

AGENDA

PUBLIC HEALTH ADVISORY BOARD

March 17, 2022, 2:00-4:30 pm

Join ZoomGov Meeting

<https://www.zoomgov.com/j/1602414019?pwd=MWtPYm5YWmxyRnVzZW0vZkpUV0lEdz09>

Meeting ID: 160 241 4019

Passcode: 577915

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Meeting objectives:

- Approve February meeting minutes
- Discuss work of PHAB subcommittees
- Discuss outcomes of 2022 legislative session
- Plan for public health modernization work in the 2023-25 biennium
- Reflect on health equity capacity building sessions and determine PHAB priorities

2:00-2:25 pm **Welcome, board updates and agenda review**

- Welcome, new member introduction and board member introductions
- Oregon Health Policy Board retreat request
- **ACTION:** Approve February meeting minutes

Veronica
Irvin,
PHAB Chair

2:25-2:40 pm **Subcommittee updates**

- Accountability Metrics
- Incentives and Funding
- Strategic Data Plan

Sarah
Present,
Accountability
Metrics

Bob
Dannenhoffer,

		Incentives & Funding Subcommittee
		Cara Biddlecom, Strategic Data Plan
2:40-3:10 pm	Legislative session recap <ul style="list-style-type: none"> Hear update on outcomes from 2022 legislative session 	Cynthia Branger Muñoz, OHA
3:10-3:20 pm	Break	
3:20-3:50 pm	Public health modernization planning for 2023 <ul style="list-style-type: none"> Continue to develop PHAB priorities 	Sara Beaudrault and Cara Biddlecom, OHA
3:50-4:20 pm	Health equity capacity building reflection and next steps <ul style="list-style-type: none"> Determine goals, priorities and next steps Discuss workgroup for charter, bylaws and work plan update 	Veronica Irvin, PHAB Chair All
4:20-4:30 pm	Public comment	Veronica Irvin, PHAB Chair
4:30 pm	Next meeting agenda items and adjourn	Veronica Irvin, PHAB Chair

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PUBLIC HEALTH ADVISORY BOARD (PHAB) MEETING MINUTES

February 17, 2022, 2:00-5:00 pm

Attendance

Board members present:

Kelle Little, Dr. Bob Dannenhoffer, Dr. Veronica Irvin, Dr. David Bangsberg, Sarah Poe, Dr. Sarah Present, Carrie Brogoitti, Dr. Jeanne Savage, Michael Baker, Rebecca Tiel, Rachael Banks, Dr. Ryan Petteway, Jackie Leung

Board members absent:

Erica Sandoval, Dr. Dean Sidelinger, Jocelyn Warren

Oregon Health Authority (OHA) staff:

Cara Biddlecom, Sara Beaudrault, Lisa Rau, Tamby Moore, Christine Rankin

Meeting objectives:

- Approve January meeting minutes
- Hear update on funding to community-based organizations
- Hear update on legislative session
- Discuss public health modernization planning for 2023
- Continue racial equity capacity building trainings with Health Resources in Action

2:00-2:10 pm Welcome, updates and agenda review

Veronica Irvin, *PHAB Chair*

- Attendance was taken and a quorum was present.
- Two new PHAB members were introduced.
 - Jackie Leung, Executive Director for the Micronesian Islander Community, filling the role of Public Health Services Provider.
 - Dr. Ryan Petteway, Assistant Director at the OHSU-PSU School of Public Health, filling the role of Population Metrics Expert
- The Governor’s Office is reviewing applications for the final two open seats, which are expected to be filled by the March meeting.
 - Health Care Representative, not a CCO
 - At Large Member
- The January minutes were approved unanimously.

2:10-2:20 pm Legislative Session

Cynthia Branger Muñoz, *OHA Staff*

- Updates on Public Health priorities for the 2022 Legislative Session

2:20 – 2:50 pm Public Health Modernization planning for 2023-25

Cara Biddlecom and Sara Beaudrault, *OHA Staff*

- Discussion from previous month continued--to develop PHAB’s priorities for future investments in public health.

2:50 – 3:00 pm CBO Funding

Christine Rankin, *OHA Staff*

- Presentation by Christine Rankin and Josillia Johnson, Community Engagement Coordinators, on funding for community-based organizations.

3:00 – 3:10 pm Break

3:10-4:50 pm Health Equity Capacity Building

Brittany Chen and Ben Wood, *Health Resources in Action*

- Continuation of racial equity capacity-building work, building on previous discussions and training.
- This is Session 4 of 4 training periods and the final meeting with Health Resources in Action.

4:50 – 5:00 pm Public comment

Veronica Irvin, *PHAB Chair*

Cara Biddlecom, *OHA Staff*

- No requests for public comments were made prior to the meeting or during this time. Public comments section was closed.

5:00 pm Next meeting agenda and adjourn

Veronica Irvin, *PHAB Chair*

- March's agenda will include reports from PHAB subcommittees and an opportunity to talk about next steps for PHAB to move in the direction of racial equity.
- Next meeting will be Thursday, March 17, from 2-4:30 pm.

Meeting adjourned at 5:00 p.m.

OHPB 2022 Annual Retreat Draft Guidance for Committee Presentations

Objective: focus on systems work of Committees. Not what Committees *would do* but how *they are* addressing systems work and systems change.

Public Health Advisory Board, March 2022. Draft for review

Committee Questions

1. How does the OHA system create barriers to the committee's ability to do its work overall? (*are there administrative burdens; compensation issues for members; scheduling concerns; state power differentials/heavy handedness; government terminology that doesn't translate; etc.*)
 - Organizational silos
 - Information sharing across silos
 - Opportunities for collaboration across OHA programs
2. How is the OHA/OHPB definition of health equity specifically incorporated into your committee's efforts/work?
 - PHAB Health Equity Review Policy and Procedure
 - Accountability metrics
 - Local public health funding formula
 - Health equity capacity building training
 - Subcommittee membership
 - New member recruitment
3. How is your committee bringing attention to and addressing the idea of 'historical injustice' in its efforts/work? (*example: western medical model consistently superseding any conversations about traditional spiritual models of healing - the committee is bringing this conversation forward and/or seeking to elevate traditional practices such as...*)
 - Opportunity: funding formula
 - Opportunity: public health modernization priorities
 - Opportunity: update to charter, bylaws, work plan, Health Equity Review Policy and Procedure

Systems Work

Thinking about systems...

Systems thinking is a sensitivity to the circular nature of the world we live in; an awareness of the role of structure in creating the conditions we face; a recognition that there are powerful laws of systems operating that we are unaware of; a realization that there are consequences to our actions that we are oblivious to.

