AGENDA

PUBLIC HEALTH ADVISORY BOARD

September 5, 2017
1:00-4:00 pm
Portland State Office Building, 800 NE Oregon St., Room 1A, Portland, OR 97232

Join by livestream
Conference line: (877) 873-8017
Access code: 767068

Meeting objectives
- Approve July meeting minutes
- Discuss tobacco prevention funding and evaluation findings
- Adopt Guiding Principles for Public Health and Health Care Collaboration
- Discuss new charter template

Time	Item	Presenter
1:00-1:20 pm	**Welcome and updates** • Approve July 20 meeting minutes • OHA update • State Health Assessment • Public health rulemaking • Local public health authority transitions	Jeff Luck, PHAB Chair
1:20-1:50 pm	**Subcommittee updates** • Accountability Metrics Subcommittee update • Health Plan Quality Metrics Subcommittee relationship to public health accountability metrics	Jennifer Vines, PHAB member Jeff Luck, PHAB Chair Shaun Parkman, Health Plan Quality Metrics Committee
1:50-2:10 pm	**Tobacco prevention evaluation findings** • Share findings from evaluation of tobacco funding opportunities • Discuss next steps	Shaun Parkman, Oregon Health Authority
2:10-2:30 pm	**Break**	

Time	Item	Presenter
2:30-3:05 pm	**Guiding Principles for Public Health and Health Care Collaboration** • Hear about Columbia Pacific CCO's framework for collaborating with local public health • Discuss feedback gathered by PHAB members • Vote to adopt guiding principles	Jeff Luck, PHAB Chair
3:05-3:20 pm	**New PHAB charter template** • Discuss purpose of new charter template • Discuss and adopt updated charter	Cara Biddlecom, Oregon Health Authority
3:20-3:35 pm	**Public comment**	
3:35 pm	**Adjourn**	Jeff Luck, PHAB chair

Public Health Advisory Board (PHAB)
July 20, 2017
Draft Meeting Minutes

Attendance:
Board members present: Carrie Brogoitti, Muriel DeLaVergne-Brown, Jeff Luck, Safina Koreishi, Rebecca Pawlak, Alejandro Queral, Teri Thalhofer, and Tricia Tillman

Oregon Health Authority (OHA) staff: Isabelle Barbour, Sara Beaudrault, Cara Biddlecom, Danna Drum, Christy Hudson, Britt Parrott, and Angela Rowland

Guests: Kathleen Johnson

Approval of Minutes
A quorum was not present. The Board could not approve the May 18, 2017 minutes.

Welcome and updates
-Jeff Luck, PHAB chair

- Diane Hoover has left her position as public health administrator in Josephine County and has since resigned from the Board.
- HB2310 requires a tribal representative as a PHAB member.
- Both Board positions will be filled soon.
- State Health Assessment steering committee met on July 12. The Health Status Assessment subcommittee will be reviewing quantitative data and the Themes and Strengths Assessment subcommittee will be reviewing qualitative data. Community listening sessions will be scheduled across the state in October.
- Wallowa County had an administrator resign and appointed a new one. They are partnering with a clinic in the community to provide direct services. WIC will no longer be provided by the health department, as Head Start will take over that role.
- Lake County is moving forward to contract their public health services with the hospital. Josephine County might change the way public health services will be delivered as well.
- Staffing and budget situations at the local level are moving quickly. Future local health department transitions will be shared with the Board via email.

AIMHI grant update
-Kathleen Johnson, Coalition of Local Health Officials (CLHO)

Today is Kathleen's last day with CLHO. She is moving to Washington County Public Health in non-regulatory environmental health.

Kathleen provided an overview of the Aligning Innovative Models for Health Improvement (AIMHI) meeting findings. These ten meetings were held across the state with 453 attendees from a wide array of sectors.

Since funding was noted but not the focus of the AIMHI meeting discussions, the data showed that change management was the biggest challenge for implementing modernization. Other challenges to note were resources, politics and culture, and workforce capacity.

Opportunities for cross-jurisdictional sharing were identified for assessment and epidemiology, leadership and organizational competencies, and communications. The maps of current cross-jurisdictional sharing arrangements by foundational programs and capabilities across the state were discussed.

Kathleen reviewed the Public Health National Center for Innovation (PHNCI) Oregon 2017 public opinion polling data, which provided information on voter perceptions about public health departments. Respondents thought that supporting women's and children's health, preventing communicable disease, and public health emergency response were most the most important public health services. They also want to ensure that every community in Oregon receives public health services and agreed that this should be a government priority. Respondents were equally divided on whether they consider direct public health services or protecting the entire population from threats to be more important. Polling information can be used as we continue to develop communications strategies for understanding and perceived value of public health.

The next steps for the AIMHI grant will involve developing a public health modernization roadmap (to debut at the CLHO retreat in September), providing technical assistance to LPHAs and ongoing communications work.

Tricia asked what percentage of voters were unaware of what public health does. Kathleen will look at the data.

Action Item: The polling reports and AIMHI report will be sent to Board members.

<u>**State Health Improvement Plan (SHIP)**</u>
Suicide Prevention
-Lisa Millet, Injury and Violence Prevention Program

The SHIP priority targets for suicide are to decrease the rate of suicide, suicide attempts, and emergency department visits for suicide attempts. The successes for suicide prevention in Oregon include the establishment of a data dashboard which provides interactive suicide data by county; helping CCOs to meet benchmarks for depression screening; passage of Senate Bill 48 related to suicide training for health professionals; and the expansion of the Zero Suicide

Initiative. The Zero Suicide Initiative is a commitment to suicide prevention in health care and behavioral health systems and includes a specific set of strategies and tools. The challenges for suicide prevention are access to complete data, the ability to ensure community implementation of services to promote safe and nurturing environments, and tackling the disparities that exist, especially among veterans.

Tricia asked whether information about suicide risk among veterans is available by race and ethnicity, and what culturally specific interventions the program is doing. Lisa has Oregon military data regarding race and ethnicity and the Department of Veterans Affairs has a few culturally-specific interventions. Tricia asked about belongingness and what data are available for suicide by law enforcement in the African American community.

Safina asked if there is ability link suicide data to substance use data. Lisa commented that these conversations are happening. Safina encourages the state to look into the Adverse Childhood Experiences (ACEs) interventions.

Teri commented that at the local level suicide prevention may sit within the behavioral health department. The level of involvement of local public health and behavioral health on suicide prevention varies across the state and could benefit from closer collaboration.

Jeff asked whether data are available on completed suicides among individuals who sought mental health assistance within the prior two to three weeks. Lisa stated 30-40 percent.

Safina inquired if the data dashboard lists the county of residence or location where the suicide occurred. Lisa answered that it is the county of residence.

Oral Health
-Cate Wilcox, Maternal Child Health Section Manager
-Bruce Austin, State Dental Director
-Amy Umphlett, Oral Health Unit

The SHIP priority targets are third graders with cavities in permanent teeth; adolescents who have had one or more cavities; and prevalence of older adults who have lost all their natural teeth. Successes include expansion of school oral health services statewide and an oral health focus in the Maternal & Child Health Title V Block Grant. In addition, oral health integration work is happening across the Oregon Health Authority through a community water fluoridation workgroup, monthly OHA oral health team meetings, and OHA oral health work plan and evaluation plan that aligns with the SHIP. Some challenges include attempts to roll back community water fluoridation, limited staff capacity, and insufficient funding to focus on adult and senior oral health care issues.

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The Dental Pilot Projects were created through statute to help train advanced practice dental hygienists across the state. The REAL+D questionnaire for schools in 2017-18 school year only reaches 20-25 schools. The school dental sealant program has been developed to certify local school dental sealant programs. The program is offered to all students regardless of insurance status. It has been difficult to get schools to participate in Smile and Healthy Growth surveys.

The oral health staff asked for advice from the PHAB on how to keep making improvements when benefits decrease.

Cate asked about the intent of PHAB's accountability measure on dental visits for children 0-5. Eli was a strong advocate for the measure since there wasn't any other oral health metrics chosen. Safina said it is important from the systems perspective since children should see a dentist by their first year.

The presenters also asked the PHAB how to address water fluoridation in Oregon.
Teri stated that dentists may not come forward until there is a problem. There are also silos between primary care, pediatric and dental providers.

Tricia applauded the workforce development work happening. She recommended building community trust to help move this work along in fluoridation. She inquired about what successes there have been with CCOs. The statewide dental sealant program has operated through general funds since 2007, serving 150 schools. Once the CCO dental sealant measure came on board, programs were developed to operate in schools. OHA is shifting their role to assurance but more schools are being served. Tricia stated that some initial work on REAL+D was related to working with school districts that collect data.

