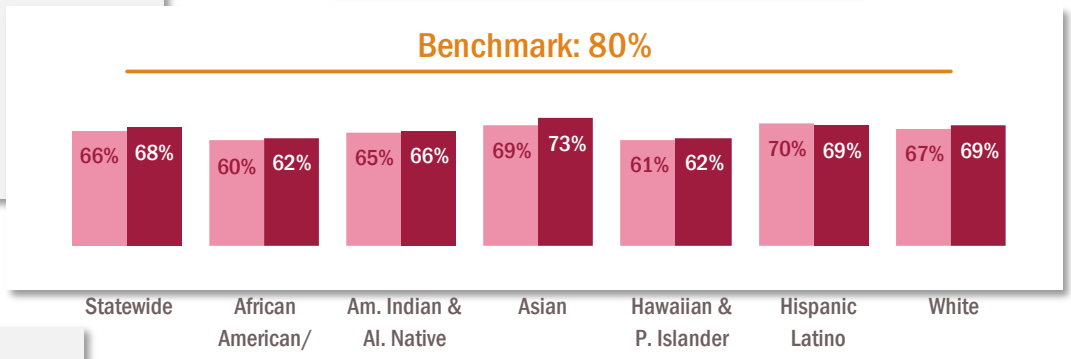
Percent of two-year olds who received recommended vaccines

Foundational program area: Communicable Disease Control

Data source: ALERT Immunization Information System

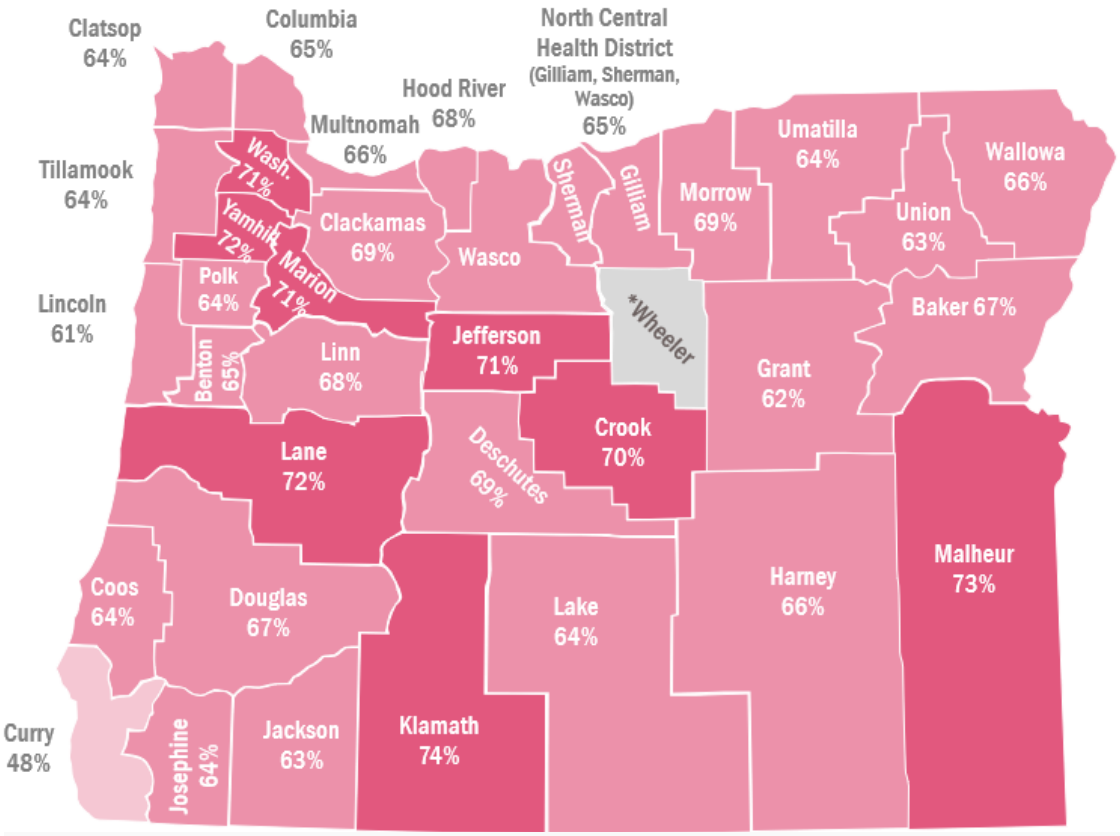
Benchmark source: 80%, Oregon State Health Improvement Plan (SHIP) 2020 target

By race and ethnicity



By county

Oregon 2017



Benchmark:

80%

Legend

- 0-59%
- 60-69%
- 70-79%
- 80-100%
- *Suppressed

Notes:

- Two-year olds are children 24 to 35 months of age residing in the county.
- The official childhood vaccination series is 4 doses of DTaP, 3 doses IPV, 1 dose MMR, 3 doses Hib, 3 doses Hep B, 1 dose Varicella, and 4 doses PCV (4:3:1:3:3:1:4 series).
- Percentage is calculated by dividing the number of children 24-35 months of age in each county who received the vaccination series (numerator) divided by number of children 24-35 months of age in each county (denominator). Numerators and denominators are not publicly available.
- Race and ethnicity categories are not mutually exclusive. One individual may contribute to one or more categories.
- * indicates where rates are not displayed for populations of fewer than 50 people in accordance with Oregon Health Authority, Public Health Division confidentiality policy.

Childhood Immunization

Local Public Health Process Measure

Percent of Vaccines for Children clinics participating in AFIX

Foundational program area: Communicable Disease Control

Data source: Assessment, Feedback, Incentives, and eXchange (AFIX) online tool

Benchmark source: 25% provided by Oregon Health Authority, Public Health Division, Immunization Program

Local public health funding

OHA funds all local public health authorities (LPHAs) to provide immunization services.

Beginning in July 2018, LPHAs are required to conduct outreach to engage health care providers in AFIX.

Some LPHAs are using 2017-19 public health modernization funding to increase the percent of Vaccines for Children providers participating in AFIX.

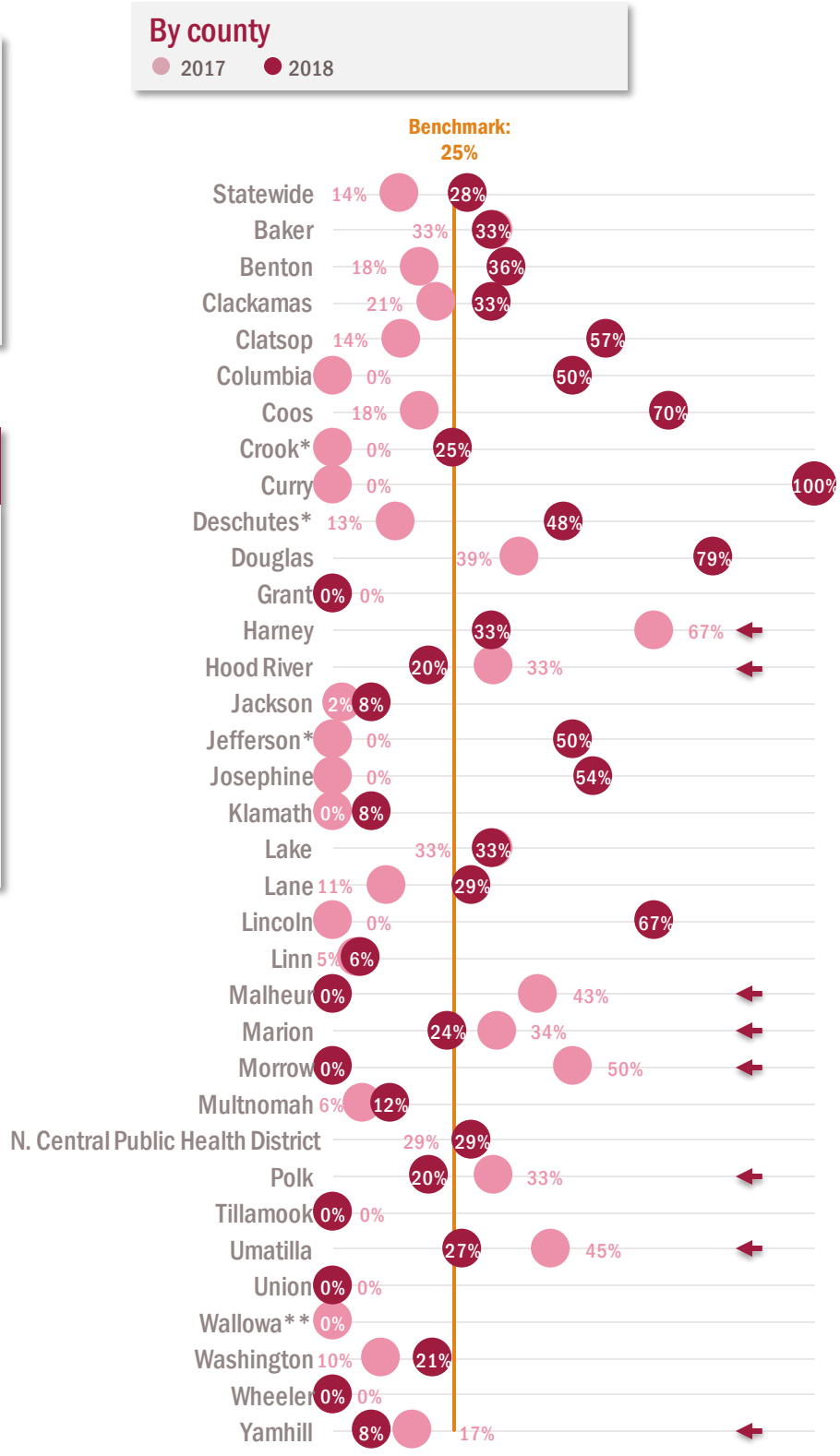
Benchmark:

25%

Notes:

- Percentage calculated by dividing the number of clinics with any AFIX visits initiated (numerator) by the number of clinics active in Vaccines for Children (VFC) (denominator). Numerator and denominator data are provided in the Technical Appendix.
- * indicates counties that completed their own AFIX visits in 2017, but these visits did not meet the CDC data reporting requirements and are not counted toward the process measure.
- **Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.

By county



Gonorrhea Rate

Health Outcome Measure

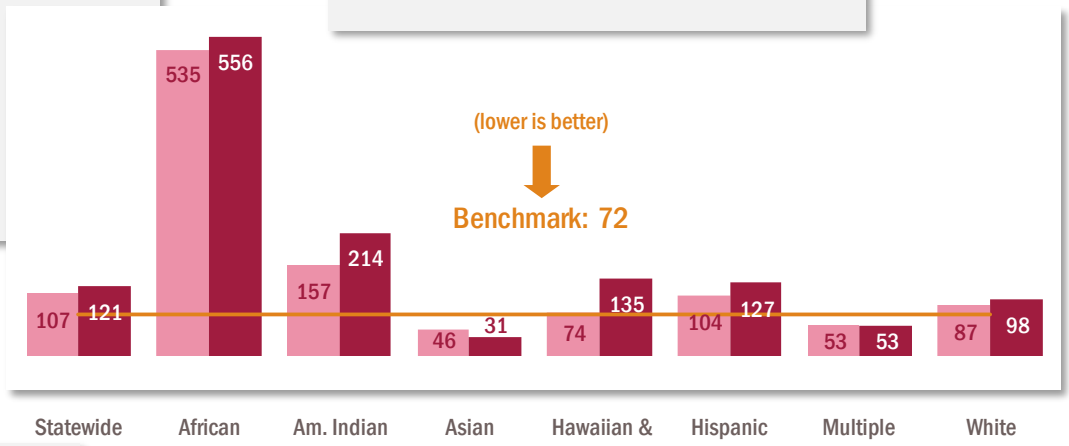
Gonorrhea incidence rate per 100,000 population

Foundational program area: Communicable Disease Control

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

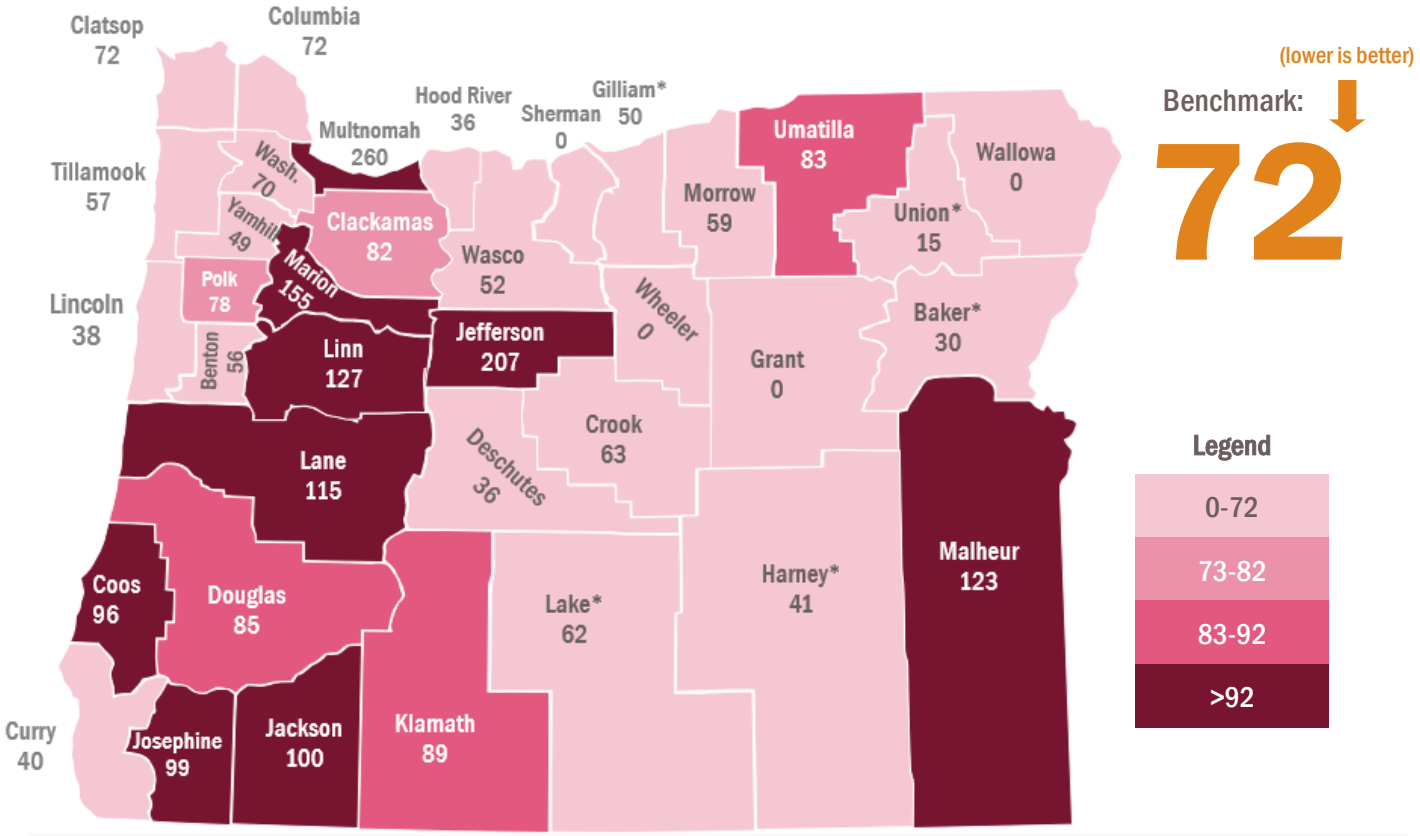
Benchmark source: 72/100,000, Oregon State Health Improvement Plan (SHIP) 2020 target

By race and ethnicity



By county

Oregon 2017



Notes:

- Population for rates by county use PSU Certified Population Estimates 2017. Population for rates by race and ethnicity use US Census Bureau Population Estimates, vintage 2016 and vintage 2017.
- All rates shown are crude rates (not age adjusted rates) and are calculated by identifying the total number of incident cases in a specified geographic area (numerator, Orpheus case counts) and dividing by the total population for the same geographic area during calendar year (denominator) and multiplied by

Gonorrhea Rate

Health Outcome Measure

Gonorrhea incidence rate per 100,000 population

100,000. Numerator and denominator data are provided in the Technical Appendix.

- Race/ethnicity data excluded cases with the following categories: missing, other, refused, “refused unknown”, unknown, and “unknown other”.
- * indicates rates for counties based on 1–5 events and are considered unreliable.

Gonorrhea Rate

Local Public Health Process Measure

Percent of gonorrhea cases that had at least one contact that received treatment

Foundational program area: Communicable Disease Control

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

Benchmark source: 35%, provided by Oregon Health Authority, Public Health Division, HIV, STD and TB Section

Local public health funding

OHA funds all local public health authorities (LPHAs) for communicable disease investigations, including those for sexually transmitted diseases (STD).

Beginning in January 2018, OHA provides funding to some LPHAs to conduct partner services for HIV and STD cases.

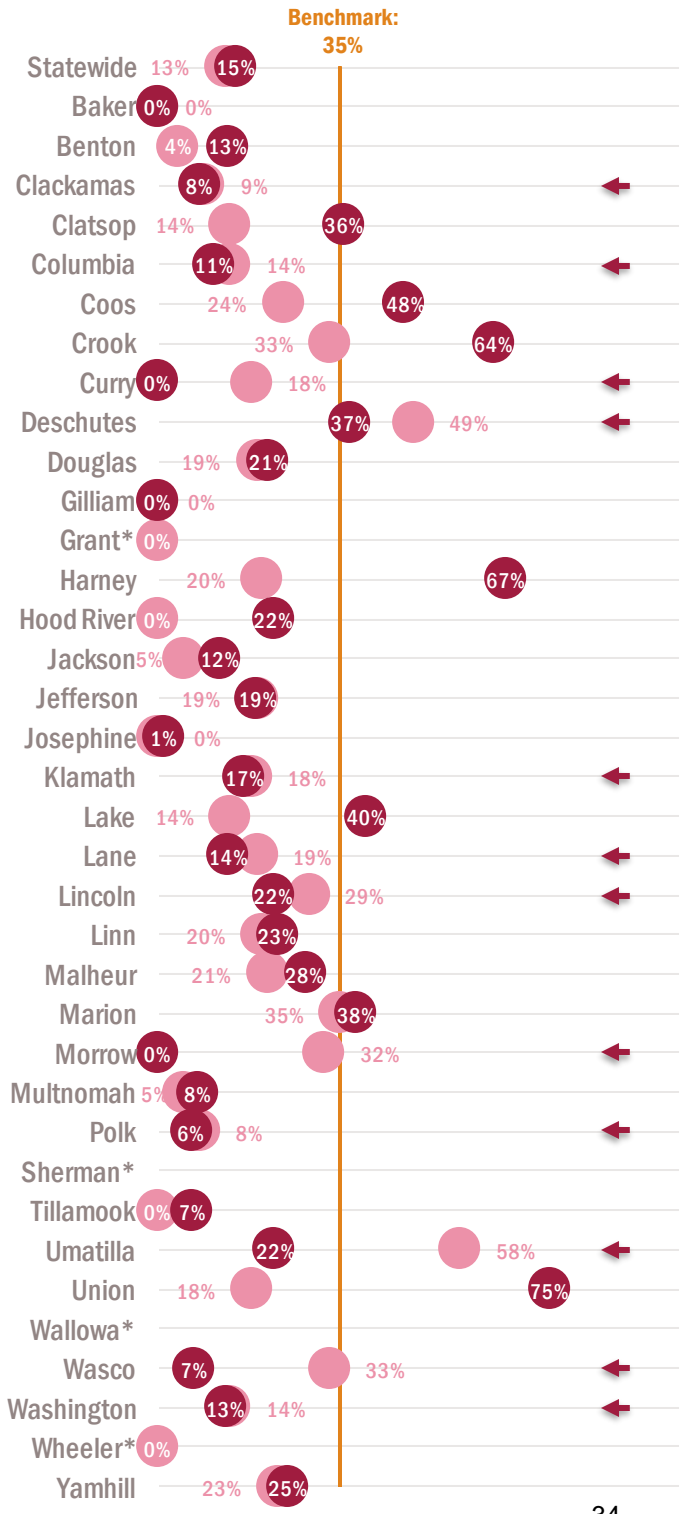
Some LPHAs are using 2017-19 public health modernization funding to improve gonorrhea investigations and case management.

Benchmark:

35%

Notes:
- Percentages are calculated by identifying gonorrhea cases with at least one contact with treatment or Expedited Partner Therapy (EPT) documented on the contact record (numerator) and dividing by all confirmed or presumptive gonorrhea cases reported during the calendar year (denominator). Numerator and denominator data are provided in the Technical Appendix.
- * indicates counties that had 0 gonorrhea cases in 2016 and/or 2017.

By county



Gonorrhea Rate

Local Public Health Process Measure

Percent of gonorrhea case reports with complete priority fields

Foundational program area: Communicable Disease Control

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

Benchmark source: 70%, provided by Oregon Health Authority, Public Health Division, HIV, STD and TB Section

Local public health funding

OHA funds all local public health authorities (LPHAs) for communicable disease investigations, including those for sexually transmitted diseases (STD).

Beginning in January 2018, OHA provides funding to some LPHAs to conduct partner services for HIV and STD cases.

Some LPHAs are using 2017-19 public health modernization funding to improve gonorrhea investigations and case management.

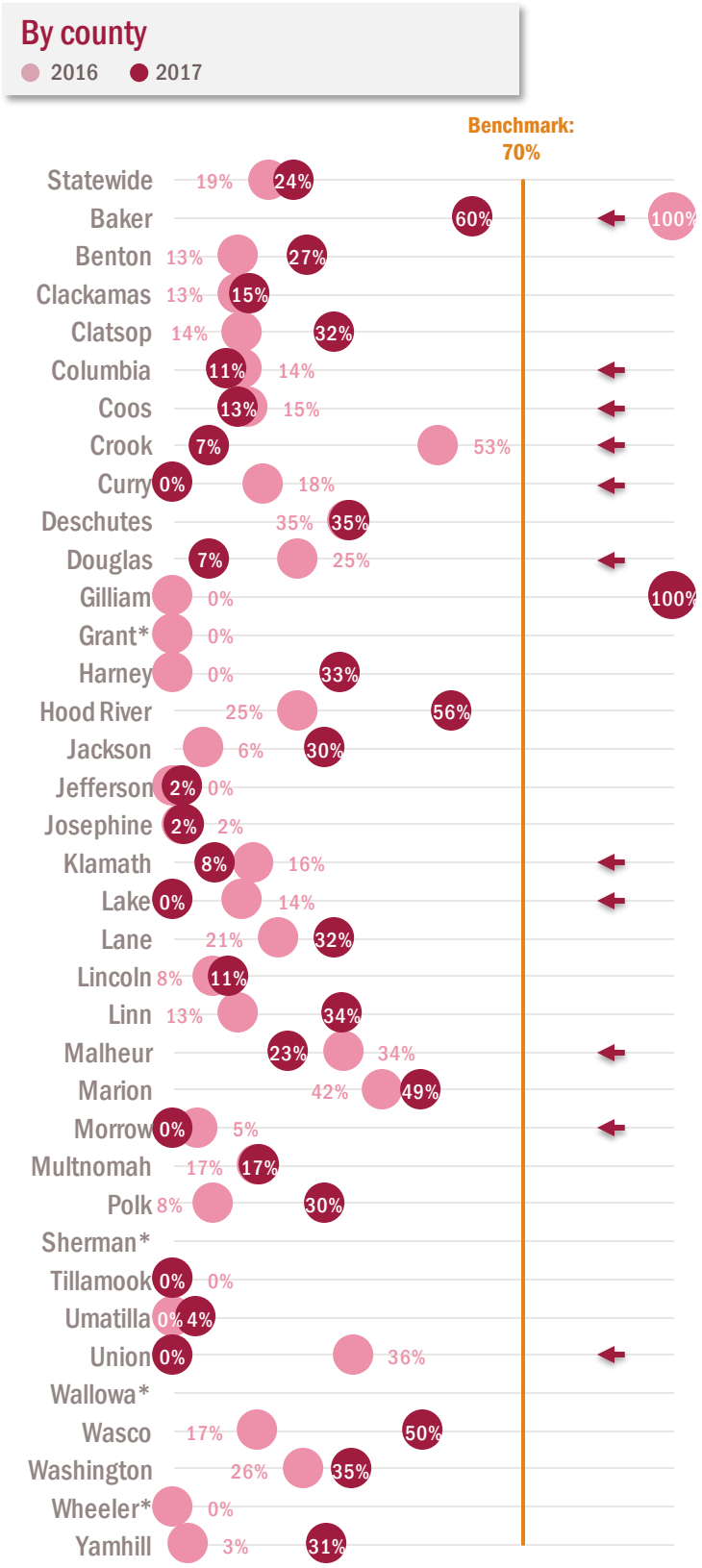
Benchmark:

70%

Notes:

- Priority fields include race, ethnicity, gender of sex partner, pregnancy status, and HIV status/date of last HIV test. Priority fields (race, ethnicity, and pregnancy status) are considered complete if they are not unknown or refused.
- Percentages are calculated by identifying gonorrhea cases with a response for each priority field (numerator) and dividing by all confirmed or presumptive gonorrhea cases reported during the calendar year (denominator). Numerator and denominator data are provided in the Technical Appendix.
- * indicates counties that had 0 gonorrhea cases in 2016 and/or 2017.

