AGENDA

PUBLIC HEALTH ADVISORY BOARD

January 18, 2018
Portland State Office Building
800 NE Oregon St., conference room 1E
Portland, OR 97232

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

Meeting objectives

- Review 2018 work plan
- Receive subcommittee updates
- Make recommendations about public health accountability measures
- Review plans for public health modernization evaluation
- Discuss progress towards Oregon's State Health Improvement Plan objectives related to obesity and substance use

2:00-2:30 pm	**Welcome and updates** • Approve November 17 meeting minutes • Provide detail about public health modernization grantee projects • Provide an update on public health modernization administrative rules • Review 2018 PHAB work plan	Rebecca Pawlak, PHAB Chair
2:30-2:50 pm	**Subcommittee updates** • Incentives and Funding subcommittee • Discuss public health system funding principles	Akiko Saito, PHAB member
2:50-3:20 pm	**Accountability metrics updates** • Accountability Metrics subcommittee	Teri Thalhofer, PHAB member Myde Boles, Program Design and Evaluation Services
3:20-3:40 pm	**Public health modernization evaluation plan** • Review public health modernization evaluation questions • Discuss next steps	Steven Fiala, Program Design and Evaluation Services
3:40-3:50 pm	**Break**	

3:50-4:45 pm	**State Health Improvement Plan updates: obesity and substance use** • Discuss progress towards obesity and substance use prevention priorities • Obtain feedback on opportunities to move work forward	Karen Girard and Lisa Millet, Oregon Health Authority
4:45-5:00 pm	**Public comment**	
5:00 pm	**Adjourn**	Rebecca Pawlak, PHAB chair

Public Health Advisory Board (PHAB)
November 17, 2017
Draft Meeting Minutes

Attendance:

Board members present: David Bangsberg, Carrie Brogoitti, Bob Dannenhoffer, Muriel DeLaVergne-Brown, Katrina Hedberg, Rebecca Pawlak, Kelle Little, Jeff Luck, Eva Rippeteau, Akiko Saito, Lillian Shirley, Teri Thalhofer, Tricia Mortell, and Jen Vines

Oregon Health Authority (OHA) staff: Sara Beaudrault, Cara Biddlecom, Julia Hakes, Royce Bowlin, Danna Drum

Approval of Minutes

A quorum was present. The Board moved to approve the October 19 minutes with all in favor.

Welcome and updates

-Jeff Luck, PHAB chair

Jeff welcomed two new members to the PHAB: Tricia Mortell, Public Health Division Director in Washington County, and Kelle Little, Health Administrator for Coquille Indian Tribe. This is Tricia's first meeting; Kelle joined remotely in October. Jeff thanked Safina for her service as a member of the PHAB. Jeff shared that work is underway to identify a new coordinated care organization representative to be appointed to PHAB when Safina's seat is vacated in January.

Cara shared that awards have been made to eight regions of the state that are implementing modern approaches to communicable disease control with an emphasis on reducing communicable disease-related health disparities. Cara shared a map of awardees and a brief description of the partnerships. Funds to these regions are effective December 1, 2017 and will go through June 30, 2019. OHA is in the process of finalizing work plans and budgets over the next three weeks.

Bob asked if the eight regions awarded aligned with the 2013 bill that lead to the creation of the PHAB and called for eight public health regions in Oregon. Cara said that was ultimately not the intention of the Task Force on the Future of Public Health Services and regions were not prescribed by the state.

Eva shared that this RFP was challenging because of the quick turnaround and the limited funds awarded. Eva noted that there is a wide range of staff capacity across the state to apply for funds. Some local health departments have allocated grant writing staff whereas others do not. Eva made the suggestion that the Public Health Division be clearer in the writing of future RFPs and to also allow for more time for submission.

Tricia commented about the ceiling for what they could apply for and asked if OHA is able to share what, if any, proposals went unfunded for this RFP. Cara stated that all proposals received funding but that the request for funding far exceeded the available $3.9M budget.

Teri shared that these funds are supporting the public health system, which includes the role of the state health department in supporting local work. Teri created a rapid partnership to submit her region's proposal and is very excited for the funding going to her region.

Muriel shared that the application was the best collaborative process for her region and facilitated bringing regional partners together.

David requested to see the abstracts of the proposals that were funded. Cara said she will send out abstracts after work plans have been finalized.

Jeff asked the PHAB to think about what they can do a year from now to capture the work done by the eight awarded regions and present to the legislature to make the case for additional funding. Jeff recommended the Board reconvene to put something together in summer 2018.

Cara shared that OHA is coordinating the development of the evaluation plan with the grantees and would like feedback from the PHAB.

Jen asked if the funding formula will be reexamined if modernization efforts are awarded less than $10M. Jeff answered that if the funding was less than $10M the funding formula does not apply.

OHA staff would like to know what is preferred by PHAB members: livestream or webinar for viewing PHAB meetings remotely. Either is sufficient to meet the requirements of a public meeting. All PHAB members voiced they preferred webinar. All meetings in 2018 will be viewable remotely through webinar.

Behavioral health collaborative update
- Royce Bowlin, Oregon Health Authority

Royce Bowlin (joined by phone), OHA Behavioral Health Director, provided an overview of the Behavioral Health Collaborative and PHAB discussed the implications of the Behavioral Health Collaborative recommendations on the public health system.

Jeff asked if regions can self-select the three priority areas they will focus on. Royce answered they are still deciding and will make a decision in the next month.

Muriel said that when looking at the health status slide, public health is not called out even though public health is often taking the lead. Royce explained that the intention of the work is to call out all collaborators in behavioral health work.

Tricia agreed with Muriel and said many local health departments have done community assessments and collected data on behavioral health within their communities. Tricia asked Royce if he is considering bringing community health assessment data and other locally collected data into this work. Tricia asked if the regions are already organized. Royce said no, the regions have not been organized and they are planning on going to regions when invited and discussing who should be at the table but they are leaving the decision up to the region.

Bob asked if there is funding for bringing together these health collaboratives. Royce said no, they are currently trying to reduce administrative burden in some areas.

Teri expressed concerns over capacity for local public health departments to do this work if it is unfunded. Eva shared that the Early Learning Council is looking for similar funding. Royce suggested that we align our work to maximize funding.

Rebecca stated that sharing who is accountable for what outcomes would be very helpful from an outside perspective.

Jen said that if this work can also support early childhood interventions it would also be taking an upstream approach.

Bob asked how OHA plans to implement this work on the non-Medicaid side. Royce said OHA plans to partner with the Department of Consumer and Business Services to look at private insurance.

Akiko asked if the Behavioral Health Collaborative has looked at metrics similar to public health modernization. Royce said yes, they have just started a work group to create a menu of behavioral health metrics to present to the Metrics and Scoring Committee.

Lillian said she will make sure to give Royce suggestions on how his slides can reflect the role of public health. She also asked the PHAB for patience in this work as it is incredibly complex and involves many stakeholders.

Katrina asked if there is any overlap between behavioral health and addictions and substance use in the collaborative. Royce said this overlap is mentioned several times within the collaborative. Unfortunately most resources are not allocated toward prevention and upstream approaches. Substance use and addiction are rolled into the definition of behavioral health.

Teri asked about the level of involvement with the Association of Community Mental Health Programs (AOCMHP) and CCO partners. Royce has communicated this information to the CCOs. AOCMHP has been involved in the governance and finance workgroups and there have been monthly meetings. Lillian said ongoing information will be shared out through OHA's Health Administrator listserv.

PHAB positions in 2018
Jeff Luck, PHAB Chair

PHAB chair and co-chair positions would be two-year terms, effective January of each even-numbered year assuming the terms are completed.

Jeff would like to step down from the chair role at the end of his term. Rebecca Pawlak has been nominated as chair and Carrie Brogoitti has been nominated as co-chair.

All in favor for Rebecca Pawlak as chair and Carrie Brogoitti as co-chair for the PHAB. None opposed.

Cara reviewed membership and 2018 work plans for the PHAB subcommittees. If you are interested in joining the Incentives and Funding and/or the Accountability Metrics subcommittee(s) for the PHAB please contact Cara. Roles and responsibilities are outlined here.

PHAB bylaws
Cara Biddlecom, Oregon Health Authority

Cara walked PHAB members through the November 2017 draft of the PHAB bylaws.

Comments: PHAB members would like to add in requirement for training in Article III. No other proposed changes. The bylaws were moved forward for adoption with this change. All in favor.

Preventive Health and Health Services Block Grant Evaluation Framework
Danna Drum, Oregon Health Authority

Danna Drum (by phone) shared the CDC Block Grant Evaluation Framework, which may be of interest to PHAB in that it aims to measure investments made that are flexible in nature. For example, the local public health modernization investment was made in communicable disease broadly; local public health authorities were able to identify what disease(s) or condition(s) they wanted to focus on based on local needs. Danna explored the applicability of this work to Oregon's public health modernization effort.

Bob asked how much money is this for Oregon. Danna said it is about $1.1M dollars.

