AGENDA

PUBLIC HEALTH ADVISORY BOARD

May 16, 2019 2:00 pm to 5:00 pm
Portland State Office Building
800 NE Oregon St., Conference room 1D
Portland, OR 97232

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

Meeting objectives:

- Hear updates on public health modernization with a focus on health equity
- Hear updates from PHAB subcommittees, approve funding recommendation for next funding tier
- Hear an update on the Public Health Block Grant
- Review LPHA investment reporting
- Discuss health equity as relates to PHAB.

2:00-2:05 pm	**Welcome and agenda review**	Rebecca Tiel, PHAB Chair
2:05-2:30 pm	**Health Equity Committee** • Update and discuss OHPB's HEC • Discuss implications for PHAB related to definitions, recommendations, frameworks, etc.	Leann Johnson, OHA Staff
2:30-2:40 pm	**PHAB Updates business** • Approve April meeting minutes • Legislative update • OHPB Digest and May 7 update	Rebecca Tiel, PHAB Chair
2:40-2:50 pm	**Public Health Block Grant** • Provide feedback and comment on draft work plan for the next year of the Block Grant	Danna Drum, OHA staff
2:50-3:00 pm	**Accountability Metrics Subcommittee** • Discuss work of the subcommittee	Jeanne Savage, PHAB member
3:00-3:10 pm	**Break**	
3:10-3:25	**LPHA investments in local system capacity:** • Review and discuss LPHA expenditure report • Review in funding formula model	Danna Drum, OHA staff

3:25-3:40 pm	**Incentives and Funding Subcommittee** • Discuss work of subcommittee	Akiko Saito, PHAB Member
3:40-4:10 pm	**Modernization Grantee Update: Health Equity Action Plans** • Update PHAB on local partnerships health equity action plans	Jocelyn Warren, Heather Amrhein, Lane County staff
4:10-4:30 pm	**Public comment**	Rebecca Tiel, PHAB Chair
4:30 pm	**Adjourn**	Rebecca Tiel, PHAB Chair

Oregon Health Authority
Office of Equity & Inclusion

Public Health Advisory Board

May 16, 2019

Oregon Health Authority | Office of Equity & Inclusion

OHA Equity & Inclusion Division

- 22 team members
- 18 functions for OHA and statewide health delivery system
- 9 of functions state or federally mandated

Health Equity Committee

- Committee of Oregon Health Policy Board
- Managed by Equity & Inclusion Division
- Evolved from Health Equity Policy Review Committee and Health Equity Policy Committee

Task and example

- Provide analysis, guidance and recommendations to OHPB on policy, including key legislation using an equity lens
  - Support implementation of CCO 2.0 from policy to practice

Task and example

- Provide assessment and actionable recommendations to OHA to achieve health equity goals, including cultural responsiveness
  - Definition for Health Equity
  - Assess and advise on OHA's progress toward health equity goals

Task and example

- Collaboratively work with other OHPB committees and make recommendations to OHPB
  - Partner with each OHPB committee to develop goals to integrate and advance equity

Definition Draft

- Health equity exists when all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, language, social and economic status, social class, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstances…

Definition Draft (con'd)

- Achieving health equity requires ongoing collaboration of all sectors to address:
  - The equitable distribution or redistribution of resources and power; and
  - **Recognizing and rectifying historical and contemporary injustices**

(Thank You PHAB, Winnipeg Regional Health Authority, Health Equity Committee, OEI)

Question

What does it mean to **recognize and rectify historical and contemporary injustices?**

How does that fit into a health equity framework?

Questions & Contact

Questions?

Contact:
Leann Johnson, MS
Director, Equity and Inclusion Division
Oregon Health Authority
Leann.r.johnson@state.or.us

OHPB Committee Digest

PUBLIC HEALTH ADVISORY BOARD, METRICS & SCORING COMMITTEE, HEALTH PLAN QUALITY METRICS COMMITTEE, HEALTH INFORMATION TECHNOLOGY OVERSIGHT COUNCIL, HEALTHCARE WORKFORCE COMMITTEE, HEALTH EQUITY COMMITTEE, PRIMARY CARE COLLABORATIVE, MEDICAID ADVISORY COMMITTEE, STATEWIDE SUPPORTIVE HOUSING WORKGROUP, MEASURING SUCCESS COMMITTEE, OPIOID TASK FORCE

Public Health Advisory Board

During the April meeting, Public Health Advisory Board members heard updates on public health modernization with a focus on health equity; heard updates from PHAB subcommittees; heard updates on the current State Health Improvement Plan; heard an update on the Preventive Health and Health Services Block Grant.

Three local partnerships funded by the 2017-2019 legislative investment in public health modernization shared their health equity action plans. These plans demonstrate how local partnerships will build internal capacity and work with communities to co-create the strategies that will achieve health equity.

PHAB is the official advisory body to the Public Health Division for the Preventive Health and Health Services Block Grant. This federal grant provides non-categorical funding that Oregon uses to fund priority initiatives that do not have other sources of funding, including the State Health Assessment and the State Health Improvement Plan and partnering with interested Tribes to modernize their public health services. This relatively small grant drives a vast amount of work by staffing foundational public health efforts.
This is the final year of the current State Health Improvement Plan. Updates this month focused on immunizations and communicable disease.

In Oregon, childhood immunization rates are improving (measure: two-year-olds up-to-date rate), but there's hidden risk when you look at what schools concentrate unvaccinated rates. The Public Health Division is using a syndemic model to understand the interactions between alcohol, prescription, and over the counter drug misuse; substance use disorder; suicidality; sexually transmitted infections; and hepatitis C and HIV. This kind of syndemic model is particularly helpful in understanding the issues facing rural Oregon and planning unified responses.

COMMITTEE WEB SITE: https://www.oregon.gov/oha/ph/About/Pages/ophab.aspx
STAFF POC: Kati Moseley, Katarina.Moseley@dhsoha.state.or.us

Primary Care Payment Reform Collaborative

In April, the Primary Care Payment Reform Collaborative convened to review and provide input on each of the four workgroup's culmination of efforts over the past few months. The Evaluation, Metrics, Technical Assistance, and Implementation workgroups provided updates of their work and received recommendations from collaborative members to further advance the collaborative's initiative. Two other workgroups, Populations not Covered by CPC+ and Behavioral Health Integration will meet twice a year and a

representative from each of these respective workgroups will help inform the work of the other four workgroups.

The workgroups will continue to convene monthly except during the month the full Collaborative convenes. The next Primary Care Payment Reform Collaborative meeting will take place on July 16, 2019, from 9am to Noon in Portland

COMMITTEE WEBSITE: http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx.
COMMITTEE POC: Susan El-Mansy, SUSAN.A.EL-MANSY@dhsoha.state.or.us

Healthcare Workforce Committee

The Healthcare Workforce Committee will meet on May 8.

Major items on the agenda include:

- A report on workforce-related legislation pending
- Review and action on recommendations of the Provider Incentive Distribution subcommittee
- A presentation on review of workforce trends and health outcomes in Oregon Counties 2010-18
- Brief reports on the HOWTO Program, National Health Service Corps, and update of Auto-Facility Health Professional Shortage Areas

COMMITTEE WEBSITE: http://www.oregon.gov/oha/HPA/HP-HCW/Pages/index.aspx
COMMITTEE POC: MARC OVERBECK, Marc.Overbeck@dhsoha.state.or.us

Health Plan Quality Metrics Committee

In March, the committee approved the 2020 Aligned Measure Menu. This measure menu set can be found on the committee's web page.

At the April 11 meeting, the committee had a year-end debrief and planning session for the next 12 months. Highlights of this meeting are:
–Discussion: identifying what worked well and topics for the next year work plan
–Prominent themes: clarifying committee scope and aligning measure set with priorities
–Addressing gaps and priorities: Behavioral Health and measures that HPQMC may consider reviewing and adding to the 2021 measure list.

Also, in April, the committee discussed the current legislative bill SB735. The original text can be found at: https://olis.leg.state.or.us/liz/2019R1/Measures/Overview/SB735.

Impacts of this bill on HPQMC include:
•Requires HPQMC to include hospital measures and to be applied to all health benefit plans sold in this state.
•Requires insurers offering health benefit plans in this state to use HPQMC measures in insurers' quality assessment program.

The next meeting is Thursday, May 9, 2019 from 1:00pm – 3:30pm.
COMMITTEE WEBSITE: http://www.oregon.gov/oha/analytics/Pages/Quality-Metrics-Committee.aspx
COMMITTEE POC: Kristin Tehrani, Kristin.Tehrani@dhsoha.state.or.us

Metrics & Scoring Committee

At its 19 April meeting the Committee continued reviewing potential measures for the 2020 measure set, including: childhood and adolescent immunization status; emergency department utilization; and the disparity measure for those with mental illness (looking specifically at emergency department use for this population). In addition, the Committee reviewed the 2020 Health Plan Quality Metrics Committee measures menu and provided feedback on a draft of the developmental equity measure specifications.

In May, the Committee will review findings from a survey of stakeholders it conducted in April, and finish reviewing all potential 2020 incentive measures against its measure selection criteria. These reviews will be used at the Committee's June and July meetings, when it will make final decisions regarding the 2020 incentive measure set.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx
COMMITTEE POC: Sara Kleinschmit, SARA.KLEINSCHMIT@dhsoha.state.or.us

Health Information Technology Oversight Council

The Health Information Technology Oversight Council (HITOC) had an exciting annual retreat on April 4, 2019, and worked on the following topics:

Data Reporting: HITOC reviewed a draft data reporting framework that outlines progress toward Oregon's HIT goals. The framework focuses on electronic health records and electronic health information sharing/exchange, plus "at-a-glance" summaries filled in with draft data. HITOC will continue working on this data reporting effort throughout 2019.

Oregon's Physician Orders for Life-Sustaining Treatment (POLST) Registry: Oregon's POLST registry stores POLST forms (which contain end-of-life care decisions that seriously ill individuals have made with their physicians and loved ones) electronically to make sure emergency medical personnel to can quickly and securely access them. In 2016, OHA awarded a grant to the registry to the information into authorized health care providers' EHR/EMRs. The POLST registry provided a progress update.

Social Determinants of Health/Health Equity: HITOC members reflected on February's social determinants of health (SDoH) panel, heard a presentation about Kaiser's planned social service resource locator, and received an update from the HIT Commons about its work exploring a statewide role in SDoH.

Path to Statewide Health Information Sharing: HITOC members received an update from OHA about efforts toward statewide health information sharing/exchange (HIE), including outcomes from its chartered workgroup on "network of networks" definitions, and major changes in federal rules (see announcements below). HITOC decided to hold on further work while federal rules are being finalized.

HITOC's next meeting will be on June 5, 2019.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/HPA/OHIT-HITOC/
Committee POC: Francie Nevill, Francie.j.nevill@dhsoha.state.or.us

Medicaid Advisory Committee

The Medicaid Advisory Committee met via webinar on March 20th. The meeting was primarily informational, with the committee receiving updates on the ongoing Legislative Session, the development of a Medicaid waiver focused on Substance Use Disorder treatment, and the progress of the HRS Housing Guide.

The Committee received information on the current progress of OHA's work to craft a Section 1115 Medicaid waiver that would give the state more flexibility in how it uses Medicaid to treat individuals with substance use disorders and to better serve Oregonians in recovery.

The committee reviewed and discussed the current near-final draft of the MAC's Health Related Services (HRS) Guide for CCOs that focuses on housing-related services. The Guide seeks to provide CCOs with additional guidance and information as to how they can use Health Related Services to help address housing-related needs of their members. Oregon's current 1115 waiver encourages CCOs to use Health Related Services and the MAC is producing the Guide based in part on requests for CCOs and other partners to better understand the ways in which these services can be used to provide housing supports as well as the limitations to the types of services that can be delivered via HRS. The guide is expected to be finalized soon, pending ongoing review from partners and stakeholders at the direction of the MAC.

The MAC will meet again on May 22nd.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/hpa/hp-mac/pages/index.aspx
COMMITTEE POC: Tim Sweeney, Timothy.D.Sweeney@dhsoha.state.or.us

Health Equity Committee DRAFT

The Health Equity Committee (HEC) has changed the schedule of meetings. HEC will meet now on the second Thursday of every month from 12-2 pm.

Also, and based on feedback received at the March retreat, the agenda format will be modified to include opportunities for members to bring items forward for committee consideration, discussion or analysis.

The April meeting was the first opportunity the full committee had to convene after the March retreat. Members provided feedback. The committee agreed that the connection with OHA Director and the opportunity to exchange ideas and ask questions was great. Members also shared that the activity around mapping critical connections for the Health Equity Committee was harder than expected.

HEC members gave feedback on the retreat report elaborated by the facilitator, Ashley Horne. There was agreement that the report provides actionable items for the full committee and each workgroup that will facilitate the development of work plans for the next 12 months.

HEC Co-Chairs consulted with the full committee about potential items that the committee would like to bring forward on the Co-Chairs presentation in front of OHPB in the month of May. Members expressed their desire to use that opportunity to reflect on the activities that took place during 2018 and that current work on the development of a health equity definition is highlighted.
The HEC Co-chairs shared that they would like each workgroup to build up from the actionable steps that resulted from the retreat, apply those to the work plans and be prepared to present to the full committee at the May meeting.

The second part of the meeting reviewed resources gathered by OEI staff and HEC members to inform the development of the health equity definition. The draft definition states:

Health equity exists when all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, language, social and economic status, social class, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstances. Achieving Health Equity requires the ongoing collaboration of all sectors to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing and rectifying historical and contemporary injustices.

There was a motion to approve a process map to work on the definition that includes opportunities for feedback from the community. The Co-Chars will share the draft definition at the OHPB meeting in May. Work on the definition will continue.

Next Health Equity Committee meeting will take place on Thursday, May 9th from 12-2 pm at the Transformation Center Conference Room. 421 SW Oak St., Suite 775.Portland, OR 97204

https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx
COMMITTEE POC: Maria Castro, Maria.Castro@dhsoha.state.or.us

Statewide Supportive Housing Strategy Workgroup

The Statewide Supportive Housing Strategy Workgroups (SSHSW) Recommendations have been incorporated into the Oregon Housing and Community Services (OHCS) Five-Year Statewide Housing Plan (appendices document), released on February 11th, 2019. The report contains recommendations regarding principles to guide permanent supportive housing, recommendations to strengthen cross agency collaboration and coordination, recommendations to expand permanent supportive housing through new and existing housing and service resources and recommendations for training and technical assistance to build permanent supportive housing capacity.

OHCS Statewide Housing Plan: https://www.oregon.gov/ohcs/pages/oshp.aspx
COMMITTTEE POC: Kenny LaPoint, Kenny.LaPoint@oregon.gov

Measuring Success Committee

The Measuring Success Committee of the Early Learning Council met on Wednesday, March 6th, at the Early Learning Division. The Committee completed its initial review of all proposed intermediate and long-term measures for the early learning system. The Committee will now take a more holistic view of the measure library to ensure it represents all sectors, key developmental domains, and objectives of the strategic plan in a balanced and meaningful fashion. The Committee will also develop a plan to ensure a thorough equity review of the proposed measures.

COMMITTEE WEBSITE: N/A
COMMITTEE POC: Thomas George, Thomas.George@state.or.us

Opioid Task Force

Proposed changes to Oregon Health Plan chronic pain benefit coverage on hold

The Health Evidence Review Commission (HERC) had planned to review proposed changes to chronic pain benefit coverage this month. However, after learning of a potential conflict of interest, Oregon Health Authority (OHA) Director Patrick Allen has put discussion of the proposal on hold so OHA can seek an independent review.

