Public Health Advisory Board (PHAB)
May 18, 2017
Meeting Minutes

Attendance:

Board members present: Carrie Brogoitti, Muriel DeLaVergne-Brown, Jeff Luck, Alejandro Queral, Rebecca Pawlak, Akiko Saito, Eli Schwarz, Lillian Shirley, Teri Thalhofer, and Jennifer Vines

Oregon Health Authority (OHA) staff: Isabelle Barbour, Cara Biddlecom, Sara Beaudrault, Christy Hudson, Britt Parrott, and Angela Rowland

Members of the public: Kathleen Johnson and Darlene King

Approval of Minutes

A quorum was present. Alejandro commented that the April 20th minutes were lacking detail. Future minutes should identify Board members and their specific comments. Akiko mentioned that Diane Hoover should be included as an attendee.

The Board unanimously voted to approve the edited April 20, 2017 minutes with the addition of Diane Hoover to the attendee list.

Welcome and updates

-Jeff Luck, PHAB chair

- The modernization of public health bill HB2310A is now in the Joint Ways and Means committee waiting for a hearing. The Oregon Health Authority (OHA) received a request from legislative fiscal office to provide a few different scenarios of what public health modernization funding would look like at a variety of different levels. Additional feedback will be used from today's Board meeting.
- Eva Rippeteau gave birth to a baby girl named Catalina on May 4, 2017. Eva will likely be back for the September PHAB meeting.

Subcommittee updates

Accountability Metrics subcommittee
– Muriel DeLaVergne-Brown

On April 26th the subcommittee reviewed feedback on proposed outcome measures. At the next meeting the subcommittee will review the accountability metrics survey results and develop recommendations for a slate of outcome measures for the PHAB to vote on at the June meeting. Subcommittee members cautioned against local measures that use Oregon Healthy Teens survey data because some schools choose not to participate in the survey. Muriel

suggested that the subcommittee should select metrics that look to the future and what potential there is to improve health. She added that metric alignment will be beneficial so that public health and health systems can work together. Eli stated that kindergarten readiness and effective contraceptive use metrics will be discussed at the Metrics and Scoring Committee on May 19th. Teri stated that there is also an opportunity to align with metrics coming out of the Early Learning Council. Jeff shared that he is a member of the Health Plan Quality Metrics Committee and there is similar alignment with what PHAB is working on.

Incentives and Funding subcommittee
-Jeff Luck

Jeff presented local public health authority funding formulas with $5M, $10M, and $15M annual funding scenarios. Jeff pointed out that the funding formulas only account for local public health funding and not any resources that would remain with Oregon Health Authority to support the public health system. The subcommittee recommends five tiers of floor payments to counties based on county size. At the $10M funding level, these floor payments total $1.8M. If available funding is more than $10M annually the subcommittee recommends that the floor payment is proportionately increased, as is represented in the $15M model.

For annual funding levels between $5M-$10M the subcommittee recommends that all counties receive the floor payments at the $10M level, with the remainder going to pilot sites. For annual funding levels below $5M, all funds should be directed to pilot sites.

OHA will be reviewing the *Modernization of Public Health Manual* with members of the OHA-CLHO Joint Leadership Team to identify specific tasks to be accomplished at the state and local levels.

Muriel commented that some local health departments don't have capacity to write competitive grants, which could be unfair. She would like to see equity for smaller county needs. Teri suggested an analysis on health disparities among counties who received the competitive Healthy Communities grants compared to counties that haven't received this funding. It is difficult for the counties with low resources and high health disparities to compete for funding.

Rebecca mentioned there are 62 hospitals in Oregon, half of which are small, rural hospitals. The Oregon Association of Hospitals and Health Systems provides resources specifically for those small hospitals including a dedicated staff member to provide assistance. She inquired if there are any combined efforts at the state to support small rural counties. Carrie said this is an opportunity to increase capacity across the system.

