AGENDA

PUBLIC HEALTH ADVISORY BOARD

February 16, 2017
2:30-5:30 pm
Portland State Office Building, 800 NE Oregon St., Room 1A, Portland, OR 97232

Join by livestream
Conference line: (877) 873-8017
Access code: 767068

Meeting objectives

- Discuss Public Health Advisory Board work plan and charter for 2017
- Share information about the work of the Public Health Advisory Board subcommittees
- Review high priority bills for the Public Health Division, including the public health modernization bill
- Provide guidance on proposal for public health system approach for health equity
- Review and provide guidance on Preventive Health and Health Services block grant activities

2:30-2:40 pm	**Welcome and updates** • Approve January 19 meeting minutes • Welcome new board member: Rebecca Pawlak, Oregon Association of Hospitals and Health Systems	Jeff Luck, PHAB Chair
2:40-3:00 pm	**Public health modernization updates** • State health assessment • Statewide public health modernization plan • ACA investments in public health	Jeff Luck, PHAB Chair
3:00-3:20 pm	**2017 work plan and charter** • Provide feedback on work plan topics, activities and deliverables • Determine meeting frequency for 2017 • Review proposed changes to PHAB charter	Jeff Luck, PHAB Chair
3:20-3:40 pm	**PHAB subcommittee updates** • Share information and progress from the January 26 Accountability Metrics subcommittee meeting • Share information and progress from the February 14 Incentives and Funding subcommittee meeting	Jennifer Vines, Accountability Metrics subcommittee Jeff Luck, Incentives and Funding subcommittee
3:40-4:00 pm	**Legislative update** **Overview:** Oregon's 2017 legislative session began on February 1st. PHAB members will receive an update on the high priority bills that are being tracked by the Public Health	Holly Heiberg, Oregon Health Authority Cara Biddlecom, Oregon Health Authority

	Division, including information about the changes proposed to Oregon Revised Statutes for public health modernization. **Objectives:** • Review high priority bills for the Public Health Division • Review House Bill 2310, public health modernization	
4:00-4:15 pm	**break**	
4:15-4:45 pm	**Public health system approach for health equity** **Overview:** Public Health Division will provide an update on the work of the PHD Health Equity Working Group and propose an approach for advancing health equity work at the systems-level across the state. **Objectives:** • Review and provide guidance on proposal for public health system approach for health equity	Tim Noe and Kati Moseley, Oregon Health Authority
4:45-5:00 pm	**Preventive Health and Health Services Block Grant** **Overview:** The Public Health Advisory Board is Oregon's advisory committee for the Preventive Health and Health Services Block Grant. At this meeting, PHAB will receive an overview of the block grant and its previous and current activities. In March, PHAB will review a proposal for the October 2017 through September 2018 work plan which will be submitted to CDC before end of March. **Objectives** • Review progress toward work plan activities • Provide feedback on planned work plan activities	Danna Drum, Oregon Health Authority
5:00-5:10 pm	**Public comment**	
5:10 pm	**Adjourn**	Jeff Luck, PHAB chair

Public Health Advisory Board (PHAB)
January 19, 2017
Draft Meeting Minutes

Attendance:

Board members present: Carrie Brogoitti, Muriel DeLaVergne-Brown, Silas Halloran-Steiner, Katrina Hedberg, Safina Koreishi, Jeff Luck, Alejandro Queral, Akiko Saito, Teri Thalhofer, Tricia Tillman, and Jennifer Vines

Oregon Health Authority (OHA) Public Health Division (PHD) staff: Cara Biddlecom, Jeston Black, Karen Girard, Tim Noe, Lisa Millet, Laura Chisholm, Gabriela Goldfarb, Isabelle Barbour, Sara Beaudrault, Holly Heiberg, Christy Hudson, Angela Rowland

Members of the public: Morgan Cowling, Coalition of Local Health Officials;

Approval of Minutes

A quorum was present. The Board unanimously voted to approve the December 15, 2016 minutes.

Public Health modernization updates

PHAB Membership update:

Jennifer Vines, Akiko Saito, and Teri Thalhofer Board have all been reappointed for four year terms. The Board member designee who represents healthcare organizations that are not CCOs will be appointed soon.

Oregon Health Policy Board update:

The Oregon Health Policy Board (OHPB) is holding their annual retreat today and Lillian Shirley is attending.

Statewide Modernization Plan update:

The Statewide Modernization Plan was reviewed in December and is presently moving through the OHA publication clearance process. Cara will let the Board know when it is approved.

Meanwhile, the *Health and Economic Benefits of Public Health Modernization* report has been approved and is available on the OHA/PHD website here: http://public.health.oregon.gov/About/TaskForce/Documents/OHA-9959-Modernization-Benefits-Report.pdf.

PHAB Statement on Funding for Public Health Modernization to Legislature and OHPB:
The statement from the PHAB regarding funding for public health modernization has been sent to Rep. Mitch Greenlick, Sen. Monnes Anderson and the Oregon Health Policy Board. The statement is posted on the OHA/PHD website: http://public.health.oregon.gov/About/Documents/phab/PHAB-Statement-on-PHM-Funding.pdf.

Aligning Innovative Models for Health Improvements in Oregon (AIMHI) Meetings:
Morgan Cowling provided a schedule update on the Aligning Innovative Models for Health Improvements in Oregon (AIMHI) meetings that the Coalition of Local Health Officials (CLHO) is holding across the state. All of the December and early January meetings were canceled due to inclement weather and rescheduled for February. Please visit: http://oregonclho.org/public-health-issues/aimhi-meetings/ for more information and to register.

PHAB Scope of Work Regarding Funding:
ORS 431.123 outlines the duties of the Public Health Advisory Board, and ORS 431.125 outlines the Oregon Health Policy Board's duties. While PHAB's role is advisory, policy change falls within the purview of the Oregon Health Policy Board. ORS 431.123(6)(a) clarifies PHAB's role to provide recommendations for the distribution of funds to apply foundational capabilities and implement foundational programs.

Tricia asked about ORS 431.123(10) *Assist the Oregon Health Authority in seeking funding, including in the form of federal grants, for ORS 431.001 to 431.550 and 431.990.* Cara stated that section 10 pertains to identifying resources to implement public health modernization including support for federal grant applications.

Alejandro stated that he interprets the PHAB's role to assist OHA to seek additional funding broadly since there are no restrictions in statute. This could include talking to legislators. Muriel stated the PHAB could look at different funding mechanisms, for example, looking to areas where prevention saves money for other sectors.

Akiko proposed that since the PHAB Incentives and Funding subcommittee has not looked at additional funding sources, the subcommittee could do so as a part of their work plan.

Action Items:
- Discuss additional funding sources to support public health modernization at the next Incentives and Funding subcommittee meeting. Begin by looking at how certain tax revenues are allocated.
- PHD staff will research if there are any minutes or documentation within OHA that pertain to public health and behavioral health and funding.

Potential Repeal of the Affordable Care Act (ACA) Impact: Cara provided a summary of impacts in Oregon if ACA Prevention and Public Health Funds (PPHF) are eliminated. In Fiscal Year 2016 PHD received $9.3M in PPHF, with $1.3M passed through to local and tribal authorities, and non-profit organizations. There are also PPHF grants that go directly to other organizations that may be eliminated.

Healthy Places Initiative

-Gabriela Goldfarb, Environmental Public Health Section Manager, Oregon Health Authority

Gabriela provided an overview of the Healthy Places Initiative. The Healthy Places Initiative was developed in response to air toxics concerns that arose in 2016, and to address public health system gaps identified in the public health modernization assessment. The public health modernization assessment showed that 2/3 of people in Oregon live in an area where the public health system's capacity for foundational environmental health work is minimal or limited. The goal is to increase capacity across the system, strengthen partnerships, and help communities set environmental health priorities.

OHA Public Health Division has formed an internal team with staff from the environmental health, chronic disease, communicable disease and emergency preparedness programs. OHA Public Health Division has also formed a working group that includes Crook, Multnomah, Jackson, Malheur, and Washington counties. The initial focus is to combat industrial point source air pollution, mobile sources, wood smoke, and wildfire smoke. The group will identify best practices to address environmental hazards to improve health outcomes.

The timeline includes identifying the health burden in January, determining evidence based strategies in February, identifying key metrics in March, and completing a discussion paper by April. Alejandro inquired whether the metrics developed by this work group will be used for the public health accountability metrics. Gabriela stated that environmental health data in this area is limited, and the March meeting will largely be about identifying gaps. However, the intent is that this group's work around metrics will inform the selection of accountability metrics for public health.

OHA legislative agenda

-Jeston Black, OHA Director of Government Relations

Jeston provided an overview of the 2017 OHA Bills. A list of bills are included with the meeting materials.

State Health Improvement Plan (SHIP)

Obesity Priority Area

-Karen Girard, PHD Health Promotion Chronic Disease Prevention Section Manager

Karen provided an overview of the SHIP priority to slow the increase of obesity. Obesity is the second leading preventable cause of death in Oregon, with 65% of adults who are overweight or obese. There are many chronic health issues that go along with obesity including diabetes, heart disease, high blood pressure, asthma, high cholesterol and arthritis. Obesity rates vary widely among race and ethnicity. The drivers of obesity are insufficient physical inactivity and poor nutrition.

The SHIP contains four priority targets: obesity prevalence in ages 2-5, youth, and adults, and diabetes prevalence. Oregon is currently only on target to meet the priority target for obesity prevalence among children ages 2-5.

Data indicate that soda consumption has declined slightly for youth and adults in Oregon.

Population-level strategies in the SHIP to decrease obesity prevalence include: increasing the price of sugary drinks; increasing the number of private and public businesses and other places that adopt standards for healthy food and beverages, physical activity and breastfeeding; increasing opportunities for physical activity; and improving availability of affordable, healthy food and beverage choices. Alejandro asked how one defines opportunities for physical activity. Karen stated this includes partnerships with parks, schools, transportation, workplace interventions, and interventions to make communities more walkable and bikeable.

Safina asked about measurement of sugary drink consumption since consumption appears to be declining but obesity rates are steady or increasing. Data on consumption are self-reported through the Behavioral Risk Factor Surveillance System (BRFSS) survey and Oregon Healthy Teens Survey. The causes of obesity are multi-factorial, and a comprehensive obesity program requires a multi-prong approach that is supported by funding.

Currently OHA Public Health Division does not receive any categorical funding for obesity prevention. The health equity interventions are to increase the number of facilities that adopt healthy standards for OHA/DHS mental and behavioral health service providers; increase the number of people with type 2 diabetes who participate in the National Diabetes Prevention Program; and increase access to healthy foods in low income communities and with poor access to healthy foods.

Tricia recommended that the obesity health equity intervention include culturally specific interventions rather than a broad systems approach. For the third intervention in this category, Safina recommends adding “low income and minority populations”.

Akiko requested additional information on mental/behavioral health and obesity. Akiko also reminded Board members about the PHAB equity review policy and procedure that the Board

worked on last fall and requested that the policy and procedure be revisited at an upcoming meeting.

OHA Public Health Division will be reviewing and revising the health equity interventions in the SHIP soon.

Tricia stated that Multnomah County's Racial and Ethnic Approaches to Community Health (REACH) Committee is looking at people-based and place-based strategies for health equity. They are looking at race-specific issues first and then mapping the interventions in a culturally specific way. Tricia recommended that REACH staff give a presentation to PHAB on this work at a future meeting.

Action Item:

- Provide additional data on sugary drink consumption and mental/behavioral health and obesity rates.
- Review PHAB equity review policy and procedure at an upcoming meeting.

Substance Use Priority Area
-Lisa Millet, Injury and Violence Prevention Section Manager, OHA Public Health Division

The SHIP includes a priority to reduce harms associated with alcohol and substance use. Oregon is a leader in its strategy to reduce opioid use.

The priority targets are to reduce prescription opioid mortality and alcohol-related motor vehicle deaths. Unfortunately both targets increased in the first year of SHIP implementation.

Lisa shared an interactive data dashboard that shows opioid data per county. The data dashboard is available at:
https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Pages/data.aspx

OHA is working with Lines for Life to develop an alcohol and other drug policy academy for medical professionals, health officers, and Coordinated Care Organizations (CCO) medical directors. The policy academy will support increased collaborations across sectors to reduce opioid mortality.

Jeff suggested in the future to start these presentations with the priority areas and interventions to allow PHAB members an opportunity to provide helpful feedback about the SHIP.

Prepare for 2017

Jeff called attention to the 2017 draft work plan and asked for feedback on the meeting schedule for the year, specifically whether Board members feel the work plan continues to warrant monthly meetings.

Akiko proposed meeting every other month with subcommittee meetings on the off months. Alejandro proposed meeting monthly during legislative session and during this period of federal policy changes that will impact health, with the possibility of shorter agendas. Katrina supports shorter monthly meetings to better maintain communication and continuity of work. Or, every other month meetings could be shorter or conducted by webinar, focusing on updates. Jeff proposed cancelling August and December meetings, as is often done by other boards and committees.

Action Item: A proposed alternate meeting schedule will be voted on as an agenda item for the February PHAB agenda.

Public Comment Period

No public comments were made in person or on the phone.

Closing

The meeting was adjourned.

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

February 16, 2017
2:30pm – 5:30 p.m.
Portland State Office Building
800 NE Oregon St., Room 1A
Portland, OR 97232

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

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February 16, 2017

DRAFT: Affordable Care Act Investments in Oregon's Public Health System

Overview

Federal grants are a primary source of funding for Oregon's public health system. A portion of the federal grants provided to governmental public health authorities are funded by the Affordable Care Act (ACA). The Prevention and Public Health Fund (PPHF), administered by the Centers for Disease Control and Prevention (CDC), accounted for 12% of the total CDC program budget in 2016. The PPHF has been used to offset $119M in base cuts to the CDC budget in order to retain core public health programs, such as the Preventive Health and Health Services Block Grant, which was authorized in August 1981.[1,2]

Additional ACA funding for public health programs is administered through the Health Resources and Services Administration (HRSA), the Administration for Community Living (ACL) and the Substance Abuse and Mental Health Administration (SAMHSA). As directed by the CDC, HRSA, ACL and SAMHSA, ACA-funded grants are used to build state, local and/or tribal public health capacity in specific program areas.

The Oregon Health Authority, Public Health Division (PHD) is the primary recipient of ACA funds in Oregon. Additional Oregon grantees include Multnomah County Health Department, the Northwest Portland Area Indian Health Board, and Yellow Hawk Tribal Health Center. In FY 2016, a total of $10,427,564 in ACA funds was provided to support public health activities in Oregon.

Oregon Investments

The table on the following page lists the grants that Oregon has received from the ACA, number of FTE supported, annual award amount, and pass-through dollars to communities.

