AGENDA

PUBLIC HEALTH ADVISORY BOARD

November 17, 2017
Human Services Building
500 Summer St. NE, Room 137 C-D
Salem, OR 97301

Join by webinar: https://attendee.gotowebinar.com/register/6698876131110674690
Conference line: (877) 873-8017
Access code: 767068

Meeting objectives

- Elect Public Health Advisory Board Chair and Co-Chair for the period of January 1, 2018-December 31, 2019
- Discuss progress on public health accountability measures
- Learn about the Behavioral Health Collaborative and discuss impacts to public health
- Adopt bylaws for the Public Health Advisory Board
- Discuss the Preventive Health and Health Services Block Grant Evaluation Framework
- Discuss Oregon's Action Plan for Health and work with CCOs

9:00-9:25 am	**Welcome and updates** • Approve October 19 meeting minutes • Provide an overview of local public health modernization grants • Discuss preferences for PHAB meeting technology	Jeff Luck, PHAB Chair
9:25-9:35 am	**Accountability metrics updates** • Accountability Metrics Subcommittee • Health Plan Quality Metrics Committee presentation	Sara Beaudrault, Oregon Health Authority Jeff Luck, PHAB Chair
9:35-10:00 am	**Behavioral health collaborative update** • Discuss initial recommendations and work to date • Provide feedback on implications for public health	Royce Bowlin, Oregon Health Authority
10:00-10:15 am	**PHAB positions in 2018** • Vote on PHAB Chair and Co-Chair positions beginning on January 1, 2018 • Review subcommittee membership and work plans for 2018	Jeff Luck, PHAB Chair
10:15-10:45 am	**PHAB bylaws** • Discuss the purpose of bylaws • Review and adopt bylaws	Cara Biddlecom, Oregon Health Authority

10:45-11:00 am	**Preventive Health and Health Services Block Grant Evaluation Framework** • Learn how the CDC is evaluating the Preventive Health and Health Services Block Grant • Discuss applicability to public health modernization	Danna Drum, Oregon Health Authority
11:00-11:45 am	**Debrief Action Plan for Health and CCO 2.0 discussion** • Discuss priorities for public health work with CCOs • Review Guiding Principles for Health Care and Public Health Collaboration • Review State Health Improvement Plan priorities	Jeff Luck, PHAB Chair
11:45 am-12:00 pm	**Public comment**	
12:00 pm	**Adjourn**	Jeff Luck, PHAB chair

Public Health Advisory Board (PHAB)
October 19, 2017
Draft Meeting Minutes

Attendance:

Board members present: David Bangsberg, Carrie Brogoitti, Bob Dannenhoffer, Muriel DeLaVergne-Brown, Katrina Hedberg, Kelle Little, Jeff Luck, Rebecca Pawlak, Alejandro Queral, Eva Rippeteau, Akiko Saito, Eli Schwarz, Lillian Shirley, Teri Thalhofer, and Jen Vines

Oregon Health Authority (OHA) staff: Sara Beaudrault, Cara Biddlecom, Myde Boles, Danna Drum, Julia Hakes, Holly Heiberg, Luci Longoria, Britt Parrott, and Angela Rowland

Guests: Morgan Cowling, Kari McFarland, Tricia Mortell

Approval of Minutes

A quorum was present. The Board moved to approve the June 15, 2017 and September 5, 2017 minutes with all in favor.

Welcome and updates

-Jeff Luck, PHAB chair

- New board membership:
  - Kelle Little, Tribal representative
  - Bob Dannenhoffer, Local Health Administrator representative
- Board member transition: Tricia Tillman is no longer the health administrator for Multnomah County and will no longer serve on the PHAB, we appreciate her service.
- Julia Hakes is the new staff support person for the PHAB.
- The State Health Assessment community meetings are almost complete.
- The cross-sector partnerships case studies handout is located here: http://www.healthoregon.org/modernization.

PHAB reappointments and chairs

- Jeff Luck, PHAB chair

Eva has applied for reappointment to the PHAB. Safina is not reapplying. A new CCO representative member of the PHAB will be needed beginning January 1, 2018.

The Board chair and co-chair terms end in December 2017. The PHAB bylaws will need to be drafted based on guidance from Oregon Health Policy Board staff. Also, the subcommittee membership will be revisited at the beginning of 2018 to ensure proper representation on each subcommittee.

Action Item: Please let Cara know if you would care to volunteer as chair or co-chair.

Tobacco funding update

-Karen Girard, Oregon Health Authority

Karen discussed the upcoming changes in the state's Tobacco Prevention and Education Program (TPEP) funding. The legislature cut the budget by 20%, from $20M to $16.3M per biennium. The state TPEP program used the Centers for Disease Control and Prevention (CDC) best practices for tobacco control as a guide for budget allocation. The Tobacco Reduction Advisory Committee and the Conference of Local Health Officials (CLHO) worked on funding decisions for local public health departments. OHA will work with CLHO for the next 18 months through two workgroups. The workgroups will look at accountability metrics, and how the funding formula may need to be changed in the 2019-21 biennium. Currently the funding formula has a base and per capita distribution.

Eva stated there is a county currently on strike that includes public health, and that counties can no longer do more with less. Karen stated that in order to preserve local base funding for tobacco prevention, the Strategies for Policy and Environmental Change (SPaRc) and Sustainable Relationships for Community Health (SRCH) grants were eliminated as well as technical assistance programs.

Muriel suggested leveraging Medicaid dollars and CCOs by looking at different improvement strategies with the whole system in mind.

Rebecca is interested in the amount of funds that have been leveraged, also she sees the TPEP workgroups are in parallel with the two PHAB subcommittees. She inquired if the PHAB will play a role in the tobacco funding formula and accountability metrics. Muriel stated that there are PHAB members who serve on CLHO and could help cross walk the subcommittee's work.

David mentioned his discussion with the Oregon Health Policy Board (OHPB) about developing shared metrics. The CCO contract negotiation has been delayed a year to design contracts for upstream impact on health and to look at a population perspective. There is a letter from the Governor to endorse that mission. PHAB could play a role to help inform CCO contract negotiations. Teri recommended that CCOs collaborate with governmental public health.

Eli stated that the PHAB could provide a formal proposal to the OHPB using the approved guiding principles for health care and public health collaboration document as a frame. PHAB should look at one or two issues that are relevant.

Katrina stated that tobacco use prevalence is a CCO incentive measure. Public health can provide tools to encourage the public health CCO partnership.

Bob stated that there are some challenges with CCOs not wanting to use the Oregon State Public Health Lab. He added that the value of tobacco cessation could save the system millions of dollars including other programs as well including immunizations.