- The review will ensure no potential conflicts of interest compromised the way the chronic pain benefit proposal was developed for HERC's consideration.
- Director Allen cited objectivity, integrity and transparency as reasons behind his decision.

Director Allen also asked Dana Hargunani, MD, OHA's chief medical officer, to conduct a full review of HERC's conflict of interest disclosure process.

In his statement Director Allen said, "It is vital for the Oregon Health Plan to cover safe and effective therapies to help people reduce and manage chronic pain. Yet it is also vital that Oregonians have full confidence in the decisions the HERC makes to assess the effectiveness of health care procedures."

Oregon Opioid Taper Guidelines Task Force

The Oregon Opioid Taper Guidelines Task Force, convened by OHA, has held the first of six meetings to develop statewide opioid taper guidelines. These guidelines will build on the work of previous task forces that developed statewide opioid guidelines for chronic pain, acute pain, dentists and pregnant women. Building the guidelines will be from available evidence, other federal and state guidelines, expert opinion, and public comment. Their purpose is to guide clinical decisions and encourage safe and compassionate prescribing and pain treatment statewide.

As stated by Dr. Katrina Hedberg, state health officer and epidemiologist at OHA, "In addition to preventing unnecessary and risky introduction of opioids to new patients, chronic pain patients currently receiving long-term opioids need compassionate, skilled care to taper to safer doses."

For more information regarding the task force please contact OOTG.info@dhsoha.state.or.us.

Public Health Advisory Board (PHAB)
April 18, 2019
DRAFT Meeting Minutes

Attendance:

Board members present: Dr. David Bangsberg, Carrie Brogoitti, Dr. Bob Dannenhoffer, Dr. Katrina Hedberg (ex-officio), Dr. Jeff Luck, Kelle Adamek-Little, Muriel DeLaVergne-Brown, Akiko Saito, Dr. Eli Schwarz, Alejandro Queral, Dr. Jeanne Savage, Eva Rippeteau (by phone), Rebecca Tiel, Teri Thalhofer (by phone).

Board members absent: Tricia Mortell.

Oregon Health Authority (OHA) staff: Danna Drum, Sara Beaudrault, Katarina Moseley, Krasimir Karamfilov, Aaron Dunn, Rex Larsen, Ann Thomas, Tim Menza.

Members of the public: Kim Handloser (Jackson County), Katherine Duarte (Klamath County), Katrina Rothenberger (Marion County, by phone), Kristty Polanco (Polk County, by phone), Carla Munns (Willamette Valley Community Health, by phone), Jenny Faith (Deschutes County), Heather Kaisner (Deschutes county).

Welcome and updates
Rebecca Tiel, PHAB Chair

Ms. Tiel welcomed the PHAB and invited the board members to introduce themselves. She reviewed the agenda for the meeting.

- *Approval of March 2019 Minutes*

A quorum was present. Mr. Queral moved for approval of the March 21, 2019, meeting minutes. Dr. Schwarz seconded the move. The PHAB approved the meeting minutes unanimously.

Ms. Tiel informed the PHAB that the meeting packet did not include the Oregon Health Policy Board Subcommittee digest. The digest will be posted with the materials online.

- *Legislative Update*

There was no legislative update.

Ms. Tiel announced that the PHAB meeting in June would be a joint meeting with the Oregon Transportation Commission. It is an opportunity to have a meeting between two advisory

boards. Dr. Charles Brown will facilitate a public health and transportation conversation around transportation. The PHAB has discussed that metric quite a bit, including the ways public health and transportation entities can work together. The time of the PHAB meeting in June will change.

Dr. Dannenhoffer remarked that this was a big problem, because CLHO (Coalition of Local Health Officers) met on the morning of the PHAB meeting. The meeting starts at 9:30 a.m. CLHO has a critical business to do next month. The change of the PHAB meeting will make it almost impossible for CLHO to get a quorum. It also means that those of us whose job is to represent those counties won't have a chance to do this. The change puts CLHO members in an almost untenable position. The meeting was probably scheduled for the convenience of the Oregon Transportation Commission, but the people who are coming from great long distances are put in a very awkward position. The question is: Could we move the meeting back, maybe from noon to 2:00 p.m., and then have the PHAB business meeting thereafter, so that CLHO could meet early that day and get its business done?

Ms. Tiel noted that that was good information to know, as she hadn't been tracking the CLHO meetings. The PHAB wants to make sure that it is accommodating the guest (i.e., Dr. Charles Brown). She would check with staff if there are any options, but, for now, the meeting is scheduled for 10:00 a.m. on June 20, 2019.

Ms. Moseley clarified that the change is in June, not in May. This was an opportunity that came back up, as these two board had tried to have a joint meeting together. What inspired the meeting was the Director of the Oregon Department of Transportation, who attended one of the Public Health Division's big conferences last fall, the Place Matters conference, and heard the speaker Dr. Charles Brown, who, as Ms. Tiel said, speaks about the intersection of not just health and transportation, but equity, health, and transportation. We wanted to create this joint opportunity for the boards to roll up their sleeves and really think about and talk about how we work together on this important social determinant. The Public Health Division and ODOT (Oregon Department of Transportation) do have a standing MoU (Memorandum of Understanding), recognizing both access to preventative health things, like parks and walking trails and roads that accommodate biking, and access to medical services. It is a joint responsibility of OHA and ODOT, working together to make sure that those things happen.

Ms. Moseley added that the meeting is a way to deepen that conversation and, perhaps, for the boards to establish some things that we want to continue talking about and things that we would like to move forward together around this important social determinant. The opportunity came up and the arrangement of this meeting time meant that neither board needed to schedule a different meeting day. Both the PHAB and the OTC convene on the third Thursday of every month. With the location in Salem, which was at the request of ODOT, which is hosting the speaker, this seemed to be what would work out for the boards.

Ms. Thalhofer stated that, in her view, the local public health administrators are not questioning the importance of this meeting or the validity of this being a huge public health topic. They are more concerned with the process of not recognizing that five members of the PHAB are significantly affected by this meeting, and that the meeting was confirmed without pre-conferencing with those five members to see if we could make another arrangement. This will mean that CLHO will not be able to have a quorum at that time of either its full board or executive board. At the end of the legislative session, that really puts us in a difficult place for decision making. In the future, it must be recognized that the LPHAs are a large part of the PHAB and that the two pieces of the system are intricately linked.

Dr. Dannenhoffer remarked that, because it was so important, that this was such a quandary. If this was a throw-away meeting, he would not go. But it is an important thing to do, so he needs to do it. If PHAB members got prizes for the most distance traveled, Ms. Thalhofer and Ms. DeLavergne-Brown would always get them. We should consider the fact that PHAB members can't be at two places at once. Could the meeting be moved? For the people in Salem, moving this meeting can be really hard, but they are meeting the same day.

Dr. Hedberg pointed out that a lot of PHAB members have many meetings conflicting with other meetings. One of the proposals could be for CLHO to change its meeting time. That oughtn't happen, but there are a variety of options. There are a couple of parts of PHAB, when we look at these agendas. Some of them are really concrete, where we need voting, or ex-officio, or there are voting members. We need to make sure that at least that part occurs. Meeting with another board to understand how we could collaborate – part of that might be figuring out the next steps moving ahead. We hope this is not a one-and-die. This is part of our upcoming State Health Improvement Plan (SHIP). We are talking about social determinants. Transportation has come up again and again.

Dr. Hedberg added that this meeting is more of a meet-and-greet. We don't know quite how to say, whether it's their board meeting or another, "Oh, but a couple of members of ours," without trying to belittle the number of members, "can't make it. Can you all change that?" We are the ones who are trying to figure out how we can collaborate with this group. One of the questions is, "Is there a way to have some of the CLHO members attend one versus the other, and who has more ability to do this?" This meeting is about establishing a relationship and we should think about ways for moving forward.

Ms. DeLaVergne-Brown said that she understood the challenge and noted that, for CLHO, we must look for possible other ways of doing the meeting, such as a webinar or some other way. Part of the challenge is that this all has to do with tobacco funding, because we have a vote. In a normal circumstance, we wouldn't have such a critical thing. We are trying to figure out how to do this, so CLHO can still have a quorum.

De. Hedberg remarked that her understating was that the tobacco funding has been mulled around for quite a while. If CLHO has a key vote around tobacco funding, is there is a way to reschedule the vote? We are reluctant to say to a key partner, with which we have really wanted to engage and are finally able to do it, and the boards are meeting, that some of the members of our board have another key vote outside of the PHAB meeting. It feels weird. We are open to suggestions, but we don't know how to get there. Maybe CLHO can move the move the vote to May. We need to understand why these two hours of overlap are the only two hours in the space of several months that are problematic.

Ms. DeLaVergne-Brown responded that, for the future, because the CLHO meeting is always before the PHAB meeting, please check with CLHO members when such meetings are scheduled, so CLHO members know and can plan accordingly.

Public Health Grant Block
Danna Drum (OHA staff)

Ms. Drum informed the PHAB that the Public Health Division at the Oregon Health Authority received a non-competitive grant. It is issued to all states and some territories to address the state-determined public state priorities. The grant was established in federal code back in 1980s. It gets zeroed out every year in the President's budget and then Congress brings it back. The PHAB is designated as the Block Grant Advisory Committee. Its role is to make recommendations regarding the development and implementation of the work plan.

Ms. Drum reminded the PHAB that around this time of every year she shares with the PHAB what has been happening over the previous year. In May, she will present to the PHAB some proposals around what would be in the work plan for the following year. This is the most flexible grant funding we received from the federal government in the Public Health Division. This allows us to fund some things that we wouldn't have otherwise the opportunity to do. We have typically used the grant to fund infrastructure-related projects.

Ms. Drum noted that, in addition, the federal code has a specific carveout for sexual violence prevention and services. Currently, that funding goes to the Oregon Coalition Against Domestic and Sexual Violence. It's a pass-through to them through a grant from OHA. That's a specific allocation that the feds give us. The work plan must be tied to Health People 2020. Oregon, like several other states, use the grant to support infrastructure. Typically, we have used the accreditation-related Healthy People 2020 objective and the Quality Improvement 2020 objective.

Ms. Drum stated that for the current year OHA received a little over $1.2 million, with 85.6K allocated and granted to the Oregon Coalition Against Domestic and Sexual Violence. Oregon's overall goal has been to support ongoing planning for an implementation of the modernization foundational capabilities. This funding has supported the development and analysis in the

annual report of the public health accountability metrics. It's also supported the work with tribal public health modernization (i.e., the tribal assessment). We also have used this funding to support staff time to work through the school year 2018 expenditures collection, so we can capture the local investment that would support the matching funds component of the modernization funding formula. In May, Ms. Drum will share with the PHAB the results of that effort. That would be the baseline on the local investment, so that when we start to move into matching funds, we'll have those data.

Ms. Drum reported that a lot of work was done around implementing, in 2018, the new administrative rules, as a result of some statutory changes, as well as work that continues to integrate modernization foundational capabilities and programs into the scopes of work and the compliance review tool (i.e., the triannual review, program elements, and contract pieces). Also, within the Public Health Division, funding for staff for the Health Equity Workgroup, as well as some of that work. Some of things they have been doing over the last year include convening listening sessions to identify highest priorities for interventions and strategies to improve workforce diversity and inclusion within the division.

Ms. Drum added that a lot of this funding goes to support local and tribal training, technical assistance, and coordination. For example, last year we conducted 14 compliance reviews, known as the triennial review, and the funding supported the staff, and the travel, and all the work that goes into that. This is part of our accountability. We also developed a resource guide, because we have had in the past several LPHAs looking at alternative models for how they organize and do their business. We felt that we needed a resource that put all that information in one place. The funding was used for intensive technical support and coordination, in person and remote, with those LPHAs that are making some sort of transition, whether it be contracting out a lot of the public health work or, in the case of Wallowa County, when they transferred their LPHA to OHA. And then, last year, working closely with Douglas County, as they were trying to determine what their next steps were going to be. The funding also supports a lot of the coordination of the Public Health Division's work with tribes, including implementation within the division of OHA's new Tribal Consultation Policy, which was adopted in March 2018. It has been a significant lift to fully implement and respect those, so that we can be better positioned to honor the government-to-government relationship.

Ms. Drum pointed out that the State Health Assessment and the State Health Improvement Plan are supported by these funds. Without these funds, there wouldn't be any other kind of funding to support the SHA and the SHIP. The SHIP coordinator, Christy Hudson, has been doing a lot of work with state agency partnerships, such as ODOT, Oregon Department of Education, and Department of Housing and Community Services, as well as exploring new partnerships with the Department of Corrections. This funding has helped maintain our public health accreditation, including support for local and tribal partners that are seeking accreditation, the roll out of the OHA performance system, and a variety of things related to workforce development.

Ms. Drum highlighted the work done by the Oregon Coalition Against Domestic and Sexual Violence. Several years ago, OHA started a conversation with the coalition. Traditionally, the coalition used the funds to help support their local coalitions, but it was like giving everybody $5. They were in a place where they were interested in moving towards primary prevention and doing that from a place of working with marginalized communities to leave that work around sexual violence primary prevention. It's gotten a lot of national recognition within the field and they have funded El Programa Hispano to identify and implement culturally-specific sexual violence primary prevention curriculum with Latinx youth. That has been very successful. They also discovered during the RFP process that they needed to do a lot of capacity building. A lot of their member organizations hadn't dealt in primary prevention. They also issued a number of capacity-building grants (i.e., mini-grants) to help prepare them to be able to move into primary prevention that resulted in a broader RFP process since the last time around. Now they are funding three organizations, with two of them being mini-grantees and have been able to build some capacity.

Ms. Drum invited the PHAB to ask questions.

Dr. Bangsberg remarked that Ms. Drum presented a long list of really important work. A long list for $1.2 million dollars. There's nothing on the list that doesn't deserve funding. What is the average size of the subcontract? When does the pool become so big that you don't get much in return?

Ms. Drum responded that the contract with the Oregon Coalition Against Domestic and Sexual Violence is $85,660. That was a strategic shift for them. They realized that, for years, they have been doing it for very little money. Several years ago, they made the shift, where they decided to fund fewer partners for a specific strategic purpose. That's been beneficial. It's taken several years to get there, but they and OHA, as the funder, are pleased with that work. In general, the rest of the funding, because it supports infrastructure, primarily goes to staff time and FTE, and there are some smaller contracts to help support that work, like the facilitation for the State Health Improvement Plan was paid for out of these funds, as well as the contract with Program Design Evaluation Services to do the accountability metrics. There are no significantly large contracts, because a lot of it is just paying staff to be able to do the work.

Dr. Bangsberg speculated that each subcontract was covering 10-15% of the staff and probably $5,000-$20,000, given the long list of activities.

Ms. Drum responded that there were a handful of subcontracts and that's just to support some of the work. Most of it is staff, Public Health Division staff who are implementing the work.

Dr. Savage asked if the 85K varied or it was the same every year.

Ms. Drum responded that for as long as she's been a part of it, it has been the same amount and it doesn't fluctuate. The number comes from the feds. It's based on a formula from decades ago. It doesn't seem to be any movement on the federal level to change it. It's not clear how that gets determined.

Dr. Schwarz wondered if, in the case of Wallowa County, some of the money could be used to correct the situation, so that the county be brought back to independent public health governance.