[1] Centers for Disease Control and Prevention. (2016). Accomplishing CDC's mission with investments in the Prevention and Public Health Fund, FY 2010-2016. Available at https://www.cdc.gov/funding/documents/cdc-pphf-funding-impact.pdf.
[2] Centers for Disease Control and Prevention. (2014). Preventive Health and Health Services Block Grant: Frequently asked questions. Available at https://www.cdc.gov/phhsblockgrant/faqs.htm.

Grant name	FTE supported	Total FY 2016 award	Pass-through to local and tribal public health authorities and nonprofit organizations*
Oregon Health Authority, Public Health Division			
CDC Childhood Lead Poisoning Prevention Program	2.05	$274,393	$30,000
CDC Diabetes and Heart Disease and Stroke Prevention	5.19	$1,279,918	$389,250
CDC Epidemiology and Laboratory Capacity	2.12	$381,352	$0
CDC Emerging Infections Program	9.00	$1,134,157	$0
CDC Section 317 Immunization Program	12.00	$2,441,466**	$0
CDC Preventive Health and Health Services Block Grant	6.75	$1,110,980	$0
CDC Quit Line Capacity Grant	0.71	$190,594	$0
HRSA Personal Responsibility Education Program	2.48	$556,126	$424,510
SAMHSA Youth Suicide Prevention Program	0.00	$736,000	$490,000
Northwest Portland Area Indian Health Board			
CDC Good Health and Wellness in Indian Country	3.90	$994,225	$125,000
Multnomah County Health Department			
CDC Racial and Ethnic Approaches to Community Health (REACH)	6.30	$986,196	
Yellow Hawk Tribal Health Center			
ACL Chronic Disease Self-Management Education	0.00	$142,958	
CDC Good Health and Wellness in Indian Country	2.00	$199,199	
Total	**52.50**	**$10,427,564**	**$1,458,760**

**PHD and Northwest Portland Area Indian Health Board grants only. Does not include funds awarded to other contractors.*

***15 month grant allocation.*

Summary of ACA Public Health Investments in Oregon
Below are descriptions of the ACA-supported federal grants and what would be at risk if funding for these programs is discontinued.

Childhood Lead Poisoning Prevention Program: Prevents lead poisoning among children through outreach, education, and statewide surveillance of blood lead levels; coordinates follow up with local physicians to ensure proper care for affected children.

- If funding is discontinued, the 279,000 children under age six in Oregon would lose the protection of the statewide lead poisoning prevention program.

Chronic Disease Self-Management Education: Provides access to an evidence-based program designed to help people living with chronic conditions better manage their health.

- If funding is discontinued, tribal members with chronic conditions will lose access to an important tool to help improve their long-term health outcomes.

Diabetes and Heart Disease and Stroke Prevention: Supports partnerships among local public health authorities and coordinated care organizations to implement programs to prevent chronic disease among Oregon adults.

- If funding is discontinued, local capacity to prevent diabetes and heart disease would be greatly diminished and access to the National Diabetes Prevention Program would be limited.

Epidemiology and Laboratory Capacity: Provides training, data and quality control for statewide outbreak investigations; promotes injection safety among local public health authorities and providers; and provides laboratory testing for non-influenza respiratory viruses, allowing investigation of respiratory illness outbreaks in schools, healthcare facilities and workplace settings.

- If funding is discontinued, support for local public health authority outbreak investigations would be limited and timeliness of outbreak investigations and prevention and control efforts would be negatively impacted. The loss of injection safety training risks the spread of HIV and Hepatitis C.

Emerging Infections Program: Supports statewide control of healthcare acquired infections; allows for collection of data on pneumococcal disease, group A and B streptococcal infections, meningococcal disease and foodborne illnesses; and provides surveillance and laboratory testing for pertussis, influenza and HPV.

- If funding is discontinued, the loss of intervention support may lead to an increase in healthcare acquired infections and multi-drug resistant organisms, diminished opportunity to leverage other federal funding sources, and a reduction in overall statewide capacity to detect and respond to disease outbreaks, such as the recent meningococcal outbreaks at the University of Oregon and Oregon State University.

Good Health and Wellness in Indian Country: Aims to reduce the burden of chronic disease among American Indians by limiting exposure to tobacco, increasing physical activity and improving access to healthy foods.

- If funding is discontinued, support for culturally-appropriate chronic disease prevention programs will end.

Section 317 Immunization Program: Provides state-level capacity for Oregon's immunization program, including vaccine safety, monitoring of immunization rates, compliance with Oregon's school immunization law, and response to vaccine-preventable disease outbreaks, including seasonal influenza.

- If funding is discontinued, the Vaccines for Children Program would end, reducing or ending access to vaccine for Medicaid-eligible, uninsured, underinsured, or American Indian/Alaskan Native children under 19 years of age. General Fund support to local public health authorities would need to be redirected to support maintenance of core immunization program functions.

Preventive Health and Health Services Block Grant: Provides technical assistance to local and tribal public health authorities, including compliance reviews of all 34 local public health authorities and support for state and local public health accreditation efforts. Provides resources to three communities for sexual violence prevention.

- If funding is discontinued, 14 local public health departments serving over 1,800,000 Oregonians will not undergo complete compliance reviews and PHD's national public health accreditation status would be at risk.

Quit Line Capacity Grant: Enhances tobacco quit line services by targeting disproportionately burdened populations through media outreach and removal of barriers to access.

- If funding is discontinued, the ability to provide tobacco cessation services to disproportionately burdened groups in rural areas of the state will be diminished.

Personal Responsibility Education Program: Supports implementation of evidence-informed programs designed to prevent unintended pregnancy and transmission of sexually-transmitted infections among high risk youth in Oregon, including youth in foster care and corrections facilities, homeless youth, and youth that identify as Latino or LGBTQ.

- If funding is discontinued, 1,000 high risk youth in Oregon would lose access to sexual health education.

Racial and Ethnic Approaches to Community Health (REACH): Engages communities to address health disparities through culturally-specific interventions.

- If funding is discontinued,17,500 Multnomah County residents would have limited access to healthy food options in retail settings and limited transportation to access healthy food; and 47,695 residents would have less access to environments that are tobacco and nicotine-free.

Youth Suicide Prevention Program: Provides the only local suicide prevention funding to five counties and ten health and behavioral health systems working to implement comprehensive Zero Suicide initiatives.

- If funding is discontinued, all local suicide prevention coordinator positions will be lost along with suicide-specific training, work with schools and the development of integrated care models.

Impact of ACA Public Health Investments in Oregon

Combating communicable disease outbreaks statewide

- Since the inception of the PHD healthcare acquired infections program, there has been a decrease in healthcare acquired infections statewide, and there has been no spread of

carbapenemase producers, a class of antibiotic-resistant “nightmare” bacteria. Carbapenemase producers are nearly untreatable and are rapidly spreading across the world.

- Union County recently responded to a foodborne illness outbreak impacting over 100 people from four states. In 2015, Deschutes County investigated and responded to more than 1,000 cases of reportable communicable diseases and a record 26 outbreaks. The ability to leverage state resources financed by the ACA allows for a prompt and comprehensive investigation and response.
- The public health system provides access to immunizations and protection from vaccine-preventable disease outbreaks. ACA funds support state-level immunization infrastructure while General Funds are provided for local communities. As a result, Crook County provides 25% of the immunizations delivered to community members and Jackson County provides 7,500 immunizations to community members. Immunization rates for children in Jefferson County are 63% prior to entering school or engaging with the health department, compared with 95% afterward.

<u>Preventing chronic disease by supporting communities through healthy eating and physical activity</u>

- In Lane County, a dozen local policies have been implemented to reduce chronic disease through the ACA-supported Healthy Communities program. More than 80 partners have been engaged in these efforts and an additional $315,000 has been leveraged in addition to the state pass-through investment. Through the Good Options (GO!) program, overall sales of food at the local hospital increased 27% while sodium consumption in hospital foods has resulted in 60 fewer pounds of salt used per year.
- Multnomah County has convened over 30 community partners to complete a community action plan, communications plan and evaluation plan designed to decrease chronic disease disparities. The REACH grant has increased the availability of healthy food options in at least six corner stores in neighborhoods that have no other full service grocery store within one quarter of a mile.

Oregon Public Health Advisory Board

2017 Work Plan and Agenda Planning

Jan 12, 2017 Draft

Meeting date	Topics	Presenter(s)	Actions/Deliverables
January 19, 2017	Modernization implementation updates	TBD	Provide guidance on implementation strategy and activities.
	Applying the public health modernization framework: Healthy Places initiative	Holly Heiberg and Gabriela Goldfarb, Oregon Health Authority	
	Legislative update	Jeston Black, Oregon Health Authority	
	SHIP deep dive: obesity and substance use	Karen Girard and Lisa Millet, Oregon Health Authority	Provide guidance on strategies to advance obesity and substance use priority areas.
	PHAB work plan for 2017	Jeff Luck, PHAB Chair	Finalize work plan for the first half of 2017
February 16, 2017	Modernization implementation updates	TBD	Provide guidance on implementation strategy and activities.
	PHAB subcommittee reports: update on funding formula and accountability metrics development	Subcommittee members	Provide feedback on funding formula and accountability metrics deliverables.
	Legislative update	TBD, Oregon Health Authority	
	Action Plan for Health update	TBD, Oregon Health Authority	
March 16, 2017	Modernization implementation updates	TBD	Provide guidance on implementation strategy and activities.
	PHAB subcommittee reports: update on funding formula and accountability metrics development	Subcommittee members	Provide feedback on funding formula and accountability metrics deliverables.
	Legislative update	TBD, Oregon Health Authority	

	Health equity: update from the Public Health Division Health Equity Committee	Tim Noe and Kati Moseley, Oregon Health Authority	Provide guidance for developing a system-wide health equity strategy. Discuss PHAB policy and procedure.
	CLHO statewide modernization meetings: summary and next steps	Morgan Cowling, Coalition of Local Health Officials	
	Preventive Health and Health Services Block Grant review	Danna Drum, Oregon Health Authority	
	PHAB charter review and update	Cara Biddlecom, Oregon Health Authority	
April 20, 2017	Modernization implementation updates	TBD	Provide guidance on implementation strategy and activities.
	PHAB subcommittee reports: update on funding formula and accountability metrics development Discuss opportunities for collaboration and alignment with other OHA metrics groups	Subcommittee members	Provide feedback on funding formula and accountability metrics deliverables Identify opportunities and strategies for PHAB to align its accountability metrics work with other existing metrics groups
	Legislative update	TBD, Oregon Health Authority	
	Applying the public health modernization framework: Public health and education partnership	TBD, Department of Education and Isabelle Barbour, Oregon Health Authority	
	SHIP deep dive: communicable disease and immunizations	Collette Young and Aaron Dunn, Oregon Health Authority	Provide guidance on strategies to advance communicable disease and immunization priority areas.
	Preventive Health and Health Services Block Grant review	Danna Drum, Oregon Health Authority	
	PHAB charter review	Cara Biddlecom, Oregon Health Authority	Charter approved by PHAB. Charter submitted to OHPB for review.
May 18, 2017	Modernization implementation updates	TBD	Provide guidance on implementation strategy and activities.

	PHAB subcommittee reports: update on funding formula and accountability metrics development	Subcommittee members	Provide feedback on funding formula and accountability metrics deliverables.
	Legislative update	TBD, Oregon Health Authority	
	Health equity: PHAB policy and procedure	TBD, Oregon Health Authority	Provide feedback and/or approve PHAB policy and procedure
June 15, 2017	Modernization implementation updates	TBD	Provide guidance on implementation strategy and activities.
	PHAB subcommittee reports: update on funding formula and accountability metrics development	Subcommittee members	Provide feedback on funding formula and accountability metrics deliverables.
	Legislative update	TBD, Oregon Health Authority	
	Applying the public health modernization framework: topic to be determined	TBD	
	Robert Wood Johnson Foundation grant/AIMHI update	Morgan Cowling, Coalition of Local Health Officials	Provide feedback on technical assistance phase of grant activities
July 20, 2017	*SHIP deep dive: oral health and suicide*	*Cate Wilcox and Lisa Millet, Oregon Health Authority*	
August 17, 2017			
September 21, 2017			
October 19, 2017	*SHIP deep dive: annual progress report and tobacco*	*Karen Girard and Katrina Hedberg, Oregon Health Authority*	
November 16, 2017			
December 21, 2017			

Oregon Health Policy Board
Public Health Advisory Board
Charter
DRAFT, 2017

~~Approved by the Oregon Health Policy Board on April 5, 2016~~

I. Overview and Authority

The Public Health Advisory Board (PHAB) is established by ORS 431.122~~House Bill 3100 (2015), Sections 5-7~~ as a body that reports to the Oregon Health Policy Board (OHPB).

The purpose of the PHAB is to be the accountable body for governmental public health in Oregon. The role of the PHAB includes:

- Oversight for the implementation of Oregon's State Health Improvement Plan.
- Oversight for the implementation of public health modernization.
- Development and implementation of accountability measures for state and local health departments.
- Development of equitable fund distributions to support ~~governmental~~ public health modernization.

This charter defines the objectives, responsibilities, and scope of activities of the PHAB. This charter will be reviewed periodically to ensure that the work of the PHAB is aligned with the OHPB's strategic direction.

II. Duties, Objectives, Membership, Terms, Officers

The duties of the PHAB as established by ORS 431.123~~House Bill 3100~~ and the PHAB's corresponding objectives include:

PHAB Duties per House Bill 3100	**PHAB Objectives**
a. Make recommendations to the OHPB on the development of statewide public health policies and goals.	• Regularly review state health data such as the State Health Profile to identify ongoing and emerging health issues. • Use best practices and an equity lens to provide recommendations to OHPB on policies needed to address priority health issues, including the social determinants of health.
b. Make recommendations to the OHPB on how other statewide priorities, such as the provision of early learning services and the delivery of health care services, affect and are affected by statewide public health policies and goals.	• Regularly review early learning and health system transformation priorities. • Recommend how early learning goals, health system transformation priorities, and statewide public health goals can best be aligned. • Identify opportunities for public health to support early learning and health system transformation priorities.