By county



Adult Smoking Prevalence

Health Outcome Measure

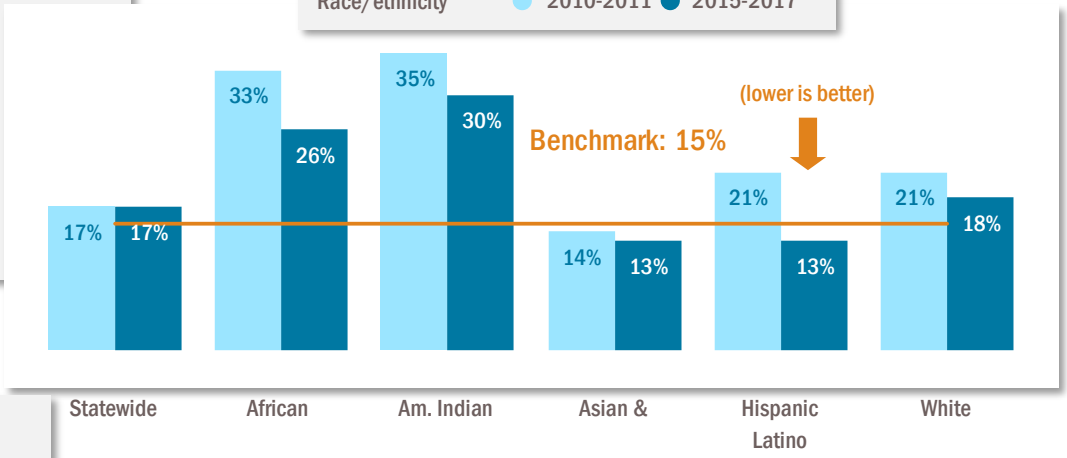
Percent of adults who smoke cigarettes

Foundational program area: Prevention and Health Promotion

Data source: Oregon Behavioral Risk Factor Surveillance System (BRFSS)

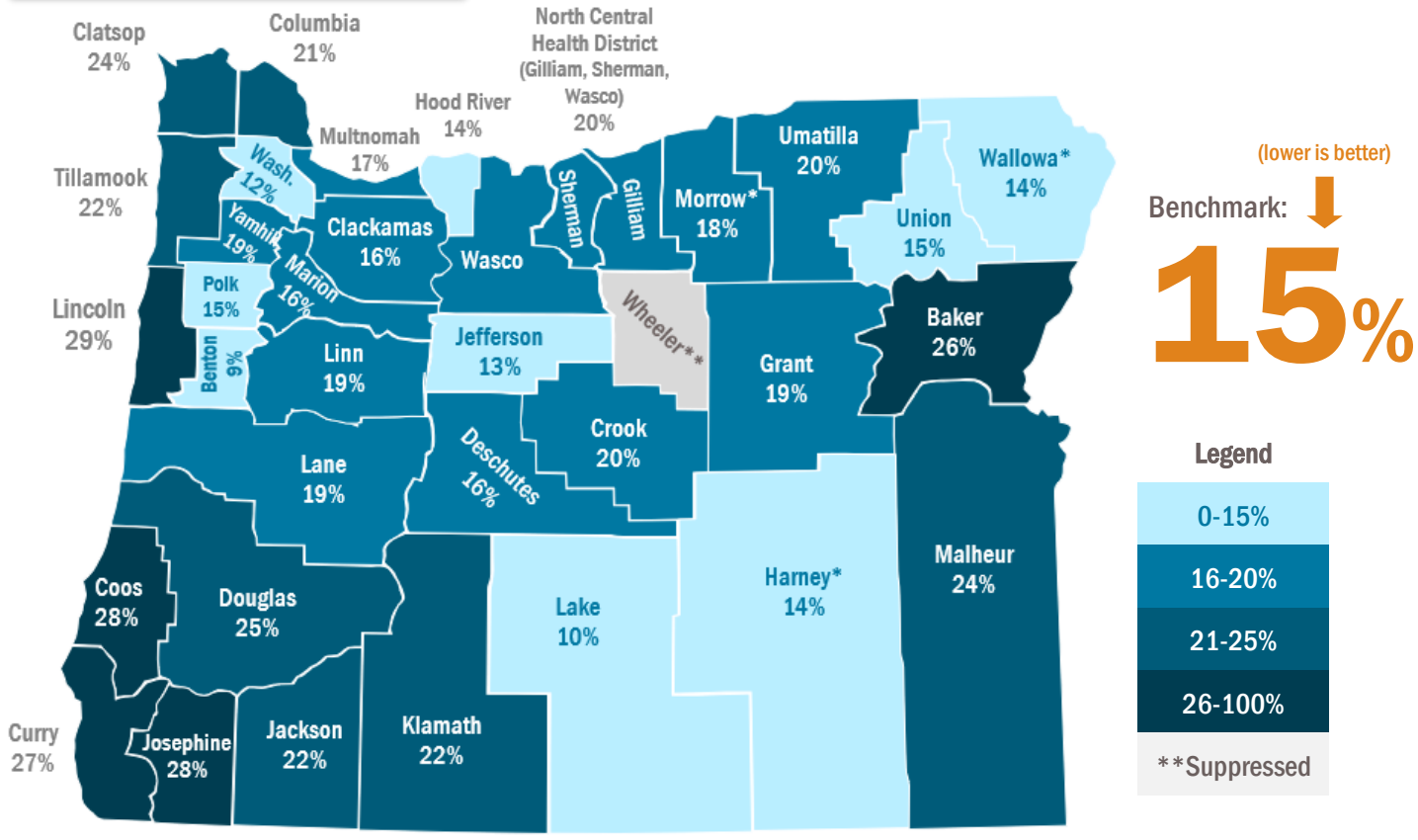
Benchmark source: 15%, Oregon State Health Improvement Plan (SHIP) 2020 target

By race and ethnicity



By county

Oregon 2014-2017



Notes:

- Race/ethnicity data are combined for years 2015-2017, the most recent year for which reporting from a race/ethnic oversample is available.
- County data are combined for years 2014-2017; statewide rate is for 2017.
- Statewide, county, and race/ethnicity rates are age adjusted.
- Survey includes only people age 18 and older. The 2017 BRFSS sample was 9,382.
- Survey responses are weighted. Numerator and denominator data are not provided for weighted survey estimates. Refer to the Technical Appendix for details about weighting procedure.

Adult Smoking Prevalence

Health Outcome Measure

Percent of adults who smoke cigarettes

- Confidence intervals are not shown. Refer to the Technical Appendix for additional information regarding reporting of confidence intervals.
- * indicates county estimates with a relative standard error (RSE, a measure of reliability of an estimate) ≥ 30 and < 50 and are considered unreliable. Refer to the Technical Appendix for details about relative standard error.
- ** indicates counties with suppressed data due to the number of respondents < 30.

Adult Smoking Prevalence

Local Public Health Process Measure

Percent of population reached by tobacco-free county properties policies

Foundational program area: Prevention and Health Promotion

Data source: Tobacco-free Properties Evaluation in Counties Data Tables

Benchmark source: 100%, provided by Oregon Health Authority, Public Health Division, Health Promotion and Chronic Disease Prevention (HPCDP) Section

Local public health funding

OHA funds all local public health authorities (LPHAs) for tobacco education and prevention, which includes creating tobacco-free environments.

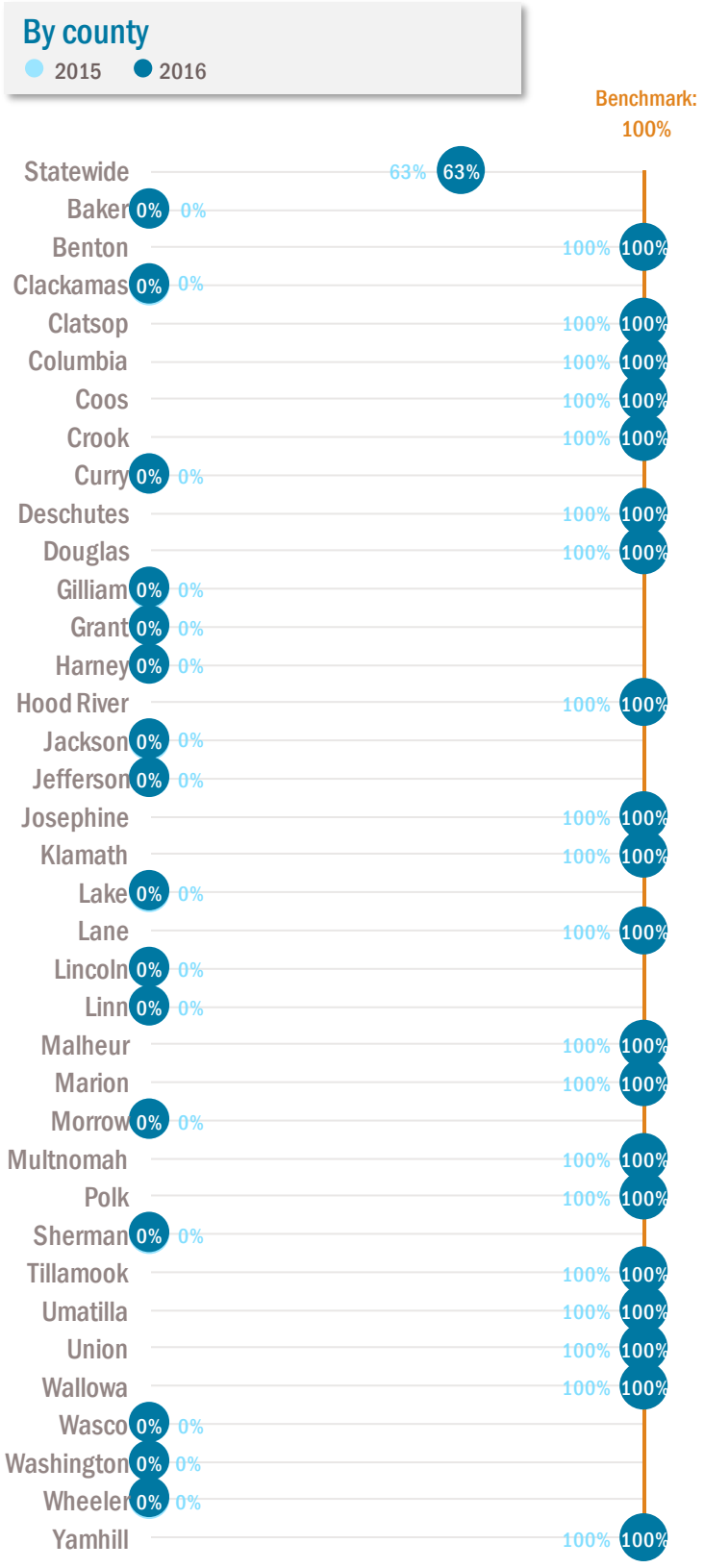
Benchmark:

100%

Notes:

- Tobacco policies include comprehensive (all properties) and partial (some properties) tobacco-free county properties. HPCDP considers everyone (100%) in the county to be covered where a tobacco-free county property policy (comprehensive or partial) is in place.
- Data include tobacco-free policies but not smoke-free policies. Data include policies for county properties but not city properties.
- Statewide percentage calculated as: population covered by comprehensive policies + population covered by partial policies) divided by total population. Numerator and denominator data are provided in the Technical Appendix.
- Source for state and county population estimates: Portland State University Population Research Center.

By county



Adult Smoking Prevalence

Local Public Health Process Measure

Percent of population reached by tobacco retail licensure policies

Foundational program area: Prevention and Health Promotion

Data source: Tobacco Policy Database

Benchmark source: 100%, provided by the Oregon Health Authority, Public Health Division, Health Promotion and Chronic Disease Prevention (HPCDP) section

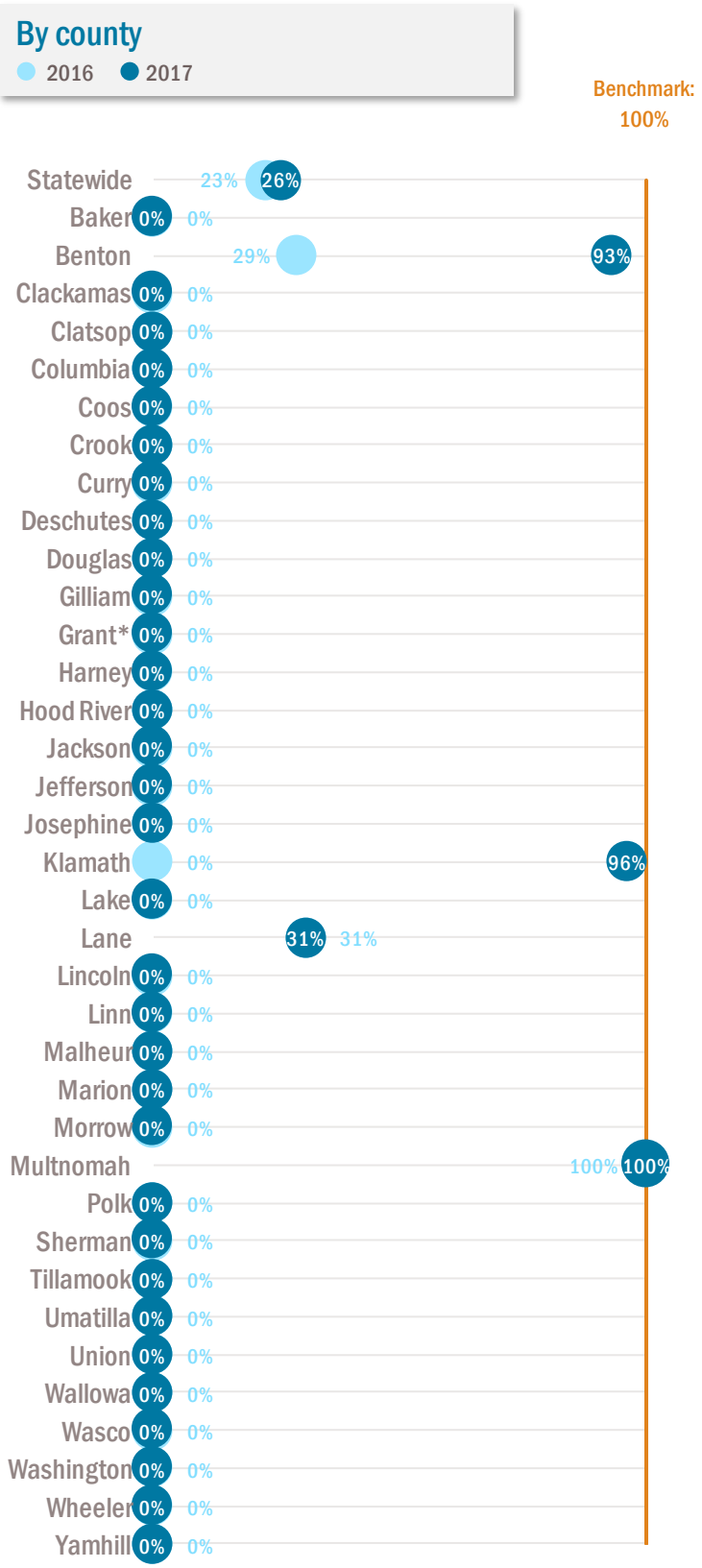
Local public health funding

OHA funds all local public health authorities (LPHAs) for tobacco education and prevention, which includes creating tobacco-free environments.

Benchmark:

100%

Notes:
- Tobacco policies include tobacco retail licensure at a point in-time assessment, October 2016 and June 2017.
- County percentages are calculated as the population within the jurisdiction (i.e., city, unincorporated portions of a county) within each county with a tobacco retail licensure policy (numerator) divided by total county population; statewide percentage is calculated as the sum of county numerators divided by total state population. Numerator and denominator data provided in the Technical Appendix.
- Source for population estimates: U.S. Census Bureau, 2016 estimate.



DRAFT

Prescription Opioid Mortality

Health Outcome Measure

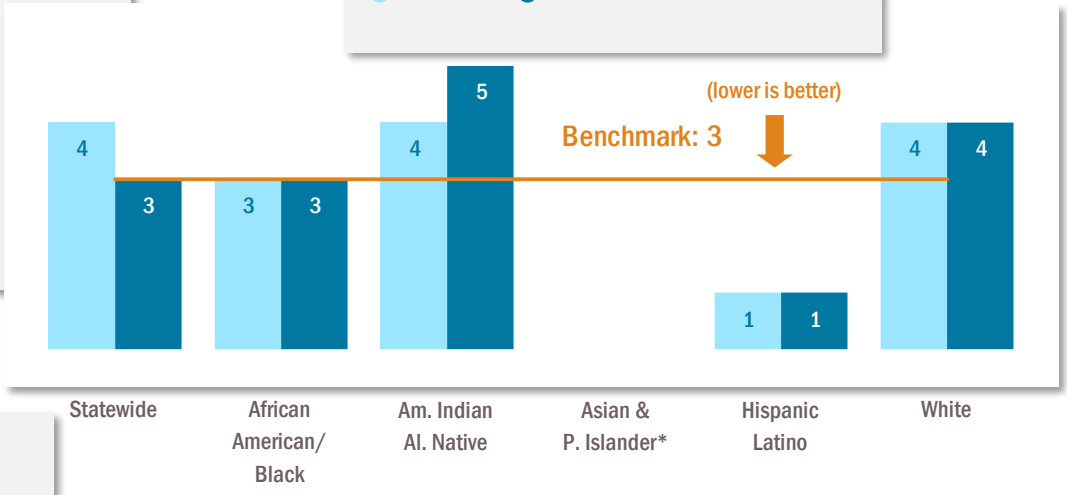
Prescription opioid mortality rate per 100,000 population

Foundational program area: Prevention and Health Promotion

Data source: Oregon Vital Events Registration System (OVERS)

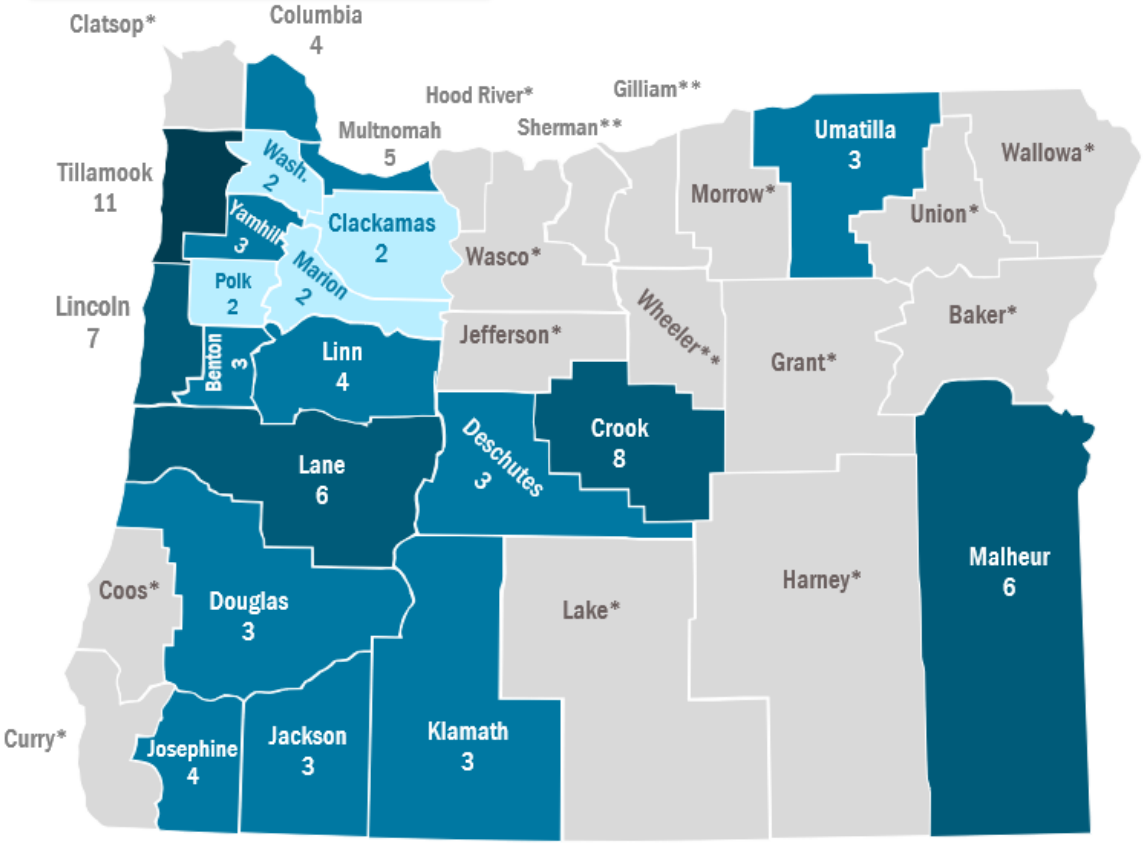
Benchmark source: Less than 3/100,000, Oregon State Health Improvement Plan (SHIP) 2020 target

By race and ethnicity



By county

Oregon 2013-2017



(lower is better)

Benchmark: **3**

Legend

- 0-2
- 3-5
- 6-8
- >8
- *Suppressed
- **No Data

Notes:

- All rates are 5-year average crude rates per 100,000.
- Population estimates are from the National Center for Health Statistics (NCHS) bridged-race annual population estimates.
- Starting in 2014, data do not include deaths from Oregon residents that occurred out of state.
- "Pharmaceutical opioids" as a category exclude novel synthetic opioids and illicit fentanyl analogs because there is not currently a mechanism for distinguishing between prescribed synthetic opioids, including prescription fentanyl, and illicit fentanyl analogs. However, this means that deaths associated

Prescription Opioid Mortality

Health Outcome Measure

Prescription opioid mortality rate per 100,000 population

with prescription synthetic opioids, such as prescription fentanyl, are also excluded (but not methadone).
- * indicates rates not displayed for groups with 5 or fewer deaths or relative standard error (RSE) > 30.
- ** indicates counties for which no deaths were reported.

Prescription Opioid Mortality

Local Public Health Process Measure

Percent of top opioid prescribers enrolled in PDMP

Foundational program area: Prevention and Health Promotion

Data source: Oregon Prescription Drug Monitoring Program (PDMP) database

Benchmark source: 95%, provided by Oregon Health Authority, Public Health Division, Injury and Violence Prevention Section

Local public health funding

OHA funds some local public health authorities (LPHAs) for prescription drug overdose prevention.

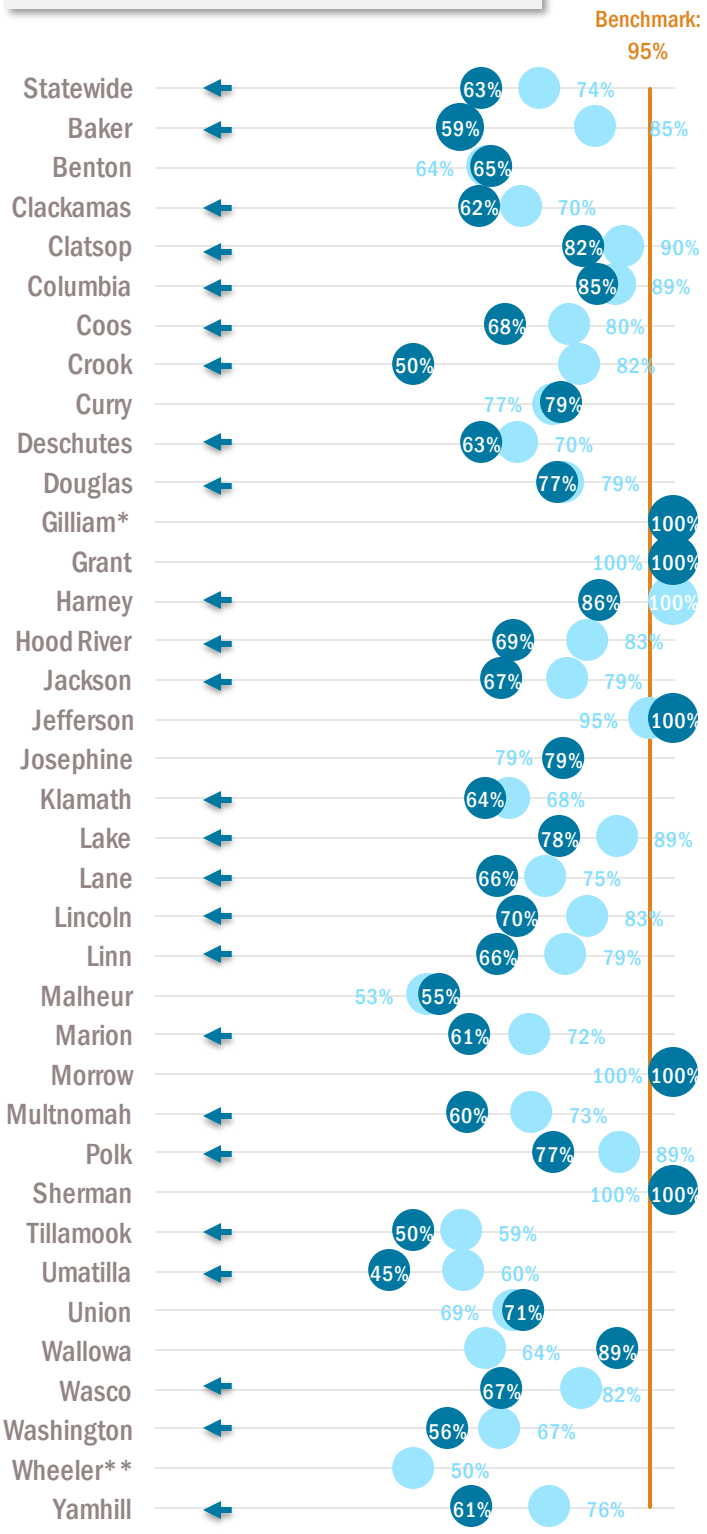
These LPHAs are required to promote prescriber enrollment in the PDMP.

Benchmark:

95%

Notes:
- Top prescribers are defined as the top 4000 prescribers by volume; this represents approximately 20% of all prescribers in Oregon.
- * There were no top prescribers in Gilliam County in 2016.
- ** There were no top prescribers in Wheeler County in 2017.

By county



Active Transportation

Health Outcome Measure

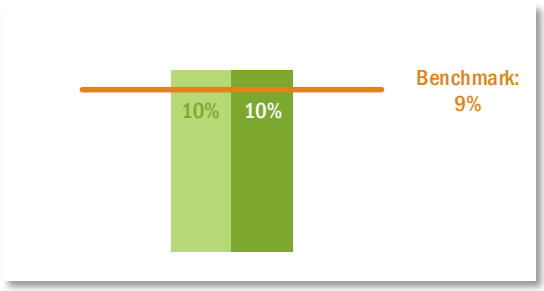
Percent of commuters who walk, bike, or use public transportation to get to work

Foundational program area: Environmental Health

Data source: U.S. Census Bureau American Community Survey (ACS) 1-year and 5-year estimates online query system

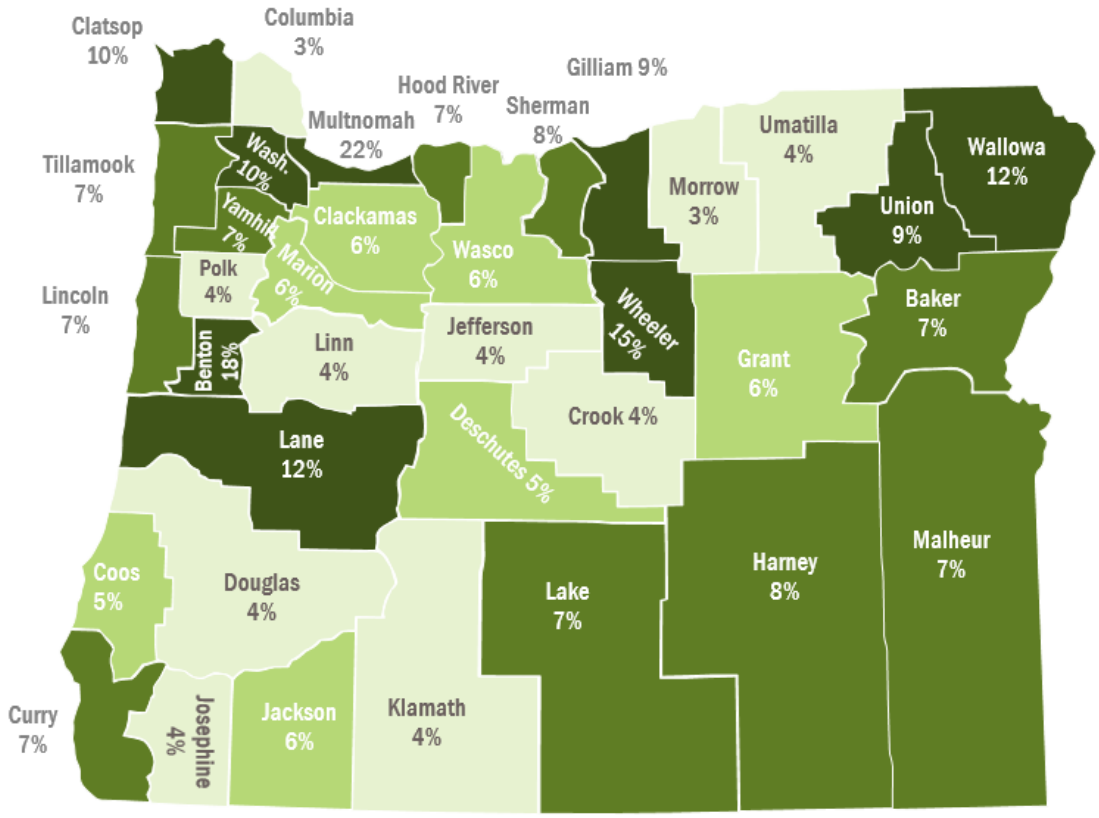
Benchmark source: 9.2%, Healthy People 2020; sum of bike .6%, walk 3.1%, and mass transit 5.5%

Statewide



By county

Oregon 2013-2017



Benchmark:

9%

Legend

- 0-4%
- 5-6%
- 7-8%
- 9-100%

Notes:

- Data are not available by race/ethnicity for this metric from the ACS online query system.
- Statewide rate is annual; county rates are 5-year average.
- Commuters are defined as workers age 16 and older.
- Numerator and denominator data are not provided for weighted survey estimates.