Ms. Drum responded that the funding wasn't so much for a specific Wallowa County project, but it funded my time and another staff person's time, plus significant amount of Department of Justice time to work through the intricacies of what needs to be dealt with when there is a transfer. In terms of the question about bringing Wallowa County back, the onus is on Wallowa County. They were very clear with us when they passed an ordinance. This is not something they are able to do. There is a bill making its way through legislature right now that would provide additional information or process on how a county could request a transfer of the LPHA responsibilities back to it. There will be a rule-making process that will need to happen as the result of that. Some of that will get clear over time.

Ms. Saito commented on the Wallowa transfer and the issue in Douglas County by reminding the PHAB that one of the foundational capabilities in public health modernization was emergency preparedness. In those two processes, the money did fund Ms. Drum's time, but we also had a large number of staff who were on the instant management team. Both of those potential transfers, and one was a real transfer, actually had an instant management team. Ms. Drum and one of our center administrators acted as the instant managers. We had multiple staff members who were also on the instant management team, doing the planning chief role, the operations chief role, et cetera. Even though the money did fund some of Ms. Drum's team, there were a lot of in-kind donations from the rest of the staff here to help the instant management team.

Ms. Drum added that that was true for most of this work. It enables us to have a basic infrastructure, so that then we can leverage a lot more resources across the system.

Ms. Tiel remarked that it is a lot less accomplishments with a little bit of money, but that's what we can get when we have infrastructure dollars to fund staff time that are so specific that you have to spend it in very specific areas.

Dr. Schwarz noted that the PHAB has never discussed a situation where, for example, ten counties next year found out that it was a really good deal to leave their responsibilities to the state. This is something the PHAB should talk about.

Ms. Tiel stated that there was a conversation to have an agenda item about some of those pieces and discuss that. It's an important topic, but something we don't necessarily hope to happen. Yet we need to have a plan in place, if that were to happen. It would be a public health emergency when that happens, so it's an important story for the PHAB to discuss as well. It's not just a contractual hand-off. We could have a discussion in a future meeting.

Accountability Metrics Subcommittee
Muriel DeLavergne-Brown

Ms. DeLavergne-Brown informed the PHAB that the subcommittee had a very good meeting on April 1, 2019. The subcommittee discussed the 2019 Public Health Accountability Metrics Annual Report, which has been updated. Another discussion revolved around the oral healthy developmental measure. The important outcome was that the subcommittee decided to keep it, as it is important to work on oral health. We do work on it without funding. We do campaigns. Our staff work on it. The issue is how do we measure public health on this when we are not the biggest player to make a big difference in it? It's dental offices and primary care. The subcommittee decided to keep it, but the issue should be kept on the horizon to think about it.

Ms. DeLavergne-Brown reported that the subcommittee discussed the development of public health metrics for 2019-2021. The biggest discussion was about not changing things too much. Another discussion, brought up by Ms. Thalhofer and echoed by Ms. DeLavergne-Brown, was about the public health changes that could happen with the influx of money for public health modernization. One of the challenges has been that when little tiny bits of funding from different programs come, to have it written in all the contracts, and we are now supposed to do this, when we are not actually getting funding for it. There is a rub that happens between state and local over that. There is this push for modernization and we are totally behind that. At the same time, when it's a tiny bit of funding, and it's not true modernization funding, how are we to be held accountable for all of that? The subcommittee discussed that without reaching any answers.

Ms. DeLavergne-Brown shared with the PHAB that at the end of the subcommittee meeting she wondered about how we could rise all boats. This goes back to local health departments deciding not to stay in. In Crook County, she often reminds the county Commissioners that they are responsible for the health of the county. This subcommittee discussion centered around how to get all counties up to a point where all are performing well.

Ms. Thalhofer added that the frustration the subcommittee has had when reviewing program elements is that there is more and more language about meeting the accountability metrics being worked into program elements. When the subcommittee developed the accountability metrics, they were not developed with the intent that LPHAs would be accountable for these measures now, before they were funded. To have them worked into current contract language

feels pretty disingenuous to what the intent was. While we all need to move toward the modernized public health system, it is not going to happen without more funding. We can't lean in anymore. It would be good if the PHAB at some point, maybe it can start with the Accountability and Metrics Subcommittee, comes up with a statement about the real intent of the metrics. It is not for now. It is for when we move toward the modernized system. I see us being accountable for the one around communicable disease – beginning that, because we did get partly funded to do that modernized work – but to have them showing up in contracts overall, it is pretty distressing.

Dr. Bangsberg remarked that having those metrics could be a really great argument to advocate for something, because if we are seeing something develop, like suicide, in certain demographic, then that becomes the data that go to legislature, with us saying that we need money for suicide prevention. The tension experienced by the counties is recognized. It is a situation in which you are measuring stuff you don't have money to intervene on and, therefore, you shouldn't or can't be accountable. The value of the data is to make the argument that we need funding in these areas.

Ms. Thalhofer responded that she is not arguing about the data being there. The concern is that they are starting to show up as deliverables in the contracts the counties have with OHA. In the current contract, it says that we should be working on those items now. The Accountability and Metrics Committee should come up with a statement about what those were created for and get the PHAB to endorse a definition of why those were created. For example, let's say the AFIX is being done in every clinic in every county, which we looked at last month when we saw the report. Our modernization collaborative didn't choose to work on the AFIX immunization assessment. We chose instead to put our money into gonorrhea rates. It would expected that eventually the counties that are participating in our collaborative would be able to show that we are addressing the gonorrhea rates. But the AFIX piece is being worked into our contract and our state partners, just this week, said, "Hey, have you thought about working on an AFIX assessment in every one of your counties, because you are getting modernization money and you should be working on that." There is a real disconnect between state staff and what's coming out in contracts and what's happening at the PHAB. There needs to be a little bit more work done on what the PHAB is saying. The PHAB is not saying, "Do it now with the money you have." The PHAB is saying, "We need this data to show the state what we need to do to move forward."

Dr. Bangsberg suggested that maybe one way to phrase is not just "accountability metrics," but "accountability surveillance and metrics." Some of these metrics are purely surveillance and some of them are metrics for which you want to move the needle and be accountable for.

Ms. Thalhofer stated that that distinction is very helpful.

Ms. Moseley thanked Ms. Thalhofer for raising this issue. This is what Ms. Thalhofer is hearing from within the Public Health Division, and the division is out of alignment internally, and that's really helpful to know. Ms. Drum will follow up with Ms. Thalhofer to get more specifics and put some specifics around this, so that we could follow up internally and make sure that we are all in alignment around this, because what Ms. Thalhofer is experiencing is not where OHA's intention is right now. Ms. Thalhofer will hear back from OHA staff to try to sort it out outside of this meeting.

Ms. Thalhofer thanked Ms. Moseley.

Dr. Schwarz mentioned that, as far as he could remember correctly, there were 45 different program elements. The accountability metrics are very, very narrow band of deliverables, compared to the breadth of program elements. It might be interesting to try to get an overview of when and how the accountability metrics are related to the program elements. The subcommittee has never touched on that.

Ms. Tiel explained that she often has to remind herself of the scope of the PHAB. Its role is not to get it in operational and contractual details, but to set direction, set intention, advise, and if that's conflicting with how things are being implemented, that's important to bring up in this meeting, but certainly isn't our world to read and review contracts.

Incentives and Funding Subcommittee
Akiko Saito

Ms. Saito informed the PHAB that the Incentives and Funding Subcommittee convened on April 9, 2019. The subcommittee has been charged with understanding and formalizing how modernization funding will go out, if we do get funding. During the last meeting, the subcommittee discussed what we would do with $5 million of funding. Last month, the subcommittee decided that the $5 million would be given out to the ongoing projects. During this month's meeting, the subcommittee was charged to formalize how funding in the range of $5-$10 million would be distributed. The first part of the discussion was around the modernization collaborative projects that were funded at $5 million in the last biennium. They only had 19 months to do the work and it was a 24-month biennium. That had a lot to do with having contracts some place.

Ms. Saito noted that, for this group, the subcommittee wants to ensure that we are seeing what can be done in those modernization projects. The subcommittee made the decision that if OHA received between $5-$10 million that it would increase the funding to the eight LPHA partnerships, so that the funding level would match the current funding for the full 24-month period. That would be an additional $1.2 million. If the funding is anywhere between $5-$10 million, we would add that additional $1.2 million, so we can make those projects full for 24 months. After that, we would then provide base funding to all the LPHAs. That total amount

would $1.845 million. The base funding is between 30K and 90K, based on the size of the LPHA. Any remining funds will be distributed through an RFP process for new partnerships and the new coordinated service delivery models.

Ms. Saito added that, based on a suggestion by Dr. Dannenhoffer, if OHA was going to do another RFP process, it would be good to have a toolkit or some other deliverable that staff at other counties can utilize for modernization.

Dr. Dannenhoffer mentioned that that was discussed this morning at the CLHO meeting and, with a deafening silence, it was supported.

Dr. Schwarz asked about the prospect of how much funding we might be getting.

Ms. Moseley answered that we would not know until the end of the legislative session. We are relatively confident that we will see an investment of some kind.

Dr. Schwarz remarked that when the PHAB discussed this two years ago, the PHAB didn't have a clue. It wasn't in the Governor's budget and it came out of the legislature. Then we got the $5 million, which was far away from what the PHAB had been discussing. Let's say we get $5 million again and we continue to do these grants. Maybe next time we'll get $5 million. We have to question at some stage: Are we actually modernizing the public health system or are we just becoming a grant body to hand out public health grants? Compared to what we were discussing a couple of years ago, it's not a very optimistic perspective.

Ms. Moseley agreed with Dr. Schwarz by noting that this was an important conversation to have. She would like to think about it and bring back some suggestions for how we do talk about that. She was not part of the PHAB years ago when that discussion took place. Now that we have this practical, applied system in place, it is a different conversation. Based on Dr. Schwarz's comments, it might be good for the PHAB to try to get back to some of the aspirational conversations that were more visionary for the public health system. That's the piece she would like to contemplate and think about how we move ourselves back there from the practical, legislative session place.

Mr. Queral remarked that we are not going to move into modernization as we thought about it unless we have the amount of funding that we need. That's evident to everyone. What's missing in this effort is that there are no public health advocates who are really pushing for public health modernization. We are proposing a new way of looking at the public health system but operating in the old model of advocacy. Certainly no advocacy from us, but also the other public health advocates – nonprofit organizations – that could be speaking on behalf of this. They are talking about the same things we have been talking about for decades, such as increasing the tobacco tax and sort of the old model. Where could we begin an effort to talk to other public health advocates? CLHO may be the place to instigate this conversation. How do

we make the link between the public health advocates and those of us who are sitting at this table?

Dr. Schwarz added that he went to the APHA meeting last year in November and he was looking in the program for other states doing public health modernization. He didn't find that title anywhere in the program. There must be some other state that is doing something similar and also trying to link up with some of these other activities that are going on. We don't know which states are doing it. There might be ideas that we could get from other states that have been more successful in terms of getting the legislators' convinced.

Ms. DeLavergne-Brown shared with PHAB that she just came back from The Occupational Safety and Health Administration (OSHA) meeting, which gathers public health directors from across the country. Oregon is so far ahead of everybody else. There are few other states, such as Ohio and Washington, that are doing things, but not as far as Oregon is doing. When the bill came up, there were a lot of people testifying from different health departments and health advocacy organizations. Morgan felt really good that day, because there was a lot positivity about modernization. A fair number of legislators came up to her afterwards, saying, "Oh, I get it now." We need to think about that from PHAB's standpoint – how do we build that bigger capacity for people to really advocate for this?

Ms. Saito underscored Mr. Queral's thought about meeting people who are not necessarily typical to public health. We were asked to provide some testimony from our partners and within four hours, we had multiple letters from people in emergency management and other walks of life. That's how we do it with not just the typical public health people.

Modernization Grantee Update: Health Equity Action Plans

Kim Handloser (Jackson County), Katherine Duarte (Klamath County), Katrina Rothenberger (Marion County), Kristty Polanco (Polk County), Carla Munns (Willamette Valley Community Health), Dr. Jenny Faith (Deschutes County), Heather Kaisner (Deschutes County)

Ms. Tiel remarked that we are starting the second round of updates. We have heard from all public health modernization grantees. This time around we are excited to hear more about each grantee's health equity action plan that they have developed to address communicable disease disparities. Today, we have three partnerships to present.

Ms. Duarte introduced herself and Ms. Handloser, who are the program coordinators for the Jackson-Klamath regional modernization partnership. Ms. Duarte stated the objectives of the partnership: (a) reduce hepatitis C rate, (b) reduce rates of STIs, (c) raise HPV vaccination rate for cancer prevention, (d) health equity and cultural responsiveness. She reviewed the targeted populations and the ways the partnership engaged with community partners.

Ms. Handloser noted that the root causes of health disparities included poverty, trauma, institutional racism, lack of health literacy, and lack of support. Many individuals are isolated due to these factors. The partnerships were required to address both proximal causes, such as needle sharing and risky sex behaviors, and root causes. In addition to identifying external opportunities to build capacity, both Jackson County Public Health and Klamath County Public Health will continue to strengthen internal capacity to address health equity.

Ms. Handloser added that some of the strategies from their health equity plans for addressing root causes included engaging directly with at risk and marginalized community members thought the creation of a feedback loop and focus groups, open dialogue with health and social service professionals about the connection between mental health and trauma and health disparities, sustaining and expanding partnerships with nonprofits and coalitions that are addressing health inequities and social determinants of health. Outcomes include identifying appropriate and actionable steps for reducing communicable disease risk in high risk community members, as well as engaging in multi-sector efforts to address housing, behavioral health, trauma, and health outcomes.

Ms. Handloser remarked that to increase staff capacity both counties developed strategies to increase staff capacity through encouraging equity and culturally responsive professional development. For example, Jackson County Public Health promotes staff attendance to workshops offered by SO Health-E, such as the racial justice training that they have scheduled for next month. Klamath County plans to create a performance measurement goal for equity that will measure the equity-linked activities involving direct work by its public health staff. An example of that would be providing safe zone training to its staff and the staff in turn will provide that training to other organizations in the community. The outcomes from these strategies culminate in providing public health services that are effective, equitable, understandable, respectful, and responsive.

Ms. Handloser outlined the strategies for implementing the plan with the next round of funding: continue the momentum of 2017-2019 funding cycle, fit within organizational capacity, foster partnerships within and across counties, build upon current programs, and emphasize equitable culturally responsive programs and systems. Since the counties were developing strategies beyond this current funding cycle, the counties stayed mindful of organizational capacity while remaining open to future opportunities. In the even of additional funding, objectives and strategies can be expanded or added to reduce health disparities through addressing root causes, building partnerships, and increasing staff capacity.

Ms. Handloser thanked the PHAB for having her and Ms. Duarte. Ms. Tiel invited the public health officials from Marion and Polk counties to introduce themselves over the phone.

Ms. Rothenberger introduced herself as the public health division director for Marion County Health & Human Services. She explained that the presentation is a follow-up on what the counties have been up to since the last time they spoke to the PHAB.

Ms. Munns introduced herself as the director of quality and transformation at Willamette Valley Community Health (WVCH). WVCH is the coordinated care organization, currently serving Marion and Polk counties' OHP (Oregon Health Plan) members.

Ms. Polanco introduced herself as a public health administrator for Polk County Public Health. She articulated the statewide objectives for public health modernization: develop a modern communicable disease control system, emphasize elimination of health disparities, establish new systems for local public health service deliver, and increase accountability for health outcomes. Marion and Polk counties have focused on implementing their regional communicable disease control strategies, which are driven by the data that reflected a disparity in the increase of STIs/STDs within age groups with populations between 25 and 64 years, as well as focusing on increasing HPV vaccination rates.