- Michael Goodman

<https://thesystemsthinker.com/systems-thinking-what-why-when-where-and-how/>

- Opportunity: modernizing public health data
4. Thinking about the identities, populations, communities named in the definition, where is your committee making specific progress in moving toward health equity? (*while this may be viewed as a representation response, really trying to hear how committees are working toward being more inclusive than just having voices at the table...how they are taking up the recommendations/solutions offered by the voices*)
 - Broader representation on the board
 - Public health accountability metrics changing to be more reflective of process versus achievement of health outcomes
 - Inclusion of members beyond appointed members in subcommittees and visioning for PHAB
 5. From the systemic focus of your committee (i.e., workforce, metrics, etc.), what does your committee need to address to take its next step toward health equity?
 - Public health funding
 - Public health policy development and implementation
 - Understanding and supporting data justice and decolonizing public health data
 - Supporting community-led data systems
 - Assessment of representation on PHAB
 - Understanding the connection to OHPB and its subcommittees

Health Equity Definition

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

New framework for public health accountability metrics

Current accountability metrics	New metrics framework
Minimal context provided for disease risks and root causes of health inequities	Provides context for social determinants of health, systemic inequities and systemic racism
Focus on disease outcome measures	Disease outcomes may be used as indicators of progress, but are secondary to process measures of public health system accountability
Focus on programmatic process measures	Focus on data and data systems; community partnerships ; and policy .
Focus on LPHA accountability	Focus on governmental public health system accountability .
Minimal connection to other state and national initiatives	Direct and explicit connections to state and national initiatives .

PUBLIC HEALTH ADVISORY BOARD Accountability Metrics Subcommittee

**February 16, 2022
8:30-9:30 am**

Subcommittee members present: Cristy Muñoz, Kat Mastrangelo, Sarah Present, Olivia Gonzalez

Subcommittee members absent: Jeanne Savage

OHA staff: Sara Beaudrault, Kusuma Madamala, Diane Leiva

PHAB's [Health Equity Policy and Procedure](#)

Welcome and introductions

November minutes were approved.

Sara B. noted that Jocelyn Warren, a PHAB member and administrator for Lane County Public Health, will join this subcommittee.

Sara B. reviewed the group agreements and subcommittee deliverables.

Metrics shifts to a new framework

Sara B. reviewed an updated timeline for subcommittee deliverables. We would like to have a new framework for metrics in place this Spring, with this subcommittee being responsible for communicating about shifts from previous accountability metrics to a new framework. Also over the Spring, this subcommittee will review metrics recommended by local public health authorities through the Coalition of Local Health Officials. Once new metrics are adopted by PHAB toward the middle of the year, the work will shift to collecting data and developing an annual report. Sara noted that this is a fast timeline but also noted the need to demonstrate progress on this legislative deliverable. We need to balance this.

Kusuma clarified that the focus right now is on communicable disease control and environmental health metrics.

Sara B. reviewed a slide that shows shifts from previous set of accountability metrics toward the direction this subcommittee is taking.

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- Shifting away from a focus on disease outcomes. Does the subcommittee recommend using health/disease outcome measures as indicators to demonstrate the need for changes and accountability within the public health system?
 - Shifting away from a framework that does not provide context for health outcomes.
 - Shifting away from programmatic process measures to a framework that emphasizes the public health system's work around data and data systems, community partnerships and policy. These span any public health program or topic.
 - Shifting away from a focus on accountability of local public health authorities to a focus on accountability of the governmental public health system.
 - Shifting toward intentional alignment with national initiatives.

Diane noted that access to health education and information could be included, in addition to access to health care.

Kat said that process measures are always just a proxy for impact and wondered to what extent we can get to impact. It is not inappropriate for a newer program to focus on process metrics. The impact can take a few years to see.

Kusuma asked how subcommittee members are thinking about providing context for disease risks and outcomes. Does something like sharing public health data with other sectors begin to provide that context?

Sarah P. said the updates are aligned with subcommittee discussions. She thinks about providing basic context as an important part of the education about the shift in metrics, for internal communication and communicating with the legislature. It should be grounded in social determinants of health, systemic inequities and systemic racism, and how we are trying to move forward. She agrees with process over outcome, and in the future we may want to look at outcomes. She also suggested flexibility so that local jurisdictions can localize it easily. As an example, the report can show how systemic racism has affected people's sexual health choices. And then an LPHA could provide additional context for their community and what steps the LPHA is taking.

Sara B. appreciated Sarah P's comments, especially if it helps to make this a report that is relevant and can be used by LPHAs and partners.

Cristy said that she feels like the subcommittee has been heard through conversations over the past months of work. She noted that public health is a critical metric of resilience in communities. A healthy community is a resilient community. If we are shifting metrics, we need to educate on why and emphasize racial equity. Rather than talking about communities being vulnerable, emphasize how communities have been underserved. There may need to be some hand-holding to make public health racial equity a more understandable concept for the community as a whole, in addition to for public health professionals.

Cristy also commented on the public health workforce and our responsibility to ensure a workforce that can address community priorities. She would like to see a focus on workforce in addition to being community-centered.

Sarah P. would like to take the opportunity to frame metrics in terms of what we have learned from the pandemic and its rattling effects on the public health workforce. She highlighted communication challenges. What is a metric that can show how communications will be better the next time we have a public health emergency?

Kusuma brought up previous comments that focus on infrastructure challenges, whether that be workforce, data systems or communications. If there are process measures related to infrastructure, those would be good to consider.

Kat asked about wastewater monitoring and how this could provide COVID surveillance but also other stressors like medications in wastewater. Are there linkages between public health and wastewater treatment in most communities?

Sarah P. said she gets a weekly report on COVID in wastewater. It is hard to know what to do with it but there are a lot of interesting possibilities.

Sara B. said this is an example of having real-time actionable data, and it goes back to whether we have the workforce and infrastructure to use it.

Olivia commented that in order to be inclusive, we need to take into consideration that some communities do not reach out to the public health system because of their legal status. In order to have accurate data, we cannot forget about those who are not counted. This takes the entire community, not just public health, reaching out to these families. There is communication through education, which could include school districts, that could be measured and contribute to sustainable data.

Sara B appreciated Olivia's comments and brought up data decolonization and needing to ensure groups are not erased because they don't easily show up in the data.

Cristy said that in groups where there have been cross sector collaborations between CBOs, LPHAs and OHA or other state departments, there is a need to stay relatively neutral on behalf of the governmental sector. But many CBOs with frontline workers or who are involved in racial justice want more accountability in public finance and infrastructure investments. How could metrics reflect the culture shift that we are hoping to see, and the positionality of government makes this challenging. How do state agencies assure equity in infrastructure investments when needing to remain neutral. This leads to a lack of trust.

Cristy noted an interest in trying to build capacity in underserved communities and wondered whether this is something that could be included in a measure. She also asked about community partnerships and how development of partnerships could be measured.