Lillian indicated that the landscape among CCOs is complex and David can help bring the PHAB perspective forward. There is a whole series of public health issues, including communicable disease prevention, to package for the OHPB to provide policy direction inform the contracts.

Katrina stated that the State Health Improvement Plan (SHIP) has a section on what the health system can do and serves as a start to this conversation.

Muriel recommended creating a crosswalk on how to improve health through public health and CCO partnership.

Rebecca said that the tobacco program funds the whole system and not just the Medicaid population. She recommended using the PHAB incentives and funding subcommittee and discuss how that formula was created.

Action Item: Cara will follow up with subcommittee members to identify a volunteer to serve on the appropriate TPEP workgroups.

Public Health Accountability Metrics
-Myde Boles, Oregon Health Authority

The CLHO committees developed the public health accountability process measures to reflect local public health activities in conjunction with state public health to achieve the health outcome measures approved by PHAB in June. The slate presented today was reviewed by CLHO and presented to the PHAB accountability subcommittee.

Recommended measures:

- *Percent of Vaccines for Children clinics [that serve populations experiencing vaccination disparities] that participate in Assessment, Feedback, Incentives and eXchange (AFIX) program*
- *Percent of gonorrhea cases that had at least one contact that received treatment*
- *Percent of gonorrhea case reports with complete priority fields (pregnancy status, HIV, most recent test date/status, gender of sex partners, proper treatment of gonorrhea)*
- *Percent of community members reached by local [tobacco retail or smoke-free] policies*
- *Percent of top prescribers enrolled in the Prescription Drug Monitoring Program (PDMP)*
- *Number of active transportation partner governing or leadership boards with LPHA representation*
- *Number of water systems surveys completed*
- *Number of water quality alert responses*

- *Number of priority non-compliers resolved*
- *Number of local policy strategies for increasing access to effective contraceptives*

Eli expressed concern about a non-standardized approach to LPHA data reporting. Jeff remarked it doesn't apply to the recommended measures. Eli suggested removing the LPHA footnote on page 51 of the packet.

Katrina recommended being clear with definitions when measuring policies by indicating if it is a local policy or an ordinance being passed. David mentioned that there are good policies and bad policies. Rebecca recommended that with community outreach it might be hard to demonstrate working toward policy change.

Cara stated this is the start of a full public health modernization systems change and these measures are only one piece of the puzzle. They will need more work to be operationalized. OHA will be working with CLHO to update Program Elements to cross reference where current funds are available and potentially add additional performance measures that would be monitored as a part of the OHA contract with LPHAs.

Bob asked about the tipping point effect on topics like local tobacco policy. Myde stated that a baseline must be established to develop criteria for success.

Alejandro stated that there is a challenge in the issue of enforcement and tracking as a part of the policy process.

David asked if the Prescription Drug Monitoring Program (PDMP) is evidence-based. Katrina stated that the PDMP measure is a part of a multi-pronged process that includes upcoming legislation that may require this proposed measure to be updated.

The Board questioned measuring *number of local strategies for increasing access to effective contraceptives*. Bob recommended operationalizing the One Key Question intervention. Alejandro asked if access ensures use. Katrina suggested measuring the number of school based health centers (SBHCs) or Planned Parenthood clinics available. Teri stated that in her county, public health is working with local health systems to set up referral process so patients get contraceptives immediately. If women have more access they will increase use of contraception. Eli recommended a collaboration between public health, health providers, and the CCO. He continued to state that many metrics are overlapping with CCO incentive metrics. Jen suggested using the gonorrhea measure to measure access.

The subcommittee recommended not to adopt the any dental visits process measures at this time. Eli commented that LPHAs are rarely involved in dental care, therefore he would like to keep this as an "on deck" measure.

David made a motion to adopt all recommended measures except *effective contraceptive use*. Katrina clarified that this means to recommend not adopting any measures in the clinical preventative services foundational program.

All in favor.

Oregon Action Plan for Health
-Steph Jarem, Oregon Heath Authority

The first Action Plan for Health was a charge from legislature to the Oregon Health Policy Board in 2009 to create a comprehensive health reform plan for Oregon. It was guided by Oregon's Triple Aim for better health, better care, and lower costs. After five years of health system transformation the Board felt a need to update the Action Plan while maintaining the overarching principles that still apply to Oregon's work. The goal with the Action Plan update was to establish a roadmap for continued innovation, building upon best practices, evidence, data, and stakeholder experience. The Board set foundational strategies within seven areas. Cara and Steph identified areas of current PHAB engagement or what the PHAB could engage in in the future. The key actions section is the true work of the Action Plan and is dynamic. The actions help to track how far the state has come, including the effects to population health.

The next steps involve a public dashboard report in mid-January 2018 and alignment with CCO 2.0 contracting. There is an internal analysis of the first stage of health system transformation underway, with further discussion about the next round of CCO contracts at the January 2018 OHPB retreat. In 2018 there will be a vast public input process both in OHPB committees and externally.

The Action Plan for Health refresh has been posted on the Oregon Health Policy Board website at https://apps.state.or.us/Forms/Served/le9963.pdf. The 2010 Action Plan for Health website is http://www.oregon.gov/oha/Pages/Action-Plan-Health.aspx.

Jen recommended distinguishing health care metrics from public health metrics and the difference in timelines since public health outcomes are slow.

Public Comment Period
No public testimony was provided.