Ms. Polanco highlighted Marion/Polk counties Year 1 accomplishments: developed policies describing regional partnerships between partners, convened a diverse communicable disease task force (meets monthly), developed a regional health equity action plan, increased provider knowledge of best practices for testing and treatment of CT and GC in Marion and Polk Counties. These accomplishments have equated to an increased adequate gonorrhea treatment in Polk County from 64% to 87%, maintained or improved rate of adequate gonorrhea treatment in Marion County, and improved HPV vaccine administration rates in Marion and Polk Counties.

Ms. Munns remarked that one of the most high-level shared goals that we can talk about with public health modernization from CCO's perspective with local public health is that we share the same vision for innovative and transformative healthcare systems. Public health modernization is a crucial component of that. The alignment that can happen between CCOs and a local public health department just makes sense. It is hard to imagine how a community can move forward with healthcare transformation, and being innovative, and on the cusp, and really making a huge difference without aligning CCOs with public health departments. That's the highest level alignment that we can have and WVCH has been fortunate to have such a great relationship through this process and through a bunch of other programs with the public health departments.

Ms. Munns noted that WVCH and the public health departments in Marion and Polk counties has been sharing best practices through out the community, so it's a combined message, a shared message the providers are hearing. An example are the training series provided by the AIDS Education Training Center (AETC) throughout Marion and Polk counties. Fifty-seven people attended these trainings. People were happy with what they learned and WVCH were

able to utilize it in their clinics. WVCH is working with AETC and other agencies, including the counties, to try to help its providers with more focused trainings for their clinics, if they would like. WVCH will be offering more education and trainings for on-site clinics for HPV vaccination and AIDS, among others. WVCH held focus groups and listening sessions among vulnerable populations to make sure that their voices were heard. We used the health equity lens in the Health Equity Tool to ensure that we were creating a broad representation of our community's voice. WVCH used clinic-specific data, using our Medicaid data for OHP members, to provide outreach to clinics to try to reduce gender and clinic disparities that WVCH noticed in HPV vaccination rates. This was eye-opening and led to great partnerships with the county, which was utilizing data from the state directly on HPV vaccination rates. WVCH was able to narrow it down into more specific disparities using a gender disparities lens in some of the larger clinics to help target interventions to the population in the two counties. In addition, WVCH launched a mobile screening and treatment van for STIs and reproductive health and increased the community support for a regional Syringe Exchange Program that includes Yamhill County CCO.

Ms. Rothenberger explained that one of the first things the counties did around health equity was to conduct a community readiness assessment to look at some of the disparities relating to communicable disease control and what the community partners' attitudes and level of readiness was. After the counties did the assessment, the officials realized that they should probably look internally to their own health departments. Polk County conducted the BARHII, the Bay Area regional health and equities initiative. Marion County decided to do it as well, so it can be aware of its own biases and institutional issues that may have contributed to the health disparities in its communities. Pairing the community readiness model and assessment with the county's BARHII results may lead some good work in the future.

Ms. Rothenberger noted that the partnership's action plan includes the creation of a communication plan that was culturally responsive to the community's needs. Health officials heard from partners that going on the Spanish radio show was a good way to reach Latinx communities and they did that a couple of times. They are also doing collaborative Facebook live sessions in English and in Spanish, with a separate video in Spanish so that it can be shared with different audiences, rather than doing Spanish and English in the same video. As part of the action plan, the health departments are creating authentic partnerships with local community agencies, as well as creating awareness of STDs through posters, flyers, and brochures.

Ms. Rothenberger agreed with Ms. Munns that working with the CCO partners has been extremely beneficial to the local health authorities. They have been able to identify the rising rates of STDs. The AETC trainings are the results of everybody coming together to look at some regional data around STDs rates. As more partners are taking on this work, the partnership decided to do listening sessions to better understand where the communities are at and what they need in terms of communicable disease control. Willamette University has been a stellar partner. They conducted their own listening session. HIV Alliance has been wonderful at

removing barriers. Work is also ongoing work with communities of color with a partnership with NAACP (National Association for the Advancement of Colored People) in the Marion County region and started working on some collaboratives. This is a new relationship.

Ms. Rothenberger outlined some of the policies and strategies in Marion County's health equity plan: implementing employment recruitment for bilingual candidates for emergency preparedness by including health equity or diversity questions in their interviewing practices, beginning the work to collaborate with Willamette University and local school boards to discuss policy change regarding sex education curriculum, creating a regional policy for treatment of gonorrhea.

Ms. Munns laid out the priorities for the modernization future work plan. Marion County will conduct a BARHII organizational self-assessment (Polk County has already done it). This will help the organizations to identify and self-assess where biases are happening, or where inequities are happening in policies, in hiring practices, and in other areas. That will help from the most basic level of the health department access to the county's community members, really looking at health equity from an internal standpoint. The partnership will continue to convene a communicable disease coalition in conjunction with the Early Intervention and Outreach (EIO) grant. By June 30, 2019, the partnership will develop and implement a regional health equity action plan to improve practices and implement policies to reduce communicable disease control-related disparities. WVCH has taken on to improve HPV vaccine administration rates among VFC providers in Marion and Polk Counties. The partnership will continue to utilize a health equity lens in all aspects of public health work, will be culturally and linguistically responsive to diverse health needs, and will work on creating authentic partnerships with broad outreach.

Ms. Munn concluded by highlighting partnership opportunities with CCOs: CCO commitment to healthy equity, local public heath partnerships, and the shared community; focus on population health, upstream approaches, and data-driven population health management regardless of whether individuals are members of WVCH or not; community health improvement plan; quality incentive metrics strategies; and contractual requirements around health equities and disparities and establish evidence-based guidelines. There are a lot of opportunities to get involved and align LPHAs' efforts with CCOs.

Ms. Tiel thanked Ms. Munn and invited the presenters from the Central Oregon public health partnership to introduce themselves.

Dr. Faith introduced herself as the Central Oregon tri-county epidemiologist. Ms. Kaisner introduced herself as a public health manager at Deschutes County, overseeing the Central Oregon partnership. Ms. Kaisner reminded the PHAB that Ms. DeLaVergne-Brown, who is a public health administrator at Crook County, is also a representative of the Central Oregon partnership.

Dr. Faith reviewed the health equity assessment components that have been done in Central Oregon over the last year and half. The assessment components include three different assessments done in reference to the modernization work: (a) analysis of local data, looking at demographics of the region and the populations vulnerable to communicable diseases and outbreaks, (b) internal staff assessment (BAR-HII), (c) external partner assessment (BAR-HII). In addition, a series of community focus groups (about 20) were done before the creation of the health equity action plan. Health equity questions were incorporated into these focus groups. That was another way to collect feedback from the community.

Ms. Kaisner explained that the results from these assessments are upcoming. That's going to be the next steps when it comes to the regional health assessment. As far as analysis of the local data, they were trying to determine what they were going to focus on as a tri-county region. The region was already doing a lot of work around AFIX rates with funds from the local CCO. In terms of STDs, the partnership received an EISO grant and had a team regionally working on that as well. The Central Oregon Health Partnerships has grown in many ways, with expanding capacity on many levels through many projects.

Ms. Kaisner remarked that the data showed that long-term care facilities (LTCF) in Jefferson, Deschutes, and Crook counties experienced a high burden of communicable disease outbreaks. Nearly 60% of all outbreaks in the tri-county area occurred in LTCF. This put a burden on local health departments and their resources, especially in smaller counties. Influenza vaccination among skilled nursing facility staff was lower in Central Oregon than the rest of Oregon. Proportion of older adults was higher in Central Oregon than the rest of Oregon. The data suggested that the tri-county needed its own epidemiologist (Dr. Jenny Faith). The results translated into action by prioritizing LTCF prevention activities and improving quality data and communication through epidemiology activities and reports, such as the Central Oregon Public Health Quarterly.

Dr. Faith noted that when we are talking about the BAR-HII assessments, they are looked at from a big-picture lens across all public health topics. If the assessments were being done, it was best to learn as much as possible about the entire public health area, not just communicable diseases. The BAR-HII assessments showed that there was a lot of work to be done internally. Some of the feedback indicated that staff had different levels of understanding and comfort with concepts of health equity. The goal was to focus on better incorporating health equity concepts in throughout the organizations through staff trainings, modeling it in day-to-day operations, and incorporating it into policies and procedures.

Ms. DeLavergne-Brown stated that Crook County also has been doing internal work. The assessment data was presented to staff and focus groups were established around the information and how it affected staff and programming. For external partners, a plan was put together for Public Health Week, as well as a thank-you breakfast, which was attended by over

fifty people and partners, including the commissioners. The information from the assessment was presented to the partners as "This is what you said. This is how you would like to see us improve and how work with you." Each table then took a different topic and discussed through the perspective of health equity what needs to be done as a community around reproductive health, communicable disease, and other topics. Some of the groups came out with a page of information on how the partners worked together to improve some of these different areas around health equity. Crook County will do one more focus group with partners that could not attend the first session.

Dr. Faith pointed out that the assessment was not a one-time thing. The plan is to do the health equity assessment once every four years and use the data to inform the regional health improvement plan and agency strategic plans. The plan is to repeat the BAR-HII health equity assessment. The current data is baseline data to see where the tri-county partnership is and where it needs to go. Every four years, the new data will show how far the work has come. Other goals include: prioritize equity-focused data and communication (e.g., epidemiology reports, communicable disease fact sheets, website, and other external communications); continue LTCF prevention work with a focus on vulnerable older adults; increase focus on STD equity data and prevention activities; work with partners to identify additional needs.

Ms. Kaisner added that Deschutes County has a van that does needle exchange and HIV and HEP-C testing. The van will also be going to Crook County. Ms. Kaisner got an approval from the county commissioners to do syringe exchange in Crook County. In addition, a Central Oregon Public Health Partnership is being created.

Ms. Tiel invited the PHAB members to ask questions related to the three presentations.

Ms. Little introduced herself to the presenters as a tribal health administrator and asked how the partnerships have worked with the tribes within their regions. Central Oregon group has the largest tribe, which is the Confederated Tribes of Warm Springs, but each county has tribes that are part of the partnerships.

Ms. Kaisner stated that Jefferson County has a very close relationship with the Warm Springs tribe. The county's public health department has a limited communicable diseases team. When the Deschutes County team met with Jefferson County's team, it became clear that the Jefferson County team needed and wanted more training on Orpheus (i.e., epidemiology user system for communicable disease investigation). The communicable disease team from Deschutes County working on this grant is now in Jefferson County doing training. It has been a huge asset because of the search capacity. The Warm Springs tribe knows that they can call on the regional team when needed. The Deschutes County team is always there to help, if needed. Also, the van has been going to different Warm Springs events when requested by the tribe.

Dr. Faith added that the Warm Springs tribe requested to look at the STD data for the tribe, which is part of the STD data for Jefferson County. The data was separated to accommodate the request. That has been another opportunity to help the tribe with surveillance data that they might want or need, and they know that they can call on Dr. Faith as well, if they wanted or needed data.

Ms. Little shared with the presenters and the PHAB that there is a lot of sensitivity within Indian tribes at varying levels about data, data collection, and becoming identified as a Native American, and how that data would be used. There is also a wide range of capacity to do any public health work. There are always opportunities to do that.

Ms. Duarte commented that the Klamath County upper tribal lead liaison Valerie Lee has been working with the tribes for many years and has developed a close relationship with a lot of sensibility. She attends a lot of their activities and tribal events, as well as participates in different health row tabling at their events. Ms. Lee held a meeting with tribal providers last fall and was able to share some of the modernization topics that the county has in common with the tribe – hepatitis C, STIs, HPV vaccination – and worked towards having the same messaging throughout the county and being there as support for them with whatever they need, with a really light and sensitive touch. Klamath County continues to participate by attending their […] council and their health equity coalition.

Ms. Polanco remarked that Polk County has had connections and collaborations with the tribes on its CD task force. That's an area of opportunity to expand collaboration beyond the task force, but there has been engagement there.

Ms. Munns reminded the PHAB that the CD task force is driving the strategic plan for these areas in those communities. Public health officials are weaving in those strategies that are recommended, which includes tribal representation for future implementation.

Dr. Schwarz congratulated the three groups on their work and reports. The PHAB was not quite sure what to expect from the project that it funded, but it sounds like the partnerships have gone beyond. It is encouraging and wonderful to see these collaborations across county boarders and the collaboration between the CCOs and the counties. The focus on health equity is fascinating. Dr. Luck and Dr. Schwarz are members of the OHA Health Equity Subcommittee and they used the first half of the year to discuss what health equity was. It doesn't sound like the partnerships have been discussing the nature of health equity, but rather they have been doing something about it. It would be good to get the partnerships to talk to the Health Equity Committee and tell it how to go about health equity. The Health Equity Committee has been struggling with that.

Dr. Schwarz also noted that the way the state records race and ethnicity is very fragmented. There are internal IT issues at the state level, in terms of letting systems talk to each other,

which has led to only half of the information related to race and ethnicity being available. We don't have information about the race and ethnicity of half of the population we are recording. How do the partnerships get that information, which they obviously don't get from the state?

Dr. Faith responded that the partnership uses American Community Survey data or their assessments. When looking at Orpheus data, it is what it is. There are a lot of missing data. There has been a discussion on how to improve that – how staff can enter the data better and how the data can be extracted better. The partnership is moving in the right direction, but it's not there yet.

Ms. Munns added that one thing WVCH has done to narrow down the data and get more accurate data is to look at language preference. That has helped identify some of the smaller pockets of members and the culturally diverse perception that they might have. For example, a Russian population – they identify as white/Caucasian, but we know that we have a strong Russian population in our community. We broke it down by language and that's how we were able to identify that population a little bit further than what data we are provided by the state.

Dr. Luck explained that the Health Equity Subcommittee is charged with measuring health equity, which is why they were picky about the definition. There is the larger OHA health equity committee, which might be interested in hearing some of the presentations from some of these partnerships about health equity. The health equity work being done by the partnerships may not be on the radar screen of that committee. If some groups are willing to present, that would be good cross-fertilization.

Dr. Hedberg remarked that most of the data in Orpheus is collected at the local level. It is not that the state doesn't have good quality of data. The way to get better data is to report out, including how many missing there are, so people can see that it is an issue. When we know what's happening at the local level, then we can see that these data are really useful. That's an important feedback loop to have. It varies a lot from data set Orpheus and those data, including race and ethnicity, are collected by local health departments, which are the ones that are interviewing people. Birth and death are entirely different. It's different standards. We are interviewing people directly on surveys and they will respond directly to those data.

Dr. Hedberg noted that some of the state data stores has much better data, others – we don't have very good data. We are all in it together – this feedback loop, this presentation, looking at the data, including the missing data. The more we can say, "These are missing," that is a way for people to say, "That's a problem. If half of it is missing, how do we actually know what's happening in these groups?" Measuring or looking at race/ethnicity is extremely problematic, because we either have very large categories that we lumped together or, sometimes, we dice, split, and dice it so much that it's not meaningful. To try to figure out why a population is white/Caucasian, but Russian-speaking – that seems to be very important, including for things like measles outbreaks and other things. We need to figure out what's important for what

disease or outcome. Certain foodborne outbreaks – it is clear that it is important because our preference often relates with very concretely with what your cultural/racial /ethnic background is.

