# AGENDA

# PUBLIC HEALTH ADVISORY BOARD

**February 15, 2018**
Portland State Office Building
800 NE Oregon St., conference room 1B
Portland, OR 97232

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

Meeting objectives:

- Receive subcommittee updates
- Determine public health modernization implementation priorities for the 2019-21 biennium
- Provide feedback on the draft public health accountability metrics report
- Review local public health authority actual expenditures data
- Finalize board recommendations for the next CCO contract

| | | |
|---|---|---|
| **2:00-2:30 pm** | **Welcome and updates**<br>• Approve January 18 meeting minutes<br>• Legislative updates | Rebecca Pawlak, PHAB Chair |
| **2:30-2:40 pm** | **Subcommittee updates**<br>• Incentives and Funding subcommittee<br>• Action required: adopt funding principles | TBD, PHAB member |
| **2:40-3:20 pm** | **2019-21 public health modernization priorities**<br>• Discuss timeline for OHA budget request process<br>• Review public health modernization priorities from 2016 and 2017; discuss currently funded priorities<br>• Determine priorities for public health modernization implementation in 2019-21<br>• Action required: adopt 2019-21 public health modernization priorities | Cara Biddlecom, Oregon Health Authority |
| **3:20-3:30 pm** | **Break** | |
| **3:30-3:55 pm** | **Public health accountability metrics report**<br>• Review draft public health accountability metrics report<br>• Provide feedback on key messages and framing | Myde Boles, Program Design and Evaluation Services |

| | | |
|---|---|---|
| **3:55-4:20 pm** | **Local public health authority actual expenditures report summary**<br>• Review data submitted by local public health authorities with actual expenditures<br>• Discuss implications for local public health authority funding formula | Joey Razzano, Oregon Health Authority |
| **4:20-4:45 pm** | **CCO 2.0 recommendations**<br>• Review and finalize PHAB recommendations<br>• Discuss next steps<br>• Action required: adopt CCO 2.0 recommendations | Rebecca Pawlak, PHAB Chair |
| **4:45-5:00 pm** | **Public comment** | |
| **5:00 pm** | **Adjourn** | Rebecca Pawlak, PHAB Chair |

**Public Health Advisory Board (PHAB)**
**January 18, 2018**
**Draft Meeting Minutes**

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**Attendance:**

*Board members present:* Carrie Brogoitti, Muriel DeLaVergne-Brown, Jennifer Vines, Alejandro Queral, Rebecca Pawlak, Jeff Luck, Bob Dannenhoffer, Eli Schwartz, Teri Thalhofer, Tricia Mortell, Kelle Adamek-Little, Katrina Hedberg, Akiko Saito, David Bangsberg, Lillian Shirley, Eva Rippeteau

*Oregon Health Authority (OHA) staff:* Sara Beaudrault, Cara Biddlecom, Julia Hakes, Steve Fiala, Myde Boles, Karen Girard, Sue Woodbury, Lisa Millet

*Members of the public:* Adam Honerman (OHSU), Monica Nunes (Rede Group)

**Approval of Minutes**

A quorum was present. The Board moved to approve the November 17 minutes with all in favor.

**Welcome and updates**

*-Rebecca Pawlak, PHAB chair*

Rebecca shared a description of each of the regional public health modernization grants that was provided in meeting materials. Work officially started on December 1, 2017.

The draft administrative rules related to the passage of the two public health modernization bills, HB 3100 (2015) and HB 2310 (2017) that were shared previously as a public draft are now operational as of January 1.

David shared an update about the January 16 Oregon Health Policy Board retreat: The Oregon Health Policy Board reflected on CCO 1.0. Data is showing decreased emergency room visits and increased primary care visits. The Health Policy Board discussed the next round of CCO contracts, which is being called CCO 2.0, with a focus around how to move upstream and how to impact covered lives through population health. David noted that Pat Allen did a great job discussing the FamilyCare transition.

Rebecca shared the CCO 2.0 recommendations document that PHAB members worked on over email. Tricia said she still has input on the recommendations. Cara recommended that the PHAB put a hold on making changes until the Oregon Health Policy Board has a charge for PHAB. David shared that the Oregon Health Policy Board will be discussing CCO 2.0 in March and will allow for public comment through September 2018. David emphasized that the PHAB needs to present their CCO 2.0 recommendations as early in the process as possible.

David recommended that at the February PHAB meeting the PHAB will review and vote to approve CCO 2.0 recommendations. The PHAB will then have the recommendations ready for the Oregon Health Policy Board meeting in March.

Cara walked the board through the 2018 work plan, which includes some important deliverables that the subcommittees will be taking the lead on over the next several months.

Rebecca thanked Jeff for his service as PHAB chair in 2016 and 2017. Jeff did a terrific job onboarding a brand-new board that started with just six months to deliver everything from an interpretation of the public health modernization assessment, to priorities for implementation, to a draft local public health funding formula and report to Legislative Fiscal Office. This was soon followed by the statewide public health modernization plan. Cara presented Jeff with a plaque for his service.

**Incentives and Funding subcommittee update**
*- Akiko Saito, PHAB member*

Akiko thanked Bob and Carrie for joining the Incentives and Funding subcommittee. Akiko asked the PHAB to review and give feedback on the proposed public health funding principles. The purpose of these principles is to have a clear platform to aid in decision-making as it relates to funding for the public health system.

Muriel noted that rural areas tend to lose funds first when funding is decreased statewide.

Eli asked the PHAB if they should plan a funding formula for scenarios where funding is less than $10 million per year. Jeff clarified that the funding principles would apply regardless of funding level.

**Accountability metrics updates**
*-Teri Thalhofer, PHAB member*
*-Myde Boles, Program Design and Evaluation Services*

Teri provided an update from the Accountability Metrics subcommittee, which met for two hours on January 3. Teri highlighted that lack of funding for local public health programs is a huge issue and she would feel more comfortable with the accountability metrics when the system is fully funded.

Myde stated that the PHAB 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 the local public health authority to make improvements in dental visits for 0-5-year-olds. David recommended that dental visits for children ages 0-5 should be incorporated in our CCO 2.0

discussion. Lillian agreed with David and sees this as an opportunity for wider reach. PHAB members discussed the option of tabling the metric but there were concerns that the metric would not be revisited.

Cara presented the PHAB with two options to vote on the dental visits for 0-5-year-olds metric after the PHAB agreed it cannot serve as an accountability measure at this time:

1. Leave it in the baseline accountability metrics report for monitoring only.
2. Remove the measure from the baseline accountability report and instead utilize the State Health Improvement Plan for annual reporting.

Carrie, Muriel, Alejandro, Rebecca, Jeff, Bob, Eli, Teri, Kelle, Akiko, Jennifer, and Eva were in favor of leaving the dental visits for 0-5 year olds measure in the baseline accountability metrics report. Tricia abstained.

Myde reviewed the effective contraceptives use process measure recommendations. Katrina liked option number one because of the language but needs more clarification. Bob said option number two is a process measure not an accountability metric. Tricia expressed concern that LPHAs have not seen the funding formula for the reproductive health Program Element and is concerned that funding will be low.

Bob made a motion to adopt option number one but also calculate and promote option number 2. All in favor.

**Public health modernization evaluation plan**

*-Steven Fiala, Program Design and Evaluation Services*

Steven Fiala reviewed the evaluation process, evaluation questions, and evaluation timeline for modernization grantees and solicited for feedback from the PHAB. Two webinars have been held with the local public health modernization grantees to help develop the evaluation plan.

Jen proposed eliminating evaluation question number two and opening up question number four. Jen emphasized that regionalization is not always a good thing. Jeff made the recommendation to use “cross-jurisdictional” instead of regional.

Eli asked if Steve has run into problems applying the CDC’s static evaluation framework to different grantees. Steve said a mixed methods approach is important in the given timeline.

Steve thanked the PHAB for their feedback and will bring it back to the stakeholder group.

**State Health Improvement Plan updates: obesity and substance use**
*Lisa Millet, Karen Girard, Sue Woodbury, Oregon Health Authority*

Lisa Millet gave an update on progress in the substance use priority area in Oregon's State Health Improvement Plan.

Jen asked what current research says about the effect of marijuana on alcohol and opioid abuse. Katrina answered that public health is currently tracking trends.

Jeff asked Lisa if we should talk about pain management as a public health issue. Lisa said yes and we may see more movement in therapies to mitigate pain.

Eli asked about disparities in opioid use among Native Americans. Lisa reported that her program is currently trying to develop guidance for those who should probably never take opioids.

Teri noted that most efforts for drug and alcohol prevention in her LPHA are in middle and high school. Teri emphasized that this could be a broader conversation for the early learning and health systems.

Karen Girard and Sue Woodbury gave an update on progress in the obesity priority area in Oregon's State Health Improvement Plan.

Bob asked how Oregon compares nationally in terms of obesity prevalence. Karen answered that Oregon has the 31st highest adult obesity rate in the nation.

Alejandro asked if underlying causes of increasing obesity prevalence have been explored and if there have been any effective interventions. Lillian answered that it takes a lot of policies and PHD is just beginning to map all the policies out. Lillian also highlighted that there have been effective interventions in the UK. Alejandro emphasized that the PHAB should have a good sense of the steps to take in effective interventions. Teri explained that the issue is that the interventions often are focused on individual behavior and not about systemic changes.

Muriel expressed concern that schools are dropping out of the Oregon Healthy Teens survey which means OHA will not have as much data about the health of adolescents. Tricia recommended that the PHAB look at the systems level and talk to CCOs. Eli said that we need to find a way to engage local school districts.

Alejandro asked what data says about implementing a sugary beverage tax. Tricia said there is very limited data around how successful sugary beverage taxes are.

**Public Comment Period**
No public testimony was provided.

**Closing**
The meeting was adjourned.

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

**February 15, 2018**
**2-5 PM**
**Portland State Office Building**
**800 NE Oregon St Room 1B**
**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 ADVISORY BOARD**
**DRAFT Accountability Metrics Subcommittee meeting minutes**

**January 24, 2018**

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

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

**Welcome and introductions**
The January 3, 2018 meeting minutes were approved.

Eli shared he talked to Bob and Teri after the last PHAB meeting and learned more about Program Elements. Eli explained that he is trying to understand existing funding to local public health authorities (LPHAs) and how it relates to current and future metrics.

**Public health accountability metrics report**

Myde shared the draft report of Public Health Accountability Metrics and Local Public Health Process Measures. Myde incorporated feedback on data presentation that was given at the Accountability Metrics subcommittee meeting on January 3.

Eli thanked Myde for standardizing the graphs and said the draft report looks great.

Teri asked that this report is sent to LPHA Administrators before it is shared statewide. Muriel agreed.

Eli asked what 0% means in the Local Public Health Process Measure for Adult Smoking Prevalence: Percent of community members reached by local tobacco retail and smoke free policies – tobacco-free county. Teri answered that the OHA Health Promotion and Chronic Disease Prevention section considers everyone (100%) in the county to be covered where tobacco-free county property policy (comprehensive or partial) is in place. There are two separate local public health process measures for adult smoking prevalence. Teri noted that these are very different policy battles at the local level and it makes sense to include both. Eli suggested explain what each process measure means in a footnote.