	• Identify opportunities for early learning and health system transformation to support statewide public health goals.
c. Make recommendations to the OHPB on the establishment of foundational capabilities and programs for governmental public health and other public health programs and activities.	• Participate in the administrative rulemaking process which will adopt the Public Health Modernization Manual. • Verify that the Public Health Modernization Manual is still current at least every two years. Recommend updates to OHPB as needed. •
d. Make recommendations to the OHPB on the adoption and updating of the statewide public health modernization assessment.	• Review initial findings from the Public Health Modernization Assessment. (completed, 2016) • Review the final Public Health Modernization Assessment report and provide a recommendation to OHPB on the submission of the report to the legislature. (completed, 2016) • Make recommendations to the OHPB on processes/procedures for updating the statewide public health modernization assessment.
e. Make recommendations to the OHPB on the development of and any modification to the statewide public health modernization plan.	• Review the final Public Health Modernization Assessment report to assist in the development of the statewide public health modernization plan. (completed, 2016) • Using stakeholder feedback, draft timelines and processes to inform the statewide public health modernization plan. (completed, 2016) • Develop the public health modernization plan and provide a recommendation to the OHPB on the submission of the plan to the legislature. (completed, 2016) • Update the public health modernization plan as needed based on capacity.
f. Make recommendations to the Oregon Health Authority (OHA) and the OHPB on the development of and any modification to plans developed for the distribution of funds to local public health authorities.	• Identify effective mechanisms for funding the foundational capabilities and programs. • Develop recommendations for how the OHA shall distribute funds to local public health authorities.
g. Make recommendations to the OHA and the OHPB on the total cost to local public health authorities of applying the foundational capabilities and implementing the foundational programs for governmental public health.	• Review the Public Health Modernization Assessment report for estimates on the total cost for implementation of the foundational capabilities and programs. (completed, 2016) • Support stakeholders in identifying opportunities to provide the foundational capabilities and programs in an effective and efficient manner.

h. Make recommendations to the OHPB on the use of incentives by the OHA to encourage the effective and equitable provision of public health services by local public health authorities.	• Develop models to incentivize investment in and equitable provision of public health services across Oregon. • Solicit stakeholder feedback on incentive models.
i. Provide support to local public health authorities in developing local plans to apply the foundational capabilities and implement the foundational programs for governmental public health.	• Provide support and oversight for the development of local public health modernization plans. • Provide oversight for Oregon's Robert Wood Johnson Foundation grant, which will support regional gatherings of health departments and their stakeholders to develop public health modernization plans.
j. Monitor the progress of local public health authorities in meeting statewide public health goals, including employing the foundational capabilities and implementing the foundational programs for governmental public health.	• Provide oversight and accountability for Oregon's State Health Improvement Plan by receiving quarterly updates and providing feedback for improvement. • Provide support and oversight for local public health authorities in the pursuit of statewide public health goals. • Provide oversight and accountability for the statewide public health modernization plan. • Develop outcome and accountability measures for state and local health departments.
k. Assist the OHA in seeking funding, including in the form of federal grants, for the implementation of public health modernization.	• Provide letters of support and guidance on federal grant applications. • Educate federal partners on public health modernization. • Explore and recommend ways to expand sustainable funding for state and local public health and community health.
l. Assist the OHA in coordinating and collaborating with federal agencies.	• Identify opportunities to coordinate and leverage federal opportunities. • Provide guidance on work with federal agencies.

Additionally, the Public Health Advisory Board is responsible for the following duties which are not specified in House Bill 3100:

Duties	**PHAB Objectives**
a. Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters.	• Provide guidance and recommendations on statewide public health issues and public health policy.
b. Act as formal advisory committee for Oregon's Preventive Health and Health Services Block Grant.	• Review and provide feedback on the Preventive Health and Health Services Block Grant work plan priorities.

c. Provide oversight for progress toward implementing recommendations outlined in Public Health Division's cultural competency assessment (once released).	• Receive progress reports and provide feedback on implementation of cultural competency assessment recommendations.

Membership Composition

Per House Bill 3100, Section 5, the PHAB shall consist of the following 13 members appointed by the Governor:

1. A state employee who has technical expertise in the field of public health;
2. A local public health administrator who supervises public health programs and public health activities in Benton, Clackamas, Deschutes, Jackson, Lane, Marion, Multnomah or Washington County;
3. A local public health administrator who supervises public health programs and public health activities in Coos, Douglas, Josephine, Klamath, Linn, Polk, Umatilla or Yamhill County;
4. A local public health administrator who supervises public health programs and public health activities in Clatsop, Columbia, Crook, Curry, Hood River, Jefferson, Lincoln, Tillamook, Union or Wasco County;
5. A local public health administrator who supervises public health programs and public health activities in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Wallowa or Wheeler County;
6. A local health officer who is not a local public health administrator;
7. An individual who represents the Conference of Local Health Officials created under ORS 431.330;
8. An individual who represents coordinated care organizations;
9. An individual who represents health care organizations that are not coordinated care organizations;
10. An individual who represents individuals who provide public health services directly to the public;
11. An expert in the field of public health who has a background in academia;
12. An expert in population health metrics;
13. An at large member.

PHAB shall also include the following nonvoting, ex-officio members:

1. The Oregon Public Health Director or the Public Health Director's designee;
2. If the Public Health Director is not the State Health Officer, the State Health Officer or a physician licensed under ORS chapter 677 acting as the State Health Officer's designee;
3. If the Public Health Director is the State Health Officer, a representative from the Oregon Health Authority who is familiar with public health programs and public health activities in this state; and
4. A designee of the Oregon Health Policy Board.

Membership Terms

The term of office for a board member appointed under this section is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on January 1 next following. A member is eligible for

reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.
Of the PHAB members beginning their term in January 2016:

- Four shall serve for terms ending January 1, 2017.
- Three shall serve for terms ending January 1, 2018.
- Three shall serve for terms ending January 1, 2019.
- Three shall serve for terms ending January 1, 2020.

Officers
PHAB shall elect two of its voting members to serve as the chair and vice chair. Elections shall take place in January of each even-numbered year.

The chair and vice chair shall serve two year terms. If the chair were to vacate their position before their term is complete the vice chair shall become the new chair to complete the term. If a vice chair is unable to serve, or if the vice chair position becomes vacant, then a new election is held to complete the remainder of the vacant term(s).

The PHAB chair shall facilitate meetings and guide the PHAB in achieving its deliverables. The PHAB chair shall represent the PHAB at meetings of the Oregon Health Policy Board as directed by the Oregon Health Policy Board designee. The PHAB chair may represent the PHAB at meetings with other stakeholders and partners, or designate another member to represent the PHAB as necessary.

The PHAB vice chair shall facilitate meetings in the absence of the PHAB chair. The PHAB vice chair shall represent the PHAB at meetings of the Oregon Health Policy Board as directed by the Oregon Health Policy Board designee when the PHAB chair is unavailable. The PHAB vice chair may represent the PHAB at meetings with other stakeholders and partners when the PHAB chair is unavailable or under the guidance of the PHAB chair, or may designate another member to represent the PHAB as necessary.

Both the PHAB chair and vice chair shall work with OHA Public Health Division staff to develop agendas and materials for PHAB meetings.

III. Actions and Deliverables

Actions
The PHAB may take the following actions:

- Make formal recommendations, provide informal advice, and reports to the OHPB;
- Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters;
- Identify priorities for Oregon's governmental public health system;
- Charter committees (for ongoing work) and/or work groups (for short-term work) on various topics related to governmental public health;
- Request data and reports to assist in preparing recommendations to the OHPB;
- Provide a member to serve as a liaison to other committees or groups as requested.

Deliverables/Actions
The PHAB shall deliver the following:

Deliverable	Time Frame
• **A work plan for the PHAB for 2016-2017**	Spring 2016
• **A proposal for reporting to the OHPB (e.g., frequency, format, etc.)**	Spring 2016
• **Report(s) to the OHPB (as agreed to with the OHPB)**	At least annually
• **Recommendations to the OHPB**	As needed
• **Public Health Modernization Assessment report**	June 2016 (complete)
• **Public Health Modernization Plan**	December 2016 (complete)
• **Report(s) to the legislature as requested**	As needed

In addition to the deliverables listed above, the PHAB shall charter committees and work groups as needed and take direction from the OHPB.

IV. Staff Resources

The PHAB is staffed by the OHA, Public Health Division, as led by the Policy Officer. Support will be provided by staff of the Public Health Division Policy Team and other leaders, staff, and consultants as requested or needed.

V. Expectations for PHAB Meetings

The following expectations apply to all PHAB meetings:

- The PHAB will meet monthly in 2016. In 2017~~for the first six months of 2016. In July 2016~~, the PHAB will determine if meetings should continue monthly or move to an alternate schedule, with meetings occurring at least quarterly. More frequent and ad hoc meetings may be called for by the chairperson.
- The PHAB shall meet at times and places specified by the call of the chairperson or of a majority of the voting members of the board.
- A standard meeting time will be established (with special exceptions).
- Meetings shall be conducted in accordance with Oregon's Public Meetings Law (ORS 192.610 through 192.710) and Public Records Law (ORS 192.001 through 192.505) and documented on the PHAB website: www.healthoregon.org/phab.
- Official subcommittee meetings shall also be conducted in accordance with Oregon's Public Meetings Law (ORS 192.610 through 192.710) and Public Records Law (ORS 192.001 through 192.505) and documented on the PHAB website: www.healthoregon.org/phab.
- A public notice will be provided to the public and media at least 10 days in advance of each regular meeting and at least five days in advance of any special meeting.

- A majority of the voting members of the PHAB constitutes a quorum for the transaction of business during PHAB meetings.
- PHAB members are expected to review materials ahead of the meeting and come prepared to discuss and participate.
- Written minutes will be taken at all regular and special meetings. Minutes will include: members present; all motions, proposals, resolutions, orders, ordinances and measures proposed and their disposition; the substance of discussion on any matter; and a reference to any document discussed or distributed at the meeting.

Conflicts of Interest

The purpose of this conflict of interest policy is to maintain the transparency and integrity of the PHAB and its individual members, understanding that many voting members have a direct tie to governmental public health or other stakeholders in Oregon.

PHAB members shall verbally disclose any actual or perceived conflicts of interest prior to voting on any motion that may present a conflict of interest. If a PHAB member has a potential conflict related to a particular motion, the member should state the conflict. PHAB will then make a decision as to whether the member shall participate in the vote or be recused.

If the PHAB has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member and afford an opportunity to explain the alleged failure to disclose. If the PHAB determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate corrective action including potential removal from the body.

Lastly, PHAB members shall make disclosures of conflicts using a standard conflict of interest form at the time of appointment and at any time thereafter where there are material employment or other changes that would warrant updating the form.

VI. Amendments and Approval

This charter may be amended or repealed by the affirmative vote of two-thirds of the members present at any regular PHAB meeting. Notice of any proposal to change the charter shall be included in the notice of the meeting.

PHAB Accountability Metrics subcommittee
February 14, 2017
Public Health Accountability Metrics Proposal

Subcommittee members: Muriel DeLaVergne-Brown, Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Jennifer Vines

The Public Health Advisory Board Accountability Metrics subcommittee formed in May 2016 to develop recommendations for public health accountability metrics. Accountability metrics are critical to demonstrating progress toward achieving improved system performance and health outcomes.

The public health system is being called upon to collect and report on population health outcomes to demonstrate the value of public health. Establishing accountability metrics now for a modern public health system will allow for the collection of baseline data on population health priorities.

In 2016 the PHAB Accountability Metrics subcommittee reviewed existing state and national measure sets and identified preliminary measures for five foundational capabilities and programs. Throughout this process a number of barriers were identified, including:

- Lack of existing public health data sets;
- Challenges to identifying measures for which public health is solely responsible;
- Feasibility of measuring the impact of public health interventions;
- The time needed to see changes in population health outcomes resulting from public health interventions;
- Insufficient subject matter expertise for making recommendations on measures for specific health areas.

This proposal for continuing to develop accountability metrics in 2017 attempts to:

- Address the barriers listed above;
- Identify population health outcome metrics that can be achieved by a modern public health system;
- Demonstrate the connection between public health system roles and deliverables, and improved health outcomes.

Proposed steps are listed in the table below.

Identify <u>population health outcome metrics</u> for each foundational program (February-April 2017)

Population health outcome metrics are intended to measure progress for the public health system, not individual public health authorities.

1. Public Health Division will identify an initial set of recommended population health outcome metrics, pulling from the State Health Profile, State Health Improvement Plan and other health outcome metrics (for example, metrics for End HIV Oregon) for each foundational program.
2. Public Health Division will make recommendations for statewide benchmarks.
3. Public Health Division will review and solicit feedback from local and tribal public health authorities on this set of recommended population health outcome metrics.
4. Recommended population health outcome metrics will be provided to the PHAB Accountability Metrics subcommittee.

Conduct stakeholder survey on population health outcome metrics (March-May 2017)

The Public Health Division and PHAB Accountability Metrics subcommittee will field a stakeholder survey to collect feedback on the proposed population health outcome measures for the public health system, and to identify opportunities for measure alignment across sectors.

1. Public Health Division and PHAB Accountability Metrics subcommittee will develop and launch survey.
2. PHAB Accountability Metrics subcommittee will review survey results.
3. PHAB Accountability Metrics subcommittee will finalize recommendations for population health outcome measures.
4. PHAB will review and approve population health outcome measures

Identify <u>local public health accountability metrics</u> (May-July 2017)

Local public health accountability metrics will measure progress toward achieving roles and deliverables outlined in the Public Health Modernization Manual. Local public health accountability metrics will directly connect to population health outcome metrics.

1. PHD staff will convene small groups of subject matter experts (SMEs) to identify and develop local public health accountability metrics.
2. Small groups will include state and local public health staff. PHAB subcommittee members are welcome to be involved.
3. One to two small groups will be formed initially to focus on accountability metrics for 1-2 foundational programs. (possibly communicable disease and chronic disease/prevention and health promotion)
    a. These groups can look at PHAST measures, *Public Health Modernization Manual* deliverables, etc.
4. Small groups will use the criteria established by the PHAB Accountability Metrics subcommittee to select measures to identify a small number (1-2) of recommended measures.

5. Small groups will also define measurement criteria (what information is collected, pass/no pass)
6. Recommendations will be provided to the PHAB Accountability Metrics subcommittee
7. PHAB will review and approve local public health accountability metrics.

Identify and establish mechanism for data collection (July-September 2017)

1. Public Health Division will identify short-term and long-term data collection mechanisms.
2. Public Health Division will make recommendations to the PHAB Accountability Metrics subcommittee

Collect baseline data (October-December 2017)

1. Collect and analyze baseline data
2. Set benchmark and improvement targets
3. Issue accountability metrics report

Develop mechanism for awarding performance-based incentives to local public health authorities (timeline TBD)

1. Work with Incentives and Funding subcommittee to develop a mechanism for awarding performance-based incentives to local public health authorities through the local public health funding formula.