Cristy also mentioned that the Environmental Health Team was connected with the Prevention Institute. They do a lot of upstream, equity-based work. She shared this link: <https://www.preventioninstitute.org/equity-through-line-four-part-summit-series-social-movements-public-finance-and-infrastructure>. We are not the only state thinking about shifts in metrics and how this is applicable in partnership with various other sectors.

Sara B. said that, based on this discussion, it sounds like OHA can continue to work with local public health authorities to identify process measures, looking at data, community partnerships and policy. We will continue in this group to work on framing, deliverables, how to communicate about these shifts, which sets up how the measures will be used. Measures will come back to this group for review and then to PHAB to be adopted.

Subcommittee business

Sarah P. agreed to provide a subcommittee update at the March PHAB meeting.

The subcommittee will meet again on March 16.

Public comment

John Zall, University Professor Adjunct who teaches business, strategic planning and metrics. He noted that it is rare to see a public sector process like this and would like to keep in contact. He noted the subcommittee's process is strong. It is easy to get buried in all types of metrics with a lot of outside opinions. One of the things the subcommittee could think about, in particular for big picture metrics, would be to use pilot studies. Are the data available and what would we need to do to get the data before making decisions?

Obinna Oleribe commented in the chat: What is the data for? This is what will determine what you would be collecting. What is the long-term goal of this process? This is what will determine how you go about collecting the data. Who will use the data? This is what will determine how the data will be presented and published. What are the key challenges to collecting data in our community? This is what will determine the risk management strategies in the process. How much time do we have for this process? This will determine whether we will handle this in-house or outsource part of the process. In all, I think that our activities should cover the six building blocks of health system - services delivery, financing, HRH, leadership and governance, medicines and technology and information science. We can also focus on one block per time, but connecting the data to address these issues will make the document very useful for decision making... In choosing metrics, we can look at process, output.

Adjourn

LPHA funding formula survey preliminary results

March 3, 2022

1. How many LPHAs have completed the survey?

Extra small/small	16 of 18
Medium	6 of 7
Large/extra large	7 of 7
Total	29 of 32

Base funding

2. Compared to other county size bands. LPHA jurisdictions in my size band receive sufficient base funds to fulfill PE51 requirements.

	All	Extra small/small	Medium	Large/extra large
Strongly agree	2	1	1	
Agree	21 (72%)	11 (69%)	5 (83%)	5 (71%)
Disagree	6	4		2
Strongly disagree	0			
Total	29	16	6	7

3. What changes are needed so that LPHA jurisdictions in each size band receive sufficient funding to fulfill PE51 requirements?

Responses in rank order
Increase floor funding to provide a minimum FTE to every LPHA. Increase the minimum FTE with funding and requirements. (20 responses)
Specify core positions that should be funded through PE 51 in every county and factor the costs of those positions into the floor funding for each LPHA. (15 responses)
Explore ways to use the funding formula to support regional partnerships and other shared service delivery models, while also providing funding for each LPHA. (10 responses)
Explore ways to factor in funding to CBOs that supports PE 51 requirements. (4 responses)
No changes needed (1)
Other (3) <ul style="list-style-type: none"> - Smaller counties should be incentivized to band together for some of this work. - In Washington State Seattle/King has their own metrics and funding, separate from the rest of the state. It's something Oregon should seriously explore. - The rurality component should not have the same pot of funding as the other components, while poverty has a smaller pot of funding. Rural populations may drive further, but urban staff spend a lot of time in traffic and have much higher costs. - Think about making the number of available non-governmental health/community services an indicator, since smaller counties have less access. - Rurality ignores the issues in the urban counties and continues the urban/rural divide.

- Consider using housing status in the components, since that is a big issue around the State.
- Please consider granting part of the regional funding to individual LPHA if the LPHA chooses not to join a region
- I'm not opposed to increases at the base funding level, but I do wonder at what level will that negate the additional factors that are taken into account. While I do not believe they are perfect, I do think it is the best attempt I have seen thus far to equitably distribute funds. That being said, I do believe that each LPHA should be able to hire at least 1.0 FTE staffing given the funding investment.

Indicators

4. The indicators in the funding formula are an effective mechanism for using funds to eliminate health inequities.

	All	Extra small/small	Medium	Large/extra large
Strongly agree	0	0		
Agree	24 (83%)	13 (81%)	6 (100%)	5 (71%)
Disagree	4	3		1
Strongly disagree	1	0		1
Total	29	16	6	7

5. What changes are needed to make the funding formula a more effective mechanism for eliminating health inequities.

Responses in rank order
Discuss weighting certain indicators more heavily in funding formula allocations. (14 responses)
Review and make updates to the current set of indicators. (7 responses)
No changes needed. (6 responses)
Modify the funding formula to display each LPHA's rank on each indicator, in addition to each LPHA's allocation. (6 responses)
Proportionally increase allocations to the LPHAs that rank lowest on one or more health status indicators. (5 responses)
Other (1 response) <ul style="list-style-type: none"> - The formula needs to be more transparent in order to appropriately answer this question. The document handed out currently as "the formula" is really just something that shows allocation; it does NOT show HOW these factors determine the monetary amount. - One of the biggest factors to addressing inequities and ensuring that any progress toward eliminating inequities is maintainable is ensuring consistency in funding and ensuring that programs and positions can stay in place. Ensuring that the work is aimed at eliminating inequities through evidence-based and innovative strategies is also key. I don't think that adjusting funding based on health status or demographic factors actually does anything to ensure an effective mechanism for eliminating health inequities.

Floor payments and indicators

6. For the 2023-25 funding formula, I would like PHAB to:

Keep the proportion of funds allocated to floor funding and indicators the same as in 2021-23.	3
Increase the proportion of funds allocated to floor funding, so that the minimum amount received by each LPHA is increased.	18 (62%)
Increase the proportion of funds allocated to demographic and health status indicators so that more funding is directed to eliminating health inequities.	7
Other	1
Total	29

PHAB Funding Principles

The public health modernization funding formula advances the following Funding Principles:

	Strongly agree	Agree	Disagree	Strongly disagree
Funding Principle #1: Ensure that public health services are available to every person in Oregon, whether they are provided by an individual LPHA, a Tribal public health authority, through cross-jurisdictional sharing arrangements and/or by OHA.	0	20 (69%)	7	2
Funding Principle #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.	1	16 (55%)	11	1
Funding Principle #3: Use funding to advance health equity in Oregon, which includes directing funds to areas of the state experiencing a disproportionate burden of disease or where health disparities exist.	1	18 (62%)	9	1
Funding Principle #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.	2	20 (69%)	5	2
Funding Principle #5: Align public health work and funding to leverage resources with health care, education and other sectors to achieve health outcomes.	0	18 (62%)	8	3

Comments

Infrastructure

- All public health departments should receive enough funding to maintain an infrastructure that includes program leadership, staff support, and content experts. Without a sustainable infrastructure, it is not feasible to accomplish the goals and objectives.
- If we truly want to modernize all LPHAs, we need to ensure that the small counties are able to support adequate staffing. Raising the floor could help that.
- Counties need basic infrastructure to function. As a large county I have relied on my medium and smaller neighbors from time to time. It is critical that we have infrastructure in place. Enable us to better share services across counties.
- More emphasis on regionalization is needed.