Myde noted issues with the active transportation accountability metric. Percent of commuters who walk, bike, or use public transportation to get to work does not have a benchmark and data are not available across all counties. Cara noted that Healthy People 2020 has a related benchmark that can be used. The current measure is calculated using the American Communities Survey data, as recommended by this

subcommittee in August. This subcommittee identified Oregon Department of Transportation (ODOT) survey data as a potential data source for this measure in the future, but currently resources don't exist to support the work that would need to happen in order to use ODOT survey data. The ODOT survey is currently collected about once every 10 years. Myde explained that all existing data for active transportation are problematic and the data used in the report is the least problematic.

Myde reviewed the Public Health Accountability Metrics Benchmarks Summary. The baseline year is 2016 unless otherwise noted.

Jen asked if the percent of community water systems meeting health-based standards metric should be changed if we are starting at close to 100%. Sara explained that the Drinking Water Services workgroup, which is comprised of state and local staff, recommended using these, as they are established performance measures included in the Drinking Water Services Program Element. The workgroup may develop new measures at some point. Muriel said drinking water is important to monitor and recommends keeping these process measures, even though most LPHAs are meeting the measures.

The Subcommittee moves to present the draft report at the February PHAB meeting.

**Subcommittee business**

Sara asked the Subcommittee if they are interested in electing a chair. Subcommittee members said they are happy with the current operation and do not want to elect a chair.

Myde will present on behalf of the Accountability Metrics Subcommittee at the February PHAB meeting.

**Public comment**

No public comment was provided.

**Adjournment**

The meeting was adjourned.

The next Accountability Metrics Subcommittee meeting is scheduled for:

February 28, 2018 from 1-2 pm

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
February 12, 2018
12:30-2:00 pm

*Welcome and Introductions*

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

Oregon Health Authority (OHA) staff: Cara Biddlecom, Sara Beaudrault, Julia Hakes, Joey Razzano, Danna Drum, Chris Curtis

The January 8 meeting minutes were approved.

There will be a PHAB joint subcommittee meeting on March 29 from 1-3pm.

*Principles for public health funding*

Sara reviewed the draft public health funding principles with subcommittee members.

Subcommittee members gave feedback and updated the language in the introductory framing of the principles and the principles themselves.

- Alejandro recommended that the document include a preamble describing current funding for foundational capabilities and programs, and highlighting the need for innovation. Jeff requested that a definition for "public health system" be included.
- The subcommittee recommended changes to #1 to describe different models for how services are provided to every person in Oregon.
- The subcommittee recommended replacing the word "considering" with "minimizing" in #2 to clarify the intent of the principle.
- The subcommittee felt it was important to reference regional approaches or cross-jurisdictional sharing in #4, and recommended using cross-jurisdictional sharing.
- The subcommittee appreciated the inclusion of #5.
- The subcommittee did not recommend changes to the remaining funding principles.

The subcommittee will present the principles at the February PHAB meeting for discussion and adoption.

*Local public health expenditures*

Danna Drum presented on fiscal expenditures for LPHAs in 2017.

Jeff said the charts looked great but asked that the dollar amount be rounded to the nearest thousand dollars. Jeff also requested the following changes in chart titles:

| Current Chart Name | Recommended Chart Name |
|---|---|
| Total LPHA Expenditures FY2017 | Total LPHA Expenditures by Source |
| Total LPHA Expenditures FY2017 | Total LPHA Expenditures by Program |

Jeff asked what All Other Funds represents in LPHA Prevention & Health Promotion FY2017. Danna answered that they are grants, contracts, and any other funds that are not state or federal funds.

Jeff requested notes on which activities are represented in each pie in the chart.

Danna asked subcommittee members to consider how we measure in-kind investments. Bob said that as someone who had to report on his LPHA expenditures, the in-kind investments had the least specific directions. Danna agreed that the directions should be more specific and perhaps we should be looking at types of in-kind funds: county or not county.

Bob said he is surprised in the disparity across spending county to county. He said this demonstrates we are not providing services equitably.

Jeff asked if OHA examined 2016 LPHA expenditures. Danna said they were examined at a very high level and expenditures were consistent.

*2019-21 modernization funding formula*

Chris Curtis reviewed the 2019-21 modernization funding formula and Appendix C: Local public health funding formula model of the SHIP.

Bob asked why County 26 has a higher floor than all the other counties in its county group. Chris answered that County 26 represents a three county regional health district.

Bob asked about the method the PHAB Incentives and Funding used to add indicators not required by statute to the funding formula. Subcommittee members described the rationale for why indicators were added. This subcommittee will review the indicators that were added in 2016 to confirm whether they should continue to be used or if changes are warranted. Sara shared public health modernization funding formula: review of indicators document with the objectives being: (1) review indicators that were added by PHAB in 2016; decide whether changes are needed for these indicators and; (2) discuss measures and data sources for health status and poverty.

Bob asked if this funding formula will vary by program. Sara answered that this funding formula is for public health modernization funds specifically. However, this funding formula could be a model for other funding streams.

*Subcommittee business*

Jeff will provide a subcommittee update at the February 15 PHAB meeting.

Subcommittee members decided to hold the meeting scheduled for March 12.

The subcommittee decided to appoint a rotating chair. Alejandro will serve as chair in this first rotation.

*Public Comment*

No public testimony.

Public Health Advisory Board
Public health funding principles –for discussion and adoption
February 12~~8~~, 2018

The Public Health Advisory Board recognizes that funding for foundational capabilities and programs is limited, but innovations can maximize the benefit of available resources. These funding principles are designed to apply to the public health system, which means state and local public health authorities in Oregon. These funding principles can be applied to increases or decreases in public health ~~modernization funding and other state and local public health funding~~funding.

## Public health system approach to foundational programs

1. Ensure services are available ~~everywhere across~~to every person in Oregon, ~~but not necessarily county by county~~whether they are provided by an individual local public health authority, through cross-jurisdictional sharing arrangements, and/or by the Oregon Health Authority.

2. Align funding with burden of disease~~, and~~ risk, and state and community health assessment and plan priorities, while ~~considering~~ minimizing the impact to public health infrastructure when resources are redirected.

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~~ innovative approaches to service provision, such as cross-jurisdictional sharing.

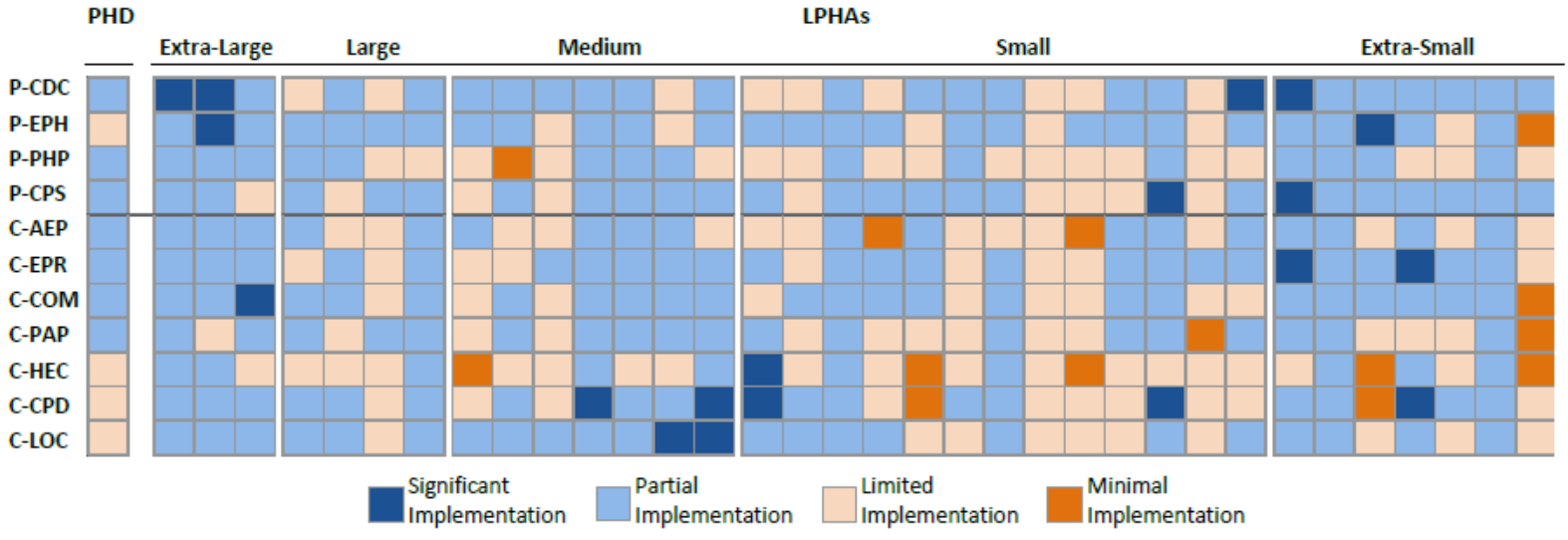
5. Leverage opportunities to align work with health care, education and other sectors.

## Transparency ~~of state and local roles~~across the public health system:

6. Recognize how ~~state and local public health authority roles~~the public health system works to achieve outcomes, and ~~identify the most effective and efficient delivery of funded roles.~~ direct funding to close the identified gaps across the system in all governmental public health authorities.

~~7.~~ Improve transparency about funded work ~~and state and local roles~~across the public health system and scale work to available funding.