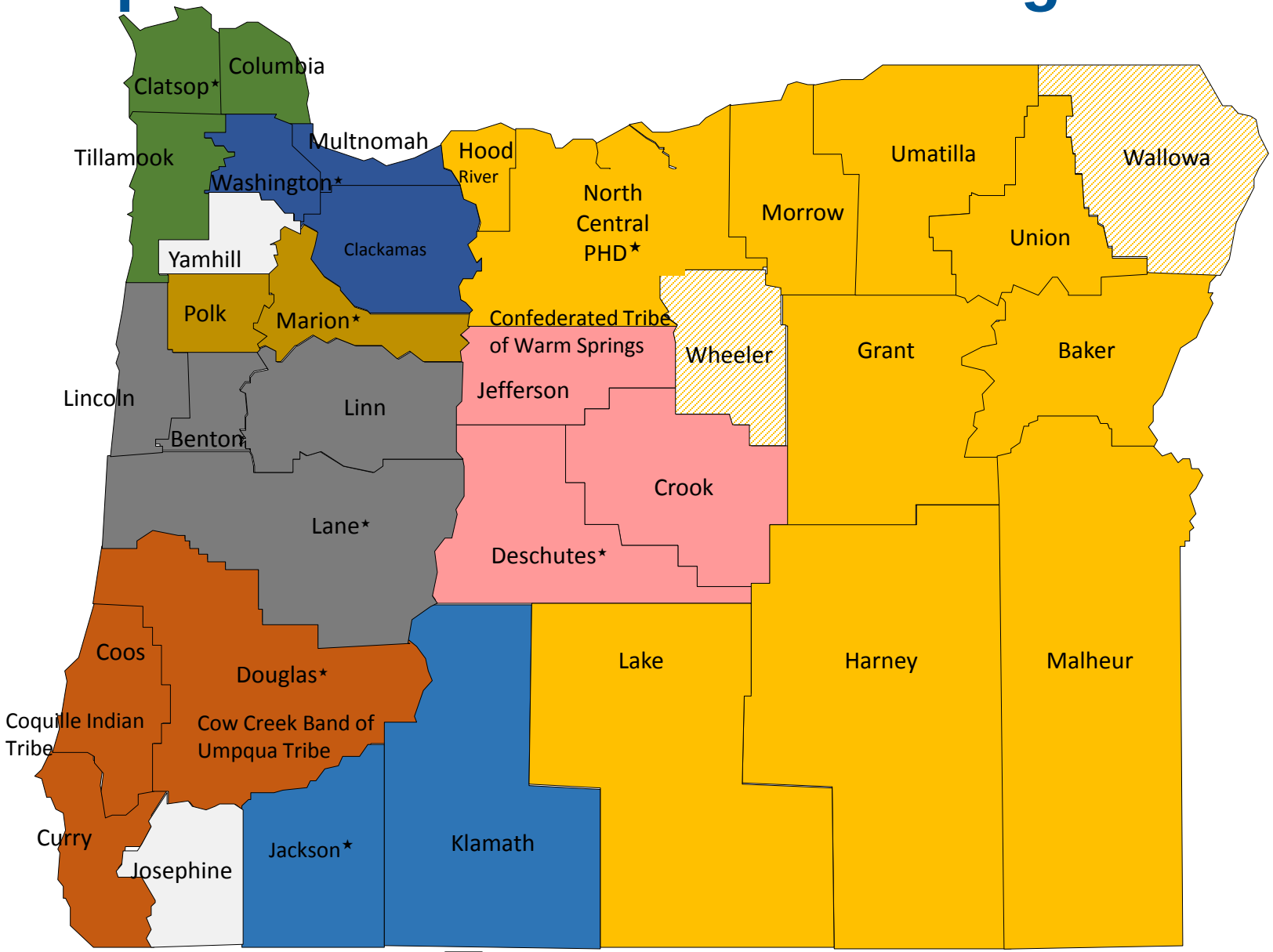
Closing
The meeting was adjourned.

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

November 17, 2017
9AM – 12PM
Human Services Building Room 137 C-D
500 Summer St. NE,
Salem, OR 97301

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.org/phab

Local public health modernization grantees



★ = fiscal agent for the regional partnership

= not included in partnership but will receive support from partnership

November 2017

Local public health modernization grantees

- **Clatsop**, Columbia and Tillamook counties
- **Deschutes**, Crook and Jefferson counties; St. Charles Health System; Central Oregon Health Council
- **Douglas**, Coos and Curry counties; Coquille and Cow Creek Tribes; Western Oregon Advanced Health CCO
- **Jackson** and Klamath counties; Southern Oregon Regional Health Equity Coalition; Klamath Regional Health Equity Coalition
- **Lane**, Benton, Lincoln and Linn counties; Oregon State University
- **Marion** and Polk counties; Willamette Valley Community Health CCO
- **North Central Public Health District;** Baker, Grant, Harney, Hood River, Lake, Malheur, Morrow, Umatilla and Union counties; Eastern Oregon CCO; Mid-Columbia Health Advocates
- **Washington**, Clackamas and Multnomah counties; Oregon Health Equity Alliance

