

AGENDA

PUBLIC HEALTH ADVISORY BOARD

October 17, 2019 2:00-5:00 pm

Portland State Office Building

800 NE Oregon St.

Conference Room 177

Portland, OR 97232

Join by conference line: 1-877-873-8017

Access code: 767068#

Meeting objectives:

- Review 2017-19 public health modernization evaluation report and plan for the 2019-21 evaluation
- Discuss plans to modernize Oregon Health Authority public health survey systems in the 2019-21 biennium and solicit feedback
- Share Oregon Health Policy Board-adopted definition of health equity
- Discuss wildfire policy development and health effects of wildfire smoke
- Receive information about progress toward oral health and tobacco prevention goals in the State Health Improvement Plan and provide input on strategies

2:00-2:15 pm

Welcome and agenda review

- ACTION: Approve September meeting minutes
- Update on PHAB mini-retreat at November meeting
- Fair Housing Coalition of Oregon bus tour discussion

Rebecca Tiel,
PHAB Chair

2:15-2:45 pm

Public health modernization evaluation

- Discuss evaluation questions for 2019-21 evaluation

Kusuma Madamala,
Program Design and
Evaluation Services

2:45-3:15 pm

Public health survey modernization

- Review investments in public health survey data collection modernization
- Provide feedback on public health surveillance needs and potential modern strategies for data collection

Julie Maher,
Program Design and
Evaluation Services

3:15-3:25 pm

Break

3:25-3:35 pm

Oregon Health Policy Board health equity definition

- Share Oregon Health Policy Board-adopted definition of health equity

Cara Biddlecom,
Oregon Health Authority

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- Discuss process for updating the definition of health equity in PHAB meeting materials

3:35-3:55 pm

Public health response to wildfires

- Share information about the Governor’s Wildfire Council
- Discuss response to the health effects of smoke

Kirsten Aird,
OHA staff

3:55-4:40 pm

State Health Improvement Plan: Oral health and tobacco priority updates

- Discuss progress toward oral health and tobacco priorities

Bruce Austin, Amy
Umphlett, and
Karen Girard,
OHA staff

4:40-4:55 pm

Public comment

Rebecca Tiel,
PHAB Chair

4:55 pm

Adjourn

Rebecca Tiel,
PHAB Chair

Public Health Advisory Board (PHAB)

DRAFT September 19, 2019

Meeting Minutes

Attendance:

Board members present: Dr. David Bangsberg, Dr. Jeff Luck (by phone), Akiko Saito, Dr. Jeanne Savage, Rebecca Tiel, Alejandro Queral, Kelle Adamek-Little (by phone), Dr. Paul Lewis, Carrie Brogoitti (by phone), Dr. Bob Dannenhoffer, Dr. Dean Sidelinger, Eva Rippeteau, Lillian Shirley (ex-officio)

Board members absent: Dr. Eli Schwarz, Teri Thalhofer, Tricia Mortell, Muriel DeLaVergne-Brown

Oregon Health Authority (OHA) staff: Cara Biddlecom, Sara Beaudrault, Danna Drum, Krasimir Karamfilov

Members of the public: Sierra Prior (CLHO), Morgan Cowling (CLHO)

Welcome and Agenda Review

Rebecca Tiel, PHAB Chair

Ms. Tiel welcomed the PHAB to the meeting. She introduced herself. The PHAB members introduced themselves.

Ms. Shirley introduced OHA's new health state officer, Dr. Dean Sidelinger, who came to OHA from San Diego County, CA, which is about as big as the state of Oregon in terms of population. Dr. Sidelinger has dealt with a lot of similar issues seen across Oregon, as well as structural and system issues.

Dr. Sidelinger introduced himself. He is a pediatrician by training. He is originally from the east coast. He has been living in Oregon for most of the last ten years and commuting to California to work. The county of San Diego is bigger than about 20 states. It is the most southwestern county in continental United States. It's a very diverse county. It's the busiest land border crossing in the western hemisphere with a big military presence and 18 Native American recognized tribes. He worked for a large integrated health social and housing services agency, where public health was a part of it alongside behavioral health and child protective services, among others. He has done a lot of work in food systems. He oversaw the implementation of San Diego County's food system work around chronic disease prevention and environmental change. He's worked on various outbreaks, such as Hepatitis A among homeless people. He's happy to be at OHA.

- Approval of August 2019 Minutes

A quorum was present. Dr. Dannenhoffer moved for approval of the August 15, 2019, meeting minutes. Ms. Saito seconded the move. The PHAB approved the meeting minutes unanimously.

- Update on PHAB Mini-Retreat at November Meeting

Ms. Tiel informed the PHAB that the planning for the November PHAB meeting was on the way. The PHAB would utilize the meeting time a little differently, thinking about what it might want to accomplish in the next biennium. It's time to re-look at where the PHAB's goals are. Also, external speakers will be brought in. It's been confirmed that Jessica Fisher from the Public Health National Center for Innovation will join the meeting in November to talk about a national perspective and where Oregon fits in the context of public health modernization.

Ms. Tiel introduced the next agenda item. Ms. Beaudrault would provide some information about how the \$10 million local public health modernization investment was allocated to the local public health authorities (LPHAs) for the 2019-2021 biennium.

2019-2021 Public Health Modernization Funding Awards

Sara Beaudrault (OHA Staff)

Ms. Beaudrault explained that at the last PHAB meeting, Ms. Biddlecom shared with the board that of all funds available, \$10 million would be allocated to LPHAs, with a portion (\$3 million) going to continue to support the regional partnerships. The remaining \$7 million will be allocated through the public health modernization funding formula that the PHAB is responsible for. In terms of the regional partnerships, OHA received proposals from seven partnerships, and all of them were funded.

Ms. Beaudrault noted that in terms of the changes we are seeing since 2017-2019, the most notable is that Jackson and Klamath counties did not apply for funding to continue their regional partnership. Some really positive changes are that Yamhill County has joined the Multnomah-Washington-Clackamas counties partnership. On the north coast, the Clatsop-Columbia-Tillamook partnership was funded at a lower level two years ago to do capacity building to set the stage to begin the work as a regional partnership. They did some amazing work to prepare. With this round of funding, they are funded at a higher level so they can really implement strategies around sexually transmitted infection (STI), prevention, and control.

Ms. Beaudrault pointed out that in terms of Jackson and Klamath counties, it was disappointing that they wouldn't be continuing in this capacity. They did great work over the past two years. They were focusing on STI, Hepatitis C, and HPV vaccination. They did some really nice work within their respective health systems to engage the healthcare community via social media and engage with their community members. Ultimately, they felt that they could not adhere to the requirements around regional partnerships that OHA put forth. They communicated to OHA that they do work closely and will continue to work closely, just not with this funding.

Ms. Beaudrault remarked that regarding the proposals that OHA received, PHAB provided guidance that encouraged OHA to use funding to allow these partnerships to continue and let their work evolve and take it to the next level. OHA worked with the Joint Leadership Team (JLT) that involved CLHO to determine the portion of funds that would go to regional partnerships. That's how we came to the decision to put \$3 million in funding to regional

partnerships, which is less funding than we had for regional partnerships two years ago. The proposals that came in greatly exceeded the amount of funding that OHA had to put to the regional partnerships. It's exciting that counties see the value of this work and want to continue it. It did lead to some hard funding decisions for all partnerships.

Ms. Beaudrault showed a slide that provided a high-level snapshot of the projects and initiatives the seven partnerships would be working on, given that OHA had to reduce funding from what the partnerships requested across the board. Details could not be provided because the partnerships still need to look at the work that they proposed to do and potentially scale it back to the funding that they have available for their regional partnership work.

Ms. Beaudrault showed a table of funding amounts by county and stated that the exciting news about how the funding went out was that the PHAB funding formula was in play in this biennium, with \$7 million allocated across all LPHAs. The table was broken out by the county size bands which is consistent with the funding formula the PHAB put together, with the extra small counties at the top and the extra large counties down at the bottom. Subsection 1 lists the funding that goes out to all LPHAs through the public health modernization funding formula. Extra small counties receive significantly less funding than extra large counties since a lot of the funding formula is built around population, as well as health indicators. PHAB might receive some feedback on how this funding distribution is working at the local level. There will be opportunities to make adjustments, if PHAB chooses to do so. Subsection 2 lists the funding for the regional partnerships.

Ms. Rippeteau noted that the total investment for modernization was \$15 million. She asked Ms. Beaudrault to elaborate on how the remaining \$5 million would be spent.

Ms. Beaudrault answered that Ms. Biddlecom shared some of that information at PHAB's last meeting. Another thing that is exciting is that a portion of those funds will go to the tribes, NARA, and other tribal partners. OHA has been trying to bring them into this work, as they wished to be, but without any funding in the last biennium. For the first time, OHA is putting funding to allow tribes and tribal partners to engage, if they want to.

Mr. Queral asked about what happened in Jackson County and what prevented that relationship from moving forward. This could be a great opportunity to learn some lessons and perhaps adjust how we think about that. He also asked how the grantees are making decisions about allocation of resources, how counties are reaching decisions and agreements.

Ms. Beaudrault answered that in terms of Jackson and Klamath counties, when OHA took PHAB's guidance to the JLT to figure out how to put it into action, JLT was trying to balance funding for regional partnerships with a real need for all LPHAs to receive some funding to begin meeting needs in their own community. JLT's direction was to make sure that all of the funding for regional partnerships was for truly regional work – regional positions that would be working in all of the counties in the partnerships, or regional contracts that would be functioning in all of the counties. JLT narrowed the scope of how funding could be used, which was a little bit different than how Jackson and Klamath counties had been using their funding.

Dr. Dannenhoffer explained that, for example, the projects the Douglas County partnership is working on include improving immunization rates, especially among young children, with a focus on the special challenge of vaccine refusal and improving communicable disease reporting. Each of the partnership counties are relatively small counties that don't have the wherewithal themselves to do that. The issues are similar among the three counties. The counties are sharing positions and making that work.

Dr. Lewis added that for the counties in the Portland metro area, this was awkward work, especially for the extra large counties. It's not clear if this model really works for the extra large counties. They don't need extra population to make for [...] body of work. There are all very different bodies of work in the metro area. The counties have a long history of working together and work easily together. The administrators understand the modernization goals. The partnership designated Washington County as the lead county, and they chose an excellent person with really good group facilitation skills to work on that. One of the projects has evolved and turned out to be a little bit abstract. It has to do with how to legally share data among entities. It is a steep hill to climb, as there are different legal opinions in different jurisdictions. Overall, there has been impressive progress on that. Since the counties share largely a footprint for a CCO, that turns out to be critical, because getting information shared between the CCOs and the public health sectors is really important. Fortunately, the partnership has the commitment of the legal teams, and one of the lead epidemiologists is also a lawyer, which helps as well.

Ms. Saito pointed out that it was exciting to see the CCO involvement in some of these partnerships. Kudos to the southwest regional partnership, but also to two of Oregon's tribal nations. She asked how the information was shared with the CCOs and if the tribal modernization work was highlighted with the southwest regional partnership.

Ms. Beaudrault answered that all that will be done. At this moment, OHA staff are still working on the details and will ensure that this information gets out to CCOs. Dr. Savage was an advocate of this two years ago. It's really important that CCOs know of this work happening in their communities, with some really terrific outcomes in Marion and Polk counties because of it. It's the same with the tribes. Over the next few weeks, LPHAs are working on their workplans and budgets, and OHA will have more information at that point in time, as well as get further along in the work with the tribes for how these funds will be used.

Ms. Shirley remarked that in terms of capacity at OHA, we have been absorbed with getting the CCO contracts out and getting the Metrics and Scoring Committee's approvals, among other work. One of OHA's goals would be, particularly with OHA's evaluation and modernization report and some of these new alliances, to get ourselves some air time in front of the CCO medical directors meetings over the next 12 months. That's exactly what we are hoping to be able to share it in a broader venue, like we shared with the Oregon Health Policy Board (OHPB). A lot of this information was new to the OHPB.

Dr. Bangsberg suggested for the OHA to bring the CCOs together in a summit to look at their progress in investing in social determinants of health, public health modernization, and the newer, more exciting parts of CCO 2.0. We can look at implementation and best practices and

have the CCOs learn from each other. This would be a great opportunity to advance a public health agenda within the CCOs.

Ms. Brogoitti stated that the Eastern Oregon Modernization Collaborative (EOMC) functions by a steering committee of 14 members that meets on a regular basis to give input and set direction for the staff who are working on the partnership. There is a CCO representative on the steering committee. Tribal representation might be present in the future. The EOMC is already advancing a public health agenda with the CCOs.

Ms. Little provided an update about the tribal public health modernization workplan proposal that was proposed to the nine federally recognized tribes of Oregon and NARA on September 13, 2019, by Danna Drum (OHA staff). The proposal was for two different tracks for the public health modernization funding that has been set aside for tribes (\$1.28 million), which would provide opportunity for each tribe to complete the public health modernization assessment, if they have not done so yet (there are only three that have). For those that have done the assessment, the funding will be for implementation of various projects that were prioritized from the modernization. Two proposals were set forth, one was for the funding to be divided equitably among the 10 organizations, plus a contract set aside for assessment and analysis. The other proposal was for those tribes that have already completed the assessment to be awarded a proportionally larger piece of the pie. Both options were presented and discussed on September 13. There will be another discussion on September 20, 2019. The tribes will have an answer to OHA within the next few weeks.

Ms. Biddlecom assured Ms. Rippeteau that she would receive the slides from the last PHAB meeting. Components of the OHA-specific work will be coming to the PHAB for a more in-depth conversation. Specifically, OHA staff would like to discuss OHA's evaluation questions with the PHAB, as well as some investments that OHA is making in "survey modernization," which relates to the overall data strategic plan work that OHA is going to be doing. OHA wants to get PHAB's guidance on how to move forward on those specific investments that are going to OHA, but are designated for the public health data systems for the entire state.