Active Transportation

Local Public Health Process Measure

Local public health authority participation in leadership or planning initiatives related to active transportation, parks and recreation, or land use

Foundational program area: Environmental Health

Data source: Survey of local public health authorities (LPHAs)

Benchmark source: 100% of LPHAs that have eligible initiatives or activities

Local public health funding

OHA does not fund local public health authorities (LPHAs) for active transportation.

Benchmark:

100%

Notes:
- Statewide percentage calculated as the number of counties that participate in planning initiatives, standing committees, or boards (numerator) divided by the number of counties with eligible processes or committees (denominator).
- Excluded from the denominator: Josephine, Linn, Malheur, Polk and Wallowa counties:
  * did not respond to survey;
  ** LPHA reported there were no planning initiatives or standing advisory committees or boards in 2018 or the LPHA was unsure of whether there were planning initiatives or standing advisory committees or boards in 2018;
  ***Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.
- Numerator and denominator data are provided in the Technical Appendix.

By county

● 2018

Statewide 59%	Participated in planning initiatives, committees or boards	Did not participate in planning initiatives, committees or boards
Baker	√	
Benton		√
Clackamas		√
Clatsop	√	
Columbia	√	
Coos	√	
Crook		√
Curry	√	
Deschutes		√
Douglas		√
Grant		√
Harney		√
Hood River	√	
Jackson	√	
Jefferson		√
Josephine*		
Klamath		√
Lake	√	
Lane		√
Lincoln		√
Linn**		
Malheur**		
Marion		√
Morrow	√	
Multnomah		√
N. Central Public Health District		√
Polk**		
Tillamook		√
Umatilla	√	
Union	√	
Wallowa***		
Washington		√
Wheeler	√	
Yamhill		√

Drinking Water

Health Outcome Measure

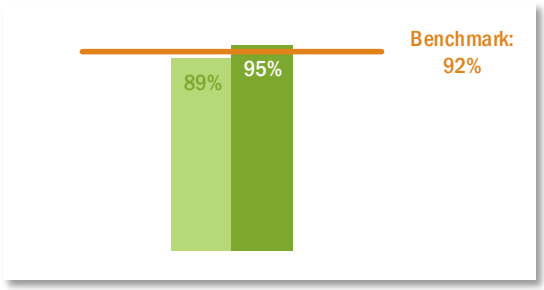
Percent of community water systems meeting health-based standards

Foundational program area: Environmental Health

Data source: Safe Drinking Water Information System (SDWIS) Federal Reporting Services, the Environmental Protection Agency's (EPA) national regulatory compliance database

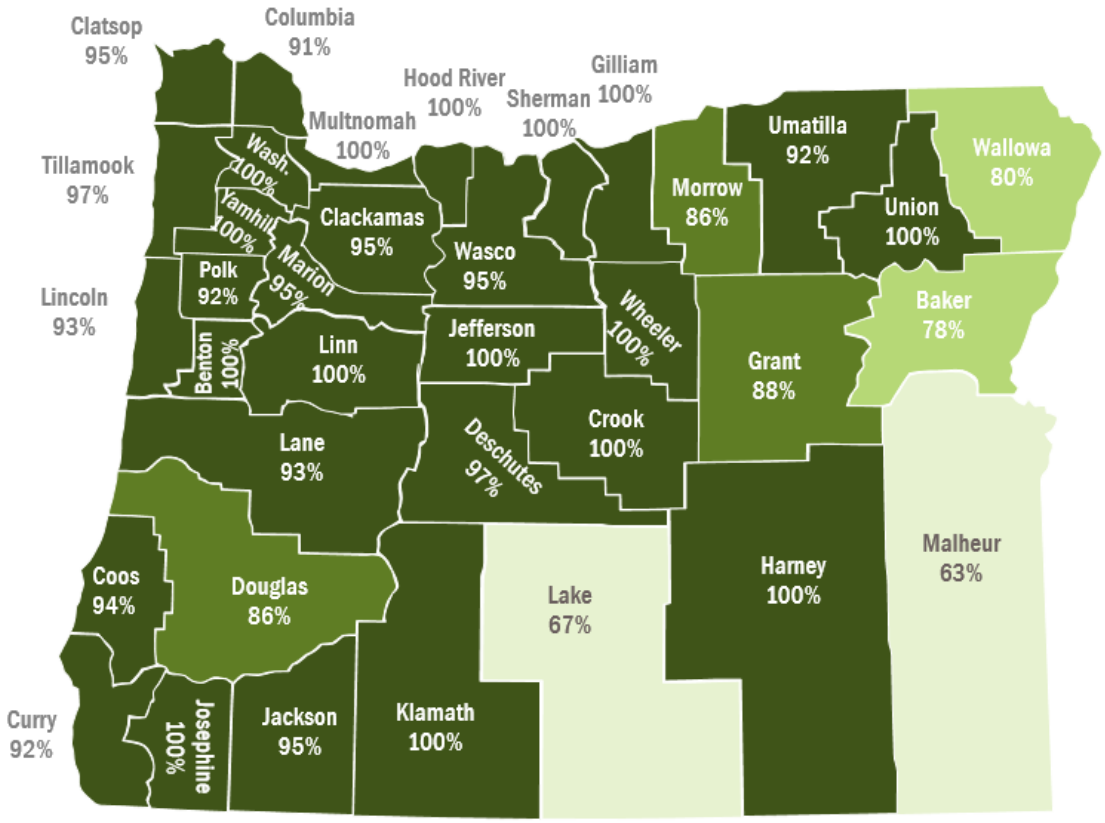
Benchmark source: 92%, EPA

Statewide



By county

Oregon 2017



Benchmark:

92%

Legend

- 0-71%
- 72-81%
- 82-91%
- 92-100%

Notes:

- Unit of analysis is water systems; race/ethnicity data do not apply.
- Percentages are calculated by dividing the number of community water systems that met standards (numerator) by the number of community water systems (denominator). Numerator and denominator data are provided in the Technical Appendix.

Drinking Water

Local Public Health Process Measure

Percent of water systems surveys completed

Foundational program area: Environmental Health

Data source: Oregon Drinking Water Database

Benchmark source: 100%, provided by Oregon Health Authority, Public Health Division, Drinking Water Services Section

Local public health funding

OHA funds some local public health authorities (LPHAs) for safe drinking water programs.

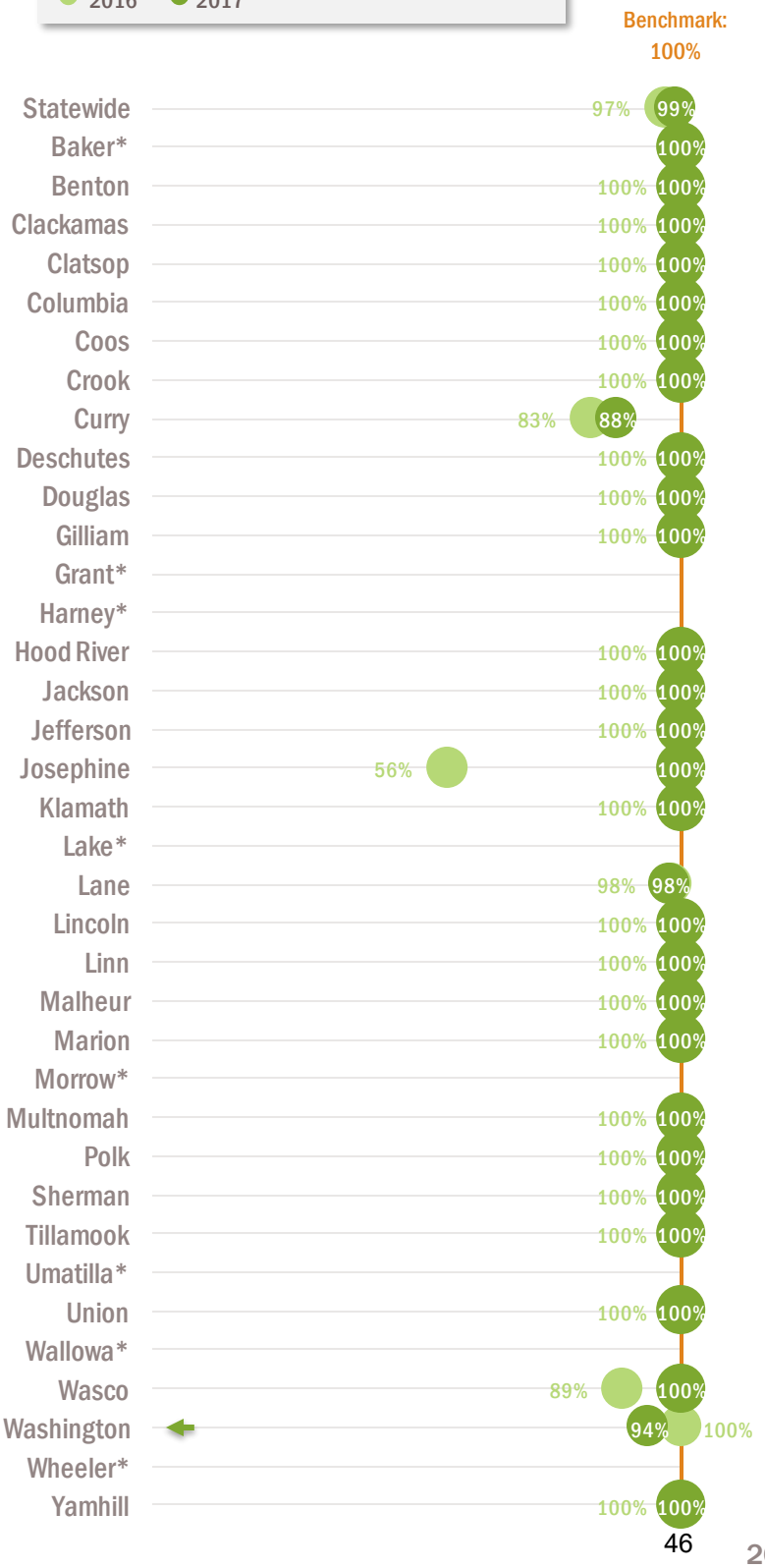
In other counties OHA provides those services.

Benchmark:

100%

Notes:
- Percentages are calculated by dividing the number of water systems surveys completed (numerator) by the number of surveys (denominator). Numerator and denominator data are provided in the Technical Appendix.
- * indicates counties for which no water system surveys were conducted in 2016 and/or 2017.

By county



Drinking Water

Local Public Health Process Measure

Percent of water quality alert responses

Foundational program area: Environmental Health

Data source: Oregon Drinking Water Database, Water Quality Alerts

Benchmark source: 100%, provided by Oregon Health Authority, Public Health Division, Drinking Water Services Section

Local public health funding

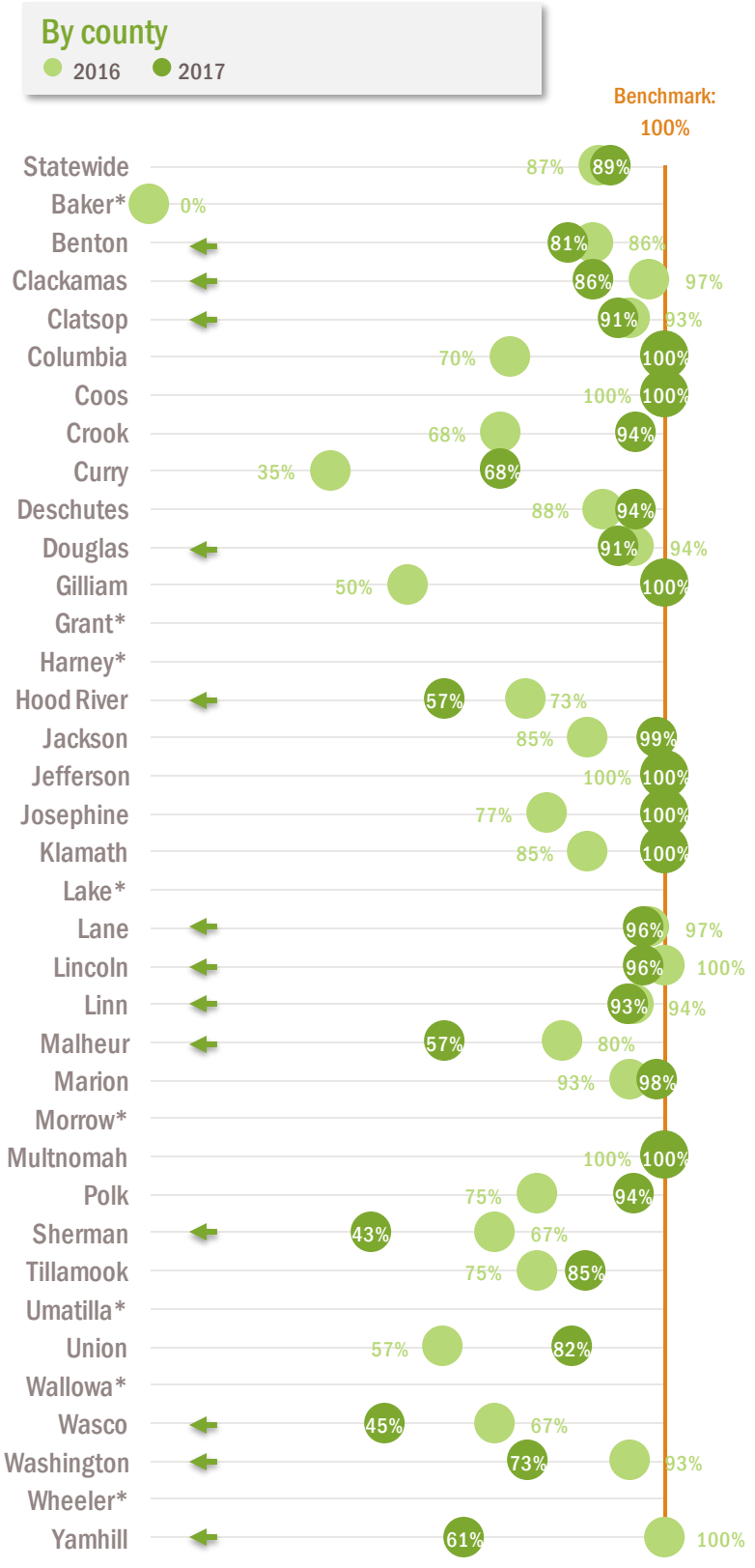
OHA funds some local public health authorities (LPHAs) for safe drinking water programs.

In other counties OHA provides those services.

Benchmark:

100%

Notes:
- Water quality alerts are generated when drinking water monitoring results indicate detection of a contaminant at a level of concern. Prompt investigation and resolution of these alerts is vital to ensuring safe drinking water.
- Percentages are calculated by dividing the number of alert responses (numerator) by the number of alerts (denominator). Numerator and denominator data are provided in the Technical Appendix.
- * indicates counties for which water quality alerts were not applicable in 2016 and/or 2017.



Drinking Water

Local Public Health Process Measure

Percent of priority non-compliers resolved

Foundational program area: Environmental Health

Data source: Oregon Drinking Water Database

Benchmark source: 100%, provided by Oregon Health Authority, Public Health Division, Drinking Water Services Section

Local public health funding

OHA funds some local public health authorities (LPHAs) for safe drinking water programs.

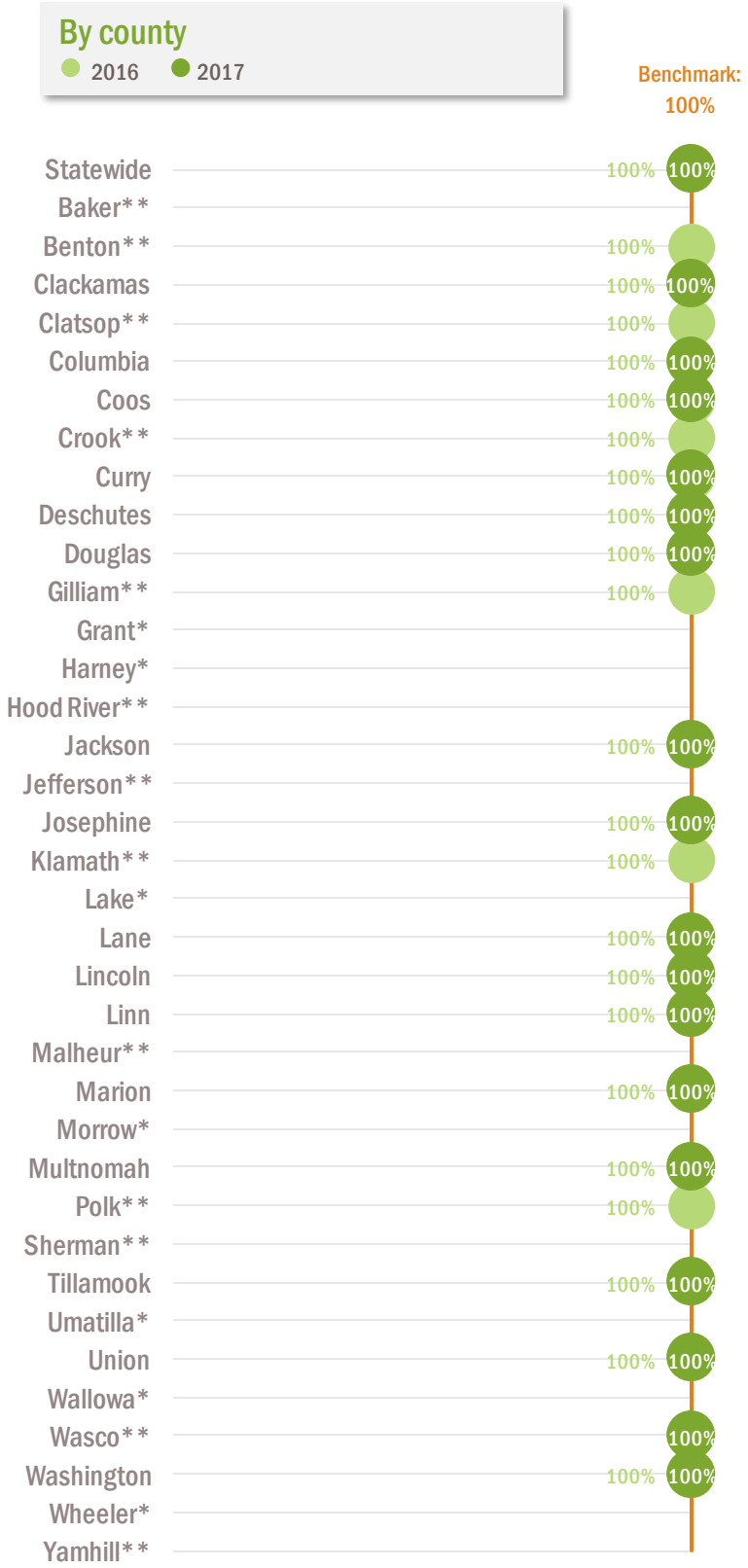
In other counties OHA provides those services.

Benchmark:

100%

Notes:
- A priority non-complier is a water system that accumulates 11 or more points from violations. Violation points are issued for failure to meet drinking water standards.
- Percentages are calculated by dividing the number of PNCs resolved (numerator) by the number of PNCs (denominator). Numerator and denominator data are provided in the Technical Appendix.
- * indicates counties for which priority non-compliers (PNCs) were not applicable in 2016 and 2017.
- ** indicates 0 PNCs in 2016 and/or 2017.

By county



Effective Contraceptive Use

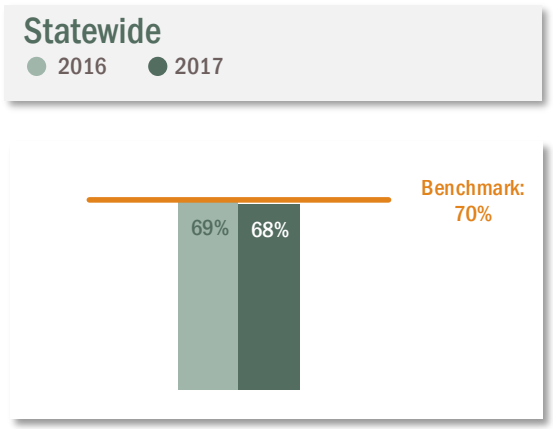
Health Outcome Measure

Percent of women at risk of unintended pregnancy who use effective methods of contraception

Foundational program area: Access to Clinical Preventive Services

Data source: Oregon Behavioral Risk Factor Surveillance System (BRFSS)

Benchmark source: 70%, provided by Oregon Health Authority, Public Health Division, Reproductive Health Program



Benchmark:

70%

Notes:
- Effectiveness is only one factor that influences contraceptive method choice. Client-centered approaches should always be used in contraception counseling to ensure that an individual's choices are respected.
- Effective methods of contraception are asked in BRFSS only of women, age 18-49, who are of reproductive age and at risk of unintended pregnancy.
- There are no estimates by race/ethnicity or county. Refer to the Technical Appendix for additional information.
- Confidence intervals are not shown. Refer to the Technical Appendix regarding the reporting of confidence intervals.
- Numerator and denominator data are not provided for weighted survey estimates.

Effective Contraceptive Use

Local Public Health Process Measure

Annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use

Foundational program area: Access to Clinical Preventive Services

Data source: LPHA annual reporting to Oregon Health Authority, Public Health Division, Reproductive Health Program

Benchmark source: 70% by 2023, provided by Oregon Health Authority, Public Health Division, Reproductive Health Program

Local public health funding

OHA funds local public health authorities (LPHAs) for assuring access to reproductive health services.

LPHAs work collaboratively within their community to identify gaps and barriers in access to reproductive health services. Funding supports LPHAs to take key steps toward developing a strategic plan, which may include identifying partners, developing collaborative relations, conducting a needs assessment or developing a strategic plan.

Benchmark:

70%

Notes:
- This measure includes only strategic plans that are reported to the Oregon Health Authority Reproductive Health Program and does not include strategic plans that are funded and implemented through other community initiatives.
- The statewide percentage is calculated by dividing the number of LPHAs that completed a strategic plan (numerator) by the number of LPHAs (denominator). Numerator and denominator data are provided in the Technical Appendix.
- *Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.

By county

● 2018

Statewide 0%	Provided a strategic plan	Did not provide a strategic plan
Baker		√
Benton		√
Clackamas		√
Clatsop		√
Columbia		√
Coos		√
Crook		√
Curry		√
Deschutes		√
Douglas		√
Gilliam		√
Grant		√
Harney		√
Hood River		√
Jackson		√
Jefferson		√
Josephine		√
Klamath		√
Lake		√
Lane		√
Lincoln		√
Linn		√
Malheur		√
Marion		√
Morrow		√
Multnomah		√
Polk		√
Sherman		√
Tillamook		√
Umatilla		√
Union		√
Wallowa*		
Wasco		√
Washington		√
Wheeler		√
Yamhill		√

Dental Visits Children Aged 0-5

Developmental Metric

Percent of children age 0-5 with any dental visit

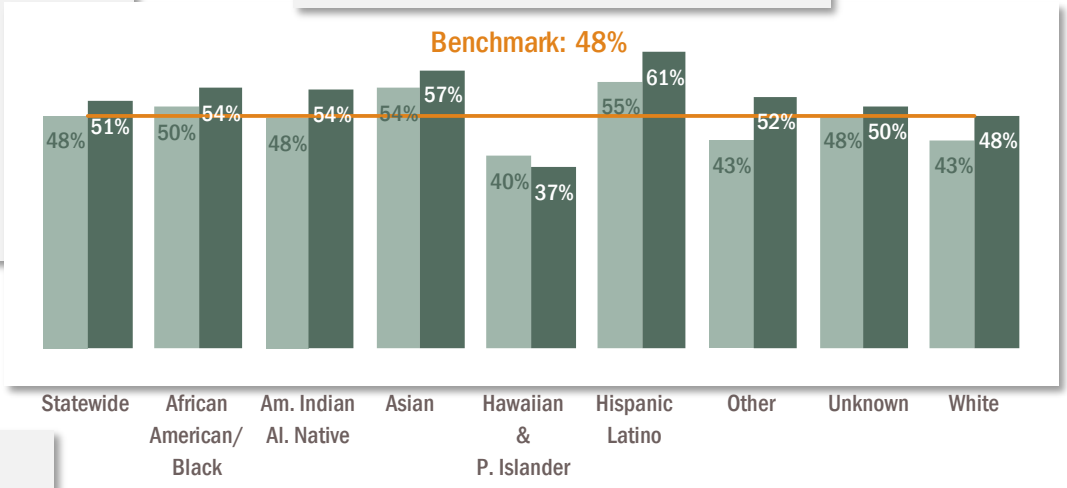
Foundational program area: Access to Clinical Preventive Services

Data source: MMIS Medicaid administrative claims data

Benchmark source: 48%, Oregon State Health Improvement Plan (SHIP) 2020 target

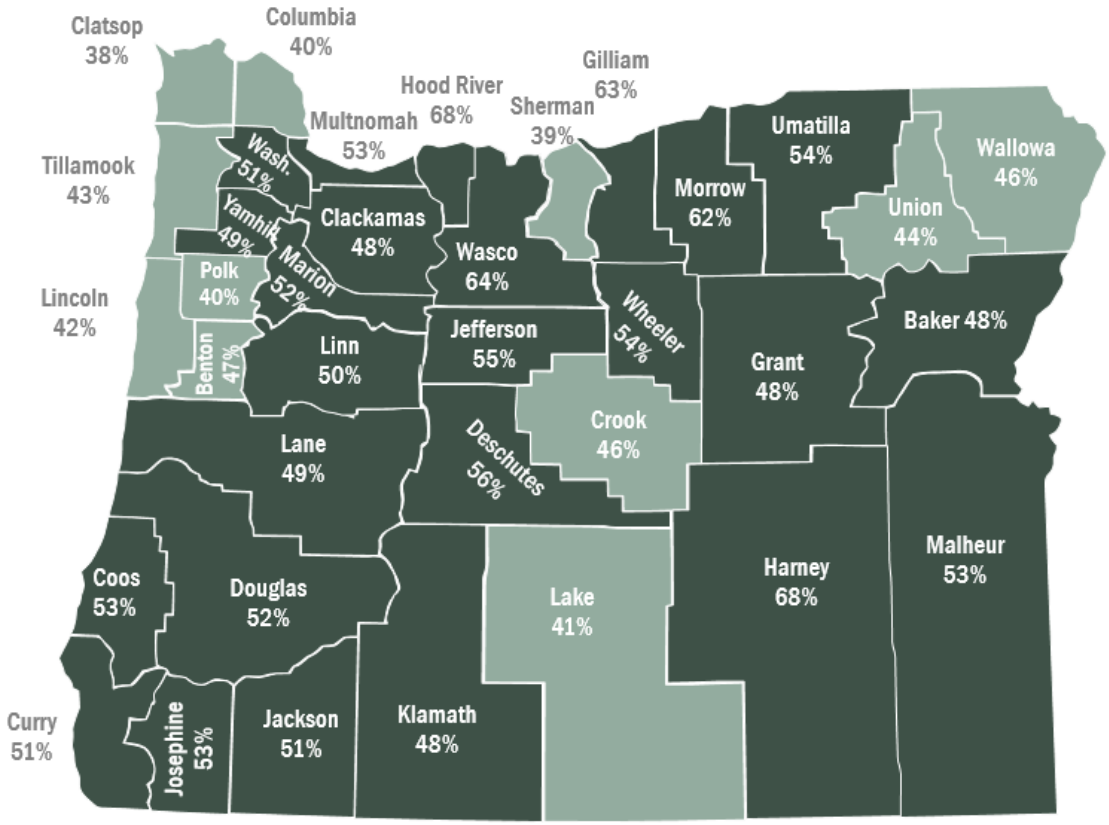
By Race/Ethnicity

Oregon Medicaid 2016 2017



By county

Oregon Medicaid 2017



Benchmark:

48%

Legend

- 0-27%
- 28-37%
- 38-47%
- 48-100%

Notes:

- This measure includes any dental service by a dentist or dental hygienist. It does not include dental services provided in a medical setting.
- This metric is considered developmental.
- Percentages are calculated by dividing the number of Medicaid enrolled children age 0-5 with any dental visit by the number of Medicaid enrolled children age 0-5. Numerator and denominator data are provided in the Technical Appendix.

