AGENDA

PUBLIC HEALTH ADVISORY BOARD

June 15, 2017
2:30-5:15 pm
Portland State Office Building, 800 NE Oregon St., Room 1A, Portland, OR 97232

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

Meeting objectives

- Approve May meeting minutes
- Select public health accountability measures
- Discuss public health modernization implementation

2:30-3:00 pm	**Welcome and updates** • Approve May 18 meeting minutes • Legislative session updates • Public health Rules Advisory Committee timeline and process	Jeff Luck, PHAB Chair
3:00-3:10 pm	**Incentives and Funding Subcommittee update** • Incentives and Funding subcommittee: share information and updates from June 13 meeting	Akiko Saito, Oregon Health Authority
3:10-4:00 pm	**Public health accountability metrics** • Provide an update on the May 31 Accountability Metrics subcommittee meeting • Review process for selecting public health accountability metrics • Discuss proposal made by the Accountability Metrics subcommittee • Adopt public health accountability metrics • Review process for identifying public health system performance metrics	Myde Boles, Program Design and Evaluation Services
4:00-4:15 pm	**Break**	

4:15-5:00 pm	**Modernization implementation planning** • Review prioritization of foundational capabilities and programs based on ranges of funding • Provide information from the meeting with the Conference of Local Health Officials • Review and discuss governance criteria for implementation of public health modernization • Determine selection criteria for pilot projects	Cara Biddlecom, Oregon Health Authority
5:00-5:15 pm	**Public comment**	
5:15 pm	**Adjourn**	Jeff Luck, PHAB chair

Public Health Advisory Board (PHAB)
May 18, 2017
Draft 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 $5, 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 will bring this to the Health Share of Oregon board and the Metrics and Scoring Committee. 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 angela.d.rowland@state.or.us. For more information and meeting recordings please visit the website: healthoregon.gov/phab

Public health Rules Advisory Committee (RAC) timeline

Activity	Timeline
Workgroup meetings	July-August
RAC meetings	August-September
Public comment period	October-November
Rules go into effect	January 1, 2018

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes DRAFT
June 13, 2017
1:00-2:00 pm

Welcome and roll call

Meeting Chair: Akiko Saito

PHAB members present: Diane Hoover, Jeff Luck, Akiko Saito

Oregon Health Authority (OHA) staff: Sara Beaudrault, Cara Biddlecom, Chris Curtis, Angela Rowland

Members of the public: Kelly McDonald and Darren Yesser

May meeting minutes

A quorum was present. The May 9th meeting minutes were approved.

PHAB funding formula discussion

Sara provided a recap of the initial recommendations the subcommittee provided on the PHAB funding formula from the prior subcommittee meeting.

Minimum funding level for using the funding formula

- If less than $5M per year for LPHAs, direct all funds to pilot projects. Subcommittee members recommend considering that pilots from each size band are selected. Funds would not be distributed through the funding formula.
- If $5M-$10M per year, include floor payments at the levels set in the $10M model (ranging from $30,000-$90,000, totaling $1.8 million). All remaining funds would be used for pilots. Funds would not be distributed through the funding formula.
- If funds are equal to or above $10M per year, funds would be distributed to all LPHAs through the funding formula.

- For annual LPHA funding above $10M, floor payments would be proportionally increased.

The subcommittee agreed to continue with the previously proposed funding recommendations at each funding level.

Akiko recommended discussions to clarify the scope of pilot projects and consider mechanisms for awarding funds based on county size bands with the potential for regional projects. She suggested including new partners or non-public health partners in regional projects. In May the PHAB recommended additional criteria or suggestions for pilot projects. PHAB members have expressed concern that smaller, less-resourced counties might not have capacity to write competitive grants. Cara reminded the subcommittee of the Board's recommendation to allocate funds for groups of counties that identify an opportunity to work together on a specific need.

Diane suggested a separate subcommittee be formed to develop selection criteria for pilot projects. Sara stated that OHA is asking this subcommittee to make initial recommendations which will be taken to the Board on June 15th.

Selection Criteria

Cara provided an overview of the PHD and Coalition of Local Health Officials (CLHO) Joint Leadership Team (JLT) work regarding potential funding to local public health authorities (LPHAs) for the implementation of modernization. JLT walked through the 2017-2019 deliverables for local public health authorities in the Public Health Modernization Manual. They came to agreement on recommendations for the LPHA deliverables to which available funding should be tied. The OHA/PHD budget is being heard this afternoon in Ways and Means. Last week the Ways and Means subcommittee allocated a proposed $5M for public health modernization in the 2017-2019 biennium. The actual funding amount will not be final until the end of session.

During the JLT meeting there was general consensus that targeting available funding toward public health modernization planning is not necessarily politically palatable. JLT members stated that planning can be ongoing work for LPHAs. JLT suggested directing available funds toward achieving health outcomes and making system changes in a short period of time. They suggested prioritizing

communicable disease control with a specific focus on sexually transmitted infections (STIs).

JLT discussed PHAB's recommendation to include floor payments to all counties that could be used for public health modernization planning. Some JLT members reiterated that targeting dollars to planning would not drive system change. One JLT member stated that the floor payments are not sufficient for supporting system change and improved health outcomes.

Focusing on a specific health area may provide a mechanism for public health modernization planning related to developing new service delivery models across county lines and new cross sector partnerships.

Akiko described a matrix used for Public Health Preparedness no-cost extension dollars that ties funding to foundational capabilities. Akiko proposed using a similar matrix in a RFP for public health modernization dollars, including the funding formula indicators related to health equity and social determinants of health. Jeff stated that if the available funding is small, criteria should be matched to funding and the most important components should be prioritized.

Diane recommended that additional points be awarded for personalized letters of support rather than form letters.

Sara recommended that a matrix require respondents to use modernization assessment information to inform their responses. She cautions providing funding to those who scored the lowest in the assessment since all counties had gaps. But LPHAs can target their proposal to specific gaps and needs in their local modernization assessment.

Jeff recommended that funding proposals should explicitly address public health modernization activities. Sara said that JLT reviewed deliverables for communicable disease control and the other prioritized foundational capabilities and programs, and JLT was most interested in prioritizing those deliverables related to new work and system change, for example, forming new partnerships with hospitals, schools and long-term care facilities.

Akiko stated that focusing on regional projects is the right step toward modernization. Jeff agreed and added that community partnerships and health equity are also important components.

Cara stated that this approach of focusing on deliverables for partnerships and equity would allow communities to address the communicable diseases that are of greatest importance in their area of the state. This could help weather any future funding shocks and help to plan for sustainability.

Jeff suggested the subcommittee identify criteria for public health modernization funding that remains with OHA to support the public health system. Some examples could be providing granular data for counties, providing state level expertise, and using funds for state-level communicable disease activities. Sara stated that at lower funding levels OHA will provide fiscal oversight, grant management and technical assistance. With additional funding OHA could target resources to enhancing data systems and population health surveillance.