Workforce

- I think the biggest challenge is hiring for positions using funding that has an end date and is not guaranteed to be renewed.
- We have had problems recruiting people to fill our positions. Pay inequities between public and private employers makes it difficult. It is also hard for us to afford multiple positions, and often we need to cobble funding streams to be able to hire a FTE. Sometimes funding rules precludes us from doing this.
- Community challenges regarding hiring, welcoming, support and including diversity in the workforce, policies, and organizational culture.
- Ways to support a remote workforce and workforce report findings from CLHO.

Funding formula performance

- It seems to make things unnecessarily complicated. The goal is for everyone to have access to the same capabilities and programs then that's what the funding should be aimed at. Closing gaps in inequities, stimulating innovation, increasing efficiency, etc should be built into what is requested from the work itself. The funding formula doesn't affect how we use the money and the actions taken with the money are what is going to make the differences.
- The funding formula is definitely one of the better things I have seen when it comes to funding public health.

Funding Principles

- Rural and frontier issues are not taken into consideration when apply blanket funding principles.
- Funding Principle #4 I have some very real concerns about being able to "change" public health systems.
- Funding Principle #5 A challenge occurs when our health care, education and public health sectors all follow different metrics and rules.

- Principle #1 : does "delivered by OHA" mean delivered by CBOs?
- Principle #2: I'm not sure that alignment with CHA/CHP is happening or what adjusting for redirected resources means
- Funding Principle #5: Align public health work and funding to leverage resources with health care, education and other sectors to achieve health outcomes - our cross-sector partnerships and collaborations are not supported by modernization funding.
- I don't think the current formula is transparent enough to determine how will it advance principles #2-5.
- The funding principles do not prioritize population, however the distribution of funds always has a population element to them and not a burden of disease element.
- For Funding Principles #1 & #5, I marked Disagree mostly because I don't think it adequately advances the principle. The funding formula can slightly advance a principle, but that's not acceptable to me in these cases. I think the funding formula should CLEARLY advance these principles.

Indicators

- A metric (e.g., interaction term) that serves as proxy measure of intersectionality and cumulative impact of systematic racism, exclusion, social determinants of health and health equity, and COVID-19.
- Some of the funding formula needs to be updated. At least in the most recent I received for PE51, rurality was determined by population estimates from 2010.
- Basing funding on health status and inequities ends up taking away funding from those that are successful in closing gaps. We need to know that systems put in place, especially successful systems can be maintained because these efforts are not "one and done."

Other

- Wait to review / evaluate / revise the formula until outcome from the AAR / Evaluation of COVID response is completed (Steiner-Haywards bill).
- This was challenging. Without having the requirements for the required assessments it is hard to say if this is enough funding for us to do the work.
- Create and implement a budget equity tool by learning from ARPA (e.g., <https://home.treasury.gov/system/files/136/SLFRF-Equity-Webinar.pdf>) and others (e.g., <https://www.transformgov.org/programs-and-projects/racial-equity-budgeting-tools>)
- Health equity in rural Oregon - how does that apply in counties that are solely rural? How does it apply in counties that are a combination of urban and rural?
- Racial justice and equity capacity building at the LPHA level as well as community and systems levels. What additional funds may be needed - not necessarily at a local level, but possibly the state or regional levels to support that capacity building?
- Health equity appears different in rural areas. In Oregon urban areas will have more racial inequities. In rural areas, it's less about race, yet inequities are evident.

- I appreciate having this communication and overall feel good about the funding coming to my county.
- A targeted universalism approach to equity investments.
- Thank you for taking such thoughtful approaches to the funding formula and for seeking input from LPHAs.
- I am afraid that funding will fall as we move further away from pandemic support dollars. We have worked for 2 years to build capacity and systems that support the needs of our communities and I don't want to see us go backwards again.
- Overall focus on equitable resource distribution with an emphasis on outcomes. Also follow the principle of spending twice as much time getting new resources as you spend making a distribution plan. :-)
- There is no clear analysis or evidence apparent to me as to why counties receive what funds and how each county is expected to meet measurable targets. The goals are so broad with little guidance or clear expectations that it seems like a waste. Dumping money where there isn't infrastructure and not bringing LPHAs to the table with all the CBOs receiving funding has divided our work and made public health extremely fractured. Without help with hiring and the training of a workforce to do this work, and leveraging community support at the actual community level WITH LPHAs, the funding principles are disingenuous.

PUBLIC HEALTH ADVISORY BOARD Incentives and Funding Subcommittee

March 3, 2022

1:00-2:30 p.m.

Subcommittee members present: Bob Dannenhoffer, Carrie Brogoitti, Michael Baker, Veronica Irvin, Jackie Leung (tentative subcommittee member),

OHA staff: Sara Beaudrault, Cara Biddlecom, Andrew Cohen, Ilana Kurtzig

Guest: Laura Daly and Sarah Lochner, Coalition of Local Health Officials

PHAB's [Health Equity Policy and Procedure](#)

Welcome and introductions

COVID-19 response

Cara talked about COVID-19 resilience planning, which is being done through OHA and the Governor's Office. Goals include:

- Continuing COVID-19 response, centering equity, not losing gains that have been made with communities, and looking at secondary impacts of COVID and building strategies to look more broadly at health. Cara gave housing, behavioral health, and unmet health care needs during the pandemic as examples.
- The plan that will be released 3/11 is a bridge to community resilience and toward meeting goals in the statewide health improvement plan, Healthier Together Oregon.

Cara stated that there will be opportunity for discussion with PHAB. What roles can PHAB have to lead this work going forward? How can PHAB support, provide leadership, guidance or structure? She noted the connections to public health modernization work.

Bob said that the COVID pandemic was the first time where not having enough money wasn't the top concern. There was never something public health needed to do and couldn't do, due to lack of funding.

Mike said that a concern he heard locally is, what happens when the money goes away? What happens if it isn't all spent and needs to be given back?

Jackie said that, through her work with the Micronesian community, she hears concerns about whether communities will continue to be prioritized and whether the work will be done. They do not want lip service or checking the box.