Initial proposal for accountability metrics		
Achieving improved health for all people in Oregon requires comprehensive, multi-sector approaches. The public health modernization accountability metrics measure both the specific roles and functions that are the primary responsibility of public health authorities and the health outcomes that are expected to improve when those roles and functions are achieved. The PHAB subcommittee will continue to develop this initial set of accountability metrics in 2017.		
Foundational program/capability	Local public health authority metrics	Statewide population health metrics (Note: this column was not included in the statewide modernization plan. PHD proposes adding a short list of population health metrics to the framework for accountability metrics)
	These metrics measure progress toward achieving public health system roles and functions that are essential for improve population health outcomes. Achieving these measures is within the control of state and local public health agencies. In the future a subset of these measures may be used to award performance-based incentives.	These metrics measure progress toward achieving population health outcomes. Making improvement in these population health indicators requires comprehensive, cross-sector approaches. Achieving the local public health authority metrics will directly lead to improvements in these population health outcomes. The metrics listed below are existing state health profile indicators.
Communicable disease control	Increase capacity to respond to epidemiological changes and communicable disease threats • Documented provision of timely and relevant epidemiological information to community members • Evidence that outbreak summaries have been made available to community members	Pertussis among infants Influenza hospitalizations Salmonellosis incidence HIV infections Clostridium difficile incidence

	Demonstrate public health expertise by providing health education resources and technical assistance for vaccine-preventable diseases, health care-associated infections, antibiotic resistance and related issues. Increase partner notification for HIV, syphilis and gonorrhea (Update) • Number of sexually transmitted infection (STI) contacts followed by the public health authority in the past 12 months • Number of FTE trained and employed to conduct STI case management including: client interviewing, partner notification and referral, untreated patient referral, education, and consultation for individuals diagnosed with an STI • The portion of cases that had at least one contact that received treatment (all syphilis and gonorrhea cases who are HIV co-infected) Convene health care, early learning and other partners to develop state and community strategies to improve childhood and adolescent immunization rates • Documented state and local plans to improve childhood immunization rates that include ongoing evaluation and reporting	Norovirus outbreaks in long-term care facilities Tuberculosis incidence Gonorrhea incidence Syphilis incidence *100% of Oregonians diagnosed with HIV are in medical care within 30 days. (Proposed by Dr. Vines)* *The percentage of people diagnosed with HIV in a given calendar year that had one or more documented medical visits, viral load or CD4 tests within 3 months after diagnosis (Proposed by Dr. Vines)*
Environmental health	Demonstrate public health expertise by providing timely, accurate and culturally appropriate technical assistance to partners and the community on environmental health hazards.	To be developed through *Healthy Places Initiative*

	• Documented assessments of environmental health hazards and protection recommendations • Documented health analyses prepared for other organizations Demonstrate public health expertise to address challenges in health resulting from changes to the built and natural environment • Documentation of reports on projected changes in health resulting from changes to the built or natural environment • Documentation of trained state and local public health staff in health impact assessments Demonstrate local planning for environmental health and environmentally-related disease • Evidence that state and local community health assessments include data and information on environmental health and environmentally related diseases • Evidence that state and community health improvement plans include strategies to address environmental health threats and reduce environmentally related diseases	
Prevention and Health Promotion		Opioid-related overdose deaths Suicide deaths Falls among older adults

		Lung cancer Heart attack hospitalizations Tooth decay Diabetes prevalence Obesity in children, adolescents and adults Alcohol-related deaths Binge drinking Current cigarette smoking Marijuana use Sugar-sweetened beverage consumption Physical activity
Access to Clinical Preventive Services		Childhood developmental screening Effective contraceptive use Dental visits Influenza vaccination HPV vaccination rates Colorectal cancer diagnosis and screening Breast and cervical cancer screening
Emergency preparedness	Increase state and local capacity to respond during an event • Evidence of training for all state and local staff that would be called upon to assist during an event	

	• Evidence of current emergency preparedness plans in all state and local jurisdictions that meet established state and federal guidelines Increase community engagement in emergency preparedness activities • Evidence of community engagement strategy in emergency preparedness plans • Documented evaluation of community needs and engagement efforts in situational assessments and after-action plans	
Health equity	Health equity will be a component in metrics for all foundational program and capabilities, in addition to being a stand-alone set of metrics. Reduce health disparities by ensuring measure sets for all 2017–19 priority areas include a focus on achieving health equity. Increase capacity for state and local public health authorities for advancing health equity. This will be measured by: • Evidence of increased workforce recruitment from communities adversely affected by health disparities *(NACCHO measure)* • Increased percentage of state and local public health authorities with policies for training, engagement and recruitment *(Public Health Modernization Manual)* • Increased percentage of state and local public health authorities that have fully integrated health equity into	

	the strategic plan and SHIP/CHIP *(Public Health Modernization Manual)*	
Public health system change	Increase public health leadership, expertise and involvement in state and local policy that may affect health. This will be measured by: • Prepared issue briefs and recommendations for policymakers *(NACCHO measure)* • Technical assistance provided to legislative, regulatory or advocacy groups *(NACCHO measure)* • Evidence of health in all policies Increase the efficiency and effectiveness of the public health system through cross-jurisdictional sharing. This will be measured by: • Increased percentage of LPHAs with MOUS or contracts for cross-jurisdictional sharing with other LPHAs or the Oregon Public Health Division Increase the impact of health interventions by forming cross-sector partnerships and collaborations. This will be measured by: • Increased percentage of state and local public health authorities with MOUs, contracts or shared work plans in place with health care and early learning providers, CCOs and other community partners • Evidence of evaluation of shared projects or initiatives	

PHAB Funding and Incentives Subcommittee

Subcommittee Members: Silas Halloran-Steiner, Jeff Luck, Alejandro Queral, Akiko Saito, Tricia Tillman

February 14, 2017

Tobacco Master Settlement Agreement and Tobacco Tax Funds in Oregon[1]

Tobacco Master Settlement Agreement (TMSA) funds: In the 2015-17 biennium, Oregon allocated about $158 million of TMSA funds. Table 1 below summarizes how the TMSA revenue is distributed for 2015-17. Of the $158 million total, the legislature allocated about $4.1 million (2.6%) to OHA to support tobacco prevention and cessation. Of this $4.1 million, $1.6 million went directly to local public health agencies and their partners to fund community level interventions through the Sustainable Relationships for Community Health (SRCH) and Strategies for Policy and Environmental Change, Tobacco-Free (SPArC) initiatives (see Oregon Tobacco Funding Map 2016). The remaining TMSA funds ($2.5 million) went towards tobacco-related health communications interventions, cessation interventions, surveillance and accountability, and administration and management.

Table 1. Oregon TMSA Allocation FY 2015-17

OHSU Bonds	$ 30,909,888	19.5%
OHP	$ 101,800,000	64.3%
OHA--community mental health	$ 16,000,000	10.1%
DoE--PE related grants	$ 4,100,000	2.6%
OHA--TURA/TPEP	$ 4,100,100	2.6%
DOJ-Enforcement	$ 1,300,000	0.8%
TOTAL	**$ 158,209,988**	**100%**
Source: TMSA Budget Information Report, Oregon Legislative Fiscal Office. August 2016		

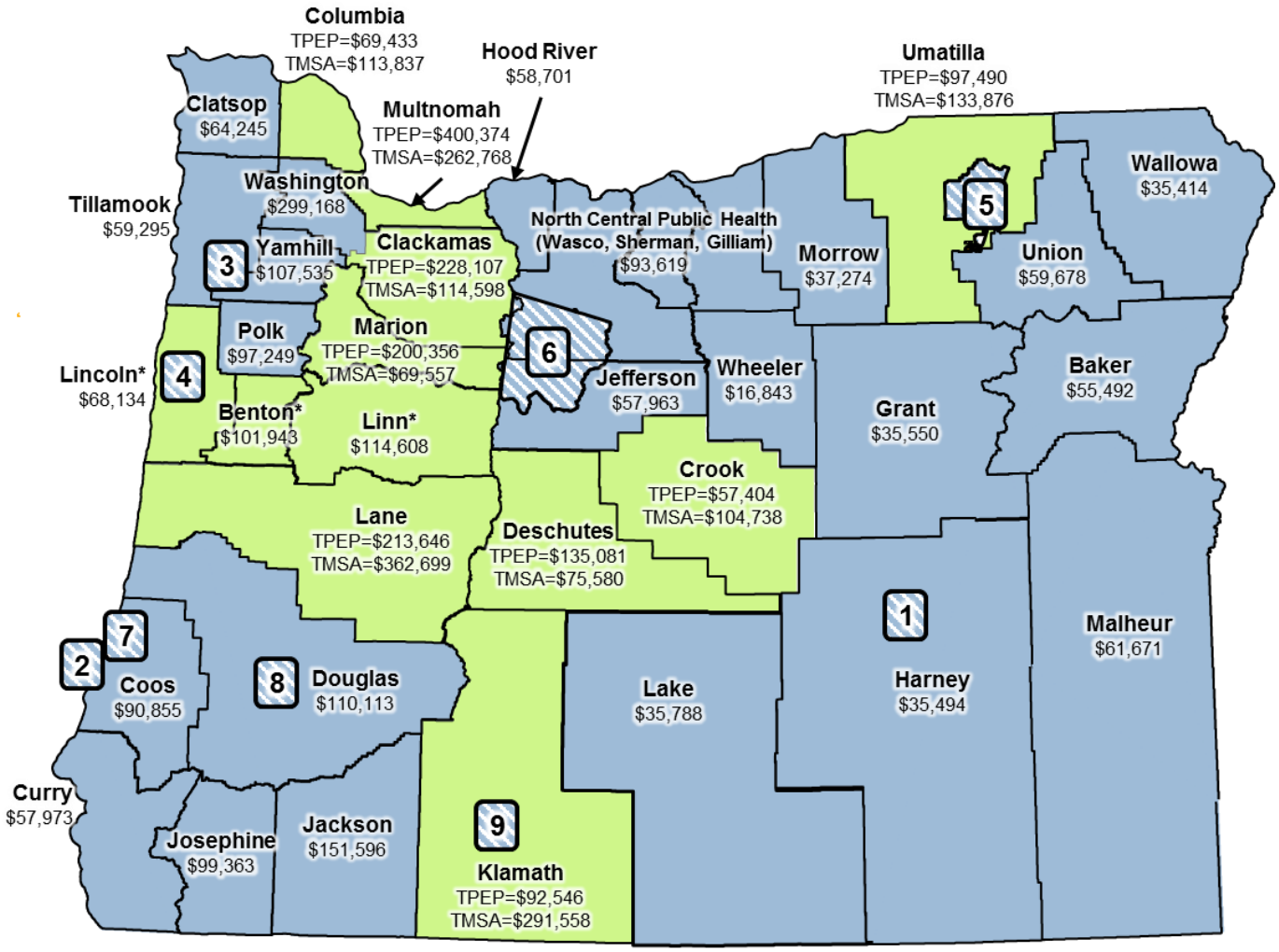
Tobacco taxes: For the 2015-17 biennium, state taxes on tobacco products brought in about $532 million. Table 2 displays how the combined state (cigarette + tobacco product) tobacco tax revenues are currently distributed. Most of this revenue comes from cigarette taxes (78%), and the rest (22%) comes from taxes on other tobacco products. OHA's Tobacco Prevention and Education Program (TPEP), receives funds from both cigarette and tobacco product taxes via the Tobacco Use Reduction Account (TURA). In 2015-17, TPEP received 3% of all tobacco tax revenues, equaling about $16 million. The TPEP program report for FY 2015-17 describes how the TPEP monies are distributed. About two thirds (62%) goes directly into communities to

[1] The information in this document was provided by the Oregon Health Authority, Public Health Division, Health Promotion and Chronic Disease Prevention section. Additional information is available upon request.

support local initiatives; 12% goes in to health communications; 12% goes into cessation interventions; 10% goes into data and accountability; and 4% supports program administration and management. The attached map displays how much TPEP funding each county and tribe received in 2016-17.

Table 2. Current (2017) distribution of state tobacco tax receipts		
General Fund	$ 131,008,093	24.6%
Oregon Health Plan	$ 316,576,508	59.5%
Tobacco Use Reduction Account	$ 16,079,067	3.0%
Cities	$ 7,126,493	1.3%
Counties	$ 7,126,493	1.3%
Department of Transportation	$ 7,126,493	1.3%
Oregon Health Plan (mental health)	$ 47,009,851	8.8%
TOTAL	**$ 532,053,000**	**100%**

Oregon tobacco funding map, fiscal year 2016-2017



Tobacco Prevention and Education Program (TPEP) funded counties
TPEP and Tobacco Master Settlement Agreement (TMSA) funded counties
TPEP funded Oregon tribes

* Benton, Linn and Lincoln counties collectively receive $120,000 TMSA funding.

Oregon's federally recognized tribes	Tribal TPEP funding
1. Burns Paiute Tribe	$35,449
2. Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians	$40,768
3. Confederated Tribes of Grand Ronde	$70,545
4. Confederated Tribes of the Siletz Indians	$69,557
5. Confederated Tribes of the Umatilla Indian Reservation	$53,666
6. Confederated Tribes of Warm Springs	$70,604
7. Coquille Indian Tribe	$40,080
8. Cow Creek Band of Umpqua Tribe of Indians	$49,825
9. Klamath Tribes	$69,506

Tobacco Prevention and Education

Expanding our reach for a healthier Oregon

Program Report 2015–2017

Oregon Health Authority

This report provides a snapshot of current TPEP accomplishments. It also looks ahead to show how state support will further reduce Oregon's burden of tobacco-related diseases and make our communities healthier and safer.

TPEP: 20 years of success

2017 marks the 20th year of the Oregon Tobacco Prevention and Education Program (TPEP). The program was started by Oregonians for Oregonians with the passage of Measure 44, which raised the price of tobacco and dedicated a portion of the increase to tobacco prevention and education. Since TPEP started, cigarette consumption in Oregon has declined by more than 50 percent.

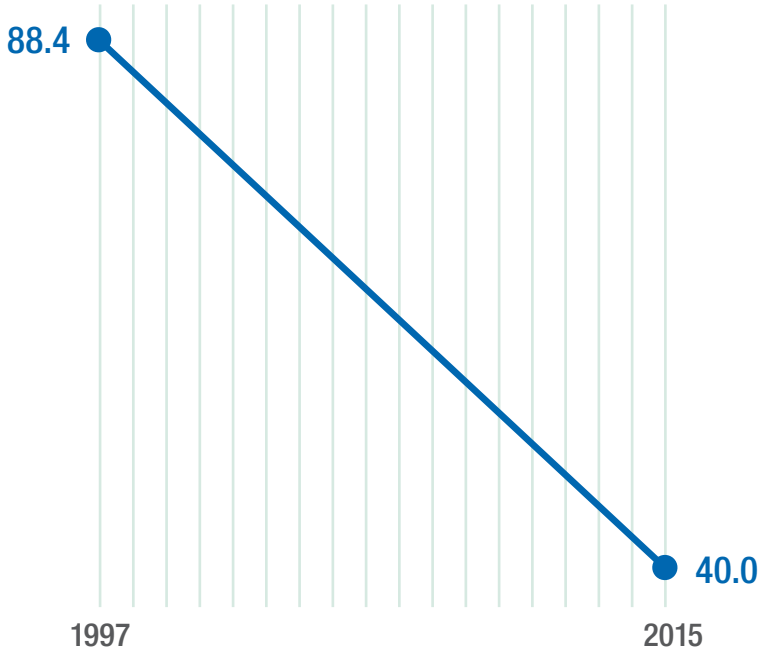
Despite this good news, tobacco use remains Oregon's number-one preventable cause of death and disease. It is responsible for more than 7,000 deaths in our state each year. Secondhand smoke causes an additional 625 deaths.* As a result, TPEP's work continues to be vital to Oregonians' health.