Guiding Principles for Public Health and Health Care Collaboration
This agenda item was slated for a later meeting.

Subcommittee updates
-Incentives and funding subcommittee July 11, 2017

The subcommittee discussed using general fund investment for local public health authorities in a two track funding award. This approach received general approval from the subcommittee.

- **Track 1** Funding on communicable disease control and reducing health disparities with regional partnerships
- **Track 2** Capacity building

CLHO would like more outcomes driven in track 2 with more flexibility to align with the local need. There was an overall consensus with this model.

Katrina asked why health disparities and communicable disease control is not separated. Cara stated that the subcommittee felt since this will be a small initial investment, it would be best to combine them by using data within each jurisdiction for targeting those communicable disease issues and where disparities exist.

Katrina asked which specific communicable diseases is the state looking to improve. Teri stated there was a discussion at CLHO and under Collette Young's advice not to pick just one disease for the entire public health system. This will allow local public health authorities to focus on individual needs while building a communicable disease control system that will work for any disease they encounter in the future.

Track 2 is focused on counties ready to implement public health modernization but are in need of partners. If no one applies for track 2 then all funds go to track 1. And in reverse, if many counties apply for track 2, possibly more money could go to track 2. Carrie commented that there is a need to go to legislature to show how investment makes outcomes.

Public Health Modernization implementation updates

Public Health Modernization Timeline:

- July - PHAB and JLT funding concept developed
- August - OHA finalizes RFP
- September - RFP released
- October - proposals submitted
- November - notices to award issued
- December - finalize contracts
- January 2018 - funds allocated

Action item: Provide a brief email highlighting this discussion.

Cara noted the successes so far include that HB2310 passed unanimously in both chambers and the legislature made a $5M initial investment in public health modernization.

Public Comment Period

No public testimony was provided.

Closing

The meeting was adjourned.

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

September 5, 2017
1pm – 4pm

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Portland State Office Building
800 NE Oregon St., Room 1A
Portland, OR 97232

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Angela Rowland at (971) 673-2296 or angela.d.rowland@state.or.us. For more information and meeting recordings please visit the website: healthoregon.gov/phab

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Oregon Health Authority

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics subcommittee meeting minutes

August 23, 2017

PHAB Subcommittee members in attendance: Eva Rippeteau, Teri Thalhofer and Jen Vines

Oregon Health Authority staff: Isabelle Barbour, Sara Beaudrault, Vicky Buelow, Steve Fiala, Joey Razzano, Angela Rowland, Amy Umphlett, Steve White and Cate Wilcox

Members of the public: Ken House, Rosa Klein, Channa Lindsay and Danielle Sobel

Welcome and introductions

The May 31, 2017 meeting minutes were approved.

Subcommittee updates

- Eli Schwarz will be doing a presentation to the Metrics and Scoring Committee in September on the accountability metrics.
- Public Health Division (PHD) is creating a webpage for accountability metrics
- PHD is writing rules for HB3100 and 2310 to include accountability metrics and pieces of the funding formula related to incentives and matching funds. A few PHAB members sit on the Rules Advisory Committee. The rules add that PHD will consult with PHAB and local public health when updating the metrics.

Active Transportation

Although an active transportation metric was adopted by PHAB in June, PHD does not have an established measure for active transportation. Measures of active transportation exist, but these measures are either too narrow in scope or they don't currently meet the required selection criteria established by PHAB. PHD staff requested a recommendation from this subcommittee for which existing measure to use now to begin reporting on active transportation. PHD staff also requested a recommendation for developing a measure that will meet selection criteria for active transportation.

Steve White from PHD presented information on existing measures of active transportation, including the types of active transportation activities measured, sample size and frequency of measurement, survey method, and whether results are available by race/ethnicity and at the county level.

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PHD staff recommend using the *Percent of commuters who walk, bike, or use public transportation to get to work* by the American Community Survey now to report on active transportation. PHD staff feel that enhancing the Oregon Household Activity Survey (OHAS) is the best route to an active transportation measure that meets PHAB's selection criteria.

OHAS is currently fielded on an infrequent basis. Jen asked about a plan for doing the Oregon Household Activity Survey (OHAS) more frequently. Steve stated that Oregon Department of Transportation (ODOT) is responsible for this survey, and fielding it more frequently will require resources that are not currently available. Since this is an ODOT survey, this is an opportunity for public health and transportation to work together to develop and support a metric that meets both agency's needs. PHD and ODOT have an established relationship.

Isabelle Barbour from PHD will present at the September 5th PHAB meeting to discuss the upcoming joint Oregon Transportation Commission meeting with the PHAB.

Decision: There was consensus among subcommittee members to recommend that the existing ACS measure (*Percent of commuters who walk, bike, or use public transportation to get to work*) be used now to report on active transportation. Subcommittee members also recommended that, moving forward, PHD pursue opportunities to enhance the OHAS survey. These recommendations will be discussed with PHAB on September 5.

Health Outcome Metrics

Sara provided updates on the health outcome metrics adopted in June 2017.

The PHAB had a conversation about the "for consideration" measures including *secondary salmonella infections, new hepatitis C cases, youth who smoke cigarettes*, etc. and requested that these measures are reported on, in addition to the eight selected public health accountability metrics. The "for consideration" measures are reported on annually as part of the state public health indicators. These measures can also be a starting point for future discussions when public health accountability metrics needs to be reviewed and updated. Jen recommended removing the *secondary salmonella infection* measure as an additional measure.

The PHAB also requested that PHD report on both prescription opioid and heroin overdoses for the opioid overdose deaths metric. PHD can provide data on both.

The *dental visit for 0-5 year* old metric doesn't have an established measure at this time. This subcommittee will review existing measures and data sources at the September meeting and make a recommendation for which to use to begin reporting on dental visits for children.

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CLHO Committee Process measure development

The Coalition of Local Health Officials (CLHO) committees are looking at process measures to measure local public health department activities and outputs that are essential for meeting the public health accountability metrics. The subcommittee will review proposed process measures in September.

Subcommittee Business

Jen will provide the subcommittee update at the September PHAB meeting

The subcommittee will move their standing meeting time to the fourth Wednesday of the month from 1:00-2:00 pm. The September meeting will be held on September 26th from 1-2pm.

Public Comment: No public testimony.

Adjournment

The meeting was adjourned.

The next Accountability Metrics Subcommittee meeting is scheduled for:

September 26, 2017 from 1-2pm.

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Potential Active Transportation Metrics: Transportation Behavior and Mode Share Measures

Prepared by: Vicky Buelow and Eric Main (OHA Research Analysts), July 2017

Measure	Percent of Oregon commuters who walk, bike, or use public transportation to get to work	Percent of trips made by walking or biking among Oregonians	Percent of Oregon commuters who usually bike or walk to work or school	Any use of alternative transportation (walk, bike, or public transportation)	Commute days by public transportation, walking, or biking in past week
Data Source	American Community Survey (ACS)	Oregon Household Activity Survey (OHAS)	ODOT Transportation Needs and Issues Survey	HPCDP Prevention Panel Survey	Oregon Behavioral Risk Factor Surveillance System (BRFSS)
Survey method	Multi-method (web, mail, telephone, in-person) survey of Oregon households.	Travel diary survey (web, mail, phone) of Oregon households to identify where and how they traveled on a specific, designated 24 hour travel day. Multi-agency effort (ODOT/Metro).	Web and mail based survey of Oregon households selected by stratified random sample based on ODOT regions.	Online web-based survey of Oregon adults recruited from a panel based on age, sex, and region quotas.	Telephone survey of Oregon adults selected via random-digit dialing.
Sample size	~27,000 households	~18,000 households	~2,000 households	2,000	~1,050
Description	Questionnaire asks "How did this person usually get to work LAST WEEK? If this person usually used more than one method of transportation during the trip, mark the one used for most of the distance."	Respondents were asked to record their transportation mode for all trips made during a 24 hour period.	Respondents were asked "How do you usually get to work or school?"	Respondents are asked: "In a typical week, do you walk, bike, ride a bus, or use another type of public transportation to get to or from places? For example, to work, to school, for shopping, or to run errands." (Yes/No)	Respondents were asked a series of 4 questions: "During your last work week, on how many days did you drive/take public transportation/walk/bike to get to work?"
Results	4.2% Walk; 2.4% Bike; 4.2% Public transit (2013 3-year estimate)		4.1% bike / 3.5% bus / 1.5% Max or Light Rail / 1.6% walk (2017)	41% of Oregon adults reported "Yes" (Spring 2017)	10.7% of Oregon adults walked; 4.4% biked; and 6.8% took public transportation to work on *1 or more days* in the past week.

