May 16, 2019

Meeting of the Conference of Local Health Officials

**Members Present:**

 Hood River – Trish Elliot

 Jackson – Jackson Baures

 Jefferson – Mike Baker

☐ Josephine – Audrey Tiberio

 Klamath – Jennifer Little

☐ Lake – Judy Clarke

 Lane – Jocelyn Warren

☐ Lincoln – Rebecca Austen

☐ Linn – Glenna Hughes

 Malheur – Sarah Poe

 Marion – Katrina Rothenberger

 Morrow – Sheree Smith

 Multco – Rachael Banks

 Baker – Nancy Staten

☐ Benton – Charlie Fautin

 Clackamas – Julie Aalbers

☐ Clatsop – Mike McNickel

☐ Columbia – Mike Paul

☐ Coos – Florence Poutal-Stevens

 Crook – Muriel DeLaVergne-Brown

 Curry – Ben Cannon

☐ Deschutes – Hillary Saraceno

☐ Douglas – Bob Dannenhoffer

☐ Grant – Jessica Winegar

☐ Harney – Jolene Cawlfield

 North Central PHD – Teri Thalhofer

 Polk – Jacqui Beal

☐ Tillamook – Marlene Putman

 Umatilla – Joe Fiumara

 Union – Carrie Brogoitti

 Washington – Tricia Mortell

 Wheeler – Karen Woods

 Yamhill – Lindsey Manfrin

 HO Caucus – Pat Luedtke

 CLEHS Caucus – Joe Fiumara

☐ AOPHNS - vacant

**Public Health Division:**

Danna Drum, Sara Beaudrault, Tim Noe

**Coalition of Local Health Officials:**

Morgan Cowling, Caitlin Hill

**Minutes**

Karen Woods motioned to approve, Jocelyn Warren seconded. Minutes approved.

**Appointments**

No appointments

**PE 46: Reproductive Health Services**

PE 46 is about community participation and assurance. Goal was to make sure the program element matched the tool. Technical administrative changes, formatting changes, ensuring templates match. Updating to formatting. Suggested activities were added. PE 46 is not about family planning services which is done through a contract with the state. Receiving less funding but it is through a different avenue. Less about content more about format. Even after CLHO approves it will have to go through DOJ so some minor changes might be brought then.

Teri Thalhofer seconded. CLHO Board approved.

**TPEP Funding Workgroup Update**

Documents are posted on the CLHO website. CLHO not taking a vote today because the workgroup is still working through decision-making process. Wanting to get feedback from administrators about where the workgroup is headed. Looked at using a tiered model for TPEP funding. Different tiers based on the capabilities that the county is able to do.

Tier 1 - Have some communities with zero clean air act complaints. Range of funding for the work based on the number of complaints. State was able to look back and see an average per county.

Discussion about the options to pay per complaint or pay for base. A base makes sense. Amount you know you are getting. Some counties would get 15k even when they have no complaints. There is a fair amount of training to be able to train staff appropriately. At minimum would need a .5 FTE. Different in terms of financing. People thought you could use more FTE.

How would you determine range for LPHA? Would depend on the workplan proposal. If a county determined they would want to be in this tier the objectives in this tier would help determine the funding amount. What criteria is used to determine the funding. Certainly developing strategic plan would be more than just ICAA response. Allows counties to have flexibility.

County proposes the budget. Every county has different needs and budgets so they would propose the budget they would need for activities for Tier 1. Teri suggested clear values for each activities. North central is one authority and Teri’s view is that she is penalized in the tiered model. If it was by county it NCPHD would not be penalized.

Tier 2 focuses more heavily on policy work. Tier 2 provides funding to advance at least two priority policy strategy areas, selected by local program from a menu of options: Tobacco Retail Licensure (TRL), Indoor Clean Air Act (ICAA) expansion, or tobacco-free government properties. The program must also choose at least one multi-sector systems change initiative in collaboration with health systems partners.

Again what is determined to be a more costly activity so people have clarity about what they are selecting. Proposing what you need.

If state partners are making the decision about the funding there needs to be transparency about how much activities will cost. Transparency around context of work and why you need what you need.

You can get bumped down if you are not able to keep going. An LPHA is able to identify what tier they are working in. You are at the beginning of one policy strategy and see tremendous progress. Advancing continually moving forward in the policy arenas.

A couple counties brought up that they may not fall within a tier.

Danna said the intention is that as the work evolves the work overall will shift. CLHO asked if people could move within a contract period? Feedback to the group about what would bridge the funding.

TRL can be a difficult lift in more rural communities.

Tier 3 programs implement Program Element 13 in all three priority strategy areas – TRL, ICAA expansion, tobacco-free government properties (identified in submitted workplans) – as well as at least one multisector initiative for tobacco prevention in collaboration with health systems. LPHAs will have opportunities to propose community-tailored strategies within the four priority areas listed above.

Lindsey asked for overall feedback about the concept of tiered structure to take back to the workgroup.

Rachael – looks like improving what you already have done. Folks should think about policies coming forward and demonstrated capacity and less about policies and strategies that could happen in the future. Criteria could include statewide work. This is heavy on the health systems work. We could look at policies at the local level and pushing towards state policy. Regional approach – thinking about how progressive or advanced a regional approach could be. It’s challenging since regions are really different.

Question of local accreditation was raised. Clarity around what the expectation is related to accreditation. It isn’t a requirement.

Teri – 5 of the 8 criteria in tier 3 seems like a high bar. Who would be eligible for tier 3? Could we test which counties would be eligible for tier 3? Poll was requested to see where counties would be for evidenced implementation. Will look 36 different ways.