Akiko recommended that OHA commit to coordinating a learning environment, perhaps through quarterly conference calls with pilot project recipients. This would add structure for system change. Jeff agreed. He stated it will help LPHAs learn from one another, clarify lessons and put the public health system in a better position to ask for additional resources for modernization in the future. Diane discussed her participation in a similar required learning community for OHA grants and is supportive of the concept.

Akiko asked the subcommittee to discuss mechanisms for ensuring that less-resourced counties are supported with a regional project concept. She described the Public Health Preparedness regions.

Jeff suggested that one option may be to create regions and to divide projects across these regions. This would ensure that regions that would include less-resourced counties are funded.

Sara suggested that during the proposal review process additional points could be awarded to projects that explicitly demonstrate how less-resourced counties are included or supported.

Akiko asked whether there are additional funds from the Robert Wood Johnson Funding (RWJF) grant or a different funding source that could be used to provide technical assistance to counties for developing grant proposals and work plans.

Subcommittee recommendations

- No changes to funding level suggestions that were already put forward
- Target available dollars to communicable disease first, with a focus on deliverables tied to regional approaches, expanded cross sector partnerships and health equity.
- Develop criteria for funds that remain with OHA and ensure funds are used to support the public health system. This may include:
    - Providing granular local data
    - Provide expertise and technical assistance
    - Convene a learning community
- For funding proposals for regional projects, ensure a mechanism to connect assessment results to the proposal. This could be a matrix that includes how the proposal will address cross jurisdictional sharing, cross sector partnerships and health equity. Consider also including indicators from the funding formula related to health equity and social determinants.
- Consider mechanisms to ensure that smaller or less-resourced counties are supported in a regional project model. Suggestions from the subcommittee included:
    - Forming predetermined regions that could apply for funds.
    - Provide more points in a funding proposal for regions that specifically include smaller or less-resourced counties, or address how these counties will benefit from the project.
    - Consider options to ensure funding goes to LPHAs that had the biggest gaps in the modernization assessment.
- Explore opportunities to provide technical assistance for grant applications and work plans.

Subcommittee Business

Akiko will lead this discussion at the June 15th PHAB meeting. These minutes will go out to PHAB members June 14th for review.

Public Comment

No public testimony.

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics subcommittee meeting minutes

May 31, 2017
9:30am – 11:30am

PHAB Subcommittee members in attendance: Muriel DeLaVergne-Brown, Eli Schwarz, Teri Thalhofer, and Jen Vines

OHA staff: Sara Beaudrault, Cara Biddlecom, Myde Boles, and Angela Rowland

Members of the public: Jody Daniels, Channa Lindsay, and Kelly McDonald

Welcome and introductions

The April 26, 2017 meeting minutes were approved.

Subcommittee updates

- The Metrics and Scoring Committee will postpone the public health accountability metrics presentation until the August meeting.

Health outcome metrics selection

Myde Boles provided a presentation on the stakeholder survey results based on information included in the *Stakeholder Metrics Survey Results: Proposed Outcome Accountability Metrics for Public Health Modernization* report. The 24 proposed metrics included in the survey were identified by Public Health Division managers. Prior to fielding the survey, feedback was collected from Coalition of Local Health Officials (CLHO), Public Health Environmental Health specialists (CLEHS), and PHAB Accountability Metrics subcommittee members. Two hundred and one people responded to the survey with the majority identifying as community members or local public health officials (LPHO). Respondents could select more than one category.

The *Stakeholder Metrics Survey Results: Proposed Outcome Accountability Metrics for Public Health Modernization* report compiles survey findings, feedback collected through other venues and a review of selection criteria identified by this subcommittee.

For the 24 metrics, respondents were asked to identify which metrics align with priorities for their organization, and which they rank as most important. These results are displayed on the first table under each foundational program section. Results are reported separately for all respondents and LPHOs. Myde stated that LPHO responses

are included in the *All Respondents* column to reflect the entire survey results, and since LPHOs were a strong majority the numbers left over would be very small. Also, respondents were able to check multiple categories.

The second table for each foundational program displays whether each proposed metrics meets the five “must have” criteria identified by this subcommittee, based on PHD staff’s interpretation. These “must have” criteria include health equity, is respectful of local priorities, has transformative potential, is consistent with state and national quality measures, and feasibility of measurement.

Communicable disease control metrics

All respondents ranked *two-year old vaccination rate* as the top ranked metric and the *gonorrhea rate metric* as number two. LPHOs ranked *two-year old vaccination rate* as the top-ranked metric and *new hepatitis C cases* as the second ranked metric. The proposed metrics for communicable disease control meet most “must have” selection criteria.

The Public Health Division recommends *two-year old vaccination rate* as the first metric choice and *gonorrhea rate* as a potential second choice.

Eli inquired why *new hepatitis C cases* was ranked as a priority for LPHOs when there is a low incidence in the state. Teri stated that hepatitis C is seen as a large health issue that is fairly costly. Her county doesn’t provide direct hepatitis C clinical services, but they do prevention and testing of gonorrhea. Muriel agreed. Jen stated that hepatitis C is an emerging opportunity for public health and health care to tackle hepatitis C prevention together. Health officers propose altering the measure to *hepatitis C prevalence in young adults*. Teri stated there is an uptick in screening for hepatitis C. Incidence is low in some areas of the state, so 4-5 year rolling averages are needed for reporting new hepatitis C cases at the local level. Jen stated this is similar to the gonorrhea rate.

Jen proposed modifying the salmonella measure to track secondary infections to show the work that public health does.

Jen questioned whether public health has control for the immunization measure. Muriel doesn’t provide immunizations in her public health department, but she works with the private sector on that. Teri stated that public health is looking at different work than needles in arms, like working with providers, public messaging and addressing anti-vaccine groups. Jen agreed and noted that this is currently the only recommended measure focusing on early childhood health.

Eli recommended reviewing the State Health Improvement Plan (SHIP) STD presentation from a previous PHAB meeting to look at data on STDs.

Decision: The subcommittee recommends in order the *two-year old vaccination rate* and *gonorrhea rate* metrics. They would like to also bring forward to PHAB the

Infections salmonella from food and *new hepatitis C cases* metrics for consideration. OHA will work on gathering data sources for these two metrics and the modifications proposed by Jen.

Prevention and health promotion metrics

All respondents ranked *suicide deaths* as the top ranked metric and *adults who smoke cigarettes* as number two. LPHOs ranked *adults who smoke cigarettes* as the first choice metric and suicide *deaths* and *youth smoking* as a tie for the second metric. All proposed metrics meet most of the "must have" selection criteria.

The Public Health Division recommends *adults who smoke cigarettes* as the first metric choice and *youth who smoke cigarettes* as the potential second choice. They propose adding or substituting smokeless tobacco and vaping/e-cigarettes particularly for the youth metric.

In discussing why suicide was ranked as more important than tobacco use by all respondents, Teri commented that some feel that the tobacco war has already been won. Subcommittee members noted that tobacco continues to be the number one preventable cause of death. Eli proposed that it may make more sense to focus interventions on youth who just started smoking or have not yet started smoking.

Jen heard a lot of support for tobacco metrics but they should include nicotine to capture vaping/e-cigarette prevalence. Muriel concurs that both of these measures are important since this is in the public health's wheelhouse and can be addressed through policy. Jen stated that tobacco-use involves entrenched health disparities and certain demographics are still having issues with quitting tobacco. Teri and Muriel agree.

