AGENDA

PUBLIC HEALTH ADVISORY BOARD

Health Equity Policy Ad-Hoc Committee

April 11, 2017
1:00-2:30 pm
Portland State Office Building, 800 NE Oregon St., Room 918, Portland, OR 97232

Join by webinar: https://attendee.gotowebinar.com/register/1017967828287751171
Conference line: (877) 873-8017
Access code: 767068

Meeting objectives

- Develop a recommendation for a definition of health equity
- Review and edit the draft Public Health Advisory Board health equity policy

1:00-1:05 pm	**Welcome and introductions** • Purpose of the meeting and desired outcome: make a recommendation for a definition for health equity and make any necessary changes to the Public Health Advisory Board health equity policy	Jeff Luck, PHAB Chair
1:05-1:40 pm	**Health equity definition** • Discuss the use of the term health equity versus health disparities • Review compiled list of health equity definitions • Make a recommendation for a definition • Compare PHAB ad-hoc committee recommendation to that of the Public Health Division Health Equity Working Group	PHAB members
1:40-2:20 pm	**Health equity policy** • Review procedure for decision-making • Review procedure for presentations to the Public Health Advisory Board • Run a recent decision made by the Public Health Advisory Board through the draft procedure	PHAB members
2:20-2:30 pm	**Public comment**	
2:30 pm	**Adjourn**	Jeff Luck, PHAB chair

Health Equity Definitions
Adapted from the PHD Health Equity Working Group, October 2016

1. Health equity exists when all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.
   (CDC) http://www.cdc.gov/nchhstp/socialdeterminants/definitions.html
   https://www.nap.edu/download/24624

2. Health equity means all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions.
   National Collaborating Centre for Determinants of Health
   (2014). http://nccdh.ca/resources/glossary

3. Health equity asserts that all people can reach their full health potential and should not be disadvantaged from attaining it because of their social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance.
   Braveman, P, (2006). Health Disparities and Health Equity: Concepts and Measurement. Annual Review of Public Health 27: 167-94.

4. Health equity means that all persons have fair opportunities to attain their health potential to the fullest extent possible.
   LaVeist, T., Issac, L. (2011). Race, Ethnicity and Health: A Public Health Reader. Centers for Disease Control.

5. Health equity is defined as the absence of unfair, avoidable or remediable differences in health among social groups.
   World Health Organization, Commission on Social Determinants of Health, (2007). A Conceptual Framework for Action on the Social Determinants of Health.

6. Health equity means that everyone has a fair opportunity to live a long, healthy life. It implies that health should not be compromised or disadvantaged because of an individual or population group's race, ethnicity, gender, income, sexual orientation, neighborhood or other social condition. Achieving health equity requires creating fair opportunities for health and eliminating gaps in health outcomes between different social groups. It also requires that public health professionals look for solutions outside of the health care system, such as in the transportation or housing sectors, to improve the opportunities for health in communities.
   http://www.bphc.org/whatwedo/health-equity-social-justice/what-is-health-equity/Pages/what-is-health-equity.aspx)

7. Health equity is the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

8. Health equity is the value underlying the commitment to reduce and ultimately eliminate health disparities. Disparities in health and its determinants are the metric for assessing health equity, the principle underlying a commitment to reducing disparities in health and its determinants; health equity is social justice in health.
   Braveman, P. et al. (2011). Health Disparities and Health Equity: The Issue is Justice. *American Journal of Public Health*, (101)S1: S150-155.

9. Health equity is defined 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 geography or other social condition. 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.
   2017. Oregon Health Authority, Public Health Division.

Public Health Advisory Board
Health equity review policy and procedure
~~February~~ April 2017 DRAFT

Background

The Public Health Advisory Board (PHAB), established by House Bill 3100 (2015), serves as the accountable body for governmental public health in Oregon. PHAB reports to the Oregon Health Policy Board (OHPB) and makes recommendations to OHPB on the development of statewide public health policies and goals. PHAB is committed to using best practices and an equity lens to inform its recommendations to OHPB on policies needed to address priority health issues in Oregon, including the social determinants of health.

Definition of health equity

The Public Health Division and the Public Health Advisory Board define 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 geography 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.

Policy

The Public Health Advisory Board demonstrates its commitment to advancing health equity by implementing an equity review process for all formally adopted work products, reports and deliverables. In addition, all presenters to the Board will be expected to specifically address how the topic being discussed is expected to affect health disparities or health equity. The purpose of this policy is to ensure all Board guidance and decision-making will advance health equity and reduce the potential for unintended consequences that may perpetuate disparities.