On the right track it just needs more detail. There is distrust in the system at the county level about how this work moves forward locally. There was a reminder that the CLHO Board requested local representatives on the review committees.

If you have any big overarching concerns and something occurs to you share with Lindsay. The last couple months working through this there has been a lot of progress and collaboration. Regroup of workgroup has been full collaboration in the system.

**HP & P Opioid Funding Update**

Laura Chisolm, section manager of the IVPP, presented. Coming to the end of a four year cycle of funding for prescription overdose grant. OHA put in proposal earlier this month for overdose data to action. Plan is to continue to blend the funding they are receiving from CDC for prescription overdose prevention. Blending SAMSHA funding with this funding and trying to make it seamless for counties. Nine regions are being funded. Hoping to expand that to fund the entire state. Change in epidemiology of overdose. CDC has changed to overdose instead of just opioid. Mary Borges has been working with the P & HP committee to get some advice about new funding opportunity. With CDC funding it is pretty expansive. There could be seamless funding coming into the state for things like surveillance of non-fatal overdose. Looking at process over the summer and hoping to have notification by August 15th. Transparency around CJS for regions to share local context. Very interested in providing flexibility to local partners since epidemic looks so different across the state. RFP will contain focus for coordination. A lot of new partners working on this. Wanting to ensure there are resources for that coordination piece regionally. RFP will be developing drug overdose emergency response plan. CDC is recognizing the ability to be more nimble to outbreaks as they are occurring. At the state level there will be increased work to surveillance on ESSENCE to look at overdose closer to real time. Looking to shore that up. Continued exploration of evidence – based strategies. Local coordinators working on data to action. Opportunities to work with hospitals and harm reduction strategies. Expanding sorts of partners working with at state and local level. P & HP Committee has been meeting with Mary to pull together a draft RFP. Hoping to be able to expand entire state with regional approach. Danna will send out the regional map of who is currently funded. Could be pretty fast turnaround on this RFP. Mary is planning on making trips to local jurisdictions.

Who should Mary meet with. Should it be local health administrator or coordinator. Should start with administrator.

Feedback from Tricia: Regional approach where there is only funding for a regional person does not really work at the local level.

**PHAB Accountability Metric: Opioids**

Discussed the 19-21 biennium changes. Each outcome measure has a corresponding process measure. Over time looking at individual LPHAs. Each row is noted as outcome or process measure. Dental visits from age 0-5. PHAB feels this is important to track but haven’t gotten to where they can make improvements. Hard to get population data on this. This year making progress about prescription opioids but feeling they aren’t looking at the full impact of the opioid epidemic. Changing the outcome measure would mean we would need to change the process measure. If county has property tobacco policy it is showing complete, PHAB is wanting to look at partial. Active Transportation changes the measure in what counts. For drinking water most of the measures across the state are at 100%. Contraceptive use – pulled it from PE 46 reporting. Does not capture strategic planning.

Opioid outcome measure: Matt Laidler discussed the limitations of the data. As rate of mortality increases associated with fentanyl it has become problematic. ICD 10 coding doensn’t account for illicit drugs. Metric that they settled on excluded fentanyl. Excluding fentanyl would exclude other opioids. Potential of expanding metric to any opioid. There are other options as well. Maintaining definition of opioids but it would exclude synthetic opioids. Using any opioid might be preferable.

What does Local public health think about moving from prescription opioid to a broader measure.

Discussion: Only get funded for opioids. Need to tee a metric up for what locals are funded to do.

Tracking – is there a way to change the metric while tracking progress? Is there a risk in changing the metric too frequently? If we opt for a more inclusive measure would it be helpful to include prescription specific measure? Concern was brought up at PHAB.

If you have concerns contact Teri or Muriel.

**Universally Offered Home Visiting RFP**

Discussed where we are in legislature process, SB 526, and governor’s budget. POP funding for universally home visiting for family connects for Medicaid. SB 526 for commercial insurers to pay for home visiting. Funding for OHA to manage this across the state. On the 3rd released a LOI to tribe, LPHAs, and early learning hubs to solicit input. Community alignment process. Community driven. People are allowed to submit LOIs. Very high level. Part of the process is to prepare communities for preparing communities who are interested in being early adopters. Looking to get 5-6 communities. LOIs are due June 3rd. Diverse group of communities for the cohort. Tiered approach for a learning process and in the fall they would develop a broader RFP for the whole state. There was a question about why this came out before the end of session. Actually receiving funds from early learning division. Preschool development grant for the early adopter communities. End of June will be able to make more concrete plans. State received funds. Are there funds attached to the local planning activities. Family connects will be very engaged with local communities. Once they know about funding there could be funds to the planning communities.

No funding attached to the RFP. Concern that there is a lot of work for no money. Community alignment specialist would come during implementation. Need to know the FTE. With no funding attached, Teri’s view is that it is not acceptable.

Rebecca might have some information about how FTE is dedicated to family connects.

Early adopters would be part of process to start the projects. The early adopters will get to do the first round of implementing.

When does funding that legislature has go to communities? If they find the early adopters need support there may be more funds for that. Gov’s budget is for implementation.

Thought that there was support for local training and staff. CLHO Board requested information about money and details of the planning and implementation.

**CLEHS/EH Workgroup Update**

Caitlin shared that the CLEHS/EH Workgroup decided to designate two members to serve as liaison between the two groups for improved communication and workflow. Danna will be better about flagging information for Julie Hamilton. Information isn’t always being relayed to EHS.

**Food, Pool, Lodging Health and Safety Pool Plan Review Position**

Staff resigned without notice. Looking at a Plan B.