Technical Appendix

Data for this report were obtained from numerous public health programs and data systems, each having its own set of technical requirements and reporting conventions. Health outcome measures and local public health process measures presented in this report are generally consistent with how these data are reported elsewhere.

Survey estimates and 95% confidence intervals

Data for adult smoking prevalence and effective contraceptive use were obtained from the Behavioral Risk Factor Surveillance System. Data for active transportation were obtained from the American Community Survey. Weighted survey estimates for population surveys that use complex sampling designs are calculated with a margin of error or confidence interval. Confidence intervals provide a measure of how much an estimate varies due to chance. 95% confidence intervals are not shown in this report.

Race and ethnicity categories

Race/ethnicity categories for each measure are determined by the data collection system and associated public health program and may vary among accountability metrics. The race categories of African American, American Indian & Alaska Native, Asian, Pacific Islander, and White do not include individuals of Hispanic ethnicity. Data for individuals of Hispanic ethnicity are presented separately.

Age-adjusted versus crude rates

Unadjusted or crude rates provide an estimate of the overall burden of disease; age-adjusted rates can be used to compare among counties for measures that are sensitive to age, such as tobacco use. Data in this report are shown as Oregon Health Authority programs typically report their data. Age-adjustment, if shown, is based on three age groups: 18-34, 35-54, and 55+ per the U.S. 2000 Census Standard Population.

Communicable Disease Control

Health Outcome Measure: Percent of two-year olds who received recommended vaccines

Data source

ALERT Immunization Information System (ALERT IIS), 2016 - 2017

Benchmark

80%, Oregon State Health Improvement Plan (SHIP) 2020 target

Data collection procedure

Data accessed online at http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/Pages/researchchild.aspx.

Measure specification

Percentage is calculated by dividing the number of children 24-35 months of age who received the vaccination series (numerator) by number of children 24-35 months of age (denominator). Numerator and denominator data are not publicly available (Table 2).

Race/ethnicity categories provided by ALERT IIS are: African American, American Indian & Alaska Native, Asian, Hawaiian/Pacific Islander, Hispanic, and White. Race/ethnicity categories are not mutually exclusive, one individual may contribute to one or more categories.

Additional notes

- Baseline year is 2016.
- Two year olds are children 24 to 35 months of age.
- The official childhood vaccination series is 4 doses of DTaP, 3 doses IPV, 1 dose MMR, 3 doses Hib, 3 doses Hep B, 1 dose Varicella, and 4 doses PCV (4:3:1:3:3:1:4 series).
- Rates not displayed for populations of fewer than 50 people in accordance with OHA Public Health Division, Immunization Program confidentiality policy.
- Data for Gilliam, Sherman, and Wasco counties are combined. This is the North Central Public Health District.
- Oregon immunization rates measure vaccination levels among two-year-olds in a given year. Rates are based on ALERT IIS data for all two-year-olds with an Oregon address and a post-birth immunization record. Over 95% of all childhood immunizations given in Oregon since 1999 are in ALERT IIS and reporting levels have been higher in recent years.

Table 2. Communicable Disease						
	Health outcome measure: % of 2-year olds who received recommended vaccines					
	2016	Numerator*	Denominator*	2017	Numerator*	Denominator*
Statewide	66%			68%		
African American/Black	60%			62%		
Am. Indian Alaska Native	65%			66%		
Asian	69%			73%		
Hawaiian/Pacific Islander	61%			62%		
Asian/Pacific Islander						
Hispanic/Latino	70%			69%		
Multiple races/multi						
Other/unknown						
White	67%			69%		
Baker	63%			67%		
Benton	67%			65%		
Clackamas	67%			69%		
Clatsop	62%			64%		
Columbia	58%			65%		
Coos	64%			64%		
Crook	69%			70%		
Curry	46%			48%		
Deschutes	65%			69%		
Douglas	66%			67%		
Gilliam						
North Central PH District	62%			65%		
Grant	53%			62%		
Harney	63%			66%		
Hood River	69%			68%		
Jackson	62%			63%		
Jefferson	65%			71%		
Josephine	60%			64%		
Klamath	68%			74%		
Lake	68%			64%		
Lane	66%			72%		
Lincoln	63%			61%		
Linn	64%			68%		
Malheur	70%			73%		
Marion	69%			71%		
Morrow	71%			69%		
Multnomah	64%			66%		
Polk	65%			64%		
Sherman						
Tillamook	61%			64%		
Umatilla	63%			64%		
Union	62%			63%		
Wallowa	56%			66%		
Wasco						
Washington	69%			71%		
Wheeler	**			**		
Yamhill	72%			72%		

*Numerators and denominators not publicly available.
**Rates not displayed for populations of fewer than 50 people.
North Central Public Health District is comprised of Gilliam, Sherman, and Wasco counties.

Local Public Health Process Measure: Percent of Vaccines for Children (VFC) clinics participating in AFIX

Data source

Assessment, Feedback, Incentives, and eXchange (AFIX) online tool, 2017 - 2018

Benchmark

25%, provided by Oregon Health Authority, Public Health Division, Immunization Program

Data collection procedure

Data accessed from AFIX online tool via secure login and provided by staff of the Oregon Health Authority, Public Health Division, Immunization Program.

Measure specification

Percentage is calculated by dividing the number of clinics with any AFIX visits initiated (numerator) by the number of clinics active in the Vaccines for Children Program (VFC) as of the end of the calendar year (denominator). Numerator and denominator data are shown in Table 3.

Additional notes

- Baseline year is 2017.
- Crook, Deschutes, and Jefferson counties completed their own AFIX visits in 2017, but these visits did not meet the CDC data reporting requirements and were not counted toward the process measure in 2017.
- Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018, therefore no data are shown for Wallowa County in 2018.

Table 3. Communicable Disease						
	Local public health process measure: % of VFC clinics participating in AFIX					
	2017	Numerator	Denominator	2018	Numerator	Denominator
Statewide	14%	79	569	28%	163	588
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker	33%	1	3	33%	1	3
Benton	18%	2	11	36%	5	14
Clackamas	21%	9	42	33%	14	43
Clatsop	14%	1	7	57%	4	7
Columbia	0%	0	9	50%	5	10
Coos	18%	2	11	70%	7	10
Crook	0%	0	4	25%	1	4
Curry	0%	0	7	100%	7	7
Deschutes	13%	3	23	48%	12	25
Douglas	39%	7	18	79%	15	19
Gilliam						
North Central PH District	29%	2	7	29%	2	7
Grant	0%	0	3	0%	0	3
Harney	67%	2	3	33%	1	3
Hood River	33%	2	6	20%	1	5
Jackson	2%	1	47	8%	4	48
Jefferson	0%	0	6	50%	3	6
Josephine	0%	0	14	54%	7	13
Klamath	0%	0	11	8%	1	12
Lake	33%	1	3	33%	1	3
Lane	11%	4	36	29%	11	38
Lincoln	0%	0	15	67%	10	15
Linn	5%	1	19	6%	1	18
Malheur	43%	3	7	0%	0	8
Marion	34%	14	41	24%	11	45
Morrow	50%	2	4	0%	0	4
Multnomah	6%	6	96	12%	11	94
Polk	33%	3	9	20%	2	10
Sherman						
Tillamook	0%	0	10	0%	0	9
Umatilla	45%	5	11	27%	3	11
Union	0%	0	9	0%	0	9
Wallowa	0%	0	4	*		
Wasco						
Washington	10%	6	60	21%	14	66
Wheeler	0%	0	1	0%	0	1
Yamhill	17%	2	12	8%	1	13

North Central Public Health District is comprised of Gilliam, Sherman, and Wasco counties.
*Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.

Health Outcome Measure: Gonorrhea incident rate per 100,000

Data source

Oregon Public Health Epi User System (Orpheus), 2016 - 2017

Benchmark

72/100,000, Oregon State Health Improvement Plan (SHIP) 2020 target

Data collection procedure

Data obtained from Orpheus and provided by staff of the Oregon Health Authority, Public Health Division, HIV, STD, TB Section.

Measure specification

All rates shown are crude rates (not age adjusted rates) and are calculated by counting the total number of incident cases in a specified geographic area (country, state, county, etc.) and dividing by the total population for the same geographic area (for a specified time period, usually a calendar year) and multiplied by 100,000 (i.e., crude rate = 100,000 x number of disease reports/ total population). Numerator and denominator data are shown in Table 4.

Population data for race/ethnicity were obtained from U.S. Census Bureau Population Estimates, vintage 2016 and vintage 2017. Population data for Oregon counties were obtained from Portland State University Certified Population Estimates July 1, 2016 and July 1, 2017.

Additional notes

- Baseline year is 2016.
- Rates and percentages based on 1 - 5 events are considered unreliable because of the greater influence of random variability.

Table 4. Communicable Disease						
	Health outcome measure: Gonorrhea incidence rate per 100,000 population					
	2016	Numerator	Denominator	2017	Numerator	Denominator
Statewide	107	4353	4,076,350	121	5022	4,140,100
African American/Black	535	407	76,067	556	442	79,485
Am. Indian Alaska Native	157	72	45,814	214	99	46,220
Asian	46	82	177,671	31	58	187,218
Hawaiian/Pacific Islander	74	12	16,233	135	22	16,280
Asian/Pacific Islander						
Hispanic/Latino	104	543	522,571	127	689	540,923
Multiple races/multi	53	68	128,892	53	71	132,965
Other/unknown						
White	87	2730	3,126,217	98	3074	3,139,685
Baker	6*	1	16,510	30*	5	16,750
Benton	53	48	91,320	56	52	92,575
Clackamas	69	280	404,980	82	338	413,000
Clatsop	58	22	38,225	72	28	38,820
Columbia	73	37	50,795	72	37	51,345
Coos	65	41	63,190	96	61	63,310
Crook	70	15	21,580	63	14	22,105
Curry	49	11	22,600	40	9	22,805
Deschutes	37	65	176,635	36	65	182,930
Douglas	33	36	110,395	85	94	111,180
Gilliam	51*	1	1,980	50*	1	1,995
North Central PH District						
Grant	13*	1	7,410	0	0	7,415
Harney	68*	5	7,320	41*	3	7,360
Hood River	16*	4	24,735	36	9	25,145
Jackson	83	177	213,765	100	217	216,900
Jefferson	70	16	22,790	207	48	23,190
Josephine	99	84	84,675	99	85	85,650
Klamath	90	61	67,410	89	60	67,690
Lake	87	7	8,015	62*	5	8,120
Lane	77	281	365,940	115	427	370,600
Lincoln	50	24	47,735	38	18	47,960
Linn	92	112	122,315	127	157	124,010
Malheur	91	29	31,705	123	39	31,845
Marion	104	347	333,950	155	525	339,200
Morrow	162	19	11,745	59	7	11,890
Multnomah	249	1972	790,670	260	2086	803,000
Polk	60	48	79,730	78	63	81,000
Sherman	0	0	1,795	0	0	1,800
Tillamook	12*	3	25,920	57	15	26,175
Umatilla	110	88	79,880	83	67	80,500
Union	41	11	26,745	15*	4	26,900
Wallowa	0	0	7,140	0	0	7,195
Wasco	45	12	26,700	52	14	27,100
Washington	79	459	583,595	70	417	595,860
Wheeler	68*	1	1,465	0	0	1,480
Yamhill	33	35	104,990	49	52	106,300

*Rates for counties based on 5 or fewer events are considered unreliable.
Source for race/ethnicity population estimates: US Census Bureau, vintage 2016, 2017. Source for state and county estimates: Portland State University. Population Research Center certified population estimates, July 1, 2016 and July 1, 2017.

Local Public Health Process Measure: Percent of gonorrhea cases that had at least one contact that received treatment

Data source

Oregon Public Health Epi User System (Orpheus), 2016 - 2017

Benchmark

35%, provided by Oregon Health Authority, Public Health Division, HIV, STD and TB Section

Data collection procedure

Data provided by Oregon Health Authority, Public Health Division, HIV, STD and TB Section.

Measure specification

Numerator: Gonorrhea cases with at least one contact with treatment or Expedited Partner Therapy (EPT) documented on the contact record (this will not count if a contact becomes a case and treatment is not added to the contact record) or contact EPT is reported as "yes" on the gonorrhea case.

Denominator: All Confirmed or Presumptive gonorrhea cases reported in the designated time period with State = OR.

Numerator and denominator data are shown in Table 5.

Note: credit goes to the county where the case lives. For example, if a case is in Jackson County and they have a contact in Deschutes County, metrics will be counted in Jackson County if they are treated.

Additional notes

- Baseline year is 2016.

Table 5. Communicable Disease						
	Local public health process measure: % of gonorrhea cases that had at least one contact that received treatment					
	2016	Numerator	Denominator	2017	Numerator	Denominator
Statewide	13%	552	4353	15%	742	5022
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker	0%	0	1	0%	0	5
Benton	4%	2	48	13%	7	52
Clackamas	9%	26	280	8%	27	338
Clatsop	14%	3	22	36%	10	28
Columbia	14%	5	37	11%	4	37
Coos	24%	10	41	48%	29	61
Crook	33%	5	15	64%	9	14
Curry	18%	2	11	0%	0	9
Deschutes	49%	32	65	37%	24	65
Douglas	19%	7	36	21%	20	94
Gilliam	0%	0	1	0%	0	1
North Central PH District						
Grant	0%	0	1	*	*	0
Harney	20%	1	5	67%	2	3
Hood River	0%	0	4	22%	2	9
Jackson	5%	9	177	12%	26	217
Jefferson	19%	3	16	19%	9	48
Josephine	0%	0	84	1%	1	85
Klamath	18%	11	61	17%	10	60
Lake	14%	1	7	40%	2	5
Lane	19%	52	281	14%	58	427
Lincoln	29%	7	24	22%	4	18
Linn	20%	22	112	23%	36	157
Malheur	21%	6	29	28%	11	39
Marion	35%	121	347	38%	200	525
Morrow	32%	6	19	0%	0	7
Multnomah	5%	89	1972	8%	161	2086
Polk	8%	4	48	6%	4	63
Sherman	*	*	0	*	*	0
Tillamook	0%	0	3	7%	1	15
Umatilla	58%	51	88	22%	15	67
Union	18%	2	11	75%	3	4
Wallowa	*	*	0	*	*	0
Wasco	33%	4	12	7%	1	14
Washington	14%	63	459	13%	53	417
Wheeler	0%	0	1	*	*	0
Yamhill	23%	8	35	25%	13	52

*indicates counties that had 0 gonorrhea cases.

Local Public Health Process Measure: Percent of gonorrhea case reports with complete priority fields

Data source

Oregon Public Health Epi User System (Orpheus), 2016 - 2017

Benchmark

70%, provided by Oregon Health Authority, Public Health Division, HIV, STD and TB Section

Data collection procedure

Data provided by Oregon Health Authority, Public Health Division, HIV, STD and TB Section.

Measure specification

Numerator: Gonorrhea cases with a response for each priority field

- Pregnancy Status
  - female cases 15-44 years old at time of diagnosis
  - cannot be Unknown
- HIV Status / Date of Most Recent HIV test
  - HIV case in Orpheus with HIVDxDate ≤ ReportDateLHD of Gonorrhea Case or date of most recent HIV test completed in Risk Section of Gonorrhea Case
- Gender of Sex Partner
  - Case must have documentation of sex partner risk question with an answer of "yes" for either male or female partners
- Race (cannot be Unknown or Refused)
- Ethnicity (cannot be Unknown or Declined)

Denominator: All Confirmed or Presumptive Gonorrhea cases reported in the designated time period with State = OR

Numerator and denominator data are shown in Table 6.

Additional notes

- Baseline year is 2016.

Table 6. Communicable Disease						
	Local public health process measure: % of gonorrhea case reports with complete priority fields					
	2016	Numerator	Denominator	2017	Numerator	Denominator
Statewide	19%	833	4353	24%	1217	5022
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker	100%	1	1	60%	3	5
Benton	13%	6	48	27%	14	52
Clackamas	13%	36	280	15%	52	338
Clatsop	14%	3	22	32%	9	28
Columbia	14%	5	37	11%	4	37
Coos	15%	6	41	13%	8	61
Crook	53%	8	15	7%	1	14
Curry	18%	2	11	0%	0	9
Deschutes	35%	23	65	35%	23	65
Douglas	25%	9	36	7%	7	94
Gilliam	0%	0	1	100%	1	1
North Central PH District						
Grant	0%	0	1	*	*	0
Harney	0%	0	5	33%	1	3
Hood River	25%	1	4	56%	5	9
Jackson	6%	10	177	30%	66	217
Jefferson	0%	0	16	2%	1	48
Josephine	2%	2	84	2%	2	85
Klamath	16%	10	61	8%	5	60
Lake	14%	1	7	0%	0	5
Lane	21%	60	281	32%	137	427
Lincoln	8%	2	24	11%	2	18
Linn	13%	15	112	34%	53	157
Malheur	34%	10	29	23%	9	39
Marion	42%	146	347	49%	259	525
Morrow	5%	1	19	0%	0	7
Multnomah	17%	345	1972	17%	362	2086
Polk	8%	4	48	30%	19	63
Sherman	*	*	0	*	*	0
Tillamook	0%	0	3	0%	0	15
Umatilla	0%	0	88	4%	3	67
Union	36%	4	11	0%	0	4
Wallowa	*	*	0	*	*	0
Wasco	17%	2	12	50%	7	14
Washington	26%	120	459	35%	148	417
Wheeler	0%	0	1	*	*	0
Yamhill	3%	1	35	31%	16	52

*indicates counties that had 0 gonorrhea cases.

Prevention and Health Promotion

Health Outcome Measure: Percent of adults who smoke cigarettes (i.e., adult smoking prevalence)

Data source

Behavioral Risk Factor Surveillance System (BRFSS), statewide 2016 - 2017; race/ethnicity 2010-2011 and 2015 -2017; county 2012 - 2015 and 2014 - 2017.

Benchmark

15%, Oregon State Health Improvement Plan (SHIP) 2020 target

Data collection procedure

Statewide and county estimates, overall and by race/ethnicity categories, were obtained from OHA Public Health Division, Health Promotion and Chronic Disease Prevention (HPCDP) staff.

Measure specification

The weighted proportion of survey respondents who report that they have ever smoked 100 cigarettes and now smoke all days or some days (numerator) to all respondents who responded to cigarette smoking questions other than "don't know" or refused (denominator). Numerator and denominator data are not provided for weighted survey estimates (Table 7). Race/ethnicity data are combined for multiple years and obtained from a race/ethnic oversample.

Additional notes

- Baseline year is 2016 for statewide estimates, 2010 - 2011 for race/ethnicity estimates, and 2012 - 2015 for county estimates.
- The statewide BRFSS sample for 2016 was 8,620. The statewide BRFSS sample for 2017 was 9,382.
- Statewide and county rates and rates by race/ethnicity are age adjusted.
- Survey includes only people age 18 and older.
- Survey responses are weighted to correct for differences in the probability of selection due to non-response and non-coverage errors. Weights are assigned to each response to:
  - Adjust variables of age, race, and gender between the sample and the entire population.
  - Allow the generalization of findings to the whole population, not just those who respond to the survey.
  - Allow comparability of data (to other states, to national data, etc.) according to the size of the total demographic group (age, race, and gender) in Oregon that they represent.
- Survey results are estimates of population values and always contain some error because they are based on samples. Confidence intervals are one tool for assessing the reliability, or precision, of survey estimates. This is a statistical estimate of the reliability of the rate. Rates based on small numbers have wide confidence intervals and are considered less reliable because of the greater influence of random variability. Confidence intervals are not shown in accordance with reporting conventions of the Oregon Health Authority, Public Health Division, Health Promotion Chronic Disease Prevention Section.

- A tool for assessing reliability is the relative standard error (RSE) of an estimate. Estimates with large RSEs are considered less reliable than estimates with small RSEs. Percentages with a relative standard error (RSE) greater than or equal to 30 and less than 50 are unreliable, as recommended by the National Center for Health Statistics.
- Data are suppressed where the number of respondents is less than 30.

Table 7. Prevention and Health Promotion						
	Health outcome measure: % of adults who smoke cigarettes					
	2016	Numerator*	Denominator*	2017	Numerator*	Denominator*
Statewide	17%			17%		
	2010-11			2015-17		
African American/Black	33%			26%		
Am. Indian Alaska Native	35%			30%		
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander	14%			13%		
Hispanic/Latino	21%			13%		
Multiple races/multi						
Other/unknown						
White	21%			18%		
	2012-15			2014-17		
Baker	24%			26%		
Benton	11%			9%		
Clackamas	17%			16%		
Clatsop	21%			24%		
Columbia	20%			21%		
Coos	30%			28%		
Crook	26%			20%		
Curry	26%			27%		
Deschutes	17%			16%		
Douglas	24%			25%		
Gilliam						
North Central PH District	20%			20%		
Grant	15%**			19%		
Harney	11%**			14%**		
Hood River	9%**			14%		
Jackson	20%			22%		
Jefferson	13%**			13%		
Josephine	25%			28%		
Klamath	23%			22%		
Lake	19%**			10%		
Lane	19%			19%		
Lincoln	32%			29%		
Linn	20%			19%		
Malheur	22%			24%		
Marion	17%			16%		
Morrow	16%			18%**		
Multnomah	18%			17%		
Polk	14%			15%		
Sherman						
Tillamook	31%			22%		
Umatilla	18%			20%		
Union	14%			15%		
Wallowa	11%**			14%**		
Wasco						
Washington	12%			12%		
Wheeler	12%**			***		
Yamhill	18%			19%		

*Numerators and denominators not provided for weighted survey estimates. BRFSS sample for 2016 was 8,620. BRFSS sample for 2017 was 9,382.
**Indicates estimates that have relative standard error >= 30 and <50 and are considered unreliable.
*** indicates estimates that are suppressed due to number of respondents <30.
North Central Public Health District is comprised of Gilliam, Sherman, and Wasco counties.

Local Public Health Process Measures: Percent of population reached by tobacco-free county properties policies

Data sources

Tobacco-free Properties Evaluation in Counties Data Tables, Oregon Health Authority, Public Health Division, Health Promotion Chronic Disease Prevention (HPCDP) Section, 2015 - 2016.

Benchmarks

100%, provided by Oregon Health Authority, Public Health Division, HPCDP Section

Data collection procedure

Provided by Oregon Health Authority, Public Health Division, HPCDP Section.

Measure specification

Identification of tobacco-free policies for each county, including comprehensive (all properties) and partial (some properties) tobacco-free county properties. HPCDP considers everyone (100%) in the county to be covered where tobacco-free county property policy (comprehensive or partial) is in place. Data for this process measure include policies for tobacco-free county properties, but not smoke-free county properties. Data do not include policies for tobacco-free city properties. Population estimates were obtained from the Portland State University Population Research Center.

Numerator and denominator data are shown in Table 8.

Additional notes

- Baseline year for tobacco-free county properties policies is 2015.
- For 2015, the statewide percentage 63.3% calculated as: (1,572,145 population covered by comprehensive policies + 967,460 population covered by partial policies) divided by 4,013,846 total 2015 population. For 2016, the statewide percentage 63.2% calculated as: (1,598,605 population covered by comprehensive policies + 977,025 population covered by partial policies) divided by 4,076,350 total 2016 population.