*denotes fiscal agent

Behavioral Health Collaborative Update

Royce Bowlin
Behavioral Health Director

November 17, 2017

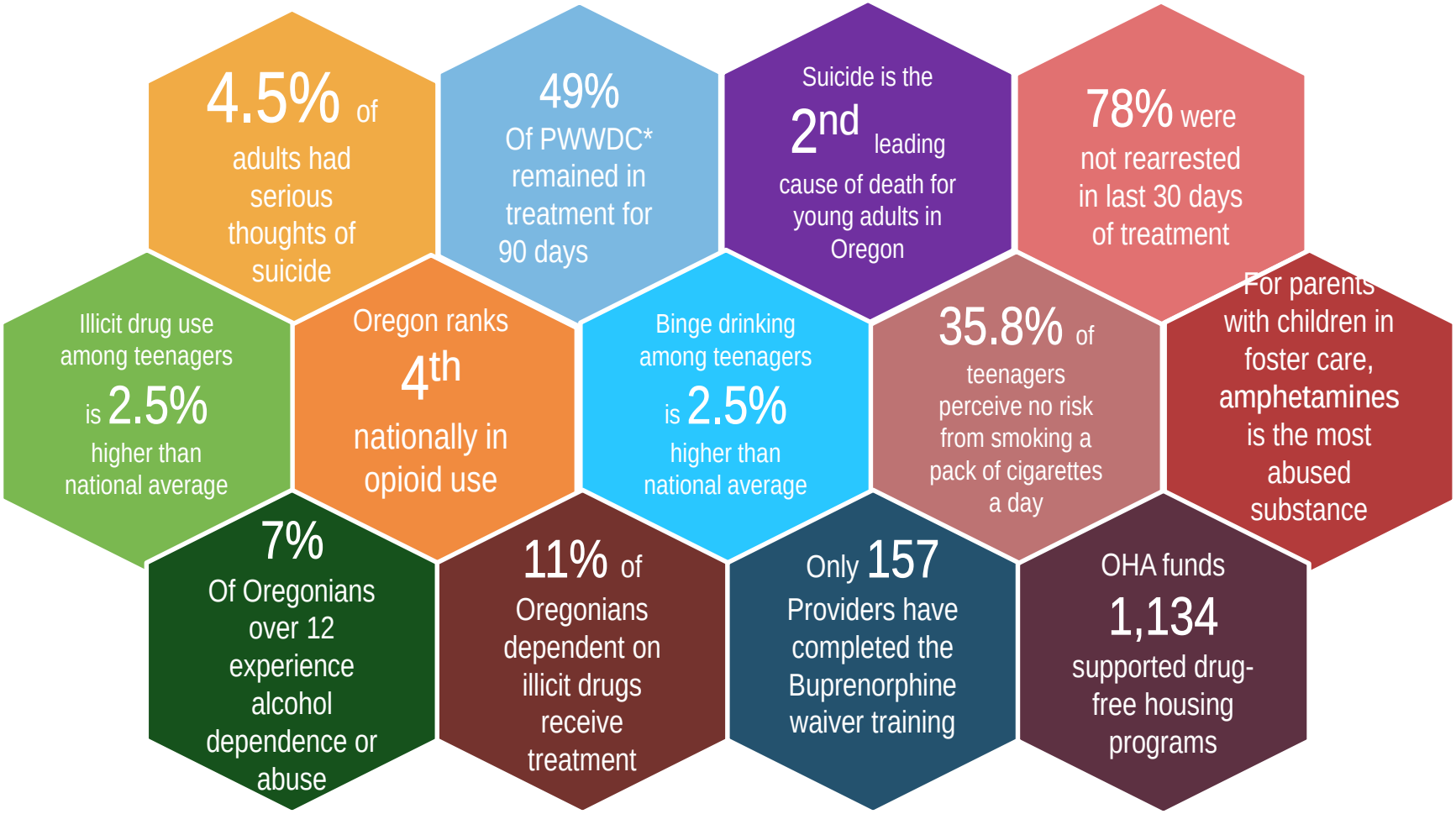
Oregon Health Authority

Oregon's current Behavioral Health System

Problem Statement:

Oregonians with substance use disorders and/or mental health issues face barriers everyday getting the services and support they need. Oregon's system is fragmented with silos between physical, oral and behavioral health care, making it difficult for care providers and individuals to work together to address their needs. Oregon has ample opportunities for improvements.

Oregon's Current Behavioral Health Status



* Pregnant women with dependent children

Vision for Behavioral Health

The vision is to create a modern 21st century behavioral health system of care. Using the coordinated care model that integrates substance use disorders and mental health with physical and oral health.

A system that is:

- Coordinated, seamless and treats the whole person, rather than a collection of problems and diagnoses
- Puts the individual and their support system at the center of care
- Accountable for all aspects of an individual's care
- Focused on early intervention, health promotion and prevention
- Community focused - systems and stakeholders come together to identify priorities and solutions specific to their community

Oregon Health Authority

Behavioral Health Collaborative Recommendations

Recommendations will transform the behavioral health system so that all Oregonians (both Medicaid and non-Medicaid) will be served by a coordinated care model for behavioral health needs. Close to 50-participants met over 7 months. The members developed four high-level recommendations through workgroups.

1. Governance and Finance: Regional governance model for behavioral health
2. Standards of Care and Competencies
3. Workforce
4. Information Exchange and Coordination of Care

Behavioral Health Collaborative Recommendations

Governance and finance - development of Regional Behavioral Health Collaboratives across the state.

Each regional collaborative will:

- Convene to review relevant state and local needs assessments, reports, data and other information.
- Select three priority areas to focus on over the next two years
- Develop an action plan that describes the specific behavioral health outcome goals, the strategies that will be employed to achieve the outcomes, and how progress will be measured.
- Key partners include Addictions and MH providers, corrections, first responders, child welfare, schools and hospitals.

Behavioral Health Collaborative Recommendations

Standards of care and competencies

- Establish and implement minimum standards and core competencies for behavioral health providers (clinic level)
- Establish minimum standards of care, standards for assessment and placement in levels of care
- Standards for the various entry points

Behavioral Health Collaborative Recommendations

Workforce

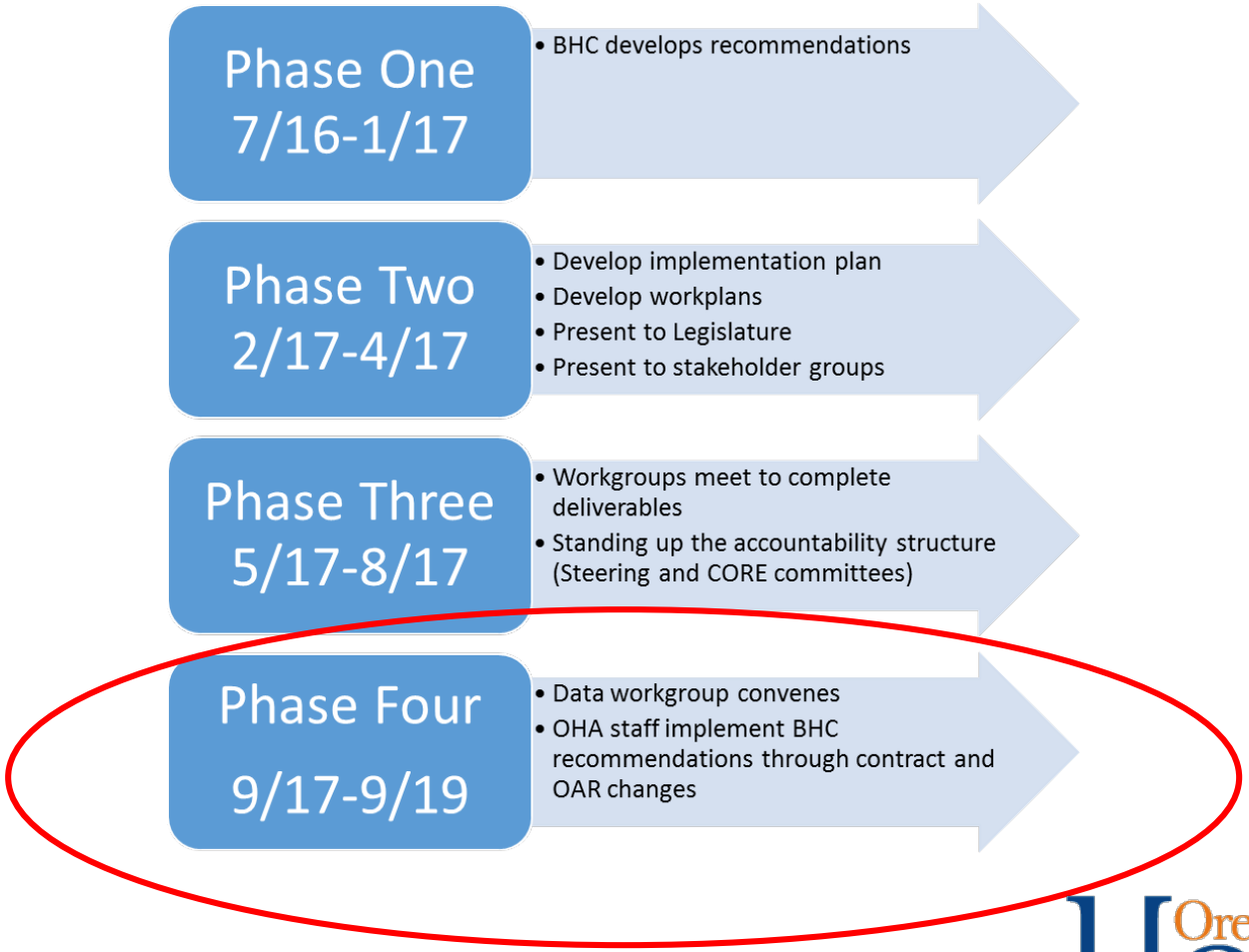
- Establish core competencies for BH staff
- Establish minimum standards of care, assessment, care coordination and placement / discharge
- Recommend recruitment and retention strategies
- Conduct an analysis of the behavioral health workforce, across multiple settings, identifying gaps and strategies
- Establish system standards for the Peer Delivered Services (PDS) workforce
- Establish standards and qualifications for PDS supervisors