Ms. Saito praised the presentations, especially the great tools that the partnerships have being doing, such as the flyers, the posters, the health equity tools, the action plan's listening sessions. One way the Incentives and Funding Subcommittee talked about that was, if we did a RFP, we should have one of the deliverables be tools. It would be great to capture some of these tools now, so we can share them with people. Other LPHAs, tribes, and partners would be interested in that. Also, a lot of this is focused on the social determinants of health, especially around poverty. We do have an AmeriCorps VISTA program. Some people have an AmeriCorps VISTAs, but this would be a great opportunity also to have an AmeriCorps VISTA and our applications for host sites are due April 30.

Ms. Thalhofer remarked that Ms. Saito's idea was great, but it is unknown what Wasco County's funding would be next year. It will likely be reduced, so it's impossible to commit to an AmeriCorps for the project. The timing is really, really difficult.

Ms. Saito responded that there would be another host site application that would be out. She had just emailed Daniel to discuss the Corporation for National Community Service and asking for the modernization VISTA program. That was done with the CCOs when they first began and also with Health Communities.

Dr. Schwarz asked that since this was a process evaluation and process presentation, when would the process finish.

Ms. Tiel answered that the process will end on June 30, 2019. The attention of these presentations is a process, checking in specifically on the health equity component of it. We will continue doing updates in whatever form or fashion the projects would like, moving forward.

Ms. Tiel introduced the State Health Improvement Plan (SHIP) update from the immunizations and communicable disease section. This is the last year of the current SHIP. We have been hearing a lot about the future state of the plan, but this is the final update on the current priorities. As the new SHIP workplan takes shape, OHA will be offering more opportunities to talk about it. Today, we are here to hear progress on improving immunization rates and protecting the population from communicable disease.

SHIP Update: Immunization and Communicable Disease

Aaron Dunn (OHA staff), Rex Larsen (OHA Staff), Ann Thomas (OHA staff), Timothy Menza (OHA staff)

Mr. Dunn introduced himself to the PHAB as the manager of the Oregon immunization program.

Mr. Larsen introduced himself as the quality improvement program manager for the immunization program.

Ms. Thomas introduced herself as a public health physician in the acute communicable disease prevention program.

Mr. Menza introduced himself as the program director of the HIV/STD/TB program.

Ms. Dunn informed the PHAB that with the measles outbreaks in Clark County, we've had 10 cases in Oregon (4 of them are related to the Clark County outbreak). Across the nation, we have seen 465 cases in 19 states. The two key questions are: (1) How does our public health work change if the level of measles activity seen this year becomes normal? (2) With the legislative activity related to immunization school requirements this year (HB3063), what do your providers and populations need to hear from us?

Mr. Dunne provided an update of the priority targets of the immunization program: (a) immunization rate among two-year-olds (at 68% in 2018, up 8% since 2014; 2020 target at 80%), (b) HPV vaccination rates among youth (at 46.4% in 2018, up 18.4% since 2014; 2020 target at 80%), (c) seasonal flu vaccination (at 45% in 2018, up 3% since 2014; 2020 target at 80%). A number of factors contribute to these increases.

Mr. Larsen explained that the childhood immunization rates are improving year over year. This reflects the work CCOs are doing and the local health departments' modernization work. Next year, OHA will be releasing the two-year-olds rates increase by another one percent. That rate is not likely to keep increasing at the same rate. It will probably start to taper off. The high rates can hide pockets of need in rates. According to CDC, 75% of the measles cases in the past five years have come from close-knit communities. As we look at these improving rates, we start to talk about ways to identify those pockets of need in those close-knit communities that we know we need to work with. One big thing the program is working on is trying to link the IIS data to more vital records data, such as country of origin and other data points that may be available, to start to identify pockets of need.

Mr. Larsen pointed out that improving rates can hide at-risk communicates. For example, the median vaccine completion rate by the 1,670 schools in Oregon, grades K-12, in 2018, was 94%. One in five of these schools falls below the threshold for measles. The schools with low vaccination rates represent communities that are at-risk for communicable disease outbreaks. How do we identify those schools and those communities that they represent? Behind each of those schools are families. The programs has started to link additional demographic data from

Oregon Department of Education to the program's school data to see if there is any way to get a better description of the communities that these schools represent.

Ms. Larsen pointed out that HPV vaccination rates are improving dramatically across the state, but those improvements are focused in metropolitan regions. There is a significant urban-rural disparity. There is a lot of work happening to try to address the urban-rural disparity. Right now, there is a research partnership with OHSU and OHSU's provider research network. The goals identify ways that we can improve rates at the practice level in rural clinics. Rural clinics struggle with HPV vaccination. The takeaway message is that rates are improving across the board, both two-year-old rates and adolescent rates, but we need to find better ways to target the specific pockets of need: close-knit communities in childhood vaccination and our rural clinics and rural rates for adolescent rates.

Ms. Tiel commented that we just heard from the modernization grantees about some health equity assessment work that they were doing. Root cause comes down to poverty and income. In the these pockets of need, which are different from the pockets targeted by other work, such as chronic disease, are we talking about communities of color or a different type of population that needs to be targeted?

Mr. Larsen answered that it is hard to know. It depends on the disparity mentioned by Ms. Tiel. With adolescent vaccinations in rural communities, there is an income disparity and education disparity. There are access disparities in rural areas, but we also know that there are complex social issues that are intertwined with this. In close-knit communities is the same thing. We have seen outbreaks in orthodox communities in New York (Orthodox Jewish communities) and we have our Russian-speaking population here. There may be income disparities that are intertwined with social issues as well.

Dr. Schwarz remarked that in the table that showed the increase of immunization rates among two-year-olds from 60% to 68%, is that what is meant by 8% increase? It is rather 8 percentage point increase. It's not 8% increase.

Ms. Larsen confirmed that it is an 8 percentage point increase.

Dr. Schwarz noted that this was very important because when we go out to applicate the numbers, we should say what it is. Another thing is that the target is so far away from where we are. Who set the target?

Mr. Larsen answered that Healthy People 2020 set the target.

Dr. Luck commented that the HPV vaccination rates map shown in the presentation was a striking map. He asked if other states also showed such a big urban-rural disparity and whether

any other states have identified any successful strategies for improving vaccination rates in rural areas.

Mr. Larsen answered that other states have identified an urban-rural disparity, but there is not a lot of research that talks about successful strategies. We know that resources are an issue in rural clinics. We know that travel time is an issue and that there are a lot of economic issues around parents not being able to take time off work. There is not a lot of research that shows us the most effective interventions to address the issue. Oregon is unique in a couple of ways. We have a different, sometimes social divide between urban and rural groups. Many states that have large rural areas also have more homogenous populations politically sometimes, so there might be some issues there.

Ms. Larsen added that one thing to point out on the HPV map is that we have outlier counties in rural areas, such as Malheur County or Jefferson County. There are rural counties that have high rates, some of the highest in the state. That is usually driven by a single provider or provider office, such as Snake River Pediatrics or Warm Springs. Those practices have addressed the issue. We are trying to figure out what those practices are doing and how to make sure that we can help all our rural practices do that. Because if one provider office can change the rate for the entire county, then we are looking at providers having a significant amount of influence on that rate. There will be some really promising interventions, but we don't quite yet know what they are.

Ms. Thomas reviewed the key questions for protecting the population from communicable disease: (1) How do we leverage policy, health systems and public health to decrease infections among people who use drugs? (2) How do we bring all stakeholders to the table for a unified response to the syndemic of substance abuse and infection diseases? (3) How can we increase funding for surveillance, primary prevention, screening and linkage to care for HIV, HCV, and STI?

Mr. Menza explained that the top two priority targets were syphilis incidence and gonorrhea incidence. Like nationwide, we have been seeing increases in STIs across the board. Oregon is not exception to that rule. Syphilis incidence (rate per 100,000) has increased from 10.4 (2014) to 13.5 (2017), with 2020 target of 11.1. It's even higher in 2018. Gonorrhea incidence has increased from 57.9 (2014) to 121.3 (2017), with 2020 target of 72. HIV incidence has decreased from 6.0 (2014) to 4.8 (2017), with 2020 target of 4.5. HIV oral suppression rates have increased from 68% (2014) to 75% (2017), with 2020 target of 90%. In some areas we are at that target. Tuberculosis incidence has decreased from 1.9 (2014) to 1.7 (2017), with 2020 target of 1.4.

Ms. Thomas stated that if we excluded gonorrhea and chlamydia, the number of annual reports equals the sum of all other infectious diseases combined. It's hard for us to track it, because most of them are asymptomatic and we don't have properly funded screening programs.

Unfortunately, one of the more impressive statistics we were able to come up with was the long terms to quality, which is mortality. We have the unfortunate distinction to have the highest Hepatitis C mortality rate in the nation. The rate climbed from 8.4 (2014) to 9.3 (2017), with 2020 target of 6.0. The rate has stabilized since then, but it's still too high. It's twice the national average.

Ms. Thomas presented a complicated slide of the syndemic model. Once broken down, it is an elegant approach to thinking about how to understand the relationships between several ongoing, concurrent epidemics. The model covers substance use and misuse, overdose, infections (e.g., HIV, HCV, syphilis, and bacterial infections), suicide, and alcohol use. The term *syndemic* comes from the Greek *syn*, which means "with" or "together". These things are all happening together. We don't call them comorbidities or cooccurring epidemics. They are more interacting. From a modeling standpoint, these are multiplicative. They share common causes and consequences. There are also some shared responses that can be used to address the epidemics.

Ms. Thomas stated that there some common things we can work on together, but, structurally, who works on these epidemics in the health department? What departments are they from? Do they often work together? The short answer is no. For example, substance use and misuse are in another OHA section (i.e., addictions and mental health). There's more work being done on those now in OHA's chronic disease program, which focuses more on alcohol. Others are covered by OHA's injury and violence prevention program. Others are covered by maternal and child health.

Ms. Thomas showed the PHAB two charts of the recent trends in injection drug use and selected infectious diseases in Oregon (2013 vs. 2018). Cases have increased in HIV, early syphilis, acute HCV (capturing only 15% of occurring cases), and invasive GAS (Group A strep). The rate of GAS had been mostly same between 1995 and 2015, but the rate has tripled in the last 3-4 years. Much of the increase has been in people who inject drugs with a big contribution in the homeless population. In terms of hospitalizations for bacterial infections related to IDU, the rate has increased five-fold in the state between 2008 and 2015.

Ms. Menza reviewed the numbers for HIV diagnoses among heterosexual PWID by reported substance use. The number of cases of HIV diagnoses among persons who inject drugs has almost tripled between 2013 (12 cases) and 2018 (34 cases). There has been an interesting trend in substance use in Oregon and across the nation. In terms of percent of cases reporting a particular substance use, the cases are reporting less and less heroin mono use and more and more combination use. A lot of that is methamphetamine and opiates taken together. In contrast to the hospital admissions for serious bacterial infections, which are opioid related, the HIV infections and the syphilis diagnoses are methamphetamine-related. It is a sort of a flip. It is almost 70% of the people diagnosed with HIV in Oregon.

Mr. Menza pointed out that in terms of HPV vaccinations and urban-rural divide, this is something we are seeing across the state, especially in rural areas. Interestingly, the rates of new HIV diagnoses in the Portland area have declined since 2012, while the rest of the HIV diagnoses for the rest of Oregon have increased slightly in the same time period. With chronic Hepatitis C, the prevalence of cases is in the more rural areas, such as Douglas County. Cases of early and congenital syphilis among women who inject drugs have risen steadily both in Portland Metro area and the rest of the state between 2013 and 2018.

Dr. Bangsberg commented that some metropolitan areas, such as San Francisco and New York, can see an increase in gonorrhea and syphilis among men having sex with men, who take HIV medications and realize that they won't transmit HIV. These strategies are great for HIV, but not very good for syphilis and gonorrhea. It doesn't look like that's what's happening in Oregon.

Mr. Menza remarked that what we are seeing among the cases of syphilis and even HIV among men having sex with men (MSM) is that methamphetamine use is flat. In the cases of syphilis, about 10-15% of MSM are reporting methamphetamine use. It's about 40% in the HIV cases. There are still increasing trends, but they are not as severe. The slope is not as deep as they are among women.

Dr. Dannenhoffer agreed that that was exactly what was happening in Douglas County. The increase in HIV, gonorrhea, and syphilis – whoever thought that in 2019 we would be spending time on measles and congenital syphilis? It's an absolutely tragic thing. The syndemic model is great. There's always the desire to add more circles. Housing clearly has to be part of it, as the homeless drug addicts are causing much of the issues with the addicts. As a pediatrician, it's interesting to see that this model also accounts for much of the foster care that Douglas County has. About two-thirds of the kids who are in foster care now are in foster care because of the syndemic drugs. We are seeing very little true abuse at this point.

Dr. Luck asked Dr. Bangsberg is there have been any particular strategies that have been effective in rural areas that are different than approaches in urban areas.

Dr. Bangsberg answered that he could not speak about the rural areas. Meth use drives the frequency of injection drug use, which is associated with […] sex. Heroin is a bad drug, but meth makes it much, much worse. Probably there is more meth use in rural areas.

Ms. Thomas noted that Dr. Dannenhoffer knew about a study in collaboration with OHSU trying to increase screening in linkage to care to HIV, Hepatitis C, and STIs. The work is conducted in Linn and Douglas counties. There is a quantitative questionnaire and there's some qualitative work that's been done with these people. The issues are on housing. Seventy percent of our enrolled clients are homeless, among people who inject. In using the CDC's Vulnerability Assessment, which predicts how many people on the county level have chronic drug, we see that for cases of HEP-C and people under the age of 30, the predictor is lack of transportation.

It's true. You can't get to needle exchange. You can't get to healthcare and access the services you need.

Ms. Tiel asked the participants on the phone if they had any questions to the presenters.

Ms. DeLavergne-Brown commented that, in terms of the question brought up about the different agencies and different groups, Crook County includes drug and alcohol prevention with tobacco, communicable disease, and other areas. It makes a big difference when all these areas sit in public health and we have the ability to do that. If you can't, you don't have to work with those other partners. Crook County is working very closely with law enforcement. Counties have to work with law enforcement and the jail. In Crook County, that's that population. We've got to bring that group in to work with public health also.

Dr. Bangsberg praised the slide about the heterogeneity of vaccine penetration among schools and how a small number of schools account for a significant portion of unvaccinated kids. Why aren't we funding public health nurses in those particular schools to provide vaccines on the spot?

Ms. DeLavergne-Brown joked that parents won't let us.

Dr. Bangsberg added that we need interventions with the parents. We can put a lot more resources in a small number of schools to have more intervention effect.

Dr. Schwarz noted that Mr. Dunn asked if this was the new normal. That reminded him that there were no measles vaccinations when he was a kid. Kids were sent to the homes of kids who had measles, so that they could get measles. This included mumps and chicken pox. The kids were cycled around between those who had the disease, in order to get the disease. Maybe that is the new normal. It's back to the future.

Dr. Dannenhoffer remarked that back in the old normal we didn't have kids with transplants and we didn't have kids with cancer. Now we are thinking about the great advances we have made in medicine and putting those kids at risk for those diseases. When they get those disease, they are going to die. They are relatively weak. Back in the old days, one or two out of a thousand died. Now we think the death rate would be just as high, because we have these new vulnerable populations. In terms of the schools that had low vaccination rates, these are not the schools that lack resources. It turns out that in Douglas County, when we look at the poor schools, they have the best vaccination rates. It's the rich schools that have low vaccination rates. A recent study in California looked at the rate of vaccination by the cost of tuition. There's an almost linear relationship between the cost of tuition and the vaccine refusal rate. This is not met by bringing a nurse there to vaccinate the kids. It's about convincing the parents, and they are hard to convince.

