PUBLIC HEALTH DIVISION

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Memorandum

To: The Honorable Senator Alan Bates, Co-Chair
The Honorable Representative Nancy Nathanson, Co-Chair
Joint Ways and Means Subcommittee on Human Services

From: Mel Kohn, MD, MPH, Director
Public Health Division

Date: February 22, 2013

Subject: Response to questions asked during the Public Health presentation to the Subcommittee on February 18 and 19, 2013

Thank you for the opportunity to provide information about Public Health Programs to your committee. The following are responses to the questions committee members asked during our presentation. Each question listed below is identified by a number and a corresponding response.

1. **► Sen. Winters: Are we working with ER docs on the prescription drug overdose issue? What sorts of partnerships have been formed?**

Emergency department physicians have been a great resource in understanding some key issues with regard to prescription drug abuse and emergency departments. Emergency department physicians have been engaged in several ways with our initiatives to reduce overdose.

During early implementation of our Prescription Drug Monitoring Program (PDMP) emergency department physicians provided testimony to the state PDMP Advisory Commission. That testimony informed us that hospital policy supports writing prescriptions that satisfy patients. This is a key problem. Performance Measures for hospital accreditation are linked to "patient satisfaction". All emergency departments track patient satisfaction. Physician performance and merit pay are linked to this measure (among other measures). An unintended consequence of linking patient satisfaction to performance of individuals and to hospital accreditation is that individuals who want an opioid prescription have leverage to get a prescription written. Their complaints about denials create an incentive to write prescriptions. The result is we have a national policy

that creates an incentive for ED physicians to prescribe what the patient wants. Each hospital is dealing with this internally. This is a problem with national and federal policy. Emergency department physicians participated in a PDMP program evaluation survey. Our PDMP program evaluation was designed to determine barriers to effective use of the PDMP system. ED physicians (like their colleagues in other specialties) report that they find the PDMP useful. They also report that they need to be able to delegate the task of querying the system and producing the patient report to other staff whose positions include chart work.
Emergency department physicians have participated in prescription drug abuse policy workgroup activities.
Emergency department physicians have established a new protocol for handling pain medications in emergency rooms. The protocol is in place but it is causing problems around patient satisfaction.
A prescription drug abuse policy workgroup appointed by Governor Kitzhaber has held several meetings in Oregon funded by the National Governor's Association. Emergency department physicians have participated in policy workgroup activities. The policy workgroup recently completed a one day multidisciplinary meeting in Salem attended by over 100 professionals. The proceedings from this meeting are being use to prepare a set of policy initiatives for Governor Kitzhaber.

2. **► Sen. Bates: The committee heard last week from PEBB that the tobacco use rates for state employees was down to 4 percent. Sen. Bates wanted to know if that was a valid number. He also wanted to know the number of packs sold and current tobacco use rates.**
   ► Rep. Nathanson: Do we have data prevalence rates for tobacco candy, chew and electronic cigarettes?

Tobacco use estimate among Oregon state employees and overall
The proportion of Oregon state employees that smoke cigarettes decreased to 4% in 2012, down from 9% in 2009 and 10% in 2007. These data were collected by way of a survey which is called the Behavioral Risk Factor Surveillance System (BRFSS) Survey of State Employees.

Data on tobacco use were collected by two other means among this population as well, and evidenced confirmatory results.

In October 2011, every PEBB-covered state employee was required to disclose his or her tobacco use status during enrollment in benefits. At that time, the proportion of tobacco users was 6.8%. In October 2012 the proportion had declined to 5.5%. By comparison, the proportion of tobacco users as determined from the BRFSS Survey of State Employees was 5.6%. These numbers are virtually the same.

Finally, in mid-2012 one of the state's major health insurers assessed tobacco use among all PEBB-covered individuals, including primary subscribers as well as spouses and partners. Among this expanded group, tobacco use was 6.7%. That this number is slightly higher likely reflects inclusion of non-state employees in the assessment.

Based on this triangulation of tobacco use data from three independent data collection systems, we feel confident that state employee smoking has decreased to 4% over the past five years.

In comparison, 16% of all Oregon adults who are employed and insured report smoking cigarettes (2011 Oregon Annual BRFSS). Among all adult Oregonians, 4% use smokeless tobacco. Data on e-cigarette usage or tobacco candy use among Oregon adults is not available.