Potential Active Transportation Metrics: Transportation Behavior and Mode Share Measures

Prepared by: Vicky Buelow and Eric Main (OHA Research Analysts), July 2017

Oregon Health Authority

Measure	Percent of Oregon commuters who walk, bike, or use public transportation to get to work	Percent of trips made by walking or biking among Oregonians	Percent of Oregon commuters who usually bike or walk to work or school	Any use of alternative transportation (walk, bike, or public transportation)	Commute days by public transportation, walking, or biking in past week
Weaknesses	Refers to the work commute only.	Surveys conducted sporadically.	Refers to the work or school commute only.	Question has not been tested for validity.	Refers to the work commute only (only asked of employed adults). Questions have not been tested for validity.
Frequency	Annual	1994, 2011, planned for 2020	Every other year (odd)	Annual (planned)	2014
Statewide	Yes	Yes	Yes	Yes	Yes
By County/Region	3-year and 5-year estimates	Yes, but sample size is low in rural counties.	5 ODOT Regions	No	No
By Race/ethnicity	Yes	Asked on survey, unsure of reliability	Asked on survey, estimates are likely unreliable	No	No

Measuring active transportation for the Environmental Public Health accountability metric

Background

- The Public Health Advisory Board (PHAB) Accountability Metrics Subcommittee has recommended active transportation as an Environmental Public Health accountability metric for the public health system.
- Active transportation has transformative potential and cuts across public health areas and across sectors, supporting the concept of a modernized public health system that works across sectors to design and implement evidence-based, shared strategies for improving population health and reducing health care costs.
- The State Health Improvement Plan (SHIP) includes active transportation as an effective strategy for increasing physical activity and reducing obesity rates.
- Both the Oregon Public Health Division and the Oregon Department of Transportation are currently engaged in multiple efforts to increase active transportation rates across Oregon.

Current Active Transportation Surveillance Measures

Active transportation is measured in various ways in multiple state and national surveys (see accompanying matrix).

- Some surveys ask about the work commute only, while others ask about all trips. Some surveys ask about a usual mode of transportation, while others detail mode type for each trip.
- Each survey measures a distinct concept of transportation behavior, each with strengths and weaknesses.
- Ideally, surveys which ask about all trips and all modes over a certain period of time (using travel diaries) will provide the most complete and accurate picture of transportation behavior.
- The Oregon Household Activity Survey (OHAS) collects this data, but is conducted infrequently.

Criteria for Choosing an Active Transportation Measure

In addition to aligning potential measures with the five “must have” and five “additional important” Accountability Metrics Selection Criteria outlined in the PHAB Accountability Metrics Report, staff also determined that a useable active transportation measure should be based on data that:

- Comes from a sample size large enough to provide estimates by factors such as location (e.g., city, county), mode (e.g., bike, walk, transit), and demographics (e.g., age, sex, race/ethnicity)
- Measures a portion of active transportation large enough to serve as a rough proxy for overall active transportation rates.

Additional preferred criteria for the active transportation measure include consideration of whether the data:

- Measures all active transportation trips
- Comes on a sample size large enough to measure changes at the local (city) level since this is the level at which most active transportation strategies are implemented.

Measuring active transportation for the Environmental Public Health accountability metric

Oregon Health Authority

Recommendations

1. **Adopt the American Community Survey's "Percent of commuters who walk, bike, or use public transportation to get to work" metric as the measure of active transportation for the Environmental Public Health accountability metric.**

   None of the active transportation measures currently in place meet all of the minimum and preferred criteria. This mode share measure best meets all of PHAB's "must have" criteria and many of PHAB's "additional important" criteria, along with the additional active transportation criteria listed above. Until a better, more comprehensive measure is developed, it is recommended that this measure be used.

Strengths:	Weaknesses:
• Large sample size (~27,000 households) • Allows for local comparisons and analysis • Accompanied by demographic data • Updated annually (based on 3-year sampling and estimates) • Correlated with body mass index • Part of the US Census dataset, allowing for comparisons to other localities	• Captures work commute only, not trips made for other purposes (e.g., shopping, recreation, school). Active transportation commute trips make up less than half of all active transportation trips.

2. **Assess options to enhance existing surveillance systems that would provide a more comprehensive and precise measure of active transportation.**

   While the ACS measure can serve as a useful measure of active transportation in Oregon communities, PHAB should also consider expanding or adapting current surveillance systems to develop a more precise, comprehensive and useful metric that better meets all of the Accountability Metrics Selection Criteria.

   The best starting point for this would likely be the Oregon Household Activity Survey (OHAS) that ODOT conducts once every 8-10 years. This survey is based on respondents filling out a travel diary that captures data on all trips made by a person over a specific time period, providing information useful for both designing and assessing appropriate interventions. Increasing the sample size and frequency of this survey would provide PHAB and other active transportation stakeholders with a more robust and useful measure of active transportation in Oregon.

Overview of the Health Plan Quality Metrics Committee for the Public Health Advisory Board

September 5, 2017

Health Plan Quality Metrics Committee Overview

- Background & Statutory Charge
- Committee Mission and Vision
- Committee Membership
- Measure selection process and timeline
- Measure domains (for initial measure review)

Oregon Health Authority

Background & Statutory Charge

- Senate Bill 440 (2015) established the Health Plan Quality Metrics Committee (HPQMC) as the single body to align health outcome and quality measures used in the state

- SB440 includes criteria (summarized below) to guide the committee's measure selection, including prioritizing measures that:
  - Have been adopted or endorsed by other state or national organizations and have a relevant benchmark
  - Are not prone to random variation
  - Rely on existing data systems to the extent practicable
  - Use a common format in the collection of data and facilitate public reporting
  - Can be meaningfully adopted for a minimum of three years
  - Can be reported in a timely manner

- The committee shall ensure that measures are coordinated, evidence-based, and focused on long term statewide vision

Oregon Health Authority

Background & Statutory Charge

- The committee adopted additional criteria, consistent with the intent of SB 440, to guide their measure selection process, including that individual measures selected
  - Present an opportunity for performance improvement
  - Promote increased value to providers, patients, and purchasers

- And criteria to ensure that the measures set as a whole
  - Represents the array of services that affect health
  - Represents the diversity of patients served
  - Is collectively parsimonious
  - Includes measures with transformative potential

Background & Statutory Charge

- HPQMC is a committee of the Oregon Health Policy Board (OHPB)
- Quality measures selected by HPQMC apply to coordinated care organizations, health benefit plans sold though the health insurance exchange and benefit plans offered by the Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB)
- These state health care programs are not required to adopt every quality measure selected by HPQMC, but cannot adopt any measures that are different from the measures selected by HPQMC
- The committee is required to establish a process for regular and ongoing evaluation of measures selected for the aligned measures set

Committee Vision and Mission

HPQMC has adopted a vision and mission statement to guide their selection of aligned state quality measures.

Vision

Aligned measurement to promote optimum health and wellbeing for all Oregonians.

Mission

Improving physical, behavioral and dental health for individuals and communities through meaningful and timely quality measures to guide health care purchasing and value.

Oregon Health Authority

Committee Membership

Fifteen members appointed by the Governor, including:

- One individual to represent each of the following:
  - Oregon Health Authority
  - OEBB
  - PEBB
  - Department of Consumer and Business Services (DCBS)
  - Hospitals
  - Insurers, large employers, or multiple employer welfare arrangements
  - Health care research expert
  - Health care quality measurement expert
  - Mental health and addiction services expert
- Two individuals to represent each of the following:
  - Health care providers
  - Health care consumers
  - Coordinated care organizations
- Committee members were appointed to one year terms in April 2017 with the potential for reappointment

Oregon Health Authority

Measure Selection Process & Timeline

- HPQMC adopted 12 domains to organize initial review of potential measures
- Candidate measures within each domain are identified by reviewing eight existing state and national measures sets and evaluating the measures within these sets against the committee's criteria
- Additional candidate measures are to be identified by consulting a broader measure "library" for domains where few candidate measures are found in the initial state and national sets reviewed
- Once the candidate measures in all 12 domains are reviewed the committee will evaluate the initial draft measures set to identify gaps and ensure the measures set as a whole meets the committee's criteria
- The committee will seek comment from stakeholders as they refine the draft measures set prior to adopting a final measures set

Oregon Health Authority

Measure Selection Process & Timeline

- Currently the committee expects to complete initial review of measures in all 12 domains in late fall
- An initial draft measures set is targeted for early 2018
- A final version of the aligned measures set is expected in spring 2018. At this time the committee will also establish an ongoing annual process for measure set review and refinement

Oregon Health Authority

Measure Domains (for initial candidate measure review)

- HPQMC has adopted the 12 domains listed below to categorize measures for initial review

Prevention/Early Detection	Dental Health
Behavioral Health	Overuse/Waste
Chronic Illness Conditions	Patient Experience
Acute Illness Conditions	Provider Satisfaction
Inpatient Care	Cost/Efficiency
Maternity Care	Access

- The committee will not necessarily organize the final measures set in these same domains and plans further deliberations on their framework for structuring the final aligned set

Oregon Health Authority

Questions?