Table 8. Prevention and Health Promotion						
	Local public health process measure: % of population reached by tobacco-free county properties policies					
	2015	Numerator	Denominator	2016	Numerator	Denominator
Statewide	63%	2,539,605	4,013,845	63%	2,575,630	4,076,350
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker	0%	0	16,425	0%	0	16,510
Benton	100%	90,005	90,005	100%	91,320	91,320
Clackamas	0%	0	397,385	0%	0	404,980
Clatsop	100%	37,750	37,750	100%	38,225	38,225
Columbia	100%	50,390	50,390	100%	50,795	50,795
Coos	100%	62,990	62,990	100%	63,190	63,190
Crook	100%	21,085	21,085	100%	21,580	21,580
Curry	0%	0	22,470	0%	0	22,600
Deschutes	100%	170,740	170,740	100%	176,635	176,635
Douglas	100%	109,910	109,910	100%	110,395	110,395
Gilliam	0%	0	1,975	0%	0	1,980
North Central PH District						
Grant	0%	0	7,430	0%	0	7,410
Harney	0%	0	7,295	0%	0	7,320
Hood River	100%	24,245	24,245	100%	24,735	24,735
Jackson	0%	0	210,975	0%	0	213,765
Jefferson	0%	0	22,445	0%	0	22,790
Josephine	100%	83,720	83,720	100%	84,675	84,675
Klamath	100%	67,110	67,110	100%	67,410	67,410
Lake	0%	0	8,010	0%	0	8,015
Lane	100%	362,150	362,150	100%	365,940	365,940
Lincoln	0%	0	47,225	0%	0	47,735
Linn	0%	0	120,860	0%	0	122,315
Malheur	100%	31,480	31,480	100%	31,705	31,705
Marion	100%	329,770	329,770	100%	333,950	333,950
Morrow	0%	0	11,630	0%	0	11,745
Multnomah	100%	777,490	777,490	100%	790,670	790,670
Polk	100%	78,570	78,570	100%	79,730	79,730
Sherman	0%	0	1,790	0%	0	1,795
Tillamook	100%	25,690	25,690	100%	25,920	25,920
Umatilla	100%	79,155	79,155	100%	79,880	79,880
Union	100%	26,625	26,625	100%	26,745	26,745
Wallowa	100%	7,100	7,100	100%	7,140	7,140
Wasco	0%	0	26,370	0%	0	26,700
Washington	0%	0	570,510	0%	0	583,595
Wheeler	0%	0	1,445	0%	0	1,465
Yamhill	100%	103,630	103,630	100%	104,990	104,990

Source of population estimates: Portland State University Population Research Center certified population estimates, July 1, 2015 and 2016.

Local Public Health Process Measures: Percent of population reached by tobacco retail licensure policies

Data sources

Tobacco retail licensure policy coverage point-in-time assessments, October 2016 and June 2017, Oregon Health Authority, Public Health Division, Health Promotion and Chronic Disease Prevention (HPCDP) Section.

Benchmarks

100%, provided by Oregon Health Authority, Public Health Division, HPCDP Section

Data collection procedure

Provided by Oregon Health Authority, Public Health Division, HPCDP Section.

Measure specification

County percentages are the identification of the population of jurisdictions that have passed a tobacco retail licensure policy (city, unincorporated portions of a county, or entire county). (numerator) divided by the population of the entire county (denominator). Statewide percentage is a sum of all jurisdiction numerators divided by total state population. Population estimates were obtained from the U.S. Census Bureau, 2016.

Numerator and denominator data are shown in Table 9.

Additional notes

- Baseline year for tobacco retail licensure policies is 2016.
- (2) Benton County (26,125/89,385=29% in 2016 and 83,235/89,305=93% in 2017); Klamath County (63,644/66,443=96% in 2017); Lane County (113,880/369,519=31% in 2016 and 2017); Multnomah County (799,766/799,766=100% in 2016 and 2017); State (939,771/4,093,465=23% in 2016 and 1,060,545/4,093,465=26% in 2017).

Table 9. Prevention and Health Promotion						
	Local public health process measure: % of population reached by tobacco retail licensure policies					
	2016	Numerator	Denominator	2017	Numerator	Denominator
Statewide	23%	939,771	4,093,465	26%	1,060,545	4,093,465
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker						
Benton	29%	26,125	89,385	93%	83,235	89,385
Clackamas						
Clatsop						
Columbia						
Coos						
Crook						
Curry						
Deschutes						
Douglas						
Gilliam						
North Central PH District						
Grant						
Harney						
Hood River						
Jackson						
Jefferson						
Josephine						
Klamath				96%	63,664	66,443
Lake						
Lane	31%	113,880	369,519	31%	113,880	369,519
Lincoln						
Linn						
Malheur						
Marion						
Morrow						
Multnomah	100%	799,766	799,766	100%	799,766	799,766
Polk						
Sherman						
Tillamook						
Umatilla						
Union						
Wallowa						
Wasco						
Washington						
Wheeler						
Yamhill						

Source of population estimates: U.S. Census Bureau, 2016.

Health Outcome Metric: Prescription opioid mortality rate per 100,000

Data source

Oregon Vital Events Registration System (OVERS) accessed from online Opioid Data Dashboard http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/data.aspx

Benchmark

Less than 3/100,000, Oregon State Health Improvement Plan (SHIP) 2020 target

Data collection procedure

Statewide and county data obtained directly from the Opioid Data Dashboard. Race/ethnicity data provided by Oregon Health Authority, Public Health Division, Injury and Violence Prevention Section.

Measure specification

All rates shown are crude rates and are calculated by counting the total number of events (i.e., deaths) in a specified geographic area (state, county) and dividing by the total population for the same geographic area (for a specified time period, usually a calendar year) and multiplied by 100,000 (i.e., crude rate = 100,000 X number of events/total population). Numerator and denominator data are shown in Table 10.

Additional notes

- Baseline year is 2012-2016 5-year average.
- All rates are 5-year average crude rates per 100,000 for 2012-2016.
- Population estimates are from the National Center for Health Statistics (NCHS) bridged-race annual population estimates.
- Starting in 2014, data do not include deaths from Oregon residents that occurred out of state.
- Rates not displayed for groups with 5 or fewer deaths or relative standard error > 30.
- The Public Health Advisory Board approved the Accountability Metric, “Prescription opioid mortality rate.” Data obtained from the Opioid Data Dashboard are categorized as “Pharmaceutical Opioids.”
- “Pharmaceutical opioids” as a category exclude novel synthetic opioids and illicit fentanyl analogs because there is not currently a mechanism for distinguishing between prescribed synthetic opioids, including prescription fentanyl, and illicit fentanyl analogs. However, this means that deaths associated with prescription synthetic opioids, such as prescription fentanyl are also excluded (but not methadone).

Table 10. Prevention and Health Promotion						
	Health outcome measure: Prescription opioid mortality rate per 100,000 population					
	2012-2016	Numerator	Denominator	2013-2017	Numerator	Denominator
Statewide	4	730	3,960,673	3	686	4,016,537
African American/Black	3	15	91,713	3	15	95,163
Am. Indian Alaska Native	4	11	54,813	5	13	55,467
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander	*	*	197,248	*	*	206,147
Hispanic/Latino	1	27	493,179	1	26	507,666
Multiple races/multi						
Other/unknown						
White	4	669	3,123,720	4	622	3,152,094
Baker	*	*	16,011	*	*	15,867
Benton	3	15	86,956	3	14	88,106
Clackamas	2	48	393,355	2	44	399,825
Clatsop	4	7	37,421	*	*	37,783
Columbia	5	12	49,479	4	10	49,648
Coos	*	*	62,333	*	*	62,662
Crook	9	9	20,958	8	9	21,469
Curry	*	2*	22,130	*	*	22,283
Deschutes	3	27	169,497	3	23	174,288
Douglas	4	22	106,657	3	18	107,152
Gilliam	**	**	**	**	**	**
North Central PH District						
Grant	*	*	7,191	*	*	7,209
Harney	*	*	7,119	*	*	7,147
Hood River	0	0	22,685	*	*	22,955
Jackson	5	51	209,140	3	34	211,868
Jefferson	*	*	22,219	*	*	22,582
Josephine	4	18	83,350	4	18	84,422
Klamath	3	11	65,364	3	9	65,777
Lake	*	*	7,810	*	*	7,759
Lane	6	111	357,564	6	106	361,721
Lincoln	9	20	46,349	7	17	47,051
Linn	5	29	119,025	4	22	120,210
Malheur	8	12	30,367	6	9	30,204
Marion	2	37	324,461	2	40	329,335
Morrow	*	*	11,075	*	*	11,117
Multnomah	4	166	777,418	5	181	790,305
Polk	2	8	77,656	2	8	78,991
Sherman	**	**	**	**	**	**
Tillamook	10	13	25,345	11	14	25,616
Umatilla	2	9	76,670	3	10	76,481
Union	*	*	25,610	*	*	25,676
Wallowa	*	*	6,777	*	*	6,810
Wasco	*	*	25,293	*	*	25,500
Washington	2	61	561,650	2	56	572,414
Wheeler	**	**	**	**	**	**
Yamhill	4	18	100,744	3	15	101,417

*Suppressed for 5 or fewer events or relative standard error >=30.
**No deaths reported.
Population estimates are 5-year averages.

Local Public Health Process Measure: Percent of top opioid prescribers enrolled in the Prescription Drug Monitoring Program (PDMP)

Data source

Oregon Prescription Drug Monitoring Program database, 2016. Accessed online at: http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/data.aspx

Benchmark

95%, provided by Oregon Health Authority, Public Health Division, Injury and Violence Prevention Section

Data collection procedure

County data were obtained directly from online Opioid Data Dashboard. Statewide percentage was obtained from Oregon Health Authority, Public Health Division, Injury and Violence Prevention Section.

Measure specification

Top prescribers enrolled (numerator) divided by top prescribers (denominator), by county and statewide. Numerator and denominator data are shown in Table 11.

Additional notes

- Baseline period is 12/31/2016.
- Top prescribers are defined as the top 4000 prescribers by volume; this represents approximately 20% of all prescribers in Oregon.
- There were no top prescribers in Gilliam County as of 12/31/2016.
- There were no top prescribers in Wheeler County as of 12/31/2017.
- Data provided in the PDMP online dashboard are quarterly, not annual. The measure combines being a top prescriber in a time period and whether or not that person is enrolled in the PDMP at the end of that time period. Calculating the number of top prescribers for the whole year is difficult because of churn in both the top prescriber list and in PDMP enrollment; accounts are deactivated and reactivated frequently. Quarterly data reflect enrollment as of the last day of the quarter.
- As of July 1, 2018, all prescribers in the state of Oregon were required to enroll in PDMP as mandated by Oregon statute.

Table 11. Prevention and Health Promotion						
	Local public health process measure: % of top opioid prescribers enrolled in PDMP					
	12/31/2016	Numerator	Denominator	12/31/2017	Numerator	Denominator
Statewide	74%	2,960	4,000	63%	2537	4000
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker	85%	17	20	59%	10	17
Benton	64%	50	78	65%	63	97
Clackamas	70%	247	351	62%	204	327
Clatsop	90%	33	37	82%	28	34
Columbia	89%	23	26	85%	17	20
Coos	80%	59	74	68%	44	65
Crook	82%	9	11	50%	5	10
Curry	77%	23	30	79%	22	28
Deschutes	70%	162	232	63%	145	231
Douglas	79%	100	127	77%	102	132
Gilliam	*	*	*	100%	1	1
North Central PH District						
Grant	100%	6	6	100%	6	6
Harney	100%	8	8	86%	6	7
Hood River	83%	15	18	69%	18	26
Jackson	79%	215	271	67%	172	257
Jefferson	95%	13	14	100%	14	14
Josephine	79%	67	85	79%	62	79
Klamath	68%	41	60	64%	33	52
Lake	89%	8	9	78%	7	9
Lane	75%	337	448	66%	280	425
Lincoln	83%	40	48	70%	28	40
Linn	79%	90	114	66%	64	97
Malheur	53%	10	19	55%	11	20
Marion	72%	275	381	61%	198	327
Morrow	100%	5	5	100%	7	7
Multnomah	73%	553	762	60%	470	779
Polk	89%	25	28	77%	43	56
Sherman	100%	1	1	100%	1	1
Tillamook	59%	13	22	50%	13	26
Umatilla	60%	31	52	45%	19	42
Union	69%	20	29	71%	17	24
Wallowa	64%	7	11	89%	8	9
Wasco	82%	23	28	67%	16	24
Washington	67%	337	507	56%	297	527
Wheeler	50%	1	2	**	0	0
Yamhill	76%	60	79	61%	49	80

*There were 0 top prescribers in Gilliam County as of 12/31/2016.
**There were 0 top prescribers in Wheeler County as of 12/31/2017.

Environmental Health

Health Outcome Measure: Percent of commuters who walk, ride bicycles, or use public transportation to get to work

Data source

U.S. Census Bureau, American Community Survey (ACS) 1-year and 5-year estimates online query system, accessed at https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#acsST

Benchmark

9.2%, Healthy People 2020. This represents the sum of mutually exclusive categories: bike .6%, walk 3.1%, and mass transit 5.5%

Data collection procedure

Data were obtained directly from the ACS online query and downloaded as Excel file.

Measure specification

Selection of "Means of Transportation to Work" from online query, specifying geographic location (state or counties). Add together categories "Walked," "Bicycle," and "Public transportation (exclude taxicab)." The percentages are mutually exclusive and were added together. Numerator and denominator data are not provided for weighted survey estimates. Numerator and denominator data are shown in Table 12.

Additional notes

- Baseline year is 2016 (statewide) and 2012-2016 (county).
- Data are available by total and by gender and not by race/ethnicity for commuters who walk, bike, or use public transit from the ACS online query system.
- Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. Margins of error are not shown in the charts.
- County data are 5-year average estimates.

Table 12. Environmental Health						
	Health outcome measure: % of commuters who walk, bike, or use public transportation to get to work					
	2012-2016	Numerator*	Denominator*	2013-2017	Numerator*	Denominator*
Statewide	10%			10%		
Race/Ethnicity**						
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker	8%			7%		
Benton	18%			18%		
Clackamas	6%			6%		
Clatsop	9%			10%		
Columbia	4%			3%		
Coos	6%			5%		
Crook	3%			4%		
Curry	6%			7%		
Deschutes	5%			5%		
Douglas	4%			4%		
Gilliam	11%			9%		
North Central PH District						
Grant	5%			6%		
Harney	7%			8%		
Hood River	7%			7%		
Jackson	6%			6%		
Jefferson	4%			4%		
Josephine	4%			4%		
Klamath	5%			4%		
Lake	9%			7%		
Lane	12%			12%		
Lincoln	7%			7%		
Linn	4%			4%		
Malheur	7%			7%		
Marion	6%			6%		
Morrow	4%			3%		
Multnomah	22%			22%		
Polk	5%			4%		
Sherman	7%			8%		
Tillamook	7%			7%		
Umatilla	5%			4%		
Union	10%			9%		
Wallowa	12%			12%		
Wasco	5%			6%		
Washington	10%			10%		
Wheeler	14%			15%		
Yamhill	7%			7%		

*Numerators and denominators are not provided for weighted survey estimates.
**Estimates not provided by race/ethnicity.

Local Public Health Process Measure: Number of active transportation partner governing or leadership boards with LPHA representation

Data source

Survey of Local Public Health Authorities

Benchmark

100% of LPHAs that have eligible initiatives or activities

Data collection procedure

Online survey

Measure specification

Statewide percentage calculated as the number of counties that participate in planning processes or standing committees (numerator) divided by the number of counties with eligible processes or committees (denominator).

Excluded from the denominator: Josephine, Linn, Malheur, Polk, and Wallowa counties:

- did not respond to survey (Josephine);
- LPHA reported there were no planning initiatives or standing advisory committees or boards in 2018 or the LPHA was unsure of whether there were planning initiatives or standing advisory committees or boards in 2018 (Linn, Malheur, and Polk);
- Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.

Numerator and denominator data are shown in Table 13.

Additional notes

- Baseline year is 2018.

Table 13. Environmental Health						
	Local public health process measure: Local public health authority participation in leadership or planning initiatives related to active transportation, parks and recreation, or land use					
	2018	Numerator	Denominator			
Statewide	59%	17	29			
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker			√			
Benton	√	√	√			
Clackamas	√	√	√			
Clatsop			√			
Columbia			√			
Coos			√			
Crook	√	√	√			
Curry			√			
Deschutes	√	√	√			
Douglas	√	√	√			
Gilliam						
North Central PH District	√	√	√			
Grant	√	√	√			
Harney	√	√	√			
Hood River			√			
Jackson			√			
Jefferson	√	√	√			
Josephine	*					
Klamath	√	√	√			
Lake			√			
Lane	√	√	√			
Lincoln	√	√	√			
Linn	**					
Malheur	**					
Marion	√	√	√			
Morrow			√			
Multnomah	√	√	√			
Polk	**					
Sherman						
Tillamook	√	√	√			
Umatilla			√			
Union			√			
Wallowa	***					
Wasco						
Washington	√	√	√			
Wheeler			√			
Yamhill	√	√	√			

*LPHA did not respond to the survey.
**LPHA responded no or unsure to all.
***Wallowa County transferred its public health authority to the Oregon Health Authority in 2018.

Health Outcome Measure: Percent of community water systems meeting health-based standards

Data source

Safe Drinking Water Information System (SDWIS) Federal Reporting Services, the Environmental Protection Agency's (EPA) national regulatory compliance database

Benchmark

EPA standard is 92%

Data collection procedure

Data provided by Oregon Health Authority, Public Health Division, Drinking Water Services Section.

Measure specification

Numerator: number of (county, state) water systems on Government Performance and Results Act (GPRA) list, indicating non-compliance. Denominator: number of water systems (county, state). Numerator and denominator data are shown in Table 14.

Additional notes

- Baseline year is 2016.
- The EPA database includes information on the nation's 160,000 public water systems and violations of drinking water regulations. The database contains aggregated information on water systems; violations reported by violation type and by contaminant/rule, and GPRA data.
- Unit of analysis is water systems; race/ethnicity data do not apply.

Table 14. Environmental Health						
	Health outcome measure: % of community water systems meeting health-based standards					
	2016	Numerator	Denominator	2017	Numerator	Denominator
Statewide	89%	794	891	95%	846	891
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker	78%	7	9	78%	7	9
Benton	93%	14	15	100%	15	15
Clackamas	84%	68	81	95%	77	81
Clatsop	100%	21	21	95%	20	21
Columbia	91%	32	35	91%	32	35
Coos	94%	17	18	94%	17	18
Crook	89%	17	19	100%	19	19
Curry	92%	11	12	92%	11	12
Deschutes	88%	58	66	97%	64	66
Douglas	86%	25	29	86%	25	29
Gilliam	67%	2	3	100%	3	3
North Central PH District						
Grant	75%	6	8	88%	7	8
Harney	100%	3	3	100%	3	3
Hood River	100%	7	7	100%	7	7
Jackson	90%	54	60	95%	57	60
Jefferson	75%	3	4	100%	4	4
Josephine	100%	32	32	100%	32	32
Klamath	93%	25	27	100%	27	27
Lake	33%	1	3	67%	2	3
Lane	94%	64	68	93%	63	68
Lincoln	80%	24	30	93%	28	30
Linn	95%	39	41	100%	41	41
Malheur	25%	2	8	63%	5	8
Marion	85%	63	74	95%	70	74
Morrow	71%	5	7	86%	6	7
Multnomah	96%	22	23	100%	23	23
Polk	75%	9	12	92%	11	12
Sherman	100%	4	4	100%	4	4
Tillamook	97%	34	35	97%	34	35
Umatilla	89%	32	36	92%	33	36
Union	90%	9	10	100%	10	10
Wallowa	80%	4	5	80%	4	5
Wasco	85%	17	20	95%	19	20
Washington	97%	28	29	100%	29	29
Wheeler	100%	3	3	100%	3	3
Yamhill	94%	32	34	100%	34	34

Local Public Health Process Measure: Percent of water systems surveys completed

Data source

Oregon Drinking Water Database, Water Quality Alerts, 2016 and 2017. Accessed online at: https://yourwater.oregon.gov/alertscounty.php

Benchmark

100%, provided by Oregon Health Authority, Public Health Division, Drinking Water Services Section

Data collection procedure

Selection criteria for online data query:

Regulating Agency: County
County: All Counties and each County
Year Due: 2016
Survey List Options: "All Systems on Due List"

Measure specification

Numerator: water systems surveys completed in the calendar year. Denominator: water system surveys due in calendar year. Numerator and denominator data are shown in Table 15.

Additional notes

- Baseline year is 2016.
- Inactive and non-EPA (state regulated) systems excluded.
- 9 counties had no water systems surveys in 2016 and/or 2017.

Table 15. Environmental Health						
	Local public health process measure: % of water systems surveys completed					
	2016	Numerator	Denominator	2017	Numerator	Denominator
Statewide	97%	414	428	99%	429	432
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker	*	*	*	100%	1	1
Benton	100%	6	6	100%	7	7
Clackamas	100%	45	45	100%	44	44
Clatsop	100%	7	7	100%	6	6
Columbia	100%	13	13	100%	12	12
Coos	100%	9	9	100%	9	9
Crook	100%	9	9	100%	9	9
Curry	83%	5	6	88%	7	8
Deschutes	100%	29	29	100%	30	30
Douglas	100%	14	14	100%	15	15
Gilliam	100%	2	2	100%	2	2
North Central PH District						
Grant	*	*	*	*	*	*
Harney	*	*	*	*	*	*
Hood River	100%	3	3	100%	4	4
Jackson	100%	36	36	100%	37	37
Jefferson	100%	5	5	100%	5	5
Josephine	56%	14	25	100%	31	31
Klamath	100%	24	24	100%	24	24
Lake	*	*	*	*	*	*
Lane	98%	46	47	98%	42	43
Lincoln	100%	7	7	100%	8	8
Linn	100%	31	31	100%	31	31
Malheur	100%	2	2	100%	1	1
Marion	100%	37	37	100%	36	36
Morrow	*	*	*	*	*	*
Multnomah	100%	10	10	100%	9	9
Polk	100%	4	4	100%	4	4
Sherman	100%	4	4	100%	2	2
Tillamook	100%	13	13	100%	11	11
Umatilla	*	*	*	*	*	*
Union	100%	4	4	100%	4	4
Wallowa	*	*	*	*	*	*
Wasco	89%	8	9	100%	10	10
Washington	100%	15	15	94%	15	16
Wheeler	*	*	*	*	*	*
Yamhill	100%	12	12	100%	13	13

*No water systems surveys.

Local Public Health Process Measure: Percent of water quality alert responses

Data source

Oregon Drinking Water Database, Water Quality Alerts, 2016 and 2017. Accessed online at: https://yourwater.oregon.gov/alertscounty.php

Benchmark

100%, provided by Oregon Health Authority, Public Health Division, Drinking Water Services Section

Data collection procedure

Online query on "Water Quality Alerts" page.
Regulating Agency: County
County: All Counties
Alert Type: "All alert types"
Date Range: 1/1/2016 to 12/31/2016 and 1/1/2017 to 12/31/2017
Other options: [show non-alerts (sodium, coliform source and special samples), show non-EPA (state regulated) systems, show inactive systems] not selected
Steps:

1. Download query results to Excel spreadsheet.
2. Sort by Alert ID, then by County. Purpose: to identify unique alert IDs for which a contact report date is available.
3. Non-responded alerts (i.e., no alert report date for a unique alert ID) were summed for each county.
4. All unique alert IDs were summed for each county. This is the denominator.
5. Calculation of numerator, the unique alert IDs responded to – was performed by subtracting the total in step 3 from the total in step 4 (for each county).
6. The process measure, % of water quality alert responses, was calculated by dividing the numerator in step 5 by the denominator in step 4.

Measure specification

Numerator: count of water quality alerts responded to. Denominator: unique alert IDs. Numerator and denominator data are shown in Table 16.

Additional notes

- Baseline year is 2016.
- Water quality alerts are generated when drinking water monitoring results indicate detection of a contaminant at a level of concern. Prompt investigation and resolution of these alerts is vital to ensuring safe drinking water.
- There were 7 counties for which quality alerts were not applicable in 2016: Grant, Harney, Lake, Morrow, Umatilla, Wallowa, and Wheeler. In addition to these 7, Baker County was not applicable in 2017.

Table 16. Environmental Health						
	Local public health process measure: % of water quality alert responses					
	2016	Numerator	Denominator	2017	Numerator	Denominator
Statewide	87%	653	749	89%	642	718
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker	0%	0	1	*	*	*
Benton	86%	18	21	81%	13	16
Clackamas	97%	71	73	86%	56	65
Clatsop	93%	13	14	91%	10	11
Columbia	70%	7	10	100%	18	18
Coos	100%	15	15	100%	21	21
Crook	68%	13	19	94%	16	17
Curry	35%	6	17	68%	13	19
Deschutes	88%	37	42	94%	67	71
Douglas	94%	33	35	91%	20	22
Gilliam	50%	2	4	100%	1	1
North Central PH District						
Grant	*	*	*	*	*	*
Harney	*	*	*	*	*	*
Hood River	73%	8	11	57%	4	7
Jackson	85%	70	82	99%	67	68
Jefferson	100%	1	1	100%	3	3
Josephine	77%	26	34	100%	17	17
Klamath	85%	17	20	100%	20	20
Lake	*	*	*	*	*	*
Lane	97%	63	65	96%	70	73
Lincoln	100%	34	34	96%	23	24
Linn	94%	60	64	93%	42	45
Malheur	80%	4	5	57%	8	14
Marion	93%	55	59	98%	65	66
Morrow	*	*	*	*	*	*
Multnomah	100%	21	21	100%	16	16
Polk	75%	18	24	94%	17	18
Sherman	67%	6	9	43%	3	7
Tillamook	75%	12	16	85%	11	13
Umatilla	*	*	*	*	*	*
Union	57%	4	7	82%	9	11
Wallowa	*	*	*	*	*	*
Wasco	67%	12	18	45%	10	22
Washington	93%	14	15	73%	11	15
Wheeler	*	*	*	*	*	*
Yamhill	100%	13	13	61%	11	18

*Water quality alerts not applicable.

Local Public Health Process Measure: Percent of priority non-compliers (PNCs) resolved

Data source

Oregon Drinking Water Database, Priority Non-Compliers, 2016 and 2017. Accessed at https://yourwater.oregon.gov/reports/county-pncs.php

Benchmark

100%, provided by Oregon Health Authority, Public Health Division, Drinking Water Services Section

Data collection procedure

Online query on "County Review - PNCs" page
Select the county to review: each available county selected from the drop down list
Date range: from 1/1/2016 to 12/31/2016 and 1/1/2017 to 12/31/2017

Measure specification

Numerator: count of resolved PNCs. Denominator: all PNCs. Numerator and denominator data are shown in Table 17.

Additional notes

- A priority non-complier is a water system that accumulates 11 or more points from violations. Violation points are issued for failure to meet drinking water standards.
- There were 7 counties for which PNCs were not applicable in 2016 and/or 2017: Grant, Harney, Lake, Morrow, Umatilla, Wallowa, and Wheeler.
- The following counties had no PNCs during 2016 and/or 2017 (online query revealed a blank listing): Baker, Benton, Clatsop, Crook, Gilliam, Hood River, Jefferson, Klamath, Malheur, Polk, Sherman, Wasco, and Yamhill.
- All PNCs were resolved in both 2016 and 2017.