Myde stated that vaping and e-cigarette use is a newer public health issue for youth and have surpassed tobacco use among youth.

Teri reminded the subcommittee of their previous discussions to focus on new and emerging work for public health. Public health is just starting to focus on vaping and e-cigarette use; funding could help address the issues before they get a hold of our communities.

The subcommittee agreed to remove the *binge drinking* measure as well as any measures in this section with less than a 10% response rate.

Jen asked whether there were additional comments from survey respondents about suicide. Myde replied that additional comments were limited, but noted that in some counties suicide prevention falls under behavioral health and not public health. Also, small numbers of suicide deaths require combining multiple years of data to report at the local level.

Related to the youth cigarette and e-cigarette/vaping measures, data for these measures comes from Oregon Healthy Teens Survey. Teri and Muriel noted that school districts can opt out of this survey and data may not reflect comprehensive data for the entire state.

Decision: The subcommittee recommends the following metrics in order: *tobacco use among adults with additional reporting on both youth measures*, *opioid mortality*, and *suicide deaths.*

Environmental public health metrics

The *active transportation* metric was ranked the highest for all respondents and the *drinking water standards* metric was second. LPHO ranked the *food facility inspections* first and there was a three-way tie for *resilience strategies, active transportation, and drinking water standards*.

The Public Health Division recommends *drinking water standards* as the first metric choice and a*ctive transportation* as the potential second choice.

Myde noted that active transportation may be urban-centric and the measure for active transportation is a survey measure that is under development and has not been implemented statewide. The air quality measure may vary across the state.

Muriel is a proponent of active transportation as it is transformative and future thinking.

Jen said there was a lot of hesitation around *Particulate Matter 2.5* (PM 2.5) as an air quality measure, since it isn't under public health control. Muriel agreed. Eli stated active transportation has a lot of health effects and this presents an opportunity to engage communities in active transportation efforts. He suggests using a term other than active transportation.

Muriel stated active transportation is how public health works with cities on biking and walking and the built environment. There is huge potential in working with planning departments and bringing in the public health view. Jen stated that active transportation is a strategy to address physical activity and chronic disease.

Decision: The subcommittee recommends *active transportation* and *drinking water standards* in that order.

Access to clinical preventative services

The *effective contraceptive use* metric was ranked the highest for all respondents and the *dental visits for children ages 0-5* metric was second. LPHOs ranked the *effective contraceptive use* first and *partner expedited therapy* second. These measures met most of the "must have" criteria.

The Public Health Division recommends *effective contraceptive use* as the first metric choice and *adolescent well visits* as the potential second choice.

Eli believes that *effective contraceptive use* and *dental visits* do have transformative potential and suggested changing these from “no” to “yes” on the selection criteria table. Unplanned pregnancy can have subsequent effects on adverse childhood experiences. Oral health, behavioral health, and medical health should be aligned as a transformative goal through these metrics. This age group often does not visit the dentist, which presents an opportunity for screenings and preventive care in the primary care setting. Eli stated that there are crossovers with public health, like through WIC.

Teri offered support for the *expedited partner therapy* measure. Jen stated that it is a proven strategy for chlamydia but not gonorrhea.

Jen questioned the usefulness of the *adolescent well care visits* metric. It is not tied directly to anything other than going to a clinic and the public health role is not clear. Eli agreed and stated that the Metrics and Scoring committee has generally avoided measures that count attendance. Teri thought that adolescent well-care visits could only be coded if specific activities are addressed and done during the visit.

Jen offered support for the oral health measures. Teri agreed but questioned the public health role. Teri stated that the DCOs are doing dental sealants. Myde commented that the *dental visits for children age 0-5* measure is from Medicaid claims data.

Jen and Teri recommend removing the *expedited partner therapy* measure since gonorrhea rates were selected for communicable disease control. Jen noted that primary care is largely responsible for expedited partner therapy.

Decision: The subcommittee recommends in order: e*ffective contraceptive use, dental visits*, *children 0-5*, *partner expedited therapy*, and *adolescents well care visits* metrics.

Public health accountability metrics Phase 2

The next step for public health accountability metrics is to develop process metrics for public health authorities to help meet these health outcome metrics. That work will be done through the CLHO committees and CLEHS in July and August. The PHAB Accountability Subcommittee will continue to meet and be the decision makers for the process metrics.

Eli asked if the community needs assessments are occurring now. Cara stated that organizations follow a different scheduled and timeline. Eli asked about a cross-walk of all Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP). Eli would like to look at the priorities and how they align with this crosswalk. OHA will provide that information.

Subcommittee Business

Myde will provide the stakeholder survey results presentation at the June 15th PHAB meeting update. Since the results have conflicting information that might be difficult to assemble, she will streamline the information for the PHAB to help facilitate decision-making. The full report will be available online. Myde recommends the input from today's meeting can be weaved into the report with the subcommittee's rank order and to consolidate the report. The presentation to PHAB will recapture the process to date with measures recommended by the subcommittee.

Public Comment: No public testimony.

Adjournment

The meeting was adjourned.

PHAB Accountability Metrics Subcommittee

June 15, 2017

PUBLIC HEALTH DIVISION
Office of the State Public Health Director

Survey methods

Survey development:

- Initial list of metrics proposed by Public Health Division managers for each foundational program.
- Feedback solicited from local public health administrators and health officers, the Coalition of Local Health Officials (CLHO), the Conference of Local Environmental Health Supervisors (CLEHS) and the PHAB Accountability Metrics subcommittee.
- Metrics narrowed to a list of 24 proposed metrics for inclusion on the stakeholder survey.

Survey methods

Survey distribution:

- Local health administrators and health officers
- Tribal health officials
- Community-based organizations
- Public health environmental health specialists (CLEHS)
- Coordinated Care Organizations (CCOs)
  - QHOC members
  - Community Advisory Councils
  - Metrics and Scoring Committee
  - CCO Technical Advisory Group
- Public Health Advisory Board
- Health care providers
  - PEBB and OEBB carriers
  - Rural and frontier providers
- Early learning
  - Early learning hubs
  - Early learning providers
  - Measuring Success Committee
- Hospitals/health systems
  - Hospital Metrics Committee
  - Hospital Technical Advisory Group
  - Critical Access Hospitals

