AGENDA

PUBLIC HEALTH ADVISORY BOARD

March 15, 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:

- Receive subcommittee updates
- Adopt baseline public health accountability metrics report
- Discuss the progress of the 2017-18 Preventive Health and Health Services Block Grant
- Discuss the progress of the AIMHI grant

2:00-2:30 pm	**Welcome and updates** • Approve February 15 meeting minutes • Legislative updates • CCO 2.0	Rebecca Pawlak, PHAB Chair
2:30-2:40 pm	**Subcommittee updates** • Incentives and Funding subcommittee	Alejandro Queral, PHAB member
2:40-3:30 pm	**Public health accountability metrics report** • Review final public health accountability metrics baseline report • Action required: adopt final public health accountability metrics baseline report	Myde Boles, Program Design and Evaluation Services
3:30-3:40 pm	**Break**	
3:40-3:55 pm	**Preventive Health and Health Services Block Grant update** • Review current grant year progress • Discuss next steps	Danna Drum, Oregon Health Authority
3:55-4:30 pm	**AIMHI grant update** • Receive an update on grant progress over the course of the AIMHI grant period • Discuss next steps	Morgan Cowling, Coalition of Local Health Officials

4:30-4:45 pm	**Public comment**	
4:45 pm	**Adjourn**	Rebecca Pawlak, PHAB Chair

Public Health Advisory Board (PHAB)
February 15, 2018
Draft Meeting Minutes

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, Eva Rippeteau

Oregon Health Authority (OHA) staff: Cara Biddlecom, Sara Beaudrault, Julia Hakes, Myde Boles, Joey Razzano

Members of the public: Renee Sells (OHSU), Joanna Cintora (OHSU)

Approval of Minutes

A quorum was present. The Board moved to approve the January 18 minutes with all in favor.

Welcome and updates

-Rebecca Pawlak, PHAB Chair

Rebecca outlined the three actions that the PHAB will take today: adopt the public health funding principles, adopt public health modernization implementation priorities for the 2019-21 biennium, and adopt the CCO 2.0 recommendations that were discussed during the last two PHAB meetings.

Rebecca made a few public health modernization announcements: since December, OHA and local public health authorities have been working to implement the public health modernization general fund investment and as a part of this work have also begun to brief legislators about the new general fund investment going into their communities. Many of the local projects have kicked off and hired core staff. Legislative briefings held to date have all gone well.

Rebecca and Cara gave an update about the 2018 short legislative session. Some of the significant public health priorities that are being discussed are air quality, opiates, and maternal mortality. There continue to be discussions about changes to CCOs as a continuation from the 2017 session. David asked about more specific legislative updates. Cara shared that HB 4018 just passed out of the House Interim Committee on Health Care on 2/14. HB4018 establishes meeting requirements for governing bodies of CCOs and adds new requirements and clarifications for CCOs contracting with OHA and other entities.

Incentives and Funding subcommittee update

-Jeff Luck, PHAB member

Jeff went over the proposed funding principles for the public health system for the PHAB's review.

Principle number one: Tricia shared that CLHO recommended inserting language that public health and preventive services are available. Alejandro asked if this principle is meant to include the entire public health system. Cara said yes and stated that this clarification was added to the introductory paragraph.

Principle number two: Eli asked how this principle relates to local public health authority Program Elements. Cara answered that the PHAB funding principles apply to the entire public health system whereas current Program Elements operate program by program. Eli asked if there is any discussion about how Program Elements relate to public health modernization. Cara answered that the program element template has been redesigned to align with public health modernization and the new format will be effective in contracts as of July 1, 2018.

Principle number three: No changes or comments.

Principle number four: Katrina recommended replacing or removing the word innovative. Katrina expressed her concern that innovation does not always mean the focus is on data and evidence-based practice. Teri stated that there is no evidence that regional work is more efficient and recommended replacing innovative with cross-jurisdictional.

Principle number five: Tricia shared that CLHO recommended changing the principle to "Align public health work and funding to coordinate resources with health care, education and other sectors to achieve health outcomes."

Principle number six: David recommended changing the word recognize to acknowledge.

Principle number seven: Katrina asked how this principle is operationalized. Tricia answered that not all programs are transparent about local and state funding.

Bob made a motion to adopt the funding principles with amendments.

Carrie, Muriel, Alejandro, Rebecca, Jeff, Bob, Tricia, Teri, Kelle, Akiko, Jennifer, and Eva were in favor of adopting the funding principles with amendments. Eli abstained.

2019-21 public health modernization priorities
-Cara Biddlecom, OHA

Cara reviewed the 2019-21 public health modernization priorities with the PHAB. This is a duty of the Public Health Advisory Board per ORS 431.123(3): *Make recommendations to the Oregon*

Health Policy Board on the establishment of the foundational capabilities under ORS 431.131, the foundational programs under ORS 431.141 and OAR 333-014-0560(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.*

OHA will need to spend the coming months developing a budget request for the 2019-21 implementation of public health modernization. The actual budget request is an internal OHA process but OHA is requesting PHAB input early on per the OAR and ORS requirement above. The timeline for development will be as follows:

- February 2018: PHAB determines priority foundational capabilities and programs to implement during the 2019-21 biennium.
- March-April 2018: OHA works with CLHO to prioritize work within the PHAB's selected foundational capabilities and programs, using the Public Health Modernization Manual.
- April-May 2018: The Public Health Division develops the policy option package and submits it to OHA for review and possible approval.
- August 2018: OHA releases its 2019-21 Agency Request Budget.
- December 2018: The Governor releases the Governor's Recommended Budget in preparation for the 2019-21 legislative session.
- February-June 2019: The legislature develops the 2019-21 balanced budget.