Ms. Rippeteau asked what was required from the LPHAs to show the work (e.g., documentation) and how we can replicate that on what's being done for modernization in the time for how that money is being used at the division level or the state level. How is it all tying in and being used to promote modernization?

Ms. Biddlecom answered that that was exactly the mindset that we want to be having on the evaluation planning as well.

Mr. Queral noted that he had been on the PHAB for the last 10 years. Back then, even before the state health reform started in earnest, the vision of the board was to see this happen. And it had happened. This feels like success, even if the work is really hard, and much harder on the local level among LPHAs. But it is happening, and it should be recognized. Kudos to all.

Ms. Tiel remarked that it has been a while since the PHAB has talked about the phenomenon that happens when a LPHA transfers their duties to the state. She introduced Ms. Drum, who

would present an overview of the state statutes that guide the responsibilities of OHA in the event when this happens.

Public Health Modernization in Jurisdictions Without a Local Public Health Authority

Danna Drum (OHA Staff)

Ms. Drum explained that there was a specific condition in the statute for transfer of LPHA responsibilities. It is tied to the money that the legislature allocates for each biennium related to modernization. Each biennium, OHA submits an estimate to the legislature fiscal office and if the legislature doesn't allocate the full amount that OHA estimates, then a governing body, which in most cases is the Board of County Commissioners, can transfer LPHA responsibilities to the state. In the last two biennia, we have been in a situation where OHA submitted an estimate and it was not fully funded. Because of that, any governing body of a LPHA is able to transfer their responsibilities to OHA. They have to pass a resolution or an ordinance, and the transfer can't take effect until six months after the adoption date, unless OHA agrees to an earlier date.

Ms. Drum added that, in practice, OHA had to do that with Wallowa County. Statutorily, the transfer didn't occur until October 2018, but in practice it occurred in May 2019, because they didn't have any staff. When there is a transfer, all responsibilities are transferred to OHA. The governing body cannot pick and choose what responsibilities to keep. It's an all-or-nothing deal. As OHA has operated in this environment over the last year and a half, the governing body has chosen to no longer be responsible for public health in their jurisdiction or to be part of the public health system. That is a local decision. From an agency perspective, OHA needs to respect that.

Ms. Drum stated that OHA's responsibilities have been carefully reviewed by the Department of Justice (DOJ). Based on the advice from the DOJ, OHA is responsible for monitoring communicable diseases and controlling outbreaks, enforcing the Indoor Clean Air Act, ensuring access to safe drinking water, ensuring access to WIC services, licensing and inspecting food, pool, and lodging facilities.

Ms. Drum remarked that in terms of Wallowa County, the Wallowa County Board of Commissioners transferred LPHA responsibilities to OHA in May 2018. PHA-PHD staff exercise communicable disease control from Portland. OHA doesn't have the bandwidth to do prevention. OHA is monitoring lab reports and following up accordingly. A lot of that work can be done remotely. OHA-PHD licenses foo, pool, and tourist facilities and conducts the inspections. OHA has tried working with subcontractors, but that has not worked. OHA is exploring the possibility of a contract with other LPHA partner or organizational contract to provide the inspection services. OHA will still do all licensing and enforcement activities. OHA contracted with Umatilla Morrow Head Start public services. The organization was already an OHA contractor in Umatilla and Morrow counties. They serviced a Head Start provider in Wallowa County and they are willing to take on that work. OHA-PHD does all Indoor Clean Air Act enforcement activities. Historically, the number of complaints from Wallowa County have been very low, so it will be easy to maintain. OHA was already performing the safe drinking water activities for Wallowa County prior to the transfer of LPHA responsibilities to OHA.

Ms. Drum noted that OHA looked at other activities that were in addition to its statutory responsibilities. OHA's public health executive team worked on some criteria around how to look at the additional work. The work is always grounded in community needs and data, and it must align with state priorities. A big issue is availability of resources, as well as availability of a potential contractor or partner and OHA's capacity to provide oversight and technical support, if it took additional work. All these things are considered before making a decision about what OHA should do.

Ms. Drum explained that, in Wallowa County, OHA is exploring a contract with a LPHA partner to provide TB (tuberculosis) and STI (sexually transmitted infections) case management and investigation services, if needed. Because the Wallowa Health District (WHD) was already part of the Hospital Preparedness Program, OHA contracted with WHD to do some limited work related to public health emergency preparedness. In 2019, OHA's immunization program performed all school law functions (i.e., redeeming immunization records and issuing exclusion orders). Because of the public health risk around that, OHA staff felt that OHA needed to do that. OHA is exploring a possible contract with a LPHA partner to do the records review. OHA will issue the exclusion orders through the state health officer or another physician designee within the Public Health Division.

Ms. Drum added that there was limited funding when there was a transfer to OHA to do the work, because much of the LPHA's funding is categorical. For example, for communicable disease, there is state support for public health, which was \$7,000 for Wallowa County. That doesn't cover the time that it takes to do all the follow-up. OHA collects fees from facility licenses, which are set at the marker fees in statute. They were just increased partly because, with the transfer of Wallowa to OHA, OHA staff became aware that the fees wouldn't be able to cover the cost. With LPHAs, the fees are set by their Board of County Commissioners. Different communities have greater or lesser tolerance for that, but OHA doesn't have the possibility of that potential flexibility. The one area where OHA has some access to funding is based on a statute that says that the funding that would have gone towards public health modernization in a community or a jurisdiction that transfers its local public health responsibilities could be used by OHA to provide or contract for public health programs and services and activities in that jurisdiction. OHA's understanding and review of that statute by OHA's Department of Justice attorney is that those funds are no longer specific to public health modernization at that point. They are about covering the basic public health safety functions.

Ms. Drum invited the PHAB members to comment or ask questions. OHA is interested in PHAB's feedback on what it means for the public health system when local elected officials say that they don't want to support public health. How do we balance between honoring the local decision-making and public health needs?

Ms. Shirley clarified that OHA has never faced this situation before until a year and a half ago. OHA's executive team and programmatic staff spent about a year trying to figure out how to do this fairly. The criteria came out of that. OHA vetted them and shared them with partners. The question was: How can OHA be transparent about the criteria it was going to use? There was a lot of concern that this might be a trend, which it doesn't seem to be, but OHA wanted to

approach it using its epidemiology and history of what's happened in this particular part of the state.

Ms. Shirley added that, at first, it seemed easy to extrapolate from the overall data needs and one-size-fits-all. OHA staff realized that they should consider the community needs and think about the epidemiology of a given area in the county. Health preparedness was an area of concern, because OHA overlapped with the hospital system and the CCO there, as well as the local public health authority around emergency. Working out who would make the first call was a struggle. OHA's work is the result of a lot of thought and deliberation. For example, in the case of food, pool, and lodging, if it wasn't working for OHA to do it directly, OHA staff deliberated on how OHA could make it work better and what were the pieces that could be done without violating the decision of the county commissioners in Wallowa County.

Mr. Queral asked if the transfer was in perpetuity.

Ms. Drum answered that there was some work done with CLHO (Coalition of Local Health Officers) and AOC (Association of Oregon Counties) this last legislative session and OHA will be working on rulemaking related to it. There had been a provision in OAR (Oregon Administrative Rules) that alluded to a transfer of responsibilities back to a jurisdiction. The statute now states how that could happen. OHA is working through that. There is a stipulation in the statute that says that unless it is mutually agreed upon, it's four years before a county could reverse the transfer. Some work needs to be done around the criteria by which that could happen and a written agreement between OHA and the jurisdiction.

Mr. Queral remarked that this was an opportunity to understand the impact of not investing modernization dollars in these local jurisdictions. How is OHA planning to track outcomes? We are gathering data, but we need to pay attention to whether those disparities are exacerbated over time.

Ms. Drum answered that OHA will continue looking at outcome data.

Dr. Bangsberg asked Ms. Drum if she could give the PHAB some background about the decision-making process to see these responsibilities. Does it come from a place that this is a major responsibility, but there isn't enough funding to do what we are supposed to do and we call the state as backup, or is it a decision-making process along the lines of this isn't that important and we don't want to bother, or somewhere in between?

Ms. Drum answered that it is different with different communities. OHA had these conversations with Douglas County and its concerns were different, and they pulled back. In the case of Wallowa County, there were one and a half FTEs. They had their full-time public health administrator who did most things. The other person was doing more administrative, program assistance kind of work. The administrator got another job and that was the beginning. The part-time person became full-time, but then she found another job, and they decided not to hire anybody. There are only 7,175 people in the whole county. They were not any general county dollars that were going into public health. It was based on what OHA was providing to the county.

Ms. Saito pointed out that the whole point of modernization was for any person in Oregon to be able to come to a health department or health location and get the same amount of services. It would be interesting to use Wallowa County as an example of looking at the data from when the county had a health department and now that things are coming to the state. It would be interesting to see how these two states compare and do the health assessment again, as the county was part of the assessment originally. If we are saying that everybody has a place to go to and get the same amount of quality services, somebody from Wallowa County, even though it's only 7,000 people, doesn't have anywhere to go to get those services. How are we going to do this as a case study for later on to talk about modernization? The other thing is that we need to do a better job on the preparedness side, because it's one of our foundational capabilities. For this particular event, and for Douglas County, OHA put together an incident management team. That's how we came to these criteria. Before this happened, OHA put in a lot of funding and a lot of staff extra time into this. It's an interesting thing as far as the modernization dollars are concerned. We need something to note that it takes this amount of time when a decision is made to the 180 days later. That's some funding that we are missing and don't have.

Dr. Savage stated that on the solution side of things, with the contracting back with different parts of it, it seemed a little messy. What has the thought process been in terms of combining the work of Wallowa County into one of the surrounding counties? Have the surrounding counties been positive about that, or have they been not so supportive of that idea?

Ms. Drum answered that there were a couple of pieces to that question. Whenever OHA has this conversation, which it did have with Wallowa County, with Ms. Drum leading the conversations and getting the call, OHA staff always stress that the county health administrators need to talk with their counterparts in the adjacent counties and see if there are opportunities. In other words, find a buddy. Ultimately, that is a political decision of the local elected leaders. Even if the local elected leaders of a county, which is looking to transfer [its responsibilities to the state], want to consider that, their neighboring counties may or may not want to. Those are commissioner conversations. OHA is not able to turn around and delegate the LPHA for, say, Wallowa County, to, say, Union County. The reason OHA can't do that is because the people in Wallowa County have not elected the leaders in Union County, so they don't have a recourse. It is messy. This is not OHA's first choice. Public health is local. It's done better when it's closer to where the people are.

Dr. Dannenhoffer remarked that coming from a county that has teetered on the edge, the story is that there's not a lot of funding for public health, especially in those very small counties. The budget for Wallowa County is about half a million dollars a year, which is not very much money and funds these two people. In a small health department like that, there's one person who wears 32 hats. Staff at the Douglas County health department calculated that in a small health department, if staff went just to the trainings, they would have nothing else to do, but just go to the trainings. There is 20 hours per year TB training and 20 hours some other training and so on. If one person is doing that, they would spend all their time training. And they are not good at it. It's hard to find people who are willing to take on so many different responsibilities. When Douglas County tried to hire a nurse at one of its clinics, and they informed candidates that they

had to do STD and immunizations, the candidates responded that they could do one, but certainly not both. In Wallowa, an employee had to do STD and immunizations and WIC all together and put out all the reports. Public health is incredibly hard in those areas there. When you talk to the commissioners, they say, “It’s not that public health isn’t important. Everything we deal with is important.”

Dr. Dannenhoffer noted that there was one distinction. If a county said that it would stop doing the roads, the state would not pave the county roads. If the county closed their jail, the state wouldn’t run in and run their jail. But with public health, if a county leaves, OHA runs in and does a great job running public health. The story is – counties actually do have a back-up plan for public health. If you are a commissioner, it’s not unreasonable to see why they would say, “Well, we could close the jail, or we could close public health. What happens if we close the jail? We don’t have a jail. What happens if we close public health? Damn, it will come a whole army and do public health.” Because there is an option for commissioners that they would choose to give up public health. There is no option for the jails. There is no option for the roads.

Ms. Drum added that when OHA is having these conversations with commissioners, the myth is that somehow OHA is going come and set up shop in your county and do public health. The message that Ms. Drum gives them is that that is not what happens. OHA will cover the basics. The reality is that the county is going to give up local control, it will not have a say in how it’s done, and most of it is going to be done from Portland. They have to weigh that with all the other options that they have.

Ms. Drum remarked that one of the things she and Ms. Biddlecom continue to talk about, and OHA’s executive team struggles with it, is the balance between honoring the local control and local decision-making and OHA’s level of responsibility for public health. What does that mean for the public health system broadly? This is a question OHA staff will continue to struggle with. Wallowa County will not be the last county to transfer control. There will be probably more counties, because local communities are feeling more and more fiscal pressure.

Mr. Queral shared with the PHAB that the conversation made him think of two things. One was that perhaps the ability to make the choice to transfer was too easy and it didn’t require more deliberation among elected officials locally. He wondered what incentives, or disincentives, or processes the state could put in place to force that conversation. Along those lines, could there be an opportunity, perhaps legislatively, where OHA and the local health authority have a conversation, where it’s not an all-or-nothing transfer, but perhaps there’s room for some degree of shared responsibility?

Ms. Shirley answered that one of OHA’s hopes is that the work that is being done around the partnerships with the modernization money is modeling some of these options. There are eight partnerships – they have friends. OHA had the evaluation reports that showed that it worked, and OHA also had testimonies from locals who said that both local governmental public health and some of the community partners in these local jurisdictions really liked the idea of shared partnerships. Part of what OHA is trying to do with all of its new work is to turn it, so people can see other options. It’s not a dollar for a ticket and that’s it, but how can we leverage the dollars across the epidemiology, across different communities with different needs and different

expectations of government; how can OHA support the local jurisdictions to think through that for themselves and together. Hopefully, this is modeling some of that chance to have those discussions.