Survey methods

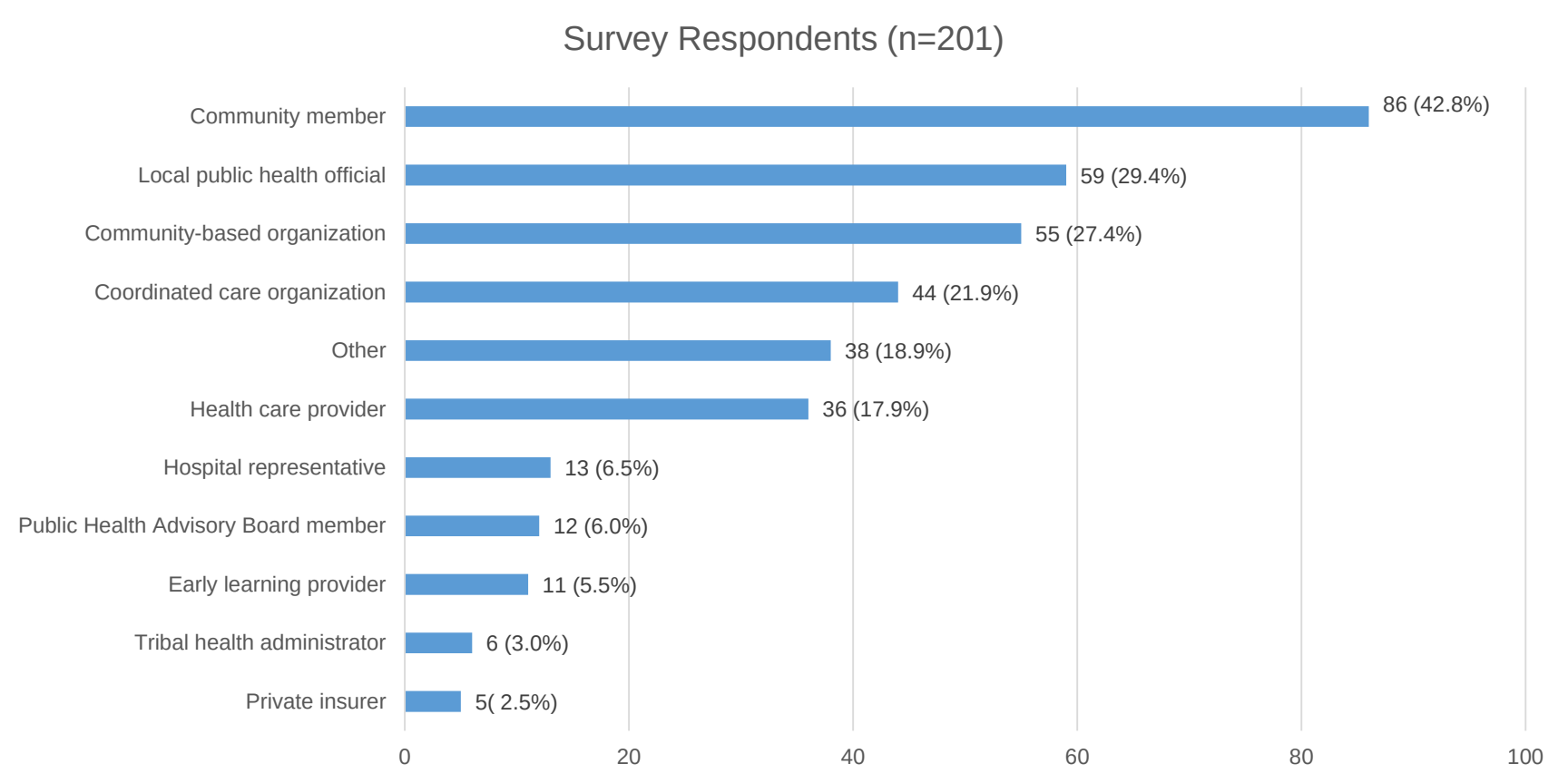
Survey analysis:

- Open-ended survey questions reviewed for relevance and summarized
- Feedback from the webinar and other stakeholders incorporated
- Assessment of selection criteria
- Information about feasibility of reporting and availability of data considered

Metric review and recommendations:

- Survey results reviewed by Accountability Metrics subcommittee.
- Consensus reached about metrics to propose to full PHAB for final selection.

Survey results



Communicable disease control

Table 4. Proposed Communicable Disease Control Metrics Survey Results				
	All Respondents (n=201)*		LPHO (n=59)	
	% checked (n)	All Ranked #1	% checked (n)	LPHO Ranked #1
Two-year old vaccination rate	67.2% (135)	**63.7% (128)†**	69.5% (41)	**61.0% (36)†**
Gonorrhea rate	40.3% (81)	**8.5% (17)‡**	59.3% (35)	13.6% (8)
Infections *salmonella* from food	31.8% (64)	6.5% (13)	50.8% (30)	8.5% (5)
New hepatitis C cases	37.3% (75)	8.0% (16)	42.4% (25)	**27.1% (16)‡**
None of these	10.0% (20)		1.7% (1)	

Communicable disease control

Table 5. Assessment of Top 5 "Must Have" Selection Criteria					
Communicable Disease Control Metrics	**Promotes health equity**	**Respectful of local priorities**	**Transformative potential**	**Consistency with state and national quality measures**	**Feasibility of measurement**
Two-year old vaccination rate	Yes[1,2]	Yes[3,4]	No	Yes[6,7]	Yes[8]
Gonorrhea rate	Yes[1,2]	Yes[3,4]	No	Yes[6,7]	Yes[9]
Infections *salmonella* from food	Yes[1,2]	Yes[3,4]	No	Yes[6,7]	Yes[9,10]
New hepatitis C cases	Yes[1,2]	Yes[4]	Yes[5]	Yes[6,7]	No[9, 11]

Communicable disease control

Accountability Metrics Subcommittee recommendations:

- Recommend two-year old vaccination rate as first choice

  Rationale:

  – Is aligned with priorities for a strong majority of local public health authorities
  – Although some health officials expressed concern about whether two year old vaccination rates are within the control of public health to improve, it was ranked as #1 most important metric by a strong majority of all survey respondents and LPHO respondents
  – Meets 4 out of 5 “must have” selection criteria
  – Is aligned with CCO metric
  – Important to include at least one early childhood metric
  – Improvement of the two-year old vaccination rate requires a community strategy and messaging; this a broader role for public health than “needles in the arm” and reflects a modernized public health system

Communicable disease control

Accountability Metrics Subcommittee recommendations:

- Recommend gonorrhea rate as second choice

  Rationale:

  – Is aligned with priorities for a majority of local public health authorities
  – Meets 4 out of 5 “must have” selection criteria
  – Ranked as #1 most important metric by the second highest proportion of all survey respondents (behind two-year old vaccination rate)
  – Although a larger proportion of LPHO survey respondents ranked hepatitis C as #1 most important metric, public health has a clear role in prevention and control of gonorrhea; feasibility of screening and intervention for hepatitis C is low
  – It is important to include a sexually-transmitted infection (STI) metric
  – Although chlamydia is a higher priority in some areas of the state than gonorrhea, there was consensus by the Accountability Metrics subcommittee to recommend gonorrhea rate to the PHAB

Communicable disease control

Accountability Metrics Subcommittee recommendations:

- Consider infections caused by salmonella through food

  Rationale:

  – The smallest proportions of LPHO respondents and all survey respondents ranked this metric as #1 most important metric

  – Primary salmonella outbreaks typically not under control of public health

  – Burden of foodborne illness is from other pathogens (e.g., E. coli)

  – A preferred metric would be secondary salmonella infections, which better reflects the role of public health

- Consider new hepatitis C cases

  Rationale:

  – This metric was ranked as #1 most important metric by over a quarter of LPHO respondents