Cara walked through guiding documents for the discussion:

- Summary findings from the 2016 statewide public health modernization assessment
- Proposed phases for implementation of public health modernization which were originally determined by PHAB in Spring 2016 and included in the 2016 Statewide Public Health Modernization Plan
- The funding level pyramid used by PHAB in 2017 to determine where to allocate funds at different levels in the 2019-21 biennium

Cara asked the PHAB to determine:

- If any changes need to be made to the phases
- What to prioritize for the next biennium given that the focus for the current biennium is limited to a portion of communicable disease control, health equity and cultural responsiveness, and assessment and epidemiology

Eli asked if emergency preparedness and response is federally funded. Akiko answered that there are federal funds for emergency preparedness, but gaps exist in implementation of this foundational capability per the 2016 public health modernization assessment. Rebecca noted that there is some alignment between the Governor's priorities and phase 1 of public health modernization. David agreed and cited the letter Governor Brown wrote to the Health Policy Board encouraging CCO 2.0 to focus on the social determinants of health and health equity.

Teri noted that the first phase was not fully funded. Eli asked if PHAB is proposing a dollar amount. Rebecca clarified that the PHAB's role is advisory and it is up to the determination of the agency to ask for a specific dollar amount. David asked if it is the PHAB's prerogative to say that public health modernization is not viable based on current funding. Katrina clarified that public health modernization is more than just funding: it is a framework.

Akiko made a motion to recommend to stay in phase one of public health modernization for 2019-2021. All in favor.

Public health accountability metrics report
-Myde Boles, OHA

Myde reviewed the Public Health Accountability Metrics: Baseline Report.

Eli requested a place where all acronyms are listed, preferably in each graph.

Bob noted the urban/rural divide related to the active transit metric, citing that some counties have no public transit or have no existing active transportation partner governing or leadership boards. Bob also recommended that OHA be mindful that for some metrics higher is better and for others lower is better.

Bob emphasized that OHA be very sensitive to very small counties with accountability metrics. Jen shared that the state of Washington approached the urban/rural divide by creating a different set of accountability metrics for King County. Cara answered that this is important to consider should the PHD incentivize unfunded work.

Local public health authority actual expenditures report summary
-Joey Razzano, OHA

Joey shared Local Public Health Authority expenditure data for fiscal year 2017.

Tricia and Eli asked for more clarification on what is included in administrative/other expenditures. Bob earmarked the administrative/other expenditures as a future item to be discussed at CLHO. Joey said the PHD is developing more guidance for the administrative expense category for next year. Teri expressed concern over the potential administrative burden on LPHAs if they must break out staff time even further.

Alejandro highlighted the disparity in the per capital total LPHA expenditures. He asked what the right balance of funding would be and how the PHAB can incentivize county boards to fund the local public health system. Bob noted that the PHAB needs to consider how matching funding could harm counties and could grow the disparity. Teri said PHAB needs to

acknowledge that there are no county general funds in some counties. Cara asked the PHAB if in-kind expenditures should be incentivized. David made the point that if the PHAB was examining the expenditures with an equity lens, counties with less would receive more funding. Jen asked if OHA has considered looking at similar counties in size beyond state lines.

Eli asked how these expenditures connect to summary findings from the 2016 statewide public health modernization assessment. Cara reminded PHAB members that local public health authorities did not want to be identified in the assessment report. Bob answered that some counties only have 2.0 FTE running all public health programs.

CCO 2.0 recommendations
Cara Biddlecom, OHA

Cara reviewed the draft Public Health Advisory Board Initial CCO 2.0 Recommendations.

Bob provided feedback from CLHO:

- Add "shared" to number six to ensure state health improvement plan implementation is the same in number five.
- CLHO also discussed that CCOs invest one percent of revenue but this has not been decided.

Alejandro asked that the PHAB incorporate a baseline investment based on CCO savings. Katrina said that the funding piece is not entirely clear and asked the PHAB if we should look for a simpler solution. Rebecca clarified that the overall concepts of the recommendations are what are important and not the exact language. Rebecca shared that what success would look like to her in this process would be to see the PHAB's recommendations in the work plans going to the Oregon Health Policy Board for review and approval in March, not necessarily this exact document.

Jen said she would like to see population health instead of fee-for-service in number three.

Eli made a motion to approve the recommendations and send them to the Oregon Health Policy Board. All in favor.

Public Comment Period
No public testimony was provided.

Closing
The meeting was adjourned.

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

March 15, 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 Advisory Board
Funding principles for state and local public health authorities
February 15, 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 funding.

Public health system approach to foundational programs

1. Ensure that public health services are available to every person in Oregon, 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, risk, and state and community health assessment and plan priorities, while 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 cross-jurisdictional sharing.

5. Align public health work and funding to coordinate resources with health care, education and other sectors to achieve health outcomes.

Transparency across the public health system:

6. Acknowledge how the public health system works to achieve outcomes, and direct funding to close the identified gaps across the system in all governmental public health authorities.

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

February 15, 2018

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. Recommend there be a CCO voting member position on the LPHA advisory committee, when a LPHA has an advisory committee.
3. Require that LPHAs are compensated for the 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 shared 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. 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 (PHAB)
Incentives and Funding Subcommittee meeting minutes
March 12, 2018
1-2:00 pm

Welcome and Introductions

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

Oregon Health Authority (OHA) staff: Cara Biddlecom, Julia Hakes, Chris Curtis

The February 12 meeting minutes were approved.