Current Implementation of Foundational Programs and Capabilities



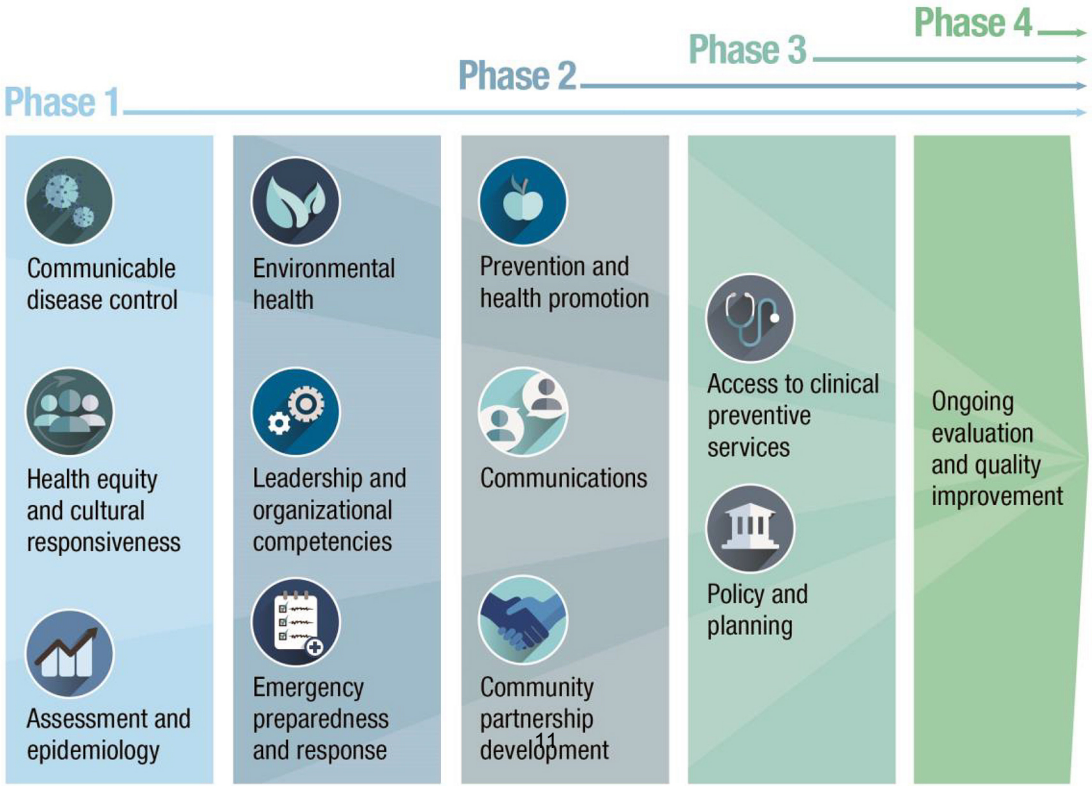

Above are the foundational program and capability implementation levels for PHD and a randomized ordering of the LPHAs by size bands.

Each vertical set of boxes represent one public health authority. There are no foundational programs or capabilities that are significantly implemented universally across all governmental public health authorities. There are some areas with a higher concentration of limited and minimal implementation, such as the Health Equity and Cultural Responsiveness capability and the Prevention and Health Promotion program. Additionally, some governmental public health authorities have larger programmatic gaps than others. However, there are gaps across the system in every size category.

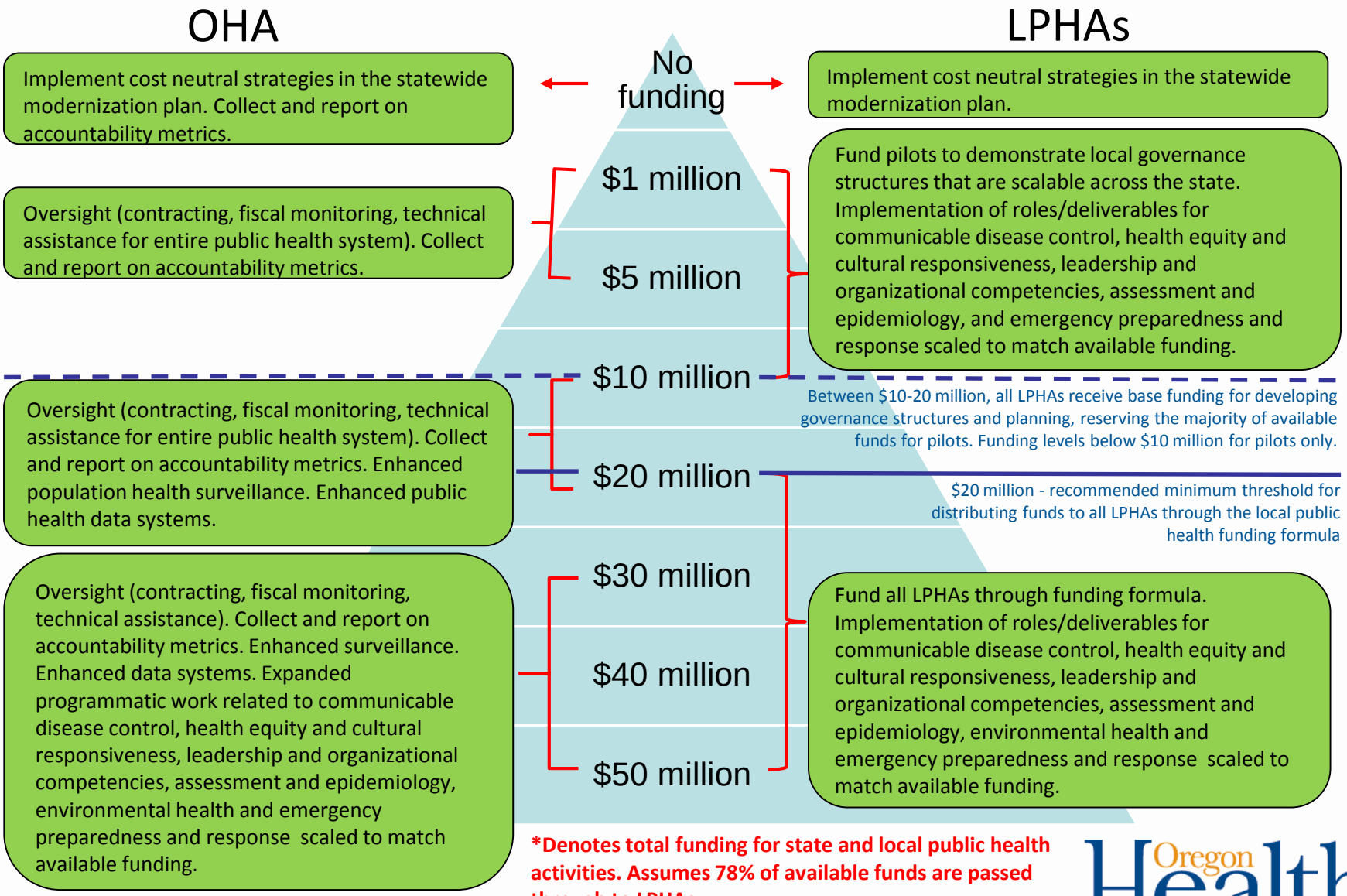
**Foundational Programs and Capabilities Code Key**

**P-CDC:** Communicable Disease Control
**P-EPH:** Environmental Public Health
**P-PHP:** Prevention and Health Promotion
**P-CPS:** Access to Clinical Preventive Services
**C-AEP:** Assessment and Epidemiology
**C-EPR:** Emergency Preparedness and Response
**C-COM:** Communications
**C-PAP:** Policy and Planning
**C-HEC:** Health Equity and Cultural Responsiveness
**C-CPD:** Community Partnership Development
**C-LOC:** Leadership and Organizational Competencies

# Proposed phases for foundational capabilities and programs



# Scope of work at a range of funding levels for 2017-19*




***Denotes total funding for state and local public health activities. Assumes 78% of available funds are passed through to LPHAs.**



Oregon Health Authority

# Public Health Accountability Metrics:
## Baseline Report

Public Health Advisory Board Meeting
February 15, 2018

Oregon Health Authority

PUBLIC HEALTH DIVISION
Office of the State Public Health Director

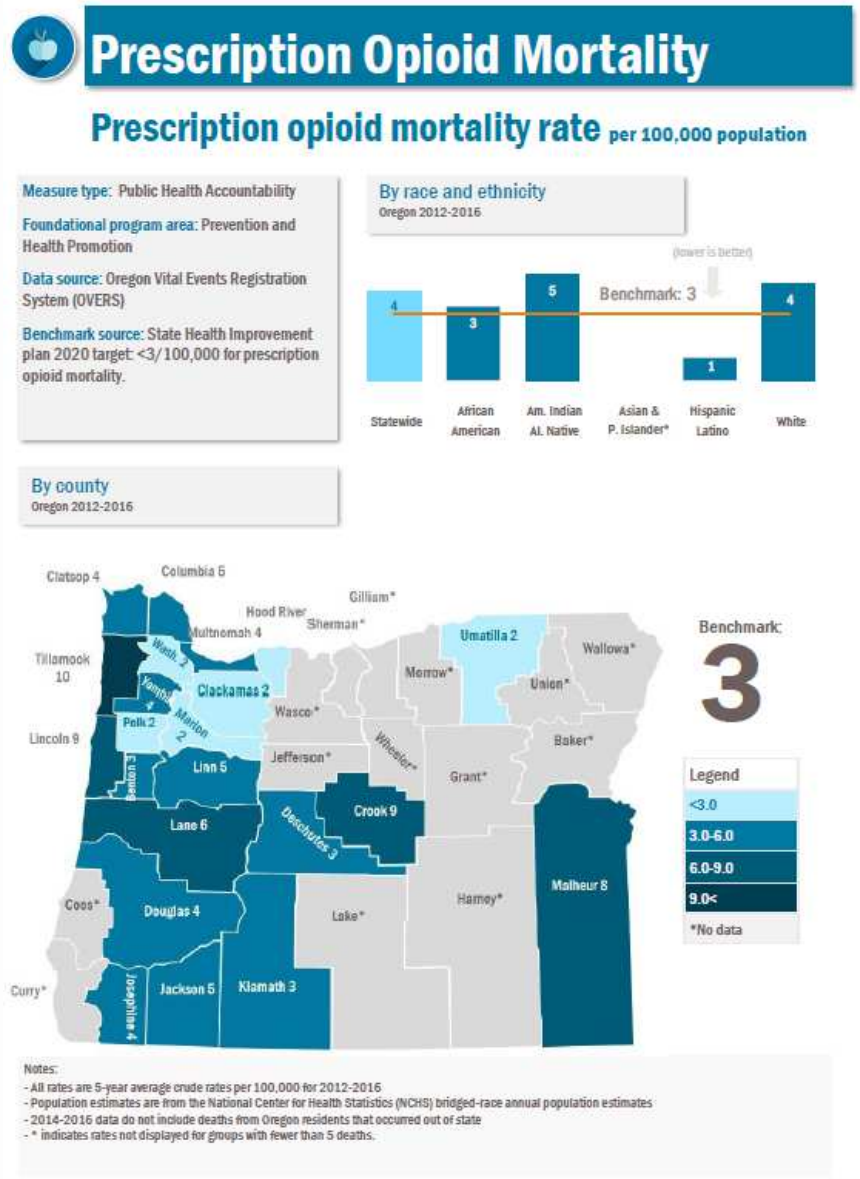
# Objectives for today's discussion

- Accountability Metrics Subcommittee recommendation to present draft report at February PHAB meeting
- Highlights from draft baseline report
  - format
  - data sources
  - technical considerations
- Example of format for final report
- Benchmarks summary
- PHAB feedback

# Report highlights - format

- Draft report organization
  - Introduction, Baseline Metrics (graphs), Technical Appendix
  - Table 1 for Table of Contents
- Graphs
  - Accountability metric – statewide, benchmark, race/ethnicity
  - Accountability metric – county
  - Local public health process measure
- Footnotes
  - data source,
  - benchmark source,
  - technical notes “lite,”
  - LPHA funding
- Technical Appendix
- Final format example