Incentives and Funding subcommittee overview

Sara reviewed the statutory authority for the public health modernization LPHA funding formula. The language is included in the meeting packet.

She noted that PHAB's role is to make recommendations on the development and any modifications to the funding formula. This is a very specific responsibility of PHAB. For the legislators who drafted the statute, it was a priority to have this sit with PHAB to ensure different perspectives to ensure public health funding is being used to reach public health priorities and goals.

Mike asked to clarify the last statement in Section A, about the ability of a LPHA to invest in public health services. Does this mean that the ability of a county government needs to be taken into consideration in funding allocations? Who defines what ability means, and does OHA or the LPHA decide this?

Sara responded that the subcommittee addressed this through the matching funds component of the funding formula. The data comes from the annual expenditures reporting that each LPHA completes.

Sara reviewed deliverables and a draft timeline for the subcommittee's work, included in the meeting packet.

Public health modernization funding formula

Sara reviewed the funding formula and discussed county size bands and each component of base funding.

- Floor funding goes to each LPHA and is intended to make sure every LPHA has funds to do the work. It is different for each county size band. Above \$10 million, floor funds increase proportionally.
- Indicators are used to allocate funds based on health and demographic differences among counties. All indicators are weighted equally.
- In addition to looking at total awards by LPHA, PHAB can also look at awards per capita.

Mike asked how percentages for each indicator was decided.

Sara said that the amount of funds for all indicators are the same, except for when two indicators were bundled. Indicator payments are tied to population size, so two counties with similar ranks for indicators may receive very different payments based on population size.

Bob noted that no one is thrilled with the funding formula and no one objects, so generally the subcommittee has done its work.

Sara reviewed funding formula feedback provided by most LPHAs. Refer to meeting packet.

Veronica noted that most LPHAs feel they are getting enough funds and are generally satisfied with the framework.

Bob noted that most LPHAs are receiving enough funding to employ an FTE, with the exception perhaps of Wheeler County. We need to understand what people meant by suggesting an FTE in every county because for some programs or functions, that wouldn't make sense. He noted that shifting funds to small counties will take from large counties. FTE may make sense for modernization, but we need to be careful that this does not become the standard for all programs

Mike said it is less whether there are enough funds to fund a full-time employee and more that the workload may be more work than one person can complete, especially when it is new work or spans multiple program areas.

Veronica said that for core FTE, are there certain positions that cost more that would indicate a need to raise the base. Is it helpful to think about what types of positions are needed.

Laura reviewed some findings from the CLHO Workforce Report. The goals were to get a baseline of FTE prior to public health modernization investments, compile public health pay scales, explore challenges to recruiting and retaining staff, exploring successful strategies for recruitment and retention, and provide recommendations for LPHA workforce development.



CLHO_Workforce_Report_2021.pdf

- There is very little epi capacity in counties under 50,000 unless through a regional partnership.
- LPHAs increased public health workforce by 60% during COVID-19. There is interest in keeping this workforce in place. Laura noted that this increase was consistent with recommendations from a recent national [Staffing Up](#) report.
- One recommendation included establishing standard FTE needed in each department to deliver essential public health services.

Jackie asked how many positions created by the pandemic will be maintained or changed?

Laura said it varies from county to county. Some LPHAs are eliminating these positions. Other LPHAs are able to continue these positions through other funding.

Bob said that the issue is less with modernization funding, and more with funding through other Program Elements. In many cases, the allocations are very small by county, and this is what results in one person having to wear many hats. It is an issue of how to run an LPHA in areas with smaller populations. We have to, as a state, figure out how to do that to ensure great public health services everywhere.

Sara said we are trying to build a public health system where people have access to the same level of public health services, programs and protections, no matter where they live. And we need to be cautious that we're not building a system that increases the gaps between counties. With current modernization funding and requirements, LPHAs are doing communicable disease, climate and health, community partnerships and expanding capacity with public health data. These are very different skills and small LPHAs are trying to complete it with one position whereas larger counties are hiring multiple people with subject matter expertise. Sara also noted that as the Legislature continues to increase its investment, the gaps in funding between extra small and extra large counties will continue to grow.

Carrie said that when there is not enough funding, there is no perfect formula. Carrie reflected that when we envisioned this, one of the objectives was to be able to do work that demonstrates outcomes to the legislature to encourage additional investments. How can you demonstrate outcomes without enough funding to do the work? Carrie has also been thinking about equity and reducing disparities. In Union County about 90% of the population is white. So maybe it is even more important for counties like hers to do more work to eliminate disparities because there aren't as many resources, and it's more important to use modernization funds in this way. She expressed gratitude for the community partners that have shown up and done a lot of the work that needed to be done throughout the pandemic. We need to continue investing in these partnerships, and it takes time and resources but it is needed to address disparities. This is the piece of the funding formula she's been thinking about. It's hard to pinpoint the changes needed to address disparities.

Veronica asked whether there is a chance of increasing the \$28 million going out to LPHAs now. Sara responded that the hope is to continue to increase Legislative investments each biennium.

Sara reviewed LPHA survey feedback on indicators. Most LPHAs responded that indicators are effective for working toward health equity. Sara reviewed the top suggestions for changes made by LPHAs.

Bob said that adding indicators makes the overall impact watered down. He suggests sticking to around 4-5 indicators. He does not think much is needed.

Sarah Lochner stated that it would be helpful if the base is at least one FTE. The public health system is only as strong as its weakest link.

Laura agreed that focusing on the base is the priority for LPHAs.

Veronica asked about lack of epidemiologists in many counties. Is this a discussion for another meeting or a PHAB meeting? Should we discuss recruitment or incentives?

Laura said that sometimes a county doesn't have enough work for an FTE epi, so there is also an opportunity for shared positions. This could work for epis, but maybe not all position types.

Carrie stated that shared, regional positions are great but there needs to be local capacity within the LPHA to take advantage of the resource.

Subcommittee business

- Bob will provide a subcommittee update at March PHAB meeting
- Subcommittees agreed to keep the current meeting time but shorten to one hour.

Public comment

No public comment was provided.