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

2019-21 modernization funding formula

Alejandro walked subcommittee members through a review of funding formula indicators, measures and data sources. Subcommittee members had no changes to the county population, burden of disease, health status, and racial and ethnic diversity measures or data sources.

Alejandro proposed changing the poverty measure to either 133 or 185 percent of federal poverty level as 100 percent of federal poverty level is only representative of extreme poverty. Staff will look for additional county-level indicators and Chris will input these measure scenarios into the funding formula for review at the subcommittee at the next meeting.

Jeff recommended looking at percent of population that has a bachelor's degree as a measure for the education indicator.

Alejandro asked subcommittee members if English not being the primary language spoken at home would be a better measure for the limited English proficiency measure. Subcommittee members were unsure whether "speaks English less than 'very well'" is the right indicator. Jeff sent out https://www.lep.gov/ for subcommittee members to review.

Subcommittee members agreed that the geographic complexity and community complexity indicators would likely be correlated. Cara proposed using a point

system from 1-3 based on county rurality for the geographic complexity indicator. A similar point system is used for the Maternal and Child Health Title V and reproductive health funding formulas already.

Subcommittee business

Alejandro will provide a subcommittee update at the March 15 PHAB meeting.

Akiko will chair the subcommittee meeting April 9. If Akiko is no longer available, Alejandro is willing to chair.

Public Comment

No public testimony.

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics Subcommittee meeting minutes

March 8, 2018

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

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

Welcome and introductions
The January 24, 2018 meeting minutes were approved.

Public health accountability metrics report

Myde walked subcommittee members through the Public Health Accountability Metrics Report.

Eli asked how LPHAs will achieve the benchmark without improvement targets. Myde explained that improvement targets and incentive funding will be discussed at the joint Accountability Metrics and Incentives and Funding subcommittee meeting on March 29.

Jennifer cited the percent of gonorrhea cases that had at least one contact that received treatment as a process measure where it is important to be specific with numbers. Jennifer gave the example of Multnomah County which has significantly more cases of gonorrhea than smaller counties but is not represented when shown by percentage. Myde agreed and will put the raw data on a table in the next iteration of the report.

Eli asked what it means when the benchmark has been established by the Public Health Division. Sara explained that Division programs either use existing benchmarks or look at benchmarks used by other states and/or other resources to establish benchmarks.

Eli expressed concern that some of the benchmarks are very high compared to the baseline and is worried that LPHAs will not be able to hit the benchmark in the given timeline. He gave the example of the percent of gonorrhea case reports with complete priority fields as a very high benchmark. Muriel said this is a process measure and the high benchmark does not concern her, it tells her that there needs to be more training. Cara clarified that the process measure timeline is more nimble than the accountability metric timeline because process measures reflect how the work is done and accountability metrics have a much longer timeline for change.

Muriel asked if the benchmark is too high for the percent of top opioid prescribers enrolled in PDMP process measure. Subcommittee members cited the passage of HB 4143 as justification for the high benchmark as all providers will now be required to register for PDMP.

Jennifer drafted some language for the introduction of the report that explains the importance of metrics and the process that PHAB used to identify measures and will send to Sara to be included in the report.

The subcommittee moves to present the report to the PHAB for adoption. All in favor.

Public comment

No public comment was provided.

Adjournment

The meeting was adjourned.

The next Accountability Metrics Subcommittee meeting is scheduled for:

March 29, 2018 from 1-3 pm

APPENDIX B (EXAMPLE TABLE)

Gonorrhea Rate

Local Public Health Process Measure

Percent of gonorrhea case reports with complete priority fields, 2016

County	Number of Case Reports with Complete Priority Fields	Total Case Reports	Percent
Baker	1	1	100.00
Benton	6	48	12.50
Clackamas	36	280	12.86
Clatsop	3	22	13.64
Columbia	5	37	13.51
Coos	6	41	14.63
Crook	8	15	53.33
Curry	2	11	18.18
Deschutes	23	65	35.38
Douglas	9	36	25.00
Gilliam	0	1	0.00
Grant	0	1	0.00
Harney	0	5	0.00
Hood River	1	4	25.00
Jackson	10	177	5.65
Jefferson	0	16	0.00
Josephine	2	84	2.38
Klamath	10	61	16.39
Lake	1	7	14.29
Lane	60	281	21.35
Lincoln	2	24	8.33
Linn	15	112	13.39
Malheur	10	29	34.48
Marion	146	347	42.07
Morrow	1	19	5.26
Multnomah	345	1972	17.49
Polk	4	48	8.33
Sherman*	NA	0	NA
Tillamook	0	3	0.00

County	Number of Case Reports with Complete Priority Fields	Total Case Reports	Percent
Umatilla	0	88	0.00
Union	4	11	36.36
Wallowa*	NA	0	NA
Wasco	2	12	16.67
Washington	120	459	26.14
Wheeler	0	1	0.00
Yamhill	1	35	2.86
Total	833	4353	19.14

Data source: Orpheus, 2016

Priority fields include race, ethnicity, gender of sex partner, pregnancy status, and HIV status/date of last HIV test. Priority fields (race, ethnicity, and pregnancy status) are considered complete if they are not unknown or refused.