# Report highlights – final report format




Oregon Health Authority

# Prescription Opioid Mortality

## Percent of top opioid prescribers enrolled in PDMP

**Measure type:** Local Public Health Process

**Foundational program area:** Prevention and Health Promotion

**Data source:** Oregon Prescription Drug Monitoring Program database, 2016

**Benchmark source:** 95%, provided by Injury and Violence Prevention Section staff

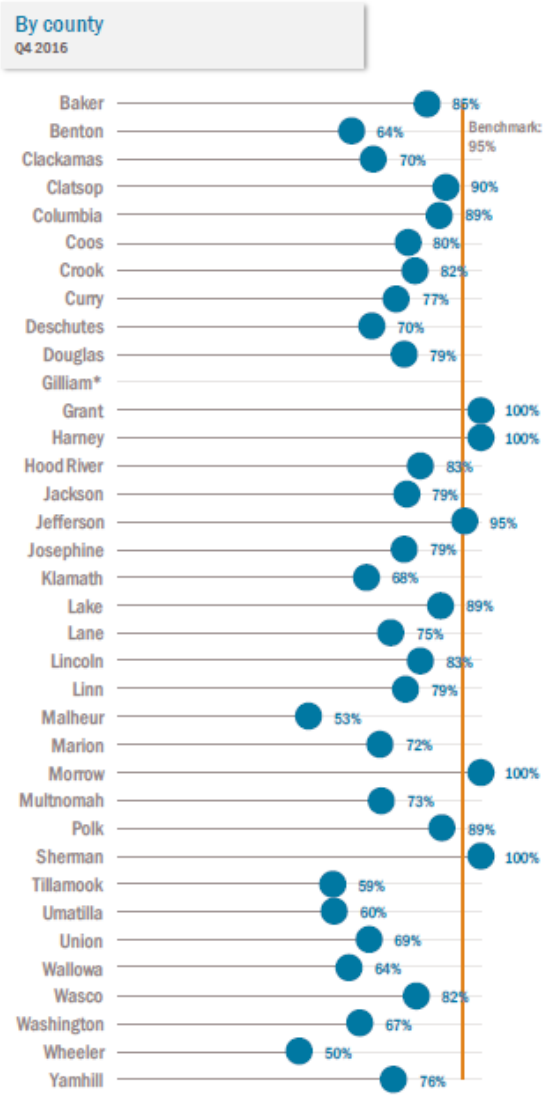
### Local public health funding

Local public health funding: Some LPHAs receive funding for Prescription Drug Overdose Prevention. These counties are required to promote prescriber enrollment in the PDMP

**Benchmark:**

**95%**

Notes:
- Top prescribers are defined as the top 4000 prescribers by volume; this represents approximately 20% of all prescribers in Oregon.
- *Data not available for Gilliam County
- Data provided in the PDMP online dashboard are quarterly, not annual. Injury and Violence Prevention staff recommend using Q4 2016 as baseline.




Oregon Health Authority

# Report highlights – data & technical

- Baseline year 2016, except where noted
- Many data systems and methods for data collection
- Reporting conventions for each public health program
  - Age-adjusted versus crude rates
  - 95% confidence intervals for survey estimates
  - Data suppression rules
- Gaps
  - Local public health process measure for active transportation
  - Benchmark for effective contraceptive use
  - Local public health process measure for effective contraceptive use
- Technical considerations for incentive payment system
  - Wide ranges for numerators & denominators for county percentages
  - Suppressed data and combined years of data
  - Yes/no process measures

# Benchmarks summary

| Public Health Modernization Foundational Program Area | Accountability Metric | Benchmark | Local Public Health Process Measures | Benchmark |
|---|---|---|---|---|
| **Communicable Disease** | 2-year old vaccination rate | 80% Oregon State Health Improvement Plan (SHIP) 2020 target | Percent of Vaccine for Children Clinics that participate in Assessment, Feedback, Incentives and eXchange (AFIX) program | 25%, provided by Oregon Health Authority, Public Health Division, Immunization Program. |
| | Gonorrhea rate per 100,000 | 72/100,000 SHIP 2020 target | (1) Percent of gonorrhea cases that had at least one contact that received treatment | (1) 35%, provided by Oregon Health Authority, Public Health Division, HIV/STD/TB Program |
| | | | (2) Percent of gonorrhea case reports with complete priority fields | (2) 70%, provided by Oregon Health Authority, Public Health Division, HIV/STD/TB Program |

# Benchmarks summary

| Public Health Modernization Foundational Program Area | Accountability Metric | Benchmark | Local Public Health Process Measures | Benchmark |
|---|---|---|---|---|
| **Prevention and Health Promotion** | Adults who smoke cigarettes (i.e., adult smoking prevalence) | 15% SHIP 2020 target | Percent of community members reached by local tobacco retail/smoke free policies | 100%, provided by Oregon Health Authority, Public Health Division, Health Promotion Chronic Disease Prevention Program |
| | Prescription opioid mortality rate per 100,000 | <3/100,000 SHIP 2020 target | Percent of top opioid prescribers enrolled in the Prescription Drug Monitoring Program database | 95%, provided by Oregon Health Authority, Public Health Division, Injury and Violence Prevention Program |

# Benchmarks summary

| Public Health Modernization Foundational Program Area | Accountability Metric | Benchmark | Local Public Health Process Measures | Benchmark |
|---|---|---|---|---|
| **Environmental Health** | Active transportation: percent of commuters who walk, ride bicycles, or use public transit to get to work | 9%<br>Healthy People 2020 | Number of active transportation partner governing or leadership boards with LPHA representation | TBD |
| | Percent of community water systems meeting health-based standards | 92%<br>EPA standard | (1) Percent of water systems surveys completed<br><br>(2) Percent of water quality alert responses<br><br>(3) Percent of priority non-compliers resolved | 100%, provided by Oregon Health Authority, Public Health Division, Drinking Water Services Program (all 3 measures) |

# Benchmarks summary

| Public Health Modernization Foundational Program Area | Accountability Metric | Benchmark | Local Public Health Process Measures | Benchmark |
|---|---|---|---|---|
| **Access to Clinical Preventive Services** | Percent of women at risk for unintended pregnancy who use effective contraceptives | TBD | Annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use | 100%, provided by Oregon Health Authority, Public Health Division, Reproductive Health Program |
| | DEVELOP-MENTAL METRIC Dental visits among children 0-5 years old | 48% SHIP 2020 target | Not applicable | Not applicable |

# Next steps

- Finalize report content and format
- Joint meeting of the Accountability Metrics subcommittee and the Incentives and Funding subcommittee

# Prescription Opioid Mortality

## Prescription opioid mortality rate per 100,000 population

**Measure type:** Public Health Accountability

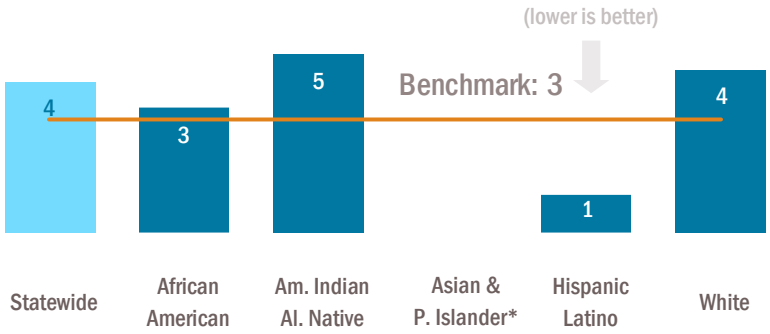
**Foundational program area:** Prevention and Health Promotion

**Data source:** Oregon Vital Events Registration System (OVERS)

**Benchmark source:** State Health Improvement plan 2020 target: <3/100,000 for prescription opioid mortality.

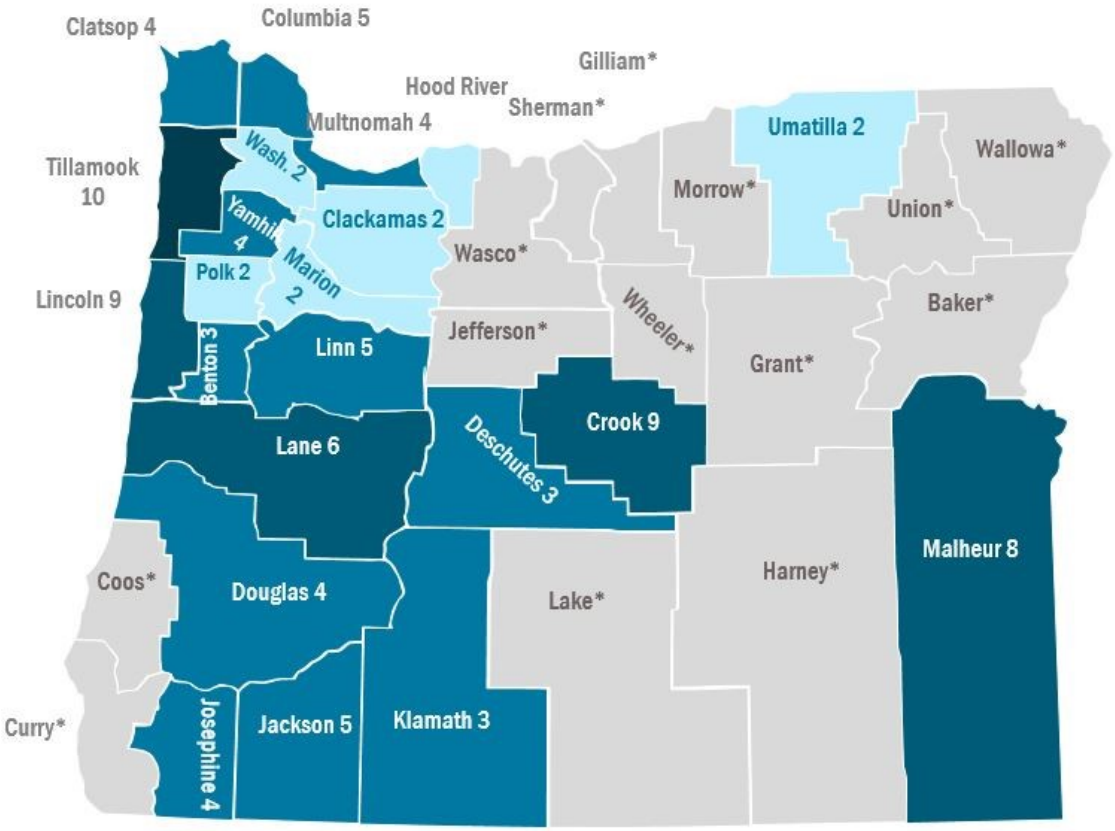
### By race and ethnicity

Oregon 2012-2016




### By county

Oregon 2012-2016




Benchmark:

**3**

| Legend |
|---|
| <3.0 |
| 3.0-6.0 |
| 6.0-9.0 |
| 9.0< |
| *No data |

Notes:

- All rates are 5-year average crude rates per 100,000 for 2012-2016
- Population estimates are from the National Center for Health Statistics (NCHS) bridged-race annual population estimates
- 2014-2016 data do not include deaths from Oregon residents that occurred out of state
- * indicates rates not displayed for groups with fewer than 5 deaths.