Mr. Larsen stated that we do have school-based health centers in public schools, but there's no organized system of providing care to students in a private or many other types of schools. Maybe part of the answer is that we have to push for some way to have better healthcare in the school for private schools. OHA doesn't have any power over that.

Ms. Tiel thanked the presenters for their time.

Public Comment Period

Ms. Tiel asked if members of the public on the phone or in person wanted to provide public comment. No public comment was provided.

Closing

Ms. Tiel thanked the PHAB for their time and adjourned the meeting at 4:45 p.m.

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

May 16, 2019
2:00-5:00 p.m.
Portland State Office Building
800 NE Oregon St Room 1D
Portland, OR 97232

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

Oregon Health Authority

May 2019

Preventive Health & Health Services Block Grant (Block Grant)
October 2019 – September 2020 Work Plan Proposal

Background

- Non-competitive grant issued to all states and territories to address state/territory 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, including public health modernization. Healthy People 2020 objectives in the 2019-20 work 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)

A Modern Public Health System

- Oregon's public health system is changing how it prevents disease and protects and promotes health.
- A modern public health system ensures critical public health protections are in place for every person in Oregon, that the public health system is prepared and has the right resources to address emerging health threats, and that the public health system is engaged daily to eliminate health disparities.
- To accomplish these objectives, foundational capabilities and expertise are needed within the public health system as defined in the Public Health Modernization Manual.

Proposed October 2019 – September 2020 Work Plan

- Oregon proposes to use the Block Grant funds to continue to modernize Oregon's public health system through the following foundational capabilities:
    - Leadership and organizational competencies
    - Policy and planning
    - Community partnership development
    - Health equity and cultural responsiveness
- Please see attached table for additional information
- The Oregon Coalition Against Domestic and Sexual Violence proposed to use Block Grant funds to:
    - Support domestic and sexual violence programs throughout Oregon in developing community-based sexual violence prevention efforts.

- Continue to build capacity statewide to create equitable prevention in communities most impacted by sexual violence, including people with disabilities, People of Color, LGBTQ communities and elders.

Funding

- Total PHHS Block Grant funding for October 2019 through September 2020 is $1,118,743 with $85,660 designated for sexual assault prevention and services.
- Funding by Health Objective:
  - Accredited Public Health Agencies – $631,240 (Estimate)
  - Quality Improvement – $298,535 (Estimate)
  - Reduce sexual violence -- $85,660
  - Indirect Costs (capped at -- $103,308

Oregon Health Authority

Oregon PHHS Block Grant – Proposed 2019-20 Work Plan

OVERALL PRIORITY AREAS • Support implementation of Oregon's plan for a modern public health system • Continue to build and expand public health system foundational capability capacity in leadership and organizational competencies (L&OR), community partnership development (CPD), policy and planning (P&P), health equity and cultural responsiveness (HE&CR) • Support national public health accreditation		
Leadership & Organizational Competencies (L&OC)	***Community Partnership Development (CPD)***	***Policy & Planning (P&P)***
• Quality improvement and performance management through LPHA contract administration, compliance reviews and technical assistance (CPD, P&P) • Support national public health accreditation and re-accreditation for OHA-PHD and local and tribal partners and align modernization efforts with reaccreditation requirements (P&P) • Align public health system processes and structures to support a modern public health system (P&P, CPD) • Maintain and refine the PHD performance system • Implement quality improvement plan and assess quality improvement activities • Continue implementation and tracking of OHA-PHD Strategic Plan (P&P)	• Support and coordinate work between OHA-PHD, Conference of Local Health Officials and LPHAs (P&P, L&OC) • Support and coordinate work between OHA-PHD and Federally-recognized Tribes (L&OC, P&P, HE&CR) • Provide ongoing public health-related technical assistance to LPHAs and Federally-recognized Tribes (L&OC, P&P, HE&CR) • Increase PHD's effective engagement with communities experiencing health inequities (HE&CR, P&P)	• Complete implementation of and progress reporting for 2015-2019 State Health Improvement Plan • Complete development of 2020-2024 State Health Improvement Plan through robust community input processes and cross-sector partnerships (CPD, HE&CR) • Continue implementation of public health modernization tribal assessment and planning (CPD, HE&CR) • Collect, analyze and report public health accountability metrics and local investment data (L&OC) • Develop and implement an OHA-PHD strategic partnerships plan to support prioritization of prevention and public health in the state (CPD, HE&CR)

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics Subcommittee meeting minutes

May 6, 2019
1:00-2:00 pm

PHAB Subcommittee members in attendance: Jeanne Savage, Muriel DeLaVergne-Brown

Oregon Health Authority staff: Sara Beaudrault, Myde Boles, Kati Moseley, Matt Laidler, Josh Van Otterloo

Welcome and introductions

Since only two PHAB members were on the call, minutes from the April 1, 2019 meeting were not approved.

OHA has not yet released the 2019 Public Health Accountability Metrics Annual Report, but Sara expects it will be released within the next few days.

Prescription opioid mortality metric

Sara reviewed a table showing which outcome and process measures will be reviewed and possibly updated for the 2019-21 biennium, based on PHAB's feedback on this year's report.

Two outcome measures will be reviewed. The oral health developmental metric was reviewed by this subcommittee last month, with a recommendation to keep the metric without changes. The other outcome metric, prescription opioid mortality, will be reviewed at today's meeting.

The other measures on the list are process measures, which describe the core roles of local public health authorities (LPHAs) to make improvements in the outcome measures. The process to update the process measures is to work through the Conference of Local Health Officials (CLHO) to get feedback and recommendations from local public health, which then come to this committee for discussion. Process measure reviews will occur over the next few months.

Matt Laidler reviewed the slides in the meeting packet on the current opioid mortality metric, including limitations related to the data source and challenges in classifying opioid poisoning deaths as prescription vs illicit (slides 12-15 in the meeting packet).

- There are challenges to classifying prescription vs. illicit drugs. There is no variable in the data that flags this, and the designation is problematic because some dugs can be both prescribed and illicitly manufactured.

- We are also experiencing changes in drug use and overdose. As an example, the U.S. is experiencing a surge in illicitly manufactured fentanyl, which until recently was exclusively a prescription drug. The categories need to adapt to these changes.
- Matt reviewed T codes, which describe contributing causes of death. T codes can be used to try zero in on what we would consider an overdose or poisoning and whether poisoning is intentional or unintentional.
- Another confounding factor is that many overdoses include many drugs, not a single drug. As an example, approximately 30-50% of heroin overdoses include another drug.
- Fentanyl and fentanyl analogs: we can sometimes identify pharmacy-manufactured vs. illicitly-manufactured fentanyl analogs in the death record, but not always. Because of this, Oregon has updated how it measures "prescription" opioid deaths to only include "other opioids" and "methodone," and to exclude "other synthetic narcotics". This measure is specific, but not sensitive, as it specifically leaves certain drugs out.

Matt reviewed options for the accountability metric.

- Continue using the limited definition of "prescription opioids," minus synthetic opioids.
- Classify drugs by ICD-10 codes. This option is less intuitive, especially for the general public.
- Use "any opioid," which aligns with the State Population Health Indicator and does not differentiate between prescription and illicit. SPHI. This is the OHA program's recommendation. The opioid crisis is often viewed as being about an individual drug but is actually an evolving set of drugs based on circumstances. CDC talks about the opioid crisis in terms of waves.
    - 1st wave: prescription drug epidemic.
    - 2nd wave: increaed use of heroin when there was a decrease in availability of prescription opioids.
    - 3rd wave: illicitly manufactured fentanyl.

    It is hard to approach this crisis by focusing on individual drugs or even illicit vs. pharmaceutical.

Jeanne stated that clinicians have put significant effort into making a dent in the number of opioids on the street. By understanding where these drugs are originating (i.e. by looking at prescribing patterns), we can use the information to drive interventions. Jeanne is hesitant to move away from this breakdown. Matt stated that the OHA program can break the data down in a way that makes sense, including providing more than one measure. Sara stated that PHAB members voiced a need to look at a broader context for opioid overdose and mortality, and we also need to consider what we want to hold the public health system accountable to.

Josh Van Otterloo stated that the OHA program used to provide funding to some LPHAs for PDMP outreach but is no longer doing so. Moving forward the program will look at funding broader interventions for prevention and intervention.

Muriel stated that there are differences at the county level that need to be considered, in terms of whether drug and alcohol prevention sits in public health or somewhere else. In Crook County, drug and alcohol prevention is with public health, and they are building a strong program with local law enforcement. Some LPHAs have no money for drug and alcohol prevention, and this is an important consideration.

Josh discussed the current local public health process measure for PDMP enrollment and options for other process measures.

- The law requiring PDMP enrollment, which went into effect in mid-2018 has had a positive effect on PDMP enrollment, with around 94% of top prescribers currently enrolled.
- Limitations in process measure include: legislative mandate for enrollment; county rates unstable due to small numbers; LPHAs no longer funded to increase PDMP enrollment; only addresses legally-prescribed opioids which may not be sufficient if PHAB changes the outcome measure; measure is about enrollment but not use of system; measure does not include prescribers who are registered in a state that is not Oregon, like all VA prescribers.
- Sara reminded the group that the process measures are intended to reflect what every LPHA should be doing to make improvements in the outcome measure, and what local public health's unique role is. Is it okay if the process measures are aspirational because we do not currently have the resources to meet the process measure in every county.
- Muriel stated that LPHAs do have a role in preventing opioid deaths. Examples of public health interventions include naloxone to law enforcement; naloxone to people leaving treatment, syringe exchange.
- Jeanne agrees with focusing on harm reduction and prevention interventions. She does not agree with keeping the current process measure or switching to measuring PDMP queries.

Sara asked what additional information subcommittee members need to make a recommendation for the outcome measure. Jeanne stated that she thinks the outcome measure should include all opioids but thinks the group should discuss whether deaths per 100,000 population is the right outcome. She would like the group to discuss other options, like nonfatal overdoses.

Next steps:

1. Matt will come back to the June subcommittee meeting to talk about data sources for nonfatal overdoses.

2. Sara will solicit feedback from local public health administrators at the next CLHO meeting.
3. Muriel will look at recent NACCHO policy papers on opioids and the role of public health. She suggests hearing from administrators about what LPHAs are doing if they do not have an alcohol and drug prevention program.

Purpose and use of accountability metrics

This discussion was postponed until next month.

Subcommittee business

Jeanne will provide the subcommittee update on May 16.

The next Accountability Metrics Subcommittee meeting is scheduled for June 3 from 1:00-2:00.

Public comment

No public comment was provided.

Adjournment

The meeting was adjourned.

Fiscal Year 2018 Local Governmental Public Health Investment - FINAL 5/8/2019

County	Population*	Local Expenditures (less exclusions[1])	In Kind Support	Total Local Investment	Per Capita Total Local Investment
Oregon	**4,195,300**	$ 69,230,127	$ 812,425	$ 70,042,552	$ 16.70
BAKER	16,765	$ 278,170	$ 83,594	$ 361,764	$ 21.58
BENTON	93,590	$ 1,791,995	$ -	$ 1,791,995	$ 19.15
CLACKAMAS	419,425	$ 5,019,520	-	$ 5,019,520	$ 11.97
CLATSOP	39,200	$ 446,000	$ -	$ 446,000	$ 11.38
COLUMBIA	51,900	$ 531,625	$ 83,703	$ 615,328	$ 11.86
COOS	63,275	$ 255,216	$ 77,437	$ 332,653	$ 5.26
CROOK	22,710	$ 1,484,699	$ 99,989	$ 1,584,688	$ 69.78
CURRY	22,915	$ 703,878	$ -	$ 703,878	$ 30.72
DESCHUTES	188,980	$ 3,814,900	$ -	$ 3,814,900	$ 20.19
DOUGLAS	111,735	$ 444,652	$ -	$ 444,652	$ 3.98
GRANT~	7,400	$ -	$ -	$ -	$ -
HARNEY	7,380	$ 159,509	$ 12,761	$ 172,270	$ 23.34
HOOD RIVER	25,310	$ 572,647	$ 157,029	$ 729,676	$ 28.83
JACKSON	219,200	$ 2,298,330	$ -	$ 2,298,330	$ 10.49
JEFFERSON	23,560	$ 261,557	$ -	$ 261,557	$ 11.10
JOSEPHINE	86,395	$ 641,298	$ 16,700	$ 657,998	$ 7.62
KLAMATH	67,960	$ 542,426	$ -	$ 542,426	$ 7.98
LAKE	8,115	$ 187,877	$ -	$ 187,877	$ 23.15
LANE	375,120	$ 4,024,080	$ -	$ 4,024,080	$ 10.73
LINCOLN*	48,210	$ 1,458,472	$ -	$ 1,458,472	$ 30.25
LINN	125,575	$ 1,327,242	$ -	$ 1,327,242	$ 10.57
MALHEUR	31,925	$ 435,955	$ 38,230	$ 474,185	$ 14.85
MARION	344,035	$ 4,647,307	$ -	$ 4,647,307	$ 13.51
MORROW	11,885	$ 702,506	$ 10,317	$ 712,823	$ 59.98
MULTNOMAH	813,300	$ 25,329,190	$ -	$ 25,329,190	$ 31.14
North Central PHD	30,970	$ 682,867	$ 89,574	$ 772,441	$ 24.94
GILLIAM	1,985				
WASCO	27,200				
SHERMAN	1,785				
POLK	82,100	$ 291,010	$ -	$ 291,010	$ 3.54
TILLAMOOK	26,395	$ 119,798	$ -	$ 119,798	$ 4.54
UMATILLA	80,765	$ 435,117	$ 97,200	$ 532,317	$ 6.59
UNION	26,885	$ 112,200	$ 41,090	$ 153,290	$ 5.70
WALLOWA^	7,175				$ -
WASHINGTON	606,280	$ 8,674,852	$ -	$ 8,674,852	$ 14.31
WHEELER	1,450	$ 1,991	$ 4,800	$ 6,791	$ 4.68
YAMHILL	107,415	$ 1,553,242	$ -	$ 1,553,242	$ 14.46

Prepared by :Charles Rynerson, Population Research Center
College of Urban and Public Affairs, Portland State University
December 17, 2018

This table reflects all county government investments in local public health as measured by expenditures paid by county funds or other revenue generated by the county or public health district (insurance reimbursement, license fees, etc) minus exclusions outlined below during fiscal year 2018.