* indicates counties that had 0 gonorrhea cases in 2016

Public Health Advisory Board
Public Health Accountability Metrics Report health equity review
March 15, 2018

1. **How is the work product, report or deliverable different from the current status?**
   Public health accountability metrics focus attention on population health priorities in Oregon and the role of the public health system to improve population health. These metrics will demonstrate progress through public health modernization and will set the stage for increased cross sector collaboration on shared metrics. The 2018 Public Health Accountability Metrics Report is a baseline report and will be published annually hereafter.

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

3. **How does the work product, report or deliverable support individuals in reaching their full health potential?**
   The Public Health Accountability Metrics Report does not directly support individuals.

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

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

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

6. **How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?**
   Feedback was solicited from partners and community members through a stakeholder survey. Of 201 survey respondents, 86 identified as a community member. Survey respondents provided input on which measures are priorities for themselves or the organizations they represent, and which measures are most important.

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

8. **How will data be used to monitor the impact on health equity resulting from this work product, report or deliverable?**
   OHA will publish the Public Health Accountability Metrics Report annually, beginning in 2018. The annual report will be the primary mechanism for monitoring the impact on health equity resulting from increased focus on population health issues for which there is a public health accountability metric.

   The public health modernization funding formula includes a component for performance-based payments to local public health authorities. The public health modernization funding formula includes indicators for equity and social determinants of health.

March 2018

Preventive Health & Health Services Block
Grant – Fact Sheet

Background

- Non-competitive grant issued to all states and territories to address state determined public health priorities.
- The Public Health Advisory Board (PHAB) is designated as the Block Grant Advisory Committee which makes recommendations regarding the development and implementation of the work plan.
- Federal code states that a portion of the allocation (pre-determined) be used for rape prevention and victim services. This funding currently goes to the Oregon Coalition Against Domestic and Sexual Violence.
- Work plan must be tied to Healthy People 2020 objectives. Oregon has historically used the block grant to support infrastructure. Healthy People 2020 objectives in the 2018-19 work plan:
    - Public health infrastructure *(PHI-2. Increase the proportion of Tribal, State and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals)*
    - *Public health infrastructure (PHI-15. Increase the proportion of Tribal, State and local public health agencies that have developed a health improvement plan and increase the proportion of local public health agencies that have a health improvement plan linked with their state plan.)*
    - *Public health infrastructure (PHI-16. Increase the proportion of Tribal, State and local public health agencies that have implemented an agency-wide quality improvement process.)*
    - Accredited public health agencies *(PHI-17. Increase the proportion of Tribal, State and local public health agencies that are accredited.)*
    - Sexual Violence *(IVP-40. Reduce sexual violence.)*

Funding

- For October 2017 – September 2018 work plan, $1,117,102 is available ($85,660 for rape prevention and victim services).
- For October 2018 – September 2019 work plan, funding is uncertain and allocations unknown at this time. PHHS Block Grant is funded through the Prevention and Public Health Fund.

Funded Work Plan and Activities – Work Plan 2018

Oregon's overall goal has been to support ongoing planning for and implementation of Public Health Modernization's foundational capabilities so all Oregonians have access to the public health foundational capabilities and programs to prevent disease, injury and death.

- Continuing education for governmental public health professionals in Oregon (Leadership and organizational competencies)
    - Oregon Health Authority-Public Health Division (OHA-PHD)
        - Establish OHA-PHD Workforce Development Council.
        - Establish and monitor core training requirements for PHD managers and new employees.
        - Provide OHA-PHD staff access to vetted continuing education opportunities.
        - Conduct OHA-PHD all-staff engagement activities and communications.
        - Provide funding for Oregon Public Health Association (OPHA) annual conference.
    - Local and Tribal public health authorities
        - Provide online access to vetted continuing education opportunities.
        - Fund OPHA annual conference.

- State health improvement plan (Assessment and epidemiology, policy and planning, community partnership development)
    - Oregon Health Authority – Public Health Division
        - Develop new state health assessment (SHA), including hosting community input meetings around the state.
        - Monitor and report on current state health improvement plan (SHIP) implementation.
        - Develop cross-agency partnerships to facilitate successful implementation of current SHIP.
        - Plan for next SHIP development process.
    - Local public health authorities
        - Establish and maintain platform for sharing community health assessments (CHAs) and community health improvement plans (CHIPs).
        - Provide information and technical assistance on how the SHA and SHIP can inform CHAs and CHIPs.

- Quality improvement (Leadership and organizational competencies, community partnership development)
    - Oregon Health Authority-Public Health Division (OHA-PHD)

        - Maintain performance management system through monthly dashboards and implement quality improvement projects to increase efficiency and effectiveness of business processes and public health interventions.
    - Local public health authorities
        - Coordinate and conduct triennial reviews for Oregon local public health authorities to identify strengths and areas for improvement in implementation of public health services.
        - Utilize review of 2014-16 triennial review findings to identify areas for improving triennial review process and public health services.
        - Provide technical assistance, training, tools and resources to LPHAs, including new local and tribal public health staff orientations.
        - Partner with Conference of Local Health Officials (CLHO) on provision of OHA-PHD funded public health services.
    - Nine federally-recognized tribes in Oregon
        - Coordinate OHA-PHD work with Tribes.
- Public health accreditation (Leadership and organizational competencies, health equity and cultural responsiveness)
    - Oregon Health Authority-Public Health Division
        - Maintain national accreditation status through annual reporting and re-accreditation.
        - Implement statewide modernization plan, including tribal public health modernization assessments, implementation of accountability metrics, Oregon Administrative Rules revisions and alignment of OHA-PHD processes with public health modernization.
        - Implement OHA-PHD health equity action plan by supporting a shared understanding of health equity within OHA-PHD, documenting existing OHA-PHD health equity work, implementing an internal health equity communications and engagement plan, and compiling an easy-to-use resource on existing social determinants of health indicators.
    - Local and tribal public health authorities
        - Co-facilitate (with CLHO) community of practice for local and tribal health department accreditation coordinators.
        - Provide local and tribal accreditation technical assistance, including assistance with OHA-PHD accreditation documentation requests.
        - Collect and report baseline data for public health modernization accountability metrics and collect LPHA FY17 expenditure data for 2019-21 public health modernization funding formula planning.
        - Begin aligning contracts and triennial review with public health modernization as appropriate.
        - Continue implementing tribal public health modernization programmatic assessment.

