AGENDA

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

June 24, 2020
3:00-4:00
Portland State Office Building, room 900

Join Zoom Meeting
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Meeting Objectives
- Review draft Public Health Accountability Metrics Annual Report.
- Recommend the draft report go to the Board for approval.

PHAB members: Muriel DeLaVergne-Brown, Eva Rippeteau, Jeanne Savage, Eli Schwarz, Teri Thalhofer, Rebecca Tiel

3:30-3:40 pm	**Welcome and introductions** • Approve February minutes	Sara Beaudrault, Oregon Health Authority
3:40-4:10 pm	**2020 Public Health Accountability Metrics Annual Report review** • Review and provide feedback on draft report. • Recommend the draft report go to the Board for approval.	Myde Boles, Program Design and Evaluation Services
4:10-4:15 pm	**Subcommittee business** • Subcommittee update at July PHAB meeting • Upcoming subcommittee work • No additional subcommittee meetings scheduled •	All
4:15-4:20 pm	**Public comment**	
4:20 pm	**Adjourn**	

Public Health Advisory Board (PHAB)
Accountability Metrics Subcommittee meeting minutes
February 12, 2020
3:30-4:30 p.m.

PHAB members present: Muriel DeLaVergne-Brown, Rebecca Tiel, Eli Schwarz

PHAB members absent: Jeanne Savage, Teri Thalhofer, Eva Rippeteau

Oregon Health Authority (OHA) staff: Sara Beaudrault, Dr. Myde Boles, Cara Biddlecom

Welcome and introductions

Ms. Beaudrault introduced the meeting. Subcommittee members introduced themselves.

Ms. Beaudrault noted that the subcommittee wouldn't be able to approve the minutes, with only two of the five members who were at the December meeting present.

Ms. Beaudrault reviewed the timeline for subcommittee work between February and June. She noted that today's meeting will focus on reviewing changes to the layout and framing to the report, and 2020 data will be reviewed at the April and May meetings.

Report layout

Dr. Boles reviewed the draft introduction. She noted that this section has not been formatted and today's discussion is to confirm that suggestions made at the December meeting have been incorporated.

Dr. Boles reviewed each section in the introduction.

Dr. Schwarz noted the use of the acronym "LPHA" and stated that it should be spelled out or OHA should include a glossary of acronyms.

For the section on funding, Ms. Tiel suggested a change to the statement that *"Efforts to modernize the governmental public health system have been driven by Oregon's legislature".* She stated that there have been other important drivers and suggested including those drivers while also acknowledging the role of legislators.

Ms. Beaudrault stated that this is an old talking point and there are many other factors in the momentum for public health modernization.

Dr. Boles stated that this change could be made.

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Ms. Biddlecom noted that the funding section makes reference to the use of funding for communicable disease control, but it does not state that funding has also been used for health equity and cultural responsiveness and other foundational capabilities.

Ms. Beaudrault agreed and stated that those additions can be made.

Dr. Schwarz asked whether there are options to use an e-book format so that it is easy to access individual sections of the report.

Dr. Boles responded that OHA plans to produce this as a PDF document but that it will be streamlined, with almost all the technical information pulled out of the body of the report and into the technical appendix.

Dr. Boles asked whether anything is missing from the introduction.

Subcommittee members did not note anything that was missing.

Dr. Boles reviewed changes to the layout of the data pages, using immunization data as an example. On the health outcome page, rates by racial and ethnic group are displayed on a horizontal bar graph. The map has been simplified by removing county name and the data point. Dr. Boles noted that the purpose of the map is not to see a rate for individual county but to see trends across counties. Overall, there is more white space on the page.

Dr. Schwarz asked whether the greater than/less than symbol on the map was incorrect.

Dr. Boles agreed that it was.

Ms. Beaudrault stated that she liked the changes to how rates by race and ethnicity are displayed, so that groups are listed in order of disease rates. Ms. Beaudrault noted that people want to know whether rates are going up or down, and this format doesn't show trend data.

Dr. Boles noted that the trend data will be available in the technical appendix and a description of changes was included in one of the call outs.

Subcommittee members appreciated that there is more white space on the page and the call outs. Ms. Beaudrault noted that OHA will continue to refine the information to be included in the call outs.

Subcommittee members recommended including a link to the website for additional data, for example, to the OHA Immunization Program's data page, and consider an addition to state the corresponding pages in the technical appendix.

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Dr. Boles reviewed the example page for the immunization process measure. Dr. Boles has used spark lines to show rates for each county by year. She noted that spark lines only show whether a rate has gone up or down but does not show the scale of the change.

Ms. Tiel suggested arrows as another option to show whether rates are going up or down.

Ms. Tiel stated that it is important to clearly differentiate the outcome measures and the process measures.

Dr. Schwarz stated that he likes the spark lines and asked what a rate of zero or a big drop in rates means.

Ms. DeLaVergne-Brown described what the process measure measures and stated that AFIX is an intervention that truly improves immunization rates. Ms. DeLaVergne-Brown noted that in her county the CCO provides funding for the county to do AFIX with health care providers. It requires that the LPHA have a staff person that can build relationships with health care providers and work with them throughout the AFIX process to implement quality improvement changes. Ms. DeLaVergne-Brown stated that other counties do not receive funding for AFIX.

Ms. Beaudrault noted that some LPHAs and regional partnerships are using modernization funding to conduct AFIX with health care providers.

Ms. Tiel called attention to the call out that describes which foundational capabilities are necessary for an LPHA to meet the process measure. She stated that this is important to emphasize.