Procedure

Board work products, reports and deliverables

These questions have been adapted from the Multnomah County Equity and Empowerment Lens.

The answers to the following questions will be submitted to PHAB for review with the meeting materials prior any official Board action involving a vote to adopt a work product, report or and deliverable. The subcommittee or Public Health Advisory Board member responsible for bringing the work product, report or deliverable forward for a motion will begin by walking through the responses to the equity review, prior to introducing the work product, report or deliverable for a motion.

1. Whom does the policy or decision benefit? Community members? The public health system? Both?
    - If the answer is one or the other, how can the policy or decision be changed to incorporate the needs of both?
2. How does the policy or decision advance health equity?
3. How have diverse perspectives been integrated into this decision or policy?
4. How will data be used to monitor the impact on health equity resulting from this policy or decision?
5. How does the policy or decision explicitly acknowledge the value of equity and racial justice to the public health system?
6. How does the policy or decision anticipate and address influence or differential power within the public health system?

Presentations to the Board

OHA staff will work with presenters prior to Board meetings to ensure that presenters specifically address the following, as applicable:

- Which specific populations experience health disparities related to the topic being discussed?
- How will the work discussed during the presentation ~~reduce disparities or~~ improve health equity or reduce disparities?
- How have affected communities been involved in the work being presented?
- How will the impacts of this work be monitored to know whether health ~~disparities have been reduced?~~equity has been advanced?

Policy and procedure review

The PHAB health equity review policy and procedure will be reviewed annually by the Board. Board members will discuss whether the policy and procedure has had the intended effect of reducing disparities or improving health equity to determine whether changes are needed to the policy and procedure.

Resources

The City of Portland, Parks and Recreation. Affirmation of Equity Statement.

Multnomah County Health Department (2012). Equity and Empowerment Lens.

Oregon Health Authority, Office of Equity and Inclusion. Health Equity and Inclusion Program Strategies.

Oregon Education Investment Board. Equity Lens.

Oregon Health Authority, Office of Equity and Inclusion. Health Equity Policy Committee Charter.

Jackson County Health Department and So Health-E. Equity planning documents and reports.

Local public health authority funding formula

Legislative requirements

ORS 431.380 requires OHA to submit a funding formula to Legislative Fiscal Office by June 30 of every even-numbered year.

The local public health funding formula is comprised of three components, listed below. This funding formula is intended to equitably distribute monies made available to fund implementation of foundational capabilities and programs.

Baseline funds

Awarded based on county population health status and burden of disease

State matching funds

For local investment in foundational capabilities and programs

Performance-based incentives

To encourage the effective and equitable provision of services

Baseline funds. This component awards funding to LPHAs based on their county population, health status and burden of disease. Counties with a larger population will receive a larger portion of the pool of available funding. Similarly, counties with a greater burden of disease or poorer health status will receive a proportionally larger portion of the pool of available funding.

State matching funds for county investments. This component awards state matching funds for local public health authority investment in foundational programs and capabilities.

Performance-based incentives. This component uses performance-based incentives to encourage the effective and equitable provision of public health programs and capabilities by LPHAs.

OHA submitted an initial framework for the funding formula to the Legislative Fiscal Office on June 30, 2016. The funding formula described below was built from this framework. This funding formula will continued to be developed over the coming months and will be finalized at the conclusion of the 2017 legislative session.

PHAB has formed an incentives and funding subcommittee to develop the local public health funding formula. This subcommittee has met monthly since May 2016.

Guiding principles

The incentives and funding subcommittee has applied these guiding principles to decisions made about the funding formula:

- The funding formula should advance equity in Oregon, both in terms of health equity and building an equitable public health system.
- The funding formula should be designed to drive changes to the public health system intended to increase efficiencies and effectiveness.
- Decisions made about the funding formula will be compared with findings from the public health modernization assessment to ensure funds will adequately address current gaps in implementation of foundational programs.

Funding formula recommendations

The incentives and funding subcommittee makes the following recommendations:

1. All monies initially made available for implementing foundational capabilities and programs should be directed to the baseline component of the funding formula. Monies will be used to fill critical gaps that result from the historical un- or under-funding for foundational public health work. Payments to LPHAs for the other two components of the funding formula (state matching funds and performance-based incentives) will be incorporated into the funding formula in future biennia.
2. This funding formula dictates how funds will be distributed to LPHAs and does not inform how funds are split between state and local public health authorities. OHA Public Health Division and PHAB intend for the majority of funds to be distributed to LPHAs to address gaps and priorities locally. Dollars that remain with OHA Public Health Division will be specifically used to address statewide requirements to support local improvements, and to monitor implementation and accountability.
3. The funding formula must provide for the equitable distribution of monies. Some counties may receive proportionally more or less than an "equal" share based on need. While extra small and small counties will receive a proportionally larger per capita payment, extra-large and large counties will receive a proportionally larger total dollar amount of funding[‡]. This is

[‡] Counties were divided into five size bands based on county population in the public health modernization assessment report. County size bands are as follows: extra small = fewer than 20,000 residents; small = 20,000–75,000 residents; medium = 75,000–150,000 residents; large = 150,000–375,000 residents; extra large = greater than 375,000 residents.

consistent with the financial resource gaps identified in the public health modernization assessment.