  – Hepatitis C has high visibility because of the high cost of treatment

  – Public health feasibility of screening and intervention for hepatitis C is low

  – Prevention of new cases would require a focus on young adults through needle exchange programs and other public health interventions that are not readily embraced across all jurisdictions

  – Hepatitis C prevention and screening could be a transformative alignment between public health and the health care system in a modernized public health system

Prevention and health promotion

Table 6. Proposed Prevention and Health Promotion Metrics Survey Results				
	All Respondents (n=201)*		LPHO (n=59)	
	% checked (n)	All Ranked #1	% checked (n)	LPHO Ranked #1
Adults who smoke cigarettes	54.2% (109)	13.4% (27)‡	50.8% (30)	18.6% (11)†
Youth who smoke cigarettes	51.2% (103)	11.4% (23)	54.2% (32)	15.3% (9)‡
Obesity adults	49.3% (99)	7.0% (14)	42.4% (25)	8.5% (5)
Obesity 2-5 year olds	43.8% (88)	8.5% (17)	49.2% (29)	6.8% (4)
Obesity youth	45.8% (92)	1.5% (3)	47.5% (28)	5.1% (3)
Opioid mortality	47.8% (96)	10.0% (20)	39.0% (23)	1.7% (1)
Adult binge drinking	36.8% (74)	1.0% (2)	32.2% (19)	3.4% (2)
11th grade binge drinking	34.8% (70)	1.5% (3)	39.0% (23)	3.4% (2)
Suicide deaths	48.3% (97)	18.4% (37)†	50.8% (30)	15.3% (9)‡
None of these	3.5% (7)		6.8% (4)	

Prevention and health promotion

Table 7. Assessment of Top 5 "Must Have" Selection Criteria					
Prevention and Health Promotion Metrics	**Promotes health equity**	**Respectful of local priorities**	**Transformative potential**	**Consistency with state and national quality measures**	**Feasibility of measurement**
Adults who smoke cigarettes	Yes[1,2]	Yes[3,4]	No	Yes[6,7]	Yes[8]
Youth who smoke cigarettes	Yes[1,2]	Yes[3,4]	No	Yes[6,7]	Yes[9]
Obesity adults	Yes[1,2]	Yes[4]	No	Yes[6,7]	Yes[8]
Obesity 2-5 year olds	Yes[1,2]	Yes[4]	No	Yes[6,7]	Yes[12]
Obesity youth	Yes[1,2]	Yes[4]	No	Yes[6,7]	Yes[9]
Opioid mortality	Yes[1,2]	Yes[4]	Yes[5]	Yes[6,7]	Yes[10,11]
Adult binge drinking	Yes[2]	Yes[4]	Yes[5]	Yes[6,7]	Yes[8]
11th grade binge drinking	Yes[2]	Yes[4]	Yes[5]	Yes[6,7]	Yes[9]
Suicide deaths	Yes[1,2]	Yes[3,4]	Yes[5]	Yes[6,7]	No[10,11,13, 14]

Prevention and health promotion

Accountability Metrics Subcommittee recommendations

- Recommend adults who smoke cigarettes as first choice

  Rationale:

  - Is aligned with priorities for over half of local public health authorities
  - Is ranked as #1 most important metric by 19% (the largest proportion) of LPHO respondents and ranked as #1 by the second largest proportion of all survey respondents
  - Meets 4 out of 5 “Must Have” selection criteria
  - Is aligned with CCO metric
  - Strong disparities exist
  - Although some members of the Accountability Metrics subcommittee expressed preference for youth tobacco or youth vaping/e-cigarette use as the first choice metric, there are concerns about declining school participation in the Oregon Healthy Teen survey and access to representative youth data. They suggest that these youth measures be reported jointly with adults who smoke cigarettes.

- Recommend opioid mortality as second choice

  Rationale:

  - Mentioned for inclusion by several survey respondents and Accountability Metrics subcommittee members
  - Meets 5 out of 5 “must have” selection criteria, although cases at the local level are small and data are reported in combined year averages
  - Is in alignment with nearly half of all survey respondents’ priorities and 39% of LPHO’s priorities

Prevention and health promotion

Accountability Metrics Subcommittee recommendations

- Consider youth who smoke cigarettes

  Rationale:

  - Is aligned with priorities for over half of local public health authorities
  - Is ranked as #1 most important metric by the second largest proportion of LPHO respondents (in a tie with suicide deaths)
  - Meets 4 out of 5 “must have” selection criteria
  - Although some members of the Accountability Metrics subcommittee expressed preference for youth tobacco as the first choice metric, there are concerns about declining school participation in the Oregon Healthy Teen survey and access to representative youth data

- Consider youth use of vaping/e-cigarettes

  Rationale:

  - Mentioned for inclusion by several survey respondents and Accountability Metrics subcommittee members
  - E-cigarette use has surpassed cigarette use among Oregon youth
  - Prevention and control of e-cigarettes/vaping products is a nascent public health activity (and potentially has transformative potential), whereas prevention and control of youth tobacco use has a strong evidence base for public health intervention and justifies its position ahead of vaping/e-cigs

Prevention and health promotion

Accountability Metrics Subcommittee recommendations

Consider suicide deaths

Rationale:

- Although the suicide death metric aligns with priorities of about half all respondents (and over half of LPHOs) and is top ranked by the largest proportion of all survey respondents, stakeholders from LPHAs expressed concern about local public health role for addressing this problem
- In some areas of the state, suicide prevention falls outside of public health
- Numbers are small at the local level and are reported in combined years
- Accountability Metrics subcommittee members questioned why so many survey respondents ranked this as their #1 choice; explanation not available from survey results
- Suicide deaths is potentially a new area for local public health and could be considered transformative

Prevention and health promotion

Accountability Metrics Subcommittee recommendations

- Metrics recommended for removal from consideration: adult obesity, youth obesity, 2-5 year old obesity, adult binge drinking, and 11th grade binge drinking

  Rationale:

  – All of these metrics had low to very low proportions of LPHO survey respondents who ranked them as #1 (although they are in alignment with local priorities for 30% - 50% of respondents)

  – Data on obesity in 2-5 year olds is available only from WIC data; not a population-based metric

  – Binge drinking is not under the jurisdiction of public health in some localities

Environmental public health

Table 8. Proposed Environmental Public Health Metrics Survey Results				
	All Respondents (n=201)*		LPHO (n=59)	
	% checked (n)	All Ranked #1	% checked (n)	LPHO Ranked #1
Resilience strategies	27.4% (55)	13.9% (1)	25.4% (15)	10.2% (6)‡
Annual PM 2.5	18.9% (38)	5.0% (10)	20.3% (12)	3.4% (2)
Active transportation	40.3% (81)	19.4% (39)†	35.6% (21)	10.2% (6)‡
Food facility inspections	31.8% (64)	12.4% (25)	54.2% (32)	28.8% (17)†
Drinking water standards	32.8% (66)	18.4% (37)‡	44.1% (26)	10.2% (6)‡
None of these	13.4% (27)		3.4% (2)	