Teri offered the historical perspective of forced relationships when tasked with determining CCO geographic areas and Early Learning Hubs. She proposes using funding for cross

jurisdictional sharing a different way. She noted the added challenge to sharing services in Eastern counties of significant distances between communities. She encourages innovative ways for small communities to come together that isn't forced.

Eli recommends focusing on a strategic priority for the whole state. For example, if obesity is the biggest priority, use that as a guiding light to determine how funding is allocated.

Muriel remarked on her experience completing the public health modernization assessment along with her colleagues in Deschutes and Jefferson counties. In this process, these counties identified 7 positions that could be shared cross jurisdictionally, including communicable disease staff. Rather than funding county by county, it could go by function.

Jennifer noted that specific communicable diseases occur where there are large populations, so PHAB should be strategic about where to focus money by targeting the disease prevalence areas in order to see the greatest population impact.

Modernization implementation planning
-Cara Biddlecom, Oregon Health Authority

Cara presented the main inputs for making decisions about how to prioritize funding for public health modernization. Most of the ground work has been completed including the *Public Health Modernization Manual*, the public health modernization assessment, the forthcoming public health accountability metrics, local public health funding formula, and the *Health and Economic Benefits of Public Health Modernization* report. The available funding and legislative guidance is to be determined in June or July.

Alejandro recommended utilizing the local public health modernization assessment to determine which counties are the farthest back on foundational capabilities so they can be funded first.

Cara offered a few value questions to consider: What is balance of funding areas that are ready versus greatest need? How can we set this up in order to have quick wins, show progress in a short timeframe, and set the entire system up for success? How can we make sure we are building public health infrastructure that is sustainable through future funding shifts?

Rebecca would like to determine the balance between evidence based strategies and innovation to do the work.

Akiko asks how to evaluate while moving forward as building a sustainable system to ensure it's staying on the right track.

Muriel would like to consider how to engage the local public health authority governing body including county commissioners as well as understanding their responsibility.

Jeff recommends turning the funding formula upside down. Eli stated that larger better off counties need less money.

Teri reminded the Board that the results in the assessment displayed a patchwork quilt and not simply by the size of the county. There are gaps across the entire public health system and they are not uniform. She recommends funding the specific capability.

Jeff speculated that if the large county PHAB representative was here today, she would comment that just because it's a large county, making an impact might still require more dollars. He mentioned if you hone in on one capability identified, one can use the assessment to see where the need is per county.

Alejandro wants to ensure that all counties will be set up in a good way and determine how to plan a long arc that eventually gets all counties together at the same level.

Teri comments that each county in the assessment is unidentifiable. Perhaps you could identify that information to determine potential cross jurisdictional sharing. The counties don't all have strengths in the same area so the investment could be in a region.

Lillian comments on the issue for counties with difficulty in competing successfully for a competitive Request for Proposals (RFP). Perhaps we could frame the RFP criteria in a different way to address health equity.

Muriel stresses the need for individual county flexibility. Teri commented that many counties share work cross jurisdictionally in a beneficial way.

Alejandro stated it is not just all about money. He wants to make sure this work and systems change will be institutionalized and not a one-time shot.

Cara presented the graphic on the scope of work at a range of funding levels for 2017-19. Legislative Fiscal Office asked OHA to provide a public health modernization funding scenario at each funding level.

Alejandro questions if a formula is required regardless of the state investment. Cara stated that there have been amendments in HB 2310A that specify if resources are too low to meaningfully fund every local public health authority, funds can be allocated to pilot alternative projects.

Eli inquires if it is more cost effective to manage certain programs at the state level and have the state provide capacity to local public health authorities.

Muriel explains that certain communicable disease outbreaks require a fast response time at the local level.

Teri mentioned that the *Public Health Modernization Manual* offers a delineation on responsibility for state versus local. She values help from state partners. She stated that regional epidemiology is a focus area that would benefit and that data systems don't need to live at the counties.