Dr. Dannenhoffer stated that there was a great opportunity here. The state did need to do immunization school law locally back in the days when people brought in their crumpled immunization card that [doctors] had to look through and figure out what shots they needed. In that case, there would be no way to get it from the state. But now, with the alert you could do from Mars, because [...] much of the process used for immunization school law is based on the strategy of manually collecting the data, manually writing on these little sheets, and then manually calculating the rates. This is one of the things in modernization that we really could do as a state for each of the counties. We can say, “Look, we figured out the electronic way to do immunization school law and there it is,” because it really could be that easy. One of his hopes for modernization is that modernization is about modernizing principles, because we do now have the world’s best immunization registry.

Ms. Brogoitti remarked that some of the questions she had would require more time than the PHAB had today. This discussion was of interest to her, because Wallowa County is a neighboring county to Union County. The diseases don’t care about county lines. It’s really important to Union County that there is some level of service being provided in Wallowa County. She still had questions about where the funding was coming from. Is it all coming from the local funding formula? Also, she had questions about how the Public Health Division is planning for and accounting for that funding. County health departments have a lot of requirements, such as writing work plans, submitting reports, and doing a lot of work to show how they are going to use the funding and be accountable for it. She would like to have some of that same information about what is going on in her neighboring community. As the PHAB is talking about modernization, that could also be helpful, because one could look and say, “We are doing this level of investment and getting this level of service,” whereas with some of the regional projects we are making this investment and getting this service for the residents, and there could be some really good information to help counties as they move forward with modernization.

Ms. Drum added that OHA can certainly provide that information back to the PHAB about where the funding is coming from. It is something OHA is continuing to work with. We haven’t had the funding formula in play in the past, so OHA had to piece it together. OHA is still working on what that looks like in terms of the funding formula funds.

Oregon Water Vision

Andre Ourso (OHA staff)

Mr. Ourso introduced himself as the administrator for the Center for Health Protection at the Public Health Division which includes environmental health, radiation protection services, and drinking water services, among other. Part of his administrative duties is to sit in on the Governor’s Natural Resources Cabinet (GNRC) meetings and represent OHA on the Governor’s Core Water Team (GCWT), which is a subgroup of the GNRC. The task of the GCWT over the past year has been to come up with a 100-year, or long-term, water vision and strategy for the

State of Oregon, since it's never been articulated before. A few other states have done this or have started this process. Washington State is one of them.

Mr. Ourso noted that the vision looked to address climate change and how we steward water resources in that context in the future, including investments in natural and built infrastructures. The goals are health, economy, environment, and safety. Three forces informed the premise for the vision: (a) climate change and associated increases in fire, drought, and flooding, (b) a half century of underinvestment in built and natural water infrastructure, (c) changing population and associated development.

Mr. Ourso explained that the PHAB has been identified as a part of an outreach strategy for public and private partnerships to start giving input on the water vision. This fall, the GCWT will be presenting vision and the problem statement to state agencies, associations, partners, and stakeholders throughout the state. The PHAB is invited to look at the vision and the problem statement and then answer a three-question survey for feedback.

Ms. Tiel asked what jurisdictions (i.e., state, county, city) do what when it came to water.

Mr. Ourso answered that OHA has primary responsibility for drinking water in the State of Oregon. OHA enforces the Safe Drinking Water Act, which is a federal law that sets minimum standards for public drinking water systems. There are also state standards that are stricter than the federal standards. OHA regulates down to very small systems that maybe have five connections and serve 25 people. These systems are largely in rural areas with underserved and vulnerable populations. OHA relies on counties and local public health departments to help it provide technical assistance and regulate the smaller systems. OHA covers the larger systems, such as Salem and Portland. The Department of Environmental Quality (DEQ) has a relationship with water. OHA regulates the water that comes out of your tap. DEQ regulates the water that flows in rivers or streams. The DEQ has jurisdiction over the Clean Water Act in the State of Oregon.

Mr. Ourso explained that OHA touches water in other ways. Currently, there is a voluntary surveillance system in response to a harmful algae bloom in recreational lakes and a legislative workgroup on HABs (harmful algal blooms) monitoring and prevention. That work fits in the larger context of water, particularly with natural and built infrastructures. OHA also tests domestic wells. This is a huge data gap in environmental health right now. The seller of a property has to transmit the well data to OHA upon the sale of real estate, if there is a well on the property. The seller has to test the well before selling the property to the buyer, but then it's voluntary whether they transfer that data to OHA. There is a big data gap on what we understand with contaminants and water quality related to domestic wells in the state. That's probably about a quarter of the population in Oregon.

Dr. Dannenhoffer asked if anyone had costed out the vision.

Mr. Ourso answered that it was likely to be very expensive. The strategy and the outreach right now were to prep people on the need for the vision moving forward. It's 100 years. It's a very long-term strategy. The next phase will be to identify what the state's natural and built

infrastructures are. We don't know much about the state's water basins and how the water flows to a community as a whole. We might know a little bit about the Deschutes water basin or the Klamath water basin, but we don't have the larger context for the state. The next phase would be to get that inventory of where we are at. The second phase will then determine infrastructure needs. OHA will look at costs during the second phase. The third phase is to go back to the community, partners, and stakeholders and ask them for assistance with infrastructure investments. It's not going to be legislative-level funding. OHA can do federal grant funding and ask communities and private entities to invest as well. No cost for now, but it's upcoming, and it will likely involve a lot of factors and participants to get us there.

Mr. Queral asked why it was a 100-year vision. The reason he asked was because we don't have the time. A 100 years – we may be too late. The impact on health, the economy, and all the goals that the GCWT has – by then may be too late. Is the time period statutory, or is it a decision? Why can't it be 50 years? A 100 years gives a lot of leeway to legislators. Fifty years still gives too much leeway. It's clear that we have to be strategic, and maybe it's unrealistic, but the reality is that we won't have 100 years.

Mr. Ourso answered that Mr. Queral brought up a great point and encouraged him to provide that feedback in the SurveyMonkey survey. When the GCWT initially looked at 50- and 100-year water vision, the goal was to provide a long-term vision, making sure the needs of 2-3 future generations were met. The ask for investment and the sense of urgency is now. It's unknown if it would work for 100 years, but point was to show that it was a long-term strategy, and not a quick fix. These are infrastructure investments that will last us another 50 or 100 years. This has been ignored for about 50 years.

Ms. Rippeteau stated that a few years ago there was a push federally to do water infrastructure. Senator Merkley had been involved in that conversation. She asked if there was any legislature that came through.

Mr. Ourso answered that the legislature passed. Senator Merkley was instrumental in getting the legislation pushed through. The Environmental Protection Agency (EPA) gives money to Oregon to invest in fresh water infrastructures through OHA. It's called the Clean Water State Revolving Fund. It's very low interest loans for systems to upgrade their infrastructure. There are larger loans that the EPA likes to give out and not get to the states to delegate that responsibility. That fund recently allocated upwards of \$600 million for infrastructure upgrades for Beaverton and Hillsboro, based upon seismic resiliency. The bill was related to that grant. It did pass. That would be part of the next phase of assessing what resources we have.

Ms. Saito asked Mr. Ourso to comment on the recent repeal of the Clean Water Act, which reversed water standards to 1986 standards. She asked how the tribes were involved with formulating this vision. Tribes have a big stake in water. They have a lot of water rights. They have a lot of cultural resources that have to do with a lot of the state's water systems. Were tribes involved? How can tribes be involved?

Mr. Ourso answered that, to his knowledge, the tribes were not represented on the GCWT. That would be great feedback to provide. He wasn't sure what the outreach to tribes was

currently but presumed that there must be some. It's important to note that and provide feedback on it.

Ms. Shirley added that in the last legislative session, the Governor put forth a bill that passed, asking the legislature to allow Oregon to set standards from the EPA that would be whatever they were in January 2019. It's unknown if that water has been tested through this recent development, but it was particularly around pesticide use and led use. Basically, the Oregon legislature said, "We, in Oregon, can hold to the EPA standards before these rollbacks." The intent of it is to let us hold our own around some of these things. There was some industry pushback from the forest products industry, but even they came onboard by the time the bill got to the floor.

Mr. Ourso explained that the DEQ had authority over the Clean Water Act. The rule that was repealed was Waters of the United States (WOTUS). The Obama administration expanded what we consider protected waterways and the Trump administration wants to pull that back. House Bill 2250 will allow DEQ to hold the state standards. In addition, the Oregon Attorney General has been suing the Trump administration on regulatory rollbacks. Based on the input and advice from DEQ, they would probably sue to keep this law in place. If asked, OHA would provide any relative health information to DEQ.

Ms. Little thanked Mr. Ourso for asking how the Oregon tribes should be involved or could be involved. She suggested to Mr. Ourso reach out to the OHA tribal affairs director, Julie Johnson, who would be able to direct and provide an opportunity for that information to be shared with the tribes. It's always the health officials. Each tribe has different capacities on how they manage issues related to water quality.

Mr. Ourso thanked Ms. Little and promised to reach out to Ms. Julie Johnson and go back to the GCWT to see if it was doing some outreach to the tribes. The vision website is oregonwatervision.org. The website contains the vision, problem statement, and some additional information on the strategy. He promised to send Cara the SurveyMonkey link for the three-question survey for the PHAB to provide specific feedback on the vision and problem statement.

Ms. Rippeteau asked if the survey was also linked on the vision website.

Mr. Ourso answered that it wasn't linked. He had to send a separate link to the survey.

Ms. Tiel noted that the survey sounded like a specific outreach to the PHAB, not necessarily a public survey.

Mr. Ourso agreed. The survey is only for the PHAB members and should not be forwarded to others. This would help with measuring input.

Dr. Dannenhoffer remarked that the goals seemed great, but it must be the hardest thing when there were so many competing goals. In industry, someone might need a million gallons of water a day for a plant. Somebody might request for health a little less than 0.1. Others might

say that they wanted all the water in the word for fish. Who would decide which among the competing goals would beat out the others?

Mr. Ourso answered that he hoped the GCWT would be able to meet all the goals without beating out one goal at the expense of another. What's good for economy isn't always good for the health of people. What's good for fish isn't always good for the economy. The goal is to provide healthy, clean water that supports a growing economy and the environment, but also be safe. It's a large task.

Public Health System Priorities for 2019-2021

Rebecca Tiel (OHA staff)

Ms. Tiel stated that the last agenda item was an opportunity for the PHAB to plan for its November meeting and break out of its technical, spreadsheet mindset that its been diving into over the last couple of years. In terms of modernization, we've come a long way. She has been involved with modernization since OHA did the state health assessment six years ago. Now we have solid investment in public health infrastructure.

Ms. Tiel added that in terms of the public health context for the 2019-2021 biennium, there was public health modernization investment in all LPHAs, all tribes that wish to participate, and OHA. The funding covers all parts of the system, particularly in the areas of health equity and cultural responsiveness, assessment and epidemiology, communicable disease control, and leadership. As Ms. Beaudrault mentioned earlier, we have started to build the regional work. There have been opportunities to organize system changes to deliver the best possible outcomes to the people of Oregon.

Ms. Tiel pointed out that the other big initiative with health system transformation was CCO 2.0 on which the PHAB spent quite a bit of time and put forward specific recommendations for the procurement aspect of CCO 2.0. Those contracts and the procurement process will be finalized soon. Once that happens and the CCOs are up and running, there will be plenty of opportunities for work around social determinants of health and health equity. We also have a new and reimagined SHIP, along with new requirements for [...] needs assessments from CCOs, local public health and nonprofit hospitals. That's one bucket of work.

Ms. Tiel noted that there was also the Student Success Act (SSA). At the last PHAB meeting, Ms. Shirley read a summary, written by OHA director Pat Allen, in which he talked about the links between the SSA and health. The SSA is a \$1 billion per year investment in the Oregon education system, trying to course-correct from defunding education at the local level from Measure 5 in 1990. There are specific requirements in the SSA around mental health. Another opportunity for the PHAB is related to universally-offered home visiting services per a bill that passed in the most recent legislative session. It is a very specific program around expanding the scope of that program beyond the Medicaid population. One last opportunity is the implementation of the SHIP.

Ms. Tiel shared that, thinking about those opportunities, she had a couple of discussion questions, which would help the PHAB plan for its agenda in November. The first question was:

How can the PHAB, as an advisory board to the Public Health Division, support innovation in Oregon's public health system?

Dr. Bangsberg stated that things were going to happen – some great things and some not-so-great things – and the PHAB should be on top of them in real time. The OHPC and all the CCOs have to see what the best practices are that inform the SHIP implementation, so that every CCO can do well. It's a great opportunity for the PHAB.

Ms. Tiel asked whether innovation was of value to the PHAB.

Dr. Savage said that one thing about innovation, which we all love, was that it was new, it was great, and it was exciting to see opportunities that could work. What the PHAB can do is to help focus things, because a lot of things and a lot of ideas will come from different CCOs. Maybe what the PHAB can do is triage and label priorities.

Ms. Saito added that, yes, innovation was new ideas, but how would the PHAB monitor it and have a performance metric around it. Similar to the criteria for health equity, it would be good for the PHAB to come up with a way to check if innovation works. What is the performance measure or criteria that shows that this innovation is worth doing over again, as opposed to just having a great, cool idea?

Dr. Sidelinger remarked that if the PHAB looked at the universally-offered home visiting and focus on social determinants of health, a role for the board could be to keep focus on the long-term. The PHAB can pick the buckets of things that work, and continuously look to make sure that they are working, but know that the course can't be changed every three years or five years, because that won't produce a long-term impact.