# Prescription Opioid Mortality

## Percent of top opioid prescribers enrolled in PDMP

**Measure type:** Local Public Health Process

**Foundational program area:** Prevention and Health Promotion

**Data source:** Oregon Prescription Drug Monitoring Program database, 2016

**Benchmark source:** 95%, provided by Injury and Violence Prevention Section staff

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**Benchmark:**

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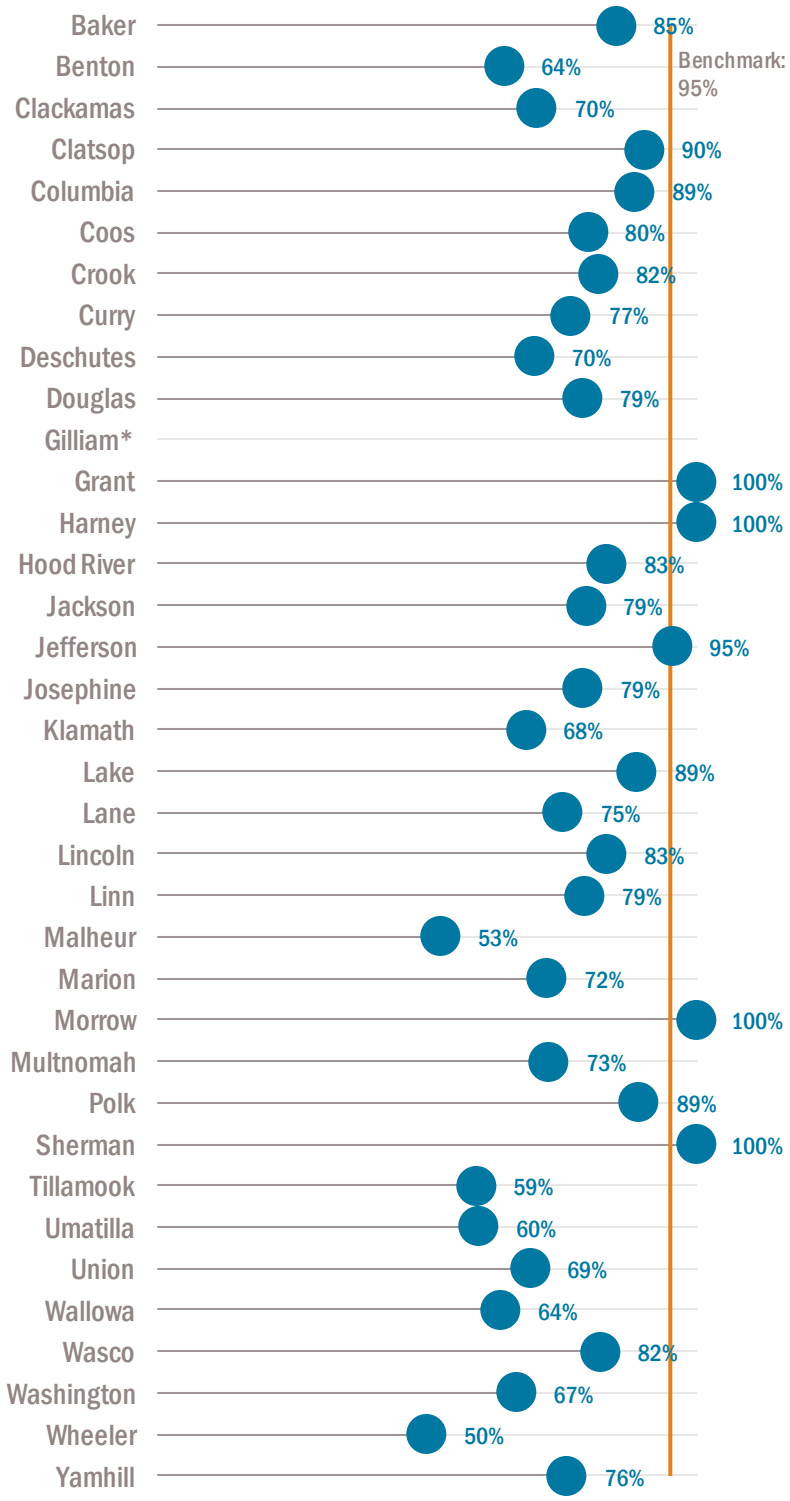
Notes:

- Top prescribers are defined as the top 4000 prescribers by volume; this represents approximately 20% of all prescribers in Oregon.
- *Data not available for Gilliam County
- Data provided in the PDMP online dashboard are quarterly, not annual. Injury and Violence Prevention staff recommend using Q4 2016 as baseline.

### By county

Q4 2016



## PUBLIC HEALTH ADVISORY BOARD ACCOUNTABILITY METRICS SUBCOMMITTEE – JAN 24, 2018

## PUBLIC HEALTH ACCOUNTABILITY METRICS BENCHMARKS SUMMARY

| Public Health Modernization Foundational Program Area | Accountability Metric | Benchmark | Local Public Health Process Measures | Benchmark |
|---|---|---|---|---|
| **Communicable Disease** | 2-year old vaccination rate | 80% Oregon State Health Improvement Plan (SHIP) 2020 target | Percent of Vaccines for Children Clinics that participate in Assessment, Feedback, Incentives and eXchange (AFIX) program | 25%, provided by Oregon Health Authority, Public Health Division, Immunization Program. |
| | Gonorrhea rate per 100,000 | 72/100,000 SHIP 2020 target | (1) Percent of gonorrhea cases that had at least one contact that received treatment<br><br>(2) Percent of gonorrhea case reports with complete priority fields | (1) 35%, provided by Oregon Health Authority, Public Health Division, HIV/STD/TB Program.<br><br>(2) 70%, provided by Oregon Health Authority, Public Health Division, HIV/STD/TB Program. |
| **Prevention and Health Promotion** | Adults who smoke cigarettes (i.e., adult smoking prevalence) | 15% SHIP 2020 target | Percent of community members reached by local tobacco retail/smoke free policies | 100%, provided by Oregon Health Authority, Public Health Division, Health Promotion Chronic Disease Prevention program. |
| | Prescription opioid mortality rate per 100,000 | <3/100,000 SHIP 2020 target | Percent of top opioid prescribers enrolled in the Prescription Drug Monitoring Program database | 95%, provided by Oregon Health Authority, Public Health Division, Injury and Violence Prevention program. |
| **Environmental Health** | Active transportation: percent of commuters who walk, ride bicycles, or use public transit to get to work | 9% Healthy People 2020 | Number of active transportation partner governing or leadership boards with LPHA representation | TBD |
| | Percent of community water systems meeting health-based standards | 92% EPA standard | (1) Percent of water systems surveys completed<br><br>(2) Percent of water quality alert responses<br><br>(3) Percent of priority non-compliers resolved | 100%, provided by Oregon Health Authority, Public Health Division, Drinking Water Services program (all three measures). |
| **Access to Clinical Preventive Services** | Percent of women at risk for unintended pregnancy who use effective contraceptives | TBD | Annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use | 100%, provided by Oregon Health Authority, Public Health Division, Reproductive Health program. |
| | DEVELOPMENTAL METRIC<br>Dental visits among children 0-5 years old | 48% SHIP 2020 target | Not applicable | Not applicable |

# Fiscal Year 2017:
# LPHA Expenditures

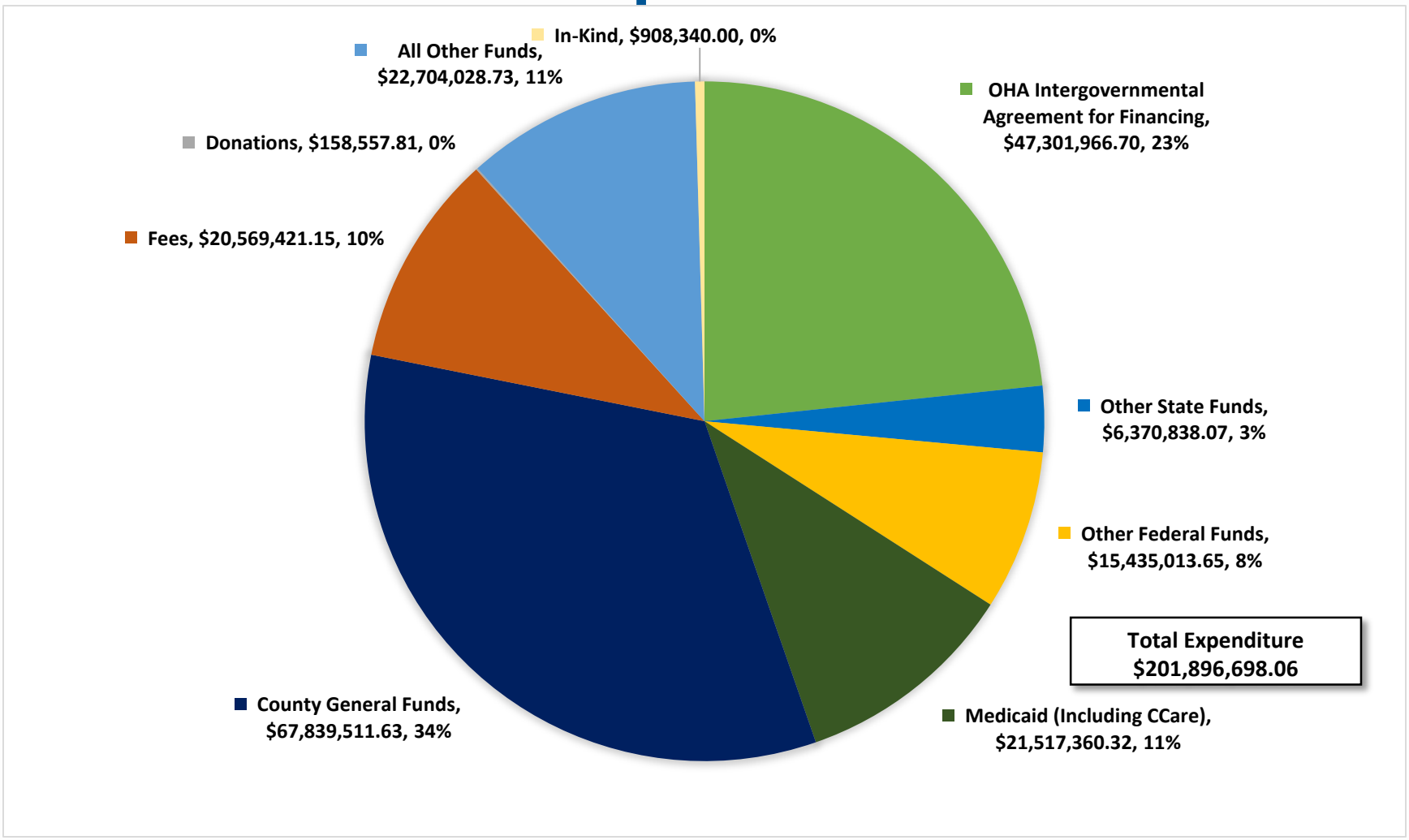
Office of the State Public Health Director