Jeff inquires if state resources should go toward communicable disease and environmental health priority areas of local public health first. Teri stated that capacity for environmental air quality issues require more expertise. Eli states that environmental health hazards have societal and community issues. He recently attended a meeting where CDC is developing small area estimation models as a tool to help with regional epidemiology.

Summary

- An RFP makes it hard to compete among counties. It should be framed it in a way to meet needs of smaller departments.
- State level resources should be focused on meeting the needs of the local public health system, especially small local health departments. State level resources should be allocated to assessment and epidemiology work and technical support.
- Allocate funds for groups of counties who self-identified as working together to improve a need or capability.
- Identify a key capability to focus on and identify which counties need more improvement based on the public health modernization assessment.
- If available funding is less than $20M total for the biennium, could have benefit for some allocation to all counties, i.e. planning for public health modernization and determining how to implement cross-jurisdictional sharing and strategic partnerships with other organizations to leverage funding. Additional pilot project work to move the needle on foundational capabilities and programs, structured in a way that creates equity across the public health system.

Cara confirms if the funding is fairly low the core funding should be to invest in order of these priority areas:

1. Leadership and organizational competencies
    - Time spent to develop local modernization plan, relationships with other organizations
    - Cross jurisdictional sharing
    - Memoranda of understanding
2. Health equity and cultural responsiveness
3. Communicable disease control (funded cross-jurisdictionally or counties with most need)

4. Assessment and epidemiology (focus area for state and regional public health work)
5. Emergency preparedness, for that work that supports communicable disease control efforts
6. Environmental health

Jen remarked that the technical piece including leadership and organizational competencies is important and needed.

Jeff recommends another document with the funding pyramid turned upside down or with concentric circles could be helpful for legislative staff.

Teri says that a focus on leadership and organizational competencies will address all capabilities and could serve as a selling point. As more money comes in, it can impact more capabilities. She says that planning takes dollars, which has not been allocated to public health in the past around planning for the CCOs and Early Learning Hubs.

Cara concurs around leveraging work with partners and coalescing around something that is not being accomplished now.

During the next PHAB meeting in June, the Board will vote to adopt accountability metrics for health outcomes. The Joint Leadership Team (JLT) will review the *Public Health Modernization Manual* to discuss deliverables in early June. The Legislature's decision will be in July. If funding will be distributed, it will occur in January 2018 because the effective date in HB 2310A is January 1, 2018.

Guiding principles for public health and health care collaboration
-Cara Biddlecom, Oregon Health Authority

During the February PHAB meeting the Board considered creating guiding principles to identify opportunities for public health to work more closely with hospitals, CCO boards, etc. There were a few changes at the March PHAB meeting. The decision was to bring this document to partners for feedback.

Rebecca stated that she shared this document with the Oregon Association of Hospitals and Health Systems. The feedback was overall good and they felt it was a useful document. The Community Health Need Assessment (CHNA) is the most tangible example of the hospital's work on population health. They felt that the language could be clearer to display who is accountable for what but at times the language was too strong. She recommends that emergency preparedness be included as well as the National Hospital Health Equity pledge.

Teri says based on her experience in health system transformation if language wasn't strong it didn't happen. Jeff recommended changing language to say *aligned* rather than *shared*.

Alejandro asked about shared metrics and data from the hospital point of view. Rebecca stated that there are 62 hospitals and they don't always work together since they are also competitors. Rather than public health where partners work together, internal hospital performance metrics are kept private since it's a business development.

Sara Beaudrault shared this document with CCO medical directors, but there wasn't enough time to collect feedback in person. Eli plans to bring this to the Health Share of Oregon board and the Metrics and Scoring Committee but unfortunately the Board had a conflict. Jeff offered to share with Charlie Fautin and Silas Halloran-Steiner. Teri will share with the Columbia Gorge Health Council.

Cara will be taking Board edit suggestions by May 24th. She will send the third draft out so it can be used for additional feedback and then further discussed at the July PHAB meeting. The Board will then consider bringing this forward to the Oregon Health Policy Board to potentially align with their forthcoming Action Plan for Health.