Environmental public health

Table 9. Assessment of Top 5 "Must Have" Selection Criteria					
Environmental Public Health Metrics	**Promotes health equity**	**Respectful of local priorities**	**Transformative potential**	**Consistency with state and national quality measures**	**Feasibility of measurement**
Resilience strategies	Yes	Yes[4]	Yes[5]	Yes[6,7]	No[13]
Annual PM 2.5	Yes	Yes	Yes[5]	Yes[6,7]	Yes[9]
Active transportation	Yes	Yes	Yes[5]	Yes	Yes[10]
Food facility inspections	Yes	Yes[3,4]	No	Yes[7]	Yes[11]
Drinking water standards	Yes	Yes[4]	No	Yes[7]	Yes[12]

Environmental public health

Accountability Metrics Subcommittee recommendations

- Recommend active transportation as first choice metric

  Rationale:

  - Active transportation is aligned with priorities of more than one-third of LPHOs and all survey respondents
  - Ranked as #1 most important metric by all survey respondents
  - Active transportation has transformative potential and cuts across public health areas (e.g., prevention/health promotion and environmental health) and across sectors (e.g., public health, land use planning, transportation)
  - Supports the concept of a modernized public health system that works with cities, built environment, health impact assessments, and planning
  - Although not relevant in some areas of the state, it could be combined with a land use planning metric
  - Active transportation will require additional support for metric development and reporting

Environmental public health

Accountability Metrics Subcommittee recommendations

- Recommend drinking water standards as second choice metric

  Rationale:

  – More closely tied to health outcomes than some of the other proposed metrics in the Environmental Public Health foundational program area

  – Is a priority for CLEHS

  – However, the baseline for this measure is currently at 90%, with a Healthy People 2020 goal of reaching 92%

Environmental public health

Accountability Metrics Subcommittee recommendations

- Metrics recommended for removal from consideration: resilience strategies, annual average PM 2.5, and food facility inspections

  Rationale:

  – Resilience strategies is a process measure; very indirectly tied to health outcomes; high variability across local jurisdictions for local support and resources

  – Air quality/average annual PM 2.5: the nature of particulate matter is highly variable across the state; not directly under the control of LPHAs

  – Food facility inspections: evidence for the relationship of this metric to health outcomes is tenuous. Although a top-ranked metric by LPHOs, performance is already high with little room for improvement. Expansion into facilities other than restaurants, like LTC facilities, may occur through legislation.

Access to clinical preventive services

Table 10. Proposed Access to Clinical Preventive Services Metrics Survey Results				
	All Respondents (n=201)*		LPHO (n=59)	
	% checked (n)	All Ranked #1	% checked (n)	LPHO Ranked #1
Effective contraceptive use	47.8% (96)	**32.8% (66)†**	44.1% (26)	**37.3% (22)†**
Adolescent well care visits	46.3% (93)	8.0% (16)	37.3% (22)	6.8% (4)
HPV Vaccine	41.3% (83)	3.5% (7)	45.8% (27)	1.7% (1)
Dental visits, children 0-5	48.8% (98)	**10.0% (20)‡**	44.1% (26)	3.4% (2)
Dental sealants schools	40.3% (81)	5.5% (11)	32.2% (19)	5.1% (3)
Colorectal screening	40.3% (81)	5.0% (10)	27.1% (16)	1.7% (1)
Partner expedited therapy	32.3% (65)	3.5% (7)	39.0% (23)	**8.5% (5)‡**
None of these	6.0% (12)		3.4% (2)	

Access to clinical preventive services

Table 11. Assessment of Top 5 "Must Have" Selection Criteria					
Access to Clinical Preventive Services Metrics	**Promotes health equity**	**Respectful of local priorities**	**Transformative potential**	**Consistency with state and national quality measures**	**Feasibility of measurement**
Effective contraceptive use	Yes[1,2]	Yes[4]	Yes[5]	Yes[6,7]	Yes[8]
Adolescent well care visits	Yes[1,2]	Yes[4]	No	Yes[6,7]	Yes[9]
HPV Vaccine	Yes[1,2]	Yes[4]	No	Yes[6,7]	Yes[10]
Dental visits, children 0-5	Yes[1]	Yes	Yes[5]	Yes[6,7]	Yes[11]
Dental sealants schools	Yes	Yes[4]	No	Yes[6,7]	Yes[12]
Colorectal screening	Yes[1,2]	Yes[4]	No	Yes[6,7]	Yes[8]
Partner expedited therapy	Yes[2]	Yes	Yes[5]	Yes[6,7]	Yes[13]

Access to clinical preventive services

Accountability Metrics Subcommittee recommendations

- Recommend effective contraceptive use as first choice

  Rationale:

  – Is aligned with priorities for nearly half of local public health authorities
  – Is ranked as #1 most important metric by large proportions of all survey respondents and LPHOs
  – Meets 5 out of 5 “must have” selection criteria
  – Significant population impact
  – Is aligned with CCO metric
  – Is considered transformative because of its impact on unintended pregnancies – a salient policy issue

Access to clinical preventive services

Accountability Metrics Subcommittee recommendations

- Consider dental visits for children 0-5 and dental sealants in schools

  Rationale:

  - Is aligned with priorities for nearly half of local public health authorities (dental visits)
  - Is ranked as #1 most important metric by second-largest proportion of all survey respondents (dental visits)
  - Meets 5 out of 5 “must have” selection criteria (dental visits)
  - Is considered transformative (dental visits) and reflects a modernized public health system through system integration (dental visits & dental sealants)
  - Data are available only from Medicaid claims; not a population-based metric (dental visits)
  - Important to include an oral health metric (dental visits & dental sealants)
  - In some areas of the state, public health does not have a role in the provision of dental sealants in schools

- Consider partner expedited therapy

  Rationale:

  - Recommend changing this metric to “proportion of persons diagnosed with **chlamydia”** (instead of gonorrhea)
  - Is ranked as #1 by second-largest proportion of LPHO respondents
  - Because an STI metric is included in Communicable Disease Control, may not need to include an STI-related measure under Access to Clinical Preventive Services

Access to clinical preventive services

Accountability Metrics Subcommittee recommendations

- Metrics recommended for removal from consideration: HPV vaccine, adolescent well care visits, and colorectal cancer screening

  Rationale:

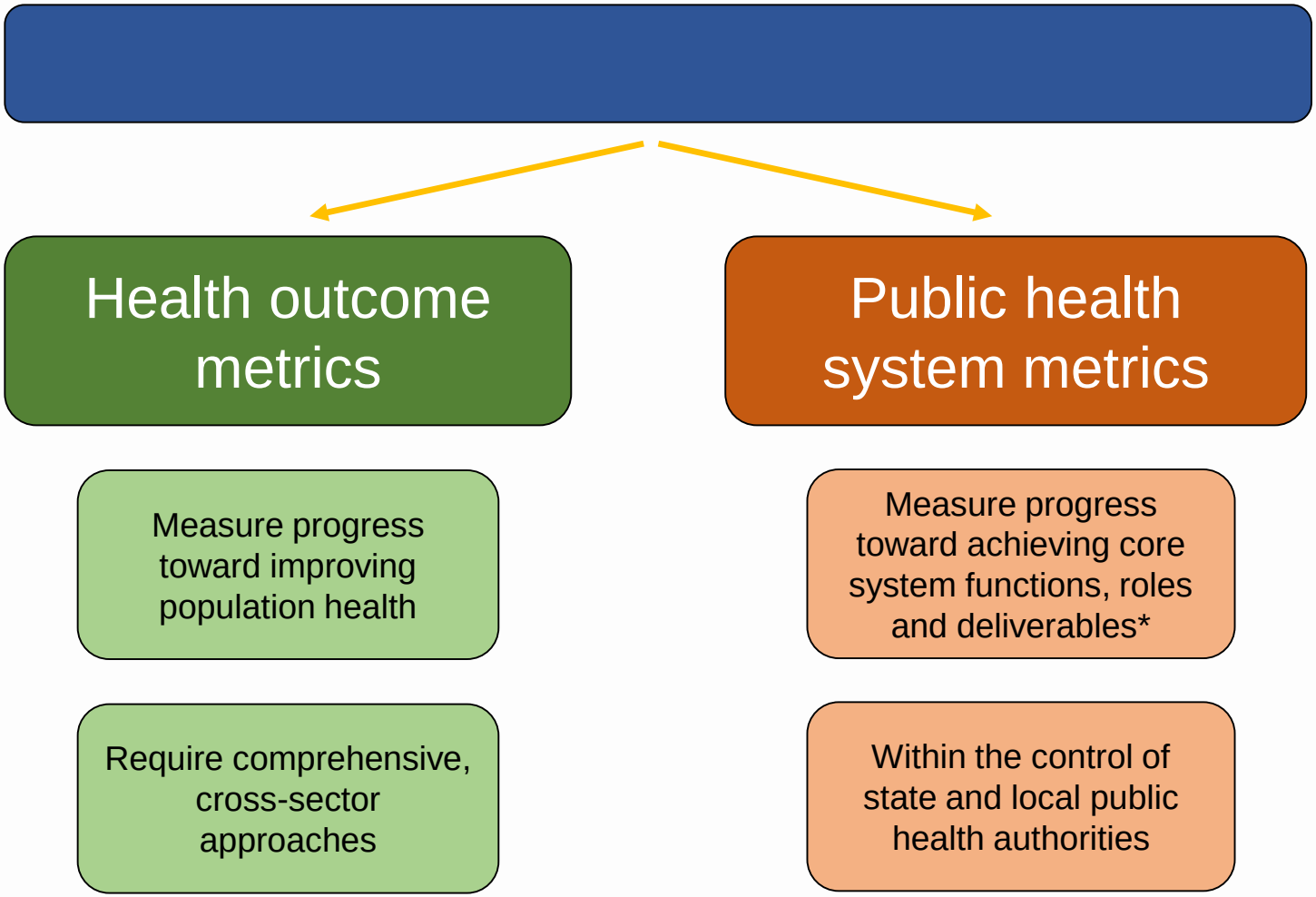
  – HPV vaccine: a vaccination metric already included in Communicable Disease Control foundational program area

  – Adolescent well care visits: not directly associated with local public health activities or strategies

  – Colorectal cancer screening: high variability among LPHAs for involvement in this area

Summary: Top ranked metrics by Accountability Metrics Subcommittee

- Communicable Disease Control
  - 1st choice: two-year old vaccination rate
  - 2nd choice: gonorrhea rate
  - For consideration: secondary salmonella infections
  - For consideration: hepatitis C
- Prevention and Health Promotion
  - 1st choice: adults who smoke cigarettes
  - 2nd choice: opioid mortality
  - For consideration: youth who smoke cigarettes
  - For consideration: youth rates of vaping/e-cigarettes
  - For consideration: suicide deaths
- Environmental Public Health
  - 1st choice: active transportation
  - 2nd choice: drinking water standards
- Access to Clinical Preventive Services
  - 1st choice: effective contraceptive use
  - For consideration: dental visits, children 0-5, dental sealants in schools
  - For consideration: partner expedited therapy – chlamydia



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

Accountability metrics timeline

Activity	Timeline
Identify population health outcome metrics	March-May
Conduct stakeholder survey	April-May
Finalize health outcome metrics	June
Identify public health system metrics	July-September
Establish data collection mechanisms	September-October
Collect baseline data	November-December
Publish first accountability metrics report	2018

Public Health Advisory Board
Public health accountability metrics health equity review
June 15, 2017

1. **How is the work product, report or deliverable different from the current status?**
   Public health accountability metrics will focus attention on population health priorities in Oregon and the role of the public health system to improve population health. These metrics will demonstrate progress through public health modernization and will set the stage for increased cross sector collaboration on shared metrics.

2. **What health disparities exist among which groups? Which health disparities does the work product, report or deliverable aim to eliminate?**
   The PHAB Accountability Metrics subcommittee established "must have" selection criteria for public health accountability metrics. One of the "must have" selection criteria is that the metric promotes health equity. Operationally, this means that disparities for each of the recommended metrics are documented and data are reportable by race/ethnicity.

3. **How does the work product, report or deliverable support individuals in reaching their full health potential?**
   Public health accountability metrics do not directly support individuals.

   However, public health accountability metrics will increase visibility and understanding of the health disparities that exist for the metrics that are adopted. This information will be useful to state and local public health authorities and partners in planning interventions and the allocation of resources to reduce disparities.

4. **Which source of health inequity does the work product, report or deliverable address (social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?**
   The set of public health accountability metrics do not specifically address one source of health inequity.

5. **How does the work product, report or deliverable ensure equitable distribution of resources and power?**
   This is not directly addressed by public health accountability metrics. However, adopting metrics where racial and ethnic data are available supports the public health system to deploy resources to address racial and ethnic health disparities.

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?**
   Feedback was solicited from partners and community members through a stakeholder survey. Of 201 survey respondents, 86 identified as a community member. Survey respondents provided input on which measures are priorities for themselves or the organizations they represent, and which measures are most important. Information on the final set of public health accountability metrics will be shared with partners and community members after metrics are adopted by PHAB.

7. **How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?**
   A number of these metrics will require coordination with cross-sector partners. These partners include early learning, k-12 education, transportation, local planning and CCOs. Partnering with these sectors will support strategic deployment of interventions to address health disparities. Where possible, metrics are aligned with established metrics for CCOs and early learning.

8. **How will data be used to monitor the impact on health equity resulting from this work product, report or deliverable?**
   OHA will publish an initial public health accountability metrics baseline report in 2018. Subsequent reports will be issued on a regular basis as a mechanism to monitor progress.

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

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

Draft summary of public health modernization planning, June 13, 2017

Public Health Advisory Board funding recommendations and additional guidance

PHAB funding recommendations for 2017-19
(Discussed at May 9 Incentives and Funding subcommittee meeting and May 18 PHAB meeting)

- Include a floor payment to all LPHAs in the modernization funding formula. Floor funding will ensure that all LPHAs have resources to engage in modernization planning. PHAB recommends five tiers of floor funding, ranging from $30,000 to $90,000 based on county population. Floor funding levels can be scaled up with additional funding but should not drop below these levels.
- Award funds to all LPHAs through the modernization funding formula at funding levels at or above $20 million for the 2017-19 biennium.
- At biennial funding levels between $10-20 million, all LPHAs should receive the floor payment, with remaining funds allocated to pilot projects.
- At biennial funding levels below $10 million, PHAB recommends that all funds are allocated to pilot projects.