Behavioral Health Collaborative Recommendations

Information exchange and coordination of care

- Advance the implementation of technology to further care coordination across the state and behavioral health system
- Identify ways for the state and regional collaborations to support the continued adoption and utilization of electronic health records and information sharing across payers and platforms
  - Environmental scan completed of Health Information Technology (HIT) use by BH organizations
  - The Office of Health IT will publish a report on current status of HIT in BH in December. This will lay groundwork for future work to support and spread adoption of HIT in BH.

BHC Implementation Timeline



Oregon Health Authority

OHA Request

OHA would like the opportunity to come to your community and present the BHC work with a focus on the formation of the Regional Behavioral Health Collaboratives. If you would like OHA to present to your community, please connect with the BHC Project Manager, Jackie Fabrick at:

Jackie.FABRICK@dhsoha.state.or.us

Questions?

Oregon Health Authority

PHAB subcommittees
Key tasks for 2018

Incentives and Funding
Meets the second Tuesday of each month from 1:00-2:00
Current membership: Jeff Luck, Akiko Saito, Alejandro Queral

Key tasks for January-June 2018

1. Review funding formula and make recommendations for changes for 2019-21
2. Review county expenditures data
3. Make recommendations for mechanisms to award incentive funds and matching payments
4. Consult as needed on other issues related to public health funding

Accountability Metrics
Meets the fourth Wednesday of each month from 1:00-2:00
Current membership: Muriel DeLaVergne-Brown, Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Jennifer Vines

Key tasks for January-June 2018

1. Provide recommendations for setting metrics bechmarks and targets
2. Review and provide recommendations for public health accountability metrics report
3. Continue to develop oral health metric
4. Maintain communication with Metrics and Scoring; seek opportunities to expand cross sector partnerships

Major task for July-December 2018

1. Consider whether changes are needed to accountability metrics for 2019-21

PUBLIC HEALTH ADVISORY BOARD BYLAWS
November 2017 DRAFT

ARTICLE I

The Committee and its Members

The Public Health Advisory Board (PHAB) is established by ORS 431.122 for the purpose of advising and making recommendations to the Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB).

The PHAB consists of the following 14 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 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; and
14. An at-large member.

Governor-appointed members serve four-year terms and are eligible for reappointment. Members serve at the pleasure of the Governor.

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 OHPB liaison.

Date approved:

Members are entitled to travel reimbursement per OHA policy and are not entitled to any other compensation.

Members who wish to resign from the PHAB must submit a formal resignation letter. Members who no longer meet the statutory criteria of their position must resign from the PHAB upon notification of this change.

If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

ARTICLE II

Committee Officers and Duties

PHAB shall elect two of its voting members to serve as the chair and vice chair. Elections shall take place no later than January of each even-numbered year and must follow the requirements for elections in Oregon's Public Meetings Law, ORS 192.610-192.690. Oregon's Public Meetings Law does not allow any election procedure other than a public vote made at a PHAB meeting where a quorum is present.

The chair and vice chair shall serve two year terms. The chair and vice chair are eligible for one additional two-year reappointment.

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 OHPB as directed by the OHPB 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 OHPB as directed by the OHPB 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.

ARTICLE III

Committee Members and Duties

Members are expected to attend regular meetings and are encouraged to join at least one subcommittee.

Absences of more than 20% of scheduled meetings that do not involve family medical leave may be reviewed.

In order to maintain the transparency and integrity of the PHAB and its individual members, PHAB members must comply with the PHAB Conflict of Interest policy as articulated in this section, understanding that many voting members have a direct tie to governmental public health or other stakeholders in Oregon.

Date approved:

All PHAB members must complete a standard Conflict of Interest Disclosure Form. PHAB members shall make disclosures of conflicts at the time of appointment and at any time thereafter where there are material employment or other changes that would warrant updating the form.

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 PHAB.

ARTICLE IV

Committee and Subcommittee Meetings

PHAB meetings are called by the order of the chair or vice chair, if serving as the meeting facilitator. A majority of voting members constitutes a quorum for the conduct of business.

PHAB shall conduct its business in conformity with Oregon's Public Meetings Law, ORS 192.610-192.690. All meetings will be available by conference call, and when possible also by either webinar or by livestream.

The PHAB strives to conduct its business through discussion and consensus. The chair or vice chair may institute processes to enable further decision making and move the work of the group forward.

Voting members may propose and vote on motions. The chair and vice chair will use Robert's Rules of Order to facilitate all motions. Votes may be made by telephone. Votes cannot be made by proxy, by mail or by email prior to the meeting. All official PHAB action is recorded in meeting minutes.

Meeting materials and agendas will be distributed one week in advance by email by OHA staff and will be posted online at www.healthoregon.org/phab.

ARTICLE V

Amendments to the Bylaws

Bylaws will be reviewed annually. Any updates to the bylaws will be approved through a formal vote by PHAB members.

Date approved:

Preventive Health & Health Services Block Grant Evaluation: A Tool for Oregon?

Danna Drum, MDiv
Strategic Partnerships Lead

Public Health Advisory Board Meeting
November 17, 2017

PUBLIC HEALTH DIVISION
Office of the State Public Health Director

PHHS Block Grant

- Established through Federal legislation in 1981
- Flexible public health funding
- Focus on Healthy People Objectives
- Administered by Centers for Disease Control and Prevention
  - Previously housed in NCCDPHP
  - In 2014 – moved to Office of State, Tribal, Local and Territorial Support (OSTLTS)
  - Now funded with Prevention and Public Health Fund dollars
- Congressional and CDC Director evaluation expectations with move to OSTLTS

Evaluation Challenges

- Very flexible funding
- Rigid legacy management information system
- Block grant v. Cooperative agreement
- Need to communicate and demonstrate the value of the block grant
- How do you demonstrate overall impact while allowing for grantee flexibility?