Table 17. Environmental Health						
	Local public health process measure: % of priority non-compliers resolved					
	2016	Numerator	Denominator	2017	Numerator	Denominator
Statewide	100%	76	76	100%	57	57
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker	**	0	**	**	0	**
Benton	100%	2	2	**	0	**
Clackamas	100%	4	4	100%	5	5
Clatsop	100%	1	1	**	0	**
Columbia	100%	4	4	100%	3	3
Coos	100%	2	2	100%	2	2
Crook	100%	1	1	**	0	**
Curry	100%	7	7	100%	5	5
Deschutes	100%	3	3	100%	3	3
Douglas	100%	5	5	100%	5	5
Gilliam	100%	1	1	**	0	**
North Central PH District						
Grant	*	*	*	*	*	*
Harney	*	*	*	*	*	*
Hood River	**	0	**	**	0	**
Jackson	100%	6	6	100%	2	2
Jefferson	**	0	**	**	0	**
Josephine	100%	4	4	100%	5	5
Klamath	100%	3	3	**	0	**
Lake	*	*	*	*	*	*
Lane	100%	8	8	100%	7	7
Lincoln	100%	1	1	100%	1	1
Linn	100%	7	7	100%	2	2
Malheur	**	0	**	**	0	**
Marion	100%	7	7	100%	5	5
Morrow	*	*	*	*	*	*
Multnomah	100%	2	2	100%	1	1
Polk	100%	1	1	**	0	**
Sherman	**	0	**	**	0	**
Tillamook	100%	1	1	100%	3	3
Umatilla	*	*	*	*	*	*
Union	100%	1	1	100%	1	1
Wallowa	*	*	*	*	*	*
Wasco	**	0	**	100%	4	4
Washington	100%	5	5	100%	3	3
Wheeler	*	*	*	*	*	*
Yamhill	**	0	**	**	0	**

*Priority non-compliers (PNC) not applicable.
**0 PNCs.

Access to Clinical Preventive Services

Health Outcome Measure: Percent of women at risk for unintended pregnancy who use effective methods of contraception

Data source

Behavioral Risk Factor Surveillance System, 2016 - 2017

Benchmark

70%, provided by Oregon Health Authority, Public Health Division, Reproductive Health Program

Data collection procedure

Data provided by Oregon Health Authority, Public Health Division, Reproductive Health Program.

Measure specification

"Effective methods of contraception" includes most effective and moderately effective methods.

Definition of most effective methods: IUD, implant, female sterilization or vasectomy

Definition of moderately effective methods: pill, patch, ring, or shot

Definition of reproductive-age women at risk of unintended pregnancy:

Age: 18-49
Not currently pregnant
Have not had a hysterectomy
Not currently abstinent
Have an opposite-sex partner
Not "too old" or told by a healthcare worker they cannot get pregnant
Not trying to get pregnant or "don't mind if get pregnant" (2014)
Excludes any without known contraceptive use status (such as those who ended the survey early)

Numerator and denominator data are not provided for weighted survey estimates (Table 18).

Additional notes

- Baseline year is 2016.
- Effectiveness is only one factor that influences contraceptive method choice. Client-centered approaches should always be used in contraception counseling to ensure that an individual's choices are respected.
- There are no estimates by race/ethnicity or by county. Because of small numbers, five years of combined data are required for reporting. Five years of combined data, 2014 – 2018 for race/ethnicity and county estimates will be examined according to data suppression rules after the 2018 BRFSS data become available. Data prior to 2014 cannot be combined with later years because of the substantial changes to the wording of the BRFSS questions.
- Survey results are estimates of population values and always contain some error because they are based on samples. Confidence intervals are one tool for assessing the reliability, or precision, of survey estimates. Confidence intervals are not shown.

Table 18. Access to Clinical Preventive Services						
	Health outcome measure: % of women at risk of unintended pregnancy who use effective methods of contraception					
	2016	Numerator*	Denominator*	2017	Numerator*	Denominator*
Statewide	69%			68%		
Race/ethnicity**						
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
County**						
Baker						
Benton						
Clackamas						
Clatsop						
Columbia						
Coos						
Crook						
Curry						
Deschutes						
Douglas						
Gilliam						
North Central PH District						
Grant						
Harney						
Hood River						
Jackson						
Jefferson						
Josephine						
Klamath						
Lake						
Lane						
Lincoln						
Linn						
Malheur						
Marion						
Morrow						
Multnomah						
Polk						
Sherman						
Tillamook						
Umatilla						
Union						
Wallowa						
Wasco						
Washington						
Wheeler						
Yamhill						

*Numerators and denominators are not provided for weighted survey estimates.

**Data for race/ethnicity and county require combined years of data and are not yet available due to change in the wording of the survey question in 2014.

Local Public Health Process Measure: Annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use

Data source

LPHA annual reporting, Oregon Health Authority, Public Health Division, Reproductive Health Program

Benchmark

70%, provided by Oregon Health Authority, Public Health Division, Reproductive Health Program

Data collection procedure

The focus of funding is to support LPHAs to work collaboratively within their community to identify gaps and barriers in access to reproductive health services and ultimately develop a strategic plan focused on improving access. Funding supports LPHAs to take key steps toward developing a strategic plan, which may include identifying partners, developing collaborative relations, conducting a needs assessment or developing a strategic plan.

LPHAs are required to report their selected strategy to the Adolescent, Genetics & Reproductive Health Section, Public Health Division, Oregon Health Authority.

Measure specification

The measure is a yes-no count of LPHAs that completed strategic plans. Yes = 1 and no = 0.

The statewide percentage is the total number of LPHAs that completed strategic plans (numerator) divided by the total number of LPHAs (denominator). Numerator and denominator data are shown in Table 19.

Additional notes

- Baseline year is 2018.
- This measure includes only strategic plans that are reported to the Oregon Health Authority Reproductive Health Program and does not include strategic plans that are funded and implemented through other community initiatives.
- Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018, therefore no data are shown for Wallowa county in 2018.

Table 19. Access to Clinical Preventive Services						
	Local public health process measure: Annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use					
	2018	Numerator	Denominator			
Statewide	0%	0	35			
African American/Black						
Am. Indian Alaska Native						
Asian						
Hawaiian/Pacific Islander						
Asian/Pacific Islander						
Hispanic/Latino						
Multiple races/multi						
Other/unknown						
White						
Baker			√			
Benton			√			
Clackamas			√			
Clatsop			√			
Columbia			√			
Coos			√			
Crook			√			
Curry			√			
Deschutes			√			
Douglas			√			
Gilliam			√			
North Central PH District						
Grant			√			
Harney			√			
Hood River			√			
Jackson			√			
Jefferson			√			
Josephine			√			
Klamath			√			
Lake			√			
Lane			√			
Lincoln			√			
Linn			√			
Malheur			√			
Marion			√			
Morrow			√			
Multnomah			√			
Polk			√			
Sherman			√			
Tillamook			√			
Umatilla			√			
Union			√			
Wallowa	*					
Wasco			√			
Washington			√			
Wheeler			√			
Yamhill			√			

*Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018 (not included in the denominator).

Developmental Metric: Percent of children age 0-5 with any dental visits

Data source

Medicaid administrative claims data

Benchmark

47.8%, State Health Improvement Plan (SHIP) 2020 target

Data collection procedure

Data provided by Oregon Health Authority, Public Health Division, Oral Health Program.

Measure specification

Numerator: number of clients who received any dental service under the supervision of a dentist or dental hygienist in the measurement year. Denominator: number of clients who have continuous enrollment for 12 months in a coordinated care organization. Numerator and denominator data are shown in Table 20.

Additional notes

- Baseline year is 2016.
- This metric is considered developmental and will be tracked and reported.
- This measure includes any dental service by a dentist or dental hygienist. It does not include dental services provided in a medical setting.
- There is no local public health process measure associated with this developmental metric.
- Data are for Medicaid clients only.

Table 20. Access to Clinical Preventive Services						
	Developmental measure: % of children age 0-5 with any dental visit*					
	2016	Numerator	Denominator	2017	Numerator	Denominator
Statewide	48%	33,772	71,022	51%	38,657	75,875
African American/Black	50%	649	1,305	54%	770	1,434
Am. Indian Alaska Native	48%	402	846	54%	512	957
Asian	54%	616	1,150	57%	721	1,256
Hawaiian/Pacific Islander	40%	140	353	37%	124	332
Asian/Pacific Islander						
Hispanic/Latino	55%	4,359	7,872	61%	4,934	8,061
Multiple races/multi						
Other	43%	326	765	52%	449	867
Unknown	48%	17,190	35,446	50%	19,801	39,521
White	43%	10,090	23,285	48%	11,346	23,447
Baker	44%	137	312	48%	170	354
Benton	41%	363	891	47%	458	984
Clackamas	46%	2,293	4,969	48%	2,484	5,209
Clatsop	28%	189	665	38%	255	677
Columbia	32%	238	738	40%	310	776
Coos	49%	618	1,270	53%	733	1,371
Crook	35%	180	508	46%	241	520
Curry	43%	142	331	51%	190	372
Deschutes	51%	1,536	2,989	56%	1,801	3,225
Douglas	51%	1,084	2,114	52%	1,183	2,264
Gilliam	50%	10	20	63%	15	24
North Central PH District						
Grant	41%	37	91	48%	47	98
Harney	51%	77	152	68%	127	187
Hood River	58%	332	573	68%	404	594
Jackson	48%	2,225	4,645	51%	2,579	5,044
Jefferson	53%	303	569	55%	314	572
Josephine	46%	920	1,985	53%	1,133	2,142
Klamath	51%	697	1,379	48%	697	1,463
Lake	33%	37	111	41%	57	138
Lane	50%	3,192	6,430	49%	3,379	6,839
Lincoln	38%	321	834	42%	389	927
Linn	44%	1,138	2,577	50%	1,347	2,700
Malheur	46%	409	881	53%	533	1,012
Marion	48%	4,005	8,347	52%	4,699	9,050
Morrow	51%	150	293	62%	179	290
Multnomah	50%	5,996	12,038	53%	6,984	13,218
Polk	40%	549	1,364	40%	598	1,477
Sherman	41%	7	17	39%	7	18
Tillamook	35%	159	451	43%	191	447
Umatilla	49%	887	1,824	54%	1,019	1,886
Union	40%	210	528	44%	261	592
Wallowa	42%	56	134	46%	66	144
Wasco	52%	321	614	64%	431	677
Washington	48%	3,819	7,958	51%	4,207	8,240
Wheeler	24%	4	17	54%	13	24
Yamhill	47%	882	1,873	49%	965	1,961

*Medicaid claims data.

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Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
March 12, 2019
1:00 p.m. - 2:00 p.m.

PHAB members present: Carrie Brogoitti, Dr. Jeff Luck, Alejandro Queral, Akiko Saito, Dr. Bob Dannenhoffer
PHAB members absent: None
Oregon Health Authority (OHA) staff: Sara Beaudrault, Katarina Moseley, Karen Girard, Krasimir Karamfilov

Welcome and Introductions

Mr. Queral invited the subcommittee members and members of the public to introduce themselves. Members of the public on the call included Wendy Zieker (Marion County Health Department), Mr. Bowen (Coalition for a Healthy Oregon), Angela Johnson (Linn County Public Health), and Glenna Hughes (Linn County Public Health).

A quorum was present. Mr. Queral moved for approval of the February 12, 2019, meeting minutes. Dr. Luck seconded the motion. The subcommittee approved the meeting minutes unanimously.

Increasing Funding through Tobacco Tax Revenue

Ms. Beaudrault reminded the subcommittee that the Governor's budget for 2019-2021 included funding for public health modernization. That was the first time public health modernization funding showed up in the Governor's budget. The Governor's budget builds on the existing $5 million for the current biennium with an additional $13.6 million for the next biennium.

Ms. Beaudrault added that the Governor's budget is not our final budget. The final budget is developed and put in place by the legislature. The additional funding for public health modernization would come from increased tobacco tax revenue that Oregon would have if the tobacco tax increase passed. If that happens, these funds would be allocated for the final six months of this biennium (January-June 2021) and those funds would be in place for future biennia.

Ms. Beaudrault noted that, in terms of the Governor's budget, and what Governor Brown would like to see happen with increased tobacco tax revenue, the majority of those funds will go to Oregon Public Health (OHP). Ninety percent of those increased dollars would go to OHP, with 10% coming for public health modernization, including tobacco prevention. It will be important, as we move forward, to show how our current efforts of building capacity in communities across the state support our current direction for public health modernization,

and also support the work that can happen around tobacco prevention. These are not distinct things. We use the same tools and rely on the same skills and strategies whether we are talking about communicable disease control or tobacco prevention.

Dr. Luck asked if, according to the funding allocation graph in the packet, the new proposal would not have any tobacco tax going to the General Fund and all will go to the Oregon Health Plan or Modernization and Tobacco Prevention.

Ms. Girard confirmed that 90% of the tobacco tax funds will go to the OHP and 10% will go to Modernization and Tobacco Prevention. Also included in that are some very small amounts that would hold the existing programs funded by tobacco taxes harmless, because, if tobacco consumption goes down, the statutes in the graph that denote Counties, Cities, and ODOT will see a decrease in their funding.

Ms. Girard stated that the Governor's office is convening representatives from communities experiencing inequities and disparities in tobacco use, such as communities of color, lower income communities and organizations that represent them, and tribes to talk about the importance of a tobacco tax, both in funding prevention through the Oregon Health Plan and in providing services to reduce inequities in tobacco use. The Governor's office has held one meeting a couple of weeks ago, with another meeting coming up next week to continue these discussions.

Ms. Beaudrault clarified that the subcommittee is not talking about a course change from communicable disease control to tobacco prevention. It is talking about foundational capabilities. That is, building the local and state-wide capacity for partnership development and working with communities and groups that are most affected by health disparities. These are the things we are investing in with public health modernization. Right now, the initial dollars have been going to communicable disease control, but the work is setting the stage to enhance tobacco prevention as well.

Mr. Queral asked about the framing of communicable disease within the context of the foundational capabilities, whether it is epidemiology or several of the foundational capabilities.

Ms. Beaudrault referred Mr. Queral to the modernized framework for government public health services in the packet that showed all foundational capabilities and foundational programs. The foundational capabilities are the foundation for the programs that need to be in place. The ones we have been focusing on for the initial investment in communicable disease control have been Health Equity and Cultural Responsiveness and Assessment and Epidemiology. We have not called out Community Partnership Development explicitly, but the work is founded in strengthening community partnerships.

Ms. Moseley remarked that what we are experiencing in the Public Health Division as we are looking at health and working on enhancing our capacity in health equity and cultural

responsiveness is that it has pulled in other foundational capabilities. Community partnership development is one capability that is naturally attached to health equity and cultural responsiveness. One of the things that is helpful to think about are examples in the division, programmatically, as to where infection (STD) and HIV work cross with tobacco prevention work, is seeing these foundational capabilities rise and become attached to each other, and pull each other along, as those areas of interest come together. It is becoming harder and harder to draw lines around the foundational capabilities and say that we are doing just one or another.

Mr. Queral asked about the sustainability component of the foundational capabilities. For example, when we talk about the communicable disease and HIV prevention program, aren't we talking about not only building on the program, but also creating the foundational pieces that one would presume would stay in place even if the program is not being deployed?

Ms. Moseley responded that the foundational capabilities are how we do our work. We use the same capabilities around communicable disease, as well as around tobacco prevention, or environmental health, or access to clinical preventive services. The benefit that that starts to have is that we start to see where the populations that bear greater burden of – fill in the blank – cross over each other and become the same populations. When we start to think about communicable disease and tobacco prevention, there are examples where these are the same humans.

Mr. Queral asked if Ms. Brogoitti and Dr. Dannenhoffer could share their perspective on this, based on their experience or observation of the foundational capabilities and how they can be established beyond the life of the program. This is important because a percentage of the additional dollars would likely be linked to tobacco and there needs to be a nexus between modernization and tobacco prevention. Could we make the same case that by applying the elements of the Tobacco Prevention and Education program, we are also building on the foundational capabilities of those LPHAs that are implementing it?

Dr. Dannenhoffer noted that we are a little shy, because the last time we got money from the federal tobacco settlement, many states, including Oregon, used the money for things other than tobacco prevention, such as roads, and prisons, and whatever else. We are always cautious when we have tobacco tax money that is being spent for anything other than tobacco prevention. In the past, we focused narrowly on programs, and had to spend all our money on programs, so that there was no money to be spent on other important things. For example, in the last few biennia, Douglas Country had very little money for chronic disease and no money for suicide prevention, which are two of the big issues on the State Health Improvement Plan. Because of all this, Dr. Dannenhoffer is torn about this and does not have good advice.

Ms. Brogoitti agreed with Dr. Dannenhoffer. In the absence of a clear answer or path and considering that local health departments have been working in an under-resourced system for so long, there are needs everywhere. It is hard to pick and choose and prioritize. While we do have needs in tobacco prevention, and we know how much tobacco impacts the health of our

communities, there are also other needs that we have identified in our communities where we don't get any resources to support them. There is no one right or wrong answer.

Mr. Queral reminded the subcommittee that during its last meeting the subcommittee came up with a recommendation to the PHAB to stay the course with respect to the first $5 million dollars that are going to be allocated towards modernization. Is it correct that there is $5 million allocated from the General Fund, plus the $13.6 million coming from tobacco tax increase, if the bill passes and survives a challenge at the ballot?

Ms. Beaudrault responded that that was correct. We feel confident the $5 million that is currently in the OHA budget for public health modernization will be there going into the next biennium, although there is no guarantee. The $13.6 million would be new money coming into the system. The subcommittee already discussed the challenges of handling the money, as it will hit the system fast, with a very short amount of time (i.e., six months) to spend the first chunk of money at the end of this biennium.

Ms. Beaudrault added that public health modernization sets up the PHAB to have a large role in setting the direction for how the system is scaled up, which also includes a component of how funding is directed. It is important that new money coming into the system remain flexible enough to honor the role of the PHAB. To the extent that we can, we want to avoid being prescriptive about how funding is used for categorical public health programs, because that would keep us in the system in which we already exist.

Ms. Queral stated that the LPHAs that received funding in the first round would be informed that we would stay the course with those $5 million. In addition, we would have another $5 million. Could the PHAB frame this second round as work on any of these foundational capabilities through the application of their program? If it's tobacco, they could say that they would work on health equity and cultural responsiveness to build their capacity of, for example, health equity and cultural responsiveness, community partnership development, and communications, which are three key elements of TPEP. It can be expressed in such a way that regardless of what the program is, their focus is on building their foundational capabilities. In a sense, the program becomes the money vehicle. Would that be an approach that allows us enough flexibility and, at the same time, sets up LPHAs to receive the additional funding from the tobacco tax, if that comes through?

Ms. Beaudrault clarified that we have $5 million in the current biennium. We are looking at the same, flat funding in the next biennium. That is what is sitting in the budget right now. It would not be an additional $5 million. It would be the same level of funding (i.e., $5 million) in the next biennium, with the potential for increased funding through tobacco tax.

Mr. Queral noted that the PHAB could inform LPHAs to stay the course, without altering the recommendation from last time. If they are working on communicable disease and feel that they need more money, they should keep working on that. But if they feel that they can

develop any of the foundational capabilities, anticipating additional funding from the tobacco tax, that scenario would be Option B.

Ms. Beaudrault remarked that OHA puts funding out to LPHAs through program elements, which are contracts that spell out the requirements. The requirements for the current funding are not specifically focused just on communicable disease control. The requirements include engaging local organizations, building partnerships with tribes and recs, providing culturally responsive interventions within in the community, and working towards health equity. The contractual requirements already set up the work to build capacity for the foundational capabilities.

Mr. Queral ensured that all PHAB members were clear about what the subcommittee was being asked to recommend to the PHAB. The subcommittee already made a recommendation. Now the subcommittee needs to reaffirm it and then the PHAB will vote on it during the March 21, 2019, PHAB meeting.

Mr. Queral asked for questions from the subcommittee members about how to set up the programs if there was an additional $13.6 million from tobacco taxes, and how that money would be spent or distributed.

Dr. Luck confirmed that the options are clear. Because the $13.6 million is uncertain, he did not feel that the subcommittee should be too prescriptive about how the money should be spent.

Mr. Queral noted that, to some extent, the subcommittee has to be prescriptive with the tobacco tax revenue. Some portion of that would need to go directly to TPEP implementation at the local level. The subcommittee has to be flexible enough so that LPHAs can work on the foundational capabilities and building that capacity, while, at the same time, being aware that there may be additional dollars that would allow them to further work on their foundational capabilities, but through the implementation of TPEP, not something else that they decide.

Mr. Queral stated that, in a sense, that could be the subcommittee's recommendation: Stay the course. Keep working on foundational capabilities, with the anticipation of additional dollars coming to continue working on foundational capabilities; and emphasizing TPEP.

Dr. Luck asked if the 10% of the tobacco revenue equal the $13.6 million, and if the $13.6 million has to be allocated to both modernization and tobacco prevention.

Ms. Beaudrault responded that that is approximately 10%.

Ms. Girard remarked that all this is assuming that the tobacco tax goes into effect in the last six months of the biennium. Roughly, it is a fourth of what we would expect the tobacco tax increase to bring in over a biennium.

Ms. Beaudrault recommended not focusing too heavily on the $13.6 million. In the first full biennium (2021-23), it would be a large increase in funding coming to public health to support modernization and tobacco prevention.

Dr. Luck calculated that to estimate that for a biennium, we roughly multiply 13 by 4.

Ms. Girard confirmed the accuracy of the rough calculation.

Ms. Saito suggested that one of the subcommittee's recommendations should be to not separate public health modernization from tobacco prevention, because tobacco prevention is part of the foundational program Prevention and Health Promotion. If we are talking about modernization dollars, we should be talking about more of what Ms. Beaudrault mentioned. Namely, what we want these funds to be, not necessarily what program we want them to go to. For instance, whatever this money comes for, whether it is for tobacco prevention or communicable disease, we should be focusing on making sure there is leadership and organizational competencies, making sure that there is a focus on health equity and communities that experience health inequities, and making sure that there is a policy piece.

Ms. Saito added that if we are saying 10%, and that some of it will go to tobacco prevention and the other part will go to modernization, that is not the message we want to send. We want to say that everything is going to modernization, and because tobacco prevention is one of the foundational programs that really helps, we want to make sure that even tobacco prevention dollars that we use is within the modernization perspective and using all modernization pieces.

Mr. Queral agreed with Ms. Saito and invited comments from the subcommittee members. Dr. Luck, Dr. Dannenhoffer, and Ms. Brogoitti liked Ms. Saito's suggestion.

Ms. Beaudrault pointed out that OHA is not asking for well-developed recommendations from this subcommittee on additional funds coming though tobacco tax revenue at this point in time. There is way too much activity, and we are early in the conversation. It has been very helpful to hear the subcommittee's thinking on it, and to hear that there is some understanding and agreement about how we can move these conversations.

Mr. Queral agreed that there was a consensus and that it was a good time to go back to the PHAB and report the subcommittee's perspective. Will the PHAB vote and formalize the recommendations during its March 21, 2019, meeting?

Ms. Beaudrault remarked that we are going to ask the PHAB through this subcommittee to vote just on the $5 million. That is, use of the $5 million that we have now and that should be in place at the beginning of the next biennium. This is the only piece we want to get formalized.

Sustaining 2017-2019 investment in LPHA partnerships

Ms. Beaudrault presented the subcommittee's recommendations from its February 12, 2019, meeting for distributing funds to LPHAs if funding remained at $5 million. It is important to have the recommendations captured exactly as the subcommittee members defined them. The reason we want to get firm on the use of the $5 million, assuming we have flat funding going into the next biennium, is because we at OHA need to start doing the planning work to make sure we can get these dollars out immediately to LPHAs. That work needs to start now, so we want to make sure that the PHAB is settled on these recommendations.

Mr. Queral read the four recommendations. Although he did not recall discussing one of the recommendations (#3), he invited the subcommittee members to comment on the recommendations, ask questions, or propose changes.

Ms. Saito remembered discussing recommendation #3 because there were a couple of counties that were not involved initially and the subcommittee wanted to give them an opportunity to join another group. Some of counties in eastern Oregon (e.g., Wallowa) did not apply initially. Ms. Saito approved the four recommendations moving forward and asked if the other subcommittee members were ready for a motion.

Ms. Beaudrault commented that the subcommittee does not need to make a motion as long as its members come to an agreement. We do want the PHAB to take some sort of action toward approval.

Mr. Queral invited Ms. Brogoitti, Dr. Luck, and Dr. Dannenhoffer to express any concerns or thoughts.

Dr. Dannenhoffer informed the subcommittee that he presented the four recommendations to the CHLO meeting in February and they were well accepted.

Ms. Brogoitti stated that she felt strongly about allowing all local health departments to participate. The whole intent behind what we are doing is to raise everybody up. It would be good if LPHAs that have not participated were allowed to join an existing group.

Dr. Dannenhoffer noted that this was discussed during the last CLHO meeting. Yes, LPHAs should be able to come in at the same level as everybody else could, but not as a single country, but as a group. If people wanted to form their own group, or join an existing group, that would be acceptable.

Dr. Luck asked how many LPHAs are not participating now.

Dr. Dannenhoffer responded that there are three counties: Josephine, Yamhill, and Wallowa.

Ms. Beaudrault clarified that there are two, as Wallowa Country does not have a local public health authority.

Dr. Dannenhoffer remarked that the two counties that have health departments and are not participating are Josephine County and Yamhill County. Both counties are between groups that are already existing.

Mr. Queral concluded that the subcommittee is clear on the recommendations and can move forward.

Ms. Beaudrault stated that the recommendations will be included in the agenda for the PHAB meeting on March 21, 2019, for formal discussion and vote. The reason we want to have the PHAB vote on this is because, in order to get the dollars out to LPHAs, beginning in July 2019, we need to start doing the planning work now. We heard loud and clear that we needed to take whatever efforts we could to minimize break in funding, protect the staff that have been hired, and protect the ongoing partnerships that have been developed.

Ms. Beaudrault emphasized the goals: No interruptions in work, and allowing the eight LPHA partnerships time to identify whatever course corrections and natural progressions they want to start building in in 2019-2021, which would include bringing in Yamhill and Josephine counties, if they want to join. In addition, we will be working with CLHO through our regular processes to make updates to the program element to reflect the changes that we need to make. We are planning to do a 3-month continuation of current workplans and budgets to get us through the first quarter of the next biennium, since we won't have the final OHA budget as of July 1. This is the way we have figured out to get the funds out and allow the work to continue, while we are still sorting out some of the details of the biennium.

Mr. Queral asked if Ms. Saito could chair the subcommittee meeting on April 9, 2019.

Ms. Saito responded that she could, and thanked Ms. Queral for chairing two subcommittee meetings in a row.

Public Comment

Mr. Queral invited members of the public to ask questions and provide comments.

There was no public comment.

Closing

Mr. Queral adjourned the meeting at 1:46 p.m.

The next Public Health Advisory Board Incentives and Funding subcommittee meeting will be held on April 9, 2019, at 1:00 p.m.

Incentives and Funding subcommittee recommendation for distributing funds to LPHAs if funding remains at $5 million

1. Use funding to continue LPHA partnerships that are currently funded.
2. Avoid an RFP process, and take steps to minimize funding disruptions.
3. Allow LPHAs that were not involved in 2017-19 to join an existing group.
4. Use funding to advance local/regional systems for Communicable Disease Control and Health Equity and Cultural Responsiveness.
   - The general framework would remain the same, but partnerships could change goals, strategies and focus areas. This will allow for natural progressions and course corrections.