Oregon's per capita pack sales have declined during the same time period, from 55.1 in 2007 to 46.5 in 2011. This is a continuation of an ongoing downward trend since Oregon's Tobacco Prevention and Education Program first began in 1996, when Oregon's per capita cigarette pack sales was 92.1.

3. **► Sen. Steiner-Hayward: Can you speak to the coordination between OHA and DHS on WIC issues?**

WIC is administered under the Oregon Health Authority (OHA) because their mission of helping people achieve optimum health through partnerships, prevention, and access to healthcare directly aligns with WIC's purpose. WIC is a public health prevention program, funded by the US Department of Agriculture (USDA) and is committed to advancing the nutrition status and health of women, infants and children. WIC's placement in OHA and public health clinics allow for immediate referrals for key health services such as immunizations, nurse home visiting, Oregon Mothers Care and Babies First.

DHS is a vital partner to WIC. Referrals are one of the four key services provided to WIC participants. Each family is screened for participation in SNAP and given information on that program. SNAP offices have WIC posters in their waiting areas and small business card sized referral cards to give to families with young children or pregnant or postpartum women. A WIC state staff is a member of the SNAP Outreach advisory group. SNAP managers are members of the WIC Advisory Board. WIC and SNAP are both members of the Nutrition Council of Oregon and use that link to coordinate nutrition education messages.

WIC also coordinated with other DHS programs serving families with younger children, such as Foster Care and child care programs.

SNAP and WIC utilize the same referral services through SafeNet/211. SafeNet/211 screens and refers callers to all programs that they are potentially eligible.

WIC will continue to communicate and collaborate with these programs to ensure that referrals are happening between DHS and OHA programs. Similar referrals and collaborations occur between WIC and all Head Start programs including those run by the Oregon Department of Education.

4. **► Sen. Steiner-Hayward and Rep. Nathanson: Value of accreditation and the progress made to date.**

Public health accreditation is a national, voluntary process to demonstrate organizational performance. The process is administered by the Public Health Accreditation Board, a nonprofit based in Alexandria, VA. Accreditation documents a public health department's capacity to deliver high quality and effective services within the three core functions and Ten Essential Public Health Services. The applicant provides existing documents drawn from its full range of programs and services. Through this process, organizations have a new opportunity to identify and standardize best practices and share them across the organization and broader system. The process also allows agencies to identify gaps and to improve service delivery. This critical capacity analysis spurs continuous review and performance discussions with a goal of ensuring that all people in Oregon have access to efficient and effective public health services, no matter where they live. Resulting reports and activities ensure accountability to communities that they are receiving high quality and equitable services.
The Oregon Health Authority is preparing to finalize its application in September 2013, and is busy finalizing and implementing its prerequisites (community health assessment, community health improvement plan and divisional strategic plan), and scoring documents. Many Local Public Health Authorities (LPHA) are involved in the same accreditation readiness activities. Solid connections exist between Oregon's Health System Transformation activities, as well as national health reform agendas, and accreditation preparation. Local Public Health Authorities (LPHA) are partnering with Coordinated Care Organizations to develop shared community health assessments and community health improvement plans. Performance conversations and improvement activities directly support improved health outcomes through the Triple Aim (Improving the lifelong health of all Oregonians; Increasing the quality, reliability and availability of care for all Oregonians; and Lowering or containing the cost of care so it's affordable to everyone). Additionally, accreditation requirements and prerequisites resonate with nonprofit hospitals required, by IRS, to develop community health assessments and community health improvement plans, as well as maintain Joint Commission on Accreditation of Healthcare Organizations standards.