Evaluation Development Process

- CDC convened PHHS Block Grant Evaluation Work Group
  - Diverse mix of states and territories
  - Diverse uses of PHHS Block Grant funds
  - Newer and seasoned block grant coordinators
  - National partners
  - CDC evaluation experts

- Investment in work group and process

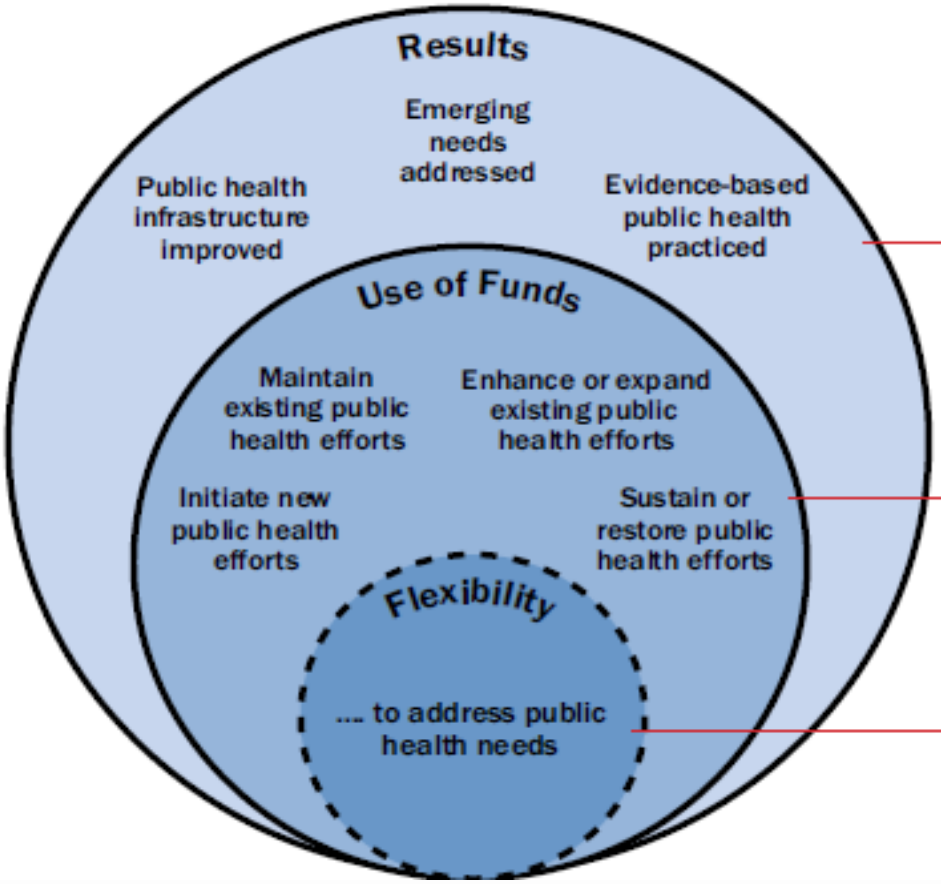
- Focused partnership to review and refine concepts developed by the CDC (2015 to Present)

Overarching Evaluation Questions

1. How does the PHHS Block Grant support grantees in addressing their jurisdictions' prioritized public health needs related to *Healthy People 2020* objectives?

2. How does the PHHS Block Grant contribute toward the achievement of organizational, systems, and health-related outcomes?

Evaluation Framework



Results – Outcomes of the grant resulting from successful use of PHHS Block Grant funds

Use of Funds – Grantees use PHHS Block Grant funds to address their prioritized public health needs

Flexibility – Grantees' ability to identify, prioritize, and address their public health needs

Using the Framework

Overarching Evaluation Question	Logic Model Component	Measurement Framework Component
1. How does the PHHS Block Grant support grantees in addressing their jurisdictions' prioritized public health needs related to HP2020 objectives?	Activities Outputs Short-Term Outcome	Flexibility Use of Funds
2. How does the PHHS Block Grant contribute toward the achievement of organizational, systems, and health-related outcomes?	Short-Term Outcome Intermediate Outcomes Long-Term Outcomes	Results

Current Measures

Public Health Infrastructure Improved:

- Information systems capacity improved
- Quality improved

Emerging Public Health Needs Addressed

Evidence-Based Public Health Interventions Implemented

How might Oregon use this approach?

- Is there a specific value of Public Health Modernization that us applicable across the system?
- Are there ways to articulate how PH Modernization addresses state and local PH needs?
- Are there results that can be measured from the successful application of PH Modernization?
- Other thoughts?

Background

The Centers for Disease Control and Prevention's (CDC's) Office for State, Tribal, Local and Territorial Support is evaluating the Preventive Health and Health Services (PHHS) Block Grant. The purposes of the evaluation are to assess the grant's value, strengthen its performance and accountability, and describe and measure select outputs and outcomes of the grant. The evaluation assesses the grant as a whole—not individual grantee activities or outcomes.

There are two overarching evaluation questions:

1. How does the PHHS Block Grant support grantees in addressing their jurisdictions' prioritized public health needs related to *Healthy People 2020* objectives?
2. How does the PHHS Block Grant contribute toward the achievement of organizational, systems, and health-related outcomes?

These evaluation questions are intended to assess how the PHHS Block Grant contributes to the grantees' ability to meet prioritized public health needs and achieve outcomes. To help address the evaluation questions, CDC developed the PHHS Block Grant Measurement Framework.

