

AGENDA

PUBLIC HEALTH ADVISORY BOARD Incentives and Funding Subcommittee

May 14, 2019

1:00-2:00 pm

Portland State Office Building, 800 NE Oregon St., Conference Room 915, Portland, OR 97232

Webinar: <https://attendee.gotowebinar.com/register/3531740595390230274>

Conference line: (877) 873-8017

Access code: 767068

Please do not put your phone on hold – it is better to drop the call and rejoin if needed.

Subcommittee Members: Carrie Brogotti, Bob Dannenhoffer, Jeff Luck, Alejandro Queral, Akiko Saito

Meeting Objectives

- Approve April 9 meeting minutes
- Review county investments in public health for Fiscal Year 2018
- Make recommendations for distributing funds to local public health authorities at a funding level above \$10 million

1:00-1:10 pm	Welcome, introductions and updates <ul style="list-style-type: none">• Approve April 9 meeting minutes• Hear update on OHA planning for distributing modernization funds to LPHAs• Hear updates from subcommittee members	Akiko Saito, Meeting Chair
1:10-1:25 pm	County investments in public health <ul style="list-style-type: none">• Review LPHA expenditures data for Fiscal Year 2018• Review how these data are used in the public health modernization funding formula for local public health authorities	Danna Drum, Oregon Health Authority
1:25-1:45 pm	LPHA funding above \$10 million – planning scenario <ul style="list-style-type: none">• Discuss and make recommendations on distribution of funding to LPHAs at a funding level above \$10 million	Akiko Saito, Meeting Chair
1:45-1:50 pm	Subcommittee business <ul style="list-style-type: none">• Confirm that Akiko will provide subcommittee update at May 16 PHAB meeting.• Decide who will chair the June subcommittee meeting.	Akiko Saito, Meeting Chair
1:50-1:55 pm	Public comment	

1:55 pm

Adjourn

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
April 9, 2019
1:00 p.m. - 2:00 p.m.

PHAB members present: Carrie Brogoitti, Dr. Jeff Luck, Alejandro Queral, Akiko Saito, Dr. Bob Dannenhoffer

PHAB members absent: None

Oregon Health Authority (OHA) staff: Sara Beaudrault, Katarina Moseley, Danna Drum, Krasimir Karamfilov

Welcome, introductions, and updates

Ms. Beaudrault introduced the meeting and thanked everybody for joining. She apologized for not having the meeting materials posted online and assured the subcommittee that the materials would be posted as soon as possible after the meeting.

Ms. Saito introduced herself and invited meeting attendees and the subcommittee members on the phone to introduce themselves.

A quorum was present. Ms. Saito asked the subcommittee members to review the meeting minutes from March 12, 2019, before the subcommittee approved the minutes.

Ms. Saito asked if the subcommittee would entertain a motion to approve the meeting minutes. Dr. Dannenhoffer made a motion to approve the meeting minutes. Dr. Luck seconded the motion. The subcommittee approved the meeting minutes unanimously.

Dr. Dannenhoffer expressed appreciation for the quick preparation and distribution of the meeting minutes. Ms. Saito agreed with Dr. Dannenhoffer and added that the meeting minutes were detailed.

LPHA funding between \$5-10 million – planning scenario

Ms. Beaudrault followed up on the work the subcommittee did during its last meeting to formalize the recommendations for use of the \$5 million in funding, with \$3.9 million going to LPHAs, if we have the same level of funding in the next biennium. Because of the work the subcommittee did, OHA has been able to put plans in place to ensure that funds go out to the eight LPHA partnerships that are funded now in July and not go through a RFP process. There should be very little or no interruption in funding out to those groups. OHA will continue to provide updates.

Dr. Dannenhoffer pointed out that because the funding is spread over 24 months rather than over 19 months, it is a monthly decrease of \$5,000/\$6,000 per month for the plans, which would most likely result in reductions of personnel in most of the programs.

Ms. Saito asked Ms. Beaudrault if she had heard from any of the partnerships whether that was a concern.

Ms. Beaudrault remarked that LPHAs have expressed that concern through the Conference of Local Health Officials (CLHO). Some of the partnerships can absorb the reduction in funding more easily because they had spent funds on up-front costs that they would not necessarily need in the next biennium. For other partnerships, it is not how they used their funding, so it is a real impact.

Ms. Beaudrault guided the subcommittee members to page 11 of the packet, displaying the funding pyramid and funding levels. Until now, the subcommittee has been talking about the very top of the pyramid, up to \$5 million in funding to local public health authorities (LPHA)s. Today the subcommittee will take it down to the next tier, between \$5 and \$10 million in funding to LPHAs. This is just planning for if OHA ends up with additional General Fund investment at the end of Legislative Session. Funding to LPHAs is a portion of total funding for public health modernization.

Ms. Beaudrault called the subcommittee's attention to page 10 of the packet, listing the funding priorities that the Public Health Advisory Board (PHAB) developed in 2018. She emphasized the first four priorities as being relevant to the discussion:

- (a) Ensure that public health services are available to every person in Oregon, whether they are provided by an individual local public health authority, through cross-jurisdictional sharing arrangements, and/or by the Oregon Health Authority.
- (b) Align funding with burden of disease, risk, and state and community health assessment and plan priorities, while minimizing the impact to public health infrastructure when resources are redirected.
- (c) Use funding to advance health equity in Oregon, which may include directing funds to areas of the state experiencing a disproportionate burden of disease or where health disparities exist.
- (d) Use funding to incentivize changes to the public health system intended to increase efficiency and improve health outcomes, which may include cross-jurisdictional sharing.