Adjourn

Oregon Health Authority Public Health Advisory Board 2022 Legislative Update

March 17, 2022

Cynthia Branger Muñoz, OHA Government Relations



Number of Bills

- Total bills: 219
- Bills related to health (OHA was tracking): 113
- Public Health bills tracked: 81
- Public Health Division high priority bills passed: 13

Public Health Bills

- HB 4034: Technical Fix bill
- HB 4045: Community violence prevention
- HB 4052: Mobile Health Units
- HB 4068: Emergency Preparedness
- HB 4077: Environmental Justice Council
- HB 4098: Opioid Settlement Prevention, Treatment and Recovery Fund (OSPTR Fund)

Public Health Bills

- SB 1529: Volunteer Health Care Providers
- SB 1549: Temporary Staffing Agency Licensing
- SB 1554: After Action Report on COVID response
- SB 1585: COVID Workers Compensation
- Budget: Healthy Homes

Building Healthier Communities

- HB 4150: Community Information Exchanges
- HB 4002: Farm Worker Overtime Pay
- SB 1536: Extreme Heat Emergencies

Access to Care

- HB 4035: CCO Bridge Plan
 - Covers individuals who earn less than 200% FPL who no longer qualify for OHP because of end of Public Health Emergency
- HB 4095: Veterans Dental Care
- SB 1538: COFA Dental Care
- HB 4134: Covering Out of Network Labor & Delivery

Transforming the Behavioral Health System

- HB 4004: Behavioral Health Grants
 - \$132 million grants to behavioral health providers for staff compensation and work force retention and recruitment.
- Budget: Behavioral Health Rate Increases
- Budget OSH Staffing
- Budget: 988 Crisis Services System
- Budget: Behavioral Health Housing
- HB 4012: Child Services Rates

Thank you!

The logo for the Oregon Health Authority is centered on a light blue, curved background. It features the word "Oregon" in a smaller, orange, serif font positioned above the "Health" part of the word "Oregon Health". The word "Health" is in a large, dark blue, serif font. Below "Health" is the word "Authority" in a smaller, orange, serif font. A thin blue horizontal line is positioned just above the "Authority" text, extending from the left side of the "H" in "Health" to the right side of the "y" in "Authority".

Oregon
Health
Authority

Public Health Advisory Board

Priorities for 2023-25 public health modernization investments – for discussion

February 9, 2022

1. Ensure investments accelerate work toward racial equity.

Discussions from 1/20 PHAB meeting:

- *Fund projects with specific equity outcomes at both the community and policy/systems level.*
- *Ensure public health priorities are guided by the communities we serve.*
- *Support an intentional pivot from a system that is set up to provide the “greatest good for the greatest number” to one that focuses on people experiencing health inequities.*
- *Need to be able to measure equitable health status.*

2. Ensure investments support long-term COVID recovery and resilience.

Discussions from 1/20 PHAB meeting:

- *Community partners will help Oregon come out of the pandemic. We can't do it alone and are casting a wider net.*

3. Protect and promote health through a sustainable public health system that is equity-focused, community-centered, responsive and forward-thinking.

Discussions from 1/20 PHAB meeting:

- *Need data systems that collect the right data that is actionable; data sharing across partners.*
- *Identifying and focusing on our priorities should be our priority.*
- *Increase the public health workforce pipeline.*
- *Clarify roles of the governmental public health system and broader public health system and leverage roles to address community needs. We need to make sure the system is in place for the next public health emergency.*
- *Recognize the differences among counties and avoid “one size fits all” approaches or “shoulds”.*

4. Continue and expand investments in communicable disease control and environmental health. With additional funds, invest in prevention and health promotion.

Discussions from 1/20 PHAB meeting:

- *Public health is inherently about health promotion. Public health is for everyone.*
- *Public health has become the safety net of the safety net.*
- *Preventive health services are a mechanism toward equity and health promotion.*

Health Resources in Action – Health and Racial Equity Training for PHAB; reflections and recommendations

OHA staff collected reflections and next steps from Brittany Chen and Ben Wood for PHAB to consider in implementing work after their series of trainings.

Reflections:

- Palpable energy around understanding that things need to change.
- Working to understand breadth of PHAB's role, power and influence, as well as who is the PHAB's community, who is PHAB accountable to? How can PHAB activate an equity agenda?
- Working to affirm PHAB's statutory authority.
- Opportunity to look at the culture and way of being in the PHAB. This can include protecting time to cultivate a relationship across members.
- There is momentum and interest in connecting PHAB across state agencies and with OHPB.
- With many changes in membership, there is an opportunity to create more structured onboarding, regular setting a time for moments to reflect on shared racial equity goals, as well as relationship building with each other.

Recommendations:

- Consider formalizing the roles of subcommittee members.
- Consider changing the PHAB meeting schedule to lessen the feeling of being outside of the conversation for non-LPHA and OHA members.
- Consider rotating facilitation or external facilitation to allow the chair to participate fully.
- Consider using the iceberg analogy to maintain focus on racial equity and where PHAB is at with a regular cadence.

- Take steps back to reflect as a group on why we commit to racial equity, what do we want to see, if we are successful, what will happen/ vision for change to build alignment and not assumptions.
- Consider developing and adhering to group agreements.

Advancing Equity through Systems Change

OR Public Health Advisory Board - Session 4

February 17, 2022 from 2:50-4:50 PM



Health Resources in Action
Advancing Public Health and Medical Research

Our Team



Brittany Chen
Managing Director, Health Equity



Ben Wood
Senior Director, Policy and Practice

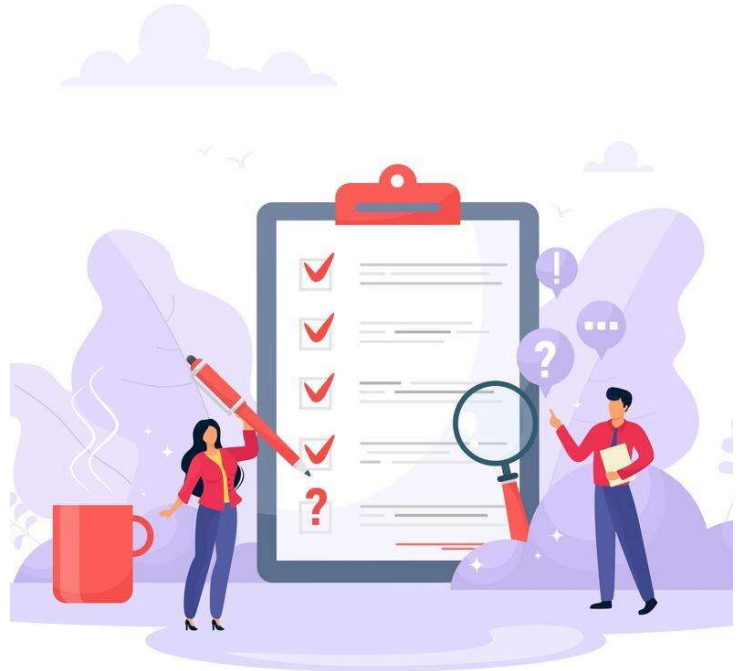


Training Overview and Grounding



Session 4 objectives

- I. Build additional relationships and connection with one another
- II. Review and practice operationalization of shifts in practices and actions proposed through Session 2 and the Survey Modernization Retreat
- III. Prepare for next steps to embed systems change and deep equity practice in PHAB work planning



Agenda

5
min

Welcome, introduction, and grounding

15
min

Community building

10
min

Learning Journey Overview &
Systems Change Refresher

15
min

Another metaphor: Getting to the
Roots of Structural Change

40
min

Shifts in Action

10
min

Looking forward: Embedding equity into
work planning and Close



Group agreements

- Be present
- Take space, make space
- Challenge by choice, but do challenge yourself
- Bold humility
- Listen deeply
- Join by video, if you can!
- Have fun!