Dr. Bangsberg asked if the PHAB were to encourage the OHPB to do a CCO summit, some of the things the PHAB could look at include comparing community health assessments and community health improvement plans; look at where the investment for the social determinants of health are and what are the metrics that are being monitored; are the CCOs really moving outside the clinic and outside the covered population to the population at large. We had a little bit of challenge in getting the policy language into contractual language that required a public health approach. That was learning process for us all at OHA. We didn't quite get there, but we have another opportunity to push the ball a little further during implementation, if we can be clear about what these specifics are and look at the energy across CCOs as they implement.

Dr. Lewis stated that there may be a role for the PHAB to push with OHPB to evaluate the assumption from OHA that competition between CCOs is good. Some of us don't feel that that is empirically true. As we try to make these additional investments, multiple competing CCOs might or might not be more successful doing that [...].

Mr. Queral commented that the PHAB should think about the climate change issue, not just about the water issue, especially the impact of climate change on the health and wellbeing of Oregonians throughout the state.

Dr. Dannenhoffer shared that innovation for him meant that the PHAB should look at the areas where Oregon was not the best. What can we do to be the best or nearly the best in the country? In some things, we are nearly the best in the country, but in others maybe not so much. The PHAB should look at who are the best people in CD control, who are the best people in doing that and try to follow them.

Ms. Teal asked the PHAB what role the board wanted to have with regard to public health systems changes, particularly thinking about identifying what changes might be needed at a system level, leading change, participating in change efforts, and evaluating change. Thinking about the next couple of years and beyond, what is the PHAB's role in being an advisory body when it comes to big systems change happening in the state?

Dr. Lewis remarked that with regard to modernization, the discussion about CCOs and social determinants of health was good background. He wondered when modernization would move toward major diseases causes of death and disability. Communicable disease is not a place where we need to invest. We need to invest in prevention of trauma and chronic disease prevention. As a new member to the PHAB, he would continue to advocate for that. If he were on the board earlier, he would have said the same thing.

Ms. Rippeteau stated that the SSA is a significant investment in early learning. Home visiting is part of that early learning field. There are many other intersections with early learning in public health. There can be better connections there other than she and Ms. Teri Thalhofer being the connectors. Additionally, the mental health component for students in the SSA. Public health statewide doesn't focus on behavioral health necessarily, but there is that intersection as well. The state made significant investments in student mental health and behavioral health support through the SSA and largely missed the mark on supporting behavioral health for adults. What's the intersection there and how can the PHAB help participate in those conversations as well? In the last few weeks, various local governments have declared that addiction is a public health issue.

Dr. Bangsberg pointed out that looking at new domains for public health was really important. He agreed with Dr. Lewis that communicable diseases are not where it's at. It's around mental health. It's around suicide prevention. Oregon is the 13th leading state in suicide. This is a public health issue and also related to firearm ownership and other important public health issues that we traditionally haven't ventured into. The PHAB should think about these issues.

Ms. Tiel added that in regard to the foundational area around prevention and health promotion, we would get there eventually, but is there something that the PHAB needs to do now to get ready for that change, to help the system get towards that change, thinking about climate change and addressing chronic disease? Is there training workforce that needs to happen? Is there anything the PHAB can advocate for, or help prepare for, in getting to that section? We will get there eventually.

Mr. Queral commented that he was thinking about leading change and asked about what that meant. He would love for the PHAB to be in the driver's seat, but the PHAB is an advisory

board. The A in PHAB doesn't stand for advocacy unfortunately. What is that vision? What kind of advocacy can the PHAB do? That is a really interesting and important question.

Dr. Lewis remarked that, as a former state employee, the state employees were highly constrained, but he was not sure whether the PHAB should be. Maybe there is some of that opportunity. As far as leading change, maybe he should read the bylaws and see whether the PHAB had some ability to lead change that was not available to state employees.

Ms. Tiel asked the PHAB members about their priorities for the public health system.

Ms. Rippeteau noted that, for priorities, it goes back to those connections and how the PHAB is making them. One of the struggles she has in her day-job is that she sees how, as a state, we do spend a lot of our resources on the very expensive backend of things, such as prisons, and not having prevention. When she talks to legislators about needing to make these preventions and interventions upstream, the legislators focus on the expensive upfront costs. They do seem costly now, they will but end up saving the state money. A global priority for her across public health and other preventative policy areas as well is how do we help the legislature understand the value in making that shift and going through the growing pains of making the shift.

Dr. Lewis stated that it was like building it as a return of investment analysis. Ultimately, the PHAB has to make argument of people to make difficult budget decisions and stretch the timeframe out. If [...] was still here, he would talk about his massive infrastructure investments. They do seem incredibly expensive in year 1, but if you amortize it over 100 years, it's actually very small.

Ms. Shirley commented that when the PHAB talks about equity and health equity, it is like the topic is separated from these questions. How do we merge them and think about an agenda to invest in ways that prioritize issues of equity, as well as health equity? How can we begin that conversation? As Dr. Dannenhoffer stated, it's true on the climate cabinet on one end, it's true on the natural resources cabinet on the other end, we've got industry, we've got the fish people, we've got the forest people. Part of the job is to come to a consensus about priorities and our values and how we meet those values.

Ms. Shirley added that she would like to see somehow the PHAB understanding, whether it is investments, or priorities, or what the PHAB is advocating for, that the board has merged that conversation. The framework is the foundational capabilities. Around leadership, we have supporting change, supporting leadership at the local level and the community organization level, as well as state organizations to push forward these agendas, and don't see them as compartmentalized. How can the PHAB help OHA with a narrative about going forward with that kind of integration with the Public Health Division's values, so it guides its work and the changes it needs to make? OHA is making the changes internally at the state health department. Modernization is not something the OHA is telling the counties to do. It's going through the painful process of that kind of culture change itself. That would one of the things that she would like the PHD to get a little help or advise on.

Ms. Tiel asked how the PHAB wanted to continue this discussion at the next meeting and going into the next year. The board had its workplan and had specific deliverables that have been a great deal of work. Moving into the next several months, the PHAB will have time as a body to have these conversations.

Dr. Savage stated that it would be nice to start with a recap of what had been accomplished in a succinct way, looking back and identifying what the priorities were and what the board did to meet them, and what's left undone. The overall vision and public health perspective, which is probably the most constant thing we have in Oregon, because the CCOs will continue to change and evolve, is clear, and the PHAB needs to make sure it stays clear and concise and with a direction. The board needs to see what it did do, maybe what it didn't accomplish, and then put forward two, three concise things that can be met with the constant, clear vision.

Ms. RippetEAU commented that, building on Dr. Savage's idea, the PHAB needed to see what it had accomplished and identify what still needed to be done, including how its money spending or funding allocation compared to what the board previously thought.

Ms. Tiel noted that with the new SHIP, the PHAB had the opportunity over the next couple of months to look at the foundational documents that have gotten us where we are today. We are all trying to figure out how we are going to implement the SHIP together. It's not just a PHAB plan. The PHAB board members will be expected to have a leadership role in the SHIP. How do we want to promote it? How do we want to approach the SHIP? Hopefully, the PHAB can cover these questions in November or in a future meeting.

Dr. Dannenhoffer added that the discussion was great fodder for the PHAB retreat. This is exactly the kind of stuff the board should be discussing. Linking to what he said earlier, the PHAB may find other health departments in the country that have thought about this and did a beautiful job. If the PHAB can look around, maybe Minnesota, or California, has come up with a great framework. That would be a great place to start.

Ms. Tiel shared that she knew an individual from a national organization who could help the PHAB with the national perspective.

Dr. Luck asked if the PHAB would be hearing more about the SHIP priorities soon.

Ms. Biddlecom answered that the PHAB had circled back about the selection of the priorities. Right now, the subcommittees of the partnerships are starting to meet to develop goals, objectives and strategies for each of the five priorities for the next SHIP. Once these subcommittees have met one or two times, depending on which of the five hasn't met yet, OHA will bring draft goals, objectives, and strategies to the PHAB, before taking them back out to community and finalizing them. That would be in early 2020.

Dr. Luck asked if that would be before PHAB's November meeting.

Ms. Biddlecom answered that OHA would not have goals, objectives, and strategies by November. The big domains can be given to the PHAB by November. She asked the PHAB to

think about how we hold true to the promise we are making to communities around what we are trying to align around and build a public health system that helps to meet those needs. This is what keeps her up at night.

Ms. Shirley reminded the PHAB that several of its members participated on the partnership that helped, after the extensive outreach (over 1400 individual inputs). There are 92 separate people cross-sector working on the committees who are looking to help OHA decide what strategies to select. To Dr. Savage's point, that shows an incredible interest in public health. These people want to be part of shaping it with OHA. That's incredible. The work that's been done on the local level, on the community level, and on the state level has a lot of integrity. We couldn't have done it four years ago. It's all part of our journey.

Ms. Tiel pointed out that the subcommittee meetings and rosters could be seen online. This conversation will be continued in November. It might be hard for some board members to attend in November, but all members are encouraged to attend in person, if possible, because the discussion will be more open and will cover the planning of several meetings. The meeting will be at another venue in Portland.

Dr. Lewis commented that, in thinking about November, and trying to put together the themes of health equity, policy systems and environment, and the upstream components, the PHAB should try to think about what good examples exist. The tobacco program (TPEP) at OHA, for example, has encouraged local policy change. The PHAB should look at those examples of success and try to apply their lessons to the current situation.

Public Comment

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 4:12 p.m.

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

**October 17, 2019
2:00-5:00 p.m.
Public State Office Building
Room 177
800 NE Oregon Street
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



October 2019

Funding for OHA Public Health Responsibilities in Wallowa County

Background

In April 2018, the Wallowa County Board of Commissioners adopted an ordinance transferring their local public health authority (LPHA) responsibilities to the state. As of May 1, 2018, the Oregon Health Authority (OHA) assumed responsibility for limited public health services in Wallowa County. These services include:

- Monitoring reportable conditions and communicable diseases, and controlling outbreaks;
- Enforcing the Indoor Clean Air Act;
- Ensuring access to safe drinking water;
- Ensuring access to WIC services; and
- Licensing and inspecting food, pool and lodging facilities.

In addition, OHA has elected to also contract with Wallowa Memorial Hospital which is part of the Hospital Preparedness Program to provide some basic planning and capacity for public health emergency preparedness (PHEP). In 2019, OHA performed all school law functions in Wallowa County. For 2020 OHA is contracting with another LPHA partner to conduct the school records review with OHA issuing any exclusion orders.

Funding – April 2018 through June 2019

When a county government explores transferring its LPHA responsibilities to the state, significant state time and resources are required for transfer planning and implementation. From April through November 2018, OHA spent at least \$24,658 on planning and early implementation for the Wallowa County transfer. Planning and early implementation efforts required OHA staff time to be diverted from other priorities, including providing training and technical assistance to LPHAs. These costs were absorbed by existing funding sources including program-specific state general, other and federal funds, as no other funding source was available.

OHA has historically provided safe drinking water services in Wallowa County so no change in services or funding was required for that program as of May 1, 2018. WIC services were transferred to an existing WIC provider that already had a presence in Wallowa County and now provides WIC services using the Wallowa County WIC funding allocation. Similarly, the contract for Wallowa Memorial Hospital for basic PHEP planning and capacity is funded using the Wallowa County PHEP funding formula allocation.

FY 2019 estimated costs and funding sources for all other program areas were as follows:

	Costs	Fee Revenue	2017-19 E-board Funding*	Federal Cooperative Agreements	Tobacco Use Reduction Account	Program-Specific State General Funds	Balance
Environmental Health - Inspections, Licensing, etc.	49,173	26,201	43,021	-	-	-	20,049
Immunizations - School law review and exclusions	1,500	-	-	1,500	-	-	-
PH Emergency Preparedness - Basic planning and capacity	45,846	-	-	45,846	-	-	-
Communicable Disease - HIV, TB, & STD	7,733	-	-	6,783	-	950	-
Communicable Disease - ACDP	9,188	-	-	-	-	9,188	-
Indoor Clean Air Act Enforcement (no complaints in FY2019)	-	-	-	-	-	-	-
FY 2019 Estimated Totals	113,440	26,201	43,021	54,129	-	10,138	20,049

*In FY 2019, OHA requested one-time funding to support the costs of providing limited public health services in Wallowa County. These funds supported the Environmental Health regulatory work enabling some fee revenue to be carried over into the 2019-2021 biennium.

While OHA was able to absorb or secure funding for Wallowa County-related costs in the 2017-2019 biennium, other work was delayed or not completed due to resources being diverted to assure limited public health services in Wallowa County. Impacts to the public health system include and are not limited to:

- Decreased overall technical support to LPHAs;

- Longer response times to email and phone inquiries from LPHAs, federally-recognized Tribes and the general public;
- Insufficient time for statewide environmental health program planning and development;
- Reduced time for administration of the statewide school law program including training for schools, day cares and LPHAs, and data quality reviews; and
- Reduced tuberculosis consultation and training.

Funding – 2019-2021 Biennium

While most OHA programs were able to absorb Wallowa County-related costs in the 2017-2019 biennium, only a few programs can continue to do so. The projected costs for the 2019-2021 biennium for limited public health services in Wallowa County are as follows:

2019-2021 Biennium Estimates	Costs	Fee Revenue	FY19 Carryover Balance	Federal Cooperative Agreements	Tobacco Use Reduction Account	Program-Specific State General Funds	Balance
Environmental Health - Inspections, Licensing, etc.	146,522	66,000	20,049	0	0	0	(60,473)
Immunizations - School Law	6,000	0		1,000	0	0	(5,000)
PH Emergency Preparedness - Basic planning and capacity	101,246	0	0	101,246	0	0	0
Communicable Disease - HST – HIV, TB, STD	5,460	0	0	2,730	0	2,730	0
Communicable Disease - ACDP - all non HST reportable diseases	52,170	0	0	0	0	19,832	(32,338)
Indoor Clean Air Act Enforcement	1,200	0	0	0	1,200	0	0
2019-2021 Totals	312,598	66,000	20,049	104,976	1,200	22,562	(97,811)

These estimates are based on reasonable projections of the volume of work to be expected in Wallowa County during the biennium. These projections also include the one-time carryover of 2019 environmental health fee revenue.