Ms. Beaudrault noted that the text on the pyramid for funding between \$5-\$10 million was vetted by the Conference of Local Health Officials (CLHO) last year and states that if LPHAs are to receive between \$5 and \$10 million, then all LPHAs would receive floor funding through the base component of the local public health funding formula. This is the part of the funding formula that gives all counties some funds to work with, based on their county size. The base funds range from \$30,000 for the extra small counties up to \$90,000 for the extra large counties. The remainder of funds would be distributed through grants to LPHA projects or partnerships. The text says that it would be connected with the partnerships that were established with current funding, but there is some flexibility to how PHAB would recommend those additional funds are used.

Ms. Beaudrault added that, looking at it a different way, if there were between \$5-\$10 million for LPHAs, this is how the funding would break down: (a) The eight LPHA partnerships that are funded now would receive \$3.9 million, (b) The base funding to each LPHA totals to \$1.845 million, (c) Remainder funds that could be available. Different ideas have been voiced about how the remainder funds could be used, both in this subcommittee and in CLHO conversations. Possible

funding avenues include: (a) additional funding to LPHA partnerships, (b) new partnerships that did not meet the criteria for currently-funded LPHA partnerships (e.g., a county that wants to form a partnership with a tribe, or a CCO, or a different entity, but not with other LPHAs), (c) cross-jurisdictional service delivery models (e.g., Washington state's new service delivery models, where one county plays a role of providing foundational public health services for other counties). Other ideas might be directly related to the funding principles.

Ms. Saito commented that one of the things to consider, based on Dr. Dannenhoffer's remark about the potential decrease of funding to the partnerships, is whether the first part of the funds over \$5 million could be used to make those partnerships whole, so that the funding is there for the 24 months, and then decide on the remainder funds to do base funding, and so on. The idea was to put the money in these pilot projects, so that they could really show us what could be done and be a model project for everything else.

Dr. Luck asked how much it would cost to fully bring the partnerships back up to the same monthly level.

Dr. Dannenhoffer answered that it could cost about \$1.2 million.

Ms. Saito asked the subcommittee members if they had thoughts on bringing the partnerships whole first and then deciding on the remainder of the funds.

Dr. Dannenhoffer noted that, speaking as somebody from Douglas County who is the fiduciary for one of the projects, this would be his choice, although he is conflicted. The disadvantage of all this is that public health people come on to do projects and having to be uncertain about their continued employment is really, really, really a negative. It is such a stressor to the programs, when the two people who work on this program don't know if they are going to have jobs starting in July. That is enormously stressful.

Ms. Brogoitti remarked that even before Ms. Saito asked the question, her initial reaction was that we probably should look at using some of these funds to fill in the gaps that the partnerships will be experiencing over the next year, given the change in the funding period and the change in the number of partnerships that are getting funded. The other piece of that is thinking about how we can use those partnerships to continue expanding upon the work they are doing now. Are there natural jumping-off points to expand the scope of the capabilities and priorities we are focusing on, given the infrastructure that we have already established?

Ms. Brogoitti stated that she also would want to put value on creating space for new partnerships and new opportunities. One of her concerns that she has had all along, and continues to have, is that we would continue funding the same partnerships and that would not give us space to open it up to new things. She would like to hold both, if that is possible.

Dr. Luck agreed with Ms. Brogoitti and Dr. Dannenhoffer that bringing the existing partnerships back up to their current funding level was a good place to start.

Mr. Queral seconded Dr. Luck's remarks, pointing out that Dr. Dannenhoffer and Ms. Brogoitti had a much better sense of what was needed, and it was consistent with what the subcommittee had discussed in the past.

Ms. Saito summarized the discussion by noting that the subcommittee is suggesting that before we do the remainder of the funds, we would bring the existing partnerships up to full capacity. From there on, we would do the base funding. Then we still need to decide on, if we have even more money, which is a good problem to have, the three suggested choices or some other choices the subcommittee members might propose.

Ms. Beaudrault clarified the math, using Dr. Dannenhoffer's number of needing an additional \$1.2 million to bring the LPHA partnerships whole. That would be just over \$5 million, plus the \$1.845 million in base bunding. That takes us up to about \$7 million dollars, earmarked to go to LPHAs. We are now talking about remaining funds, above the \$7 million. The options listed under remaining funds do not necessarily need to be mutually exclusive. It is likely that OHA would need to do an RFP for these options, so it is clear where we open things up to new models, new partnerships, new opportunities to do things differently, as Ms. Brogoitti mentioned.

Ms. Moseley asked if the pyramid is the LPHA allocation of what we would assume would be more funding.

Ms. Beaudrault answered that that was correct. The pyramid shows funding to LPHAs within a broader funding level.

Ms. Saito reiterated that the funding between \$5-\$10 million would be utilized for the LPHA partnerships to bring them whole, which would be an additional \$1.2 million. Then we would take base funding to LPHAs, which ranges from 30K to 90K. The remainder of up to \$10 million would be about \$3 million, which would be done in an RFP process, which would include all potential options.

Ms. Mosely pointed out that, considering the math related to the \$5-\$10 million range, if the funding is below \$7 million, that is not achievable.

Ms. Saito remarked that if the funding is at \$7 million, we would not have the remainder RFP process. If it is at \$5 million, we would have the LPHA partnerships becoming whole.

Dr. Dannenhoffer liked this proposal.

Dr. Luck asked if the proposal was for the first \$7 million or for the last \$3 million.