Margaret Smith-Isa, MPP
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(503) 378-3958

The HPQMC meets the 2nd Thursday of each month. Meeting agendas, minutes, materials, and recordings can be found on the committee website:

http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Quality-Metrics-Committee.aspx

Oregon Health Authority

Evaluation of Tobacco Competitive Funding

Shaun Parkman, Evaluation Lead
Public Health Advisory Board

Sept. 5, 2017

Tobacco Prevention and Education Program (TPEP)

- Comprehensive Program: State and **Community Interventions**; Health Communication Interventions; Cessation Interventions; Surveillance and Evaluation; Administration and Management

TPEP Community Interventions

- All Counties and Tribes receive **base funding** for policies, systems, and environmental changes for controlling tobacco.
- Since 2014, funding provided for two **competitive grants** to local communities: SPArC and SRCH.

Strategies for Policy And environmental Change (SPArC)

- **Eligibility:** Local Health Departments
- **Goal:** Accelerate tobacco control policies in the retail environment
- **# Funded:** 9 grantees covering 13 counties

Sustainable Relationships for Community Health (SRCH): A local approach for building cross-sectoral partnerships

- Eligibility: **Coalitions** of Coordinated Care Organizations (CCO); Local public health authorities; Clinics; Community partners
- Goal: Create sustainable, effective relationships between community partners to **improve access, quality and cost** of preventive chronic disease self-management services (including tobacco cessation services)
- # Funded: **8 CCOs & 10 local health departments** have been funded in coalition models

How do we know if these worked?

Evaluation

A program evaluation is a systematic study using research methods to collect and analyze data to assess **how well a program is working** and why.

United States Government Accountability Office, Designing Evaluations, 2012 Revision

Purpose

Program evaluation studies are typically requested or initiated to provide external **accountability** for the use of public resources or to learn how to **improve performance**—or both.

Did SPArC work?

SPArC Results

- All grantees **passed** best-practice tobacco retail **policies**
- SPArC grantees had **more advancements** through the policy change process on more policies than non-SPArC counties.

Did SRCH work?

SRCH Results

- All 8 CCOs & 10 local health departments implemented **referral systems** to the tobacco quitline
- Multiple new **formal partnership** agreements secured
- Inspired new **shared projects**
  - Electronic referrals to the tobacco quitline

More SRCH Outcomes

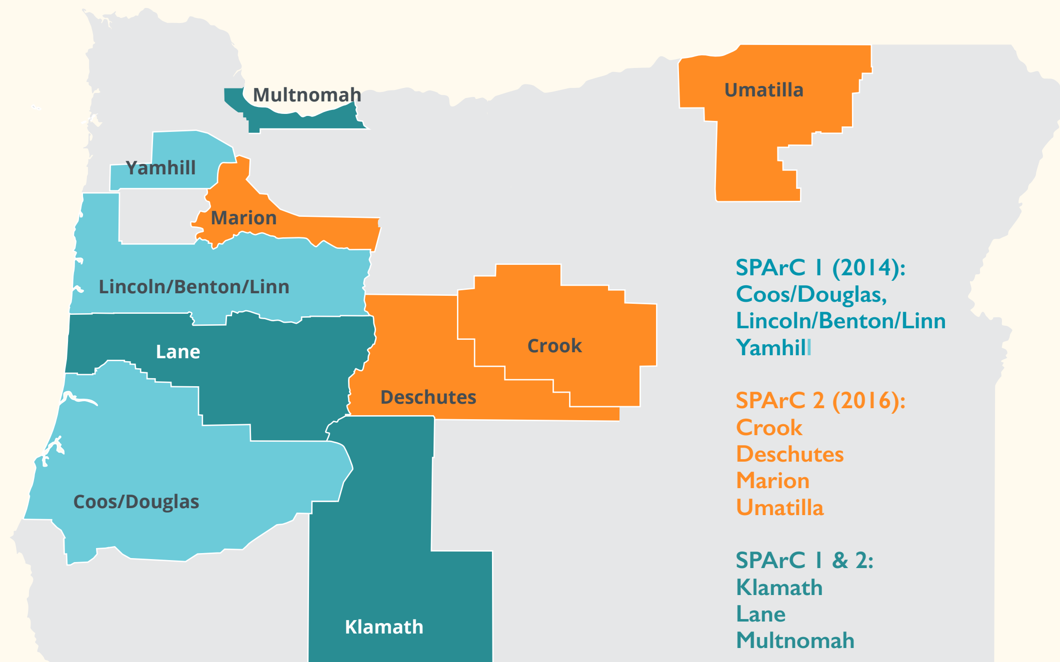
- Clackamas County & Dental Clinics screened **11,292 patients** for tobacco use and provided tobacco counseling to over **500 patients**
- Lincoln County implemented a system to **screen over 99%** of Federally Qualified Health Center patients for tobacco.
- Lane County **increased to 84%** the number of community health center patients with tobacco status documented.

(Enter) DEPARTMENT (ALL CAPS)
(Enter) Division or Office (Mixed Case)

Issue Brief:
SPArC Grants and Tobacco Retail Policy

July 2017

2014 & 2016 SPArC Grantees



Background

In 2014 and 2016, the Oregon Health Authority provided competitive funding opportunities to local health departments (LHDs) to advance tobacco prevention policy, systems, and environmental change. This funding opportunity, called Strategies for Policy And enviRonmental Change (SPArC) Tobacco-Free was intended to complement, build upon, or accelerate, but not duplicate, the current local health department tobacco prevention work.

This report focuses on SPArC grantees' achievement in the area of tobacco prevention in the retail environment.

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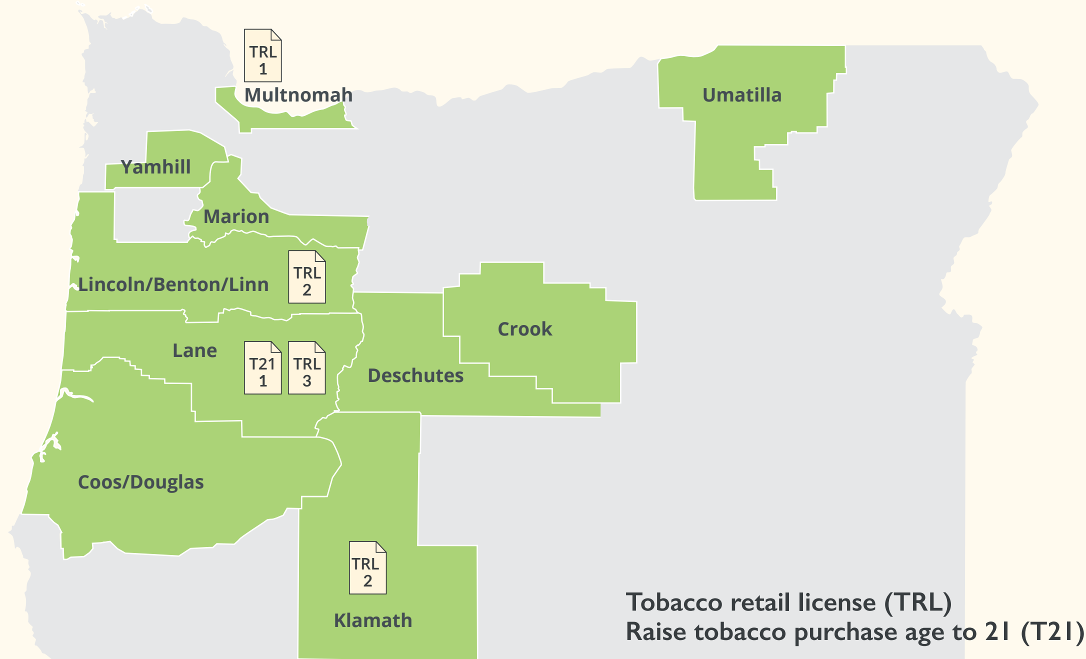
2014 & 2016 SPArC Grants

- SPArC grantees were encouraged to work with their local Coordinated Care Organizations, Regional Health Equity Coalitions, Tribes, and other community organizations representing local populations disproportionately impacted by tobacco products to implement recommendations from the Centers for Disease Control and Prevention Best-Practices for Tobacco Control.
- In 2014, six projects were funded serving nine counties.
- In 2016, seven projects were funded serving seven counties. SPArC 2 funding was focused on tobacco prevention and control in the retail environment.