Goals

TPEP's four goals for making Oregon communities safer and healthier:

1. Eliminate exposure to secondhand smoke
2. Prevent youth from initiating tobacco use
3. Identify and eliminate tobacco-related disparities in all populations
4. Help smokers quit

Per capita cigarette pack sales in Oregon, 1997 and 2015



Since TPEP started, Oregon's per capita cigarette pack sales have declined by more than 50%.

* This number is an estimate from the 7,270 Oregon deaths in 2014 from tobacco (see Oregon death certificates) and updated data on number of tobacco-related deaths and deaths from secondhand smoke from chapter 12 of the latest surgeon general report (http://www.surgeongeneral.gov/library/reports/50-years-of-progress/).

How TPEP works

The Tobacco Prevention and Education Program partners with local public health authorities, tribes and regional health equity coalitions to prevent and reduce tobacco-related deaths in every Oregon community. More than 85 percent of Oregon's TPEP funding flows directly into communities working to reduce tobacco-related illness and death across the state.

TPEP supports proven strategies to reduce tobacco use, including:

- Increasing the price of tobacco
- Promoting smoke-free environments
- Improving access to affordable and effective cessation services
- Warning of tobacco's dangers
- Reducing youth exposure to tobacco marketing

The cost of tobacco use

Tobacco use is a major risk factor for developing asthma, lung, liver, colorectal and other forms of cancer, arthritis, heart disease, stroke and diabetes. Tobacco use also worsens symptoms for people already living with chronic diseases.

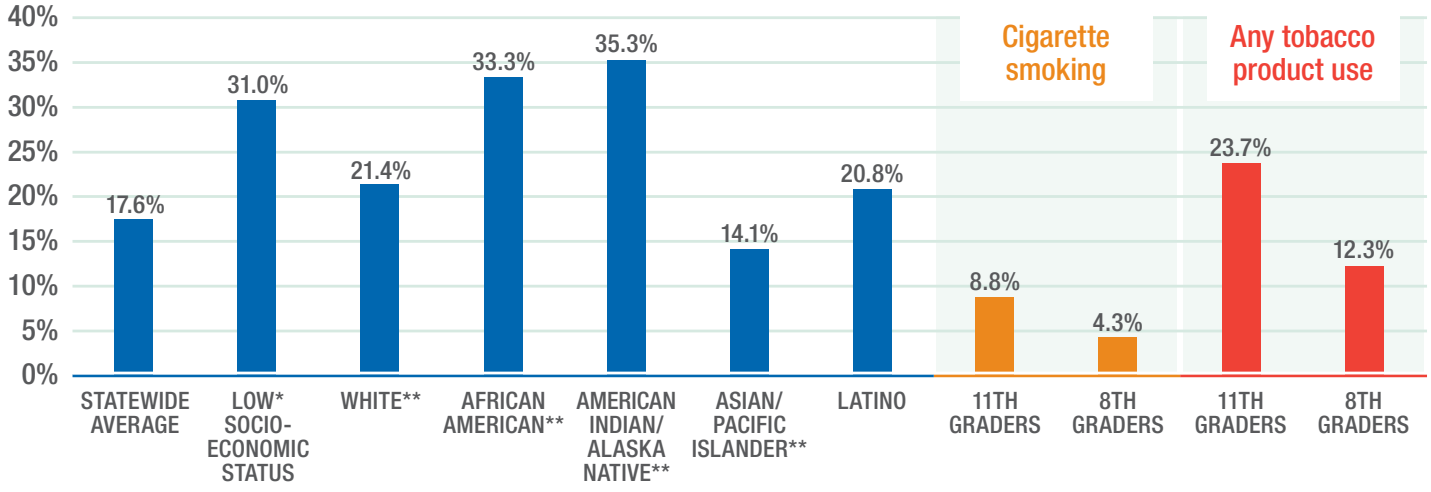
This burden falls hardest on lower-income Oregonians and certain racial and ethnic communities that use tobacco at higher rates and experience the harshest consequences.

All people in Oregon pay the price of tobacco use. Medical expenses and lost wages that result from tobacco-related disease and premature death cost Oregon $2.5 billion each year, or $1,600 for every Oregon household in our state.

Most TPEP funding comes from state taxes on tobacco products. However, in 2013, for the first time, the Legislature allocated funds from the Tobacco Master Settlement Agreement to support tobacco prevention efforts.

TPEP reduces tobacco's harm to Oregonians

Percentage of adult Oregonians who smoke, among selected groups; and teen smoking rates



Source: Oregon Behavioral Risk Factor Surveillance System (2015). BRFSS race-oversample (2010–2011), Oregon Healthy Teens (2015).

Note: Estimates are age-adjusted.

* Low socio-economic status includes having less than a high school education or being at 100% or less of the federal poverty level.

** Non-Latino

TPEP budget | 2015–2017

TPEP delivers comprehensive, evidence-based tobacco prevention and education programs to all people in Oregon.

More than two-thirds of TPEP's $15.86 million biennial budget supports public and private organizations' programs and services.

Funds support local public health authorities, tribes and community-based and not-for-profit organizations.

More than $10 million of TPEP's budget goes to communities across the state.

Community programs

TPEP provides funding to:

- All 34 of Oregon's local public health authorities;
- All nine federally recognized tribes; and
- Six coalitions of community-based organizations that represent people who are traditionally underserved and experience health disparities.

Communities use these funds to reduce tobacco use where people live, work, play and learn.

Public awareness and education

TPEP's statewide education campaigns include advertising on television, radio, digital and social media and in newspapers across Oregon.

TPEP also promotes news stories and editorials to raise Oregonians' awareness of the dangers of secondhand smoke and the benefits of quitting tobacco.

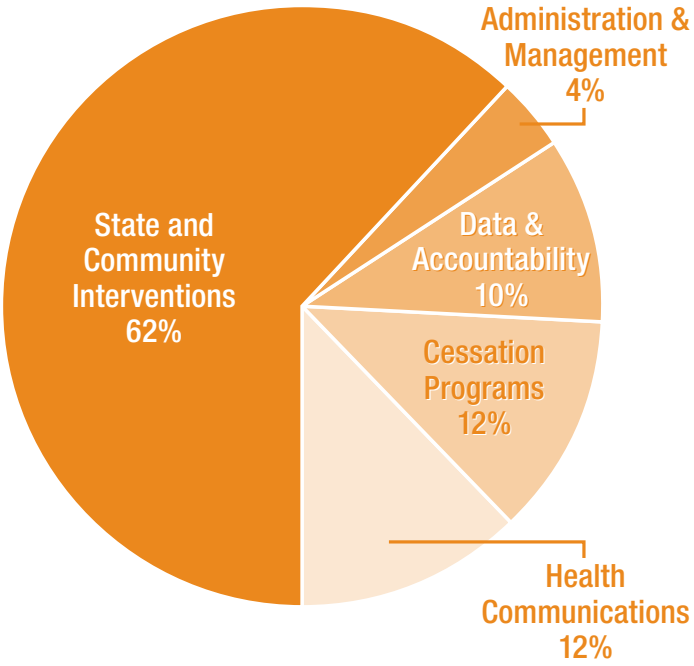
Oregon Tobacco Quit Line

The Oregon Tobacco Quit Line gives free help and coaching to all people in Oregon who want to quit using tobacco. It is also available to their friends, family and health care providers.

Data and accountability

TPEP tracks, measures and analyzes tobacco-related data on Oregon adults and youth to ensure programs are appropriate and effective.

TPEP measures effectiveness by comparing national and Oregon data and trends during the same period.



Oregon Health Authority
PUBLIC HEALTH DIVISION
Tobacco Prevention and Education Program (TPEP)
800 N.E. Oregon St., Suite 730
Portland, Oregon 97232
Telephone: 971-673-0984
Fax: 971-673-0994
public.health.oregon.gov/PreventionWellness/TobaccoPrevention

You can get this document in other languages, large print, braille or a format you prefer. Contact the Public Health Division at 971-673-0372. We accept all relay calls or you can dial 711.

OHA 9809 (12/16)

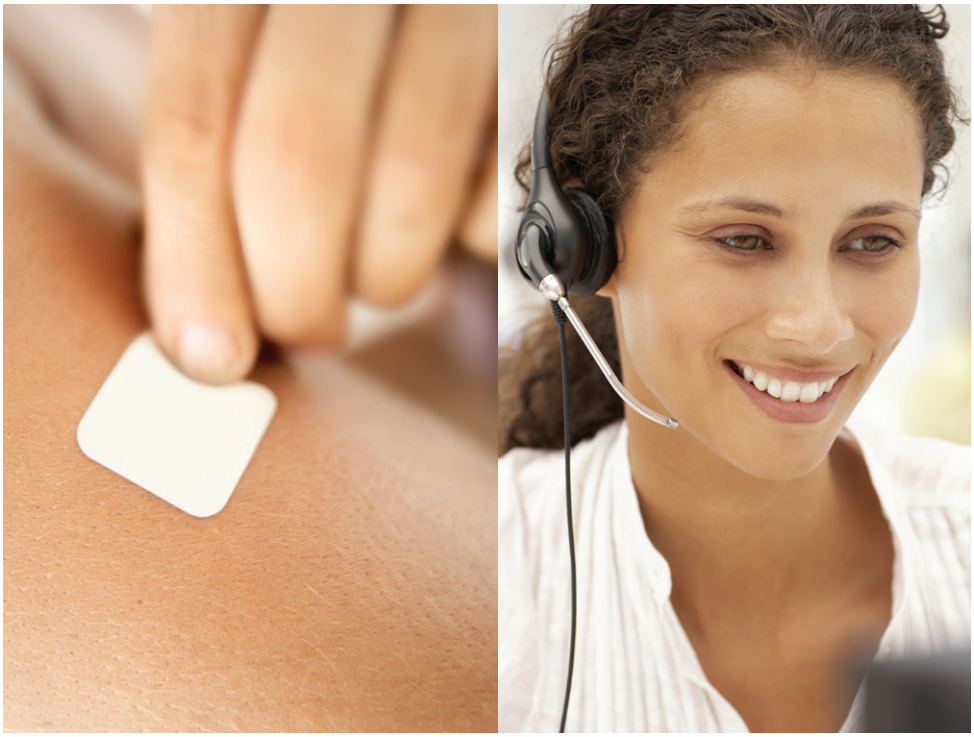
PUTTING TOBACCO MASTER SETTLEMENT AGREEMENT (TMSA) DOLLARS TO WORK

HELPING PEOPLE QUIT

OREGON'S INVESTMENT IN TOBACCO PREVENTION & EDUCATION

Despite declines in tobacco use, it remains the No. 1 preventable cause of death and disease in Oregon, killing 7,000 people each year. Tobacco use is a major risk factor for developing asthma, arthritis, diabetes, cardiovascular disease, stroke, tuberculosis and ectopic pregnancy– as well as lung, liver, colorectal and other forms of cancer. It also worsens symptoms for people already battling chronic diseases. This burden falls hardest on lower-income Oregonians and certain racial and ethnic communities who use tobacco at higher rates and suffer the harshest consequences.

ALL OREGONIANS PAY THE PRICE OF TOBACCO USE. MEDICAL EXPENSES AND LOST WAGES THAT RESULT FROM TOBACCO-RELATED DISEASE AND PREMATURE DEATH COST OREGON $2.5 BILLION EACH YEAR, OR $1,600 FOR EVERY HOUSEHOLD IN OUR STATE.



NEW TMSA FUNDING

The majority of Tobacco Prevention and Education Program (TPEP) funding comes from state taxes on tobacco products. However, in 2013, the Legislature for the first time directed a portion of funds from the Tobacco Master Settlement Agreement (TMSA) to support tobacco prevention efforts. This $4 million commitment funded:

- Community interventions to reduce tobacco use and encourage adults to quit
- Health education and communications
- Data collection and program evaluation
- Training for public health, health care and community partners
- Technical assistance to support community health
- The Oregon Tobacco Quit Line, available 24/7 by phone and online

QUIT LINE SUCCESS

This investment has increased callers to the Oregon Tobacco Quit Line by 136% from January 2015 compared to January 2014. In January 2015, a total of 1,156 people called for help–the highest number of callers Oregon has ever seen in one month. Web traffic to the Quit website increased from 510 views for the first week of December 2014 to 9,361 views for the last week in December 2014.

HELPING PEOPLE WIN AGAINST TOBACCO

In collaboration with the Conference of Local Health Officials (CLHO), the Tobacco Reduction Advisory Committee, representatives from Coordinated Care Organizations (CCOs), and the Governor's Office, the TPEP funded six local health departments with TMSA money.

COMMUNITY INTERVENTION– SOUTHWEST OREGON:

Southwest Oregon has some of the highest adult smoking rates in the state, particularly among low-income community members and people with substance use disorders. A strong partnership between public health, primary care and substance abuse prevention and treatment forms the backbone of TMSA efforts in Douglas and Coos counties. TMSA funding helped integrate comprehensive tobacco prevention and cessation interventions into medical and dental care campuses in Douglas and Coos counties, and engaged CCO-affiliated clinics in an intensive assessment and planning process to strengthen the delivery of nicotine dependence treatment.

COMMUNITY INTERVENTION– LANE COUNTY:

Eugene and Springfield comprise the second-largest urban area in the state, but outside of this metropolitan area, Lane County is primarily rural, and its large size and geographic diversity creates differences in health outcomes. TMSA funds allowed Lane County to focus on public health policies in the urban Eugene area as well as in rural areas of Lane County. In December 2014, the Lane County Board of Commissioners passed a tobacco ordinance that protects youth from new and emerging tobacco products, prohibits free sampling and coupon redemption for tobacco products, reduces the number of retailers near kid-friendly places over time, and offers health information at the point of sale.

> **"There is no simple solution to the problem of tobacco use, but we know what works to prevent young people from starting and to help people quit. This TMSA investment has allowed us to mobilize local action to apply what works to address the enormous health burden of tobacco use in Douglas and Coos counties."**
>
> **–Marilyn Carter, SPArC (Strategies for Policy And enviRonmental Change) Coordinator**

SUPPORT

TRAINING AND TECHNICAL ASSISTANCE: In partnership with the Coordinated Care Organization 2014 Summit, TPEP sponsored a half-day training for health care providers. Participants learned techniques to make sure that every patient is asked if they use tobacco, advised to quit if they do, and referred to support such as the Quit Line if they are interested in quitting. OHA is working with the Oregon Primary Care Association to provide cessation training to health workers at federally qualified health centers.