Ms. Saito answered that the proposal is for the total \$10 million, while Ms. Moseley's question concerned funding of \$7 million or less. At \$7 million, we would bring the current LPHA partnerships to a holistic number, and then using the base funding to the LPHAs in the range from 30K to 90K. We would not be doing the extra \$3 million RFP process.

Ms. Queral agreed that the proposal made sense.

Ms. Saito added that with funding at just \$5 million, we would just be funding the LPHA partnerships as a holistic number.

Dr. Luck agreed with the proposal.

Ms. Saito stated that the subcommittee members were in agreement on how funds would be allocated to LPHAs if somewhere between \$5-10 million is allocated to LPHAs. Funds would be used in this order:

1. Increase funding to the eight LPHA partnerships so that the funding level matches current funding for a full 24-month period (approximately \$5.1 million).
2. Provide base funding to all LPHAs (\$1.845 million)
3. Any remaining funds distributed through RFP for new partnerships, CJS service delivery models, or additional funding for existing LPHA partnerships.

Ms. Beaudrault called the subcommittee's attention to page 13 of the meeting packet, showing the purpose and goals of funding in the three different buckets. For the LPHA partnerships, the purpose of funding is the creation of regional systems for communicable disease control and elimination of health disparities. Another thing these partnerships are achieving is setting in place new infrastructure that was not there before; sustainable infrastructure built around policies that are in place, and shared staffing. We are hoping to get feedback on the purpose of providing base funding to each LPHA, which would help us craft our planning work. Some ideas include (a) increase local capacity to improve accountability metrics for the communicable disease process measures (i.e., improving two-year-old immunization rates, decreasing rates of gonorrhea), (b) implement local components of health equity action plan, and (c) increase local capacity to participate more fully in the regional partnership, which could include contributing some local funds to the broader partnership.

Ms. Beaudrault added that the remaining funds would likely go out through an RFP. Some ideas for the purpose and goals of that money include (a) address gaps in modernization assessment, (b) increase capacity for foundational capability, (c) consider projects or proposals that would have the largest impact on population, (d) address some of the other funding priorities, such as using funding to address health equity or targeting it to areas that have higher burden of disease, (e) prioritize proposals that focus on specific communicable diseases or that address some of the gaps around assessment and epidemiology, such as creating new ways of reporting and making disease data available to communities.

Ms. Beaudrault remarked that it would be helpful if the subcommittee members shared any initial thought they might have around these purposes, or what they would want to see OHA driving toward with funding in each of the three buckets. The feedback would be helpful for planning the requirements OHA would be putting in place around the different buckets of funding.

Dr. Dannenhoffer noted that if we were going to do an RFP, one of the deliverables has to be a toolkit or something that others could use. For example, let's say that there was a project to improve the use of social media to help fight our current battle with gonorrhea. Let's say Multnomah County got that grant, the outcome should be that they teach the rest of the counties how to go ahead and do that.

Dr. Dannenhoffer added that one of the concerns he had from the current project was that stuff that was learned in the other seven areas (i.e., partnerships) would ever be presented to the rest of the partnerships in a way that they could use it. That would be incredible useful for everybody.

Ms. Beaudrault endorsed Dr. Dannenhoffer's suggestion, in terms of being clear that we are not looking at these as one-off projects, but as potentially effective models that can be replicated across the state.

Dr. Luck liked that as criteria. We identified communicable disease, assessment and epidemiology, emergency preparedness, and health equity as priorities above other capabilities and programs, but within that group, we didn't identify any relative priorities. Thinking about broader applicability beyond the boundaries of the initial grant might be a way to help choose within that set.

Ms. Saito shared her liking of the idea of a learning network, with the partnerships having an opportunity to share learning, even if somebody came up with a curriculum like *Train the Trainer*, or something similar that will enable the partnerships to share information across the state. This could be a potential deliverable for both the base funding and the remaining funds.

Ms. Queral asked what this RFP would look like. If it is base funding for all LPHAs, we should be thinking about the most fundamentally basic RFP approach. The criteria should not necessarily be about which is the best project, but, in the spirit of what Dr. Dannenhoffer suggested, what it is that you can bring to the rest of public health across the state. That may be one element of what's in it. In essence, we are saying that we are going to provide some funds towards your base funding on this, and the RFP is giving the health authority an opportunity to articulate what's going to happen with those dollars. Billing it as an RFP makes it sound as if it is competitive, in a sense of competing against each other, or competing to be the best project, as opposed to getting the money for what would be a foundational component of something that they are intending to do in the context of modernization.

Ms. Saito clarified that the base funding for each LPHA (i.e., \$1.845 million) would not be an RFP. That money would just go out based on what we had agreed upon, which was 30K for extra small counties and up to 90K for the larger counties. The RFP process would only be on those remaining funds, which, at this point, we are only looking at between \$0-\$3 million.

Ms. Saito asked the subcommittee if everyone was in agreement with the generalized approach to the base funding and the suggested options.

Ms. Beaudrault reiterated that the options are not mutually exclusive. We could put something in place so that a LPHA could choose to work on any of the options. There might be other things that we are not thinking of yet, but it would be helpful to hear if the subcommittee thinks any of these are more or less important, and if there are any that you really want to see us emphasizing.

Ms. Saito stated that she liked the option *Implement health equity action plan* as a potential priority. It is one of the foundational capabilities and it is also important to lead with health equity. It seems that that could be done with smaller amount of funds.

Ms. Moseley wondered why that would not be in the \$3.9 million tier.

Ms. Beaudrault confirmed that it was. With the \$3.9 million, the next phase for the eight funded partnerships is that they will be focusing on implementing those plans. This would give each LPHA some funds to do some specific and targeted work in their own county that might not happen through the broader partnership. It is just driving to more money, more focus.