- Sexual Violence Prevention (Prevention and health promotion)
    - Fund El Programa Hispano, a culturally specific organization, to conduct sexual violence primary prevention with marginalized communities using an anti-oppression framework.
        - Develop and implement primary prevention curriculum.
        - Support cross-communities partnerships.
        - Develop and implement primary prevention curriculum.
        - Collect evaluation data and share learnings with the sexual violence prevention field.

<u>Next Steps for 2018-19 Work Plan Development</u>

- Draft 2018-19 proposed work plan concepts based on assumption of level funding until allocation is received. *(Tentative timeline: March 2018)*
- Hold public hearing on proposed work plan concepts. *(Tentative timeline: mid-April 2018)*
- Share proposed work plan concepts and any comments received at public hearing with PHAB for final recommendation. *(Tentative timeline: April 2018)*
- Submit final work plan to Centers for Disease Control and Prevention. (*Tentative timeline: May 2018)*

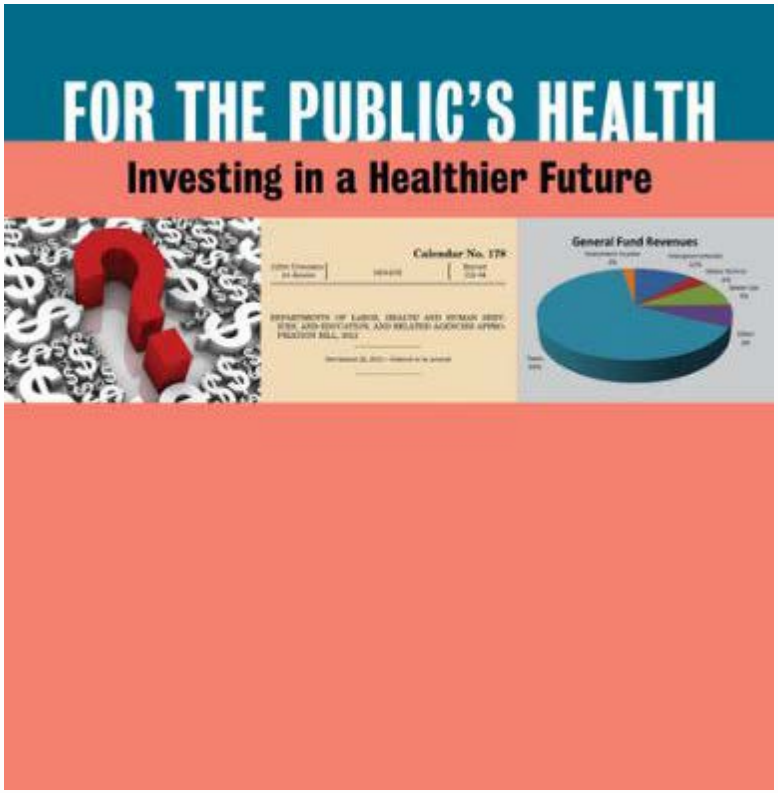
ALIGNING INNOVATIVE MODELS for HEALTH IMPROVEMENT (AIMHI) in Oregon

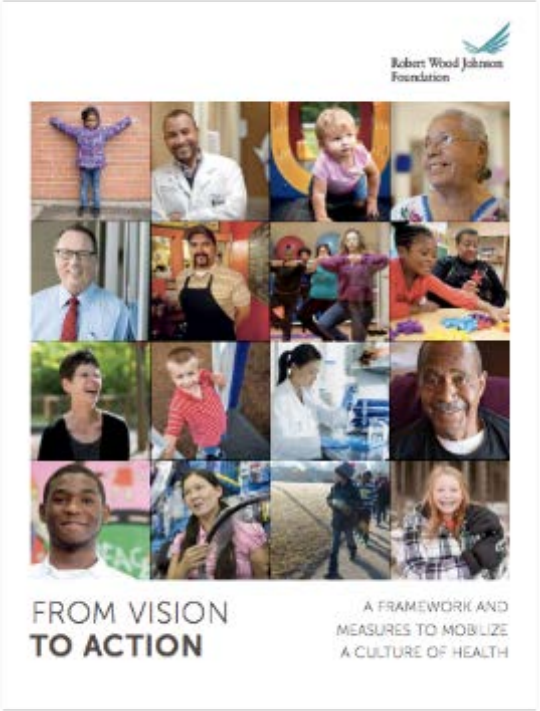
Morgan Cowling, CLHO Executive Director, Co- PI
Cara Biddlecom, PHD Director of Policy & Partnerships, Co-PI

Presentation Overview

- RWJF - About the Project
- Major Activities / Deliverables
- PHAB's Role
- What we've accomplished in 2 years
- Review Tools and Technical Assistance
- Challenges