HEALTH EDUCATION AND COMMUNICATIONS: Oregon Health Authority kicked off its English and Spanish cessation campaign using multiple media channels across the state to reach audiences with the highest tobacco use rates. In areas where local health authorities received TMSA dollars for community interventions, OHA targeted additional cessation ads to pregnant women who continue to smoke. Counties include Benton, Coos, Douglas, Klamath, Lincoln, Linn and Yamhill. The campaign began in December 2014 and runs through June 2015, achieving more than 12 million views.

TOBACCO IN THE RETAIL ENVIRONMENT

OREGON'S INVESTMENT IN TOBACCO PREVENTION & EDUCATION

Oregon's Tobacco Prevention and Education Program (TPEP) works in partnership with local public health authorities, tribes and community-based organizations to engage communities in promoting smokefree environments and reducing the influence of tobacco marketing on the most vulnerable among us, particularly kids.

NEW TMSA FUNDING

The majority of TPEP funding comes from state taxes on tobacco products. However, in 2013, the Legislature for the first time directed a portion of funds from the Tobacco Master Settlement Agreement (TMSA) to support tobacco prevention efforts. This $4 million commitment funded:

- Community interventions to reduce tobacco use and encourage adults to quit
- Health education and communications
- Data collection and program evaluation
- Training for public health, health care and community partners
- Technical assistance to support community health
- The Oregon Tobacco Quit Line, available 24/7 by phone and online

Multnomah and Lane counties were awarded grants to implement innovative retail policies to reduce the number of Oregon youth who become addicted to tobacco.

SWEET, CHEAP & EASY TO GET

Addiction to tobacco starts in adolescence; in fact, nine of ten adults who smoke report that they started smoking before turning 18. Kids in Oregon are under constant pressure to start using tobacco. It is cheap, readily available and easy to get, and it's heavily promoted and marketed in stores that kids go to. Tobacco products come in every size, shape, color, flavor and price–often displayed at young kids' eye level (three feet or lower) and near candy.

Youth who live or go to school in neighborhoods with the highest density of tobacco outlets or retail advertising have higher smoking rates compared to youth in neighborhoods with fewer tobacco outlets. While consumption of cigarettes has decreased among Oregon teens, use of flavored little cigars and e-cigarettes has remained steady or increased–in fact, use of non-cigarette tobacco products (18 percent) is twice that of cigarettes (9 percent).

Oregon Health Authority

COMMUNITY INTERVENTION– MULTNOMAH COUNTY:

Multnomah County Health Department, in partnership with the Oregon Health Equity Alliance (OHEA), focused on a policy strategy to curb youth access to and use of tobacco. Multnomah County and OHEA assessed 411 tobacco retail venues and presented the results to the Multnomah Board of County Commissioners. County health department leaders conducted a series of presentations to the Board, culminating in three policy options under consideration:

- Prohibit e-cigarette sales to, and use by, minors
- Include use of e-cigarettes in the Multnomah County Smoke-free Workplace law
- License retailers who sell tobacco and e-cigarette products

COMMUNITY INTERVENTION – LANE COUNTY:

In December 2014, the Lane County Board of Commissioners passed a tobacco ordinance that achieves the following:

- Bans the sale of e-cigarettes to minors
- Requires tobacco and e-cigarette retailers to be licensed in unincorporated areas of the county
- Prohibits free samples of tobacco products
- Prohibits the redemption of tobacco industry coupons and other price discounting practices like multi-pack discounts
- Prohibits tobacco retailers within 1,000 feet of places that serve children, like schools, child care centers, libraries, playgrounds, youth centers, recreation facilities or parks
- Prohibits self-service displays and mobile vending
- Requires posting of health warnings and Quit Line information in each retailer

SUPPORT

TRAINING AND TECHNICAL ASSISTANCE: With the help of Oregon Health Authority staff, all local public health authorities completed a tobacco retail assessment to determine tobacco product availability, price, promotion and placement.

OHA staff trained local public health authorities on proven tobacco prevention retail strategies. These strategies work to reduce (or restrict) the number, location, density and types of tobacco retail outlets; increase the cost of tobacco products; implement prevention and cessation messaging; and other point-of-sale strategies including a ban on the sale of flavored tobacco.

HEALTH EDUCATION AND COMMUNICATIONS: The Smokefree Oregon education campaign informs local communities about the retail practices of the tobacco industry and highlights retailers, students and policy makers across Oregon who have taken a stand against the tobacco industry.

Marijuana Tax

OREGON DEPARTMENT OF REVENUE

www.oregon.gov/dor/news

An overview of Oregon's recreational marijuana taxes

- The state tax rate is 17 percent.
- Municipalities can enact an additional tax of up to 3 percent with the approval of voters.
- Only retailers licensed by the Oregon Liquor Control Commission (OLCC) can sell recreational marijuana.
    - Estimates indicate approximately 350 licensed retailers in 2015–17 and approximately 550 licensed retailers in 2017–19.
- Our rules require monthly payments. Payments are due on the last day of each month for retail sales from the previous month. For example, the tax for January's sales is due by February 28.
- Payments are accepted by check, money order, cashier's check, bank account transfer, credit or debit card, or cash. Cash payments are by appointment only at the Revenue building in Salem only.
- Taxpayers can keep 2 percent of the state tax to cover their administrative costs.
- Returns are due on the last day of the month following the quarter's end (January 31, April 30, July 31, October 31).
- Returns are only accepted electronically through Revenue Online at www.oregon.gov/dor.

Revenue disbursement

Per House Bill 2041 (2015), we'll use marijuana tax revenue to cover our costs for administering the marijuana tax. After that, money will be distributed as follows:

- Common School Fund: 40 percent.
- Mental Health, Alcoholism, and Drug Services Account (ORS 430.380): 20 percent.
- State Police: 15 percent.
- Cities, for local law enforcement: 10 percent.
- Counties, for local law enforcement: 10 percent.
- Oregon Health Authority, for alcohol and drug abuse prevention, early intervention, and treatment services: 5 percent.

Disbursements will be determined by the number of licenses issued by OLCC in a given area. Areas that prohibit recreational marijuana facilities won't receive any marijuana tax revenue.

Information on local taxes

In November 2016, voters in some municipalities approved local marijuana taxes of 3 percent. Many of those municipalities decided to have us collect those taxes on their behalf. A list of those municipalities is available on our website.

Starting in with February's payment for taxes collected in January: Businesses located in municipalities where we're responsible for the collection of the tax will include both state and local taxes in their monthly payment. Businesses located in a municipality that's collecting its own taxes should contact the municipality to find out how to file and pay their local taxes. They're still required to make monthly payments and quarterly filings to the Department of Revenue for their state taxes, regardless of how the local tax is being administered.

For more information on marijuana taxes, visit www.oregon.gov/dor/marijuana.

2017 - 2019

Governor's Budget

STATE OF OREGON

Governor Kate Brown

Kate Brown

REVENUES

Revenue Summary

CURRENT LAW PROJECTION

The Department of Administrative Services Office of Economic Analysis projects General Fund revenue of $19,454.1 million for 2017-19. A beginning balance of $64.6 million is anticipated for the new biennium, after a transfer of $180.7 million is made to the Rainy Day Fund.

Personal income tax makes up the largest share of the General Fund. It accounts for about 89 percent of projected revenues. Corporate income taxes are about five percent of the total revenue amount. Other sources make up the remainder. The largest of the other sources are insurance taxes, estate taxes, and liquor apportionment transfer.

Personal income tax revenues in the 2017-19 Current Law Forecast total $17,340.4 million, and corporate income tax revenues are expected to be $988.8 million for the biennium.

New state Lottery revenues for the biennium are forecast to be $1,232.2 million. The budget anticipates a beginning balance of $46.7 million. Interest on the Education Stability Fund and Economic Development Fund provide an additional $2 million of resources. Total resources are expected to be $1,280.9 million for the 2017-19 biennium.

Dedicated distributions for the Education Stability Fund, the Parks and Natural Resources Fund, county economic development, county fairs, and problem gambling treatment will total $465.3 million. There are two new dedicated distributions that were passed by the voters at the November 2016 general election. A dedicated distribution to the Veterans' Services Fund of 1.5 percent of net lottery proceeds, or $18.5 million, is the result of the passage of Ballot Measure 96. The second new dedication is the result of the passage of Ballot Measure 99 where four percent, or $22 million per year, is dedicated to the Outdoor Education Account. Funds dedicated for debt service on Lottery bonds will total $270 million. In addition to these distributions, $481.1 million will be available for allocation to education and economic development activities in the 2017-19 biennium.

GOVERNOR'S RECOMMENDED REVENUE CHANGES

The Governor recommends continuing 10 corporate and personal income tax credits set to end in 2017-19. Several do not have a substantive effect on the General Fund and cumulate to about $4.8 million.

The Governor's Budget proposes to increase the Cigarette Tax from $1.33 per pack to $2.18 per pack effective January 1, 2018. The increase is estimated to generate an estimated $21.5 million for the General Fund per the Department of Revenue. The distribution formula will be in exact proportion to the existing distributions. The Governor's Budget also proposes to increase taxes on Other Tobacco Products, generating an estimated $13.7 million for the General Fund, in the following ways:

- Increase the per cigar cap from $0.50 to $1.00;
- Increase the rate on moist snuff by $0.89 per ounce; and,

- Increase the rate on all other tobacco products from 65 percent of the wholesale price to 75 percent of the wholesale price.
- The distribution formula will be in exact proportion to the existing distributions and are proposed to take effect in January 1, 2018.

The Governor proposes to eliminate the "Partnership Pass-through" which allows lower tax rates for non-passive partner income as well as the Interest Charge – Domestic International Sales Corporation (IC-DISC) dividend subtraction. The Department of Revenue estimates that the Partnership Pass-through elimination will increase Personal Income Tax revenue by $177.0 million. Elimination of the IC-DSC dividend subtraction will result in an additional $6.0 million in Personal Income Taxes. These changes are proposed to take effect January 1, 2018.

Finally, the Governor's Budget proposes to increase General Fund revenue raised by the Oregon Liquor Control Commission by $39.1 million in the following ways:

- Increase the surcharge on distilled spirits from $0.50 per bottle to $1.00 per bottle beginning July 1, 2017 and extending through June 30, 2019. On August 19, 2016, the Commission voted to extend its 50-cent surcharge on distilled spirits through June 30, 2019. This proposal doubles the surcharge and generates an estimated $33.8 million in revenues dedicated to the General Fund.
- Increase alcohol licensing fees while maintaining the current fee for server permits. Fee's would increase by 100 percent on July 1, 2017 and are anticipated to generate an additional $5.3 for the General Fund.

The budget includes expected costs for the issuance of Tax Anticipation Notes (TANs). These notes are used by the State Treasurer during the biennium to help with General Fund cash flow. The total cost for the biennium is estimated at $20.2 million.

When the Governor's recommended revenue changes are incorporated into the revenue forecast, total General Fund revenues for 2015-17 will be $19,772.7 million. This is a 9.7 percent increase over the latest forecast of General Fund resources for the 2015-17 biennium.

PHAB Funding and Incentives Subcommittee

Subcommittee Members: Silas Halloran-Steiner, Jeff Luck, Alejandro Queral, Akiko Saito, Tricia Tillman

February 14, 2017

Sugary Drink Taxes Update[1]

2015-2019 State Health Improvement Plan: Population Interventions

Strategy 1: Increase the price of sugary drinks

Tax advocates have won seven of the past seven tax campaigns. The beverage industry spent over $42 million this year alone to defeat taxes on sugary drinks. The total number of people benefitting from sugary drink taxes across the nation is over 8 million people.

Location	**Passed**	**Amount**	**Revenue Use**	**Est. annual revenue ($1,000,000)**
Berkely, CA Measure D	74% Oct. 2014	1 cent/oz	Health programs in schools and communities	$1.5
Philadelphia, PA-Council	13-4 June 2016	1.5 cents/oz	Pre-k, schools, parks, recreation centers, libraries	$91.0
Albany, CA Measure O1	71% Nov. 2016	1 cent/oz Exemption for distributors serving businesses with less than $100,000 in gross receipts per year	Measure didn't specify where the money would go, meaning they needed only a simple majority. Backers of the taxes vowed to use the proceeds for health-related purposes, even if that wasn't written into the measures.	$0.2
Oakland, CA Measure HH	61% Nov. 2016	1 cent/oz	" "	$7
San Francisco, CA Measure V	62% Nov. 2016	1 cent/oz	" "	$15.0
Boulder, CO Measure 2H	54% Nov. 2016	2 cents/oz	Health and nutrition programs	$3.8
Cook County, IL (Chicago)-Commission	9-8 Nov. 2016	1 cent/oz Exemption for sugary	Public health and safety programs	$223.8

[1] The information in this document was provided by the Oregon Health Authority, Public Health Division, Health Promotion and Chronic Disease Prevention section.

Location	Passed	Amount	Revenue Use	Est. annual revenue ($1,000,000)
		beverages paid for w/SNAP		

Combined, the seven Bay Area, Philadelphia, Boulder, and Cook County taxes will bring in estimated revenues of over $342 million per year. [i]

[i] http://www.healthyfoodamerica.org/cook_county_makes_soda_taxes_5_for_5_this_week

Custom Report

Report Date: February 13, 2017

Public Health Division (PHD)

Bill Name	Priority
HB 2024	1
Relating to nicotine; prescribing an effective date; providing for revenue raising that requires approval by a three-fifths majority.	
Imposes tax on inhalant-form nicotine at point of retail sale, based on percentage of wholesale price.	
HB 2032	1
Relating to taxation; declaring an emergency.	
Creates task force to identify and develop proposals for privatization of sale of distilled liquors.	
HB 2037	1
Relating to taxation of products containing nicotine; providing for revenue raising that requires approval by a three-fifths majority; providing that this Act shall be referred to the people for their approval or rejection.	
Increases rate of taxation on cigarettes and tobacco products.	
HB 2056	1
Relating to taxation of products containing nicotine; prescribing an effective date; providing for revenue raising that requires approval by a three-fifths majority.	
Increases rates of taxation on cigarettes and tobacco products.	
HB 2062	1
Relating to taxation of products containing nicotine; prescribing an effective date; providing for revenue raising that requires approval by a three-fifths majority.	
Expands definition of tobacco products for purpose of taxation to include inhalant form nicotine.	
HB 2101	1
Relating to public records.	
Sunsets certain exemptions from disclosure for public records.	
HB 2119	1
Relating to tax on cigarettes; prescribing an effective date; providing for revenue raising that requires approval by a three-fifths majority.	
Increases cigarette tax.	
HB 2128	1
Relating to pseudoephedrine; prescribing an effective date.	
Deletes requirement that pseudoephedrine be classified as Schedule III controlled substance.	
HB 2183	1
Relating to oversight of health care facility structural requirements; declaring an emergency.	
Transfers authority relating to plan review and inspections of health care facilities from State Fire Marshal to Department of Consumer and Business Services.	
HB 2198	1
Relating to cannabis; prescribing an effective date.	
Changes name of Oregon Liquor Control Commission to Oregon Liquor and Cannabis Commission.	
HB 2200	1
Relating to cannabis; prescribing an effective date.	
Changes name of Oregon Liquor Control Commission to Oregon Liquor and Cannabis Commission.	
HB 2201	1
Relating to cannabis.	
Corrects and conforms definitions for "cannabinoid concentrate" and "cannabinoid extract" in laws regulating cannabis.	