January 2018

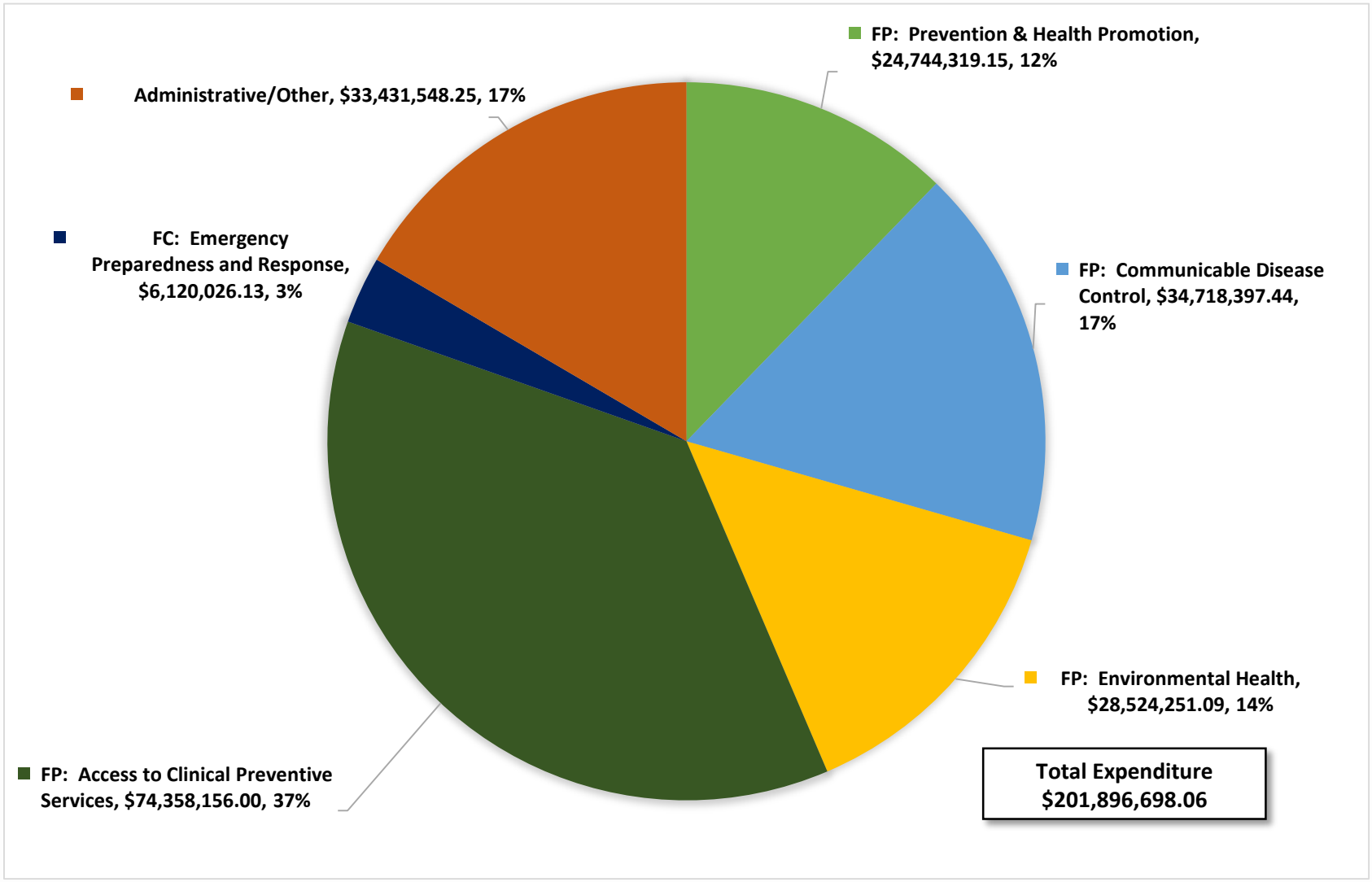
# Things to Keep in Mind

- First time LPHA expenditure data collected
- All data is self-reported by LPHAs
- Data includes all LPHAs except Wallowa County

