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MEMORANDUM

TO: The Honorable Sen. Elizabeth Steiner Hayward, Senate Co-Chair
The Honorable Rep. Dan Rayfield, House Co-Chair
Subcommittee on Human Services

FROM: Janell Evans, Budget Director, Oregon Health Authority

DATE: March 3, 2017

SUBJECT: Responses to March 1 Public Hearing Questions

During OHA's presentation before your committee on Wednesday, March 1, committee members asked questions that required additional follow-up. Here are those questions and our responses:

Sen. Steiner Hayward (12 min): Have we had any maternal-child transmissions of HIV? Are they HIV positive pregnant women getting prenatal care?

> Regarding transmission of perinatal HIV infection to babies born to HIV-infected Oregonian mothers, Oregon had a single perinatally infected baby in 2008. No such cases occurred from 2008–2015. (Though a few infants born in Oregon to mothers who immigrated to Oregon late in pregnancy infected were ultimately found to have HIV.) In 2016, there was one infant born to a young incarcerated woman who was pregnant. The correctional facility performed an HIV test, and when the HIV test was positive, antiretroviral treatment was initiated promptly. Unfortunately, prenatal antiretroviral treatment occasionally fails to prevent transmission, and the baby was found to be HIV infected.

Oregon has experienced very few perinatal HIV infections in the past decade, likely related to implementation of a law in 2005 or 2006 requiring that all prenatal providers offer HIV testing within 10 days of initiating prenatal care. Analysis of our Perinatal Risk Assessment Monitoring System data concluded that well over 90% of Oregon mothers had received prenatal testing for HIV. We typically are aware of a handful of pregnant HIV-infected each year (some diagnosed as a result of prenatal screening) who deliver uninfected babies, attesting to the effectiveness of prenatal treatment.

Oregon's End HIV Strategy, includes as a goal, universal HIV testing for all Oregonians aged ≥15 years (consistent with CDC and the US Preventive Services Task force guidelines. Approximately 1000 Oregonians are estimated to be living with yet-undiagnosed HIV, and they are likely responsible for disproportionate numbers of newly transmitted infections. Unfortunately, Behavioral Risk Factor Surveillance data indicate that fewer than 50% of adult Oregonians report ever having been tested for HIV. Healthcare institutions will need to adopt policies supporting universal HIV testing. OHA encourages all stakeholders to adopt strategies to achieve universal testing and looks forward to providing assistance and support.

Rep. Buehler (25 min): So according to statute you can't push notifications from PDMP? Technically-speaking can you do it?

The system technology could, in theory, provide push notifications to prescribers and pharmacists. However, the PDMP statute does not currently allow the program to enable push notifications in the system. Further, there isn't yet an algorithm that can reliably identify patients at high risk, the result is that many push notifications would go out but most would not be meaningful. A reliable and valid algorithm, using a combination of PDMP information, other clinical information (behavioral health and comorbid conditions), and overdose emergency care information, would need to be developed for push notifications to be viable.

Sen. Steiner Hayward (50 min): Who's tracking the enforcement of school specific immunization rates and disease-specific rates? Are schools sending that information out or just putting it on their website?

Since the passage of SB 895 (2015), schools and child care facilities have been required to share their immunization and exemption rates in three ways:

1. By posting on their website,
2. By making available in their main office, and

3. By sharing directly with parents, in paper or electronic format.

The Oregon Health Authority, Public Health Division Immunization Program provided updated data for sharing in the spring of 2016. The Immunization Program follows up with inquiries and complaints about compliance with the requirements, in addition to checking compliance at ~90 school and child care visits conducted annually. The Immunization Program has helped support implementation of the law by providing resources to schools and child care facilities, including educational materials about the requirements for sharing rates, and a fillable template for sites to make a graph of their data for sharing. The Immunization Program is currently investigating the potential to create an interactive map of school and child care immunization and exemption rates, for sites to more easily share their rates and for parents to see rates of different schools and child care facilities in their area.

Sen. Winters (56 min): Can you, when you give your report, provide the rates by each county for walking? How does Oregon rank compared to other states based on the 7 areas identified in SHIP?

According to the Centers for Disease Control and Prevention (CDC), adults need at least 150 minutes of moderate-intensity aerobic activity (or vigorous-activity equivalent) every week, AND muscle-strengthening activities on 2 or more days a week that work all major muscle groups (legs, hips, back, abdomen, chest, shoulders, and arms). However, less than 1 in 4 Oregon adults meet these recommendations.

Walking is the most common form of physical activity among adults. More than half (53%) of Oregon adults report walking as their primary or secondary form of aerobic activity (Source: 2015 Oregon BRFSS. Unpublished data).

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day. However, less than 1 in 3 Oregon 8th graders and 1 in 4 Oregon 11th graders meet these recommendations (Source: 2015 Oregon Healthy Teens)

*See Attachment for county level detail.

Rep. Buehler (59 min): I'd love to see how we compare with other states too, but then take it a step further and see your 3-5 year goal? And then maybe tie it to the regional CCO plans?