Ms. Beaudrault stated that OHA will include information about the state public health role for meeting this process measure. For this measure that could include quantifying the training OHA provides to LPHAs, conducting site visits and running the ALERT IIS, which provides the data for AFIX.

Dr. Boles reviewed a draft layout for the adult tobacco use process measure for comprehensive tobacco-free county policies. Previously reports have shown 100% met or 0% met. This format shows when an LPHA has a partial, but not comprehensive, policy in place.

Ms. Tiel stated that she likes the format.

Dr. Schwarz suggested adding a dot to indicate where no policy is in place rather than a blank space.

Subcommittee business

Ms. Beaudrault stated that the next time this subcommittee will meet is in April, once OHA has 2020 data to review.

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Ms. Beaudrault asked who would like to give a subcommittee update at the PHAB meeting on March19, 2020. Ms. Tiel and Ms. DeLaVergne-Brown agreed to tag-team it.

Dr. Schwarz requested that subcommittee members get materials with enough days in advance to review the information prior to meetings.

Ms. Beaudrault confirmed that OHA will provide materials a week in advance.

Public comment

Ms. Beaudrault invited members of the public to ask questions and provide testimony.

There was no public comment.

Closing

Ms. Beaudrault adjourned the meeting.

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OREGON STATE PUBLIC HEALTH DIVISION
Office of the State Public Health Director
Governor Kate Brown

800 NE Oregon Street, Suite 930
Portland, OR 97232
Phone: 971-673-1229
Fax: 971-673-1299

To: Metrics and Scoring Committee

From: Oregon Public Health Advisory Board

Date: ~~January~~ June 2~~1~~, 2020

RE: Public Health Advisory Board support for adoption of the Obesity and Health Equity Incentive Metric for Coordinated Care Organizations

This letter indicates the Oregon Public Health Advisory Board's (PHAB) support for the adoption of the obesity incentive metric and health equity metric ~~currently under development and consideration~~proposed for adoption July 17, 2020.

Health equity was established as a core value for the Oregon Health Authority (OHA), the Oregon Health Policy Board (OHPB), and is a cornerstone of the CCO 2.0 contracts and the State Health Improvement Plan. PHAB has long made a commitment to health equity through the development of its Health Equity Review Policy and Procedure, inclusion of health equity in public health funding principles, and as a key strategy in the 2015-2019 and 2020-2024 State Health Improvement Plans for which PHAB provides oversight.

Since the launch of the 2015-2019 State Health Improvement Plan, PHAB has provided oversight for the "slow the increase of obesity" priority; monitoring how population, health system and health equity interventions are making a change in the second leading cause of death in Oregon.

The OHA Public Health Division (PHD) has been working with staff in the OHA Health Systems Division (HSD) and Division of Health Policy and Analytics (HPA) over the past few years to inform the development of the obesity incentive metric and look for opportunities to align it with public health obesity prevention efforts. PHAB believes the adoption of this metric will be a key first step in advancing more comprehensive and effective obesity prevention efforts in Oregon.

Preventing obesity is a top priority for PHAB and the state of Oregon. Obesity is responsible for more than 2,000 deaths annually. Currently, 29% of Oregon adults are obese.

Physical inactivity and poor nutrition are the major drivers of obesity. It is linked to the other leading causes of death and disability in Oregon, including diabetes, cancer, heart disease, stroke, and depression. According to a 2012 report from the Institute of Medicine, national costs attributed to treating obesity-related diseases are estimated to be $190.2 billion and represent 21 percent of spending on healthcare. Obesity-related chronic diseases cost Oregonians about $1.6 billion in medical expenses each year, with $339 million of that paid by Medicare and $333 million paid by Medicaid.

- People who are obese are estimated to have annual medical costs that are $1,429 higher than people who are not obese.
- Obesity affects about half of Oregonians with diabetes or heart disease. The cost of hospitalizations primarily caused by diabetes, heart disease and stroke were estimated at $921 million in 2017.
- Nearly 73 percent of adult Oregonians with a history of heart attacks were overweight or obese in 2009.
- Compared to non-Latino Whites, African Americans, American Indians or Alaska Natives, and Latinos have higher rates of obesity, while Asian or Pacific Islanders have lower rates of obesity. The largest disparity is among American Indian or Alaska Natives, who are affected by obesity at a rate 55% higher than their White counterparts.

Given the enormous health burden that obesity and the drivers of obesity place on Oregonians and Oregon's health care system, and understanding that severe obesity puts people at higher risk for complications from COVID-19, PHAB supports the development and adoption of an obesity incentive metric for Coordinated Care Organizations (CCOs). A CCO obesity incentive metric has great potential to support and leverage Oregon's public health modernization efforts, which PHAB also leads for the state. These efforts focus on strengthening the ability of Oregon's public health infrastructure to work across sectors to address the upstream drivers of poor health and health disparities in Oregon. As research increasingly demonstrates, reducing obesity will require a multidimensional approach that includes policy and environmental changes in multiple settings, including not only clinical settings but encompassing worksites, schools, large institutions such as government and hospital campuses, and community settings such as parks and neighborhoods. As CCOs are driven to partner to implement

obesity prevention efforts, Oregon's public health system can serve as a key partner to engage other sectors and advance collective efforts to meet CCO and community objectives related to obesity prevention.

Similarly, PHAB supports the adoption of a health equity measure in the CCO incentive program and requests your consideration of the health equity measure and other community based and transformative measures that will help OHA achieve its goal of ending health disparities.

Thank you for your consideration.

Sincerely,

The Oregon Public Health Advisory Board