ORS 431.382 (4) allows OHA to use funding that would have gone to Wallowa County for Public Health Modernization to provide or contract for public health programs, services and activities within the county. When a transfer of LPHA responsibilities occurs, these state funds are no longer specific to public health modernization. The total amount of funding that would have been allocated to Wallowa County through the Public Health Modernization funding formula for the 2019-2021 biennium is \$ 42,576.

In addition, OHA will use \$17,330 in State Support for Public Health General Fund dollars that would have been allocated to Wallowa County for the 2019-2021 biennium to support communicable disease work in that jurisdiction.

OHA currently estimates a deficit of almost \$98,000 for providing limited public health services in Wallowa County during the 2019-2021 biennium. OHA plans to use the Public Health Modernization and State Support for Public Health funding that would have been allocated to Wallowa County to help cover this deficit. Even with the addition of that \$60,000, OHA will still have to identify funding to cover the remaining deficit.

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, MEASURING SUCCESS COMMITTEE

Public Health Advisory Board

In September, the Public Health Advisory Board (PHAB) reviewed funding distribution plans for local and Tribal public health authorities as part of the 2019-21 legislative investment in public health modernization. PHAB reviewed statutes pertaining to the transfer of local public health authority to the Oregon Health Authority and discussed how the Oregon Health Authority is currently providing public health services in Wallowa County.

PHAB also discussed the 100-Year Oregon Water Vision, a plan to steward water resources to ensure clean and abundant water for Oregonians, the economy and the environment.

PHAB had an initial discussion about priorities for the public health system for the biennium, which will support strategic planning and the development of the 2020 PHAB work plan later this fall.

COMMITTEE WEB SITE: <https://www.oregon.gov/oha/ph/About/Pages/ophab.aspx>

STAFF POC: Cara Biddlecom, cara.m.biddlecom@state.or.us

Primary Care Payment Reform Collaborative

In September, The Evaluation and Implementation workgroups convened for a joint meeting to review the PCPRC workplan and key components of moving toward infrastructure implementation. Since there is significant overlap in the work of these group workgroups, a joint workgroup meeting was essential in obtaining feedback on the Collaborative workplan, especially as it relates to the activities that fall under these two workgroups. The workplan will be presented to the full collaborative in October.

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 October 8th, 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@dhs.oha.state.or.us

Healthcare Workforce Committee

The Healthcare Workforce Committee met on September 11. Key Items included:

OHPB Updates:

Brenda Johnson shared about the previous two Board meetings. She spoke about the on-site visits the Board held in Coos County. These brought reflections by employers on the value from the Health Care Provider Incentive Program and the J-1 Visa Waiver Program in support of their ability to recruit and retain health professionals. It was noted that the Committee will be presenting to the Board at the Board's October meeting.

Primary Care Office Updates:

Marc Overbeck orally shared about the effects of the federal Auto-Facility HPSA score adjustments. He presented a screen showing changes made to score for primary (physical) care, oral health and mental health HPSAs. Members were able to see the number of decreased scores as well as facilities where scores remained the same or were increased. Marc's reminder is that the decreased HPSA scores are largely due to improvements in the health professional-to-population ratios, as well as some modest decreases in poverty in certain communities.

CCO 2.0:

Ralph Magrish and Jackie Fabrick presented a high-level summary and timetable for the work being done to develop rules and contracts under CCO 2.0. They received and answered questions from committee members. Committee members also reminded OHA staff of several of the policy pronouncements from the committee in years past regarding maximizing the contribution of existing health professionals.

Behavioral Health Workforce Implementation Plan:

Jackie Fabrick shared updates regarding legislative committee and executive branch efforts to develop plans for the BH workforce. Jackie plans to work closely with a workgroup from the Workforce Committee to help follow up on the Farley Center recommendations to expand the BH workforce.

Health Care Provider Incentive Program:

The Committee discussed OHA staff recommendations on use of the Health Care Provider Incentive Fund for the 2019-21 biennium. After considerable discussion a memo was approved to be brought to the Board, along with a presentation to the Board in October by committee leadership and OHA staff.

Health Equity:

The Committee heard from Maria Castro regarding efforts of the Health Equity Committee of the Board. The Committee will meet next on November 6.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/HPA/HP-HCW/Pages/index.aspx>

COMMITTEE POC: MARC OVERBECK, Marc.Overbeck@dhsaha.state.or.us

Health Plan Quality Metrics Committee

At the September 12 meeting the Committee discussed the Oregon Health Policy Board (OHPB) guidance letter to HPQMC with Trilby De Jung, OHA HPA Deputy Director, and John Santa, the OHPB liaison to the Committee. The Committee discussed the guidance and had a conversation about expectations and intent. The Committee asked about health plan measurement versus provider measurement as well as how CCO incentive measures and PEBB/OEBB measures might interplay and inform with a voluntary core. Trilby shared news about specific TA that will be available to the Committee from Michael Bailit of Bailit Health to help meet the Board's charge, including around criteria development for transformational measures. The Committee also noted issues related to data stratification, provider burden, opportunities to align with CPC+ and Value-Based Purchasing while discussing the guidance.

The committee elected a new Chair, Jon Collins, OHA HSD Deputy Director, and Vice-Chair, Melinda Muller, Clinical Vice-President for Care Transformation at Legacy Health

The next meeting is October 10th, 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@dhsosha.state.or.us

Metrics & Scoring Committee

At its 20 September meeting the Metrics & Scoring Committee reviewed the letter from the Oregon Health Policy Board to the Health Plan Quality Metrics Committee. The Committee heard about CCO Transformation Quality Strategies from the Oregon Health Authority's Quality Improvement Director and finalized all benchmarks and improvement target floors for 2020. Final benchmarks for the program can be found here: <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx>

At its 18 October meeting the Committee will hear an update on the evidence-based measure being developed on obesity; discuss the quality pool under CCO 2.0; and, make decisions regarding continuous enrollment and the 2020 immunization measures.

The Committee chairs will also address the Oregon Health Policy Board in November, to discuss Committee decisions regarding the 2020 measure set.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>

COMMITTEE POC: Sara Kleinschmit, SARA.KLEINSCHMIT@dhsosha.state.or.us

Health Information Technology Oversight Council

The Health Information Technology Oversight Council (HITOC) will be meeting on October 3, 2019. HITOC will hear updates on the Oregon Health IT Program, conduct chair/vice-chair elections, and discuss plans for committee leadership development. HITOC will also cover the following in-depth topics:

Health Equity and Health IT

Leann Johnson from OHA's Office of Equity and Inclusion will present on health equity. HITOC members will also explore the connection between health equity and health IT and examine opportunities to promote health equity through health IT.

2020 Strategic Plan Revision

HITOC will begin its work on the planned revision of its Strategic Plan for Health IT and Health Information Exchange. HITOC's current strategic plan runs from 2017-2020, and HITOC will spend significant time in 2020 engaging with partners and stakeholders and developing a revised strategic plan to present to OHPB in late 2020. This session will focus on reflecting on the expiring strategic plan and planning the revision work.

2020 HITOC Work Plan and OHPB Report

HITOC will reflect on its 2019 work plan progress and begin planning its 2020 work. HITOC will also begin discussing its report to OHPB about its 2019 activities, the current state of health IT in Oregon, and planned 2020 activities.

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 September 25th to hear an update on the Public Charge Rule and learn about how Oregon is preparing for the chilling effect the Rule is expected to have on immigrant children and families. Last December, the Committee joined OHA and other State agencies in submitting a formal response to the Department of Human Services opposing the proposed rule.

The MAC also heard an overview of the May 2018 report Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon's CCO Model (given the many new members who were not on the committee during the report's development) and learned about new requirements and expectations around social determinants of health and equity in CCO 2.0.

At the MAC's next meeting, October 23rd, they will review and finalize a work plan for the next 12-18 months.

COMMITTEE WEBSITE: <http://www.oregon.gov/oha/hpa/hp-mac/pages/index.aspx>
COMMITTEE POC: Milena Malone milena.malone@state.or.us

Health Equity Committee **DRAFT**

An essential part of the Health Equity Committee Charter is to work in close collaboration with other OHPB committees. The rest of this year will see presentations from staff from the Healthcare Workforce Committee, Metrics and Scoring, Health Plan Quality Metrics, OHITOC, Public Health Advisory Board, Medicaid Advisory Board, and the Oregon Health Policy Board. The purpose of these presentations is to find areas of alignment and or potential opportunities for collaboration.

Metrics and Scoring Committee Presentation

Sara Kleinschmidt, OHA Policy Advisor and lead staff for the Metrics and Scoring gave an overview of the committee, current committee work and there were questions about member composition and how the member and community should be represented and how consideration needs to be given to power dynamics when the community is brought to committees like this one. Metric and Scoring staff are working with OEI on upcoming recruitment opportunities to address that community representation need. The presentation also presented an opportunity for dialogue on how both committees can collaborate.

Healthcare Workforce Committee Presentation

Marc Overbeck, Primary Care Office Director, is the lead staff for the Healthcare Workforce Committee. The HCWFC is one of two initial OHPB Committees, codified in 2009 (ORS 413.017)

The committee's charter states that the role of the HCWFC is to coordinate efforts in Oregon to recruit and educate health care professionals and retain a quality workforce to meet the demand created by the expansion in health care coverage, system transformation, and an increasingly diverse population.

Marc provided an overview of the committee, its composition, current State workforce picture and shared some of the committee's charter deliverables that include:

- Biennial Healthcare Workforce Needs Assessment, required by HB 3261 (2017) by December 2020
- Biennial profile of Oregon's current healthcare workforce, including a demographic and geographic profile, focused on race, ethnicity, and languages spoken. By January 2021

Marc shared that there is a potential of collaboration with the HEC. He invited HEC members to consider serving on specific subcommittee's or as an ex-officio and non-voting member that could serve at HCWFC. He extended an invitation to HEC members to attend the HCWFC meetings, and he will encourage HCWFC members to participate at HEC meetings.

Co-chair Elections

HEC will hold Co-Chair elections at their November 14th meeting. Potential Co-Chairs can nominate themselves or nominate another HEC member. HEC members nominated by others must accept the nomination and complete the required materials as outlined below.

As part of the selection process, the Committee asks that all members interested in this committee leadership role complete the following requirements to be considered.

All HEC members that wish to be considered as a potential candidate for co-chair will send an email to committee staff (Maria) expressing their interest no later than October 25th by noon with responses to the "Co-Chair Interest Form." In the form, candidates should also answer the following questions:

- In 250 words or less what unique contribution you will make as HEC Co-chair.
- Identify 2 - 3 goals that you would like to see the committee achieve in the coming year.

Health Equity Definition

Work to refine the health equity definition has continued. Staff presented an overview of the work taking place to develop a framework to the health equity definition developed by HEC. This work will be shared with the OHPB at their October meeting. HEC members will send their additions and comments to the health equity definition framework no later than Tuesday, September 17th.

Health Equity Plan Guidance Document Review

HEC members had the opportunity to review and provide feedback to a draft of the Health Equity Guidance Documents that aims to support CCOs on fulfilling one of the CCO 2.0 Contract requirements. HEC would like to see on the document some guidance to CCOs on how to present the health equity plan to the community and, the addition of essential stakeholders such as the Regional Health Equity Coalitions or other grassroots organizations when Regional Health Equity Coalitions are not available.

Other feedback included, to consider moving a timeline for the plan submission process to the beginning of the document for clarity; adding contact points where CCOs and OHA can check in once plans are submitted and, adding tools such as an organizational equity audit. HEC members can submit comments until Tuesday, September 17th, 2019.

Next HEC meeting: Thursday, October 10th, 2019 at noon at OHA Transformation Conference Room (Five Oak Building)

COMMITTEE WEB SITE: <https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx>

STAFF POC: Maria Elena Castro maria.castro@state.or.us

Measuring Success Committee

The Measuring Success Committee of the Early Learning Council met on May 1. The committee completed its process of reviewing the proposed early learning system measures by mapping them across seven identified developmental domains, five sectors, and nine objectives of early learning system strategic plan, *Raise Up Oregon*. The committee determined that the proposed measures adequately covered the intended areas.

Over the course of the summer, staff will continue to document specific details of the measures and conduct a review to determine whether data can be analyzed by racial/ethnic groups. In addition, the ELD will consult with external stakeholders to conduct an equity review of the measures to determine potential bias in the measures. Further, a small workgroup will work in collaboration with OHA on the revision of the PRAMS-2 to incorporate additional early learning system items. The committee is planning on submitting the measure set to the Early Learning Council in October for consideration.

