

FUTURE OF PUBLIC HEALTH SERVICES TASK FORCE
MEETING SUMMARY
Wednesday, July 23, 2014

Task Force Members in Attendance:

Alejandro Queral (phone)	Carrie Brogoitti	Charlie Fautin
Eva Rippeteau	Gary Oxman	Jennifer Mead
Sen. Laurie Monnes Anderson (phone)	Rep. Mitch Greenlick	Nichole Maher
Tammy Baney		

Task Force Members Not in Attendance:

Sen. Bill Hansell	Carlos Crespo
Rep. Jason Conger	John Sattenspiel
Liz Baxter	

OHA Executive Sponsor: Lillian Shirley

Meeting Summary:

- **Roll was taken; a quorum was present (Tammy Baney).**
- **Announcements:**
 - The September meeting has been scheduled for September 10, 2014 at 10:00 AM – 2:00 PM at the Portland State Office Building, 800 NE Oregon, Room 1A, Portland, Oregon 97232. June’s meeting summary was approved.
- **Public Comment**

Patricia Neal, Public Health Advisory Committee, Lincoln County

- Currently all our services are local and should stay that way
- Mental health isn’t mentioned in the Task Force models but it is part of our department because we are trying to integrate behavioral health with primary care
- If regionalization occurs, knowing that all counties are not organized the same, how will individual county needs be met?

Lesli Leone Uebel, Benton County Mental Health Planning Committee

- Foundational or core components; the draft framework represents a base minimum and doesn’t incorporate the unique role of public health in population health and we do not see a role for innovation or integration of the context of community health for health care systems and community resources.

- This is a critical time for health care transformation and healthcare cannot transform in a vacuum. The draft frame is not innovative.
- Without additional funding, public health will lose ground and recommends meaningful, sustainable funding across the state; incorporate innovation in the draft framework.
- A bare minimum of funding across the state will not spark innovation or support innovation but rather it could risk lowering the services across the state to the lowest common denominator.

Morgan Cowling, Executive Director Coalition of Local Health Officials (CLHO): CHLO held a recent webinar on the task force work and there were a number of large themes that emerged for recommendations.

- Participants overwhelming support shared services in local public health
- Participants were very concerned about imposed consolidation of public health; would it be based on transformation?
- There is a belief that regional or shared services should be locally driven based on community needs, transportation corridors, political relationships and take into consideration local systems and challenges. There is widespread disregard for consolidating 34 health departments into 8 health departments.
- Substantial solutions to implement a conceptual framework like consolidation of health departments should use local funds for public health.
- During the webinar with CHLO, participants tried to answer the question “How do we try to implement this?” Participants agreed that an assessment needs to take place to answer “Where are we right now?”

Oregon Nurses Association (ONA):

ONA submitted a document for the record. They commented that traditional health workers are the only public health workers specifically mentioned in the framework; they would like to see that all public health professionals be added as a foundational capability.

• **Straw model discussion: Overview of final changes (Diana Bianco)**

Diana Bianco reviewed the changes to the Straw model that were made based on discussion at the June task force meeting. Based on feedback from this discussion, a finalized straw model will be developed for the August meeting.

The changes and comments were as follows:

Page 1: Paragraph 1 – We need to define the nature of the document. What role does this play in the report?

Paragraph 2 – In the second sentence add “It is inevitable that in the future we will be defining new relationships.”

Page 2: The word “draft” should be removed from this page.

Make the graph its own page

Page 3: There is a typo, third bullet down, under Definition – to read “Public health programs.....”

Page 6: Collapse workforce development and add to human resources element so it is a continual piece of the entire workforce.

Throughout the document change “cultural competency” to “cultural responsiveness” and mention there are cultural differences that impact health. Nicole Maher will review these sections and make proposals to finalize the language.

Page 7: Under Community Partnership Development change the first bullet to reflect public comment from June meeting.

Add a bullet at Rep. Greenlick suggestion: “Continue and strengthen relationships with personal healthcare delivery system.”

“Education” needs to be a greater mention. There is expertise in working with the education system to understand health and how it aligns with the other reforms happening in Oregon.

Page 9: The 2nd bullet – Change to reflect the goal and not the condition; tighten the language and be careful with examples, taking a centered approach.

Child abuse and neglect need to be mentioned here: 90% of all adverse childhood events are cases of child abuse and neglect.

This section might include cultural changes discussed previously.

Suicide becomes “intentional and unintentional injury and death”

Access to Clinical Preventative Services – shorten this paragraph

Page 10: Two sentences were added to clarify public health’s role

References should be included in the document if it is an academic document-not sure references are needed.

Based on the discussion, staff will make changes and resend to the task force for review.

- **Discussion of workgroup options for implementation of governmental public health model (Gary Oxman and Diana Bianco)**

Diana reminded the task force that the context for all of this is the legislation that started this task force; the Guiding Principles, the Charter, and the larger context of Transformation in the state which is what the state is doing to achieve the Triple Aim.

The task force discussed email communication sent by John Sattenspiel, MD, which challenges the task force to be bold enough to differentiate ourselves from the past and in the future.

Gary Oxman provided an overview of workgroup process between the June and July meeting. The workgroup—consisting of Carrie Brogoitti, Gary Oxman, Alejandro Qeral, and Eva Rippeteau—meet twice to brainstorm and develop options for operationalizing the straw model.

Three options were presented for consideration by the task force. On each of the three schematics (A, B, and C), the first box is the same “Foundational Capabilities and Programs are adopted by the legislature.

Option A: Regionalization. In this option, local public health regions are defined based on cultural, historical, and geographic alignments to implement the Framework for Governmental Public Health Services.

Option B: Direct Implementation

In this option, no major structural changes are forced; use existing counties and regions to determine the foundational capabilities and gaps. In this option, the focus is on changing the culture toward foundational elements. It would put the foundational elements in every health department.

Option C: Implementation by Wave

This option has some (yet to be determined) portion of state implementing the foundationally capabilities and programs. This option allows for counties to apply for funding to implement the foundational elements: it allows for single, multi-county implementation, or multi-partner initiatives. After the first wave (timeframe to be determined), we would evaluate success of various approaches, make some adjustments to the system and then do another wave of implementation. Waves and adjustments would continue until the foundational elements are available to all people living in Oregon. For all of the options, technical assistance is available to help public health authorities implement the foundational elements. Choosing the outcomes is similar to the first model; it is part of the framework which includes more explicit outcomes this will be wave implementation. This would be done with voluntary partnerships and direct implementation.

Rep. Greenlick suggested the task force start with option C and modify as necessary. Rep. Greenlick and Sen. Monnes Anderson discussed how option C could be presented to the legislature, suggesting that this be looked at over time, starting with \$5 million a biennium. Sen. Monnes Anderson agreed, saying it is reasonable to expect some dollars to implement in waves.

The task force decided to put aside options A and B. It was decided that option C gives some opportunity for innovation and doesn't force local governments and other partners into relationships. It was agreed that it is important to do an assessment first to determine what core competencies are available currently.

There was concern expressed that option C might create a bigger gap between the “haves” and “have nots”. There has to be an opportunity for people to not be left behind. It was suggested that incentives could be used to encourage smaller, less well-funded counties to be part of the first wave.

Next Steps:

There are some pieces that would need to be finished up: incentives, criteria, structure, and governance in overseeing implementation. It was suggested the workgroup continue on with this work during the interim to develop an implementation plan for consideration by the full task force in August.

- **Final Public Comment**

Morgan Cowling, Executive Director Coalition of Local Health Officials (CLHO): Morgan encouraged the task force to talk about funding in the workgroup developing the implementation plan.