Dr. Luck commented that these are good guidelines, but with the relatively small amount of money, we should not be too restrictive, but rather let the different health departments decide how they want to spend that money within these goals of communicable disease, health equity, and partnership participation.

Mr. Queral agreed with Dr. Luck and remarked that we need to be clear and specific about what we mean by each of these options, considering that it is a limited amount of money. In terms of communicable diseases, we can certainly provide some guidance that would facilitate that. In other words, it would be helpful if there are ways in which the OHA can support the LPHAs. In terms of the health equity action plan, considering the amount of money that these grants would carry, it seems that it would be useful to have the health departments outline the priorities within that plan. Expecting them to be able to implement a full plan that includes outreach in partnership development with other organizations and providers may be a bit difficult. There should be enough flexibility for prioritizing and doing those priorities well, as supposed to trying to implement a full plan.

Ms. Beaudrault remarked that it is a similar question for the remaining funds. We have talked about a few different things: increasing capacity for foundational capabilities in any of the work; making sure that it is scalable; thinking back to the funding principles and looking for proposals that build on assessment and epidemiology capacity, or focused on specific areas with burden of disease, or focused on interventions around improving health equity. These are some different options for what we would be trying to achieve with that remaining bucket of funding, if it were to become available.

Ms. Beaudrault asked the subcommittee members if anything in particular resonated for them, or if there was anything that seems less important, or anything that they wanted OHA to be prioritizing as the subcommittee thought through this.

Ms. Saito noted that it would be nice to keep it open, as there was not a lot of money in the remaining funds. It seems that the subcommittee is talking about with those remaining funds to have some kind of a deliverable around what could be used for other partners to do. It builds the learning network piece of it.

Ms. Saito asked the subcommittee members if they were fine with what was written in the additional piece around the deliverables that are resource-oriented.

Dr. Luck remarked that that generally sounded fine to him.

Subcommittee business

Ms. Saito stated that she would provide a subcommittee update at the PHAB meeting on April 18, 2019. She asked Ms. Brogoitti if she would be available to chair the May 14, 2019, subcommittee meeting.

Ms. Brogoitti remarked that she may not be available.

Ms. Beaudrault mentioned that the chairs have gone in alphabetical order and we can skip ahead and see if Dr. Dannenhoffer would be willing to chair the meeting in May.

Ms. Brogoitti thanked for the accommodation.

Ms. Saito noted that in the spirit of Mr. Queral chairing two meetings in a row, if Dr. Dannenhoffer can't chair the meeting, Ms. Saito would be happy to chair another meeting.

Ms. Beaudrault added that, in terms of the agenda for next month, usually Dr. Dannenhoffer or Ms. Brogoitti provides an update from the subcommittee to CLHO and sometimes has additional feedback to bring back. We will have an opportunity to bring back to the subcommittee any additional feedback from CLHO on what we have been talking about today, before we finalize the recommendations at that funding level. Also next month, Danna Drum will be here to talk about fiscal year 2018 LPHA expenditures reporting. This connects to the subcommittee's work around coming up with a mechanism for awarding matching funds for when we get to that funding level. It is an opportunity to look at last year's expenditures reporting and then think about how that fits in with the model for matching funds.

Public comment

Ms. Saito invited members of the public to ask questions and provide comments.

There was no public comment.

Closing

Ms. Saito adjourned the meeting at 1:45 p.m.

The next Public Health Advisory Board Incentives and Funding subcommittee meeting will be held on May 14, 2019, at 1:00 p.m.

Fiscal Year 2018 Local Governmental Public Health Investment - FINAL 5/8/2019

County	Population*	Local Expenditures (less exclusions ¹)	In Kind Support	Total Local Investment	Per Capita Total Local Investment
Oregon	4,195,300	\$ 69,230,127	\$ 812,425	\$ 70,042,552	\$ 16.70
BAKER	16,765	\$ 278,170	\$ 83,594	\$ 361,764	\$ 21.58
BENTON	93,590	\$ 1,791,995	\$ -	\$ 1,791,995	\$ 19.15
CLACKAMAS	419,425	\$ 5,019,520	-	\$ 5,019,520	\$ 11.97
CLATSOP	39,200	\$ 446,000	\$ -	\$ 446,000	\$ 11.38
COLUMBIA	51,900	\$ 531,625	\$ 83,703	\$ 615,328	\$ 11.86
COOS	63,275	\$ 255,216	\$ 77,437	\$ 332,653	\$ 5.26
CROOK	22,710	\$ 1,484,699	\$ 99,989	\$ 1,584,688	\$ 69.78
CURRY	22,915	\$ 703,878	\$ -	\$ 703,878	\$ 30.72
DESCHUTES	188,980	\$ 3,814,900	\$ -	\$ 3,814,900	\$ 20.19
DOUGLAS	111,735	\$ 444,652	\$ -	\$ 444,652	\$ 3.98
GRANT~	7,400	\$ -	\$ -	\$ -	\$ -
HARNEY	7,380	\$ 159,509	\$ 12,761	\$ 172,270	\$ 23.34
HOOD RIVER	25,310	\$ 572,647	\$ 157,029	\$ 729,676	\$ 28.83
JACKSON	219,200	\$ 2,298,330	\$ -	\$ 2,298,330	\$ 10.49
JEFFERSON	23,560	\$ 261,557	\$ -	\$ 261,557	\$ 11.10
JOSEPHINE	86,395	\$ 641,298	\$ 16,700	\$ 657,998	\$ 7.62
KLAMATH	67,960	\$ 542,426	\$ -	\$ 542,426	\$ 7.98
LAKE	8,115	\$ 187,877	\$ -	\$ 187,877	\$ 23.15
LANE	375,120	\$ 4,024,080	\$ -	\$ 4,024,080	\$ 10.73
LINCOLN*	48,210	\$ 1,458,472	\$ -	\$ 1,458,472	\$ 30.25
LINN	125,575	\$ 1,327,242	\$ -	\$ 1,327,242	\$ 10.57
MALHEUR	31,925	\$ 435,955	\$ 38,230	\$ 474,185	\$ 14.85
MARION	344,035	\$ 4,647,307	\$ -	\$ 4,647,307	\$ 13.51
MORROW	11,885	\$ 702,506	\$ 10,317	\$ 712,823	\$ 59.98
MULTNOMAH	813,300	\$ 25,329,190	\$ -	\$ 25,329,190	\$ 31.14
North Central PHD	30,970	\$ 682,867	\$ 89,574	\$ 772,441	\$ 24.94
GILLIAM	1,985				
WASCO	27,200				
SHERMAN	1,785				
POLK	82,100	\$ 291,010	\$ -	\$ 291,010	\$ 3.54
TILLAMOOK	26,395	\$ 119,798	\$ -	\$ 119,798	\$ 4.54
UMATILLA	80,765	\$ 435,117	\$ 97,200	\$ 532,317	\$ 6.59
UNION	26,885	\$ 112,200	\$ 41,090	\$ 153,290	\$ 5.70
WALLOWA^	7,175				\$ -
WASHINGTON	606,280	\$ 8,674,852	\$ -	\$ 8,674,852	\$ 14.31
WHEELER	1,450	\$ 1,991	\$ 4,800	\$ 6,791	\$ 4.68
YAMHILL	107,415	\$ 1,553,242	\$ -	\$ 1,553,242	\$ 14.46