Rebecca said this work is very similar to conversations she is having on the healthcare side around flexible funds and measuring value.

Jeff asked Danna to share Oregon's evaluation responses.

Accountability metrics updates
Sara Beaudrault, Oregon Health Authority
Jeff Luck, PHAB Chair

Jeff presented the PHAB outcome measures to the Health Plan Quality Metrics Committee. This follows the PHAB discussion with Shaun Parkman in September where PHAB members identified the importance of this committee's work in identifying upstream population health measures. The Health Plan Quality Metrics Committee is responsible for setting the pool of incentive measures to be used by all public health plans in the state, so it functions differently than the Metrics and Scoring Committee, which will choose from this pool of measures exactly what CCOs are responsible for improving on over the course of a year.

Rebecca asked for more clarification around what Jeff means by health plan. Jeff answered that the measures could be used as incentives for Medicaid, PEBB and OEBB plans.

Teri expressed concern about language where local public health and CCOs are "encourage[d] to partner" because there is no funding tied to it.

Sara shared a summary of adopted local public health process measures. Sara anticipates she will bring back additional process measures for the PHAB to review in January. OHA has also been working with local public health authorities through CLHO to identify the existing funding that we do have that lines up with these areas. Myde Boles from OHA is collecting data for all of these metrics and is working to set the benchmarks and operationalize these measures. These tasks are working toward the first public health accountability metrics report. The report should be available early 2018.

Action plan for health debrief and next steps
Jeff Luck, PHAB Chair

Jeff led the PHAB in a conversation about the PHAB's priorities for public health work with CCOs. The PHAB will be providing an update to the Oregon Health Policy Board on December 5.

PHAB members discussed the option of doubling incentives for CCOs if they meet a metric and collaborate with local public health. Eva asked what measurement of a partnership would look like. Teri explained that the community health assessment is the only partnership in current CCO contracts.

Bob made the following suggestions:

Suggested contract requirement	Background
CCOs must contract with and support LPHA clinical activities, including reproductive health and immunizations, at terms that are not worse than those terms offered to other providers	Some LPHAs have had difficulty entering into a contract with CCOs. In other cases, their contracts with the LPHAs are not equal to those of other providers in the community.
CCOs must support public health during a public health emergency, such as a mass vaccination effort	During the mass vaccination effort for Meningitis B, the CCOs were critical in reimbursement for vaccine costs among their members.
CCOs must pay for specialty clinical services for its members, including STD services and TB	CCOs have sometimes denied payment for services provided to their members because they assume that the LPHA will pick up all costs, such as nursing visits for direct observed therapy and medications for TB.
CCOs must require that immunization providers enter data into ALERT	There is no current requirement, impeding our ability to gather accurate immunization histories.
CCOs must be required to have public health representation on both the governing board and community advisory committees.	This has been very variable, but without a requirement, public health has not been included.
CCOs must include public health on their governing board and community advisory council	This has been variable, but it is critical to have a public health perspective on the CCO governing board.
CCOs must support the state public health lab	Some CCOs have made contracts for outside laboratory services and have excluded the state public health lab.
CCOs must share the incentive pools with public health for the part that public health plays in meeting their metrics.	Public health plays a pivotal role in the achievement of some measures, including contraceptive care and immunizations, but does not benefit from incentive payments. For example, if public health provides 40% of the immunizations in a community, they should be eligible for up to 40% of the incentive.

Action Item: Jeff to synthesize PHAB feedback and put into his December 5 presentation.

Public Comment Period

No public testimony was provided.

Closing
The meeting was adjourned.

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

January 18, 2018
2-5 PM
Portland State Office Building
800 NE Oregon St Room 1E
Portland, OR 97232

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

Public health modernization regional partnership grantees
December 2017

For the 2017-19 biennium, the Oregon legislature made an initial investment of $5 million for modernizing Oregon's public health system.

In September 2017, Oregon Health Authority issued a Request for Proposals to local public health authorities to establish regional communicable disease control programs. The primary objectives of the funding is to:

1. Develop regional systems for communicable disease (CD) control;
2. Emphasize the elimination of communicable disease-related health disparities; and
3. Build sustainable regional infrastructure for new models of public health service delivery.

In November 2017, Oregon Health Authority awarded $3.9 million to the following regions for the period of December 1, 2017-June 30, 2019:

Clatsop, Columbia and Tillamook counties	• Convene partners to assess regional data on sexually transmitted infections and develop priorities; • Identify vulnerable populations and develop regional strategies to address Population-specific needs.

Deschutes, Crook and Jefferson counties; St. Charles Health System; Central Oregon Health Council	• Form the Central Oregon Outbreak Prevention, Surveillance and Response Team which will improve:
	  • CD outbreak coordination, prevention and response in the region;
	  • CD surveillance practices;
	  • CD risk communication to health care providers, partners and the public.
	• Funds will be directed to CD prevention and control among vulnerable older adults living in institutional settings and young children receiving care in child care centers with high exemption rates.

Douglas, Coos and Curry counties; Coquille and Cow Creek Tribes; Western Oregon Advanced Health CCO	• Improve and standardize mandatory CD reporting. • Implement strategies for improving two year-old immunization rates. • Focus on those living in high poverty communities.
Jackson and Klamath counties; Southern Oregon Regional Health Equity Coalition; Klamath Regional Health Equity Coalition	• Work with regional health equity coalitions and community partners to respond to and prevent sexually transmitted infections and Hepatitis C, focused on reducing health disparities and building community relationships and resources. • Promote HPV vaccination as an asset in cancer prevention.

Lane, Benton, Lincoln and Linn counties; Oregon State University	• Establish a learning laboratory to facilitate cross-county information exchange and continuous learning.
	• Implement an evidence-based quality improvement program (AFIX) to increase immunization rates.
	• Pilot three local vaccination projects:
	  • Hepatitis A vaccination among unhoused people in Linn and Benton counties;
	  • HPV vaccination among adolescents attending school-based health centers in Lincoln County;
	  • Pneumococcal vaccination among hospital discharge patients in Lane County.
	• Establish an Academic Health Department model with Oregon State University to extend public health capacity and support evaluation.

Marion and Polk counties; Willamette Valley Community Health CCO	• Focus on system coordination and disease- and population-specific interventions to control the spread of gonorrhea and chlamydia. • Increase HPV immunization rates among adolescents.
North Central Public Health District; Baker, Grant, Harney, Hood River, Lake, Malheur, Morrow, Umatilla, Union, Wallowa and Wheeler counties; Eastern Oregon CCO; Mid-Columbia Health Advocates	• Establish a regional epidemiology team. • Create regional policy for gonorrhea interventions. • Engage community-based organizations to decrease gonorrhea rates through shared education and targeted interventions.

Washington, Clackamas and Multnomah counties; Oregon Health Equity Alliance	• Develop an interdisciplinary and cross-jurisdictional communicable disease team. This team will focus on developing and strengthening surveillance and communications systems to facilitate the timely collection of information and data, create surge capacity and communicate about outbreaks.
	• With leadership and guidance from the Oregon Health Equity Alliance, this cross-jurisdictional team will develop culturally responsive strategies that:
	  • Identify and engage at-risk communities.
	  • Reduce barriers (e.g., language, stigma, access to care) to infectious disease control, prevention and response.
	• Both qualitative and quantitative evaluation methods are included in the overall design. Evaluation results will guide implementation of best practices across the region focused on reducing and eliminating the spread of communicable diseases.

OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 14

STANDARDS FOR STATE AND LOCAL PUBLIC HEALTH AUTHORITIES

333-014-0510
Definitions
As used in OAR chapter 333, division 14:
(1) "Accountability metrics" means the public health system performance measures established by the Public Health Advisory Board under ORS 431.123.
(2) "Authority" means the Oregon Health Authority.
(3) "Base funds" means state funds appropriated by the Legislature to the Authority and distributed to local public health authorities through the funding formula established in ORS 431.380(1)(a) for applying the foundational capabilities and implementing the foundational programs.
(4) "Enforcement" means an action taken to compel the requirements of the law.
(5) "Financial assistance agreement" or (FAA) means the contract entered into between the Authority and a local public health authority through which base funds and other funds are distributed to local public health authorities and which details the work a local public health authority is required to perform in consideration of those funds.
(6) "Foundational capability" has the meaning given that term in ORS 431.003 and includes each capability established under ORS 431.131.
(7) "Foundational program" has the meaning given that term in ORS 431.003 and includes but is not limited to each program established under ORS 431.141.
(8) "Governing body of a local public health authority" has the meaning given that term in ORS 431.003.
(9) "Local public health administrator" has the meaning given that term in ORS 431.003.
(10) "Local public health authority" has the meaning given that term in ORS 431.003.
(11) "Person" has the meaning given that term in ORS 174.100.
(12) "Public Health Advisory Board (PHAB)" means the body established under ORS 431.122 for the purpose of advising and making recommendations to the Authority and the Oregon Health Policy Board.
(13) "Public health law" has the meaning given that term in ORS 431A.005.
Stat. Auth.: ORS 413.042, 431.149
Stats. Implemented: ORS 431.001 to 431.550