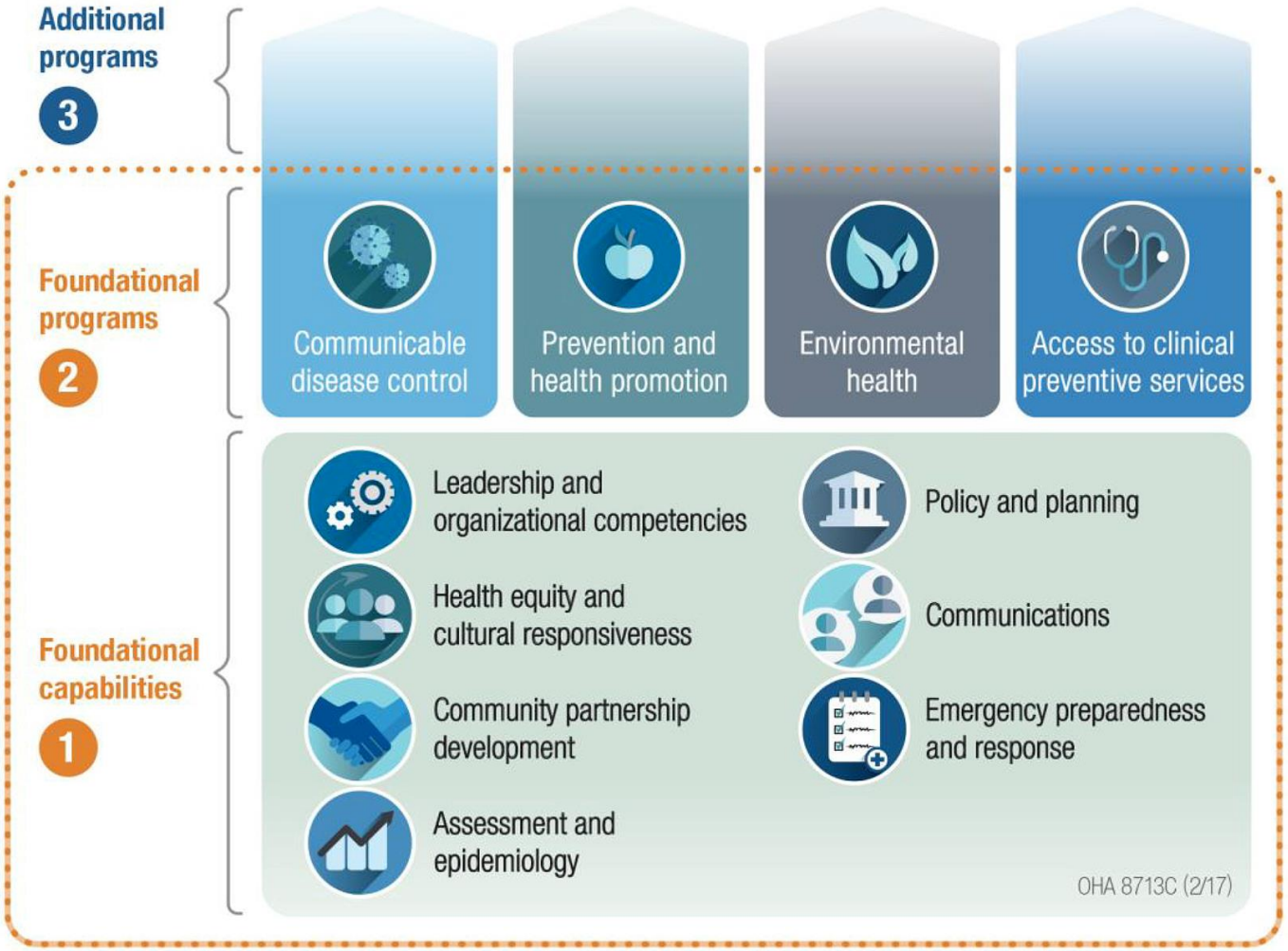
Action: vote to approve subcommittee recommendation

Public Health Modernization
Data Access and Visualization

Ali Hamade, PhD
Deputy State Epidemiologist
March 21, 2019

Oregon Health Authority

Modernized framework for governmental public health services



Public Health Modernization

Foundational programs and capabilities are present at every health department.

Additional programs address local priorities.

Items to ponder during the presentation

- Are we missing any important data access & visualization strategies in terms of modernizing Oregon's public health system?
- What feedback do you have on this plan or strategy?
- Do you see any underlying biases in our plan for data visualization?

Interactive data visualization enables data representations on a graph, table, or map with the ability to change variables and link multiple media.

Assessment and Epidemiology Capability activities for State and LPHAs

- Data collection and electronic information systems
  - Guide public health planning and decision making
- Data access, analysis, and use
  - Accurate, timely, actionable, usable, meaningful to requester
- Conduct and use community and statewide health assessments
  - Identify health priorities from assessments, including health disparities assessment
- Infectious disease related assessment
  - Identification and response to disease outbreaks and epidemics

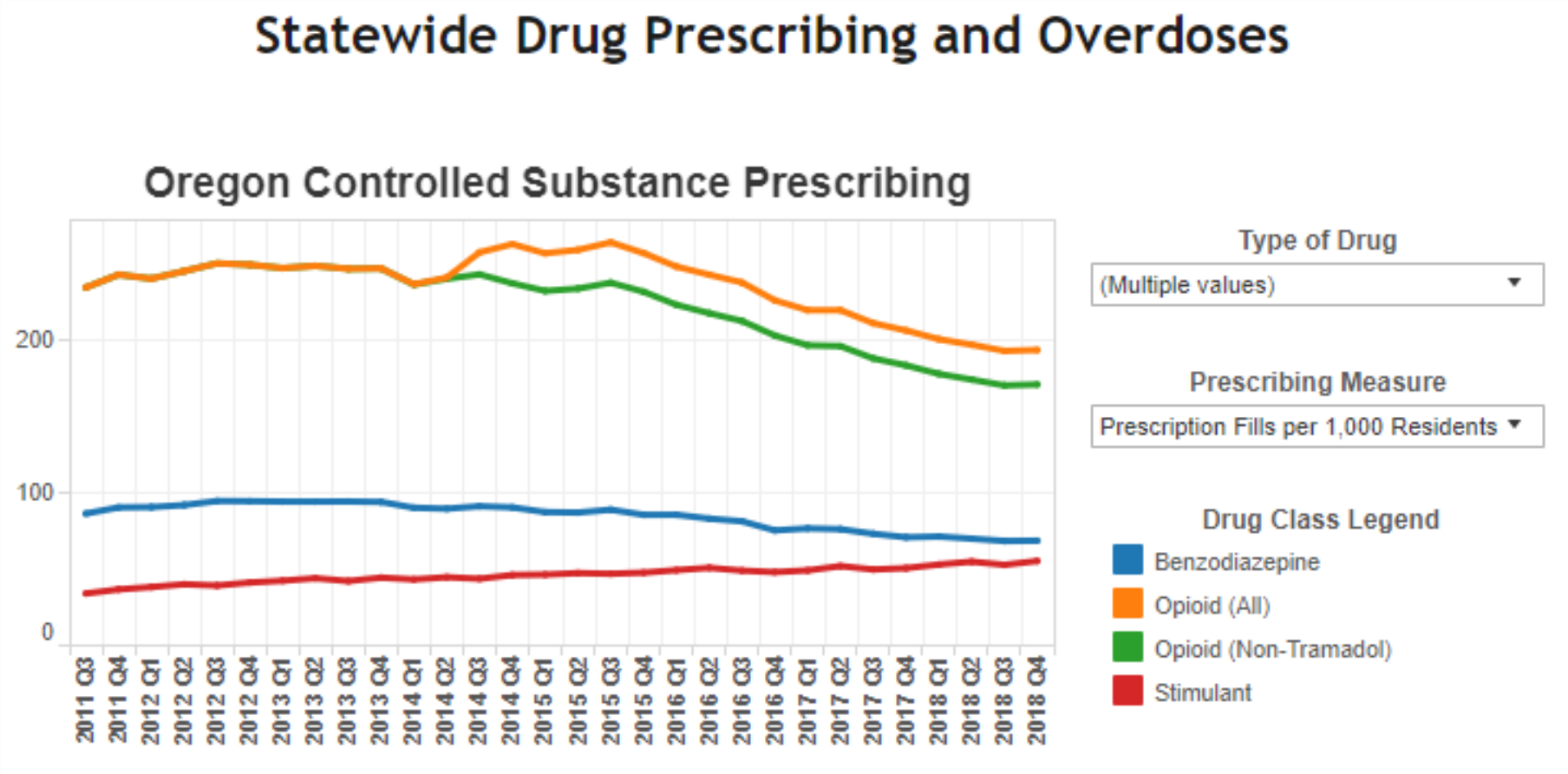
Data visualization initiative aims

- Data access
- Faster evidence-based planning
- Staff time savings and capacity increase
- Interoperability of systems

↓

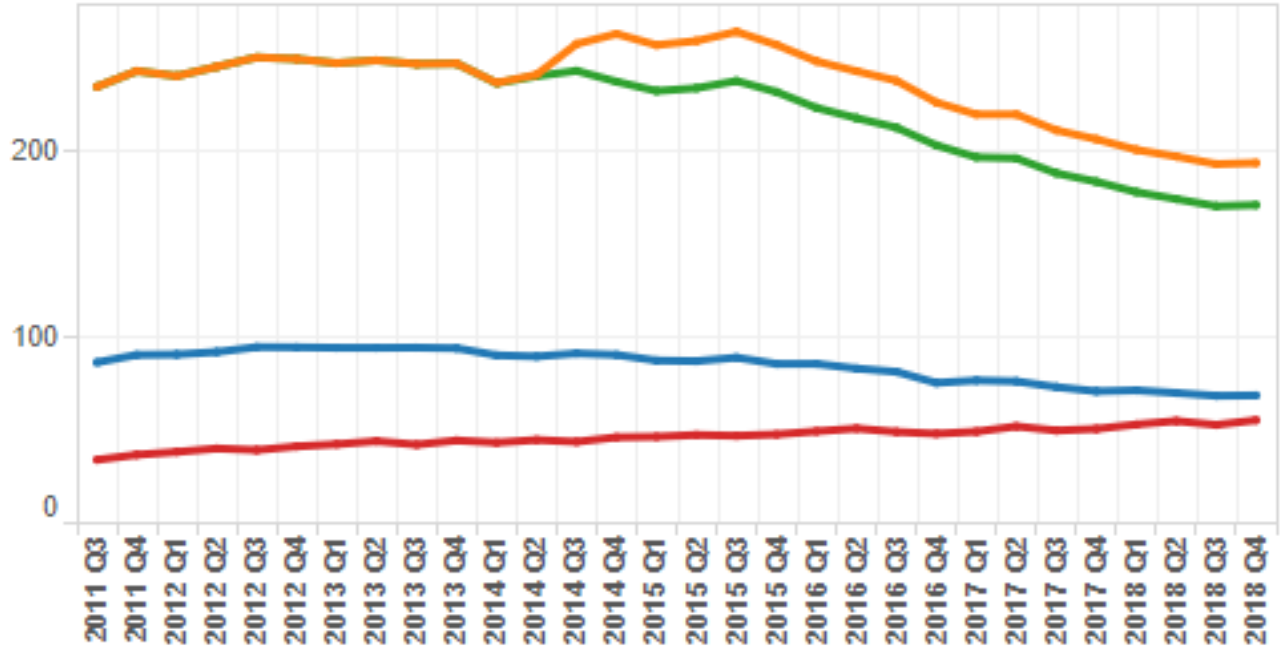
Benefits to state agencies, LPHAs, tribes, policy-makers, community-based organizations, advocates, media

Interactive data visualization



Statewide Drug Prescribing and Overdoses

Oregon Controlled Substance Prescribing

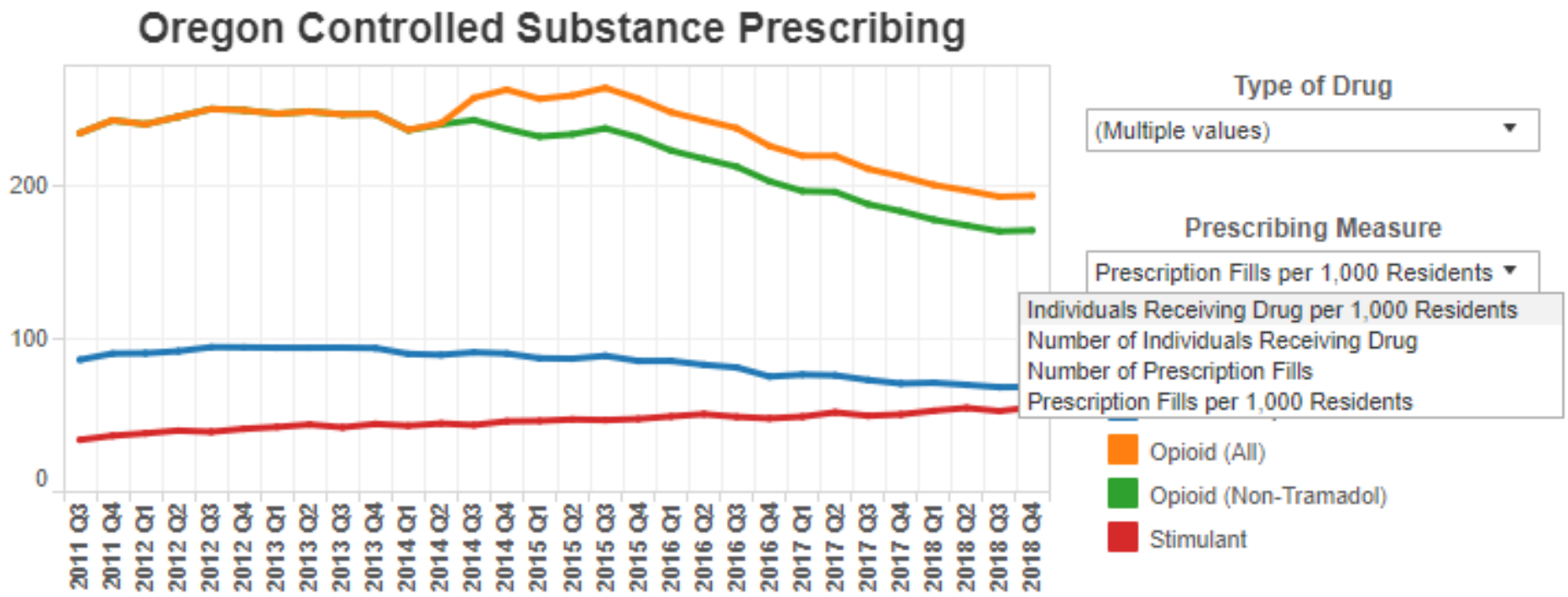


Type of Drug

(Multiple values)

- [x] Benzodiazepine
- [ ] Buprenorphine
- [ ] Buprenorphine / Naloxone
- [ ] Methadone (for pain)
- [ ] Muscle Relaxant
- [ ] Naloxone
- [ ] Non-Benzo Sedative
- [x] Opioid (All)
- [x] Opioid (Non-Tramadol)
- [ ] Pseudoephedrine
- [x] Stimulant

Statewide Drug Prescribing and Overdoses



OR Epi 2019 Registration Status

Return to the OR Epi homepage

04/24/19
Start Date

04/26/19
End Date

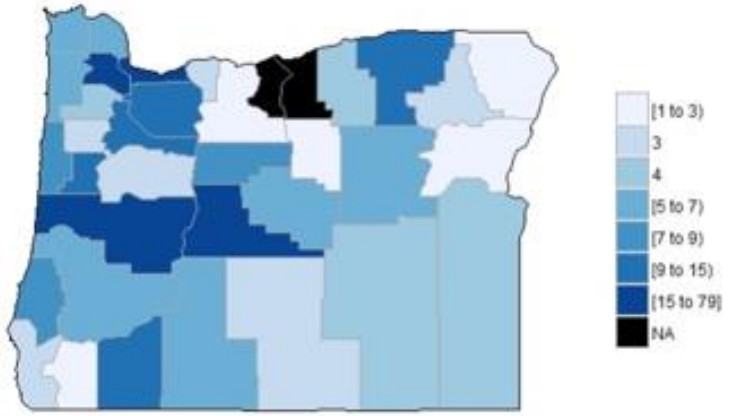
55
Days Until Event

301
Total Registrants

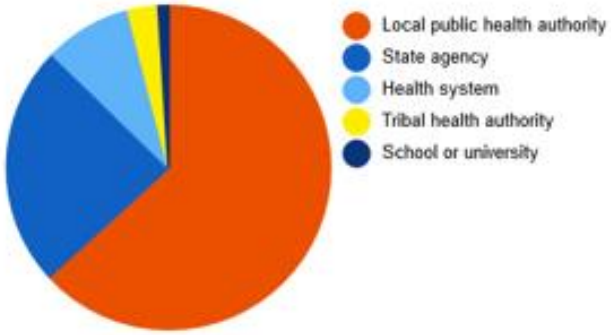
Updated: 3/1/2019

Registration, by Day

Registration, by County

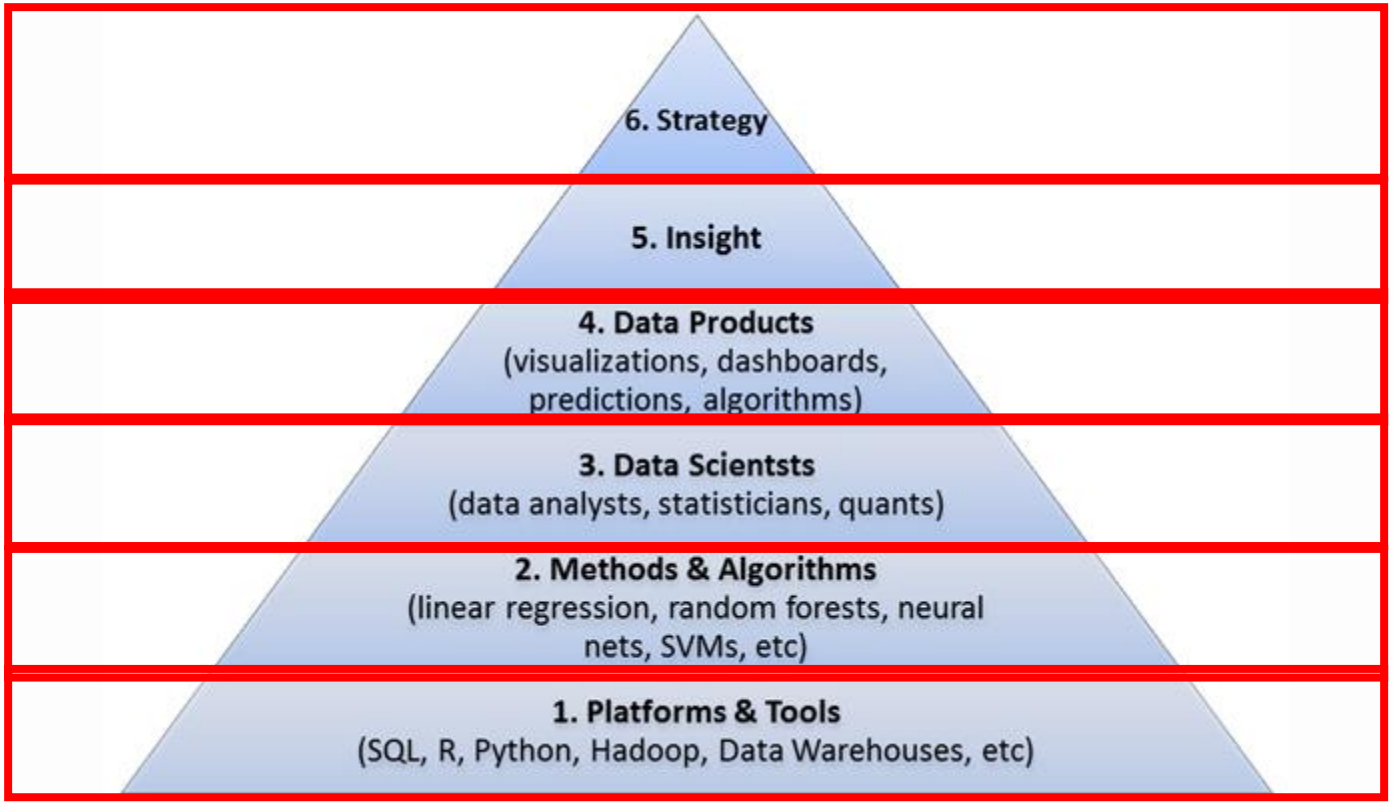


Registration, by Jurisdiction



Need to register for a post-conference session? Click **here**!

Science behind the finished product



Data access and visualization priorities

- Vital Records
  - Birth and death data
- Reportable conditions
  - ORPHEUS, OSCaR
- Survey data
  - BRFSS; OHT; Student Health Survey; PRAMS I/II
- Service delivery
  - Alert IIS (Immunizations); Oregon Trauma Registry, Prescription Drug Monitoring Program
- Environmental and Regulatory
  - Safe drinking water information system
- Emergency Preparedness and Response
  - Electronic Surveillance System for Early Notification of Community Based Epidemics (ESSENCE)

Measuring our performance on data visualization

	Benchmark	Points
1	Data visualization plan in place that includes maintenance	1
2	Data visualization and database software acquired and staff available who can use it	1
3	Back-end database created OR If project already complete, data updated per schedule in plan	1
4	Data visualization created and published	1
	Score for comprehensive projects	sum of 1 to 4
	Score for partial projects	50%

Performance measure plan

- All data set owners will develop a plan that details how they will publish and share data interactively
- Plan will include items on
  - Partner engagement
    - How to best share data with LPHAs, tribes, others
    - Ensure that data are useful for partners
  - Evaluation
  - Continuous Quality Improvement

Questions and discussion

- Are we missing any important data access & visualization strategies in terms of modernizing Oregon's public health system?
- What feedback do you have on this plan or strategy?
- Do you see any underlying biases in our plan for data visualization?

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Oregon Health Authority

Oregon Health Authority
Health Systems Division
Behavioral Health

Presented to
Public Health Advisory Board
March 21, 2019

Margie Stanton, OHA Health Systems Division Director

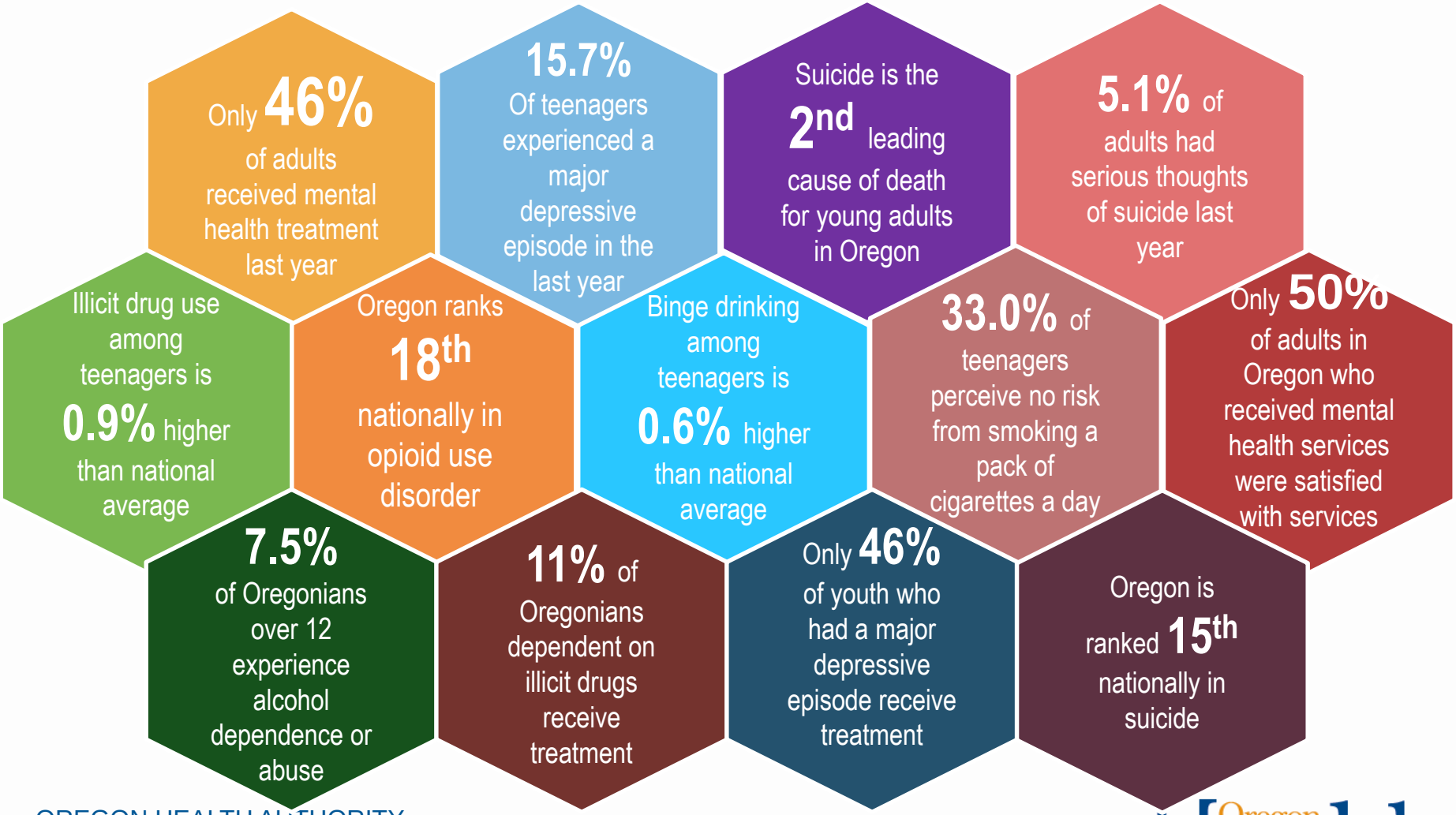
Why HSD and Behavioral Health

What Behavioral Health Does

Strategies and Successes

Challenges

Behavioral Health in Oregon



Behavioral Health Where We Live, Work, and Learn

The Triple Aim Vision for Oregon

Why HSD and Behavioral Health

What Behavioral Health Does

Strategies and Successes

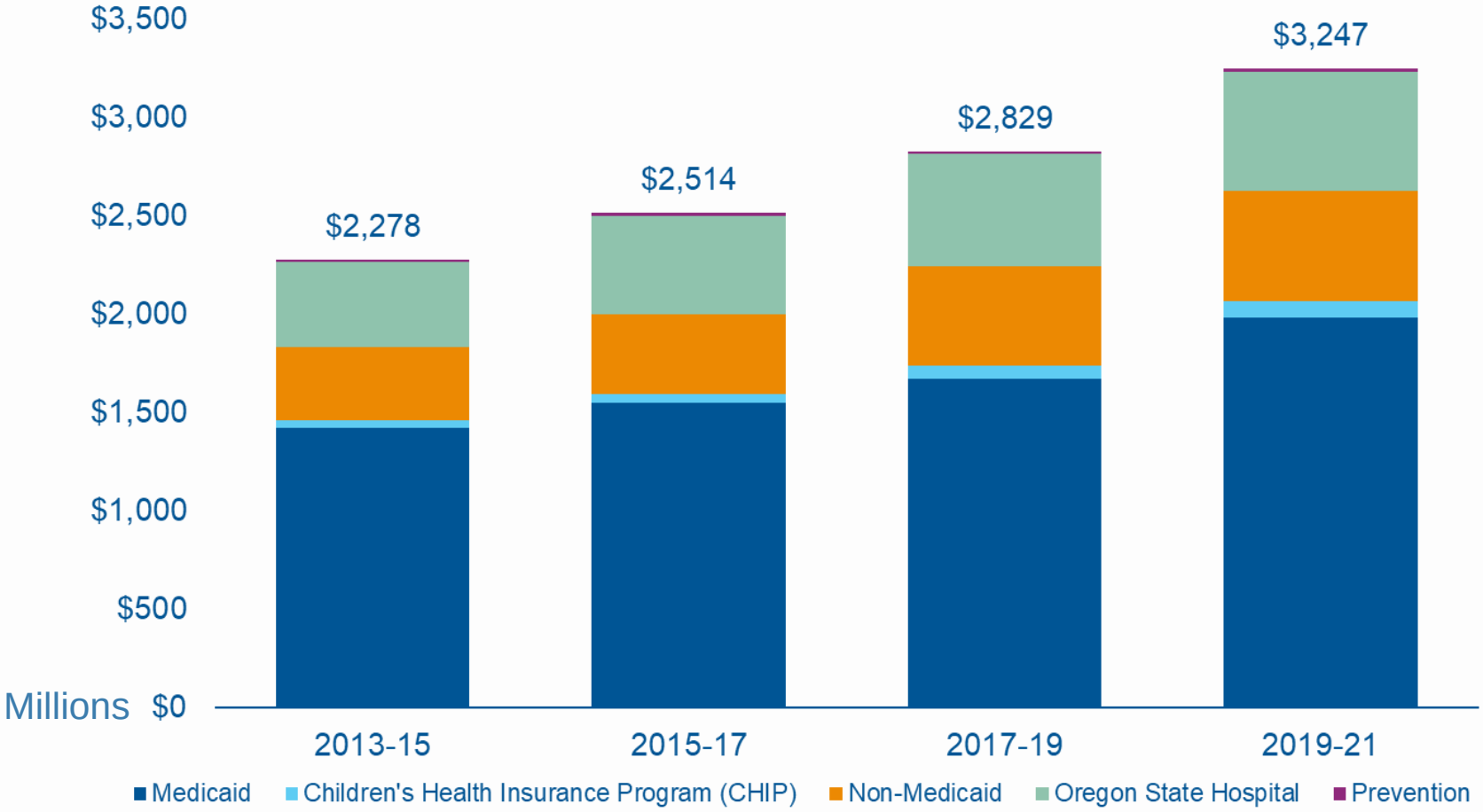
Challenges

Behavioral Health Vision

To provide access to behavioral health services in the **right place** at the **right time**