Robert Wood Johnson Foundation: Building a Culture of Health





PHAB
Advancing public health performance

AIMHI Project Activities/ Deliverables

- Participate in a 21st Century Public Health Learning Community comprised of Oregon, Ohio, and Washington
- Hold 10 meetings across Oregon engaging local communities, health and education stakeholders, and local elected officials in Public Health Modernization
- Develop a step-by-step roadmap for modernizing Oregon's public health system
- Create a set of tools to navigate and overcome barriers to implementing public health modernization
- Develop a public health modernization plan template
- Provide technical assistance and support to state and local public health to use the tools
- Five areas of the state submit Local Public Health Modernization Implementation Plans

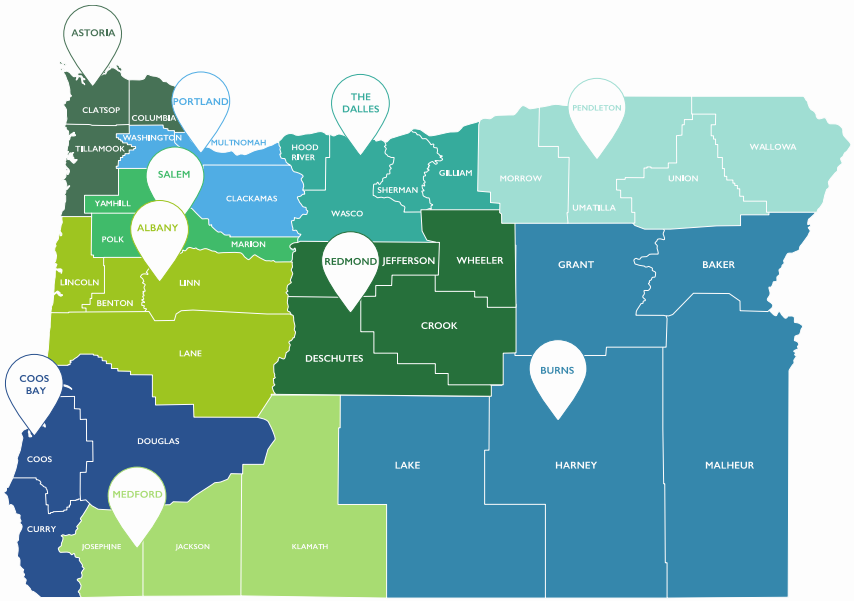
PHAB's Role

- Utilize (newly) appointed Public Health Advisory Board with oversight for the public health system in Oregon for RWJF grant purposes including:
  - Identify areas where the PHAB can support additional outreach and engagement of communities and other stakeholders
  - Assure strong connections with grant work and other stakeholders: CCOs, primary care, early learning, education and others to facilitate collaboration
  - Assist with recruitment efforts to 10 regional meetings
  - Oversee public health outcomes and metrics work to connect with RWJF's Culture of Health goals
  - Provide feedback on modernization tools

What we've accomplished in 2 years

- Engaged over 450 Oregonians in Public Health Modernization
- Identified biggest challenges with implementing Modernization and future opportunities with CJS
- Captured 78 Cross-Jurisdictional and Cross-Sector partnerships
- PHAB established Modernization Accountability metrics and process measures
- Created one orphroadmap.org with 35 + tools
- Technical Assistance provided

Raising Awareness across Oregon



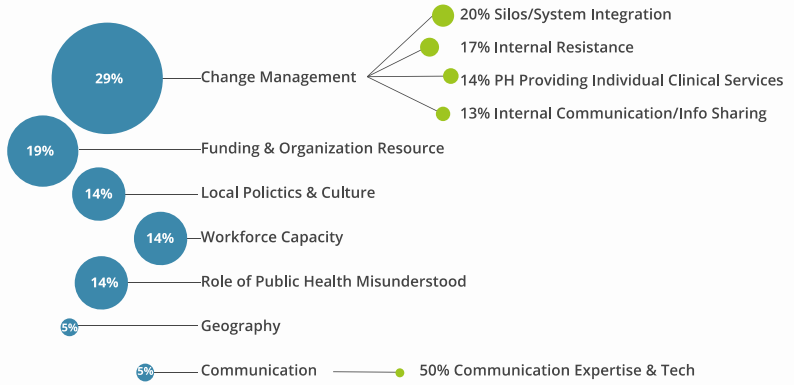
Types of AIMHI Meeting Attendees by Sector

Types of Attendees by Sector	Attendance
Local Public Health Department Staff	172
Community Based Organization	56
Local Public Health Department Administrators	33*
CCO's	33
State Public Health Department Staff	22*
Local Government Elected Officials	28
Healthcare Providers	28
Other	24
Higher Education	19
Primary Education	9
Tribal Government	8
Local Public Health Advisory Board	6

*People who attended multiple AIMHI meetings were counted once.