333-014-0520
Local Public Health Administrators
(1) An individual appointed by a local public health authority to be the local public health administrator should have the following qualifications:
(a) A bachelor’s degree; and

(b) Public health work experience and education that demonstrates competencies in the foundational programs as defined by ORS 431.141 and foundational capabilities as defined by ORS 431.131.
(2) Upon appointment of a local public health administrator a local public health authority must provide notice of the appointment to the Authority along with a copy of the administrator's resume or curriculum vitae.
(3) A local public health authority shall employ, full-time, a local public health administrator unless the Authority approves a local public health authority's request to permit the administrator to work less than full time. To seek approval for a less than full-time local public health administrator the governing body of a local public health authority must submit, in writing, a request for approval to the State Public Health Director with the following information:
(a) The number of hours per week the local public health authority intends the administrator to work; and
(b) How the administrator, if working less than full-time, can fulfill the requirements in ORS 431.418(3).
(4) The Authority will inform the local public health authority in writing whether the request to have a less than full-time administrator is approved or denied and the decision will be based on whether the Authority determines that the administrator can fulfill the requirements in ORS 431.418(3) working less than full-time.
Stat. Auth.: ORS 431.149
Stats. Implemented: ORS 431.170, 431.418

333-014-0530
Incentives and Matching Funds
(1) To the extent funds, above the base funds, are available, the Authority will make incentive and matching funds available to a local public health authority in accordance with ORS 431.380(1)(b) and (c).
(2) Incentive funds may be awarded based on data that show achievement of benchmarks or improvement targets for accountability metrics.
(3) Matching funds may be awarded to a local public health authority that invests in local public health activities and services above the base funding.
(4) The Authority will review the accountability metrics data and local public health expenditures data submitted in accordance with OAR 333-014-0540 when making decisions regarding the award of incentives or matching funds. The data will be used to determine if the benchmarks, as recommended by PHAB, in the accountability metrics have been achieved, and the extent to which a local public health authority has invested in local public health activities and services.
(5) Based on the information provided pursuant to section (4) of this rule, if funding is available, the Authority will include any incentives or matching funds in the FAA or other agreements.
Stat. Auth.: ORS 431.149
Stats. Implemented: ORS 431.170, 431.418

333-014-0540
Accountability Metrics
(1) The Authority will consult with the PHAB as necessary to identify, update and apply accountability metrics related to the distribution of incentive and matching funds.

(2) Local public health authorities will be consulted through the Conference of Local Health Officials (CLHO) on:
(a) Proposed changes to accountability metrics; and
(b) On the time, form and manner for reporting actual expenditure data and accountability metrics data to the Authority.
(3) Local public health authorities will be notified of changes and updates to the accountability metrics when finalized by the PHAB.
(4) Local public health authorities are required to report actual expenditure data and accountability metrics data if the primary data available to report is by the local public health authority, annually in a time, form and manner prescribed by the Authority, with consultation by the Conference of Local Health Officials, once the accountability metrics are finalized.
Stat. Auth.: ORS 431.149
Stats. Implemented: ORS 431.380

333-014-0550
Local Public Health Authority Statutory Responsibilities
(1) The following are activities that Oregon law specifically requires a local public health authority to perform:
(a) Accepting reports of reportable disease, disease outbreak or epidemics and investigating reportable diseases, disease outbreaks, or epidemics under ORS 433.004 and 433.006.
(b) Issuing or petitioning for isolation and quarantine orders under ORS 433.121 to 433.142 as necessary to protect the public's health.
(c) Review of immunization records and issuing exclusion orders under ORS 433.267.
(d) Making immunizations available under ORS 433.269.
(e) Duties and activities related to enforcing the Indoor Clean Air Act under ORS 433.875, if delegated by the Authority.
(f) Ensuring access to family planning and birth control services under ORS 435.205.
(g) Licensure of tourist accommodations, including hostels, picnic parks, recreation parks and organizational camps under ORS 446.310 to 446.350, if delegated by the Authority.
(h) Licensure of pools and spas under ORS 448.005 to 448.100, if delegated by the Authority.
(i) Restaurant licensure, including commissaries, mobile units, vending machines and bed and breakfasts under ORS 624.310 to 624.430, if delegated by the Authority.
(j) Regulation of public water systems under ORS 448.115 to 448.285, if delegated by the Authority.
(k) Enforcement of public health laws under ORS 431.150.
(l) The duties specified in ORS 431.413.
(2) Nothing in this rule is intended to prohibit a local public health authority from contracting with a person to perform a public health service or activity, or to perform all public health services and activities that the local public health authority is required to perform under ORS 431.001 to 431.550 and 431.990, or under any other public health law of this state, in accordance with OAR 333-014-0560, except that the person with whom the local public health authority contracts may not perform any function, duty or power of the local public health authority related to governance, as that is described in OAR 333-014-0580.
Stat. Auth.: ORS 431.141
Stats. Implemented: ORS 431.141 to 431.145

333-014-0560
Foundational Capabilities and Programs; Prioritization
(1) To the extent that funding is available, a local public health authority should implement the local foundational capabilities and the local foundational programs described as the local roles and deliverables in the Public Health Modernization Manual, available on the Authority's website
at: http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf.
(2) The FAA, or other agreements, will describe more specifically the duties and activities that are to be performed in order to carry out the local foundational programs and foundational capabilities.
(3) The Authority will consult with PHAB, as necessary, on priorities for foundational programs in ORS 431.141 and foundational capabilities in ORS 431.131.
Stat. Auth.: ORS 431.149
Stats. Implemented: ORS 431.380, 431.413

333-014-0570
Local Public Health Authority Contracts or Agreements for Local Public Health Services or Activities
(1) As provided in ORS 431.413(3), a local public health authority may contract with a person to perform a public health service or activity, or to perform all public health services and activities, that the local public health authority is required to perform under ORS 431.001 to 431.550 and 431.990 or under any other public health law of this state, except that the person with whom the local public health authority contracts may not perform any function, duty or power of the local public health authority related to governance.
(2) A local public health authority must provide written notice to the Authority at least 75 days prior to executing a new contract or agreement with a person or public body for the provision of local public health services or activities, if the local public health authority is performing the public health service or activity pursuant to a contract or agreement with the Authority, unless the local public health authority is specifically exempted from complying with this notice provision in the contract or agreement with the Authority. Contracts, subcontracts or agreements that apply to administrative contracts or contracts that do not have a direct impact on consumers of public health services or activities are excluded from the requirements in this section.
(3) Upon receipt of a notice under section (2) of this rule, the Authority may request a copy of the contract or agreement from the local public health authority for review.
(4) A local public health authority contract or intergovernmental agreement to perform a public health service or activity must clearly describe the service or activity being performed, any applicable federal or state statutes or rules, or local ordinances that are applicable to the service or activity, and the manner in which the local public health authority will oversee and monitor the contractor or public body to ensure compliance with all applicable federal or state statutes or rules, local ordinances or other funding requirements as outlined in the FAA or other agreements.
(5) If a local public health authority is unable, for reasons outside of its control, to provide the 75 day notice as required by section (2) of this rule, the local public health authority shall provide notice as soon as possible before or after the execution of the contract or agreement.
(6) The 75 day notice required in section (2) of this rule does not to apply to a contract if the procurement activities began prior to January 1, 2018.

Stat. Auth.: ORS 431.149
Stats. Implemented: ORS 431.413

333-014-0580
Local Public Health Authority Governance
As provided in ORS 431.413(3) and ORS 190.110, a local public health authority may contract or enter into an agreement with an entity to perform public health services or activities but that entity may not perform any function, duty or power of the local public health authority related to governance. Functions, duties and powers related to governance include but are not limited to:
(1) The exercise of any police power.
(2) Any duty of the governing body of a local public health authority under ORS 431.415.
(3) Enforcement of public health laws, including but not limited to taking an action on a license or permit as described in ORS 431.150.
(4) Ensuring due process for persons with due process rights.
(5) Issuing any order authorized under ORS 431A.010 or ORS chapter 433.
(6) Imposing civil penalties.
(7) Compelling the production of records during a disease outbreak investigation.
(8) Petitioning the court for an isolation or quarantine order under ORS 433.121 to 433.142.
(9) Taking any action authorized during a declared public health emergency under ORS 433.441.
Stat. Auth.: ORS 431.149
Stats. Implemented: ORS 431.413

333-014-0590
Request to Transfer Local Public Health Authority
(1) If the Authority does not receive state monies in an amount that equals or exceeds the estimate that the Authority submitted to the Legislative Fiscal Office under ORS 431.380(2), the governing body of a local public health authority may adopt an ordinance transferring to the Authority the responsibility for fulfilling the local public health authority's duties under ORS 431.001 to 431.550 and 431.990 and the other public health laws of this state.
(2) An ordinance adopted under section (1) of this rule must transfer all local public health authority duties under ORS 431.001 to 431.550 and 431.990 and under other public health laws of this state.
(3) Within two business days from the date the ordinance was adopted under section (1) of this rule, the local public health authority must inform the state Public Health Director in writing and provide a copy of the ordinance.
(4) The transfer of duties from a local public health authority to the Authority takes effect no sooner than 180 days after the date the ordinance was adopted.
(5) A local public health authority must continue to comply, until the date of transfer, with any contract or agreement it has with the Authority that concerns any of the services or activities required by a local public health authority under these rules or under any other public health law of this state including but not limited to the FAA, or other agreements, unless:
(a) The Authority authorizes a termination of a contract or agreement at an earlier date; or
(b) The contract or agreement is terminated in accordance with the terms of the contract or agreement.