COMMITTEE WEBSITE: N/A

COMMITTEE POC: Thomas George, Thomas.George@state.or.us

Public Health Modernization

Implementation Evaluation



Public Health Advisory Board Meeting
October 17, 2019

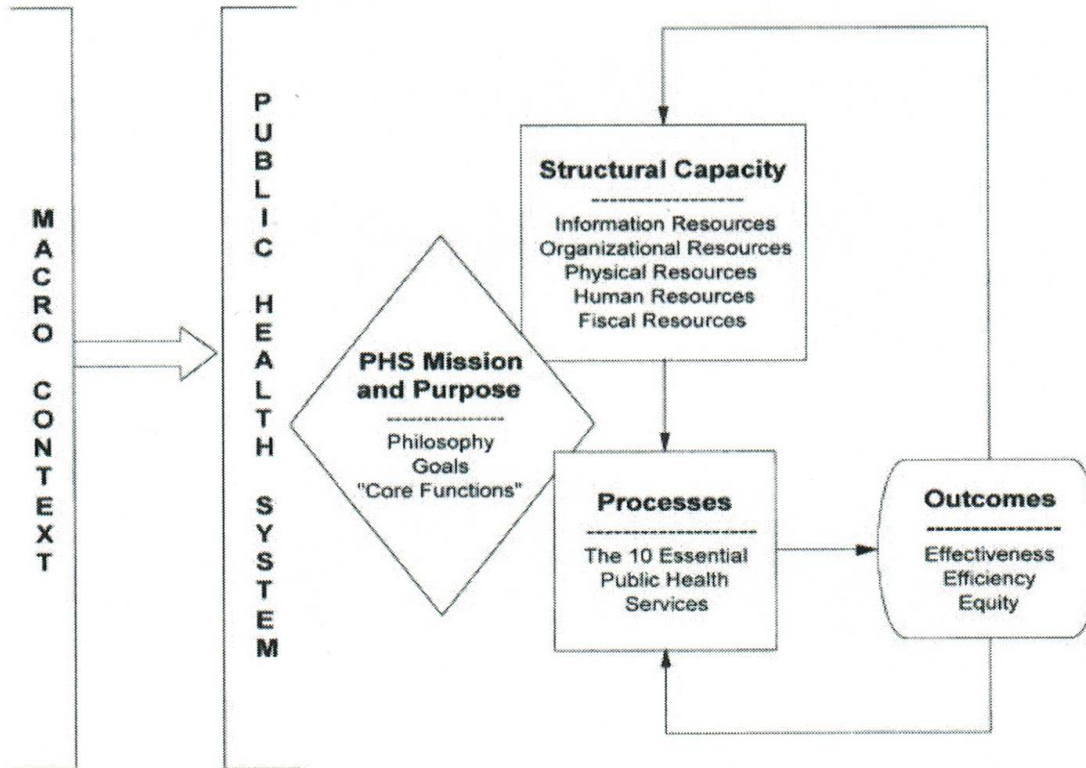


PUBLIC HEALTH DIVISION

Office of the State Public Health Director

Outline for today's discussion

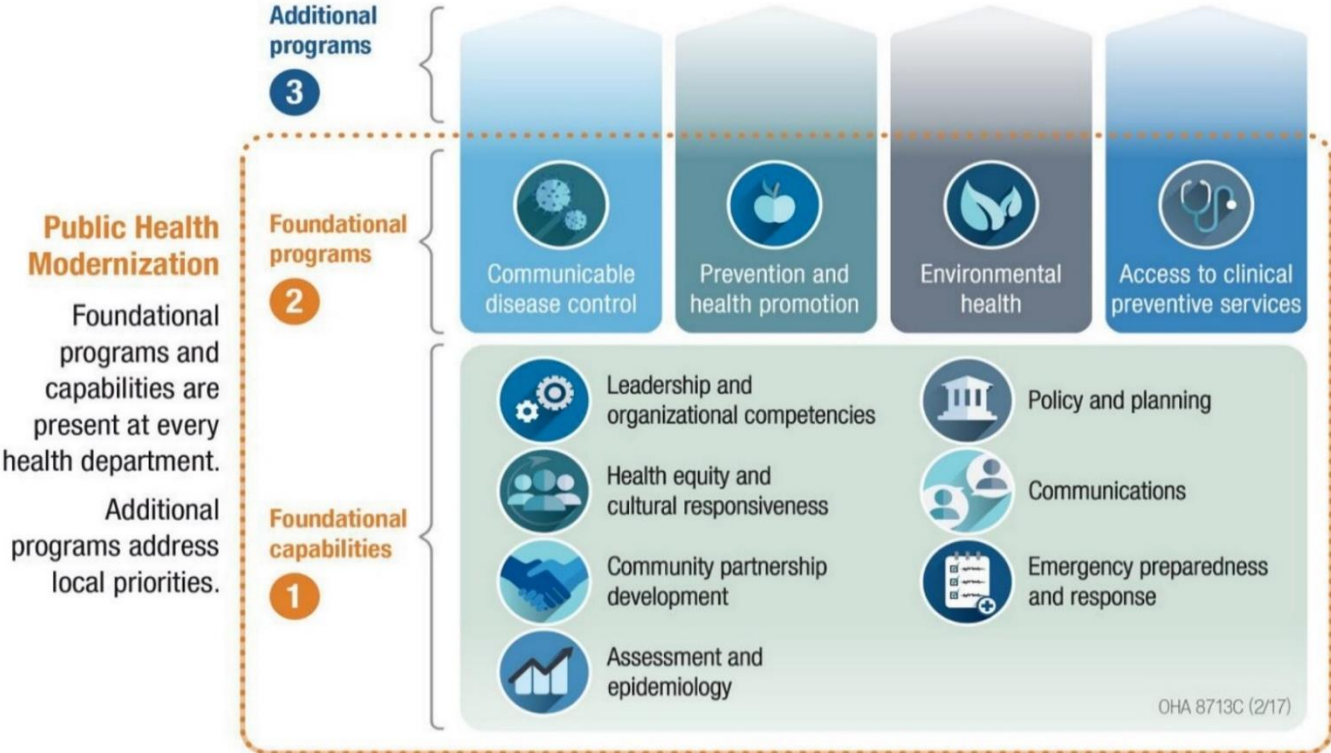
1. General evaluation questions for the new biennium
2. Possible evaluation areas
3. Revisit the evaluation purpose
4. General evaluation process



Handler, Issel, Turnock. A conceptual model to measure the performance of the public health system. [Am J Public Health](#). 2001 August; 91(8): 1235–1239.

Public Health Modernization

Modernized framework for governmental public health services



Modernization Evaluation

- Who are the priority audiences for the evaluation?
- What would successful modernization implementation look like at the end of the 2019-2021 biennium?
- What would you want to see in a final report?

Potential evaluation areas

1. System change & advancement

- Not review state and local public health activities separately rather the interaction between the two
- Potential examples
 - Surveillance - timely input of local data into state system
 - Financial resources – braiding or blending funds
 - Shared advocacy for state & local policy change
 - Explore areas in the modernization manual that state and local depend on each other
 - Suggestions?

Potential evaluation areas

2. Changes in capacity & expertise in the Capabilities and Programs (self-reported modernization assessment)

Consider developing valid measures of each to track over time in areas of CD, Health Equity & Cultural Responsiveness, Leadership & Governance.

Possible examples:

- CD – Outbreak response time, timely & accurate reporting of reportable disease, screening & follow-up treatment
- Health Equity & Cultural Responsiveness – advance equitable access to immunization and preventable health care
- Leadership & Governance - # of new hires at the local level to fill staffing gaps needed

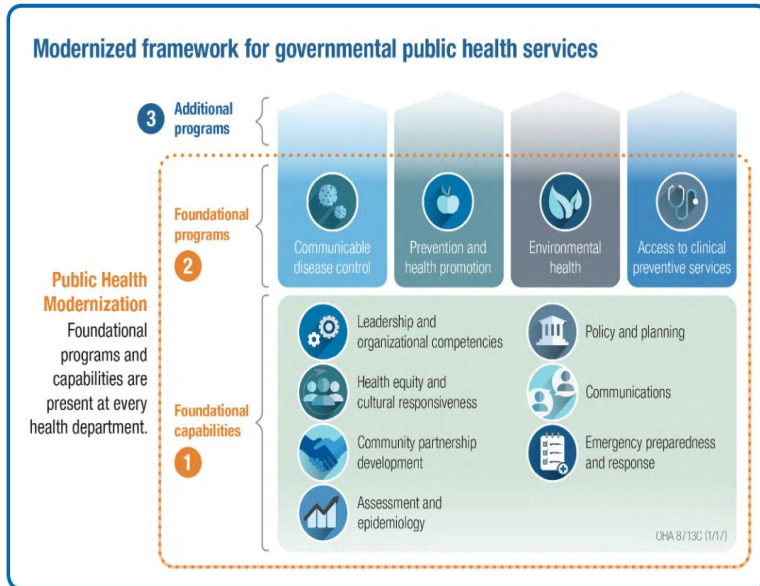
Potential evaluation areas

3. Improvements in Service Delivery

- Time savings
- Costs saved or avoided
- Improved quality of service or programs
- Expanded reach to target population
- Quality enhancements of data systems
- Increased preventive behaviors
- Decreased incidence or prevalence of disease

4. Stories of sharing services/regional work to improve local capacity and expertise

Revisit evaluation purpose



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

Given our discussion, what if any changes do you recommend to the evaluation purpose for 2019-21?

Are there other items you'd like to have included?

General Evaluation Process

- Stakeholder Evaluation Group
- Develop the evaluation plan
- Interim report Sept 2020
- Final report June 2021

Contact information

- **Kusuma Madamala, PhD,MPH |**
- Program Design & Evaluation Services
- Oregon Public Health Division & Multnomah County Health Department
Kusuma.Madamala@dhsoha.state.or.us

- **Julie Maher, PhD, MS | Director**
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- Oregon Public Health Division & Multnomah County Health Department
julie.e.maher@dhsoha.state.or.us

Modernization of a Public Health Survey System



Public Health Advisory Board Meeting
October 17, 2019

Oregon
Health
Authority

Today's presentation



Reliance on Behavioral Risk Factor Surveillance System (BRFSS)

- Telephone survey of adults in Oregon
- Part of national survey
- Range of topics: health behaviors, risk factors, diagnosis, services, demographics
- Every few years, racial and ethnic oversample conducted

Current challenges with BRFSS

- Expensive
- Lack estimates for smaller geographic areas
- Survey is long
- Concerns about representativeness and validity of data
- Lack of community engagement
- Lack data for Pacific Islander communities

Modernization framework for identifying solutions



Assessment & epidemiology



Health equity & cultural responsiveness



Community partnership development

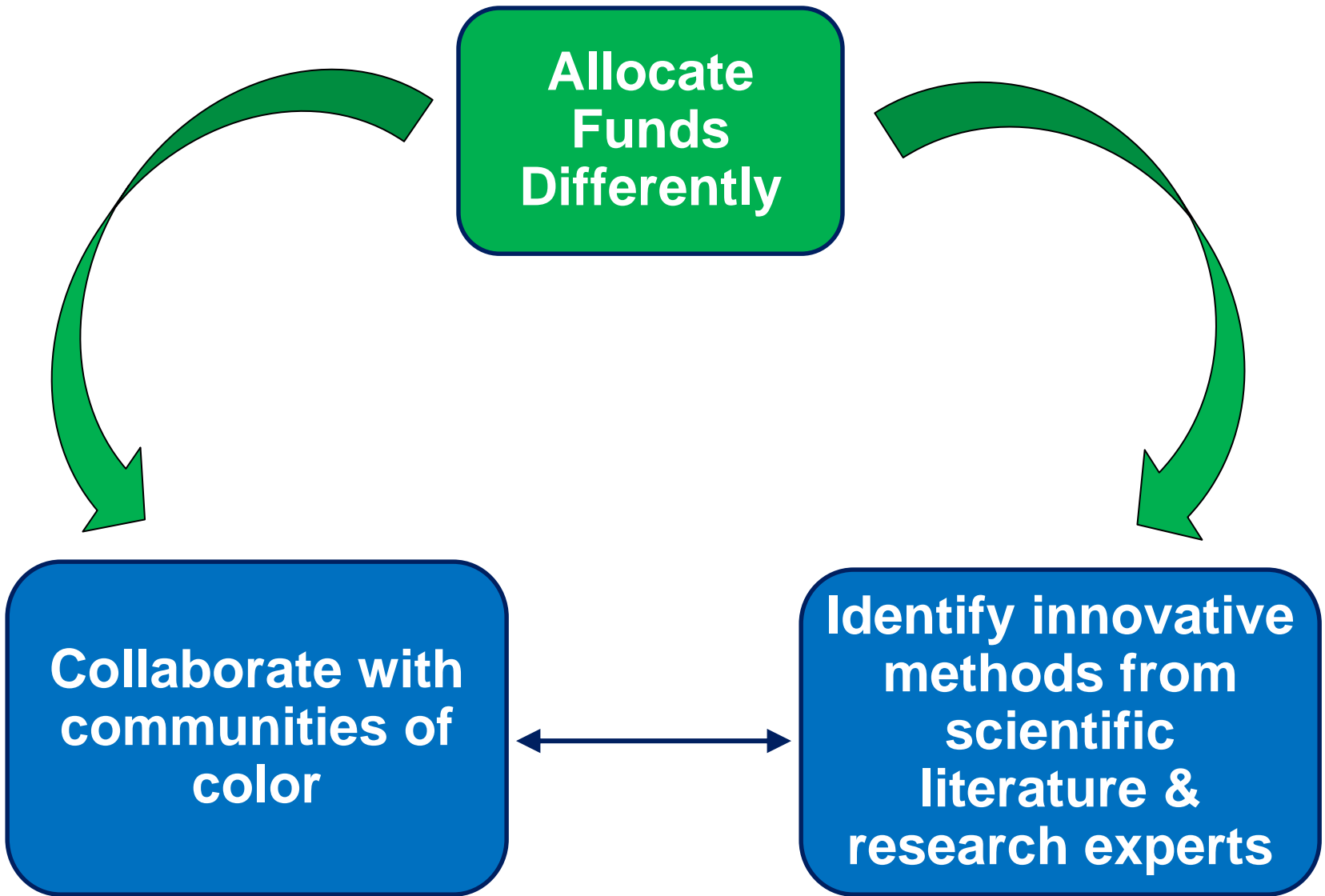


Policy & planning

Allocate Funds Differently

Instead of conducting BRFSS racial and ethnic oversample:

- Combine 3 years of standard BRFSS data for analysis for communities of color
- **AND**