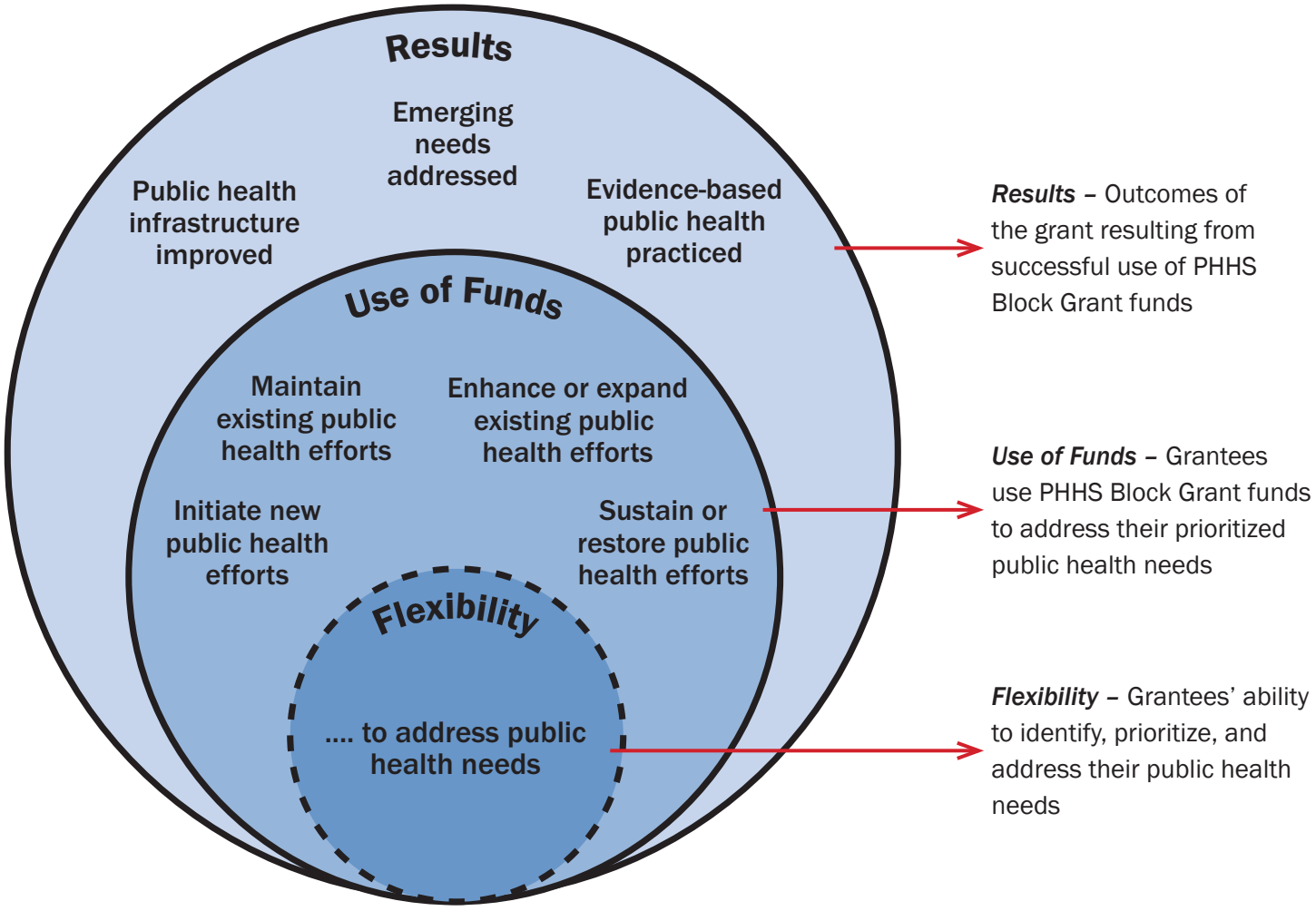
About the PHHS Block Grant

Through legislative authority, the PHHS Block Grant provides federal funding to 61 grantees—all 50 States, the District of Columbia, 2 American Indian tribes, 5 US territories, and 3 freely associated states. With these flexible funds, grantees address public health needs that are a priority within their jurisdictions in collaboration with local and tribal public health organizations. The legislation requires grantees to align their program objectives to *Healthy People 2020*, a set of national objectives designed to guide health promotion and disease prevention efforts.

What Is the PHHS Block Grant Measurement Framework?

The PHHS Block Grant Measurement Framework is an innovative approach to assessing the outputs and outcomes resulting from grantees' use of flexible grant funds. Flexible funding is a key aspect of the grant because it allows grantees to set their own goals and program objectives and implement strategies designed to meet their prioritized public health needs. The framework defines a set of measures that enable CDC to standardize the collection of data on grantee achievements. The framework is intended to apply to grantee activities, regardless of how funds are invested or which *Healthy People 2020* objectives are selected. Grantees should be able to see alignment between their work and the framework. However, depending on the grantee's activities, not every aspect of the framework will necessarily be relevant in any given reporting period. The framework consists of three components—flexibility, use of funds, and results (see Figure 1).

Figure 1: Components of the PHHS Block Grant Measurement Framework (Version 1.0)



Flexibility

The core component of the framework is the *flexibility* of the PHHS Block Grant, as it gives grantees control over identifying which jurisdictional public health needs to prioritize and determining appropriate strategies to address those needs. The public health needs can be at the grantee level or at the local level. Flexible funding allows grantees to address public health needs for which other categorical types of funding are insufficient, unavailable, or too restrictive on how program funds can be used.

Use of Funds

The *use of funds* component reflects the different ways grantees use grant funds to implement public health efforts to address prioritized public health needs, including using funds to support the needs of local and tribal health departments. It shows how flexibility in the use of these funds helps attain the results identified in the framework. This component outlines four ways grantees may use PHHS Block Grant funds:

1. **Initiate new public health efforts:** Develop and implement new programs, services, and activities that address public health needs that were previously not funded, either due to a lack of available funds or an absence of funding allotted to the need.

2. **Maintain existing public health efforts:** Support established programs, services, and activities from year to year.

3. **Enhance or expand existing public health efforts:** Enhance an effort by refining and improving its quality or expand an effort by adding components or outreach to additional populations.

4. **Sustain or restore public health efforts:** Sustain or restore efforts that have experienced a partial or complete loss in funding, and are at risk for discontinuation.[1]

   - *Sustain:* Continue an effort without disruptions after original funding for the effort has ended.
   - *Restore:* Reinstate or rebuild an effort that was significantly disrupted or had ended due to loss of original funding.[2]

Examples of the *use of funds* are provided in Table 1.

Table 1. Examples of the Use of Block Grant Funds

Use of Funds	Examples
Initiate new public health efforts	• Testing new or innovative approaches to addressing needs • Implementing programs, services, or activities that may have been conducted elsewhere but are new to the jurisdiction
Maintain existing public health efforts	• Providing ongoing support to longer-term efforts • Ensuring consistency and continuation of efforts
Enhance or expand existing public health efforts	• Fully implementing or scaling up pilots or smaller efforts • Establishing new or expanding existing partnerships, or increasing integration across categorical programs • Advancing existing work, such as updating plans or assessments
Sustain or restore public health efforts	• Ensuring a program continues until other funding sources are identified (e.g., stop-gap funding) • Institutionalizing public health efforts (e.g., restoring ongoing funding in the wake of funding loss)

[1] PHHS Block Grant funds may not be used to supplant state or local funds.