(6) The local public health authority must provide notice to the Authority, in accordance with the termination provisions of any contract or agreement for local public health services or activities prior to the final transfer of responsibility from the local public health authority to the Authority.
(7) If a local public health authority revokes an ordinance adopted under section (1) of this rule the Authority will work with the local public health authority on a transition plan for the transfer of responsibilities back to the local public health authority, on a schedule agreed upon by the Authority and the local public health authority. Nothing in this section is intended to require the Authority to provide funding to the local public health authority at the same level that had been previously provided to the local public health authority prior to the transfer, nor terminate any contract or agreement that is in place for the provision of local public health services or activities within the local public health authority's jurisdiction before the agreed upon term of the contract or agreement.
Stat. Auth.: ORS 413.042 & 431.149
Stats. Implemented: ORS 431.382

January 8, 2018

DRAFT: Public Health Advisory Board Initial CCO 2.0 Recommendations

Background

In September 2017, the Oregon Public Health Advisory Board (PHAB) adopted guiding principles for how health care and public health can partner to achieve maximum impact on health outcomes.[1]

PHAB, as a committee of the Oregon Health Policy Board, used the categories of shared work in the guiding principles to make some initial recommendations for public health-related concepts that can be included in the next coordinated care organization (CCO) contract period.

Recommendations

Leadership and governance
1. Require a local public health authority (LPHA) voting member position on the CCO governing board.
2. Require a CCO voting member position on the LPHA advisory committee, when a LPHA has an advisory committee.
3. Include LPHAs in value-based payment strategies, including sharing payments for public health contribution towards incentive measures (e.g., tobacco and immunizations).

Aligned metrics and data
4. Align CCO incentive measures with population health priorities, to the extent feasible.

Community health assessments and community health improvement plans
5. Require CCOs to develop shared community health assessments and community health improvement plans with LPHAs and hospitals. Require the use of community health assessment and community health improvement planning tools that meet requirements for LPHAs and hospitals.
6. Require CCOs to invest in community health improvement plan implementation.

Access to care
7. Support response to public health emergencies, such as participating in regional health care coalitions.
8. Include the Oregon State Public Health Laboratory as an in-network provider for CCOs.
9. Fully reimburse LPHAs for the provision of clinical services, including family planning, sexually transmitted infection treatment and contact tracing, and immunizations.

[1] Oregon Public Health Advisory Board. (2017). Guiding principles for public health and health care collaboration. Available at http://www.oregon.gov/oha/PH/ABOUT/Documents/phab/PHAB-guiding-principles-ph-and-health-care.pdf.

Current status

The table below articulates any existing CCO contract or statutory requirements related to each PHAB recommendation.

PHAB recommendation	**Existing requirements, if applicable**
1. Require a LPHA voting member position on the CCO governing board.	No existing requirement. ORS 414.625 requires that each CCO has a governing body that includes: persons that share in the financial risk of the organization who must constitute a majority of the governing body; the major components of the health care delivery system; at least two health care providers in active practice, including a primary care physician or a nurse practitioner and a mental health or chemical dependency treatment provider; at least two members from the community at large; and at least one member of the community advisory council. ORS 414.627 requires CCOs to include representatives of each county government served by the CCO on the community advisory council.
2. Require a CCO voting member position on the LPHA advisory committee, when a LPHA has an advisory committee.	Requirements for LPHA advisory committee membership vary by jurisdiction.
3. Include LPHAs in value-based payment strategies, including sharing payments for public health contribution towards incentive measures.	No existing requirement.
4. Align CCO incentive measures with population health priorities, to the extent feasible.	Statute requires a general measurement focus on health outcomes and quality. ORS 414.638 requires the Metrics and Scoring Committee to adjust CCO measures annually to reflect community health assessments.
5. Require CCOs to develop shared community health assessments and community health improvement plans with LPHAs and hospitals. Require the use of community health assessment and community health improvement planning tools that meet requirements for LPHAs and hospitals.	ORS 414.629 requires CCOs to involve county public health administrators in their community health improvement plan. Evidence-based planning tools are informally provided as a best practice to CCOs.
6. Require CCOs to invest in community health improvement plan implementation.	No existing requirement. The 2017-2022 1115 Medicaid demonstration waiver aims to increase use of health-related services, which includes community-level interventions focused on improving population health.

7. Support response to public health emergencies, such as participating in regional health care coalitions.	No existing requirement for CCOs. However, legislative recommendations submitted on behalf of the HB 3276 Task Force in October 2017 call for CCOs to cover necessary vaccines and antidotes for disease outbreaks, epidemics and conditions of public health importance, regardless of in-network status.[2]
8. Include the Oregon State Public Health Laboratory as an in-network provider for CCOs.	No existing requirement.
9. Fully reimburse LPHAs for the provision of clinical services, including family planning, sexually transmitted infection treatment and contact tracing, and immunizations.	No existing requirement related to payment relative to other providers. ORS 414.153 allows OHA to require and approve agreements between CCOs and LPHAs for authorization of payment for point of contact services.

For more information

Contact publichealth.policy@state.or.us or visit healthoregon.org/phab.

[2] Oregon Health Authority. (2017). House Bill 3276 task force report: Recommendations for the Oregon legislature. Available at http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/RULESLAWS/Documents/HB3276TaskForceRpt.pdf.

Public Health Advisory Board
2018 work plan - draft

Key to workplan symbols

★ = The Board will receive an update and provide feedback

⭘ = The Board will make a decision or recommendation, including but not limited to formal votes

♦ = The Board will complete a deliverable

Topic		Month												
		January	February	March	April	May	June	July	August	September	October	November	December	January '19
statewide public health policies and goals	**PHAB 2018 work plan, charter and bylaws**	★	⭘					★	Decision needed regarding whether to cancel the August 2018 meeting				Decision needed regarding whether to cancel the December 2018 meeting	
	OHPB policy priorities: Action Plan for Health and CCO 2.0		★		★		★			★		★		
	Achieving health equity					★	⭘							★
public health modernization	**Modernization implementation updates**	★	★	★	★	★	★	★		★	★	★		★
	Public health accountability metrics		★	♦						⭘				
	Local public health funding formula			★	★	♦	★							
	Regional partnerships		★			★								★
	Coalition of Local Health Officials AIMHI grant			★										
PHAB oversight	**State Health Assessment**		★	★										
	State Health Improvement Plan	★			★			★			★			
	Preventive Health and Health Services Block Grant			★	★									

	Topic	Purpose	Decisions, deliverables and agenda topics
statewide public health policies and goals	**PHAB 2017 work plan and charter**	Review and approve work plan for 2018	January: review draft work plan. February: approve work plan. July: mid- year review of work plan
	OHPB policy priorities: Action Plan for Health and CCO 2.0	Ensure PHAB members are aware of statewide strategies wth potential impacts to the public health system. Understand PHAB's connection to strategies in Oregon's Action Plan for Health and CCO 2.0. Provide input to statewide priorities.	Bi-monthly updates and discussion.
	Achieving health equity	Understand the Board's role to advance health equity; provide guidance for the public health system's approach to health equity	May: hear from modernization grantees about engagement of vulnerable populations for developing regional strategies for communicable disease control. June: review and update PHAB health equity policy. : January '19: hear from modernization grantees about regional health equity reviews and action plans. Additional topics to add may include updates and discussion with the OHA Office of Equity and Inclusion, the OHPB health equity committee and the PHD Health Equity Workgroup.
public health modernization	**Modernization implementation updates**	Provide regular updates on public health modernization, including progress made on the statewide public health modernization plan	Topics in the first half of 2018 may include statewide public health modernization plan progress report, evaluation and communications.
	Public health accountability metrics	Use public health accountability metrics to track progress toward improved health outcomes through a modern public health system.	February/March: review and approve accountability metrics report. September: discuss whether changes to metrics are needed for 2019-21.
	Local public health funding formula	Provide recommendations to OHA on the development of the local public health funding formula, including a mechanism for awarding matching funds and incentive payments, approve report to LFO.	March and April: receive updates and provide feedback to Incentives and Funding subcommittee. May: review and approve funding formula. June: review report to Legislative Fiscal Office.
	Regional partnerships	Receive updates on regional partnership grantees, provide recommendations for statewide approaches to support regional partnerships.	February: Hear about grantee evaluation and technical assistance. May: discuss in person learning collaborative and hear from modernization grantees about engagement of vulnerable populations for developing regional strategies for communicable disease control. January '19: hear from modernization grantees about regional health equity reviews and action plans.
	Coalition of Local Health Officials AIMHI grant	Receive updates on grant activities and deliverables.	March: Receive final grant update, including deliverables for tools and technical assistance.
PHAB oversight	**State Health Assessment**	Provide oversight for OHA's state health assessment	February and March: receive update on state health assessment. March: review final assessment report.
	SHIP deep dive	Receive update on progress toward achieving SHIP priorities. Provide guidance for overcoming barriers.	Quarterly updates as follows: Jan=obesity and substance use; April=communicable disease and immunizations; July=tobacco and suicide; October=oral health
	Preventive Health and Health Services block grant	Review and provide guidance on PHHS block grant work plan	March: receive an overview of the Block Grant. April: discuss the Block Grant work plan and findings from the Block Grant public hearing.