4. The subcommittee recommends implementing three additional indicators to the baseline funds component of the funding formula: racial/ethnic diversity, poverty and limited English proficiency. These indicators may be linked to poorer health outcomes and also indicate increased demand for LPHA resources.
5. The subcommittee recommends incorporating a floor, or base, payment per county into the funding formula. This floor payment ensures each LPHA has the resources needed to implement the modernization framework, gain efficiencies and improve health outcomes. The subcommittee recommends using a tiered floor amount, based on county population.
6. The subcommittee recommends allocating all remaining funds across the six indicators included in the baseline funds component.

These initial recommendation will continue to be developed by the PHAB Incentives and Funding subcommittee in 2017.

See Appendix C for a funding formula example and methodology.

Key activities to complete the funding formula:

- Finalize indicators and data sources for 2017–19 funding formula
- Develop method to collect standardized information on county expenditures; establish method to validate expenditures data
- Develop funding formula components for state matching funds and performance-based incentives
- Submit revised funding formula to Legislative Fiscal Office

Appendix C: Local public health funding formula model

Funding formula methodology

Purpose:

Method with which to distribute funds to local public health authorities.

Formulas:

Total funding = baseline + matching funds + incentives

Baseline = county floor payments + burden of disease pool + health status pool + race/ethnicity pool + poverty pool + education pool + limited English proficiency pool

County indicator pool payment = (LPHA weight/sum of all LPHA weights) * Total indicator pool

Indicator	Allocation
Burden of disease	20%
Health status	20%
Race/ethnicity	20%
Poverty	10%
Education	10%
Limited English proficiency	20%
Total indicator pool	**100%** of available funds to be distributed across funding formula indicators

LPHA weight = LPHA population * LPHA indicator metric percentage

Explanations:

The county floor payments are broken into five tiers based on LPHA sizing established in the Public Health Modernization Assessment Report.

All remaining baseline funding, after county floor payments have been established, is to be distributed among the baseline indicator pools (burden of disease, health status, race/ethnicity, poverty, education, and limited English proficiency). Every baseline indicator pool is tied to a metric that every LPHA reports on.

All indicator pools are calculated using a weighted average taken by multiplying the individual LPHA population and the individual LPHA indicator metric percentage. To solve for the payment for each LPHA, multiply the total indicator pool by the individual LPHA weight divided by the sum of all LPHA weights.

Data sources:

Indicator	Data source
County population	Portland State University Certified Population estimate, Jul. 1, 2015
Burden of disease	Premature death: Leading causes of years of potential life lost before age 75, Oregon. Oregon death certificate data.
Health status	Quality of life: Good or excellent health, Oregon. Behavioral Risk Factor Surveillance System. Note: The Public Health Advisory Board will explore alternative data sources to measure health status in 2017.
Race/ethnicity	U.S. Census Bureau, American Community Survey population five-year estimate, 2012
Poverty	U.S. Census Bureau, American Community Survey population five-year estimate, 2012. Note: The Public Health Advisory Board will explore alternative measures of poverty, such as income inequality, in 2017.
Education	U.S. Census Bureau, American Community Survey population five-year estimate, 2012
Limited English proficiency	U.S. Census Bureau, American Community Survey population five-year estimate, 2012

Local public health funding formula model example

Local public health funding formula model: This model includes a base/floor payment for each county. Awards for each indicator (burden of disease, health status, race/ethnicity, poverty, education and limited English proficiency) are tied to each county's ranking on the indicator and the county population. **This funding formula example assumes a $10 million investment. This is an example only.**