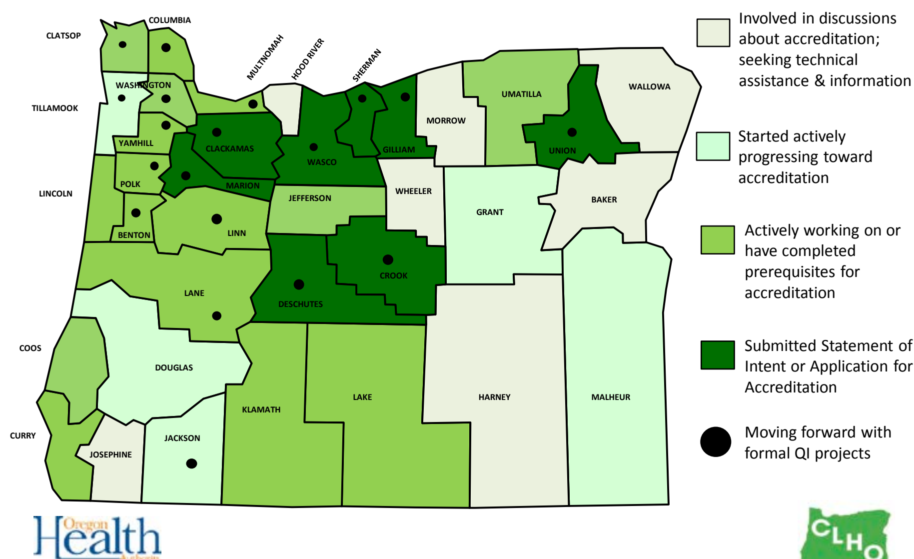
Funding for accreditation is provided under the Centers for Disease Control and Prevention's *Strengthening Public Health Infrastructure for Improved Health Outcomes grant*. This funding has allowed OHA to develop the three prerequisites and fund a small team to support Public Health's application, cross public health system activities and LPHA grants. At the local level, funding from the Infrastructure grant, combined with funds from the Northwest Health Foundation, has created significant momentum around accreditation activities. In 2009, Deschutes County was a beta site for accreditation to the national Public Health Accreditation Board (PHAB). As of December 2013, 100 percent of LPHAs have completed their accreditation readiness checklists; 26 percent have submitted their statement of intent to apply, and 56 percent of this group have also submitted their formal application for accreditation; and, at least 38 percent of LPHAs have completed at least one prerequisite.

At the State level, the Infrastructure grant funds one accreditation analyst (OPA2) who is focusing on building and implementing the system to identify, track and score documentation pulled from our 120 programs. We also have an AS1, through July 2013, who is requesting documents and editing to meet PHAB requirements. After the application is completed, the accreditation process will be maintained by part of one FTE. National organizations are actively messaging that preference for future funding may be given to accredited agencies.

Additional Web Resources

- Public Health Accreditation Board, Accreditation Process; http://www.phaboard.org/accreditation-process/
  Details on the Public Health Accreditation standards and measures, and the process for becoming accredited.
- Public Health Oregon.gov, Public Health Planning, http://public.health.oregon.gov/About/Pages/StrategicPlanning.aspx
  Public Health Division's accreditation prerequisites: community health assessment, community health improvement plan and divisional strategic plan.
- Public Health Oregon.gov, Public Health Accreditation Readiness Projects; http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Pages/AccreditationReadinessProjects.aspx
  Overview of local public health authority accreditation readiness projects funded by PHD and the Northwest Health Foundation.

Accreditation Readiness 2012



Current as of December 2012 based on status updates and surveys conducted by CLHO. Note: this may not represent all LPHA progress towards accreditation as readiness activities evolve very rapidly.

5. ► Sen. Winters: How will public health address challenges of increasing numbers of people with health disparities as the population changes?

We recently did a CD Summary on this topic. The web address is: http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/CDSummaryNewsletter/Documents/2013/ohd6204.pdf

The Oregon Health Authority is looking to address the issue of health disparities in the changing population in several ways.
1) The role of public health epidemiologists is to understand differences in disease distribution in the population, and to address those disparities if possible. We are working to collect better data on race ethnicity throughout OHA by implementing standards for "REAL" (Race, Ethnicity, and Language) as various database system are upgraded and changed. This is important so that we can really understand which health disparities affect different racial and ethnic populations. For example, we know that Native Americans in Oregon have higher rates of tobacco use that the overall population; in contrast, Hispanic mothers have better immunization rates for their children than does the overall population.

2) Efforts to improve the community's health needs to be done in partnership with those communities. Public Health, particularly at the local level, works with community health

workers to reach populations at risk, and make sure that those communities are engaged in their health.

3) Much of the actual work in public health is done at the program level, and it is these programs that help to fund specific efforts aimed at addressing health disparities. For example, the Tobacco Prevention and Education Program provides funding to tribes for tobacco control activities. Another example is funding that the Health Promotion and Chronic Disease Prevention Program provides to regional equity coalitions to do community assessments and plans focused on racial and ethnic health disparities.