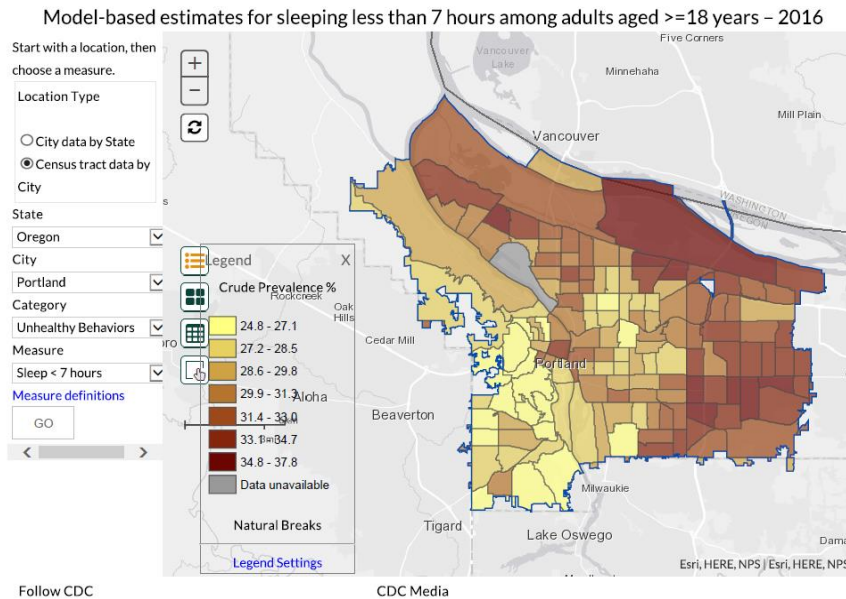


**Identify innovative
methods from
scientific
literature &
research experts**

Addressing current challenges with BRFSS

- Expensive
- Lack estimates for smaller geographic areas
 - Survey is long
 - Concerns about representativeness and validity of data
 - Lack of community engagement
 - Lack data for Pacific Islander communities

Calculate BRFSS indicator estimates for small geographic areas



Addressing current challenges with BRFSS

➤ Expensive

- Lack estimates for smaller geographic areas

➤ Survey is long

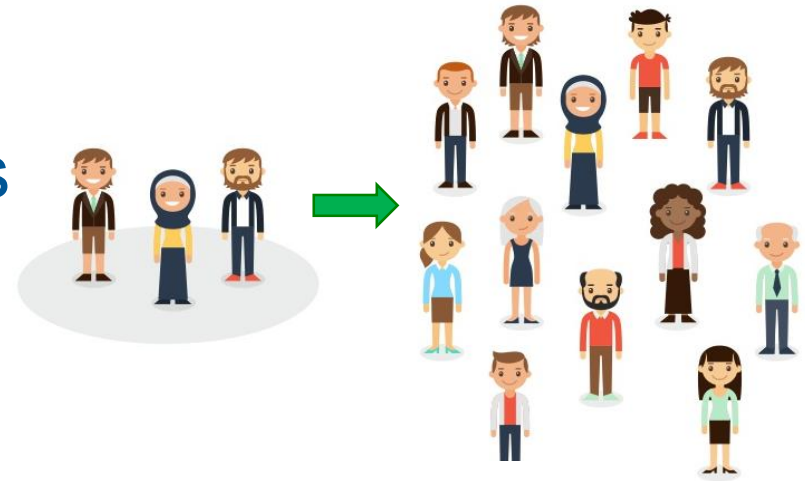
➤ Concerns about representativeness and validity of data

- Lack of community engagement
- Lack data for Pacific Islander communities

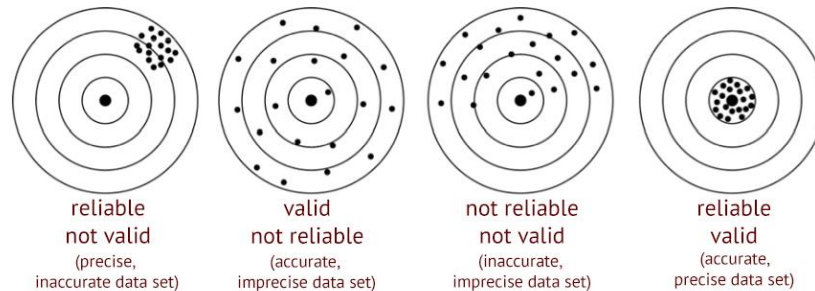
How can we modify the adult survey system overall to

Shorten the survey

Increase representativeness of data



Increase validity of measures



Approach to exploring the science to modify adult survey system overall

- Work with Oregon Public Health Division Science and Epidemiology Council
- Explore additional survey methods in scientific literature
- Conduct interviews with survey research experts
- Incorporate recommendations from community collaboration
- Develop methods to pilot
- Pilot methods

**Collaborate with
communities of
color**

Addressing current challenges with BRFSS

- Expensive
- Lack estimates for smaller geographic areas
- Survey is long
- Concerns about representativeness and validity of data
- Lack of community engagement
- Lack data for Pacific Islander communities

Collaborate with African American and Black, Latinx, Asian American, Native American communities

- Fund communities
- Conduct participatory analysis of BRFSS & youth surveys
- Communities design supplemental data collection methods
- Support communities in writing briefs
- Summarize recommendations for new methods

Collaborate with Pacific Islander communities

- Fund communities
- Summarize existing data
- Communities design data collection methods
- Conduct participatory analysis of newly collected data
- Support communities in writing brief
- Summarize recommendations for new methods

Braiding of innovative ideas

**Collaborate with
communities of
color**



**Identify innovative
methods from
scientific
literature &
research experts**



Contact information

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OHPB health equity definition

- Developed by the OHPB Health Equity Committee
- Adopted by OHPB on October 1
- Expectation for all OHPB committees to use this definition going forward

Health equity

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

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

Framework for health equity

Identifying and implementing effective solutions to move the dial on health equity demands:

- Recognition of the role of historical and contemporary oppression and structural barriers facing Oregon communities
- Engagement of a wide range of partners representing diverse constituencies and points of view.
- Direct involvement of affected communities as partners and leaders in change efforts.

The Governor's Wildfire Council (2019)

In early 2019, Governor Brown signed an executive order creating the Governor's Council on Wildfire Response. <https://www.oregon.gov/gov/policy/Pages/wildfirecouncil.aspx>

The Council is tasked to review Oregon's current model for wildfire prevention, preparedness and response, analyzing whether or not the current model is sustainable given our increasing wildfire risks.

Topic to be considered include, but are not limited to:

- Funding for wildfire response
- Response to fires on protected, under-protected, and unprotected lands
- Wildfire smoke
- Assisting communities affected by wildfires
- Prevention, treatment and cost containment of wildfires

The Oregon Health Authority-Public Health Division is represented on the council as a non-voting member. The OHA-PHD representative also chairs the health subcommittee. There are five subcommittees; Suppression, Mitigation, Economic Recovery, Health and Land use.

The health subcommittee included representation from the Oregon Association of Hospitals and Health Systems-St. Charles Medical Center, OHSU- School of Public Health, a Coordinated Care Organization, Oregon's Emergency Resiliency Office, Community Alliance of Tenants, and local and state elected officials. (Mayor of Bend, Sally Russell and Representative Pam Marsh).

Summary of Recommendations from the Health Subcommittee

Smoke and wildfire impacts are among the severe and accelerating risks to human health tied to climate disruption. Therefore, the Health Subcommittee believes that meaningful action to address climate change must be the first and overriding priority. Oregon's Climate and Health Resilience Plan reinforces the importance of actively engaging diverse community partners throughout Oregon and elevating the voices of our most vulnerable populations to inform local and state policy priorities.

The committee's recommendations cover both immediate actions and long-term preparation for protecting and preserving human health related to wildfire mitigation, and wildfire response and preparedness.

- **Immediately protect all community members, with special focus on vulnerable populations, during wildfire and smoke events. Following are a limited set of specific recommendations in the health subcommittee report.**
 - Communities designate and prepare public cleaner air spaces and shelters for refuge during smoke events (wildfire or prescribed burns), including clean air rest stations for those responding to these events.
 - Coordinated Care Organizations use Health-Related Services dollars to purchase high-efficiency particulate air filtration systems for members.

- Require assisted living, skilled nursing, and DHS-licensed facilities for youth and adults with disabilities to install or provide air filtration systems in common spaces, and individual units.
- During Wildfire or smoke events, provide clean air refuges for the emergency response staff (Fire Fighters, EMS, Police, National Guard)
- Convene a cross section of community partners and decision makers to align the Governor’s affordable housing priorities, climate change and community resiliency plans, and health and safety priorities of vulnerable populations including children and families, older adults and people living with a disability or chronic condition.
- **Help communities prepare for wildfire and smoke events so they can achieve the best possible health outcomes over the long term. Following are a limited set of specific recommendations in the health subcommittee report.**
 - Department of Environmental Quality in collaboration with community partners Increase air quality monitoring stations in all Smoke Sensitive Receptor Areas.
 - Clear expectations and directives for state and local agencies to provide resources (time, staff) to strengthen collaboration across agencies specific to addressing emergency response, including wildfire.
 - Increase awareness and efficiency of Oregon Emergency Management System and state and local agency collaborations in existence.
 - Increase resources available at the local level for emergency response planning and mitigation.
 - Support local businesses to ensure they are creating clean air space for their employees as part of their Continuity of Operations Planning (COOP)
 - Advance the early alert system through greater investments in ALERTWildfire, ensuring the Department of Forestry has camera systems set up throughout the state.
 - Included in required community health assessments and health improvement plans, hospitals should ensure communication protocols between hospitals/local governments, tribes and health authorities exist and are reviewed annually.
 - Increase awareness of Health Alert Network. Require all state and local public employees and contractors to register with the Health Alert Network (HAN).
 - Invest in and strengthen the Public Health Surveillance System to respond to acute and long-term smoke exposure through interactive data reporting.

Next steps

- The Council reported progress and an overview of all recommendations considered by the council to the Governor on September 26.
- The Council will prioritize the recommendations from all five subcommittees to present a final report and recommendations to the Governor prior to the February 2020 session.

Question for consideration:

Background: The Wildfire Council requested cost data specific to health impacts as a result of wildfire and smoke. While health impacts have been calculated for the 2012 Pole fire and the 2017 Chetco Bar fire, cost data was not determined. The question of cost continues to come up as the council and

elected officials serving on the council weigh the pros and cons of general fund investments in prevention, mitigation and suppression efforts related to wildfires. The question of cost will continue to come to OHA.

Is there an opportunity for OHA and academic partners to collaborate on a model that can be used to determine health costs due to Wildfire and smoke? What would the PHAB recommend?

- Currently the University of Portland (UP) has a request into Health Policy and Analytics for All Payers All Claims data to determine the health cost from the Eagle Creek fire. Should OHA more actively collaborate with UP on this? Are there are Universities that are looking at this same issue?

Oregon Department of Forestry's Smoke Management Program (Prescribed Burning)

Smoke Management Program and Rules: <https://www.oregon.gov/ODF/Fire/Pages/Burn.aspx>

- As informed by Oregon's climate and health work, we are in a "new normal" of recurring extended wildfire seasons that may be increasing the severity of human health impacts from wildfire.
- Prescribed burning is one of the few management tools available to reduce the intensity of wildfires. In February 2019 ODF and DEQ adopted new Smoke Management Rules related to prescribed burns.
- The prescribed burn season is generally fall and spring. Eastern Oregon started experiencing smoke from prescribed burns in mid-September. Prescribed burns will begin mid-October in the western counties.
- To protect the public's health from smoke exposure resulting from a prescribed burn, communities designated by the Oregon Board of Forestry as Smoke Sensitive Receptor Areas (SSRA), are **encouraged** to develop a community response plan to protect the public's health from smoke and warn of the dangers of smoke.
- Community Response Plans should be coordinated through Local Public Health Authorities but are driven by entities wanting to do prescribed burning (land owners) and regional Oregon Department of Forestry and Department of Environmental Health Offices.
- Entities in a SSRA designated community wanting to do more prescribed burning, may seek an exemption. An exemption **requires** a community response plan that is coordinated through the local public health authority and approved by local governing body in coordination with the county board of commissioners.
- The new rules offer an opportunity to exercise the foundational capabilities we are building through modernization. Much of the wildfire smoke preparedness and response work you do, the partnerships, health messaging and tools apply.
- The Public Health Division is here to help. If there are questions, counties can reach out to their liaison Andrew Epstein or Kari Christensen.