+ **All grantees with both SPArC 1 & 2 funding passed best-practice tobacco retail policies**
+ **SPArC grantees had more advancements through the policy change process* on more policies (per county) than non-SPArC counties**
+ **Grantees who have never received SPArC funding have not passed tobacco retail policies and are (on average) at the very initial stages of the policy change process**

All Tobacco Retail Policies Passed Were In SPArC Project Counties



The following tables compare policy progress in SPArC funded counties with non SPArC funded counties:
ever = Counties that received SPArC funding in either cycle,
SPArC 2 = Counties that received grants in the grant cycle focused on the tobacco retail environment, and
never = Counties that have never received SPArC funding.

LHDs that have passed one or more tobacco retail policy:

	percent of LHDs
ever (n=13)	31%
SPArC 2 (n=7)	43%
never (n=21)	0%

Average progress through the policy change process* made by each LHD on their main policy strategy:

	average stages progressed
ever (n=13)	1 stage
SPArC 2 (n=7)	2 stages
never (n=16)	1 stages

LHDs that had engaged tobacco retailers (beyond the required tobacco retailer assessment):

	percent of LHDs
ever (n=13)	46%
SPArC 2 (n=7)	57%
never (n=17)	12%

LHDs that had taken steps to educate others in their organization or community about preemption:

	percent of LHDs
ever (n=11)	62%
SPArC 2 (n=7)	86%
never (n=20)	69%

Average current stage of policy strategies as of June 2017:

	policy strategy stage
ever (n=13)	stage 4
SPArC 2 (n=7)	stage 5
never (n=20)	stage 2

LHDs that had engaged partners through a tobacco coalition or community coalition whose mission is broader than tobacco prevention:

	percent of LHDs
ever (n=13)	38%
SPArC 2 (n=7)	57%
never (n=18)	56%

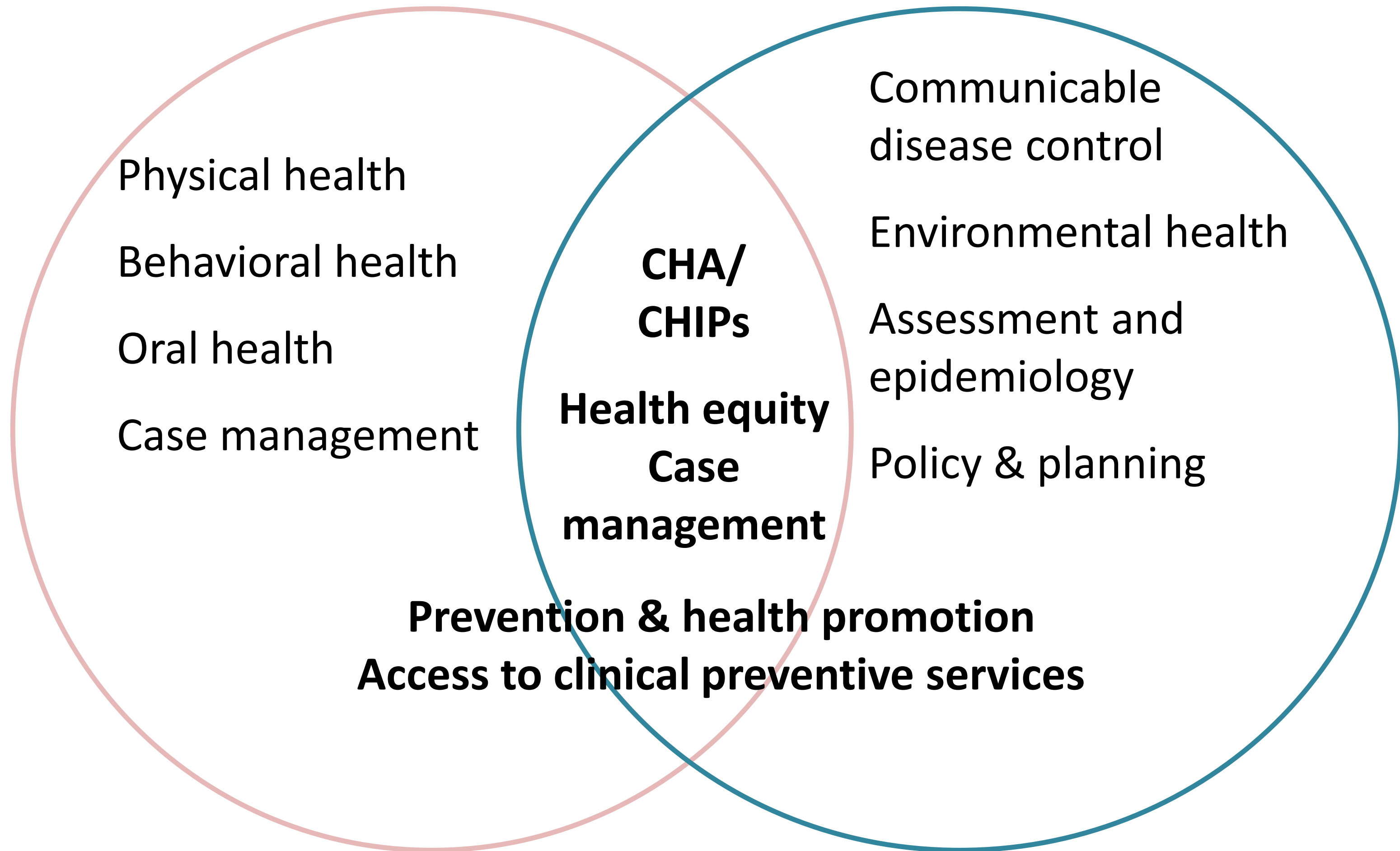
*Policy Change Process

The HPCDP Policy Change Process Model includes eight stages for changing local policy. TPEP Grantees use this model to guide their work and evaluate progress on various local policy initiatives. The eight stages are: 1. Identify & frame the problem, 2. Engage stakeholders & community, 3. Assess readiness for policy change, 4. Reach out and educate, 5. Draft policy & plan for implementation, 6. Adopt policy, 7. Implement policy, and 8. Evaluate impact.

CPCCO framework for collaboration with local public health

Safina Koreishi, MD MPH

Opportunities for partnership



Collaboration

- Shared meeting with 3 PH directors and CCO leadership
- Discussed shared priorities
- Used ease and impact scale to determine focus areas

Collaboration framework

Priority: Increase <2y/O & Decrease School Exclusions

Goal: minimum increase of 5% for each county:

Immunizations

Public Health Work
Outreach/homevisits

- Imms assessment
- Patient Education
- Administration
- Reporting
- Promotion
- School exclusion

CPCCO Work: (Clinical)

- Education: provider & member
- Workflows
- Messaging
- Advocacy
- Incentives
- Analytics/QI
- *Barrier: Access*

Timelines and deadlines…

PH/CPCCO Leads:

Public Health Advisory Board

Draft: Guiding principles for public health and health care collaboration

~~May 19~~July 10, 2017

1. Purpose

This set of guiding principles is a tool that professionals can use to build collaborations between public health and the health care sector. This tool is a starting place for ideas that public health and health care can implement to reach common goals.

2. Guiding Principles

Value statement: We will not see meaningful improvement in population health without cross-sector collaboration. (Statewide Public Health Modernization Plan).