PHAB subcommittees
Key tasks for 2018

Incentives and Funding
Meets the second Monday of each month from 1:00-2:00
Current membership: Jeff Luck, Akiko Saito, Alejandro Queral, Bob Danenhoffer, Carrie Brogoitti

Key tasks for January-June 2018

1. Review funding formula and make recommendations for changes for 2019-21
2. Review county expenditures data
3. Make recommendations for mechanisms to award incentive funds and matching payments
4. Consult as needed on other issues related to public health funding

Accountability Metrics
Meets the fourth Wednesday of each month from 1:00-2:00
Current membership: Muriel DeLaVergne-Brown, Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Jennifer Vines

Key tasks for January-June 2018

1. Provide recommendations for setting metrics bechmarks and targets
2. Review and provide recommendations for public health accountability metrics report
3. Continue to develop oral health metric
4. Maintain communication with Metrics and Scoring; seek opportunities to expand cross sector partnerships

Major task for July-December 2018

1. Consider whether changes are needed to accountability metrics for 2019-21

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
January 8, 2018
1:00-2:00 pm

Welcome and roll call

PHAB members present: Carrie Brogoitti, Bob Dannenhoffer, Jeff Luck, Akiko Saito

Oregon Health Authority (OHA) staff: Sara Beaudrault, Julia Hakes, Cara Biddlecom

Members of the public: Morgan Cowling

Subcommittee key tasks for 2018

Sara shared key tasks for the subcommittee in 2018.

Principles for public health funding

Sara shared a document that shows the 2017 funding principles used by the subcommittee and proposed 2018 funding principles for discussion.

Bob asked if the 2017 principles will be replaced by the 2018 principles or just added to. Sara clarified that the purpose is to capture key points and make sure everything is incorporated.

Akiko gave additional background on the 2017 principles: explaining that 2017's principles were created to make decisions about how a small investment from the legislature for public health modernization should be allocated. The 2018 principles are intended to be more general and could be applied whenever funding decisions for funding increases or decreases are needed.

Jeff asked who the intended audience for the principles are. Cara answered that the principles are for the PHAB to apply.

The subcommittee reviewed each 2018 principle and recommend changes.

Bob asked if 2018's funding principle #2: "Align funding with burden of disease and continuously assess how funds are allocated to burden of disease," makes sense for all public health programs. Cara made the recommendation to add

"risk" in addition to burden of disease to account for programs like environmental health or emergency preparedness.

Carrie said the principles don't express the balance of maintaining base capacity and infrastructure. Other members agreed that maintaining infrastructure where programs are functioning well and achieving successes should be accounted for in the principles. Cara suggested incorporating statutory language related to incentives and local investments. Subcommittee members made the recommendation to OHA staff to draft something for review at the next meeting.

Akiko recommended including a principle that specifically addresses supporting or incentivizing regional approaches to service provision.

Jeff asked for clarification on #5: "Improve transparency about funded work and state and local roles." Sara explained that it is intended to assure that at a basic level information is available about how local and state funding are used to support the public health system and achieve population health improvements.

Funding principles will be reviewed at the January 18 PHAB meeting.

Modernization funding formula

Sara walked subcommittee members through the local public health authority funding formula section from the Statewide Health Improvement Plan and reviewed components of the plan that will need to be reviewed and updated for 2019-21. PHAB will need to complete its revisions in May 2018, and the funding formula will be submitted to Legislative Fiscal Office In June.

Subcommittee business

Akiko will provide an update from the Subcommittee at the next PHAB meeting on January 18th.

Possible Subcommittee Chair appointment will be discussed at the next meeting in February.

Public Comment

No public testimony.

Public Health Advisory Board
Public health funding principles – preliminary, for discussion
January 18, 2018

The following set of public health funding principles were compiled from the following sources:

- PHAB Incentives and Funding subcommittee public health modernization funding formula (2016)
- PHAB and PHD/CLHO Joint Leadership Team guidance for allocating the 2017-19 legislative investment (Spring 2017)
- PHD/CLHO Joint Leadership Team funding principles discussion (December 2017)

These funding principles can be applied to increases or decreases in public health modernization funding and other state and local public health funding.

Public health system approach to foundational programs

1. Ensure services are available everywhere across Oregon, but not necessarily county by county.

2. Align funding with burden of disease and risk, while considering the impact to public health infrastructure.

3. Use funding to advance health equity in Oregon, which may include directing funds to areas of the state experiencing a disproportionate burden of disease or where health disparities exist.

4. Use funding to incentivize changes to the public health system intended to increase efficiency and improve health outcomes, which may include regional approaches to service provision.

Transparency of state and local roles:

5. Recognize the individual roles of state and local public health authorities to achieve outcomes.

6. Improve transparency about funded work and state and local roles.

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics Subcommittee meeting minutes

January 3, 2018

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

Oregon Health Authority staff: Sara Beaudrault, Cara Biddlecom, Myde Boles and Julia Hakes

Welcome and introductions
The November 22, 2017 meeting minutes were approved.

Effective contraceptive use

Sara shared feedback provided by Conference of Local Health Officials (CLHO) members on the effective contraceptive use process measure recommendations during their December 21, 2017 meeting.

Eli noted that option #2 could result in meaningless data from BRFSS and PRAMs for smaller counties. Eli stated that option #1 seems like what is naturally progressing in the field (new proposed program elements).

Myde shared that option #1 is challenging to create an incentive measure tied to funding for because it is a yes/no question.

Jen expressed concern that measuring unintended pregnancies puts focus on the individual rather than the system and does not have an equity-based lens. Teri noted that data show unintended pregnancy spans across socioeconomic status.

Eli said option #2 is a CCO measure which could create opportunity for additional partnership.

Sara shared that Oregon Health Authority has an Unintended Pregnancy Workgroup. She will have additional information to share about how the public health accountability metric aligns with the OHA Workgroup before the next PHAB Meeting.

Both process measures will be shared with PHAB on January 18. The goal is that PHAB will vote to adopt one.

Local public health process measure benchmarks and targets

Myde gave a presentation and shared data on the public health accountability metrics report and local public health process measure benchmarks and targets.

Eli asked how benchmarks are being set. Myde answered that in some areas there is an established benchmark, while in other areas PHD sections are making recommendations.

Eli made the recommendation to list counties in the metrics report from lowest to highest and asked that we standardize the way the graphs look. Myde clarified that graphs are still in draft form. Teri would like to see counties still listed in alphabetical order and clarified the differences between scope of work at the county and CCO level. Muriel agreed with Teri.

Myde reviewed the section for the Prescription Opioid Mortality Metric. Eli asked for clarification around what "top 20% of Top Opioid Prescribers Enrolled in PDMP" means. Myde clarified that top 20% includes all prescribers.

Subcommittee members provided suggestions for presenting data in the report, including use of rates and absolute numbers, and confidence intervals. Data sources and additional context for how the data for each measure are reported should be added. Myde noted that some data are suppressed due to small numbers.

Sara told the Subcommittee that OHA will continue to work on the metrics report. OHA uses many different data sources and data collection mechanisms. We will standardize to the extent we can but there will be variations in what is reported.

Myde reviewed a concept for applying benchmarks and improvement targets. Eli said benchmarks are used and vetted in the CCO work and suggested that we look at each measure and see where variability arises. Sara noted this will be discussed at the next Subcommittee meeting.

Eva asked how funding would work if an improvement target is not met. Sara clarified that the Incentives and Funding Subcommittee will work on a mechanism for awarding incentive funds. Failure to meet improvement targets would not affect base funding.

OHA's priorities for oral health

Amanda Peden gave a presentation on OHA Oral Health Priorities and Metrics.

Eva sked if there is an oral health element in well-child visits. Amanda said there are, like dental varnish. This can be captured but there are issues with under-reporting.

Amy Umphlett and Kelly Hansen gave a presentation about Accountability Metric: Dental Visits for Children 0-5: Review of public health data.