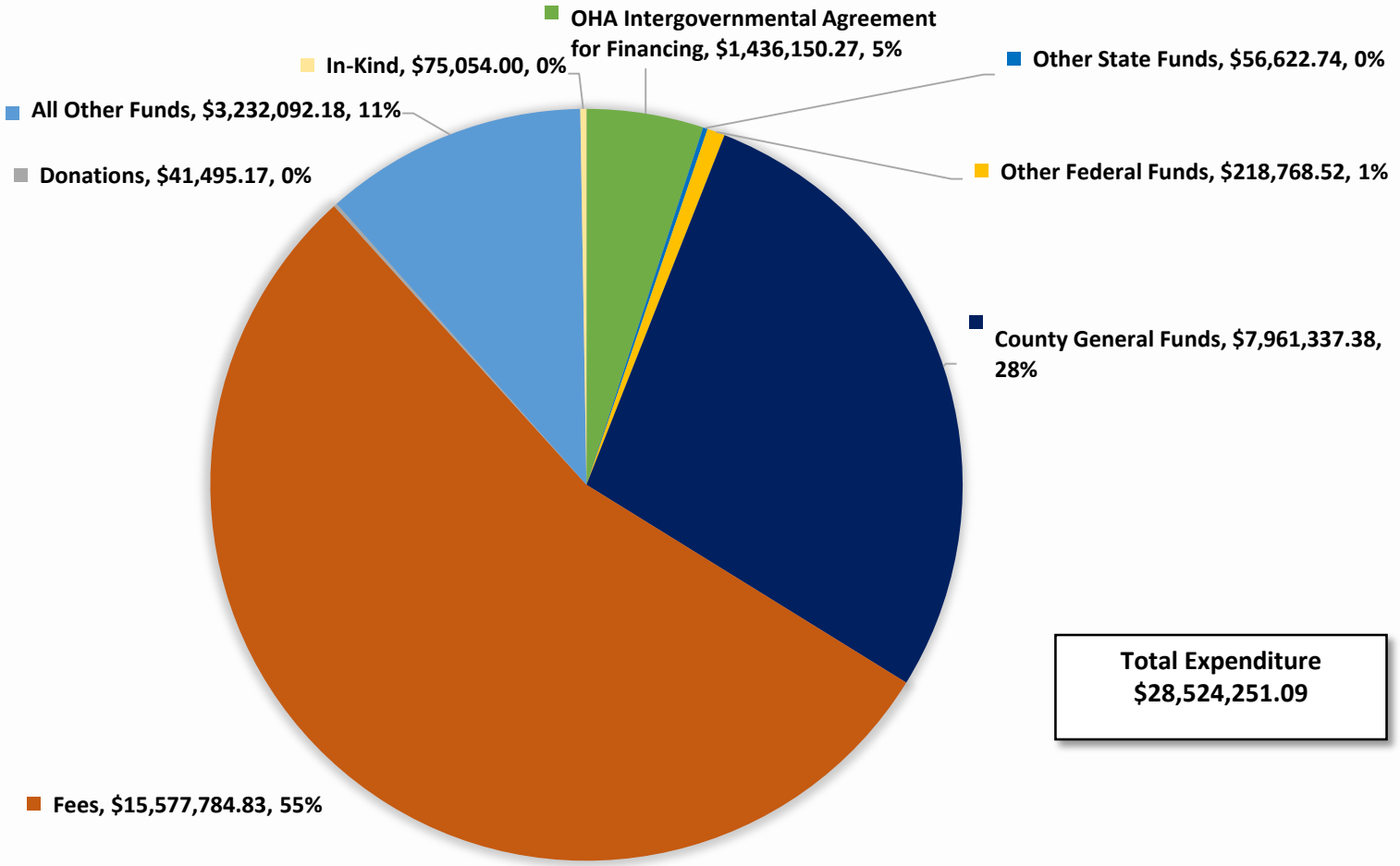
# Total LPHA Expenditures FY2017



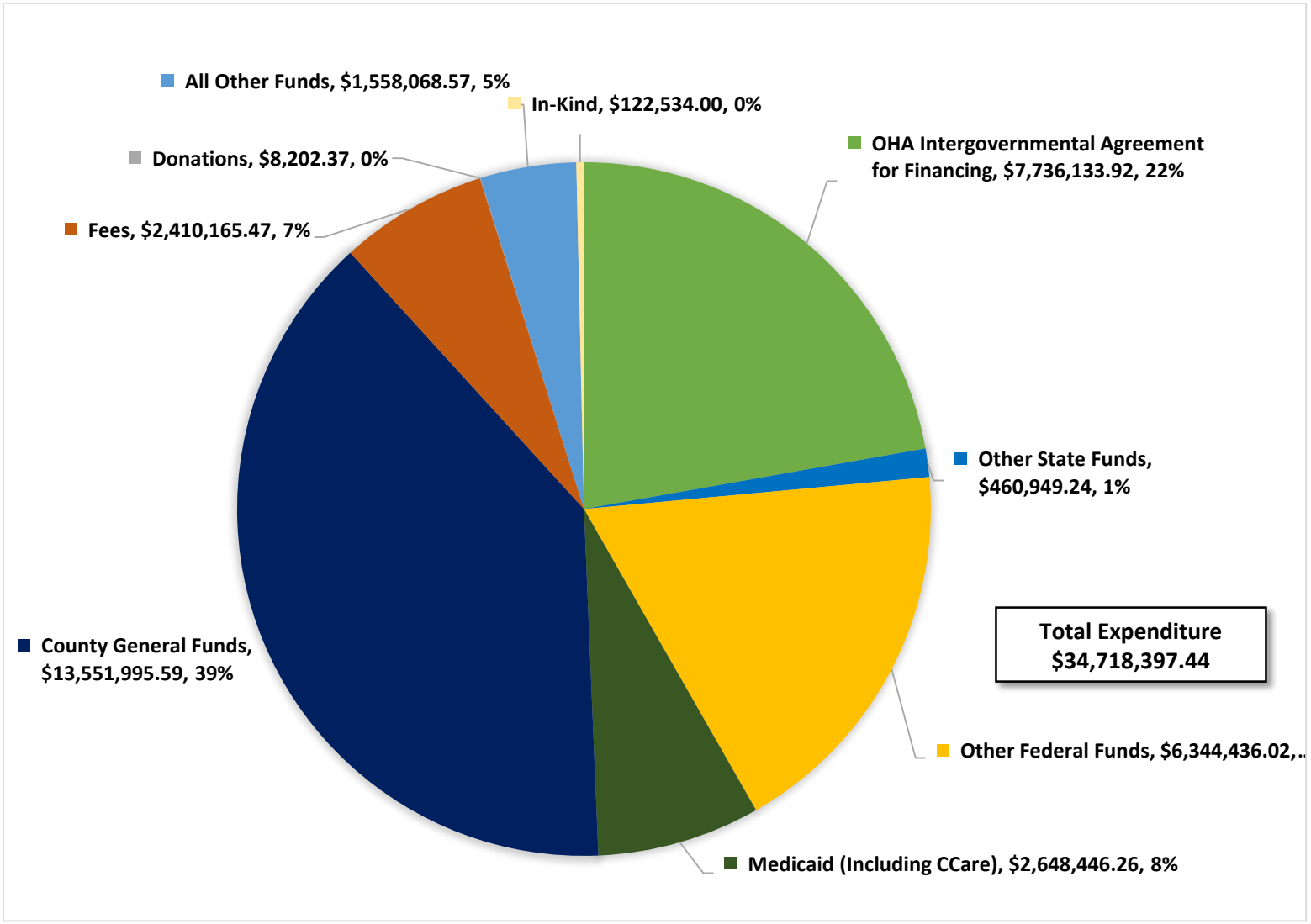
# Total LPHA Expenditures FY2017



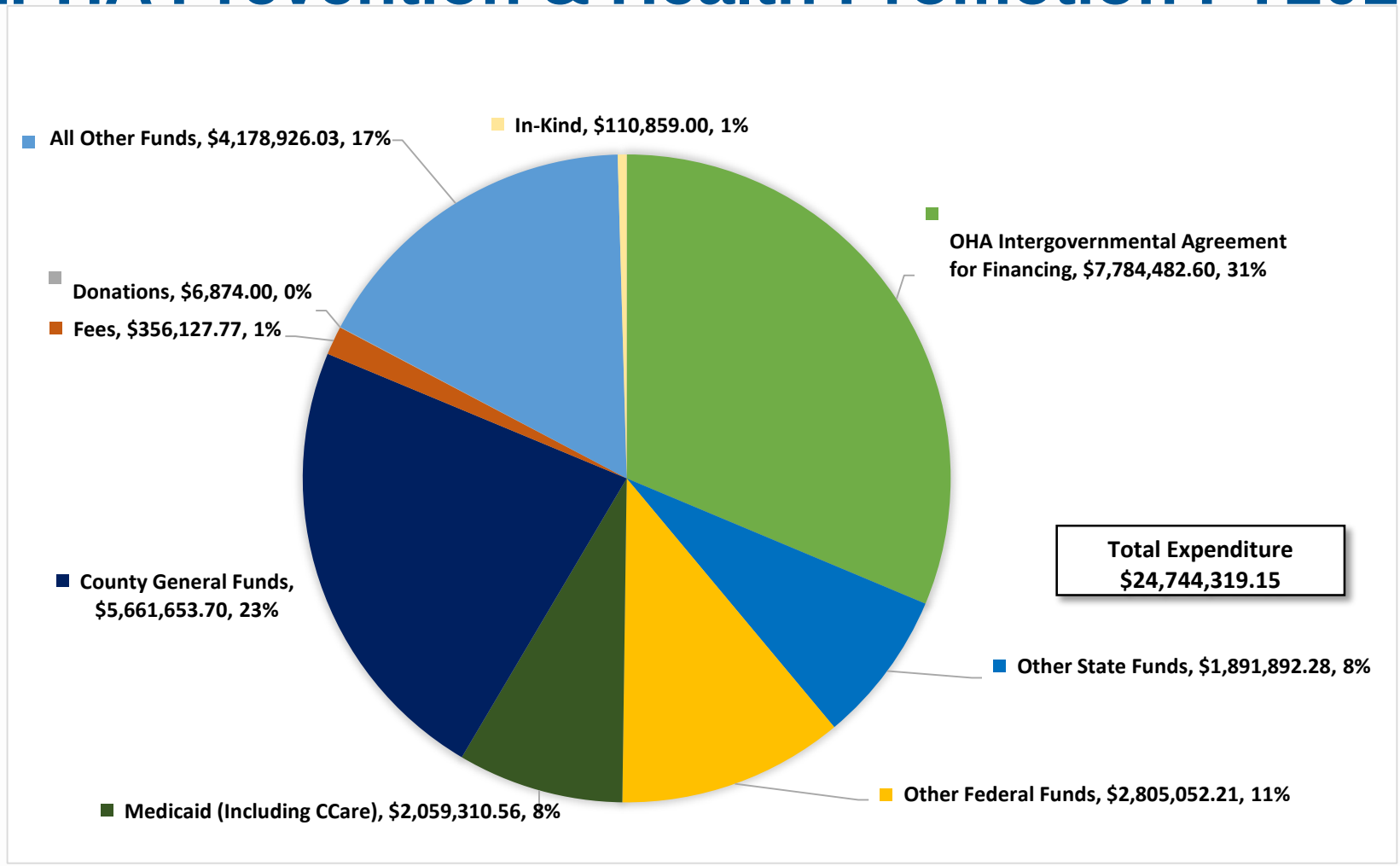
# LPHA Environmental Health FY2017



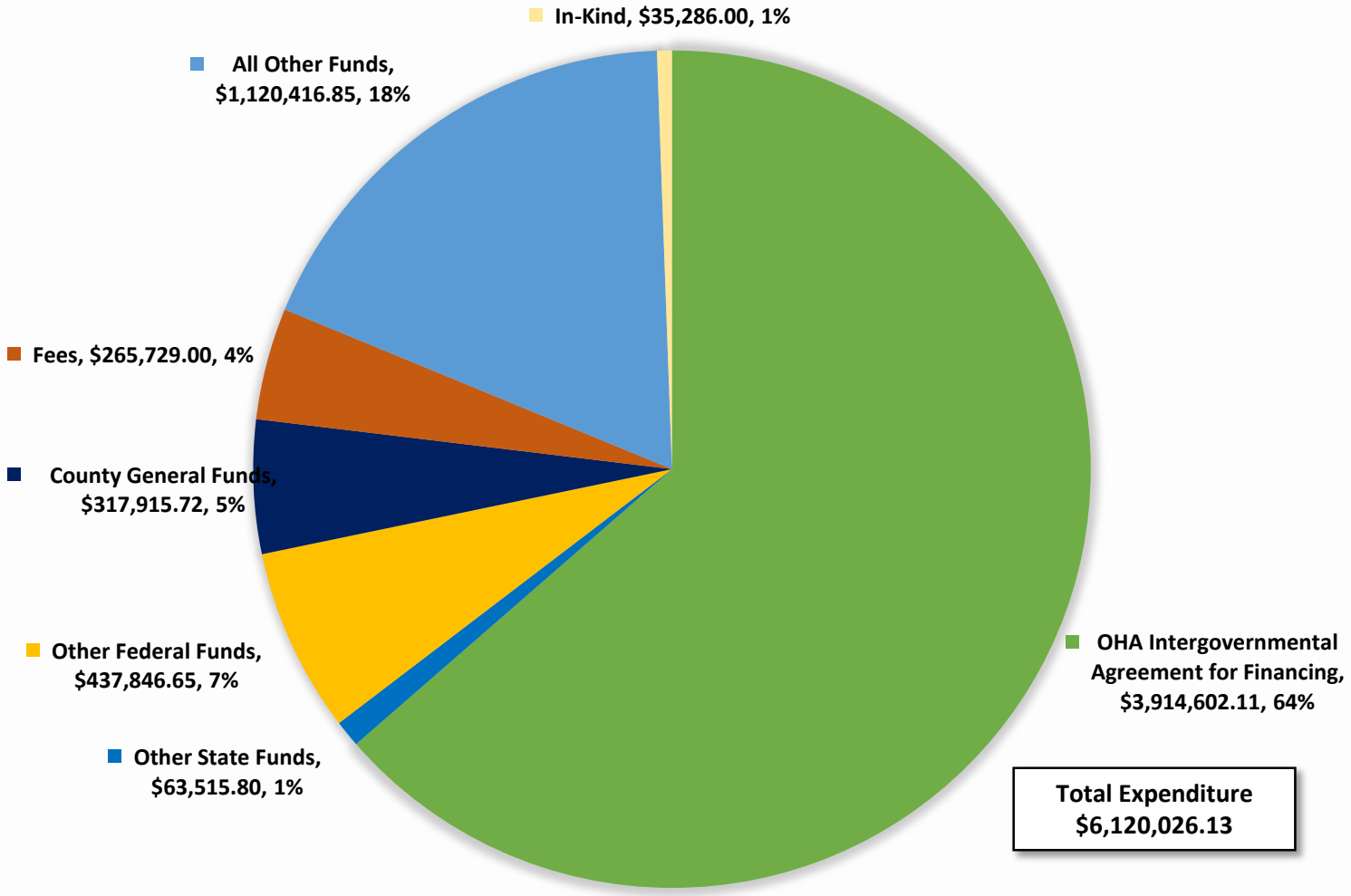
# LPHA Communicable Disease FY2017



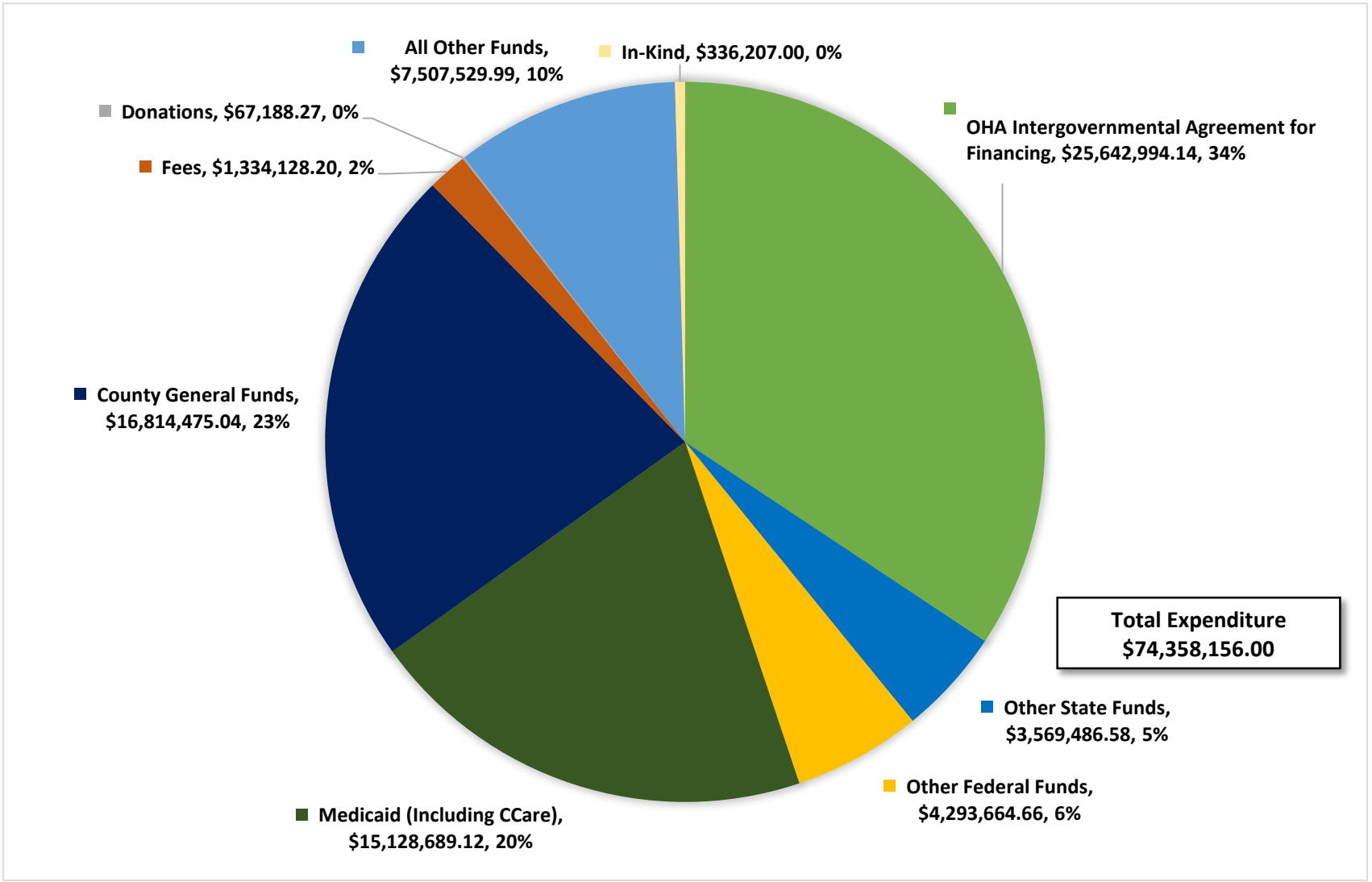
# LPHA Prevention & Health Promotion FY2017