Prepared by :Charles Rynerson, Population Research Center
 College of Urban and Public Affairs, Portland State University
 December 17, 2018

This table reflects all county government investments in local public health as measured by expenditures paid by county funds or other revenue generated by the county or public health district (insurance reimbursement, license fees, etc) minus exclusions outlined below during fiscal year 2018.

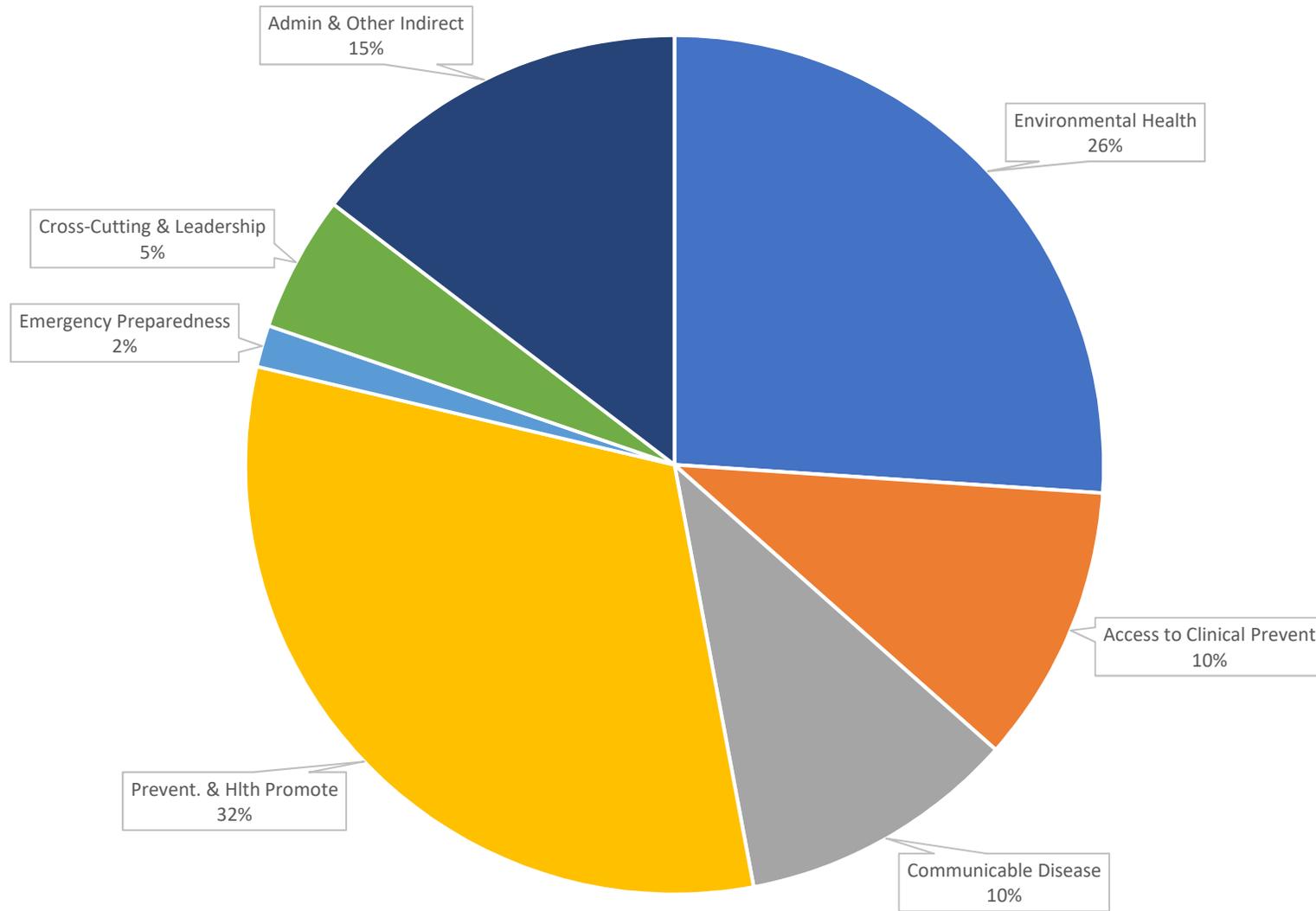
¹ Exclusions include: Ryan White case management, reproductive health client services, immunization clinics, clinical support, corrections health, individual dental services, primary care services, occupational health services, medical examiner services, mental health/addiction services and treatment, emergency medical services, refugee resettlement screening, animal control/shelter, and infrastructure costs directly related to these exclusions.