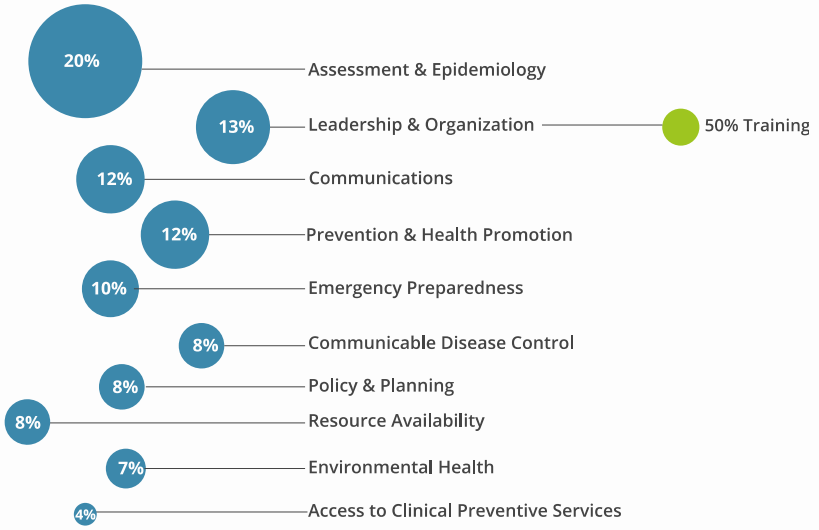
Implementing FPHS Model - Challenges, needs & opportunities

Challenges to Implementing Modernization

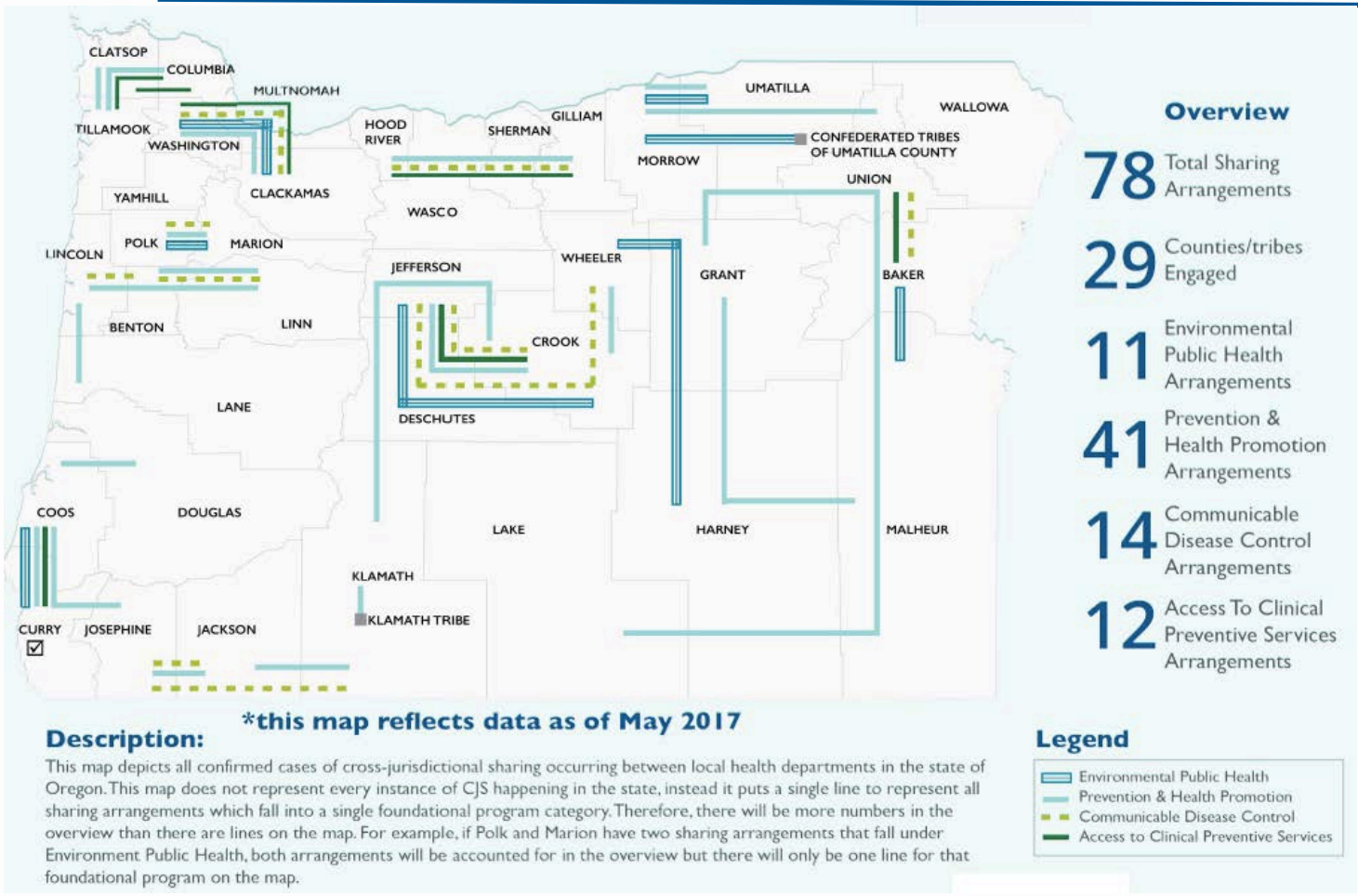


*The strength of this theme may be artificially low as attendees were encouraged not to focus solely on funding and resources.