County group (size bands):				
Extra small	Small	Medium	Large	Extra large

County group	Population[1]	Floor	County population	Burden of disease[2]	Health status[3]	Race/ ethnicity[4]	Poverty[4]	Education[4]	Limited English proficiency[4]	Matching funds[5]	Incentives[6]	Total award	Award %	% of total population	Award per capita	Avg award per capita
County 33	1,445	$ 30,000	$ -	$ 568	$ -	$ 171	$ 321	$ 297	$ 67	$ -	$ -	$ 31,425	0.3%	0.0%	$ 21.75	
County 31	7,100	$ 30,000	$ -	$ 3,353	$ 1,067	$ 592	$ 1,197	$ 945	$ 235	$ -	$ -	$ 37,388	0.4%	0.2%	$ 5.27	
County 12	7,295	$ 30,000	$ -	$ 4,652	$ 4,422	$ 1,078	$ 1,872	$ 1,735	$ 270	$ -	$ -	$ 44,029	0.4%	0.2%	$ 6.04	
County 11	7,430	$ 30,000	$ -	$ 2,787	$ 1,657	$ 806	$ 1,394	$ 1,731	$ 286	$ -	$ -	$ 38,661	0.4%	0.2%	$ 5.20	
County 18	8,010	$ 30,000	$ -	$ 3,992	$ 2,039	$ 1,993	$ 1,733	$ 2,240	$ 1,033	$ -	$ -	$ 43,030	0.4%	0.2%	$ 5.37	
County 24	11,630	$ 30,000	$ -	$ 4,539	$ 7,642	$ 12,890	$ 2,729	$ 5,302	$ 10,291	$ -	$ -	$ 73,393	0.7%	0.3%	$ 6.31	
County 1	16,425	$ 30,000	$ -	$ 8,673	$ 6,412	$ 2,007	$ 3,659	$ 3,232	$ 1,038	$ -	$ -	$ 55,020	0.6%	0.4%	$ 3.35	$ 5.44
County 7	21,085	$ 45,000	$ -	$ 9,707	$ 7,873	$ 5,124	$ 5,328	$ 6,193	$ 2,713	$ -	$ -	$ 81,937	0.8%	0.5%	$ 3.89	
County 15	22,445	$ 45,000	$ -	$ 13,862	$ 11,266	$ 14,596	$ 5,689	$ 6,769	$ 9,583	$ -	$ -	$ 106,765	1.1%	0.6%	$ 4.76	
County 8	22,470	$ 45,000	$ -	$ 15,280	$ 13,784	$ 4,519	$ 4,197	$ 3,986	$ 1,551	$ -	$ -	$ 88,318	0.9%	0.6%	$ 3.93	
County 13	24,245	$ 45,000	$ -	$ 7,658	$ 8,465	$ 24,510	$ 4,615	$ 8,304	$ 27,291	$ -	$ -	$ 125,843	1.3%	0.6%	$ 5.19	
County 28	25,690	$ 45,000	$ -	$ 12,659	$ 11,337	$ 8,275	$ 5,504	$ 5,196	$ 5,651	$ -	$ -	$ 93,622	0.9%	0.6%	$ 3.64	
County 30	26,625	$ 45,000	$ -	$ 11,545	$ 10,781	$ 3,760	$ 6,085	$ 4,702	$ 3,931	$ -	$ -	$ 85,804	0.9%	0.7%	$ 3.22	
County 26	30,135	$ 105,000	$ -	$ 15,489	$ 16,075	$ 14,911	$ 6,014	$ 8,096	$ 14,857	$ -	$ -	$ 180,441	1.8%	0.8%	$ 5.99	
County 22	31,480	$ 45,000	$ -	$ 13,844	$ 20,228	$ 34,104	$ 10,862	$ 12,053	$ 21,200	$ -	$ -	$ 157,291	1.6%	0.8%	$ 5.00	
County 4	37,750	$ 45,000	$ -	$ 20,438	$ 15,927	$ 9,976	$ 7,236	$ 6,627	$ 7,412	$ -	$ -	$ 112,616	1.1%	0.9%	$ 2.98	
County 20	47,225	$ 45,000	$ -	$ 28,909	$ 21,871	$ 13,019	$ 9,820	$ 10,554	$ 9,491	$ -	$ -	$ 138,665	1.4%	1.2%	$ 2.94	
County 5	50,390	$ 45,000	$ -	$ 23,353	$ 25,658	$ 7,405	$ 8,053	$ 10,058	$ 3,682	$ -	$ -	$ 123,209	1.2%	1.3%	$ 2.45	
County 6	62,990	$ 45,000	$ -	$ 38,344	$ 27,492	$ 12,038	$ 13,782	$ 13,814	$ 5,416	$ -	$ -	$ 155,886	1.6%	1.6%	$ 2.47	
County 17	67,110	$ 45,000	$ -	$ 39,167	$ 38,077	$ 25,122	$ 15,161	$ 16,302	$ 15,280	$ -	$ -	$ 194,110	1.9%	1.7%	$ 2.89	$ 3.50
County 27	78,570	$ 60,000	$ -	$ 28,270	$ 29,148	$ 33,073	$ 16,267	$ 14,405	$ 22,998	$ -	$ -	$ 204,162	2.0%	2.0%	$ 2.60	