~ Data not included due to lack of validation

* In-kind excluded due to lack of validation

^ No longer operates as the local public health authority

2018 Local Governmental Public Health Investment by Category



Public Health Advisory Board
Funding principles for state and local public health authorities
February 15, 2018

The Public Health Advisory Board recognizes that funding for foundational capabilities and programs is limited, but innovations can maximize the benefit of available resources. These funding principles are designed to apply to the public health system, which means state and local public health authorities in Oregon. These funding principles can be applied to increases or decreases in public health funding.

Public health system approach to foundational programs

1. Ensure that public health services are available to every person in Oregon, whether they are provided by an individual local public health authority, through cross-jurisdictional sharing arrangements, and/or by the Oregon Health Authority.
2. Align funding with burden of disease, risk, and state and community health assessment and plan priorities, while minimizing the impact to public health infrastructure when resources are redirected.
3. Use funding to advance health equity in Oregon, which may include directing funds to areas of the state experiencing a disproportionate burden of disease or where health disparities exist.
4. Use funding to incentivize changes to the public health system intended to increase efficiency and improve health outcomes, which may include cross-jurisdictional sharing.
5. Align public health work and funding to coordinate resources with health care, education and other sectors to achieve health outcomes.

Transparency across the public health system

6. Acknowledge how the public health system works to achieve outcomes, and direct funding to close the identified gaps across the system in all governmental public health authorities.
7. Improve transparency about funded work across the public health system and scale work to available funding.

PHAB Funding and Incentives Subcommittee

Local public health funding formula model - \$10 million example

Subcommittee Members: Carrie Brogoitti, Bob Dannenhoffer, Jeff Luck, Alejandro Queral, Akiko Saito
 May, 2018

Total biennial funds available to LPHAs: \$10 million

Base component: \$10 million
 Matching funds component: \$0
 Incentive funds component: \$0

Local public health funding formula model: At the \$10 million level, all funds are allocated to the base component of the funding formula, with 0% allocated to matching funds and 0% allocated to incentive funds.