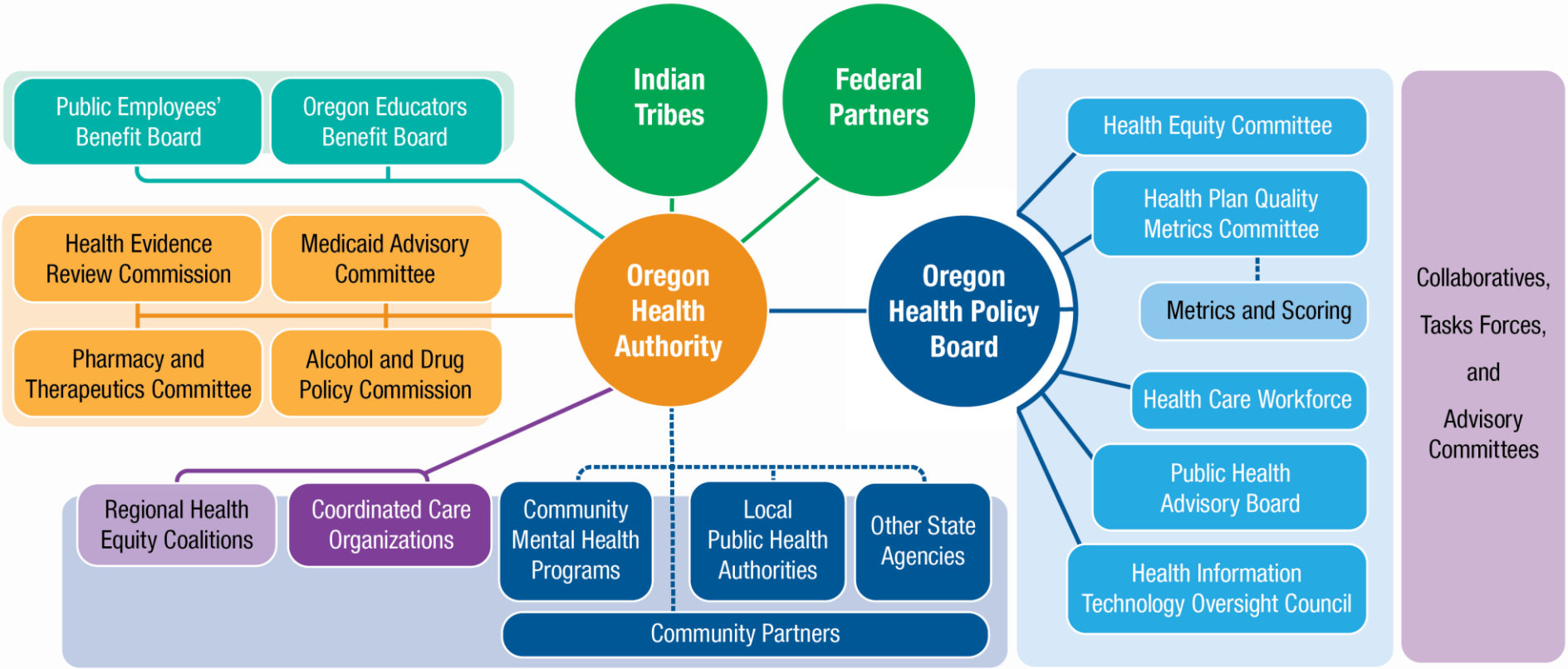
Elements of Behavioral Health Services

Historical OHA Behavioral Health Spending

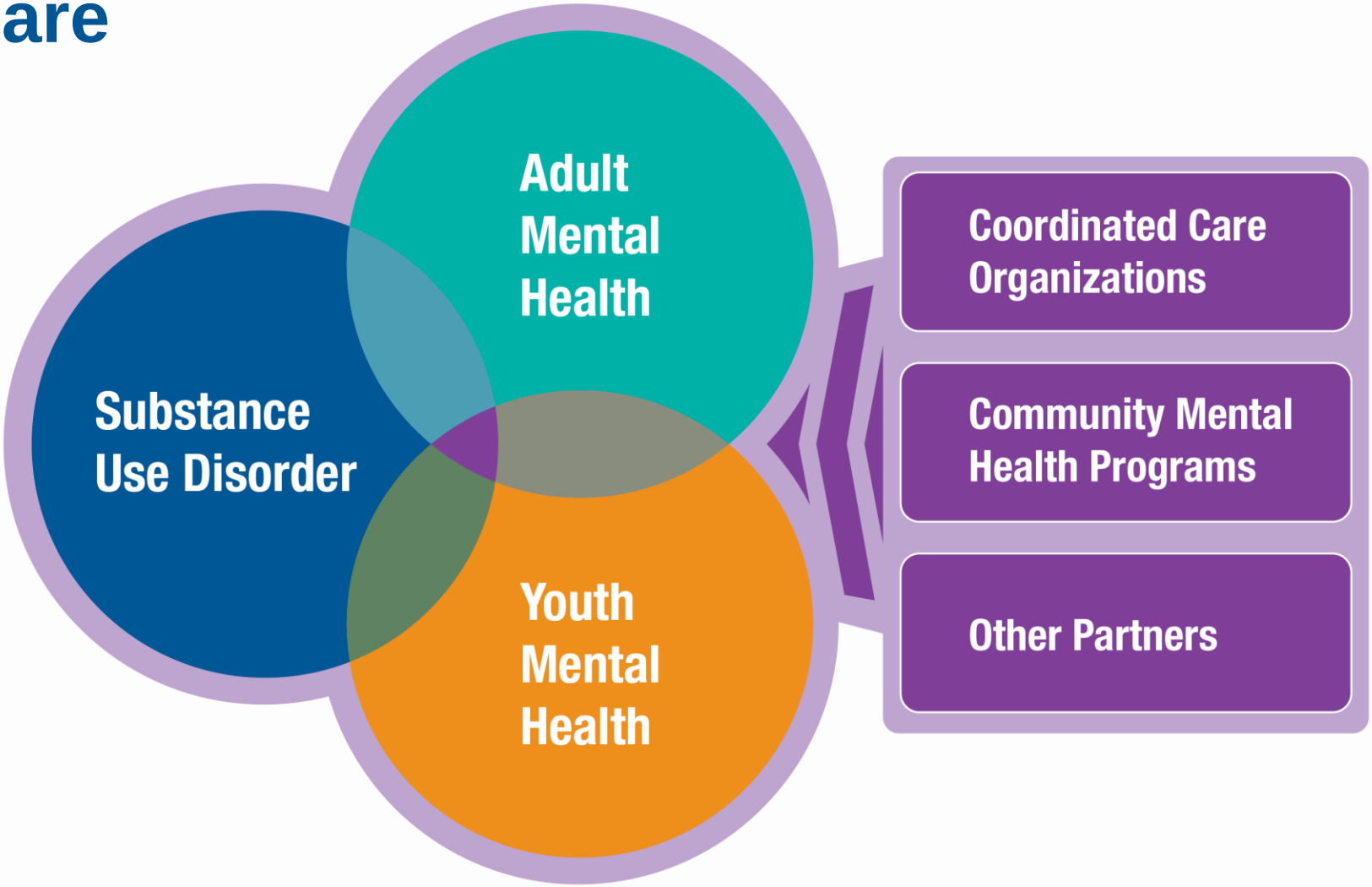


OREGON HEALTH AUTHORITY
Health Systems Division

Behavioral Health Partners



How HSD Behavioral Services Delivers Care



Why HSD and Behavioral Health

What Behavioral Health Does

Strategies and Successes

Challenges

Strategy: Strengthen Community Mental Health Services

- Oregonians with serious and persistent mental illness need access to services and supports to help them achieve and maintain stability in their own communities.
- We want to prevent crises and the need for hospitalizations whenever possible.

Success: Increased Availability of Services

Through increased services in the community:

- Mobile crisis services have increased 130%
- Supported housing has increased 134%
- Peer supported services have increased 75%
- Emergency department recidivism has reduced by 42%

Success: Permanent Supportive Housing

- Housing as a Social Determinant of Health
- Over 1600 individuals served statewide
- OHA provides rental assistance, housing support services, and barrier removal

Strategy: Expand Access to Evidence-Based Treatment

- Strategic investments to build substance use disorder treatment capacity and infrastructure in rural and underserved communities.

Success: Increased Capacity in Rural Oregon

- 200 more providers now qualify to provide MAT statewide
- Treatment access now in Oregon's most underserved areas (Douglas County and North Coast)
- 8 counties can now provide naloxone to reverse opioid overdoses (121 overdoses reversed so far)
- Beyond establishing a physical access point for treatment, these new programs are hubs for training and education for the whole community

Strategy: Supporting the Behavioral Health Priorities of Oregon's Tribes

- Provides funds to improve the tribal behavioral health system through:
  - Tribal Mental Health Investments
    - Mental health promotion and prevention
    - Crisis services
    - Jail diversion
    - Supportive housing
    - Peer supports
    - Care coordination
  - Addressing the Opioid Epidemic through prevention, treatment and recovery
  - SUD Outpatient Programs

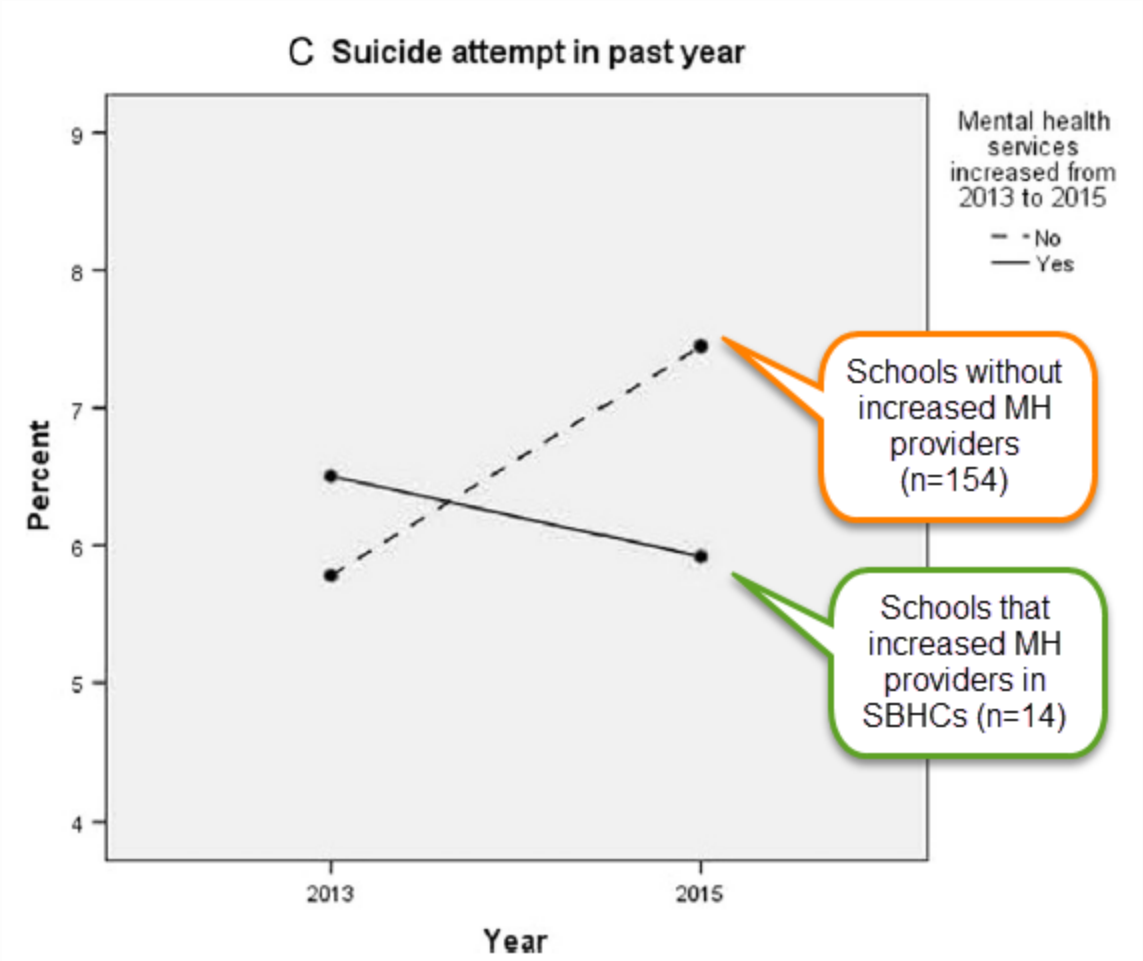
Success: Removing Barriers for Tribal Behavioral Health

- Tribal BH strategic plan is currently under development led by Oregon Tribes with support from the Urban Indian Health Program, Northwest Portland Area Indian Health Board, and OHA
- Carveout for Tribal Behavioral Health Programs based on the priorities set forth in the strategic plan.
- With this increased funding and flexibility the tribes can serve their members with culturally responsive care to best meet the individual and family needs.

Strategy: Support Children and Families

- Families need intergenerational support to facilitate healing, protective bonds between parent and child.

Success: Reduced Youth Suicide Attempts



Success: Parent Child Interaction Therapy

- PCIT is Evidence Based Treatment that teaches parents how to reduce negative behaviors in their children (ages 2-6), and reinforce positive ones, without resorting to maltreatment
- 36% reduction in disruptive behavior in school and home
- Reduced reports of child maltreatment in families who received PCIT

Success: Keeping Families Together Through Recovery

Why HSD and Behavioral Health

What Behavioral Health Does

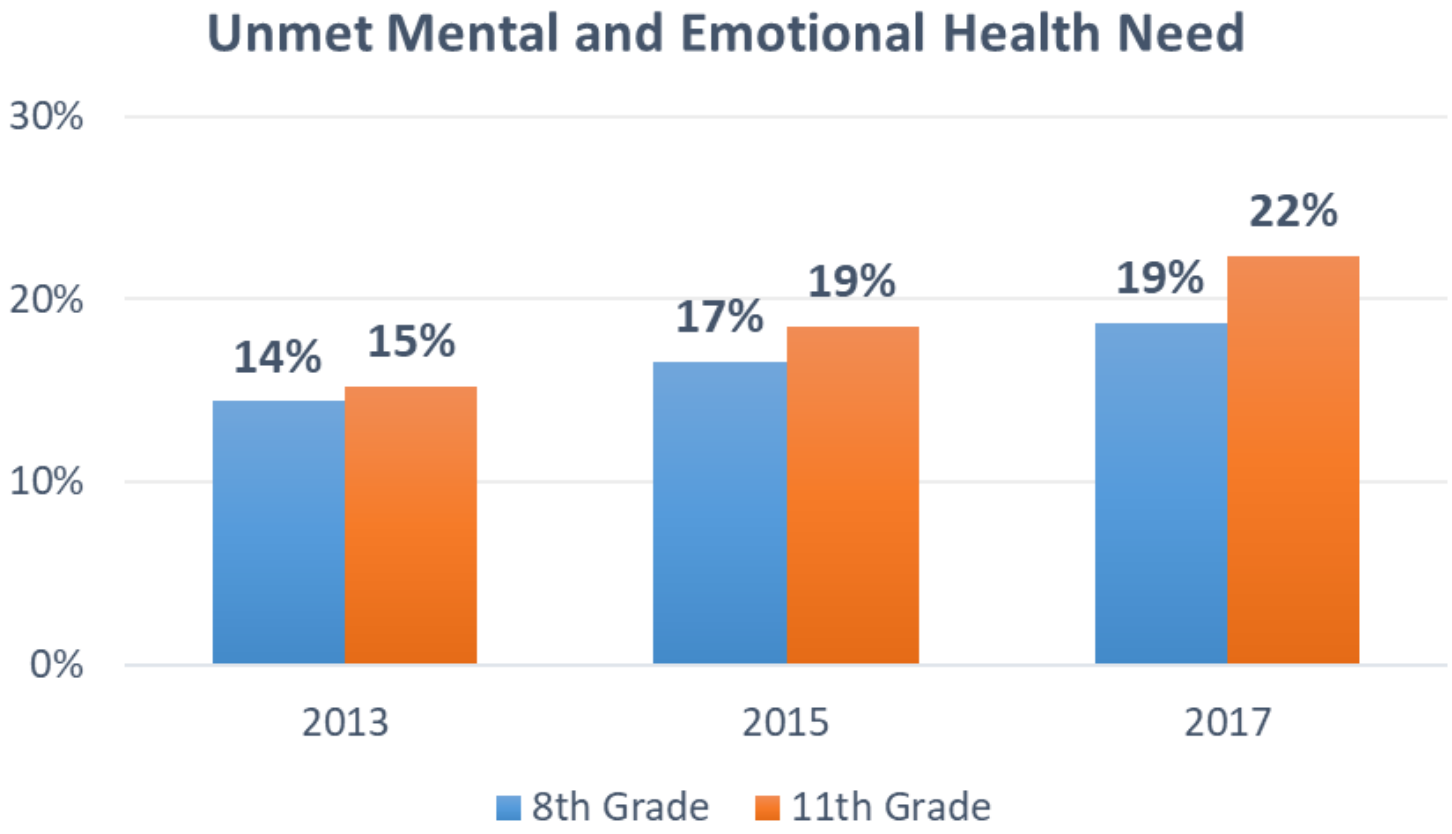
Strategies and Successes

Challenges

Challenge: Urgency for Intensive Children's Services

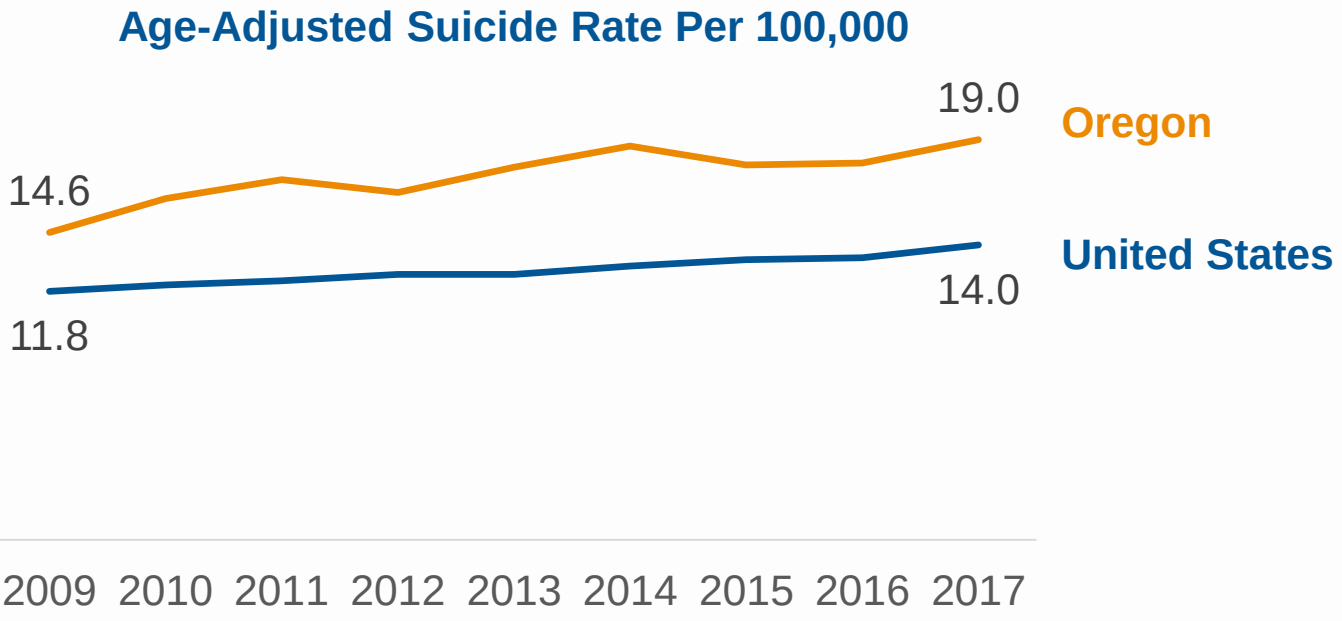
- Keeping children close to home with their families is critical
- Children with complex needs and their families need better access to community services
- Coordination challenges, often involving multiple state systems, can create unnecessary disruption and stress for children
- More residential care, more diversity in outpatient services, and more in-home crisis support are needed

Challenge: Unmet Mental Health Need in School Age Youth



Source: 2013, 2015, 2017 Oregon Healthy Teens Survey

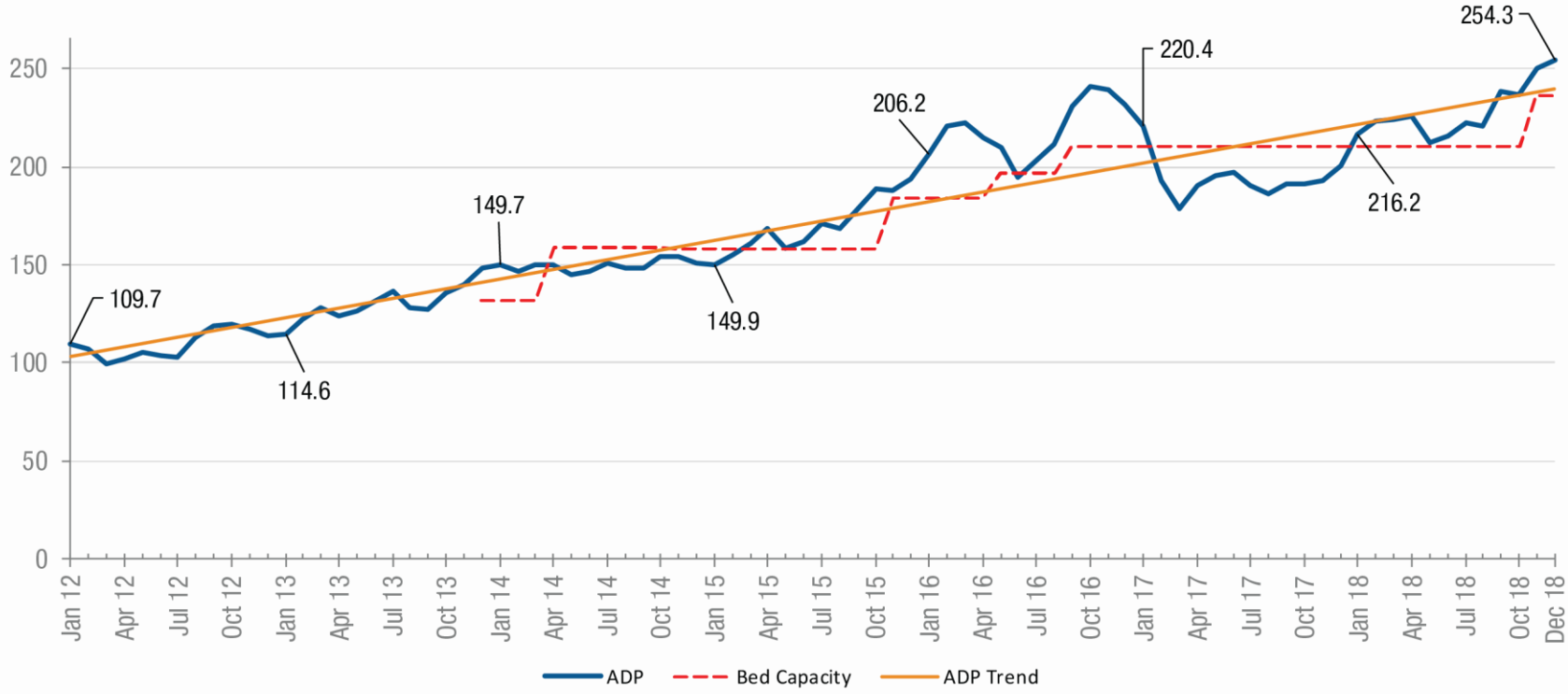
Challenge: Suicide Rate Above the National Rate



Challenge: Aid & Assist

OSH Aid and Assist (ORS 161.370) patient Average Daily Population (ADP) and Bed Capacity

(Includes OSH-Salem, OSH-Portland, OSH-Junction City & BMRC)



Challenge: Integration of Behavioral Health

- Integration of behavioral and physical health
- Expanding Evidence Based Mental Health treatments
- Connecting Behavioral Health providers

Thank You

Margie Stanton

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Oregon Health Authority