We appreciate Rep Buehler and the committee's interest in seeing where Oregon compares to the rest of the country on key population health metrics. We are in the process of developing such a report card, and should have that finalized within 1-2 weeks. We are also very interested in making sure that the State Health Assessment and State Health Improvement Plan, aligns with assessments and health improvement plans done by CCOs as well local health departments. This cross-walk is an example of cross-sectoral alignment of efforts, which is a goal of public health modernization. We will plan on producing this cross-walk over the next couple of months.

Rep. Rayfield (1 hr 5 min): Can you get down into specific geographic areas [for health data]? How specific can you dig down currently with the data you have? Can you do city-wide or neighborhood-wide?

Public Health data is available in four large categories:

- Vital records (e.g. birth and death certificates)
- Reportable disease registries (e.g. communicable diseases, cancer)
- Service delivery (e.g. Immunization registry, C-care)
- Survey data, including adult, youth (e.g. tobacco, obesity, other health behaviors)

For the vital records, reportable disease registries, and service delivery registries, we collect individual client information, including address, so are able to determine where people live. For the data we collect from surveys, we do not have individual address but can drill down to the county level. The challenge with these data is that we may not have enough response in specific areas (ie, smaller counties in eastern Oregon) to consider it valid. To perform analyses of these public health data sets by specific geographic area, community, neighborhood, the public health division would need additional resources to support this detailed analysis.

Sen. Winters (1 hr 14 min): SNAP – Do the public health forums and conferences you attend provide an avenue for you to have discussions with other partners on the SNAP programs and its shortfalls? Do you take that opportunity to discuss common health issues?

Provided by DHS (Jill Gray)
Since 1993, SNAP-Ed has improved the diets, food-related behaviors (including shopping and food safety practices), and physical activity levels of thousands of low-income Oregonians. Oregon's SNAP Education plan and work has been highlighted

at National Conferences, due to the coordination of partnerships through-out Oregon. Some examples are linkages to Oregon's WIC program, Oregon Department of Education and the Oregon Food Bank, as well as, some community health providers.

Provided by Sue Woodbury (WIC)
In Oregon the three USDA Food & Nutrition Services (FNS) programs - WIC, SNAP, and Child Nutrition (Oregon Department of Education) - work together to coordinate nutrition messages and resources. All programs have the same overarching goal of improving the nutrition of the populations they serve but each operates under different regulations and federal guidance. USDA has commended Oregon's FNS for their collaboration on nutrition education messages, materials, projects and program work plans. This work has been held up as a best practice for nutrition programs collaboration.

For Public Health's WIC program, participants receive a monthly food benefit that includes fruits and vegetables, whole grains, low-fat dairy and iron-rich foods. Science-based healthy WIC food packages not only improve access to healthy food for the Program's target population, but also increase the demand for healthy food items in local food retail outlets. Stocking WIC food items on grocery shelves also provides access to those healthy foods for others in the community. For many consumers, eating the WIC way assures healthy eating habits. Nutrition education is an integral part of the services of WIC participant receives. This can be in the form of one-on-one counseling with a nutritionist, group classes or online classes.

Food Hero was developed by OSU Extension Services as an online tool to delivery heath messaging and nutrition education to SNAP participants and is used by WIC and Child Nutrition. Food Hero is the go-to site for quick, tasty, healthy recipes and helpful tips. Food Hero is a national model of forward thinking approach to education.

Rep. Hayden (1 hr 17 min): Is there a possibility to limit the purchases of bulk products with bottle returns to limit fraud [by returning bottles for cash on SNAP dollars]?

Provided by DHS (Jill Gray)

There is no ability currently to restrict the amount of items a participant can purchase, requiring a bottle deposit. In Oregon the EBT card or SNAP benefit does pay for the deposit. This is a State Option and not a requirement for the program to cover these costs.

There are communities in Oregon where bottle deposits are required for needed items such as milk and water.

Sen.Winters: Given the obesity problem in Oregon can we put restrictions on what can be purchased with SNAP? For instance, can we restrict purchases of soda pop or other sugary drinks?

Answer provided by DHS: Since the current definition of food is a specific part of the "Act", any change to this definition would require action by a member of Congress. Several times in the history of SNAP, Congress had considered placing limits on the types of food that could be purchased with program benefits. However, they concluded that designating foods as luxury or non-nutritious would be administratively costly and burdensome.

Food benefits are limited to food items as determined by the USDA. USDA provides a list of categories of "Eligible Food Items" as follows:

Households can use SNAP benefits to buy foods for the household to eat, such as:

- Breads and cereals;
- Fruits and vegetables;
- Meats, fish and poultry;
- Dairy products; and
- Seeds and plants which produce food for the household to eat.

Households **cannot** use SNAP benefits to buy any nonfood items, such as:

- Beer, wine liquor, cigarettes or tobacco;
- Pet foods;
- Soaps, paper products;
- House-hold supplies;
- Vitamins and medicines;
- Food that will be eaten in the store; and
- Hot foods.

Clients and Vendors who violate these restrictions are subject to penalty and/or loss of authorization to participate in program.