Health equity policy review practice

The *guiding principles for public health and health care collaboration* document was reviewed for its alignment with the PHAB health equity policy as a practice round since the health equity policy was adopted at the April meeting.

1. **How is the work product, report or deliverable different from the current status?**
    a. The guiding principles for health care and public health collaboration seek to reinforce broad, cross-sector collaboration between public health; CCOs, hospitals and other groups within the health care sector; early learning and education; and community-based organizations.
    b. More robust collaboration has the potential to lead to a greater focus across the health system on social determinants of health and health equity.

2. **What health disparities exist among which groups? Which health disparities does the work product, report or deliverable aim to eliminate?**
    a. This deliverable does not directly address health disparities or specific health disparities among identified groups.
    b. Greater collaboration with coordinated care organizations among public health may lead to additional opportunities to address health disparities that currently exist among Medicaid recipients. These include:
        i. Higher rates of chronic diseases than the general adult population
        ii. Higher rates of overweight, obesity and morbid obesity than the general adult population
        iii. Greater use of cigarettes than the general adult population
        iv. Greater food insecurity and hunger than the general adult population

- Source: 2014 Medicaid Behavioral Risk Factor Surveillance System Survey

3. **How does the work product, report or deliverable support individuals in reaching their full health potential?**
    a. This deliverable does not specifically support individuals in reaching their full health potential.
    b. However, greater collaboration between health care and public health may lead to additional opportunities to address health disparities.

4. **Which source of health inequity does the work product, report or deliverable address (social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?**
    a. This deliverable does not specifically address one source of health inequity.
    b. Alejandro stated that this question leaves out institutional racism. The question could be expanded as more about system change. Institutional racism could be addressed in leadership and governance while paying special attending to the demographic composition of the community being served. Eli states it doesn't address one source of health inequity but it does addresses basic issues.
5. **How does the work product, report or deliverable ensure equitable distribution of resources and power?**
    a. The deliverable engages partners within the health care system.
    b. The deliverable could be used as a model for collaboration with other sectors.
    c. Alejandro commented on the language of *ensure* versus *encourages*. Lillian says that stronger language is better but might not have authority. Decision-making power brings this to a more accountable level. Eli recommends looking for societal examples and how certain collaborations impact populations. Strategic initiatives underway at the CCO level and public health departments are illustrations. Jen discussed that in leadership and governance, there should be community input, data by race and ethnicity will help to measure what is happening, and that there are no examples of evidence based practices for certain population groups – we should consider promising culturally-specific practices. Akiko remarked that shows the lens the Board is looking through and the importance of workforce diversity.

6. **How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?**
    a. The community has not been engaged in the deliverable. Stakeholders from affected organizations have been involved.
    b. The deliverable has the potential to positively impact the community through greater opportunity for community input and leadership on population health

issues (e.g., community advisory councils as required of coordinated care organizations).

7. **How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?**
    a. The deliverable engages partners within the health care system.
    b. The deliverable could be used as a model for collaboration with other sectors.

8. **How will data be used to monitor the impact on health equity resulting from this work product, report or deliverable?**
    a. This deliverable does not include a specific monitoring plan.
    b. However, down the road it is possible to identify the impact of the deliverable through public health modernization. For example: partnerships formalized through contracts or memoranda of understanding; shared work plans; and/or governance structure changes.
    c. Jeff states the need to focus on specific disparities. Eli commented that there are CCO metrics that measure disparities.

Cara commented that this specific deliverable was difficult to put through the health equity policy and other deliverables might be a better fit down the road. However, the process yielded some specific additions of a health equity frame in the guiding principles and thus was a useful tool. Cara suggests to continue using this policy and make any updates along the way as needed.

Public Comment Period

-Darlene King

Darlene commented that she enjoyed listening to the meeting. She is working on a smoking prevention and use project as a nurse seeking her bachelor's degree.

Closing

The meeting was adjourned.

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

June 15, 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

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