Custom Report

Report Date: February 13, 2017

Public Health Division (PHD)

Bill Name	Priority
HB 2203	1
Relating to distribution of moneys collected as a tax imposed on the retail sale of marijuana items; prescribing an effective date.	
Changes distribution of moneys collected by Department of Revenue as tax imposed on retail sale of marijuana items.	
HB 2223	1
Relating to school nurses; declaring an emergency.	
Directs Department of Education to establish program to develop and maintain statewide school nursing services.	
HB 2301	1
Relating to health.	
Specifies circumstances under which Health Licensing Office is required or permitted to disclose information obtained during investigation of certain professions.	
HB 2310	1
Relating to the provision of public health services; prescribing an effective date.	
Modifies provisions regarding schedule by which local public health authorities must submit local plans for applying foundational public health capabilities and implementing foundational public health programs.	
HB 2402	1
Relating to individuals who are homeless; prescribing an effective date.	
Directs Center for Health Statistics to establish program allowing individual who is homeless to obtain certified copy of individual's record of live birth, free of charge.	
HB 2404	1
Relating to ground water that is used for domestic purposes.	
Requires Oregon Health Authority to analyze ground water contaminant data and provide education in areas with ground water contaminant problems.	
HB 2406	1
Relating to tax on cigarettes; providing for revenue raising that requires approval by a three-fifths majority; providing that this Act shall be referred to the people for their approval or rejection.	
Increases cigarette tax and provides for distribution of increase in revenue.	
HB 2408	1
Relating to access to health services in schools; declaring an emergency.	
Appropriates moneys to plan, establish and operate new school-based health centers, to increase student access to school-based mental health providers and to fund pilot program that uses trauma-informed approaches.	
HB 2432	1
Relating to art therapy; declaring an emergency.	
Directs Health Licensing Office to issue license to engage in practice of art therapy to qualified applicant.	
HB 2503	1
Relating to lactation professionals; declaring an emergency.	
Directs Health Licensing Office to issue lactation consultant and lactation educator licenses to qualified applicants.	
HB 2504	1
Relating to lactation professionals; declaring an emergency.	
Directs Health Licensing Office to issue lactation consultant, lactation educator and lactation peer support provider licenses to qualified applicants.	

Custom Report

Report Date: February 13, 2017

Public Health Division (PHD)

Bill Name	Priority
HB 2517	1
Relating to programs used to monitor the dispensing of prescription drugs; declaring an emergency.	
Provides that Director of the Oregon Health Authority may enter into agreements governing sharing and use of information reported to prescription monitoring program with regulatory authorities of other states that administer prescription monitoring programs.	
HB 2518	1
Relating to programs used to monitor the dispensing of prescription drugs; declaring an emergency.	
Requires pharmacy to report de-identified information to prescription monitoring program upon dispensing prescribed naloxone.	
HB 2519	1
Relating to the program used to monitor the dispensing of prescription drugs; declaring an emergency.	
Requires pharmacy to report de-identified information to prescription monitoring program upon dispensing prescribed naloxone.	
HB 2633	1
Relating to sex offender treatment; declaring an emergency.	
Expands definition of "sex offender" for purposes of sex offender treatment services.	
HB 2662	1
Relating to tax on tobacco products; prescribing an effective date; providing for revenue raising that requires approval by a three-fifths majority.	
Increases cigarette tax and provides for distribution of increase in revenue.	
HB 2664	1
Relating to health care facilities.	
Specifies criteria for licensing of extended stay centers and requires Oregon Health Authority to adopt rules.	
HB 2673	1
Relating to processes required to change information by which a person may be identified; prescribing an effective date.	
Creates alternative process for persons seeking to change name on vital record for purpose of affirming gender identity.	
HB 2735	1
Relating to tobacco products; prescribing an effective date.	
Transfers duties, functions and powers of Oregon Health Authority related to certification and regulation of smoke shops and cigar bars to Oregon Liquor Control Commission.	
HB 2736	1
Relating to certified smoke shops.	
Provides that smoke shop certified by Oregon Health Authority may allow on-premises consumption of alcoholic beverages.	
HB 5026	1
Relating to the financial administration of the Oregon Health Authority; declaring an emergency.	
Appropriates moneys from General Fund to Oregon Health Authority for certain biennial expenses.	
HB 5027	1
Relating to the financial administration of the Oregon Health Authority; declaring an emergency.	
Approves certain new or increased fees adopted by Oregon Health Authority.	
SB 52	1
Relating to emergency services; declaring an emergency.	
Requires ambulance services and emergency medical services providers to report patient encounter data to electronic emergency medical services data system managed by Oregon Health Authority.	

Custom Report

Report Date: February 13, 2017

Public Health Division (PHD)

Bill Name	Priority
SB 53	1
Relating to licensing fees paid to the Oregon Health Authority.	
Modifies licensing fees paid to Oregon Health Authority by in-home care agencies and hospice providers.	
SB 108	1
Relating to cannabis; providing for revenue raising that requires approval by a three-fifths majority.	
Modifies certain definitions for purposes of regulating cannabis.	
SB 110	1
Relating to lead-based paint.	
Directs Oregon Health Authority to prepare report on efficacy of laws regulating lead-based paint activities and potential improvements that may be made to regulation of lead-based paint activities.	
SB 111	1
Relating to school nursing services; declaring an emergency.	
Establishes grant program to assist school districts in complying with school nursing service requirements.	
SB 130	1
Relating to cannabis.	
Waives fees for obtaining medical marijuana card for veterans who have total disability rating of at least 50 percent as result of injury or illness incurred or aggravated during active military service, and who received discharge or release under other than dishonorable conditions.	
SB 180	1
Relating to taxation of products containing nicotine; prescribing an effective date; providing for revenue raising that requires approval by a three-fifths majority.	
Expands definition of tobacco products for purpose of taxation to include inhalant form nicotine.	
SB 223	1
Relating to in-home caregivers.	
Requires in-home caregivers employed by or contracting with in-home care agencies to meet training requirements for home care workers established by Home Care Commission.	
SB 235	1
Relating to public health; prescribing an effective date.	
Provides that person may not make retail sale of tobacco product or inhalant delivery system at or from premises located in this state unless person sells tobacco product or inhalant delivery system at or from premises for which license has been issued.	
SB 255	1
Relating to art therapy; declaring an emergency.	
Directs Health Licensing Office to issue license to engage in practice of art therapy to qualified applicant.	
SB 300	1
Relating to cannabis; declaring an emergency.	
Establishes Oregon Cannabis Commission to fulfill duties, functions and powers relating to medical use of marijuana.	
SB 306	1
Relating to cannabis; prescribing an effective date.	
Specifies that Oregon Health Authority may not register marijuana grow sites, marijuana processing sites and medical marijuana dispensaries.	

Custom Report

Report Date: February 13, 2017

Public Health Division (PHD)

Bill Name	Priority
SB 307	1
Relating to cannabis; prescribing an effective date.	
Provides for regulation by Oregon Liquor Control Commission of consumption and sale of marijuana items at temporary events, including licensure of premises on which temporary events are held.	
SB 308	1
Relating to cannabis; declaring an emergency.	
Establishes Task Force on Social Consumption of Cannabis.	
SB 349	1
Relating to nutrition assistance programs.	
Expands eligibility for Women, Infants and Children nutrition assistance program.	
SB 456	1
Relating to emergency medical services.	
Enacts Emergency Medical Services Personnel Licensure Interstate Compact.	
SB 494	1
Relating to health care decisions; prescribing an effective date.	
Establishes Advance Directive Rules Adoption Committee for purpose of adopting form of advance directive to be used in this state.	
SB 512	1
Relating to parentage.	
Modifies laws regarding establishment of parentage of child.	
SB 580	1
Relating to providing notice before administering vaccination.	
Requires health care practitioner, before administering vaccination to child, to provide written notice of each vaccination that child is required to receive as condition of attending school or children's facility in this state and of each exemption to that requirement.	
SB 687	1
Relating to definition of abuse of child.	
Provides that definition of "abuse" does not include refusal to vaccinate child or decision to delay vaccination of child.	
SB 708	1
Relating to care facilities; declaring an emergency.	
Modifies provisions relating to care facilities regulated by Department of Human Services.	
SB 742	1
Relating to emergency care.	
Establishes ST-Elevation Myocardial Infarction Care Committee within Oregon Health Authority.	
SB 754	1
Relating to products that have a minimum age requirement for purchase; declaring an emergency.	
Creates offense of selling tobacco products or inhalant delivery systems to person under 21 years of age.	
SB 768	1
Relating to advance directives; prescribing an effective date.	
Requires Oregon Health Authority to establish and operate statewide registry for collection and dissemination of advance directives.	

Custom Report

Report Date: February 13, 2017

Public Health Division (PHD)

Bill Name	Priority
SB 788	1
Relating to cannabis; prescribing an effective date.	
Provides for regulation by Oregon Liquor Control Commission of consumption and sale of marijuana items at temporary events, including licensure of premises on which temporary events are held.	
SB 5539	1
Relating to the financial administration of the Tobacco Settlement Funds Account; declaring an emergency.	
Requires Oregon Department of Administrative Services to transfer certain amounts from Tobacco Settlement Funds Account for certain purposes.	

HB 2310 - Public Health Modernization

- Allows for implementation of public health modernization by foundational capability and program vs. by region
- Directs OHA to establish accountability metrics
- Clarifies that the local public health funding formula is limited to moneys made available by the state
- Establishes new requirements for county relinquishment of public health authority
- Gives OHA the authority to establish fees to fulfill public health data requests for non-governmental public health entities

PHD Health Equity Work Group
Charter

Purpose:	Lead the Public Health Division's efforts to advance health equity through partnerships, capacity building and expertise development. This work is aligned with Oregon's Public Health Modernization needs (please see the accompanying diagram). The Work Group's efforts are based on the needs identified through the public health modernization assessment for the health equity and cultural responsiveness foundational capability. The Public Health Division defines health equity as the absence of unfair, avoidable, or remediable difference in health among social groups. It is important to define health equity in negative terms because it is necessary to focus on the elimination of avoidable structural determinants by which it is caused. Health equity implies that health should not be compromised or disadvantaged because of racism, classism, sexual discrimination, religious discrimination, linguistic discrimination, nationalism, ableism, or by neighborhood or other social condition. These groups are referred to as non-dominant groups throughout this document. Achieving health equity requires the equitable distribution of resources and power resulting in the elimination of gaps in health outcomes between within and different social groups. Health equity also requires that public health professionals look for solutions outside of the health care system, such as in the transportation or housing sectors and through the distribution of power and resources, to improve health with communities. This charter uses language that is defined and described the Framework and Framework narrative developed by the Health Equity Work Group.
Executive Sponsor:	Tim Noe
Governing Body Decision Date:	

Business Case:

Nationally, approximately $230 billion in direct medical care expenditure and more than $1 trillion in indirect costs associated with illness and premature death for the years 2003-2006 would have been saved by eliminating health disparities for racial/ethnic minority groups alone. According to the Pew Research Center, racial and ethnic minorities will become a majority in the United States by 2050. Racial/ethnic minorities, people with low socioeconomic status, and those living in rural and frontier areas also have worse health outcomes. The inability to understand a patient's language or cultural background contributes to the lower quality of care provided to racial/ethnic minorities.

State leaders' vision for how Oregon's public health system should support Oregon's health system is shifting its focus to prevention of disease and population health, as outlined in the 2010 Oregon's Action Plan for Health. The Oregon Public Health Division's vision is lifelong health for all people in Oregon. It seeks to achieve this vision by promotion health and preventing the leading causes of death, disease, and injury in Oregon. A modernized public health system will be well-prepared and able to meet this charge; will provide core public health functions; and will maintain the flexibility needed to focus on new health challenges.

Disparities in access to and quality of medical care only partly explain differences in health outcomes experienced by non-dominant groups. Deeper root causes of health inequities such as inadequate education, poor living conditions, unsafe neighborhoods, and institutional racism/discrimination need to be addressed within the larger public health infrastructure.

Significant and persistent inequities exist between dominant and non-dominant groups and by geographic locations across a suite of key public health indicators and risk factors including infant mortality, tobacco use, access to care, nutrition, and physical activity and in social determinants of health such as poverty, education, inadequate housing, and unsafe working conditions. These inequities are increasing and are preventable.

Scope:

In Scope:

- Facilitate the recruitment, training, and engagement of health equity Champions across the PHD to influence adoption and implementation of an organizational change process to institutionalize action on social determinants.
- Develop a health equity conceptual framework, guiding principles and definitions for the PHD
- Guide the completion of a comprehensive health equity plan for PHD
- Guide implementation of the comprehensive health equity plan for PHD, including performance monitoring.
- Facilitate the development and delivery of health equity training to PHD staff that includes an emphasis in social determinants of health and Health in All Policies for management staff across the division.
- Facilitate the development of organizational structures, policies and supports to advance health equity, diversity, cultural responsiveness and work toward institutionalizing these at the PHD
- Create a Public Health Division public facing health equity website.
- Support PHD compliance with the Racial Ethnic and Language plus Disability data policy (REAL+D)

- Assess PHD data collection related to health disparities, inequities and social determinants of health and develop a plan for addressing gaps.

Out of Scope:

- Implement health equity and/or cultural responsiveness training at the Division, Center, Section or Program level.
- Develop or implement a health equity and cultural responsiveness modernization plan for Oregon's public health system.

Objectives:

By March 1, 2018, the HEWG will foster a shared understanding of and will to achieve health equity and cultural responsiveness within the Public Health Division.

By March 1, 2018, the PHD will institutionalize necessary organizational structures, policies, and systems to advance health equity, diversity, and cultural responsiveness within the Division.

Expected Benefits:

Inequality affects everyone in a society. Even those who are the healthiest in an unequal society would be healthier if their society was more equal.

The core expected benefit of a modernized public health system that implements policies, programs, and strategies equitably and with cultural responsiveness is better health, lower health care costs, and better quality care for all people in Oregon.

A healthier workforce is more productive, misses fewer work days due to illness, and costs less for employers to provide health insurance.