What else would you like to add?



Our approach to learning

*There is a conversation in the room
that only these people at this moment
can have. Find it.*

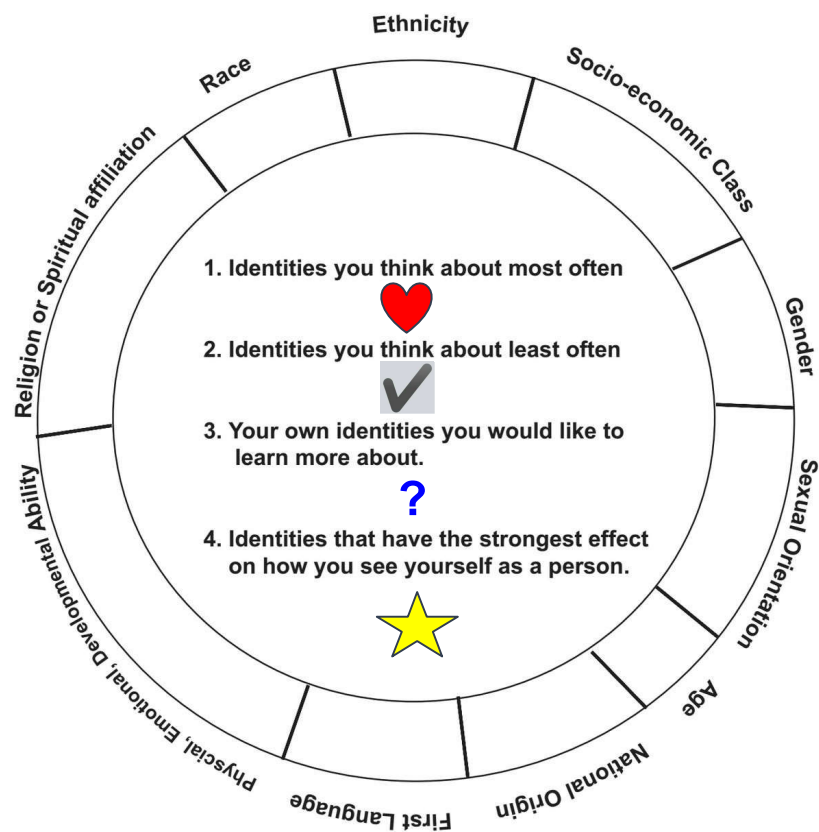
emergent strategy
adrienne marie brown



Community Building



Mental Model Kaleidoscope: Who are we?



Intersectionality: A lens through which you can see where power comes and collides, where it interlocks and intersects.

-Kimberlé Crenshaw



Equity-Centered Systems Change



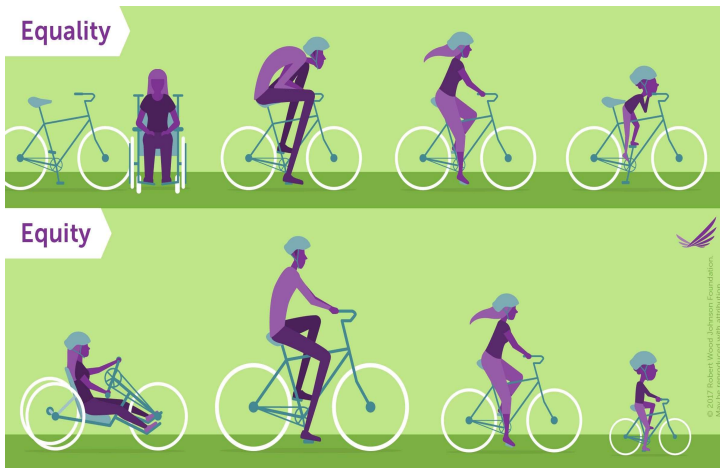
PHAB Learning Journey Goals

- ★ **Build relationships and trust** for connection amongst PHAB members and with the Public Health Division (PHD) and identify sustainable systems to maintain it (for existing and future members).
- ★ Come to a **shared understanding** of health equity, racial equity, and related concepts.
- ★ Collectively **reflect upon, unpack, and explore** application of the **Health Equity Review Policy and Procedure** as a guiding tool to support implementation of equity related practices.
- ★ **Identify possible priority areas** that PHAB may **proactively focus on** to support PHD's efforts to advance health equity.



Session 1: Challenging Our Mental Models

Health equity demands racial equity



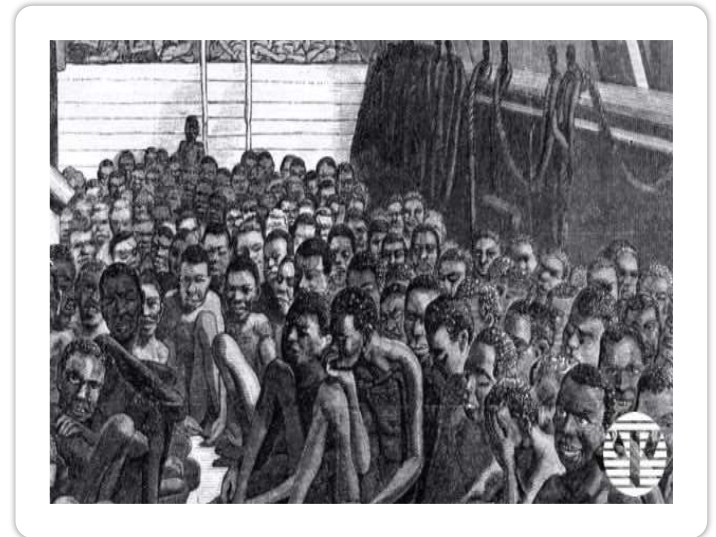
Definition of health equity

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

PHAB acknowledges historic and contemporary racial injustice and commits to eradicating racial injustice. PHAB acknowledges the pervasive racist and white supremacist history of Oregon, including in its constitution; in the theft of land from indigenous communities; the use of stolen labor and the laws that have perpetuated unjust outcomes among communities of color and tribal communities.