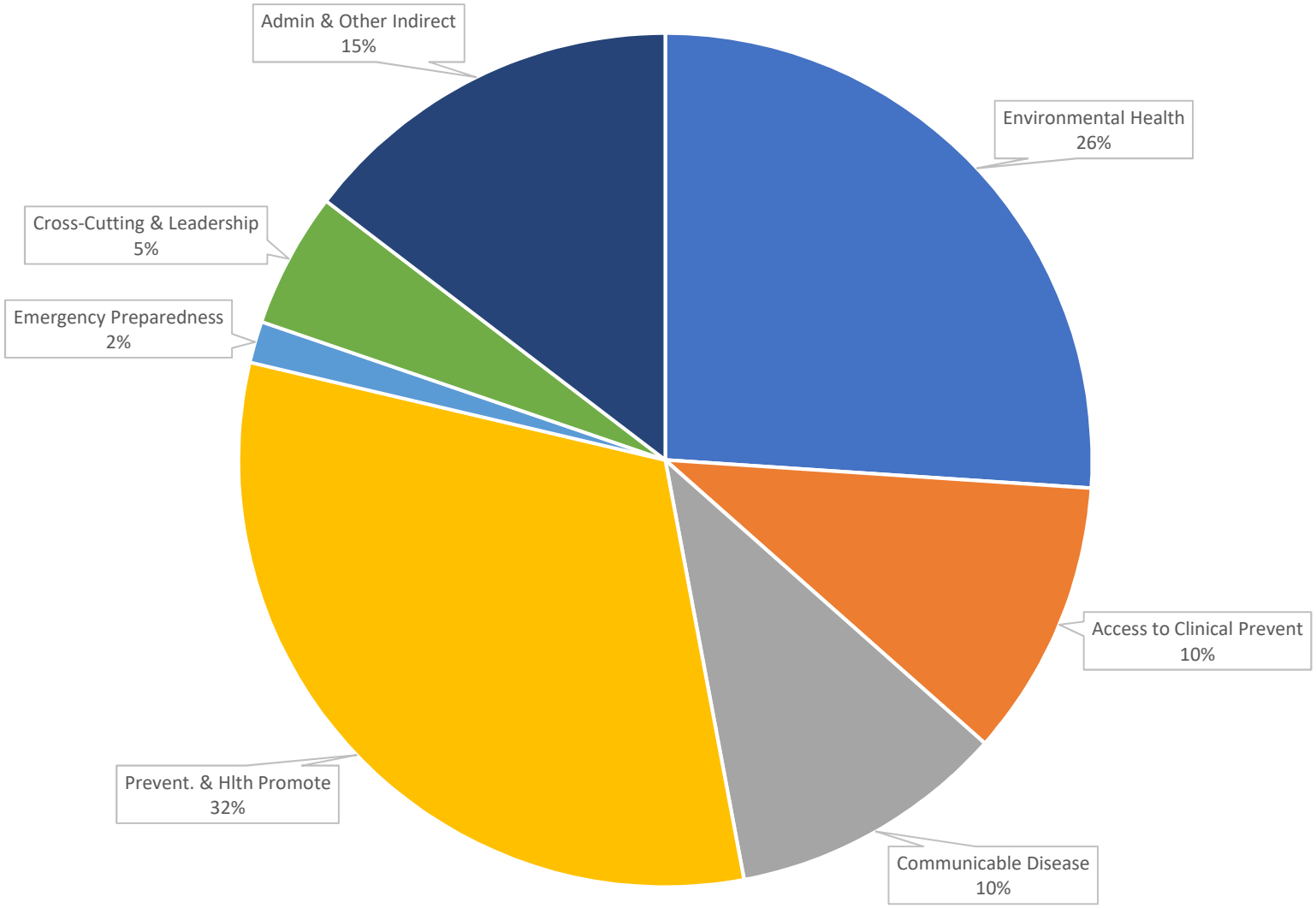
[1] Exclusions include: Ryan White case management, reproductive health client services, immunization clinics, clinical support, corrections health, individual dental services, primary care services, occupational health services, medical examiner services, mental health/addiction services and treatment, emergency medical services, refugee resettlement screening, animal control/shelter, and infrastructure costs directly related to these exclusions.

~ Data not included due to lack of validation

* In-kind excluded due to lack of validation

^ No longer operates as the local public health authority

2018 Local Governmental Public Health Investment by Category



Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
May 14, 2019
1:00 p.m. - 2:00 p.m.

PHAB members present: Carrie Brogoitti (by phone), Dr. Jeff Luck (by phone), Alejandro Queral (by phone), Akiko Saito (chair)
PHAB members absent: Dr. Bob Dannenhoffer
Oregon Health Authority (OHA) staff: Sara Beaudrault, Krasimir Karamfilov, Danna Drum, Monty Schindler

Welcome, introductions, and updates

Ms. Beaudrault introduced the meeting and thanked everybody for joining.

A quorum was present. Ms. Saito asked the subcommittee members to review the meeting minutes from April 9, 2019, before the subcommittee approved the minutes.

Ms. Saito asked if the subcommittee would entertain a motion to approve the meeting minutes. Mr. Queral made a motion to approve the meeting minutes. Dr. Luck seconded the motion. The subcommittee approved the previous month's meeting minutes unanimously.

Mr. Queral requested a correction of his title on page 4 of the April 9, 2019, meeting minutes.

Ms. Beaudrault informed the subcommittee that OHA was on track with its planning to distribute funding to the eight LPHA partnerships, starting in July 2019, so that there is no break in funding for those partnerships. Additional planning is ongoing for the distribution of funds in the $5-10 million range to the LPHAs. OHA's plan is to bring all these recommendations at each tier of funding back to the subcommittee, so that the subcommittee can look at them comprehensively and make any adjustments.

County investments in public health

Ms. Drum and Mr. Schindler introduced themselves to the subcommittee. Mr. Schindler is a fiscal analyst in the Public Health Division.

Ms. Drum explained that because the PHAB's funding formula has a matching funds component, required by statute, OHA has collected data on local county investment in public health over the last two years. Total county public health expenditures for the state was $69.2 million. The amount for each county would become the baseline by which matching funds would be determined at some point in the future, through the public health modernization funding formula for local public health authorities. Total in-kind county support was 812K. Total

local investment was $70 million. Total local investment per capita in the state ranges from $3.54 to $69.78. This range is typical with what has been found over the years with this data.

Ms. Schindler remarked that in-kind support was defined as non-cash, such as volunteers and having access to a building without paying rent, among others.

Mr. Queral pointed out that volunteers should not be included as in-kind support from public health, unless government workers volunteered their time.

Mr. Schindler agreed with Mr. Queral and stated that the example he gave was to illustrate the model of in-kind support, not to say that any county has reported volunteer services. When counties are not paying money for services related to public health, that is in-kind investment.

Ms. Drum added that local government support (i.e., revenue the county generated) is part of in-kind support, items such as insurance reimbursement and license fees. Local government public health investment by category includes: prevention and health promotion (32%), environmental health (26%), administrative (15%), access to clinical prevention (10%), communicable diseases (10%), cross-cutting and leadership (5%), emergency preparedness (2%). Although prevention and health promotion received the biggest portion of the funds, local public health officials reported that those efforts were underfunded. The categorical information is based on what the LPHAs reported to OHA. These data, however, have not been validated by the OHA. Only the $70 million investment has been validated.

Ms. Drum explained that the category *cross-cutting and leadership* was created because when OHA asked the LPHAs to report their investment categories, there were some investments that cut across multiple categories or were such core infrastructure that couldn't be assigned to a single programmatic area. Counties did a great job indicating in which category their local investments had gone.

Ms. Saito expressed a surprise that the category *emergency preparedness* received so little support. She asked Ms. Drum if tribes in Oregon did similar reporting of local public health investments.

Ms. Drum answered that there are no immediate plans to collect public health expenditures from tribes.

Ms. Beaudrault noted that OHA got solid data this year. If we get a level of funding that triggers us to turn on the matching funds component of the funding formula, OHA is well prepared to do that, using these data as baseline and collecting data annually.

Ms. Drum confirmed that OHA is required by rule to collect the data annually.

Ms. Beaudrault stated that the wide range of per capita investment suggested that public health looked very different depending on where a person lived.

Ms. Drum remarked that we are hearing anecdotally that some county governments are really struggling with their budgets moving in to the next biennium.

LPHA funding above $10 million – planning scenario

Ms. Beaudrault remarked that once we reached $10 million in funding, funds would be distributed to all LPHAS through the base funding component of the funding formula. There will be no incentives for meeting accountability metrics for matching funds for local investments, but every LPHA will be receiving funding through the funding formula.

Dr. Luck asked that in the event that we received more than $10 million for LPHAs, would OHA distribute all $11 million through the base component and not continue with funding the cross-jurisdictional partnerships?

Ms. Beaudrault answered that the funding formula was built before the LPHA Partnerships existed. We have always worked under the premise that when we hit $10 million, then all funds to LPHAs would go out on a county-by-county basis through the funding formula. But PHAB can talk about how not to unravel the gains that we have made.

Ms. Saito noted that the subcommittee has not looked at the incentives piece, because the subcommittee first needed the information that Ms. Drum presented. We could think about how to use the funding formula to incentivize regional efforts. Perhaps we could have an incentive and a certain percentage of it goes to the LPHA Partnerships that are funded now. We have an opportunity with funding over $10 million to continue encouraging the good work that has already been done.

Mr. Queral recommended to not rehash the funding formula. He agreed with Ms. Saito that there is an opportunity here to both build on what has already been started, namely, the cross-jurisdictional collaborations and the local projects we have been funding up until now. One idea is, if we get anything above $10 million of funding, to have the first $5 million go out as PHAB has already decided in that category and use the rest of the other $5 million to continue to support the existing LPHA Partnerships, or additional new proposal, but these would go through an RFP. The question is: Do we want to open it for all LPHAs, or do we want to use the additional dollars to bring in new LPHAs and new partnerships within LPHAs for that purpose? If we get that much money, it's an opportunity to bring all LPHAs to a healthier level of funding and begin to use the incentives as we had originally thought.

Ms. Saito asked if the first $5 million would be used as we have it in the pyramid graph and the other $5 million, instead of using it through the funding formula, would be money for which we would do an RFP process.

Mr. Queral confirmed that that was the idea. Unless it is a significant amount of money above $10 million, we won't change the approach we have already defined. There is no need to overcomplicate the process, when we are not talking about a lot of money, and we could help by bringing more base funding to local health departments and continue to incentivize the other pieces of work.

Dr. Luck suggested to stay with the subcommittee's recommendation for how to spend the first $7 million and allocating anything over $7 million according to the indicators in the rest of the funding formula.

Ms. Saito clarified that above $7 million, we would put out the money through the funding formula.

Dr. Luck confirmed that that was correct.

Ms. Beaudrault shared with the subcommittee that she has been looking at the funding formula, trying to translate how much the LPHA partnerships are receiving now through the partnership and then how that translates to the funding each LPHA would receive if funds were to go out to each LPHA at the $10 million level. The big winners for just using the funding formula would be extra-large counties. Right now, the tri-county LPHA partnership has a maximum award of 700K. If funds were to get out through the funding formula, they would be getting more like $3.5 million. It is a big difference and a real incentive for that group to not stay together. In other areas, the individual counties would receive only a very small increase in funding over what they receive now through the partnership. This brings up an equity issue.

Dr. Luck clarified that if we switched to full-on funding formula, once we reached $10 million, the proportion going to the largest counties would grow dramatically.

Mr. Queral noted that Ms. Beaudrault's point could create a disincentive, which is why Mr. Queral suggested to not tinker with the funding formula, but instead, because of the limitations of the funding, to change the framework for the funding so that, in the spirit of achieving some degree of equity, we continue to create incentives. Let's say that we get $10 million and have above $10 million in funding. Could we divide the $10 million in half, so that $5 million goes to fund the base funding across the board, so it's prorated and follows the funding formula, and the other $5 million goes towards the incentives, regardless of whether it goes through a RFP process, and the money is allocated specifically to create and continue investing in those counties and partnerships that are moving in that direction?

Ms. Saito remarked that the point Ms. Beaudrault had brought up was about the larger counties receiving enough money that they would not necessarily need to stay together. We sort of take off the incentive of working together. The question is: How do we build an incentive, so that when we put the funds out, there is an incentive for people to work together? Maybe we say to the partnerships that if they continue with their original project, they will get 5% more funding, or if they stay together with at least two other counties.

Dr. Luck pointed out that the funding formula doesn't take into account LPHAs working together. Every LPHA is a separate line item. None of the subcommittee's discussions about the funding formula included an aspect of incentivizing partnerships.

Ms. Saito agreed that that was one of the missing pieces in the conversation. The way the funding formula is set up, it is giving more money for several things that are population-based, such as language access.

Dr. Luck stated that his idea of allocating the first $7 million to the partnerships plus the floor portion of the base component would mean that, in the next biennium, the counties would start out continuing what they are doing now and that any dollars over $7 million would go out according to the other base component columns (i.e., burden of disease, health status, etc.), which are population-based and the larger portion would go to the largest counties, which was built into the formula originally.

Ms. Beaudrault agreed with the comments about the funding formula. When the formula was built in the county by county traditional funding methodology, the partnerships and the cross-jurisdictional sharing could not be built into it. In terms of the eight partnerships, a lot of those eight partnerships represent work that the counties have wanted to do for a long time. It is the right fit for their area of the state. There are some areas where counties are working in partnership and doing a really great job, but structurally, it might not make sense for their area of the state to be lined up like they are. It is worth thinking about how we allow flexibility for a group to step out of their partnership, if it's not the right long-term model, while also supporting the ones that want to keep going with that model, and perhaps even incentivizing them.

Dr. Luck admitted that he felt reluctant to make a recommendation about this without hearing from the LPHA members of the subcommittee and from CLHO.

Ms. Beaudrault agreed that the discussion today was a first pass recommendations and a formal process will be done to get feedback from CLHO.

Ms. Saito remarked that the points Mr. Queral and Dr. Luck brought up were important for the discussion. Her recommendation is to pose the questions discussed during this meeting to the LPHA members of the subcommittee.

Ms. Brogoitti stated that it was difficult for her to comment while driving and not having the materials in front of her. She requested a little bit of time to think about the funding and look at the materials. She proposed to continue the discussion during the next subcommittee meeting.

Mr. Queral remarked that instead of the subcommittee proving a report to the PHAB, it would be better to invite 15 minutes of discussion and input from the local health department representatives who will be at the meeting. This would be in addition to the continued discussion of the subcommittee.

Dr. Luck commented that this suggestion is very much in the spirit of how the PHAB is constituted.

Ms. Saito added that the subcommittee would not do a report out, but just talk about the highlights of the subcommittee's discussion, and then open the conversation to others, especially those who represent LPHAs. The goal today was not to make a decision, but to talk through and get thoughts and creative ideas about how to present the suggestions to the larger group. In the end, we don't know if we are going to get more than $5 million.

Ms. Beaudrault stated that the subcommittee would have 15 minutes during the PHAB meeting on May 16, 2019, to get the feedback of the PHAB.

The subcommittee members agreed that that was a good plan.

Ms. Beaudrault remarked that the meeting minutes of this meeting would include a couple of questions that the subcommittee would like to get PHAB's feedback on.

Question 1: If OHA receives a funding amount that results in $10 million or more allocated to LPHAs, how can we use the funding formula to encourage LPHAs to continue the partnership work, while also allowing flexibility for areas of the state that do not wish to continue the LPHA Partnership or wish to use a different model?

Question 2: How can we use the funding formula to incentivize cross jurisdictional sharing and new service delivery models that strengthen the public health system?

Question 3: If OHA receives a funding amount that results in $10 million or more allocated to LPHAs, would PHAB consider directing some of those funds to partnerships, cross jurisdictional sharing, and new service delivery models, with the remainder going to all every LPHA through the funding formula?

Subcommittee business

Ms. Saito confirmed that she would provide a subcommittee update at the May 16 PHAB meeting.

Ms. Beaudrault noted that the subcommittee's June 11 meeting would most likely be rescheduled. Dr. Dannenhoffer might chair the next subcommittee meeting.

Public comment

Ms. Saito invited members of the public to ask questions and provide comments.

There was no public comment.

Closing

Ms. Saito adjourned the meeting at 1:54 p.m.