- Ensure broad, cross-sector collaboration between public health; coordinated care organizations (CCOs), hospitals and other groups within the health care sector; early learning and education; and community-based organizations to improve population health.
- Leverage existing opportunities for cross sector collaboration (i.e., community health assessments and community health improvement plans). (Public Health Modernization Manual)

Value statement: Direct services to individuals, including clinical interventions, are supported by~~The expertise that~~ the public health system's focus on ~~holds in~~ prevention; policy, systems and environmental change; and evidence-based strategies to improve population health. ~~supports direct services to individuals, including clinical interventions.~~ (Statewide Public Health Modernization Plan, CDC 6|18 Initiative)

- Ensure a comprehensive spectrum of strategies are in place for assessing, developing and implementing shared priorities.

Value statement: Public health and health care must work together to ensure that every community member has access to high quality, culturally appropriate health care. This requires jointly developing and implementing solutions to address access and quality barriers. (Public Health Modernization Manual)

- Ensure health care and public health collaborations are outcomes-oriented, sustainable, and allow for transformation and flexibility in implementation.

3. Strategies that align with guiding principles

- Leadership and governance: Include health care and public health perspectives on one another's governing and/or leadership boards and/or decision-making. Ensure that governing and/or leadership boards reflect the composition of the community being served. Ensure there are regular opportunities to solicit and include community input in the decision-making of the governing and/or leadership board. Leverage health care and public health funding to improve population health outcomes. (Public Health 3.0)
- Aligned metrics and data: Implement metrics that can be analyzed and reported by race, ethnicity, primary language and disability, that move health care and public health towards improvement in community health outcomes and elimination of health disparities (e.g., tobacco use prevalence). Identify what health care and public health contribute to individual measures and what could be done in the future. Tie performance payment to improved health outcomes that are shared across health care and public health partners. Develop systems to share data in

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order to develop community health assessments, identify emerging health issues, and evaluate the effectiveness of new policies designed to improve health. (Public Health 3.0)

- Evidence-based practices: Collect and disseminate information on evidence-based clinical and population health strategies. Ensure that resources are invested in the implementation of practices that are grounded in scientific evidence, including promising culturally-specific practices. (Public Health Modernization Manual)
- Community health assessments and community health improvement plans: Ensure the continuation of partnerships across health care and public health to develop shared community health assessments and community health improvement plans; ensure assessments and plans meet all state, local and federal requirements. Utilize evidence-based and promising culturally-specific practices in the development of community health improvement plans. (Public Health Modernization Manual, Next Generation of Community Health)
- Access to care: Ensure that health care and public health organizations work collaboratively to collect data on access to care; review data to identify barriers to care; and develop solutions to improve access to care that are grounded in community needs. Ensure that health care and public health organizations work collaboratively to plan for and respond to emergencies. (Public Health Modernization Manual)
- Policy: Partner on the development and implementation of public policies that promote health and prevent disease.
- Workforce development: Collaboratively build the capacity of the health care and public health system so both are better equipped to address health outcomes and manage change. Ensure that the health care and public health workforce reflects the community being served.

4. Source documents

Oregon's Action Plan for Health
Public health modernization assessment
Statewide public health modernization plan
Public Health Modernization Manual
Public Health 3.0
CDC 6|18 Initiative
Next Generation of Community Health
Public Health Accreditation Board Standards and Measures
Coalition of Local Health Officials
Equity of Care

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Oregon Health Policy Board
Public Health Advisory Board
Charter
April 2017

Approved by the Oregon Health Policy Board on April 4, 2017

I. Overview and Authority

The Public Health Advisory Board (PHAB) is established by ORS 431.122 as a body that reports to the Oregon Health Policy Board (OHPB).

The purpose of the PHAB is to be the accountable body for governmental public health in Oregon. The role of the PHAB includes:

- Alignment of public health priorities with available resources.
- Analysis and communication of what is at risk when there is a failure to invest resources in public health.
- Oversight for Oregon Health Authority, Public Health Division strategic initiatives, including the State Health Assessment and State Health Improvement Plan.
- Oversight for governmental public health strategic initiatives, including the implementation of public health modernization.
- Support for state and local public health accreditation.

This charter defines the objectives, responsibilities, and scope of activities of the PHAB. This charter will be reviewed periodically to ensure that the work of the PHAB is aligned with the OHPB's strategic direction.

II. Duties, Objectives, Membership, Terms, Officers

The duties of the PHAB as established by ORS 431.123 and the PHAB's corresponding objectives include:

PHAB Duties per ORS 431.123	PHAB Objectives
a. Make recommendations to the OHPB on the development of statewide public health policies and goals.	• Participate in and provide oversight for Oregon's State Health Assessment. • Regularly review state health data such as the State Health Profile to identify ongoing and emerging health issues. • Use best practices and an equity lens to provide recommendations to OHPB on policies needed to address priority health issues, including the social determinants of health.
b. Make recommendations to the OHPB on how other statewide priorities, such as the provision of early learning services and the delivery of health care services, affect and are affected	• Regularly review early learning and health system transformation priorities. • Recommend how early learning goals, health system transformation priorities, and statewide public health goals can best be aligned.

	by statewide public health policies and goals.	• Identify opportunities for public health to support early learning and health system transformation priorities. • Identify opportunities for early learning and health system transformation to support statewide public health goals.
c.	Make recommendations to the OHPB on the establishment of foundational capabilities and programs for governmental public health and other public health programs and activities.	• Participate in the administrative rulemaking process which will adopt the Public Health Modernization Manual. • Verify that the Public Health Modernization Manual is still current at least every two years. Recommend updates to OHPB as needed. •
d.	Make recommendations to the OHPB on the adoption and updating of the statewide public health modernization assessment.	• Review initial findings from the Public Health Modernization Assessment. (completed, 2016) • Review the final Public Health Modernization Assessment report and provide a recommendation to OHPB on the submission of the report to the legislature. (completed, 2016) • Make recommendations to the OHPB on processes/procedures for updating the statewide public health modernization assessment.
e.	Make recommendations to the OHPB on the development of and any modification to the statewide public health modernization plan.	• Review the final Public Health Modernization Assessment report to assist in the development of the statewide public health modernization plan. (completed, 2016) • Using stakeholder feedback, draft timelines and processes to inform the statewide public health modernization plan. (completed, 2016) • Develop the public health modernization plan and provide a recommendation to the OHPB on the submission of the plan to the legislature. (completed, 2016) • Update the public health modernization plan as needed based on capacity.
f.	Make recommendations to the Oregon Health Authority (OHA) and the OHPB on the development of and any modification to plans developed for the distribution of funds to local public health authorities.	• Identify effective mechanisms for funding the foundational capabilities and programs. • Develop recommendations for how the OHA shall distribute funds to local public health authorities.
g.	Make recommendations to the OHA and the OHPB on the total cost to local public health authorities of applying the foundational capabilities and implementing the foundational programs for governmental public health.	• Review the Public Health Modernization Assessment report for estimates on the total cost for implementation of the foundational capabilities and programs. (completed, 2016) • Support stakeholders in identifying opportunities to provide the foundational capabilities and programs in an effective and efficient manner.

h. Make recommendations to the OHPB on the use of incentives by the OHA to encourage the effective and equitable provision of public health services by local public health authorities.	• Develop models to incentivize investment in and equitable provision of public health services across Oregon. • Solicit stakeholder feedback on incentive models.
i. Provide support to local public health authorities in developing local plans to apply the foundational capabilities and implement the foundational programs for governmental public health.	• Provide support and oversight for the development of local public health modernization plans. • Provide oversight for Oregon's Robert Wood Johnson Foundation grant, which will support regional gatherings of health departments and their stakeholders to develop public health modernization plans.
j. Monitor the progress of local public health authorities in meeting statewide public health goals, including employing the foundational capabilities and implementing the foundational programs for governmental public health.	• Provide oversight and accountability for Oregon's State Health Improvement Plan by receiving quarterly updates and providing feedback for improvement. • Provide support and oversight for local public health authorities in the pursuit of statewide public health goals. • Provide oversight and accountability for the statewide public health modernization plan. • Develop outcome and accountability measures for state and local health departments.
k. Assist the OHA in seeking funding, including in the form of federal grants, for the implementation of public health modernization.	• Provide letters of support and guidance on federal grant applications. • Educate federal partners on public health modernization. • Explore and recommend ways to expand sustainable funding for state and local public health and community health.
l. Assist the OHA in coordinating and collaborating with federal agencies.	• Identify opportunities to coordinate and leverage federal opportunities. • Provide guidance on work with federal agencies.