Physical activity among Oregon adults and youth

According to the Centers for Disease Control and Prevention (CDC), adults need at least 150 minutes of moderate-intensity aerobic activity (or vigorous-activity equivalent) every week, AND muscle-strengthening activities on 2 or more days a week that work all major muscle groups (legs, hips, back, abdomen, chest, shoulders, and arms). However, less than 1 in 4 Oregon adults meet these recommendations.

Walking is the most common form of physical activity among adults. More than half (53%) of Oregon adults report walking as their primary or secondary form of aerobic activity (Source: 2015 Oregon BRFSS. Unpublished data).

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day. However, less than 1 in 3 Oregon 8th graders and 1 in 4 Oregon 11th graders meet these recommendations (Source: 2015 Oregon Healthy Teens)

Physical activity among adults for Oregon and counties, 2012-2015

	Mets aerobic guidelines (%)	Mets strength guidelines (%)	Mets both aerobic and strength guidelines (%)	No physical activity outside of work within past month (%)
OREGON	62.5	31.3	23.9	17.5
Baker	36.0	23.4	11.3	34.5
Benton	68.0	40.6	31.1	9.1
Clackamas	61.4	31.4	22.7	17.3
Clatsop	63.5	43.9	35.7	22.1
Columbia	62.5	27.4	22.3	18.1
Coos	68.4	19.1	15.0	22.8
Crook	60.0	24.5	--	28.5
Curry	56.9	--	--	25.7
Deschutes	73.4	29.6	25.4	13.6
Douglas	63.2	29.8	21.0	22.0
Grant	54.8	31.9	33.1	32.2
Harney	--	--	--	22.0
Hood River	58.2	23.3	18.9	12.8
Jackson	65.7	32.5	28.0	19.9
Jefferson	58.8	17.5	12.3	20.0
Josephine	68.9	32.2	25.8	17.8
Klamath	56.3	30.5	23.8	18.3
Lake	29.1	--	--	29.9
Lane	62.8	32.9	24.0	17.1
Lincoln	64.3	31.5	22.1	17.6
Linn	62.0	28.4	21.6	20.8
Malheur	50.4	24.2	16.7	24.4
Marion	61.9	27.0	21.4	20.9
Morrow	--	--	--	11.4
Multnomah	63.3	33.9	26.1	13.7
Gilliam/Sherman/Wasco	52.5	38.8	23.5	18.1
Polk	63.2	34.9	28.2	16.6
Tillamook	52.9	19.3	14.8	20.0
Umatilla	50.5	18.1	11.8	22.9
Union	63.3	43.4	35.0	17.0
Wallowa	69.6	33.9	23.8	na
Washington	61.6	34.4	27.2	15.1
Wheeler	--	--	--	--
Yamhill	56.4	27.6	16.8	20.6

Data source: Oregon Behavioral Risk Factors Surveillance System, County combined data

-- This number is suppressed because it is statistically unreliable.

Physical activity among 8th and 11th graders for Oregon and counties, 2015

	Participated in 60+ minutes of physical activity on 7 days per week		Walked to or from school, 5 or more per week	
	8th grader (%)	11th grader (%)	8th grader (%)	11th grader (%)
Oregon	30.7	23.7	21.5	16.3
Baker	30.4	28.2	5.1	--
Benton	35.7	24.9	19.0	11.8
Clackamas	28.8	23.4	15.2	15.4
Clatsop	36.5	20.8	19.3	5.6
Columbia	35.4	30.8	27.7	17.1
Coos	41.1	30.9	19.0	13.5
Crook	39.3	27.3	26.5	20.5
Curry	32.6	29.8	30.3	23.9
Deschutes	35.9	34.1	12.5	--
Douglas	36.8	31.7	18.1	23.5
Grant	28.2	40.0	--	--
Harney	38.0	32.1	--	--
Hood River	25.3	24.0	15.5	3.5
Jackson	35.8	23.5	17.7	18.3
Jefferson	25.5	22.8	14.0	23.2
Josephine	No data collected			
Klamath	35.1	27.2	21.1	16.3
Lake	43.2	34.6	28.5	28.2
Lane	34.0	23.5	24.3	18.5
Lincoln	21.1	33.3	18.1	13.1
Linn	33.3	24.9	20.1	12.8
Malheur	26.1	27.7	18.7	10.5
Marion	29.0	23.7	26.2	20.6
Morrow	28.2	21.6	24.4	6.8
Multnomah	27.5	21.2	22.3	17.3
Gilliam/Sherman/Wasco	34.2	22.1	--	19.9
Polk	31.0	23.7	25.7	17.8
Tillamook	41.6	28.8	14.4	9.78
Umatilla	19.7	17.7	33	13.8
Union	32.5	23.2	23.7	11.9
Wallowa	No data collected			
Washington	29.3	19.3	21.3	16.3
Wheeler	No data collected			
Yamhill	32.6	24.5	32.8	25.0

Data source: Oregon Healthy Teens

-- This number is suppressed because it is statistically unreliable.