The next Public Health Advisory Board Incentives and Funding subcommittee meeting will be held on June 11, 2019, at 1:00 p.m.

PHAB Funding and Incentives Subcommittee

Local public health funding formula model - $10 million example

Subcommittee Members: Carrie Brogoitti, Bob Dannenhoffer, Jeff Luck, Alejandro Queral, Akiko Saito

May, 2018

Total biennial funds available to LPHAs: $10 million
Base component: $10 million
Matching funds component: $0
Incentive funds component: $0

Local public health funding formula model: At the $10 million level, all funds are allocated to the base component of the funding formula, with 0% allocated to matching funds and 0% allocated to incentive funds.

		Base component								Matching and Incentive fund components		Total county allocation				
County Group	Population[4]	Floor	Burden of Disease[2]	Health Status[3]	Race/ Ethnicity[1]	Poverty 150% FPL[1]	Rurality[5]	Education[1]	Limited English Proficiency[1]	Matching Funds	Incentives	Total Award	Award Percentage	% of Total Population	Award Per Capita	Avg Award Per Capita
Wheeler	1,480	$ 30,000	$ 479	$ 890	$ 120	$ 311	$ 2,600	$ 203	$ 8	$ -	$ -	$ 34,612	0.3%	0.0%	$ 23.39	
Wallowa	7,195	$ 30,000	$ 2,821	$ 1,734	$ 646	$ 1,203	$ 12,642	$ 798	$ 316	$ -	$ -	$ 50,159	0.5%	0.2%	$ 6.97	
Harney	7,360	$ 30,000	$ 3,991	$ 3,835	$ 1,342	$ 1,373	$ 5,729	$ 1,249	$ 688	$ -	$ -	$ 48,207	0.5%	0.2%	$ 6.55	
Grant	7,415	$ 30,000	$ 2,457	$ 2,673	$ 845	$ 1,383	$ 13,028	$ 1,259	$ 326	$ -	$ -	$ 51,971	0.5%	0.2%	$ 7.01	
Lake	8,120	$ 30,000	$ 3,491	$ 2,115	$ 1,666	$ 1,756	$ 9,031	$ 2,134	$ 1,116	$ -	$ -	$ 51,308	0.5%	0.2%	$ 6.32	
Morrow	11,890	$ 30,000	$ 3,934	$ 5,799	$ 6,574	$ 2,049	$ 9,589	$ 4,832	$ 10,456	$ -	$ -	$ 73,233	0.7%	0.3%	$ 6.16	
Baker	16,750	$ 30,000	$ 6,912	$ 4,364	$ 2,053	$ 2,984	$ 12,067	$ 2,624	$ 921	$ -	$ -	$ 61,924	0.6%	0.4%	$ 3.70	$ 6.17
Crook	22,105	$ 45,000	$ 8,928	$ 10,305	$ 3,591	$ 4,365	$ 18,643	$ 4,473	$ 850	$ -	$ -	$ 96,156	1.0%	0.5%	$ 4.35	
Curry	22,805	$ 45,000	$ 12,666	$ 10,587	$ 4,127	$ 4,077	$ 15,507	$ 3,833	$ 1,504	$ -	$ -	$ 97,302	1.0%	0.6%	$ 4.27	
Jefferson	23,190	$ 45,000	$ 10,805	$ 8,585	$ 13,185	$ 4,789	$ 25,711	$ 6,245	$ 5,863	$ -	$ -	$ 120,183	1.2%	0.6%	$ 5.18	
Hood River	25,145	$ 45,000	$ 6,530	$ 9,752	$ 12,720	$ 4,008	$ 23,062	$ 8,084	$ 20,039	$ -	$ -	$ 129,196	1.3%	0.6%	$ 5.14	
Tillamook	26,175	$ 45,000	$ 10,770	$ 9,947	$ 5,558	$ 4,629	$ 32,009	$ 4,357	$ 3,453	$ -	$ -	$ 115,722	1.2%	0.6%	$ 4.42	
Union	26,900	$ 45,000	$ 9,986	$ 7,588	$ 3,948	$ 5,746	$ 19,898	$ 3,249	$ 2,070	$ -	$ -	$ 97,485	1.0%	0.6%	$ 3.62	
Gilliam, Sherman, Wasco	30,895	$ 105,000	$ 12,929	$ 9,501	$ 9,946	$ 5,184	$ 22,528	$ 6,782	$ 9,426	$ -	$ -	$ 181,297	1.8%	0.7%	$ 5.87	
Malheur	31,845	$ 45,000	$ 11,781	$ 17,903	$ 17,244	$ 7,933	$ 27,081	$ 10,342	$ 16,103	$ -	$ -	$ 153,386	1.5%	0.8%	$ 4.82	
Clatsop	38,820	$ 45,000	$ 16,738	$ 11,787	$ 7,634	$ 6,489	$ 26,601	$ 5,132	$ 6,181	$ -	$ -	$ 125,568	1.3%	0.9%	$ 3.23	
Lincoln	47,960	$ 45,000	$ 24,044	$ 19,353	$ 11,687	$ 9,286	$ 31,685	$ 8,375	$ 8,172	$ -	$ -	$ 157,600	1.6%	1.2%	$ 3.29	
Columbia	51,345	$ 45,000	$ 18,858	$ 19,411	$ 7,756	$ 7,754	$ 39,334	$ 8,044	$ 3,951	$ -	$ -	$ 150,108	1.5%	1.2%	$ 2.92	
Coos	63,310	$ 45,000	$ 30,961	$ 27,283	$ 12,991	$ 13,075	$ 42,716	$ 11,469	$ 5,220	$ -	$ -	$ 188,713	1.9%	1.5%	$ 2.98	
Klamath	67,690	$ 45,000	$ 31,945	$ 28,508	$ 19,967	$ 14,198	$ 44,719	$ 13,698	$ 11,161	$ -	$ -	$ 209,196	2.1%	1.6%	$ 3.09	$ 3.81
Umatilla	80,500	$ 60,000	$ 27,773	$ 34,691	$ 37,396	$ 15,482	$ 41,160	$ 22,859	$ 46,014	$ -	$ -	$ 285,375	2.9%	1.9%	$ 3.55	
Polk	81,000	$ 60,000	$ 24,329	$ 23,007	$ 23,893	$ 12,703	$ 28,322	$ 11,897	$ 19,589	$ -	$ -	$ 203,739	2.0%	2.0%	$ 2.52	
Josephine	85,650	$ 60,000	$ 42,369	$ 32,045	$ 15,012	$ 19,734	$ 67,721	$ 15,655	$ 5,649	$ -	$ -	$ 258,185	2.6%	2.1%	$ 3.01	
Benton	92,575	$ 60,000	$ 20,591	$ 25,750	$ 24,009	$ 18,103	$ 30,580	$ 7,554	$ 19,844	$ -	$ -	$ 206,431	2.1%	2.2%	$ 2.23	
Yamhill	106,300	$ 60,000	$ 31,992	$ 39,771	$ 33,325	$ 16,945	$ 42,211	$ 20,818	$ 31,549	$ -	$ -	$ 276,611	2.8%	2.6%	$ 2.60	
Douglas	111,180	$ 60,000	$ 55,353	$ 50,961	$ 17,744	$ 20,736	$ 80,483	$ 19,777	$ 7,333	$ -	$ -	$ 312,388	3.1%	2.7%	$ 2.81	
Linn	124,010	$ 60,000	$ 45,765	$ 45,911	$ 24,563	$ 22,889	$ 68,854	$ 20,845	$ 14,313	$ -	$ -	$ 303,141	3.0%	3.0%	$ 2.44	$ 2.60
Deschutes	182,930	$ 75,000	$ 51,532	$ 40,850	$ 31,542	$ 26,799	$ 88,711	$ 20,898	$ 20,109	$ -	$ -	$ 355,439	3.6%	4.4%	$ 1.94	
Jackson	216,900	$ 75,000	$ 82,763	$ 78,176	$ 55,016	$ 41,014	$ 76,602	$ 39,291	$ 41,725	$ -	$ -	$ 489,588	4.9%	5.2%	$ 2.26	
Marion	339,200	$ 75,000	$ 108,521	$ 130,230	$ 159,992	$ 64,797	$ 78,075	$ 82,482	$ 197,618	$ -	$ -	$ 896,714	9.0%	8.2%	$ 2.64	
Lane	370,600	$ 75,000	$ 128,309	$ 116,877	$ 89,249	$ 72,948	$ 113,953	$ 53,828	$ 57,033	$ -	$ -	$ 707,199	7.1%	8.9%	$ 1.91	$ 2.21
Clackamas	413,000	$ 90,000	$ 118,354	$ 118,923	$ 98,872	$ 40,514	$ 131,344	$ 45,159	$ 99,878	$ -	$ -	$ 743,043	7.4%	10.0%	$ 1.80	
Washington	595,860	$ 90,000	$ 132,497	$ 155,237	$ 274,258	$ 71,142	$ 58,629	$ 89,464	$ 311,124	$ -	$ -	$ 1,182,351	11.8%	14.4%	$ 1.98	
Multnomah	803,000	$ 90,000	$ 257,995	$ 254,817	$ 330,694	$ 133,186	$ 18,342	$ 121,875	$ 379,559	$ -	$ -	$ 1,586,468	15.9%	19.4%	$ 1.98	$ 1.94
Total	**4,141,100**	**$ 1,845,000**	**$ 1,359,167**	**$ 1,359,167**	**$ 1,359,167**	**$ 679,583**	**$ 1,359,167**	**$ 679,583**	**$ 1,359,167**	**$ -**	**$ -**	**$ 10,000,000**	**100.0%**	**100.0%**	**$ 2.41**	**$ 2.41**

Matching and incentive funds data are not based on actual LPHA data and are included for demonstration

[1] Source: American Community Survey population 5-year estimate, 2012-2016.

[2] Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon death certificate data, 2012-2016.

[3] Source: Quality of life: Good or excellent health, 2012-2015.

[4] Source: Portland State University Certified Population estimate July 1, 2017

[5] Source: U.S. Census Bureau, Population estimates,2010

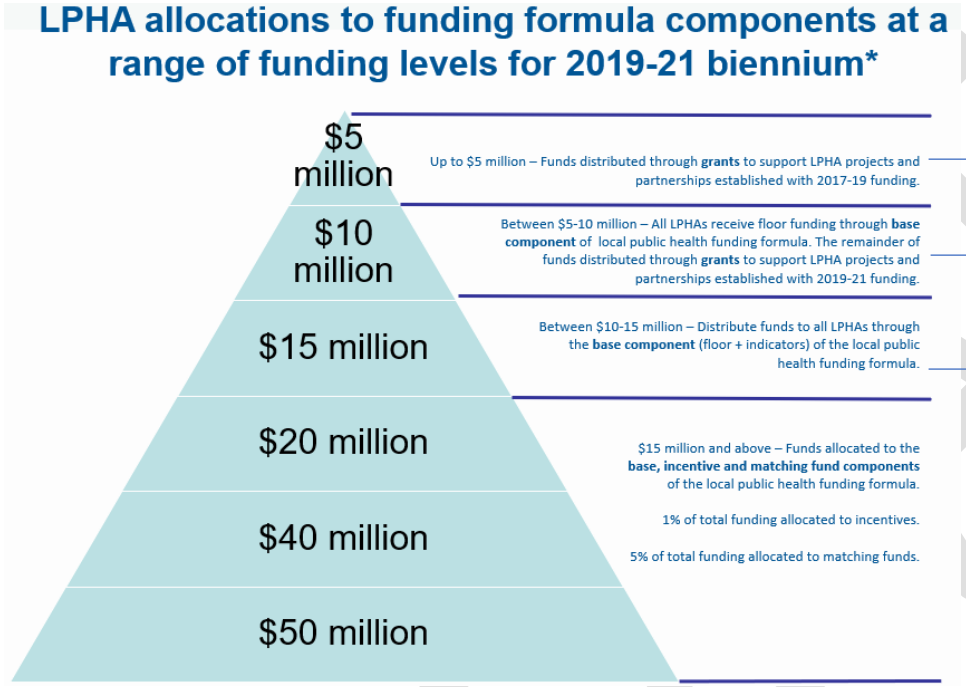
County Size Bands

Extra Small	Small	Medium	Large	Extra Large
up to 20,000	20,000-75,000	75,000-150,000	150,000-375,(	above 375,000

PHAB Incentives and Funding subcommittee

Planning for public health modernization funding to LPHAs, 2019-21 – DRAFT

May 14, 2019



PHAB recommendations for use of funding

Up to $5 million in funding to LPHAs:

1. Continue LPHA Partnerships that are currently funded.
2. Avoid an RFP process.
3. Allow LPHAs that were not involved in 2017-19 to join an existing group.

Between $5-10 million in funding to LPHAs:

1. **$5-7 million:** Provide base funding to all LPHAs, ranging from $30,000 for extra-small counties to $90,000 for extra-large counties.
2. **$7-10 million:** Use funding for new partnership models or new service delivery models. New partnerships or service delivery models must demonstrate benefits to the entire public health system.

Above $10 million in funding to LPHAs:

To be determined.

Benton, Lane, Lincoln & Linn

2017-2019 Modernization

Public Health Advisory Board
May 16, 2019
Jocelyn Warren and Heather Amrhein
Lane County Public Health

PUBLIC HEALTH
PREVENT. PROMOTE. PROTECT.

COAST-TO-VALLEY REGION

Benton County
Lane County
Lincoln County
Linn County

= 614,275 total population

PUBLIC HEALTH
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2017-2018 Goals

- Implement regional strategies to address vaccine-preventable diseases, with emphasis on reducing health disparities and fostering health equity.
- Develop and sustain regional "learning laboratory" model
- Engage local organizations and community members as strategic partners in CD control

Regional Health Equity Assessment

- Structural, social, economic and environmental inequities result in adverse health outcomes and communicable disease-related disparities
- Some communities disproportionately impacted by the burden of communicable disease
- Limited staff capacity and knowledge to fully address CD disparities and advance health equity; capacity and knowledge varies across counties

Health Equity Plans

- Our approach: individual county equity plans
- Strategies:
  - Engage underserved communities (i.e. rural, non-English speakers, homeless) to address root causes of disparities
  - Collaborate with cross-sector partners
  - Educate and communicate with public
  - Improve epidemiology capacity
  - Strengthen internal infrastructure; advance staff knowledge, skills, and abilities related to equity

Challenges & Barriers

- Limited staff capacity and funding for **implementing** equity plans (e.g., no RHEC in Lane County)
- Varying levels of knowledge, skills, and abilities related to equity work (between and within counties)

Opportunities

- Aligning equity plans with other plans/ priorities (i.e. CHIPs, county strategic plans, Lane County Board of Health equity recommendations, Benton, Lincoln, and Linn RHEC, Equity Committee work plans)
- Leveraging partnerships and resources to support equity work where possible
- Workforce development priority

TAKING ACTION FOR EQUITY

Confronting Health Disparities in Lane County

Presenting groundbreaking research identifying specific health disparities and the history of racial inequities in Lane County.

TAKE ACTION!

Create a healthier, more equitable Lane County

Thursday March 8th

5:00 - 8:00

Lane County Community College, Center for Meeting and Learning

Dinner Provided!

Register Here! (free)

LIVE UNITED United Way · PeaceHealth · Trillium

LANE COUNTY OREGON

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Thank you!

Contact:

Jocelyn Warren
Public Health Manager
Lane County Public Health
151 West 7th Ave., #360
Eugene, OR 97401
(541) 682-3950

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