Additionally, the Public Health Advisory Board is responsible for the following duties which are not specified in House Bill 3100:

Duties	PHAB Objectives
a. Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters.	• Provide guidance and recommendations on statewide public health issues and public health policy.
b. Act as formal advisory committee for Oregon's Preventive Health and Health Services Block Grant.	• Review and provide feedback on the Preventive Health and Health Services Block Grant work plan priorities.

c. Provide oversight for the implementation of health equity initiatives across the public health system.	• Receive progress reports and provide feedback to the Public Health Division Health Equity Committee. • Participate in collaborative health equity efforts.

Membership Composition

Per ORS 431.122, the PHAB shall consist of the following 13 members appointed by the Governor:

1. A state employee who has technical expertise in the field of public health;
2. A local public health administrator who supervises public health programs and public health activities in Benton, Clackamas, Deschutes, Jackson, Lane, Marion, Multnomah or Washington County;
3. A local public health administrator who supervises public health programs and public health activities in Coos, Douglas, Josephine, Klamath, Linn, Polk, Umatilla or Yamhill County;
4. A local public health administrator who supervises public health programs and public health activities in Clatsop, Columbia, Crook, Curry, Hood River, Jefferson, Lincoln, Tillamook, Union or Wasco County;
5. A local public health administrator who supervises public health programs and public health activities in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Wallowa or Wheeler County;
6. A local health officer who is not a local public health administrator;
7. An individual who represents the Conference of Local Health Officials created under ORS 431.330;
8. An individual who represents coordinated care organizations;
9. An individual who represents health care organizations that are not coordinated care organizations;
10. An individual who represents individuals who provide public health services directly to the public;
11. An expert in the field of public health who has a background in academia;
12. An expert in population health metrics;
13. An at large member.

PHAB shall also include the following nonvoting, ex-officio members:

1. The Oregon Public Health Director or the Public Health Director's designee;
2. If the Public Health Director is not the State Health Officer, the State Health Officer or a physician licensed under ORS chapter 677 acting as the State Health Officer's designee;
3. If the Public Health Director is the State Health Officer, a representative from the Oregon Health Authority who is familiar with public health programs and public health activities in this state; and
4. An Oregon Health Policy Board liaison.

Membership Terms

The term of office for a board member appointed under this section is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.
Of the PHAB members beginning their term in January 2016:

- Four shall serve for terms ending January 1, 2017.
- Three shall serve for terms ending January 1, 2018.
- Three shall serve for terms ending January 1, 2019.
- Three shall serve for terms ending January 1, 2020.

Officers

PHAB shall elect two of its voting members to serve as the chair and vice chair. Elections shall take place in January of each even-numbered year.

The chair and vice chair shall serve two year terms. If the chair were to vacate their position before their term is complete the vice chair shall become the new chair to complete the term. If a vice chair is unable to serve, or if the vice chair position becomes vacant, then a new election is held to complete the remainder of the vacant term(s).

The PHAB chair shall facilitate meetings and guide the PHAB in achieving its deliverables. The PHAB chair shall represent the PHAB at meetings of the Oregon Health Policy Board as directed by the Oregon Health Policy Board designee. The PHAB chair may represent the PHAB at meetings with other stakeholders and partners, or designate another member to represent the PHAB as necessary.

The PHAB vice chair shall facilitate meetings in the absence of the PHAB chair. The PHAB vice chair shall represent the PHAB at meetings of the Oregon Health Policy Board as directed by the Oregon Health Policy Board designee when the PHAB chair is unavailable. The PHAB vice chair may represent the PHAB at meetings with other stakeholders and partners when the PHAB chair is unavailable or under the guidance of the PHAB chair, or may designate another member to represent the PHAB as necessary.

Both the PHAB chair and vice chair shall work with OHA Public Health Division staff to develop agendas and materials for PHAB meetings.

III. Actions and Deliverables

Actions

The PHAB may take the following actions:

- Make formal recommendations, provide informal advice, and reports to the OHPB;
- Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters;
- Identify priorities for Oregon’s governmental public health system;
- Charter committees (for ongoing work) and/or work groups (for short-term work) on various topics related to governmental public health;
- Request data and reports to assist in preparing recommendations to the OHPB;
- Provide a member to serve as a liaison to other committees or groups as requested.

Deliverables/Actions

The PHAB shall deliver the following:

Deliverable	Time Frame
• **A work plan for the PHAB for 2016-2017**	Spring 2016
• **A proposal for reporting to the OHPB (e.g., frequency, format, etc.)**	Spring 2016
• **Report(s) to the OHPB (as agreed to with the OHPB)**	At least annually
• **Recommendations to the OHPB**	As needed
• **Public Health Modernization Assessment report**	June 2016 (complete)
• **Public Health Modernization Plan**	December 2016 (complete)
• **Report(s) to the legislature as requested**	As needed

In addition to the deliverables listed above, the PHAB shall charter committees and work groups as needed and take direction from the OHPB.

IV. Staff Resources

The PHAB is staffed by the OHA, Public Health Division, as led by the Policy and Partnerships Director. Support will be provided by staff of the Public Health Division Policy and Partnerships Team and other leaders, staff, and consultants as requested or needed.

V. Expectations for PHAB Meetings

The following expectations apply to all PHAB meetings:

- The PHAB will meet monthly from January 2016 through July 2017. In July 2017, the PHAB will determine if meetings should continue monthly or move to an alternate schedule, with meetings occurring at least quarterly. More frequent and ad hoc meetings may be called for by the chairperson.
- The PHAB shall meet at times and places specified by the call of the chairperson or of a majority of the voting members of the board.
- A standard meeting time will be established (with special exceptions).
- Meetings shall be conducted in accordance with Oregon’s Public Meetings Law (ORS 192.610 through 192.710) and Public Records Law (ORS 192.001 through 192.505) and documented on the PHAB website: www.healthoregon.org/phab.
- Official subcommittee meetings shall also be conducted in accordance with Oregon’s Public Meetings Law (ORS 192.610 through 192.710) and Public Records Law (ORS 192.001 through 192.505) and documented on the PHAB website: www.healthoregon.org/phab.
- A public notice will be provided to the public and media at least 10 days in advance of each regular meeting and at least five days in advance of any special meeting.
- A majority of the voting members of the PHAB constitutes a quorum for the transaction of business during PHAB meetings.
- PHAB members are expected to review materials ahead of the meeting and come prepared to discuss and participate.
- Written minutes will be taken at all regular and special meetings. Minutes will include: members present; all motions, proposals, resolutions, orders, ordinances and measures proposed and their disposition; the substance of discussion on any matter; and a reference to any document discussed or distributed at the meeting.

Conflicts of Interest

The purpose of this conflict of interest policy is to maintain the transparency and integrity of the PHAB and its individual members, understanding that many voting members have a direct tie to governmental public health or other stakeholders in Oregon.

PHAB members shall verbally disclose any actual or perceived conflicts of interest prior to voting on any motion that may present a conflict of interest. If a PHAB member has a potential conflict related to a particular motion, the member should state the conflict. PHAB will then make a decision as to whether the member shall participate in the vote or be recused.

If the PHAB has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member and afford an opportunity to explain the alleged failure to disclose. If the PHAB determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate corrective action including potential removal from the body.

Lastly, PHAB members shall make disclosures of conflicts using a standard conflict of interest form at the time of appointment and at any time thereafter where there are material employment or other changes that would warrant updating the form.

VI. Amendments and Approval

This charter may be amended or repealed by the affirmative vote of two-thirds of the members present at any regular PHAB meeting. Notice of any proposal to change the charter shall be included in the notice of the meeting.

Any amendments to the charter require approval by the OHPB before taking effect.

Public Health Advisory Board

I. Authority

The Public Health Advisory Board (PHAB) is established by ORS 431.122 as a body that reports to the Oregon Health Policy Board (OHPB).
The purpose of the PHAB is to be the accountable body for governmental public health in Oregon. The role of the PHAB includes:

- Alignment of public health priorities with available resources.
- Analysis and communication of what is at risk when there is a failure to invest resources in public health.
- Oversight for Oregon Health Authority, Public Health Division strategic initiatives, including the State Health Assessment and State Health Improvement Plan.
- Oversight for governmental public health strategic initiatives, including the implementation of public health modernization.
- Support for state and local public health accreditation.

This charter defines the objectives, responsibilities, and scope of activities of the PHAB. This charter will be reviewed no less than annually to ensure that the work of the PHAB is aligned with statute and the OHPB's strategic direction.