Sara stated that this subcommittee needs to determine whether we have a metric that meets the selection criteria set forth by the committee, and if it is possible to define the unique role of a local public health authority to make improvements in dental visits for 0-5 year olds. This will be on the agenda for the next meeting.

Teri and Muriel both noted that lack of funding for local public health programs is a huge issue and voiced that they would feel more comfortable with the accountability metrics when the system is fully funded.

Subcommittee business

Teri will be giving the Accountability Metrics Subcommittee update at the next PHAB meeting on January 18, 2018.

Public comment

No public comment was provided.

Adjournment

The meeting was adjourned.

The next Accountability Metrics Subcommittee meeting is scheduled for:

January 24, 2018 from 1-2 pm

Public Health Advisory Board
Effective contraceptive use process measure recommendations
January 18, 2018

Background: In October PHAB adopted a set of local public health process measures, but did not adopt the local public health process measure for effective contraceptive use that was recommended by the Accountability Metrics subcommittee. PHAB requested that the subcommittee do additional work to develop a process measure for effective contraceptive use.

Purpose: Review effective contraceptive use process measure recommendations and adopt a process measure.

Option	Public health accountability metric	Process measure recommendation	Data Sources	Considerations
#1	Effective contraceptive use among women at risk of unintended pregnancy *(This metric was adopted by PHAB, Oct 2017)*	Annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use	Accountability metric: Behavioral Risk Factor Surveillance System (BRFSS) Process measure: LPHA reporting[1]	This is a modification of the process measure that was reviewed but not adopted by PHAB in October. The original recommendation was *"Number of local policy strategies for increasing access to effective contraceptives".* Aligns with core system functions and deliverables for assuring access to clinical preventive services in the Public Health Modernization Manual (refer to handout on next page). An annual strategic plan is required under the revised Reproductive Health Program Element, which goes into effect July 1, 2018. LPHAs will receive funding to complete the strategic plan through the Program Element contract. This would be a yes/no measure. The PHD Reproductive Health program will define required criteria to be counted as a yes (i.e. completed needs assessment, stakeholder engagement, focus on disparities, plan to monitor implementation, etc). PHAB will need to consider how incentives could be awarded for a yes/no measure.
#2	Percent of pregnancies that are unintended	Effective contraceptive use among women at risk of pregnancy	Accountability metric: Pregnancy Risk Assessment Monitoring System (PRAMS) and Vital Statistics data	This accountability metric and process measure may better reflect what the public health system is attempting to achieve. Benefits to using effective contraceptive use as a local public health process measure that in the future may be tied to incentive payments to LPHAs:

[1] For areas where no established data collection system exists, each LPHA would be responsible for creating and supporting an internal mechanism to collect the data.

			Process measure: BRFSS	- Aligns with CCO incentive measure and encourages partnership with the health care system; - Allows each LPHA to define the barriers and appropriate strategies for the community. Challenges to using effective contraceptive use as a process measure that in the future may be tied to incentive payments to LPHAs: - Use of BRFSS data to produce county rates requires four- or five-year combined rates. Rates for very small counties would be suppressed. Difficult to see impact of interventions. - An LPHA on its own is unlikely to have a significant impact on effective contraceptive use rates, and should not be held accountable for work happening within the health care system.

Access to clinical preventive services

Vision: Ensure people in Oregon receive recommended clinical preventive services that are cost-effective.

Core system functions

The governmental public health system will:

a. Ensure ongoing planning with health care system partners, community members and organizations that represent members of priority populations to:

   i. Identify barriers to access and gaps in services;

   ii. Develop and implement strategic plans to address these gaps and barriers to care; and

   iii. Ensure access to effective clinical preventive services;

   iv. Identify opportunities to work together to improve population health.

b. Ensure access to clinical preventive services through provision or linkage to clinical preventive services to priority populations that may include youth and young adults, those not covered under federal programs because of citizenship status, and those who are historically not well-served by the health care system.

c. Recommend implementation of evidence-based clinical and community interventions for disease prevention, early detection and self-management.

d. Ensure access to laboratory services.

e. Provide data and information to health care providers, coalitions, decision-makers, legislators and other stakeholders to support health care planning.

f. Coordinate across the public health system to provide data and support planning efforts relevant to access to clinical services.

Public Health Modernization Implementation Evaluation

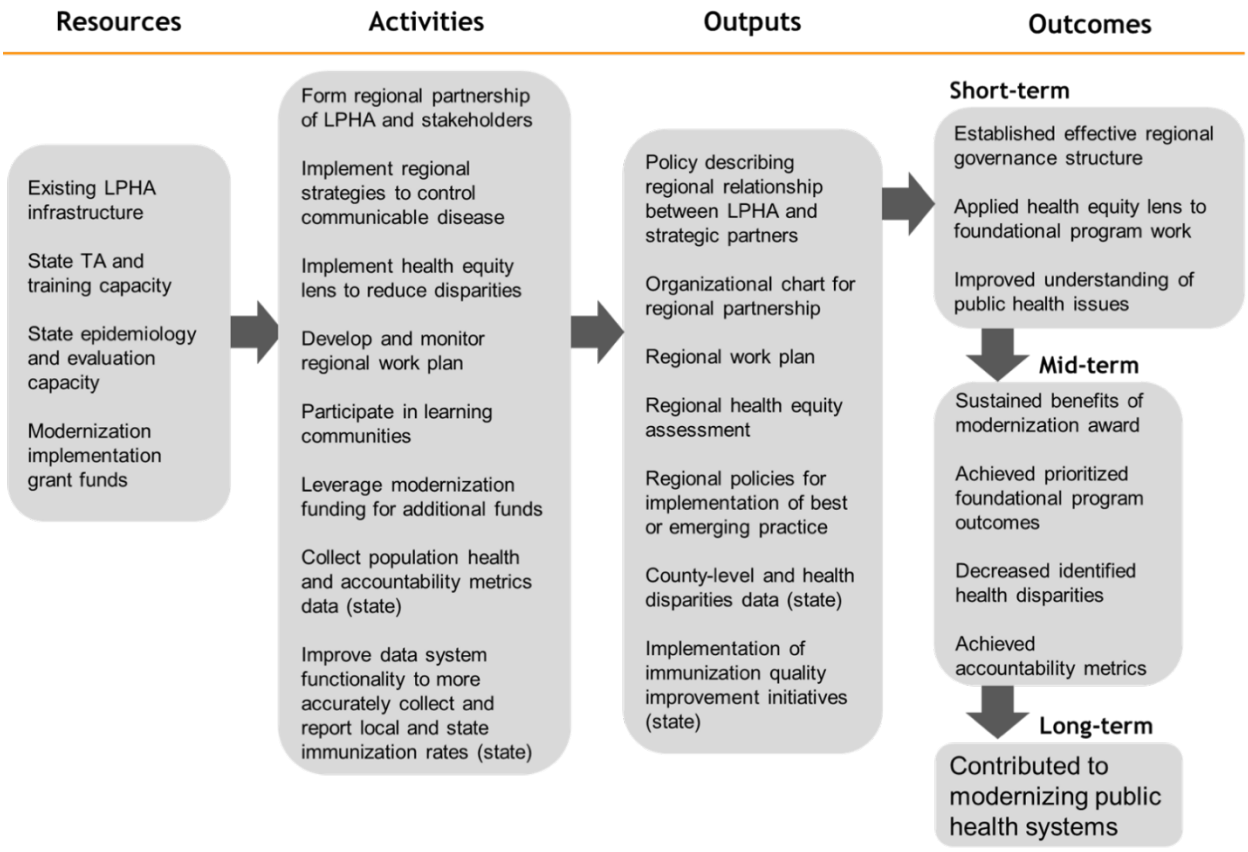
Public Health Advisory Board Meeting

January 18, 2018

Evaluation Purpose

To characterize the outcomes of a legislative investment in the governmental public health system to address communicable disease control and related health disparities.

Logic Model

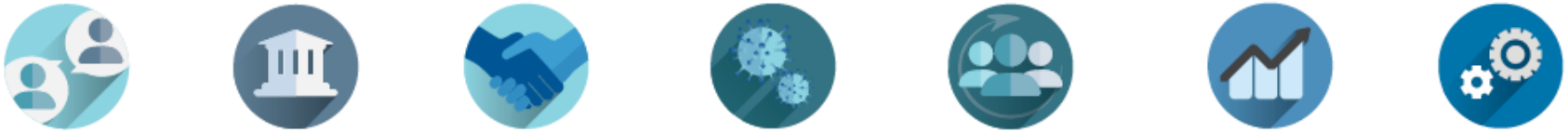


Evaluation Domains & Questions

Evaluation Domain	Evaluation Question
Use of resources	1. How has public health used funds to implement modernization?
	2. How have LPHAs with fewer resources or larger gaps benefited from regional partnerships?
Regional governance structure	3. What does the regional governance structure look like for each grantee?
	4. What are the strengths and challenges of the regional governance structure for modernization of communicable disease control?
Partnerships development & maintenance	5. What effect has modernization funding had on communicable disease partnerships?
	6. What role have partnerships served in implementing regional strategies to control CD?
Addressing disparities	7. What effect has modernization funding had on addressing communicable disease disparities?
Communicable disease outcomes	8. To what extent has modernization funding supported local public health in addressing priority CD outcomes?
Leveraging funds	9. How has modernization funding been leveraged to acquire additional funds for foundational program work and support foundational capabilities?
Sustainability	10. Which elements of the modernization award should be sustained after the funding period and at what cost?
Generalizability	11. To what extent can the regional funding model for communicable disease control be applied to other foundational programs?
State public health role	12. How has state public health supported grantees across evaluation domains?
	13. What are the strengths and challenges of state support to grantees?
	14. How has state public health used funds to implement state roles for modernization?

