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Person-Centered Behavioral & Physical Health Care Public Health & Prevention Regulatory and Population Health Health Management Services

9 March 2015

Testimony to the Senate Health Care Committee on behalf of the Oregon Coalition of Local Health Officials (CLHO)
Re: SB 663

Madam Chairman,

My name is Charlie Fautin. I am a public health nurse, the Public Health Administrator in the Benton County Health Department, a board member of the Oregon Public Health Association and was a member of the Task Force on the Future of Public Health, created by HB 2348 (2013).

I am testifying today as a member – and on behalf of - the Oregon Coalition of Local Health Officials, representing the 34 Local Health Departments who work diligently to protect the health and prevent disease in every city, town, neighborhood, school, restaurant, home, and ranch in Oregon. CLHO is supportive of the recommendations in the Task Force's final report and supportive of a bill that is amended to reflect those recommendations.

Before I talk about the work of the Task Force I'd like to tell you a little bit about Benton County Health Department as an example of the critical prevention work that is done at the local level.

In 2012 public health departments world-wide were alerted to the emergence of MERS, or Middle-Eastern Respiratory Syndrome - a new virus related to SARS which sickened thousands in 30 nations and killed over 800 in 2003. My department paid attention to the global MERS alerts immediately because we have a large middle-eastern & Muslim population.
Benton County Health Department has long-standing & strong relationships with the Oregon State University International Students office and Student Health Services, as well as with the Salman Alfarisi mosque in Corvallis. Those local relationships allowed us to get local information & education rapidly & effectively to foreign students, Haj pilgrims, and other travelers – implementing local awareness and prevention measures to help prevent a potential outbreak which would likely exceed our local response capacity and require cost-intensive intervention from OHA and CDC.

All local health departments use these sorts of local relationships every day to monitor returnees from Ebola-stricken nations in Africa; to prevent spread of measles, meningococcal disease, and food-borne illnesses; and to be ready for the next emerging pathogen that might threaten Oregonians.

Health reform and the creation of Coordinated Care Organizations has created the opportunity for new collaborations that can enhance not only clinical care but can help prevent illness from striking Oregonians in the first place.

My department, along with my colleagues in Lincoln and Linn County Health Departments, has developed outstanding regional partnerships with our Coordinated Care Organization, InterCommunity Health Network.

IHN-CCO is acutely aware that tobacco is a major insurance cost-driver, and that its membership has the second-highest tobacco use rate of any CCO. The CCO is an active partner and the fiscal agent for a region-wide tobacco prevention project titled Strategies for Policy and Environmental Change, Tobacco-Free (SPArC). The SPArC grant is funded by Tobacco Master Settlement Agreement funds that were allocated specifically for tobacco prevention in the current state budget. While IHN can and does work with medical clinicians on tobacco cessation, they are also aware that the vast sums spent on nicotine marketing mean that cessation is an endless and expensive treadmill – and that community tobacco prevention is also necessary.

Our regional SPArC project combines the leverage that the CCO has for clinical cessation interventions, with the training and expertise of local health department staff to work with schools to implement tobacco prevention curricula, with local landlords to implement cost-saving smoke-free rental policies, with counties & municipalities to adopt strong local tobacco and e-cigarette ordinances that build on, supplement, and enhance state statutes.

I am confident in testifying today that IHN is fully aware that they do not have the well-developed skills or community partnerships – and do not have the mandate - to do the population-wide prevention & policy work that public health departments are expert in, and which research indicates is necessary to truly reduce nicotine addiction and reduce the future costs of smoking-related diseases.

I tell you those stories of local work because they illustrate the perspective that I brought to Task Force meetings over ten months. The Foundational Capabilities / Programs model in the Task Force report can be a huge step toward strengthening these sorts of capabilities and collaboratives - where each partner contributes unique assets and proficiencies that others do not possess.

The Task Force Recommendations build upon great state and local public health work, but are only step one of a long-overdue process to modernize Oregon's entire public health system. The Foundational Capabilities / Programs model has the potential to provide better accountability, alignment and coordination for our state and local public health departments, and it aligns well with modernization work underway in Washington and Ohio, as well as work being done at the national Institute of Medicine.

CLHO very much appreciates the work of the Task Force and the legislature to move Oregon forward toward implementing a truly 21st century system, and urges this committee to follow the lead of the Task Force and take the perspective of local public health experts into consideration and adopt amendments to HB 3100 that will more closely align it with the Task Force recommendations.

Morgan will provide more detail about our recommendations which include:

- An enhanced Public Health Advisory Board to set metrics and have oversight responsibilities of the new conceptual framework for state and local public health.
- Recognition that public health research and practice continue to innovate and improve on past evidence-based practices
- That greater flexibility be allowed to form inter-county public health districts
- That current funding allocation systems not be abandoned until the full cost of modernization is known & the monies to implement it is available
- That the transition timeline for this new model be shortened to prevent having two concurrent systems operating in Oregon.

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I thank you for this opportunity and urge this committee to listen as carefully to the voices of local public health experts as the Task Force did, and give serious consideration to the amendment suggestions that CLHO is recommending.

Charlie Fautin RN, MPH
Health Administrator