As the CD Summary states, much of the growth in diverse populations in Oregon will be the increase in the Hispanic population, as well as in-migration from abroad (currently, the majority of TB in Oregon occurs among foreign-born). Making sure that information is made available in a culturally acceptable (and appropriate language) will of utmost importance.

6. **► Rep. Nathanson wants to know more about the impact of hearing loss on adults and children. Information requested about the work done on newborn hearing screening.**

Early Hearing Detection and Intervention Program

- Three out of every 1,000 newborns have some degree of hearing loss, making hearing loss one of the most frequently occurring birth disorders.
- Research has shown that infants, who are identified early and receive early intervention services before six months of age are 1-2 years ahead of their later-identified peers in language, cognitive, and social skills by first grade.
- Research shows that by the time a child with hearing loss graduates from high school, more than $400,000 per child can be saved in special education costs if the child is identified early and given appropriate educational, medical, and audiological services.

To ensure that Oregon infants, who are deaf or hard of hearing, can reach their potential, Oregon's Early Hearing Detection and Intervention (EHDI) Program in the Oregon Health Authority follows the Centers for Disease Control and Prevention (CDC) national recommendations as seen below:

- Screen all newborns for hearing before one month of age.
- Provide diagnostic audiology evaluations before three months of age.
- Enroll in early intervention before six months of age.

The EHDI Program facilitates Oregon's Newborn Hearing Screening legislation (ORS 433.321) mandating the following:

- Hospitals, diagnostic audiology centers and early intervention programs report individual level results to EHDI.
- DHS/EHDI develops and maintains a Newborn Hearing Screening Registry, Tracking and Recall system to ensure all infants are screened and receive necessary follow-up services.

Currently, almost all infants born in Oregon receive a hearing screening, especially if they are born at a mandated screening hospital. The EHDI program is working to increase the percentage of infants screened who are born at non-mandated hospitals and out of the hospital. Slightly less than half of all referred infants return for a diagnostic evaluation, and referred infants outside of the Portland area are even less likely to have a diagnostic evaluation. The Oregon EHDI program is working to increase access to diagnostic audiology across the state. The EHDI program has made great strides in improving the percentage of infants with confirmed permanent hearing loss who enroll in Early Intervention, and we continue to dialogue with EI about ways to streamline enrollment reporting. EHDI staff are currently working to fully integrate EI data into the EHDI system, to increase access to primary care provider information, to expand free screening clinics, and to complete hospital scorecards for each hospital in the state.

7. ► Sen. Bates and Sen. Steiner-Hayward: How many pharmacies are participating in the PDMP and are we coordinating with the VA?

Until just this month federal rules and policy did not allow the VA to submit data and did not allow VA staff to register for PDMPs in their respective states. This is changing now.

The new federal rules and policies took effect February 11, 2013 - last week. We expect to begin enrolling VA practitioners beginning this month. We aren't clear yet about the path for getting pharmacies engaged. We will be working with them on this effort but this is very new still.

There are 730 pharmacies regularly reporting data, as they dispense on a regular basis. There is a group of about 65 pharmacies that only dispense controlled substances intermittently – most often report zero. There are 8 pharmacies that we don't have enrolled.

8. ► Babies First: Information on the funding/county match. Why isn't Babies First in the ELC?

The state PH budget for Babies First! contains $1.4 million in General Fund per biennium. This is not matched within the state budget. However, $1M of this is given to local health departments through a formula, and counties then contribute local funds to

complete the required match for Targeted Case Management (TCM). Participating counties fill their match requirements, provide the services, bill directly to the Medical Assistance Program (MAP) and are reimbursed at a rate of $355/TCM encounter. TCM requires a match, and TCM reimbursement rates vary depending on if the child is eligible for Medicaid (37.56%) or SCHIP (26.29%).

The ELC is currently funded with the dollars that were going to the Commission on Children and Families. This supports staff and the Healthy Start~Healthy Families Oregon program. According to the ELC's (Governor's) Comprehensive Children's Budget, all other early childhood funds stay with the agencies and are "blended and braided" to create the early learning system. Thus, Babies First! stays with the Oregon Health Authority and is braided into the menu of services available for families at the local level (see page 4 of the 2012 report) http://www.oregon.gov/gov/docs/OEIB/1aaComprehensiveChidlrensBudgetReportFinal.pdf