County Group	Population ⁴	Base component									Matching and Incentive fund components		Total county allocation				Avg Award Per Capita
		Floor	Burden of Disease ²	Health Status ³	Race/Ethnicity ¹	Poverty 150% FPL ¹	Rurality ⁵	Education ¹	Limited English Proficiency ¹	Matching Funds	Incentives	Total Award	Award Percentage	% of Total Population	Award Per Capita		
Wheeler	1,480	\$ 30,000	\$ 479	\$ 890	\$ 120	\$ 311	\$ 2,600	\$ 203	\$ 8	\$ -	\$ -	\$ 34,612	0.3%	0.0%	\$ 23.39		
Wallowa	7,195	\$ 30,000	\$ 2,821	\$ 1,734	\$ 646	\$ 1,203	\$ 12,642	\$ 798	\$ 316	\$ -	\$ -	\$ 50,159	0.5%	0.2%	\$ 6.97		
Harney	7,360	\$ 30,000	\$ 3,991	\$ 3,835	\$ 1,342	\$ 1,373	\$ 5,729	\$ 1,249	\$ 688	\$ -	\$ -	\$ 48,207	0.5%	0.2%	\$ 6.55		
Grant	7,415	\$ 30,000	\$ 2,457	\$ 2,673	\$ 845	\$ 1,383	\$ 13,028	\$ 1,259	\$ 326	\$ -	\$ -	\$ 51,971	0.5%	0.2%	\$ 7.01		
Lake	8,120	\$ 30,000	\$ 3,491	\$ 2,115	\$ 1,666	\$ 1,756	\$ 9,031	\$ 2,134	\$ 1,116	\$ -	\$ -	\$ 51,308	0.5%	0.2%	\$ 6.32		
Morrow	11,890	\$ 30,000	\$ 3,934	\$ 5,799	\$ 6,574	\$ 2,049	\$ 9,589	\$ 4,832	\$ 10,456	\$ -	\$ -	\$ 73,233	0.7%	0.3%	\$ 6.16		
Baker	16,750	\$ 30,000	\$ 6,912	\$ 4,364	\$ 2,053	\$ 2,984	\$ 12,067	\$ 2,624	\$ 921	\$ -	\$ -	\$ 61,924	0.6%	0.4%	\$ 3.70	\$ 6.17	
Crook	22,105	\$ 45,000	\$ 8,928	\$ 10,305	\$ 3,591	\$ 4,365	\$ 18,643	\$ 4,473	\$ 850	\$ -	\$ -	\$ 96,156	1.0%	0.5%	\$ 4.35		
Curry	22,805	\$ 45,000	\$ 12,666	\$ 10,587	\$ 4,127	\$ 4,077	\$ 15,507	\$ 3,833	\$ 1,504	\$ -	\$ -	\$ 97,302	1.0%	0.6%	\$ 4.27		
Jefferson	23,190	\$ 45,000	\$ 10,805	\$ 8,585	\$ 13,185	\$ 4,789	\$ 25,711	\$ 6,245	\$ 5,863	\$ -	\$ -	\$ 120,183	1.2%	0.6%	\$ 5.18		
Hood River	25,145	\$ 45,000	\$ 6,530	\$ 9,752	\$ 12,720	\$ 4,008	\$ 23,062	\$ 8,084	\$ 20,039	\$ -	\$ -	\$ 129,196	1.3%	0.6%	\$ 5.14		
Tillamook	26,175	\$ 45,000	\$ 10,770	\$ 9,947	\$ 5,558	\$ 4,629	\$ 32,009	\$ 4,357	\$ 3,453	\$ -	\$ -	\$ 115,722	1.2%	0.6%	\$ 4.42		
Union	26,900	\$ 45,000	\$ 9,986	\$ 7,588	\$ 3,948	\$ 5,746	\$ 19,898	\$ 3,249	\$ 2,070	\$ -	\$ -	\$ 97,485	1.0%	0.6%	\$ 3.62		
Gilliam, Sherman, Wasco	30,895	\$ 105,000	\$ 12,929	\$ 9,501	\$ 9,946	\$ 5,184	\$ 22,528	\$ 6,782	\$ 9,426	\$ -	\$ -	\$ 181,297	1.8%	0.7%	\$ 5.87		
Malheur	31,845	\$ 45,000	\$ 11,781	\$ 17,903	\$ 17,244	\$ 7,933	\$ 27,081	\$ 10,342	\$ 16,102	\$ -	\$ -	\$ 153,386	1.5%	0.8%	\$ 4.82		
Clatsop	38,820	\$ 45,000	\$ 16,738	\$ 11,787	\$ 7,634	\$ 6,489	\$ 26,601	\$ 5,132	\$ 6,181	\$ -	\$ -	\$ 125,568	1.3%	0.9%	\$ 3.23		
Lincoln	47,960	\$ 45,000	\$ 24,044	\$ 19,353	\$ 11,687	\$ 9,286	\$ 31,685	\$ 8,375	\$ 8,172	\$ -	\$ -	\$ 157,600	1.6%	1.2%	\$ 3.29		
Columbia	51,345	\$ 45,000	\$ 18,858	\$ 19,411	\$ 7,756	\$ 7,754	\$ 39,334	\$ 8,044	\$ 3,951	\$ -	\$ -	\$ 150,108	1.5%	1.2%	\$ 2.92		
Coos	63,310	\$ 45,000	\$ 30,961	\$ 27,283	\$ 12,991	\$ 13,075	\$ 42,716	\$ 11,469	\$ 5,220	\$ -	\$ -	\$ 188,713	1.9%	1.5%	\$ 2.98		
Klamath	67,690	\$ 45,000	\$ 31,945	\$ 28,508	\$ 19,967	\$ 14,198	\$ 44,719	\$ 13,698	\$ 11,161	\$ -	\$ -	\$ 209,196	2.1%	1.6%	\$ 3.09	\$ 3.81	
Umatilla	80,500	\$ 60,000	\$ 27,773	\$ 34,691	\$ 37,396	\$ 15,482	\$ 41,160	\$ 22,859	\$ 46,014	\$ -	\$ -	\$ 285,375	2.9%	1.9%	\$ 3.55		
Polk	81,000	\$ 60,000	\$ 24,329	\$ 23,007	\$ 23,893	\$ 12,703	\$ 28,322	\$ 11,897	\$ 19,589	\$ -	\$ -	\$ 203,739	2.0%	2.0%	\$ 2.52		
Josephine	85,650	\$ 60,000	\$ 42,369	\$ 32,045	\$ 15,012	\$ 19,734	\$ 67,721	\$ 15,655	\$ 5,649	\$ -	\$ -	\$ 258,185	2.6%	2.1%	\$ 3.01		
Benton	92,575	\$ 60,000	\$ 20,591	\$ 25,750	\$ 24,009	\$ 18,103	\$ 30,580	\$ 7,554	\$ 19,844	\$ -	\$ -	\$ 206,431	2.1%	2.2%	\$ 2.23		
Yamhill	106,300	\$ 60,000	\$ 31,992	\$ 39,771	\$ 33,325	\$ 16,945	\$ 42,211	\$ 20,818	\$ 31,549	\$ -	\$ -	\$ 276,611	2.8%	2.6%	\$ 2.60		
Douglas	111,180	\$ 60,000	\$ 55,353	\$ 50,961	\$ 17,744	\$ 20,736	\$ 80,483	\$ 19,777	\$ 7,333	\$ -	\$ -	\$ 312,388	3.1%	2.7%	\$ 2.81		
Linn	124,010	\$ 60,000	\$ 45,765	\$ 45,911	\$ 24,563	\$ 22,889	\$ 68,854	\$ 20,845	\$ 14,313	\$ -	\$ -	\$ 303,141	3.0%	3.0%	\$ 2.44	\$ 2.60	
Deschutes	182,930	\$ 75,000	\$ 51,532	\$ 40,850	\$ 31,542	\$ 26,799	\$ 88,711	\$ 20,898	\$ 20,109	\$ -	\$ -	\$ 355,439	3.6%	4.4%	\$ 1.94		
Jackson	216,900	\$ 75,000	\$ 82,763	\$ 78,176	\$ 55,016	\$ 41,014	\$ 76,602	\$ 39,291	\$ 41,725	\$ -	\$ -	\$ 489,588	4.9%	5.2%	\$ 2.26		
Marion	339,200	\$ 75,000	\$ 108,521	\$ 130,230	\$ 159,992	\$ 64,797	\$ 78,075	\$ 82,482	\$ 197,618	\$ -	\$ -	\$ 896,714	9.0%	8.2%	\$ 2.64		
Lane	370,600	\$ 75,000	\$ 128,309	\$ 116,877	\$ 89,249	\$ 72,948	\$ 113,953	\$ 53,828	\$ 57,033	\$ -	\$ -	\$ 707,199	7.1%	8.9%	\$ 1.91	\$ 2.21	
Clackamas	413,000	\$ 90,000	\$ 118,354	\$ 118,923	\$ 98,872	\$ 40,514	\$ 131,344	\$ 45,159	\$ 99,878	\$ -	\$ -	\$ 743,043	7.4%	10.0%	\$ 1.80		
Washington	595,860	\$ 90,000	\$ 132,497	\$ 155,237	\$ 274,258	\$ 71,142	\$ 58,629	\$ 89,464	\$ 311,124	\$ -	\$ -	\$ 1,182,351	11.8%	14.4%	\$ 1.98		
Multnomah	803,000	\$ 90,000	\$ 257,995	\$ 254,817	\$ 330,694	\$ 133,186	\$ 18,342	\$ 121,875	\$ 379,559	\$ -	\$ -	\$ 1,586,468	15.9%	19.4%	\$ 1.98	\$ 1.94	
Total	4,141,100	\$ 1,845,000	\$ 1,359,167	\$ 1,359,167	\$ 1,359,167	\$ 679,583	\$ 1,359,167	\$ 679,583	\$ 1,359,167	\$ -	\$ -	\$ 10,000,000	100.0%	100.0%	\$ 2.41	\$ 2.41	