County 29	79,155	$ 60,000	$ -	$ 35,353	$ 42,033	$ 65,744	$ 16,434	$ 25,414	$ 41,455	$ -	$ -	$ 286,432	2.9%	2.0%	$ 3.62	
County 16	83,720	$ 60,000	$ -	$ 48,681	$ 35,322	$ 18,691	$ 20,021	$ 18,279	$ 6,366	$ -	$ -	$ 207,360	2.1%	2.1%	$ 2.48	
County 2	90,005	$ 60,000	$ -	$ 24,940	$ 32,736	$ 20,226	$ 24,789	$ 9,388	$ 19,428	$ -	$ -	$ 191,507	1.9%	2.2%	$ 2.13	
County 34	103,630	$ 60,000	$ -	$ 38,754	$ 36,686	$ 52,654	$ 21,040	$ 26,496	$ 44,178	$ -	$ -	$ 279,807	2.8%	2.6%	$ 2.70	
County 10	109,910	$ 60,000	$ -	$ 63,924	$ 64,760	$ 18,241	$ 26,278	$ 25,153	$ 7,203	$ -	$ -	$ 265,558	2.7%	2.7%	$ 2.42	
County 21	120,860	$ 60,000	$ -	$ 53,922	$ 54,801	$ 32,735	$ 28,631	$ 24,335	$ 19,677	$ -	$ -	$ 274,101	2.7%	3.0%	$ 2.27	$ 2.57
County 9	170,740	$ 75,000	$ -	$ 61,851	$ 40,572	$ 43,408	$ 31,155	$ 23,424	$ 29,362	$ -	$ -	$ 304,771	3.0%	4.3%	$ 1.79	
County 14	210,975	$ 75,000	$ -	$ 96,357	$ 96,173	$ 80,527	$ 45,631	$ 45,562	$ 50,295	$ -	$ -	$ 489,544	4.9%	5.3%	$ 2.32	
County 23	329,770	$ 75,000	$ -	$ 132,122	$ 170,316	$ 275,697	$ 76,427	$ 104,449	$ 238,020	$ -	$ -	$ 1,072,031	10.7%	8.2%	$ 3.25	
County 19	362,150	$ 75,000	$ -	$ 153,750	$ 144,889	$ 95,062	$ 89,647	$ 62,298	$ 71,544	$ -	$ -	$ 692,191	6.9%	9.0%	$ 1.91	$ 2.38
County 3	397,385	$ 90,000	$ -	$ 137,903	$ 139,715	$ 106,736	$ 47,083	$ 54,889	$ 116,185	$ -	$ -	$ 692,510	6.9%	9.9%	$ 1.74	
County 32	570,510	$ 90,000	$ -	$ 161,260	$ 182,600	$ 305,107	$ 81,987	$ 103,795	$ 357,130	$ -	$ -	$ 1,281,878	12.8%	14.2%	$ 2.25	
County 25	777,490	$ 90,000	$ -	$ 315,095	$ 309,174	$ 286,202	$174,859	$ 149,478	$ 465,885	$ -	$ -	$ 1,790,693	17.9%	19.4%	$ 2.30	$ 2.16
Total	**4,013,845**	**$ 1,845,000**	**$ -**	**$ 1,631,000**	**$ 1,631,000**	**$ 1,631,000**	**$ 815,500**	**$ 815,500**	**$ 1,631,000**	**$ -**	**$ -**	**$ 10,000,000**	**100.0%**	**100.0%**	**$ 2.49**	**$ 2.49**

[1] Source: Portland State University Certified Population estimate Jul. 1, 2015

[2] Source: Oregon State Health Profile. Premature death, 2010–14. Oregon death certificate data.

[3] Source: Oregon State Health Profile. Good or excellent health, 2010–2013. BRFSS

[4] Source: American Community Survey population five-year estimate, 2012

[5] Limitations exist for calculating current county contributions for public health. An updated process will be developed to address these limitations. Matching funds will be awarded based on actual, not projected expenditures, and will be limited to county contributions that support public health modernization. Given the change in process, matching funds will not be awarded until 2019.

[6] The accountability metrics subcommittee will define a set of accountability metrics. Following selection of accountability metrics, baseline data will be collected. Funds will not be awarded for achievement of accountability metrics until 2019.