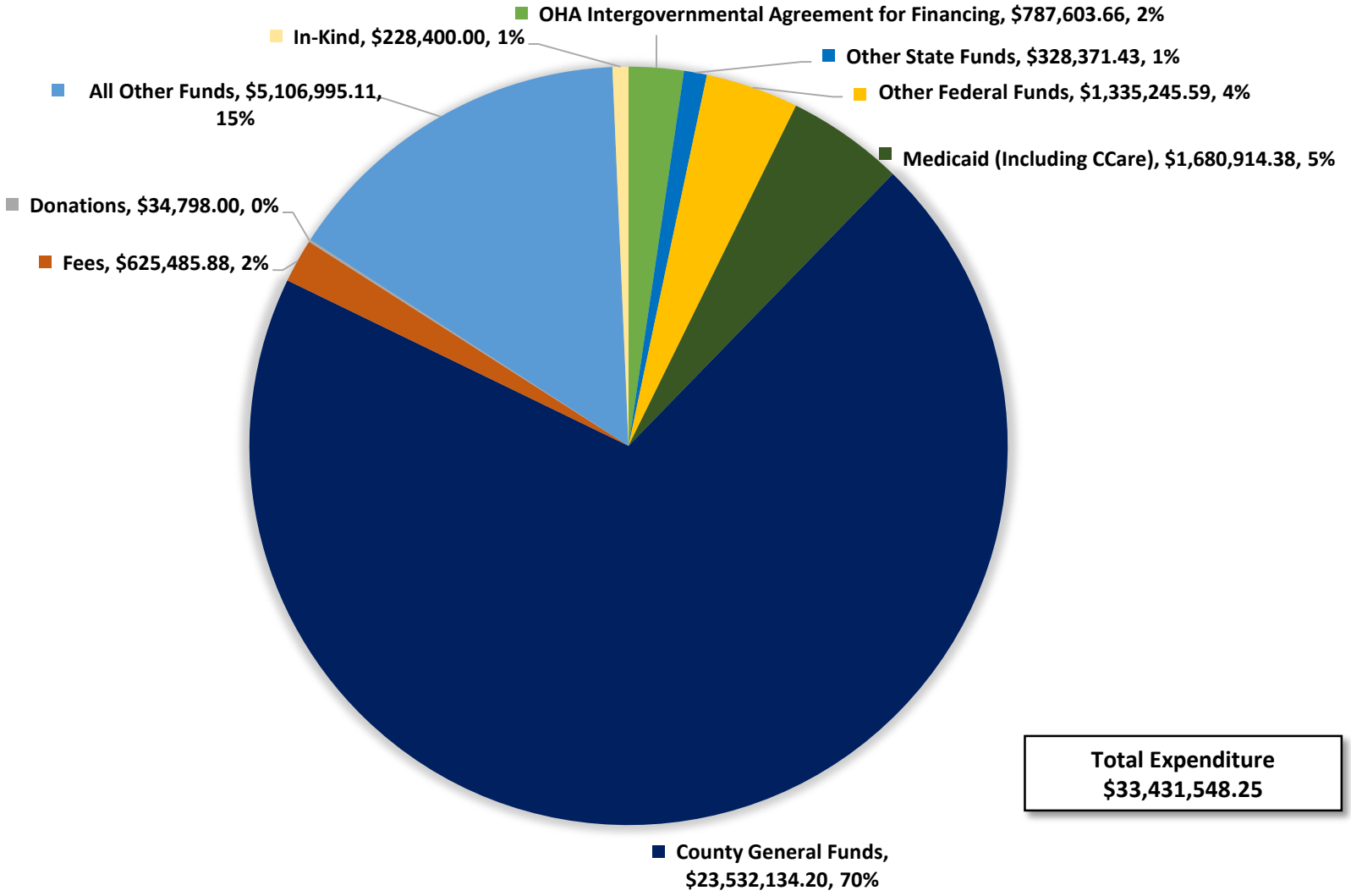
# LPHA Emergency Preparedness & Response FY2017



# LPHA Access to Clinical Preventive Services FY2017



# LPHA Administrative FY2017



| County | Population* | County General Fund (CGF) | In Kind (IK) | Total LPHA Expenditures | Per Capita CGF | PerCapita Total LPHA Expenditures |
|---|---|---|---|---|---|---|
| **Oregon** | **4,141,100** | **$ 67,839,512** | **$908,340** | **$ 201,896,698** | **$ 16.38** | **$ 48.75** |
| BAKER | 16,750 | $ 234,676 | $ 12,000 | $ 970,972 | $ 14.01 | $ 57.97 |
| BENTON | 92,575 | $ 2,090,815 | $ - | $ 6,879,081 | $ 22.59 | $ 74.31 |
| CLACKAMAS | 413,000 | $ 1,965,745 | $ - | $ 9,439,290 | $ 4.76 | $ 22.86 |
| CLATSOP | 38,820 | $ 431,075 | $ - | $ 1,612,266 | $ 11.10 | $ 41.53 |
| COLUMBIA | 51,345 | $ 100,000 | $ 44,489 | $ 2,297,089 | $ 1.95 | $ 44.74 |
| COOS | 63,310 | $ - | $ 52,178 | $ 868,650 | $ - | $ 13.72 |
| CROOK | 22,105 | $ 517,139 | $105,000 | $ 1,994,125 | $ 23.39 | $ 90.21 |
| CURRY | 22,805 | $ - | $144,795 | $ 699,023 | $ - | $ 30.65 |
| DESCHUTES | 182,930 | $ 2,968,217 | $ - | $ 9,312,609 | $ 16.23 | $ 50.91 |
| DOUGLAS | 111,180 | $ 671,902 | $ - | $ 9,322,364 | $ 6.04 | $ 83.85 |
| GRANT | 7,415 | $ 73,636 | $ - | $ 649,302 | $ 9.93 | $ 87.57 |
| HARNEY | 7,360 | $ 96,952 | $ - | $ 349,580 | $ 13.17 | $ 47.50 |
| HOOD RIVER | 25,145 | $ 425,848 | $396,903 | $ 2,125,960 | $ 16.94 | $ 84.55 |
| JACKSON | 216,900 | $ 670,465 | $ - | $ 6,746,017 | $ 3.09 | $ 31.10 |
| JEFFERSON | 23,190 | $ 462,444 | $104,500 | $ 1,468,431 | $ 19.94 | $ 63.32 |
| JOSEPHINE | 85,650 | $ 364,715 | $ - | $ 2,473,845 | $ 4.26 | $ 28.88 |
| KLAMATH | 67,690 | $ 232,280 | $ - | $ 2,214,147 | $ 3.43 | $ 32.71 |
| LAKE | 8,120 | $ 151,267 | $ - | $ 566,229 | $ 18.63 | $ 69.73 |
| LANE | 370,600 | $ 1,716,536 | $ - | $ 12,695,596 | $ 4.63 | $ 34.26 |
| LINCOLN | 47,960 | $ 307,500 | $ - | $ 4,324,367 | $ 6.41 | $ 90.17 |
| LINN | 124,010 | $ 651,346 | $ - | $ 5,319,620 | $ 5.25 | $ 42.90 |
| MALHEUR | 31,845 | $ 468,960 | $ 20,075 | $ 1,402,813 | $ 14.73 | $ 44.05 |
| MARION | 339,200 | $ 2,152,253 | $ - | $ 9,697,957 | $ 6.35 | $ 28.59 |
| MORROW | 11,890 | $ 613,474 | $ 8,000 | $ 1,312,682 | $ 51.60 | $ 110.40 |
| MULTNOMAH | 803,000 | $ 43,542,723 | $ - | $ 82,713,762 | $ 54.23 | $ 103.01 |
| North Central (Gilliam, Sherman, Wasco) | 30,895 | $ 545,643 | $ - | $ 2,039,667 | $ 17.66 | $ 66.02 |
| POLK | 81,000 | $ 251,759 | $ - | $ 1,514,098 | $ 3.11 | $ 18.69 |
| TILLAMOOK | 26,175 | $ 146,840 | $ - | $ 929,912 | $ 5.61 | $ 35.53 |
| UMATILLA | 80,500 | $ 386,278 | $ - | $ 1,981,086 | $ 4.80 | $ 24.61 |
| UNION | 26,900 | $ 145,000 | $ - | $ 2,081,900 | $ 5.39 | $ 77.39 |
| WALLOWA | 7,195 | $ - | $ - | $ 143,120 | $ - | $ 19.89 |
| WASHINGTON | 595,860 | $ 4,800,731 | $ - | $ 13,264,263 | $ 8.06 | $ 22.26 |
| WHEELER | 1,480 | $ 2,500 | $ 20,400 | $ 235,361 | $ 1.69 | $ 159.03 |
| YAMHILL | 106,300 | $ 650,791 | $ 37 - | $ 2,251,516 | $ 6.12 | $ 21.18 |

* Population figures from Portland State University

~~January 8~~February 7, 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. Re~~quire~~commend there be a CCO voting member position on the LPHA advisory committee, when a LPHA has an advisory committee.
3. ~~Include~~ Require that LPHAs are compensated for the public health contribution towards incentive measures (e.g., tobacco and immunizations) through 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 full cost of the provision of clinical services, including family planning, sexually transmitted infection treatment and contact tracing, and immunizations, whether that be through fee for service or alternative payment methodologies.

[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.<br><br>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.<br><br>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.