II. Deliverables

The duties of the PHAB as established by ORS 431.123 and the PHAB's corresponding objectives include:

PHAB Duties per ORS 431.123	**PHAB Objectives**
a. Make recommendations to the OHPB on the development of statewide public health policies and goals.	• Participate in and provide oversight for Oregon's State Health Assessment. • Regularly review state health data such as the State Health Profile to identify ongoing and emerging health issues. • Use best practices and an equity lens to provide recommendations to OHPB on policies needed to address priority health issues, including the social determinants of health.
b. Make recommendations to the OHPB on how other statewide priorities, such as the provision of early learning services and the delivery of health care services, affect and are affected by statewide public health policies and goals.	• Regularly review early learning and health system transformation priorities. • Recommend how early learning goals, health system transformation priorities, and statewide public health goals can best be aligned.

	• Identify opportunities for public health to support early learning and health system transformation priorities. • Identify opportunities for early learning and health system transformation to support statewide public health goals.
c. Make recommendations to the OHPB on the establishment of foundational capabilities and programs for governmental public health and other public health programs and activities.	• Participate in the administrative rulemaking process which will adopt the Public Health Modernization Manual. • Verify that the Public Health Modernization Manual is still current at least every two years. Recommend updates to OHPB as needed.
d. Make recommendations to the OHPB on the adoption and updating of the statewide public health modernization assessment.	• Review initial findings from the Public Health Modernization Assessment. (completed, 2016) • Review the final Public Health Modernization Assessment report and provide a recommendation to OHPB on the submission of the report to the legislature. (completed, 2016) • Make recommendations to the OHPB on processes/procedures for updating the statewide public health modernization assessment.
e. Make recommendations to the OHPB on the development of and any modification to the statewide public health modernization plan.	• Review the final Public Health Modernization Assessment report to assist in the development of the statewide public health modernization plan. (completed, 2016) • Using stakeholder feedback, draft timelines and processes to inform the statewide public health modernization plan. (completed, 2016) • Develop the public health modernization plan and provide a recommendation to the OHPB on the submission of the plan to the legislature. (completed, 2016) • Update the public health modernization plan as needed based on capacity.
f. Make recommendations to the Oregon Health Authority (OHA) and the OHPB on the development of and any	• Identify effective mechanisms for funding the foundational capabilities and programs.

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modification to plans developed for the distribution of funds to local public health authorities.	• Develop recommendations for how the OHA shall distribute funds to local public health authorities.
g. Make recommendations to the OHA and the OHPB on the total cost to local public health authorities of applying the foundational capabilities and implementing the foundational programs for governmental public health.	• Review the Public Health Modernization Assessment report for estimates on the total cost for implementation of the foundational capabilities and programs. (completed, 2016) • Support stakeholders in identifying opportunities to provide the foundational capabilities and programs in an effective and efficient manner.
h. Make recommendations to the OHPB on the use of incentives by the OHA to encourage the effective and equitable provision of public health services by local public health authorities.	• Develop models to incentivize investment in and equitable provision of public health services across Oregon. • Solicit stakeholder feedback on incentive models.
i. Provide support to local public health authorities in developing local plans to apply the foundational capabilities and implement the foundational programs for governmental public health.	• Provide support and oversight for the development of local public health modernization plans. • Provide oversight for Oregon's Robert Wood Johnson Foundation grant, which will support regional gatherings of health departments and their stakeholders to develop public health modernization plans.
j. Monitor the progress of local public health authorities in meeting statewide public health goals, including employing the foundational capabilities and implementing the foundational programs for governmental public health.	• Provide oversight and accountability for Oregon's State Health Improvement Plan by receiving quarterly updates and providing feedback for improvement. • Provide support and oversight for local public health authorities in the pursuit of statewide public health goals. • Provide oversight and accountability for the statewide public health modernization plan. • Develop outcome and accountability measures for state and local health departments.
k. Assist the OHA in seeking funding, including in the form of federal grants, for the implementation of public health modernization.	• Provide letters of support and guidance on federal grant applications. • Educate federal partners on public health modernization.

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	• Explore and recommend ways to expand sustainable funding for state and local public health and community health.
l. Assist the OHA in coordinating and collaborating with federal agencies.	• Identify opportunities to coordinate and leverage federal opportunities. • Provide guidance on work with federal agencies.

Additionally, the Public Health Advisory Board is responsible for the following duties which are not specified in ORS 431.123:

Duties	**PHAB Objectives**
a. Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters.	• Provide guidance and recommendations on statewide public health issues and public health policy.
b. Act as formal advisory committee for Oregon's Preventive Health and Health Services Block Grant.	• Review and provide feedback on the Preventive Health and Health Services Block Grant work plan priorities.
c. Provide oversight for the implementation of health equity initiatives across the public health system.	• Receive progress reports and provide feedback to the Public Health Division Health Equity Committee. • Participate in collaborative health equity efforts.

III. Dependencies

PHAB has established two subcommittees that will meet on an as-needed basis in order to comply with statutory requirements:
1. Accountability Metrics Subcommittee, which reviews existing public health data and metrics to propose biannual updates to public health accountability measures for consideration by the PHAB.
2. Incentives and Funding Subcommittee, which develops recommendations on the local public health authority funding formula for consideration by the PHAB.

PHAB shall operate under the guidance of the OHPB.

IV. Membership

Per ORS 431.122, the PHAB shall consist of the following 14 members appointed by the Governor:
1. A state employee who has technical expertise in the field of public health;

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2. A local public health administrator who supervises public health programs and public health activities in Benton, Clackamas, Deschutes, Jackson, Lane, Marion, Multnomah or Washington County;
3. A local public health administrator who supervises public health programs and public health activities in Coos, Douglas, Josephine, Klamath, Linn, Polk, Umatilla or Yamhill County;
4. A local public health administrator who supervises public health programs and public health activities in Clatsop, Columbia, Crook, Curry, Hood River, Jefferson, Lincoln, Tillamook, Union or Wasco County;
5. A local public health administrator who supervises public health programs and public health activities in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Wallowa or Wheeler County;
6. A local health officer who is not a local public health administrator;
7. An individual who represents the Conference of Local Health Officials created under ORS 431.330;
8. An individual who is a member of, or who represents, a federally recognized Indian tribe in this state;
9. An individual who represents coordinated care organizations;
10. An individual who represents health care organizations that are not coordinated care organizations;
11. An individual who represents individuals who provide public health services directly to the public;
12. An expert in the field of public health who has a background in academia;
13. An expert in population health metrics;
14. An at large member.

PHAB shall also include the following nonvoting, ex-officio members:
1. The Oregon Public Health Director or the Public Health Director's designee;
2. If the Public Health Director is not the State Health Officer, the State Health Officer or a physician licensed under ORS chapter 677 acting as the State Health Officer's designee;
3. If the Public Health Director is the State Health Officer, a representative from the Oregon Health Authority who is familiar with public health programs and public health activities in this state; and
4. An Oregon Health Policy Board liaison.

Membership Terms

The term of office for a board member appointed under this section is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

Officers

PHAB shall elect two of its voting members to serve as the chair and vice chair. Elections shall take place in January of each even-numbered year.

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The chair and vice chair shall serve two year terms. If the chair were to vacate their position before their term is complete the vice chair shall become the new chair to complete the term. If a vice chair is unable to serve, or if the vice chair position becomes vacant, then a new election is held to complete the remainder of the vacant term(s).

The PHAB chair shall facilitate meetings and guide the PHAB in achieving its deliverables. The PHAB chair shall represent the PHAB at meetings of the Oregon Health Policy Board as directed by the Oregon Health Policy Board designee. The PHAB chair may represent the PHAB at meetings with other stakeholders and partners, or designate another member to represent the PHAB as necessary.

The PHAB vice chair shall facilitate meetings in the absence of the PHAB chair. The PHAB vice chair shall represent the PHAB at meetings of the Oregon Health Policy Board as directed by the Oregon Health Policy Board designee when the PHAB chair is unavailable. The PHAB vice chair may represent the PHAB at meetings with other stakeholders and partners when the PHAB chair is unavailable or under the guidance of the PHAB chair, or may designate another member to represent the PHAB as necessary.

Both the PHAB chair and vice chair shall work with OHA Public Health Division staff to develop agendas and materials for PHAB meetings.

V. Resources

The PHAB is staffed by the OHA, Public Health Division, as led by the Policy and Partnerships Director. Support will be provided by staff of the Public Health Division Policy and Partnerships Team and other leaders, staff, and consultants as requested or needed.

PHAB Executive Sponsor: Lillian Shirley, Public Health Director, Oregon Health Authority, Public Health Division
Staff Contact: Cara Biddlecom, Director of Policy and Partnerships, Oregon Health Authority, Public Health Division

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