Additional guidance for allocating new funding for public health modernization
(Discussed at May 18 PHAB meeting)

- Public health modernization **funding that remains with OHA should be focused on meeting the needs of the local public health system**, especially small local health departments. Examples may be assessment and epidemiology work and technical support.
- If funding is to be used for pilot sites, **an RFP should be structured so that larger, more resourced counties do not have an advantage** over smaller or less resourced counties.
- **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.
- Allocating funds for planning to all LPHAs will **give LPHAs resources to implement cross-jurisdictional sharing and strategic partnerships** with other organizations and to leverage additional funding.

Recommendations for prioritization of foundational capabilities and programs
(Discussed at May 18 PHAB meeting)

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

5. Emergency preparedness (focused on the specific functions that support communicable disease control)
6. Environmental health

Conference of Local Health Officials and OHA Public Health Division Joint Leadership Team (JLT) subgroup values discussion, based on PHAB recommendations

1. Initial funds should be focused on a specific health outcome to demonstrate progress.
2. Capacity building and planning are critical, and these pieces will be emphasized in the approach to meeting the improved health outcome.
3. Ensure all LPHAs are supported with any investment in public health modernization.
4. Limit a possible have/have-not scenario by directing funds to all LPHA size bands.
5. Support/incentivize regional approaches to service provision.
6. Utilize available funding to fill gaps identified in the public health modernization assessment. Gaps are not uniform across the public health system.
7. Limit specific requirements for the delivery of foundational capabilities and programs, in lieu of common outcomes across the public health system.
8. Utilize OHA resources to increase capacity across the entire public health system, provide technical assistance, and perform state-level functions, such as assessment and epidemiology.
9. Invest in areas that can produce outcomes while also absorb any future funding shocks to the public health system.

JLT subgroup recommendations for prioritization of foundational capabilities and programs

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

Public Health Modernization Manual deliverables

The following is a list of deliverables in the Public Health Modernization Manual for the 2017-19 prioritized functional areas. Light blue cells indicate deliverables that JLT recommends for prioritization in 2017-19.

Deliverable	Functional Area (FA)
Communicable Disease Control	
• Portfolio of strategic partnerships with hospitals, health systems, providers, schools and other partners.	FA 1
• Health education resources for the general public, health care providers, long-term care facility staff, infection control specialists and others regarding vaccine-preventable diseases, healthcare-acquired infections, antibiotic resistance and related issues.	FA 3
• Protocols or process maps for information sharing between providers to reduce disease transmission.	FA 3
• Documented submission of individual communicable disease case and outbreak data, consistent with Oregon statute, rule and program standards.	FA 2
• Documented implementation of investigative guidelines.	FA 2
• Local reports of notifiable diseases.	FA 1
• Documentation of policies to ensure appropriate screening and treatment for HIV, STD and TB cases, including pre- and post-exposure prophylaxis for HIV.	FA 3
• Standards and documentation of technical support for enforcement of public health laws (e.g., isolation and quarantine, school exclusion laws).	FA 3
• Policies in place to ensure maintenance of security of personally identifiable data collected through audits, review, update and verification.	FA 2
• Protocols for proper preparation, packaging and shipment of samples of public health importance (e.g., animals and animal products).	FA 2
• Plans for the allocation of scarce resources in the event of an emergency or outbreak.	FA 3
• Reports of gaps in surveillance, investigation and control of communicable diseases in public health agencies	FA 3
Health Equity and Cultural Responsiveness	
• Documentation that demographic data are used to evaluate the impact of public health policies, programs and strategies on	FA 1

health equity and health outcomes, and to inform public health action moving forward.	
• Internal assessment, completed within the last five years, of the local public health authority's overall capacity to apply a health equity lens to programs and services; overall capacity to provide culturally responsive programming and services; and status of health department's organizational structure and culture as a barrier or facilitator for achieving health equity.	FA 1
• Action plan that addresses key findings from the internal assessment	FA 1
• Training plan to increase staff capacity to address the causes of health inequities, promote health equity and implement culturally responsive programs. Documentation that training is provided to staff annually.	FA 1
• Community health improvement plan, developed within the previous five years that specifically addresses health equity and cultural responsiveness.	FA 1, FA 2
Leadership and Organizational Competencies	
• Implementation of a performance management system to monitor achievement of public health objectives using nationally recognized framework and quality improvement tools and methods	FA 2
• Documented cross jurisdictional sharing agreements	Not in manual
• Memoranda of understanding (MOUs) or other documentation of cross sector partnerships	Not in manual
• Documentation of additional dollars leveraged for public health	Not in manual
• Local public health modernization plan	Not in manual
Assessment and Epidemiology	
• Community health assessment	FA 4*
• Demonstrated use of data to inform annual updates to the CHIP	FA 4*
• Summaries of disease occurrence; outbreaks and epidemics; the impact of public health policies; programs and strategies on health outcomes, including economic analyses; key indicators of community health, which include information about upstream or root causes of health; and leading causes of disease, injury, disability and death, which include information about health disparities.	FA 3*
• Vital records reports.	FA 2

Environmental Public Health	
• Policy briefs and other communications on environmental health impacts. (FA1)	FA 1
• Communications on environmental justice concerns and disparities. (FA3)	FA 3
• Documented communications on environmental health hazards and protection recommendations to regulated facilities, the public and stakeholder organizations. (FA1)	FA 1
• Consultations on the assessment and mitigation of environmental health hazards for the food service industry and the general public	FA 2*
• Integration of standard environmental public health practices into facilities that present high risk for harmful environmental exposures or disease transmission	FA 3
• Current community health assessment that includes environmental health. (FA3)	FA 3
• Documentation of health analyses prepared for other organizations with recommended approaches to ensure healthy and sustainable built and natural environments. (FA3)	FA 3
• Written best practices related to vector control.	FA 3
Emergency Preparedness and Response	
• Disaster epidemiology reports.	FA 2
• Documentation of enforcement of emergency public health orders.	FA 2
• Documented delivery of health alerts and preparedness communications to partners and the general public.	FA 3
• Portfolio of community partnerships to support preparedness and recovery efforts.	FA 3
• Plans for the distribution of pharmaceuticals in the event of an emergency.	FA 1
• Public health emergency plans in accordance with established guidelines.	FA 1
• Continuity of operations plan for the local health authority.	FA 1
• Documented planning for emergency preparedness exercises.	FA 1
• Documentation that planned emergency preparedness exercises have been executed.	FA 1
• Documented participation in emergency response efforts.	FA 2
• Situational assessments and resulting operational plans, including objectives, resources needed and how to resume routine operations.	FA 2

*Deliverable is not in a prioritized functional area but may represent LPHA work that should be in place sequentially before other deliverables