Public Health Modernization

Implementation Evaluation



Public Health Advisory Board Meeting

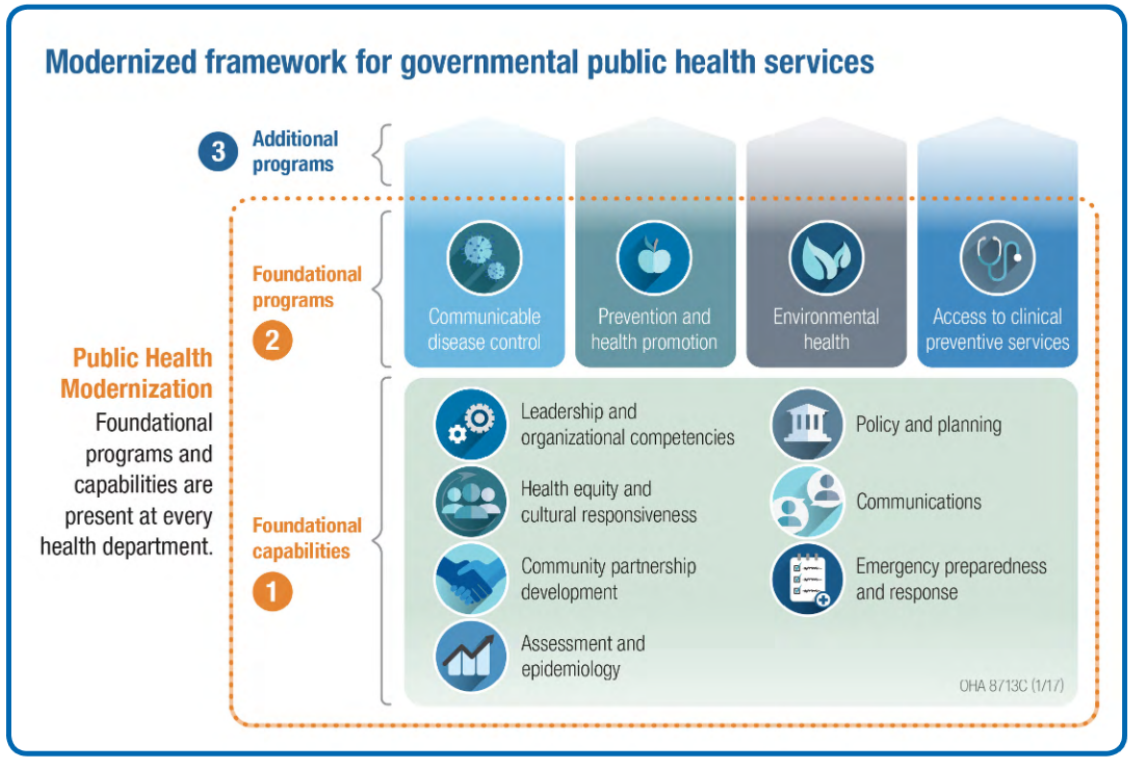
January 18, 2018

Oregon Health Authority

Agenda

1. Discuss evaluation process
2. Review evaluation questions
3. Review evaluation timeline

CDC Evaluation Framework



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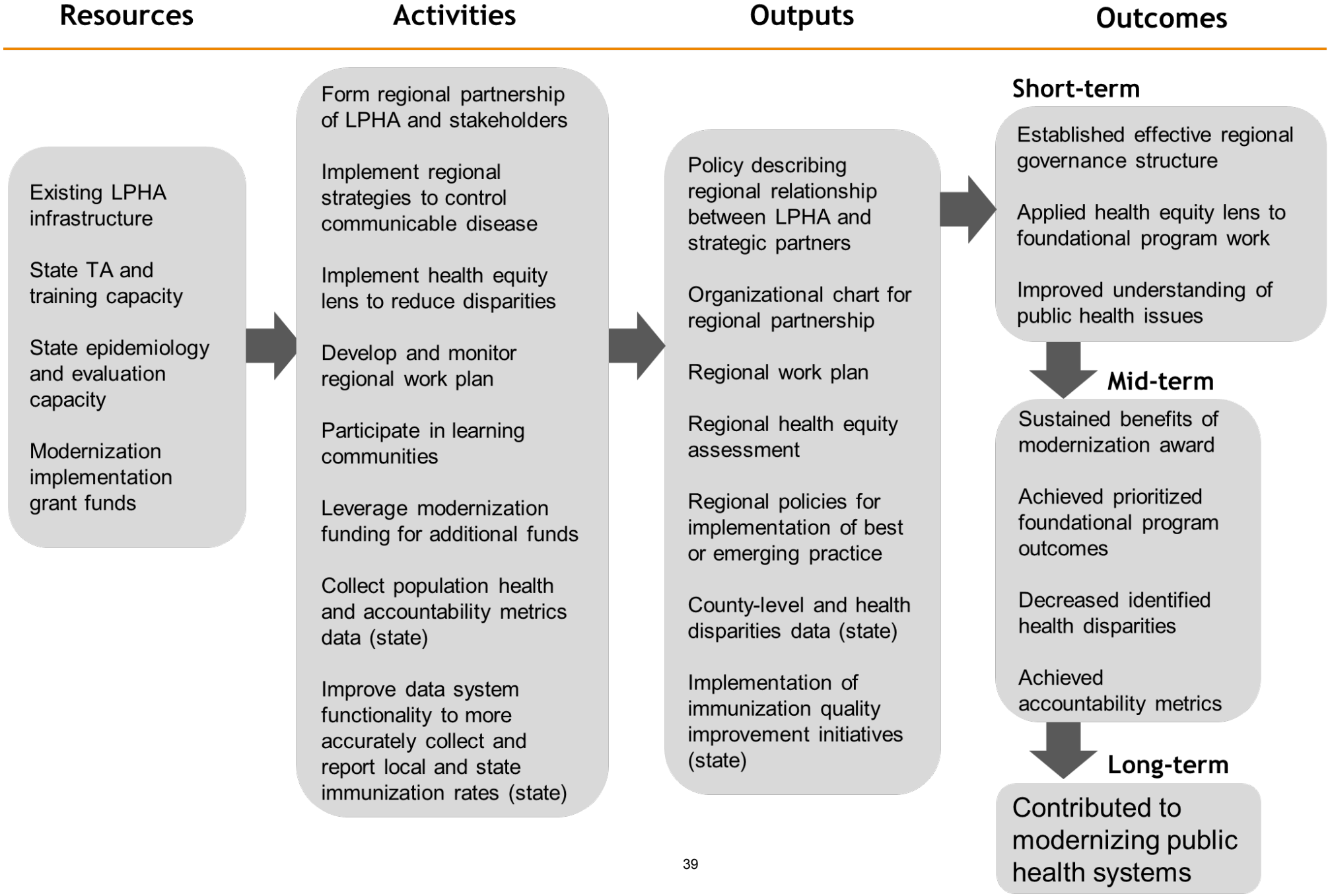
Resources
Activities
Outputs
Outcomes
Existing LPHA infrastructure
State TA and training capacity
State epidemiology and evaluation capacity
Modernization implementation grant funds
Form regional partnership of LPHA and stakeholders
Implement regional strategies to control communicable disease
Implement health equity lens to reduce disparities
Develop and monitor regional work plan
Participate in learning communities
Leverage modernization funding for additional funds
Collect population health and accountability metrics data (state)
Improve data system functionality to more accurately collect and report local and state immunization rates (state)
Policy describing regional relationship between LPHA and strategic partners
Organizational chart for regional partnership
Regional work plan
Regional health equity assessment
Regional policies for implementation of best or emerging practice
County-level and health disparities data (state)
Implementation of immunization quality improvement initiatives (state)
Short-term
Established effective regional governance structure
Applied health equity lens to foundational program work
Improved understanding of public health issues
Mid-term
Sustained benefits of modernization award
Achieved prioritized foundational program outcomes
Decreased identified health disparities
Achieved accountability metrics
Long-term
Contributed to modernizing public health systems