2015-2019 State Health Improvement Plan

Oral health and Tobacco



OFFICE OF THE STATE PUBLIC HEALTH DIRECTOR
Public Health Division

Improve oral health



Key Questions

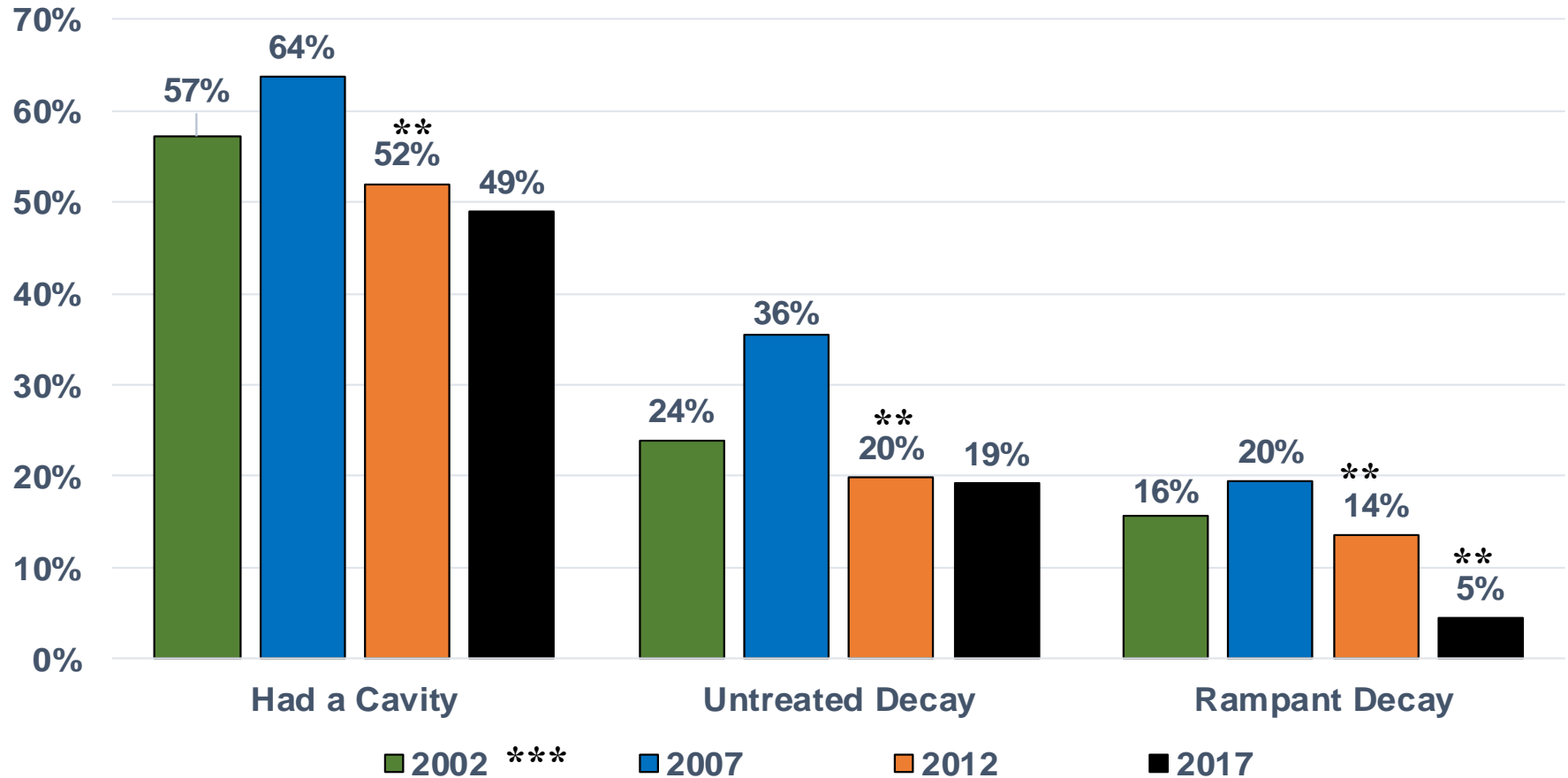
- How do we ensure oral health is integrated into all of the priority areas for the 2020-2024 SHIP?
- What community levers should we be using to continue the momentum built around oral health given funding and partnership challenges?
- How do we move towards more population-based oral health efforts across the system of care?

Priority Targets

Measure	Baseline	Current Data	2020 Target	Data Source
3 rd graders with cavities in their permanent teeth	15.5% (2012)	7.6% (2017)	14%	Oregon Smile Survey
Adolescents who have had one or more cavities	8 th grade: 70.1% 11 th grade: 74.0% (2013)	8 th grade: 68.7% 11 th grade: 75.1% (2015)	70%	Oregon Healthy Teens Survey
Adolescents (ages 12-17) who had one or more oral health problem	17.5% (2016)	13.3% (2016-2017 two-year estimate)	15.8%	National Survey of Children's Health
Prevalence of older adults (>65) who have lost all their natural teeth	17.7% (2010)	13.7% (2017)	12%	BRFSS

2017 Oregon Smile Survey Data

Oral health status,* children 6-9 years old, Oregon,
2002 – 2017 Smile Surveys

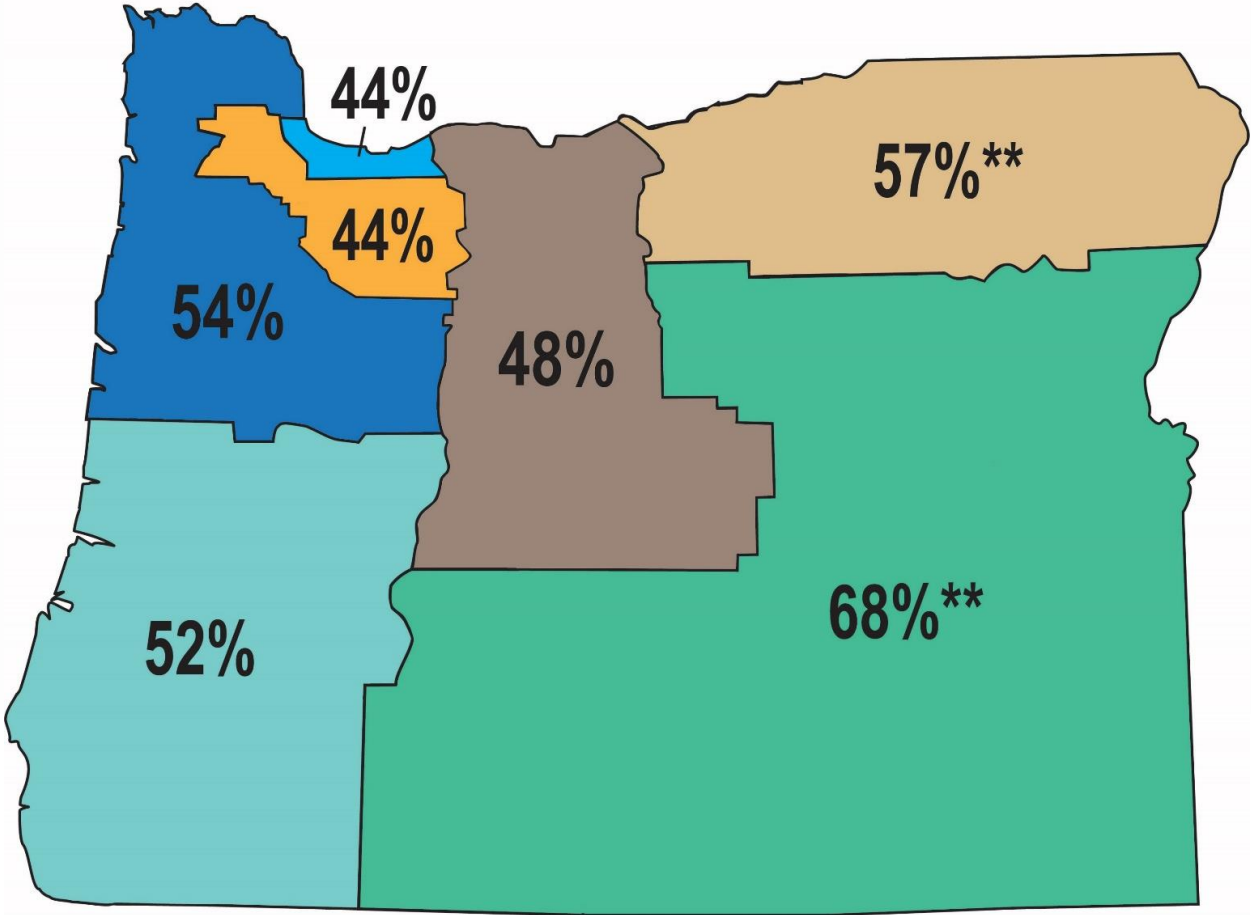


* Primary and permanent teeth

** Statistically significant change from previous survey
*** Methodology was different (opt-in versus passive)

Point #1: Substantial disparities still exist in oral health for Oregon's children

Cavity rates* by geographic region, Oregon, Smile Survey 2017

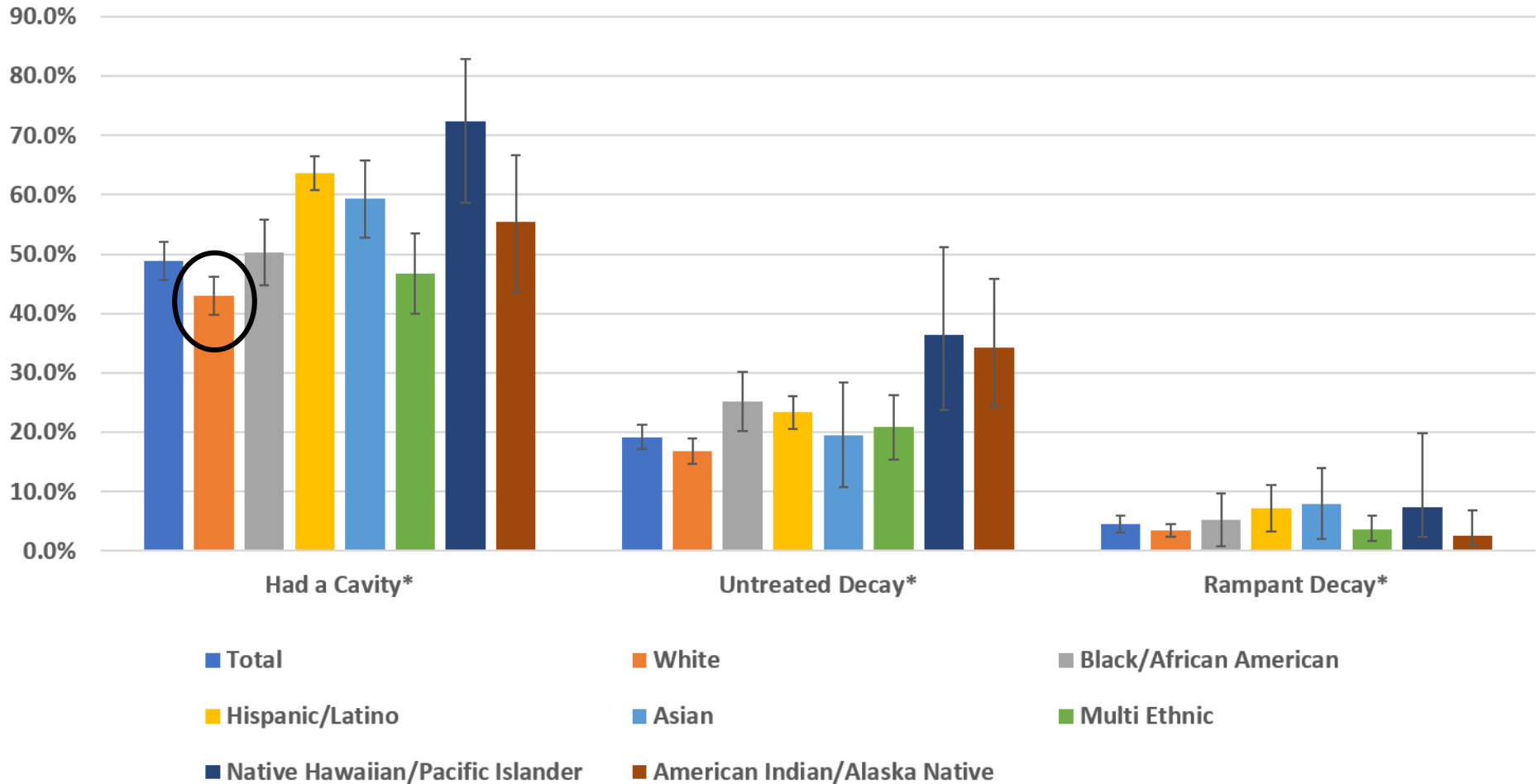


* 6- to 9-year olds, primary and permanent teeth

76 ** Statistically different from the statewide average of 49%

2017 Oregon Smile Survey Data

Race/Ethnicity Alone, 2017



Point #2: Population-based oral health

- Oregon still ranks 48th in the nation for community water fluoridation (21.9%, 2018)
- Focus on increasing access to school oral health programs
 - School Dental Sealant Programs
 - 92% of eligible elementary and 79% of eligible middle schools served (2018-19 school year)
 - CCO incentive metric for dental sealants ends this year
 - PHD School Fluoride Tablet/Rinse Program
 - 43 schools participating this year compared to 70 schools (2013-14 school year)
 - One fluoride tablet manufacturer left in the U.S.
- Opportunity in CCO 2.0 to focus on population-based efforts

Point #3: Capacity and partnership concerns

- Reduced State Level Capacity
 - HRSA oral health workforce grant went to the OHA Primary Care Office after being in PHD from 2009-2018
 - Have not received a CDC oral health infrastructure grant since developing the Oral Health Unit from the 2003-2008 grant cycle
- Limited Local Level Capacity
 - Title V funding supports 15 LHDs and 2 Tribes to work on oral health activities from July 2019 – June 2020
- No new funding opportunities are on the horizon

Point #3: Capacity and partnership concerns

- Diminished Partnership Capacity
 - National organizations that states rely on for technical assistance are struggling or have ceased operations
 - Oregon Oral Health Coalition
 - Changing its current business model due to extremely limited funds
 - Impact unknown at this time:
 - *First Tooth* and *Maternity Teeth for Two* training programs
 - Support for local regional oral health coalitions

Feedback & Discussion

- How do we ensure oral health is integrated into all of the priority areas for the 2020-2024 SHIP?
- What community levers should we be using to continue the momentum built around oral health given funding and partnership challenges?
- How do we move towards more population-based oral health efforts across the system of care?

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Prevent and reduce tobacco use



Key Questions

Priority Targets

Measure	Baseline	Current Data	2020 Target	Data Source
Cigarette smoking among 11 th graders	10% (2013)		7.5%	Oregon Healthy Teens
Other tobacco use (including e-cigarettes) among 11 th graders in past in past 30 days	18% (2013)		15%	Oregon Healthy Teens
Cigarette smoking among adults	18% (2013)		15%	BRFSS

Point #1

Point #2

Point #3

Feedback & Discussion

Contact

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