Outcome Measurements:

- Internal assessment, completed within the last five years, of the state's overall capacity to apply a health equity lens to programs and services, provide culturally responsive programming and services, and status of the division's structure and culture as a barrier or facilitator for achieving health equity.
- Action plan that addresses key findings from the internal assessment and includes organizational changes that support a health equity lens and cultural responsiveness. Action plan includes metrics and accountability structure that identifies responsible work units, tasks, timelines and performance measures.
- Documentation that OHA-PHD uses demographic data to evaluate the impact of public health policies, programs, and strategies on health equity and health outcomes, and to inform public health action moving forward. (Sustainability measure)
- Training plan to increase staff capacity to address the causes of health inequities, promote health equity and implement culturally responsive programs. Documentation that OHA-PHD provides training to staff annually. (sustainability measure)
- Revised state health improvement plan to align with the health equity and cultural responsiveness component of a modernized public health system.
- Documented strategy to increase the diversity of PHD workforce by 10 percent every five years. (Sustainability plan)

Stakeholders:	
Name	Department/Area/Program

Participants:	
Tim Noe	Executive Sponsor
Kati Moseley	Staff chair
Steve Fiala	Data support
Julie Wray	Administrative Support
Peter Ngo	VISTA
Leslie Uebel	
Peter Ngo	
Danna Drum	
Alyssa McClean	
Marjorie Mcgee	
Akiko Saito	
Tia Skerbeck	
Nhu To-Haynes	
Isabelle Barbour	
Julie Sifuentes	
Kalii Nettleton	
Kristen Rohde	
Erica Sandoval	
Julie Black	
Shelley Das	
Alex Garcia	

Participant Responsibilities:
▪ Build connections between Centers and Sections to ensure coordination and efficiency. ▪ Interact with PHD leadership and Center Administration on strategy, staff engagement, and shared responsibility. ▪ Engage their respective Section or Program to align with the overall division-wide health equity and cultural responsiveness direction set by the Health Equity Work Group. ▪ Serve as vocal champions for health equity and cultural responsiveness modernization processes and plans in their Program, Section, and Center as well as in the Division and throughout the OHA. ▪ Participate in regularly scheduled meetings (every two weeks), in person as much as possible. ▪ Review pre-prepared materials prior to meetings and come prepared for engaged discussion, active listening and respectful dialogue. ▪ Commitment to yearlong membership on the Health Equity Committee.

Impacted Groups: Who might be necessary to implement changes, or impacted by any changes/solutions put into place
Center for Protection Center for Prevention and Health Promotion Center for Practice Director's Office OHA-Office of Equity and Inclusion
Budgetary Considerations:
Modernizing Oregon's public health system is a priority for the Oregon Health Authority. Despite this, Oregon's current budget status does not allow a significant investment of new funds to support work on health equity and cultural responsiveness modernization. However, one of the Core System Functions articulated in the Health Equity and Cultural Responsiveness component of the Modernization Manual is to "leverage existing and new funding for health equity."
Constraints/Barriers:

Amendment history

Document Version #	Modified By	Section, Page(s), Text Modified	Modification Date	Approver, if necessary

Action (Decision of governing body about path forward)

☐	**Approval** - Move forward with steps as presented.
☐	**Approval with minor changes** – approved assuming minor changes will be made and move forward with next steps as presented.
☐	**Change** - make requested changes with another review for approval by <*date*>.
☐	**Hold -** hold all additional work on this request. To be reviewed again at a later date.
☐	**Denied** - Request denied, please file.

Signatures

Manager Sponsor		
	[Email]	[Telephone]
Signature:		Date:
PHD Director		
	[Email]	[Telephone]
Signature:		Date:

Proposed Approach for Health Equity Work across the Public Health System

There have been a number of questions regarding how the PHD and LPHDs will proceed in a collaborative approach to advance health equity. Both PHD and LPHDs have groundwork to lay to prepare for system work to achieve the vision of modernization for health equity and cultural responsiveness. Following is a **potential path** toward accomplishing this objective.

- There are a number of activities that the PHD will need to undertake independently in order to build internal understanding, capacity and expertise to effectively undertake broader, collaborative health equity work. These activities are essential toward laying a solid foundation from which to build broader efforts to effectively advance health equity.
- LPHDs can also assume a number of activities independent of the PHD in order to develop their internal capacity and expertise on health equity. Many of these activities could be accomplished simultaneously while the PHD is completing its internal work. However, the PHD will plan to provide training and resources to LPHDs. Therefore, LPHDs may wish to wait until those resources and training opportunities are available.
- LPHDs could also engage in externally-focused health equity activities, independent of the PHD, within their jurisdictions.
- It will also be important to develop system-wide, state-wide plans to advance health equity.
- Finally, there are a number of potential activities in which local elected officials can engage to advance health equity

Following are example activities for each component.

Example PHD Internally-Focused Activities to Build Internal Capacity and Expertise

1. Recruiting and assembling a **PHD-wide Health Equity Committee** including representation from OEI.
2. Working to **expand the understanding of health equity** and how it relates to public health across the PHD to include adopting a comprehensive health equity conceptual framework (to include principles and definitions) (e.g., WHO framework) designed to foster a deeper understanding of how the social determinants of health influence health disparities/inequities.
3. Developing the **capacity to hire and retain a diverse workforce** that reflects all the populations of the state.
4. Developing a **Health Equity Website**.
5. Building **PHD organizational structures, policies and supports** to promote health equity, diversity, and cultural responsiveness and institutionalizing these into the PHD.
6. Developing and implementing an **Action Plan for accomplishing full compliance with REALD** requirements for PHD data systems.
7. Developing an **online library of resources and tools** that LPHDs can use to advance health equity.

Example LPHD Internally-Focused Activities to Build Internal Capacity and Expertise (please note this is an example list and is not intended to instruct the LPHDs on the strategies they should use)

1. **Developing a common understanding of what health equity** means for their jurisdiction.
2. Building **LPHD organizational structures, policies and supports** to promote health equity, diversity, and cultural responsiveness and institutionalizing these into the LPHD.

3. **Developing the workforce** through continuous learning: The LPHDs develop and maintain a highly qualified, well-trained and diverse workforce, assure optimal workforce development and build a culture of learning and improvement and incorporates continuous quality improvement into daily work to advance health equity.
4. **Conducting cultural responsiveness assessments** and developing action plans to address gaps.

Example LPHD External Activities Independent of PHD (please note this is an example list and is not intended to instruct the LPHDs on the strategies they should use).

1. **Engage local elected officials** in the process of advancing health equity (see below).
2. Engage in a **conversation with other local leaders** in areas such as planning and zoning, public safety, transportation, community development, or education about how they have an impact on health.
3. Develop a social marketing approach to **assess and influence the local policy context** to influence policies to address social determinants of health and advance health equity.
4. Use data to advance health equity in their local jurisdiction: Examining data on local **structural and intermediary social determinants of health** (SDOH) by race, ethnicity and language, place, poverty status, including housing, transportation, education, etc data.
5. Examining **Health in All Policies and Health Impact Assessment** approaches in local jurisdictions to determine how our current work to address SDOH might be strengthened to increase collective impact.
6. **Build local partnerships and community capacity**: Facilitating and promoting **multi-sector leadership teams, coalitions and community engagement** across the local community and strategically engaging multiple partners to transform public health practice, collectively address SDOH and advance health equity; explicitly developing and deepening relationships with communities experiencing health inequities, and developing and deepening cross-sector and interagency relationships.

Example System-Wide, Multi-Sector Activities (We propose developing a System-Wide, State-Level Health Equity Committee with broad representation from PHD, LPHDs, REHC, NGOs, State agencies, communities, etc.)

1. **Consulting and collaborating with OEI and regional health equity coalitions**, and affected communities/populations and **developing a comprehensive state-wide health equity plan**.
2. **Assessing our ability to identify inequities** in communities, identifying ways to increase data collection capacity and highlighting the most striking inequities and communicating those through clear, consistent, and widespread messages to decision-makers, affected communities, partners, and the general public.
3. **Developing the workforce** through continuous learning: The PHD will develop and maintain a highly qualified, well-trained and diverse workforce, assure optimal workforce development and build a culture of learning and improvement and incorporates continuous quality improvement into daily work to advance health equity.
4. **Developing and maintaining data systems** with an expanded understanding of both intermediary and structural determinants and provide actionable data to promote improvement and accountability in organizational and stakeholder performance in advancing health equity.
4. **Examining our portfolio of program and projects** to assess health equity strategies embedded in those efforts and identifying gaps and develop a systemic approach to address gaps.
5. **Revisiting the SHIP** and selecting evidence-based or designing innovative strategies, implementing and evaluating additional health equity strategies and outcomes (to include racial and ethnic groups) and applying *Equity Impact Assessments* to all proposed strategies to determine their likelihood of effectively impacting targeted disparities.
6. **Assisting the PHAB to develop measures** for documenting progress on health equity across the state, including evaluating current measures and developing new ones and monitoring progress.

7. **Use data to advance health equity**: Examining data on statewide structural and intermediary social determinants of health (SDOH) by race, ethnicity and language, place, poverty status, including housing, transportation, agriculture, labor, and education data.
8. **Supporting local and state-wide efforts** to hold challenging conversations on the issues that affect health equity, including poverty, class, race, and gender.
9. **Engage state-level policy-makers, decision-makers and directors** in the process of advancing health equity (see below). This will cross over with LPHD efforts.
10. **Engage with other state agency commissioners and other state, regional, and national leaders** to expand the understanding of what creates health, to assure that health is considered in all policies, and lead toward meaningful action.
11. **Build partnerships and community capacity**: Facilitating and promoting **multi-sector leadership teams, coalitions and community engagement** across the state and strategically engaging multiple partners to transform public health practice, collectively address SDOH and advance health equity; explicitly developing and deepening relationships with communities experiencing health inequities, and developing and deepening cross-sector and interagency relationships.
12. Examine state agency **Health in All Policies and Health Impact Assessment** approaches to determine how Oregon's current work to address SDOH might be strengthened to increase collective impact.

Finally, there are a number of potential activities in which local elected officials can engage to advance health equity. PHD and LPHDs have an opportunity to educate and inform elected officials about health equity and cultural responsiveness modernization.

Example Activities for Elected Officials

As policy makers, elected officials (both local and state-level) are in a unique position to advance health equity by working to assure that new and existing policies support health equity.

1. Elected officials should become knowledgeable about the health disparities and inequities in their jurisdictions. For example, elected officials can:
    a. Ask for data that assesses inequities in their jurisdiction, and use this data to shape policies to remove structural barriers to equity. (Note: The local health department is a key resource for this data.)
    b. Engage with members of the communities experiencing the greatest health inequities to identify and understand the structures and systems that are preventing them from being as healthy as they could be, and learn to recognize and celebrate the many strengths and assets that they bring to the community and the state.
    c. Expand their knowledge about the historical experiences and structural barriers facing populations in their communities.
2. As they grow more aware of inequities in their communities, elected officials can make achieving health equity and equitable conditions across the community a priority.
    a. Elected officials can identify and act on opportunities to make sure health and equity are considered in every policy, planning effort, and program.
    b. With the understanding that advancing health equity requires working across boundaries, elected officials should work to establish goals for equity across all areas of local government, and work with staff across many departments to strategize and set appropriate milestones to advance equity.
3. Elected officials can champion and support local efforts, including those of the local health department, to develop the practices necessary to advance health equity. This includes seeking additional resources, making a long-term commitment, and being willing to take leadership on controversial issues.

PUBLIC HEALTH DIVISION
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February 2017

Preventive Health & Health Services Block Grant – Fact Sheet

Background

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

Funding

- For October 2016 – September 2017 work plan, $1,110,980 is available ($85,660 for rape prevention and victim services).
- For October 2017 – September 2018 work plan, $X,XXX,XXX is available ($XX,XXX for rape prevention and victim services).

Funded Work Plan and Activities – Work Plan 2017

Oregon's overall goal has been to support ongoing planning for and implementation of Public Health Modernization's foundational capabilities so all Oregonians have access to the public health foundational capabilities and programs to prevent disease, injury and death.

- Quality improvement (Leadership and organizational competencies, community partnership development)
    - Oregon Health Authority-Public Health Division (OHA-PHD)
        - Maintain performance management system through monthly dashboards and implement quality improvement projects to increase efficiency and effectiveness of business processes and public health interventions
    - Local health departments
        - Coordinate and conduct triennial reviews for Oregon local public health departments to identify strengths and areas for improvement in implementation of public health services
        - Complete review of all triennial review findings for last three years to identify areas for targeted training and technical assistance for PHD and/or LHD staff
        - Partner with Conference of Local Health Officials on provision of OHA-PHD funded public health services
    - Nine federally-recognized tribes in Oregon
        - Coordinate OHA-PHD's public health work with tribes
        - Work through OHA tribal consultation process to engage tribes in Public Health Modernization assessment and planning
- Public health accreditation (Leadership and organizational competencies)
    - Oregon Health Authority-Public Health Division
        - Maintain national accreditation status
        - Develop system for annual reporting and documentation for re-accreditation
        - Implement OHA-PHD workforce development plan
    - Local health departments
        - Co-facilitate (with Conference of Local Health Officials) community of practice for local and tribal health department accreditation coordinators
        - Support local accreditation documentation requests
        - As funding is available, fund workforce development opportunities that strengthen prioritized core competencies for Oregon's public health system (2016 examples: OPHA annual conference, Oregon Epidemiologists annual conference, PSU project management training, Orientation for new local and tribal public health administrators)
    - Nine federally-recognized tribes in Oregon
        - Co-facilitate (with Conference of Local Health Officials) community of practice for local and tribal health department accreditation coordinators
        - Support tribal accreditation documentation requests
        - As funding is available, fund workforce development opportunities that strengthen prioritized core competencies for Oregon's public health system (2016 examples: OPHA annual conference, Oregon Epidemiologists annual conference, PSU project management training, Orientation for new tribal and local public health administrators)

- OHA-PHD Health Equity Work Group (Health equity and cultural responsiveness)
    - Oregon Health Authority Public Health Division
        - Assess current OHA-PHD health equity practices
        - Assistance with assessment and evaluation components of work plan
        - Develop “driver diagram” to visualize work group activities and expected outcomes
- Sexual Violence Prevention (Prevention and health promotion)
    - Fund up to three domestic and sexual violence agencies or tribes in Oregon to conduct community-wide sexual violence prevention based on impact of Adverse Childhood Experiences (ACEs), trauma, toxic stress, and safe and nurturing environments
        - Promote positive social norms that protect against violence
        - Teach skills to prevent sexual violence
        - Provide opportunities to empower and support girls and women
        - Create protective environments

<u>Next Steps</u>

- March 8, 2017 Public hearing (2:00-2:30 p.m., Portland State Office Building, room 1C; Opportunity for other stakeholders and members of the public to comment on work plan priorities.
- March 16, 2017 PHAB meeting: Present overview of draft October 2017 – September 2018 work plan for discussion and input.
- March 24, 2017 Submit final work plan to Centers for Disease Control and Prevention for consideration and approval.