Evaluation Domains & Questions

Evaluation Domain	Evaluation Question
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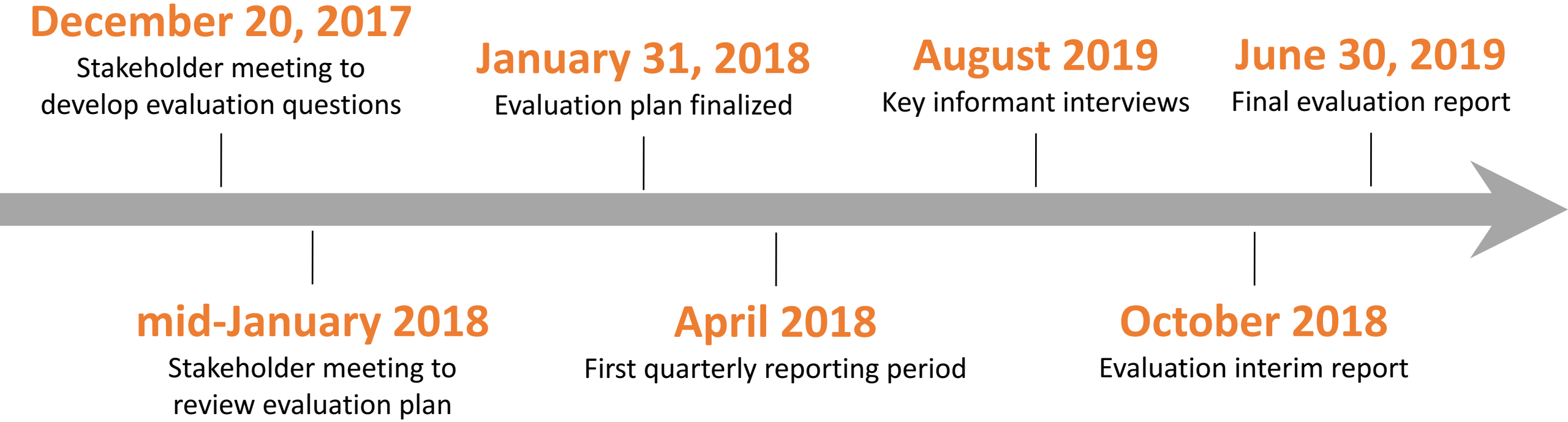
Evaluation timeline



Questions?
Comments?

State Health Improvement Plan

Reduce harms associated with alcohol and substance use &

Slow the increase of obesity

Reduce the harms associated with alcohol and substance use

Oregon Health Authority

Key Questions

- What **health equity issues** do you see associated with alcohol and other substance use?

- How can we develop **shared ownership** of this issue across the behavioral health, public health and primary care sectors – both on the state and local levels?

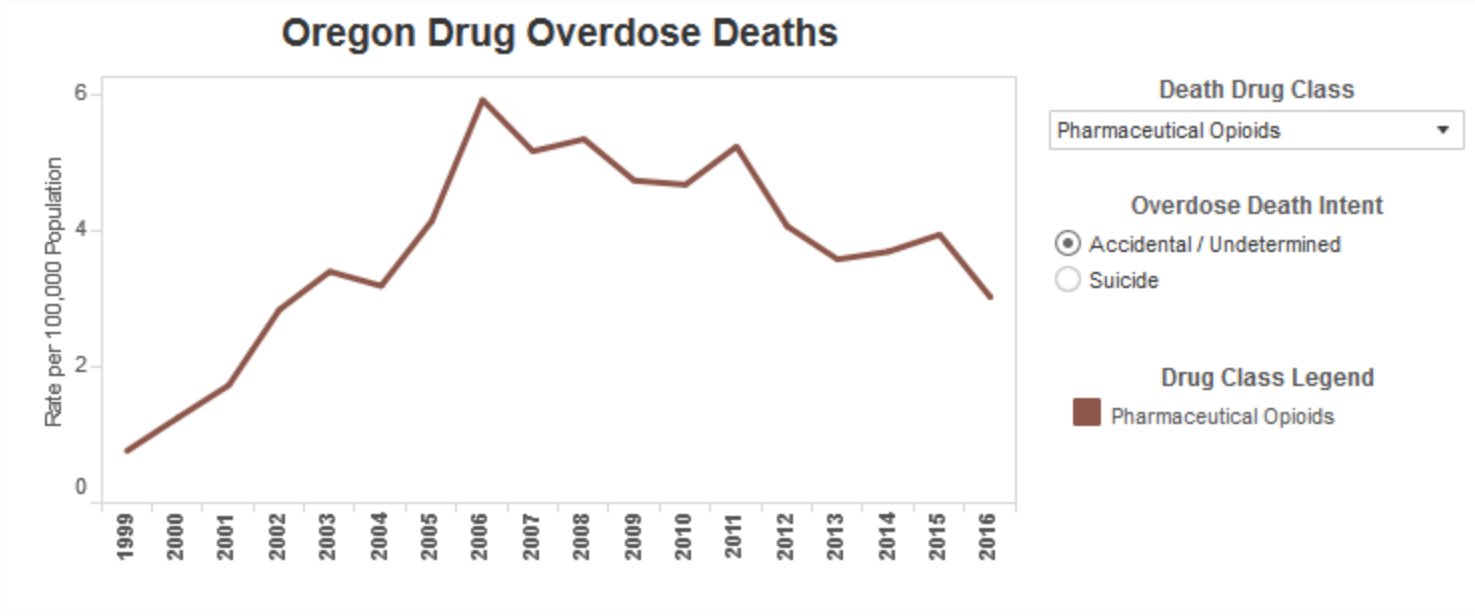
- To address the magnitude of health and economic burdens of alcohol-related harms, how do we **broaden the conversation** beyond prevention of Substance Use Disorders (SUD) and addiction to the prevention of alcohol misuse (excessive drinking)?

Priority Targets

Measure	Baseline	Current Data	2020 Target	Data Source
Prescription opioid mortality	4 deaths per 100,000 (2013)	3.029 per 100,000 (2016)	3.0 per 100,000	Death certificates
Alcohol-related motor vehicle deaths	125 (09-13 avg) (*BAC= .01%+)	176 (2015)	110	ODOT

Point #1

Pharmaceutical opioid death rate peaked in 2006 at 5.939 per 100,000. The rate has decreased to 3.029 per 100,000 in 2016.



Oregon Health Authority

Point #2

Overall, alcohol-related harms continue to **move in the wrong direction** in Oregon

Youth trends for binge drinking **are promising**

Young adult and adult heavy and binge drinking **are still a problem**

Disparities exist most notably in Native American populations

Point #3

Responsibility and accountability for reducing alcohol and other substance misuse and abuse is complex and largely driven by federal policy and grant funded initiatives that are largely not aligned across state or local sectors.

Big shifts are needed in order to reverse the harms caused by alcohol and other substances.

Increasing the price of alcohol and maintaining state control are the most effective strategies to reduce excessive drinking.

Feedback & Discussion

- How can we develop a **shared ownership** of this issue across the behavioral health, public health and primary care sectors – both on the state and local levels?

- To address the magnitude of health and economic burdens of alcohol-related harms, how do we **broaden the conversation** beyond prevention of Substance Use Disorders (SUD) and addiction to the prevention of alcohol misuse (excessive drinking)?

- What **health equity issues** do you see associated with alcohol and other substance use?

Lisa Millet
Injury and Violence Prevention Manager
Public Health Division
lisa.m.millet@state.or.us

Oregon Health Authority

Slow the increase of obesity

Oregon Health Authority

Key Questions

How can we better communicate the magnitude of the health and economic burdens of obesity?

How can we better communicate the need for a comprehensive prevention strategy to address the multiple causes of obesity, particularly those effecting low income and minority communities?

Priority Targets

Measure	Baseline (2015)	Current Data	2020 Target	Data Source
Obesity prevalence among 2- to 5-yr olds	**15.5%** (2013)	**14.9%** (2017)	**14.5%**	WIC administrative data (TWIST)
Obesity prevalence among youth	**11th: 11%** **8th: 10%** (2013)	**11th: 14%** **8th:11%** (2017)	**11th: 10%** **8th: 9%**	Oregon Healthy Teens Survey
Obesity prevalence among adults	**27%** (2013)	**29%** (2017)	**25%**	BRFSS
Diabetes prevalence among adults	**8.1%** (2014)	**8.4%** (2017)	**8.0%**	BRFSS

Point #1

There is some improvement in obesity among young children in WIC

But overall, obesity continues to **move in the wrong direction** in Oregon, **particularly in low income and minority communities**

Point #2

Obesity prevention faces many significant challenges

Currently there is **no public health capacity or funding** to comprehensively address the problem of obesity

Point #3

We continue to take small steps forward (Worksite Wellness Executive Order, nutrition standards, etc.), **but…**

Big shifts are needed in order to reverse the tide of obesity.

Reducing sugary drink consumption is the most effective strategy and starting point

Feedback & Discussion

How can we better communicate the magnitude of the health and economic burdens of obesity?

How can we better communicate the need for a comprehensive prevention strategy to address the multiple causes of obesity, particularly those effecting low income and minority communities?

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