Opportunities in Cross-Jurisdictional Sharing



Cross-Jurisdictional Sharing



Accountability Metrics

Public health is tracking eight accountability metrics

Communicable Disease Control

- ✔ Two-year old immunization rates
- ✔ Gonorrhea rates

Prevention and Health Promotion

- ✔ Adults who smoke cigarettes
- ✔ Opioid overdose deaths

Environmental Health

- ✔ Active transportation
- ✔ Drinking water standards

Access to Clinical Preventive Services

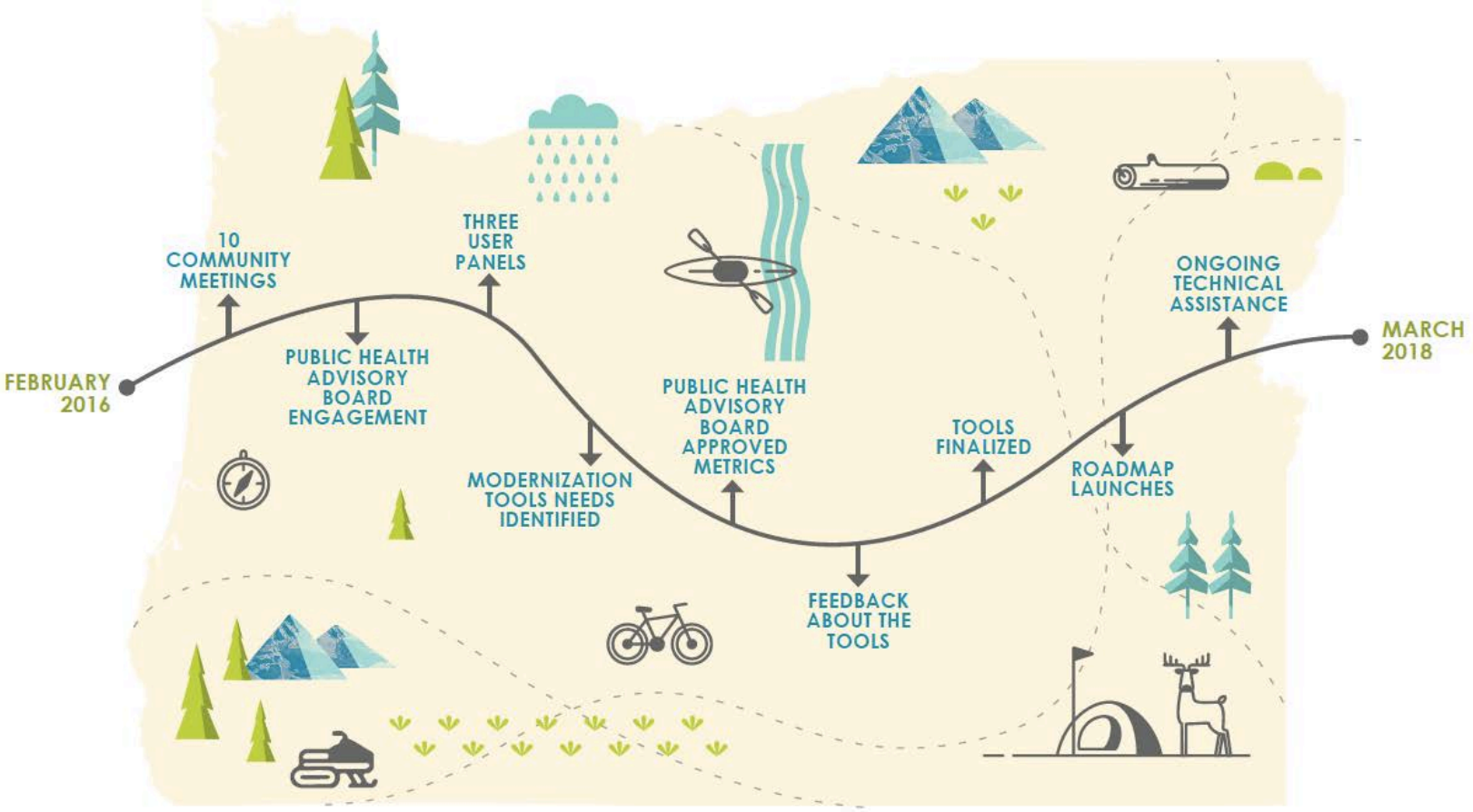
- ✔ Effective contraceptive use
- ✔ Dental visits for 0-5 year olds

Public Health Modernization Roadmap

Coalition of Local Health Officials

ORPHROADMAP.ORG

Oregon Health Authority


FEBRUARY 2016
10 COMMUNITY MEETINGS
PUBLIC HEALTH ADVISORY BOARD ENGAGEMENT
THREE USER PANELS
MODERNIZATION TOOLS NEEDS IDENTIFIED
PUBLIC HEALTH ADVISORY BOARD APPROVED METRICS
FEEDBACK ABOUT THE TOOLS
TOOLS FINALIZED
ROADMAP LAUNCHES
ONGOING TECHNICAL ASSISTANCE
MARCH 2018

Challenges to Modernization Implementation

- Change management and change fatigue
  - Orienting staff and managers to new model
  - Juggling many changes all at once (federal funding changes, programmatic, etc)
  - Embracing Accreditation and now Modernization
- LHDs in some areas of state struggling to keep lights on
- Engaging decision-makers and communicating the value of PH Modernization
- Decision-makers and public prefer and understand public health programs, not “systems”

Opportunities Moving Forward

- Regular communications with Legislature
- Explaining the value of working cross-sector, especially with healthcare partners
- Learning from current Modernization Projects / Funding to leverage future investments
- Continuous Quality Improvements - Identify other public health system “innovations” beyond CJS
- Orphroadmap.org - Continuing to identify add’l Modernization tools and resources for Roadmap in support of the public health system

Lessons Learned

- Legislature impacts local efforts
- Engagement with elected officials early and often helped understanding and support of Modernization
- Strong communication and messaging need to be tailored for external and internal audiences and for all levels
- Lack of resources in some LPHAs creates barriers for implementing modernization

THANK YOU PHAB!