Matching and incentive funds data are not based on actual LPHA data and are included for demonstration

¹ Source: American Community Survey population 5-year estimate, 2012-2016.

² Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon death certificate data, 2012-2016.

³ Source: Quality of life: Good or excellent health, 2012-2015.

⁴ Source: Portland State University Certified Population estimate July 1, 2017

⁵ Source: U.S. Census Bureau, Population estimates, 2010

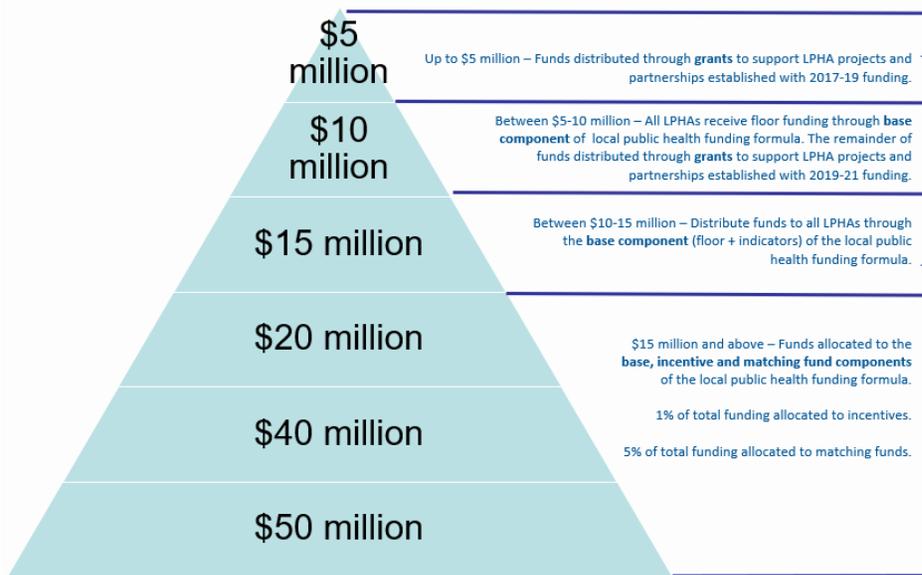
County Size Bands				
Extra Small	Small	Medium	Large	Extra Large
up to 20,000	20,000-75,000	75,000-150,000	150,000-375,000	above 375,000

PHAB Incentives and Funding subcommittee

Planning for public health modernization funding to LPHAs, 2019-21 – DRAFT

May 14, 2019

LPHA allocations to funding formula components at a range of funding levels for 2019-21 biennium*



PHAB recommendations for use of funding

- Up to \$5 million in funding to LPHAs:**
1. Continue LPHA Partnerships that are currently funded.
 2. Avoid an RFP process.
 3. Allow LPHAs that were not involved in 2017-19 to join an existing group.

- Between \$5-10 million in funding to LPHAs:**
1. **\$5-7 million:** Provide base funding to all LPHAs, ranging from \$30,000 for extra-small counties to \$90,000 for extra-large counties.
 2. **\$7-10 million:** Use funding for new partnership models or new service delivery models. New partnerships or service delivery models must demonstrate benefits to the entire public health system.

Above \$10 million in funding to LPHAs:
To be determined.

Planning for 2019-21 funding to LPHAs above \$10 million

- What are the subcommittee's high-level expectations for system changes we'd see?
- What are the subcommittee's recommendations for balancing programmatic work with infrastructure improvements?
- How do we sustain and build upon 2017-19 progress?
- In what ways would allocating funding to all LPHAs through the funding formula reduce or increase funding disparities between counties?
- What are the subcommittee's recommendations for funding to LPHAs above \$10 million?

Subcommittee business

- Confirm that Akiko will provide subcommittee update at May 16 PHAB meeting.
- Decide who will chair the June 11 subcommittee meeting.

Public comment

Adjourn