[2] Once a public health effort is restored, it would move into the "maintain" category in subsequent years.

Results

The *results* ccomponent includes three cross-cutting outcomes of health department performance and public health practice that result from the use of the PHHS Block Grant's flexible funding.

Public health infrastructure improved

Public health infrastructure includes the organizational capacity (i.e., the systems, workforce, partnerships, and resources) that enables health departments to perform their core functions and provide essential services. Improvements to infrastructure may occur within the grantee health department, either department-wide or within a specific program, or across the grantee jurisdiction's public health system. There are several aspects of improving public health infrastructure, such as improving information systems capacity, quality, and communications strategies, as well as strengthening the workforce, addressing public health standards, and supporting partnerships.

Emerging needs addressed

Emerging needs are public health issues that are beginning to present themselves as problems within the grantee's jurisdiction. Emerging needs may be newly arising problems, reemerging problems, or existing problems that have developed new characteristics (e.g., affecting new populations or geographic areas). Public health emergencies, or unexpected natural or manmade events that cause an immediate risk to the public's health, are also considered emerging needs. Emerging needs may occur in response to external factors or to changing priorities within a jurisdiction.

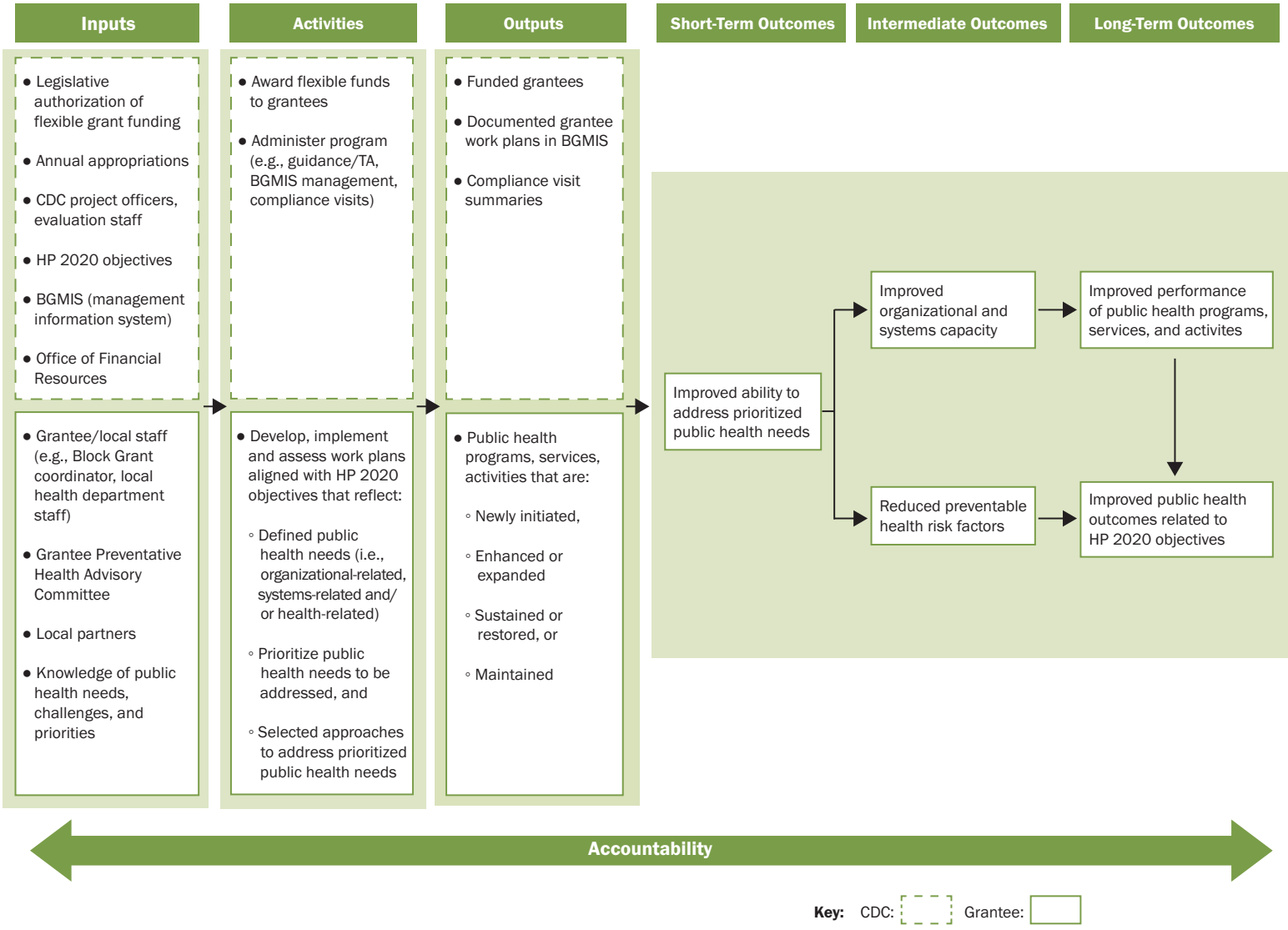
Evidence-based public health practiced

Evidence-based public health practice involves implementing effective interventions. It also includes both building and using evidence (i.e., data and information) to

- Define the public health need to be addressed (e.g., surveillance data)
- Describe the effectiveness of specific interventions with respect to outcomes (e.g., evaluation data)
- Describe how to effectively implement interventions with respect to relevant contextual factors such as setting, population, social norms (e.g., translational research data)[3]

[3] Brownson RC, Fielding JE, Maylahn CM. Evidence-based public health: a fundamental concept for public health practice. *Annual Review of Public Health* 2009;30:175–201.

Appendix A: PHHS Block Grant—Logic Model



Action Plan for Health Debrief and Next Steps

Public Health Advisory Board

November 17, 2017

PUBLIC HEALTH DIVISION
Office of the State Public Health Director

What do we want to accomplish in partnership with CCOs?

- Infrastructure for strong governance
- Specific health outcomes

Guiding Principles for Health Care and Public Health Collaboration

- Includes several domains of work:
  - Leadership and governance
  - Aligned metrics and data
  - Evidence-based practices
  - Community health assessments and community health improvement plans
  - Access to care
  - Policy
  - Workforce development

Oregon's State Health Improvement Plan

- Priorities selected based on leading causes of death, trending in the wrong direction, and/or alignment with CDC Winnable Battles
  - Tobacco
  - Obesity
  - Oral health
  - Suicide
  - Substance use
  - Immunizations
  - Communicable disease

Next steps

- January 2018 Oregon Health Policy Board retreat
- CCO 2.0 process