Racism in America

See Dr. Camara Jones at the 0:47 mark



Session 2: Transformative & Relational Change

AN ECOSYSTEM OF JUSTICE: HOW NEIGHBORS CAN BE

A Poem Story by Elissa Sloan Perry

Change Elemental CoDirector

Complex Systems Change was sitting. In a chair. At a desk. Looking. At data. Asking questions. Forming so called "liberating structures" that, as is, only liberate those he can see. In ways he can see. With feedback loops so meticulously considered they were a thing of beauty to him. Created so systems can learn and leaders can learn. To be adaptive.

He'd proclaimed this in a conference presentation. He did have good intentions.

His neighbor, Deep Equity, grew concerned. Complex Systems Change was maybe not Deep Equity's best friend, but Complex Systems was their¹² neighbor and Deep Equity cared about how pale and cut off Complex Systems was getting.

They¹³ knocked on Complex Systems' door.

"I think you might be having heart problems." They said to him. "You are pale and move about the world as if your limbs are numb. Artist and Healer say you are always knocking into people, knocking things over. Breaking them. When you come to the central marketplace."

From Elissa Sloan Perry's "An Ecosystem of Justice: How Neighbors Can Be."

Change Elemental's Systems Change and Deep Equity: Pathways Toward Sustainable Impact, Beyond "Eureka!," Unawareness, & Unwitting Harm



DEPARTMENT
OF HEALTH

[Narratives and Health Equity:
Expanding the Conversation](#)



Session 3: Shifting internal practice

HEALTH EQUITY



berkeley **media** studies group

5

Definition of community participation

Develop a process of defining community participation along a continuum for PHAB activities (from community informed to community led) and to include accountability processes.

6

Process for community engagement

Develop a process to define which actions of the PHAB require community engagement and at what level on the continuum.



Defining mental models

Six Conditions of Systems Change

Policies Practices Resource Flows

Relationships & Connections Power Dynamics

Mental Models

Structural Change
(explicit)

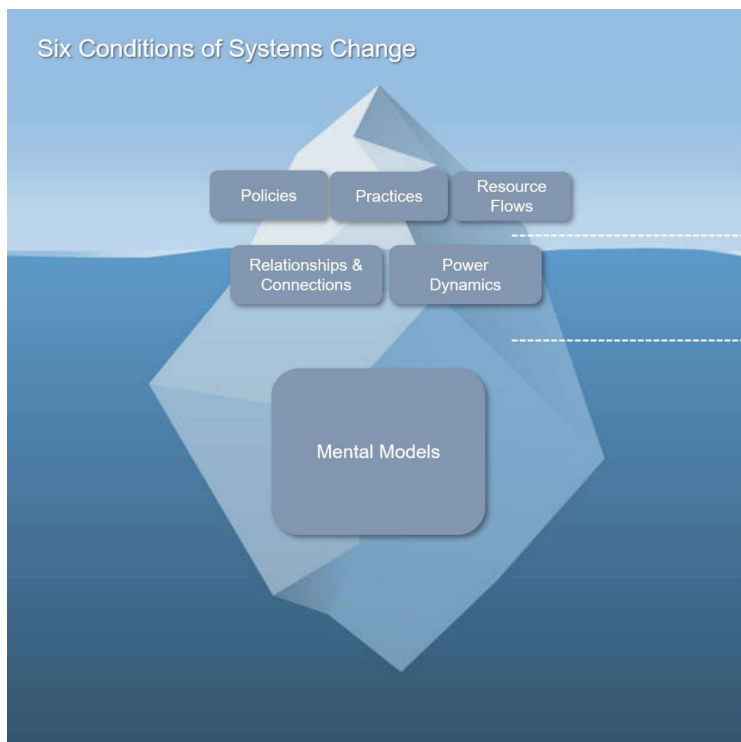
Relational Change
(semi-explicit)

Transformative Change
(implicit)

- Habits of thought
- Deeply held beliefs and assumptions
- Taken-for-granted ways of operating that influence how we think, what we do, and how we talk



Moving Towards Relational Change

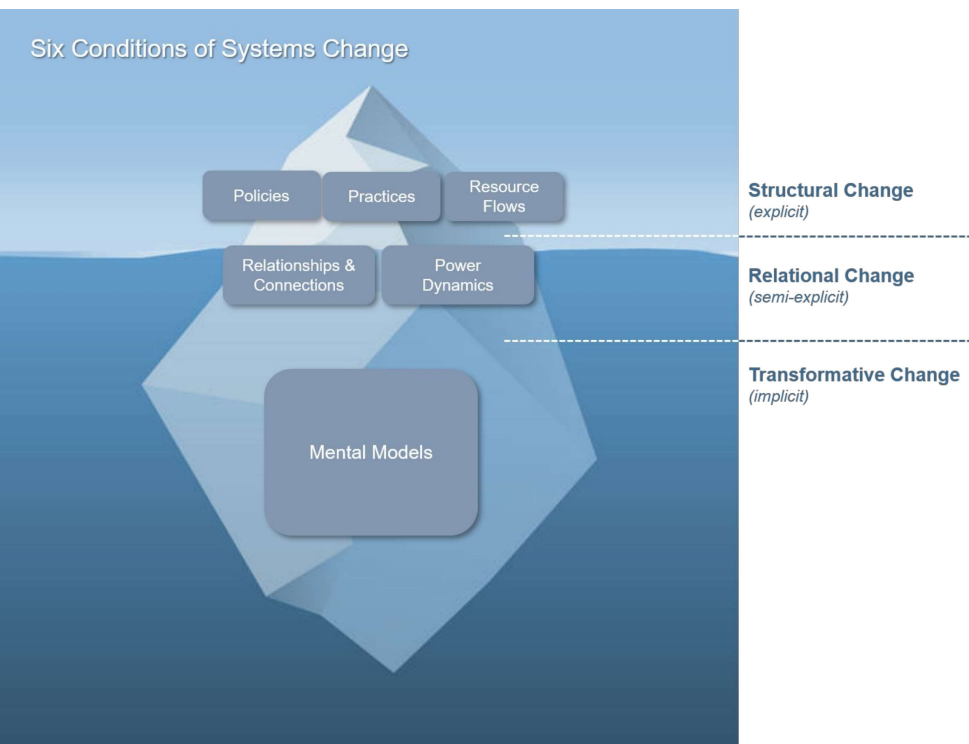


Relationships & Connections:
Quality of connections and communication occurring among actors in the system, especially among those with differing histories and viewpoints

Power Dynamics:
The distribution of decision-making power, authority, and both formal and informal influence among individuals and organizations



The tip of the iceberg



Policies: Government, institutional and organizational rules, regulations, and priorities that guide the entity's own and others' actions.

Practices: Espoused activities of institutions, coalitions, networks, and other entities targeted to improving social and environmental progress. Also, within the entity, the procedures, guidelines, or informal shared habits that comprise their work.

Resource Flows: How money, people, knowledge, information, and other assets such as infrastructure are allocated and distributed.



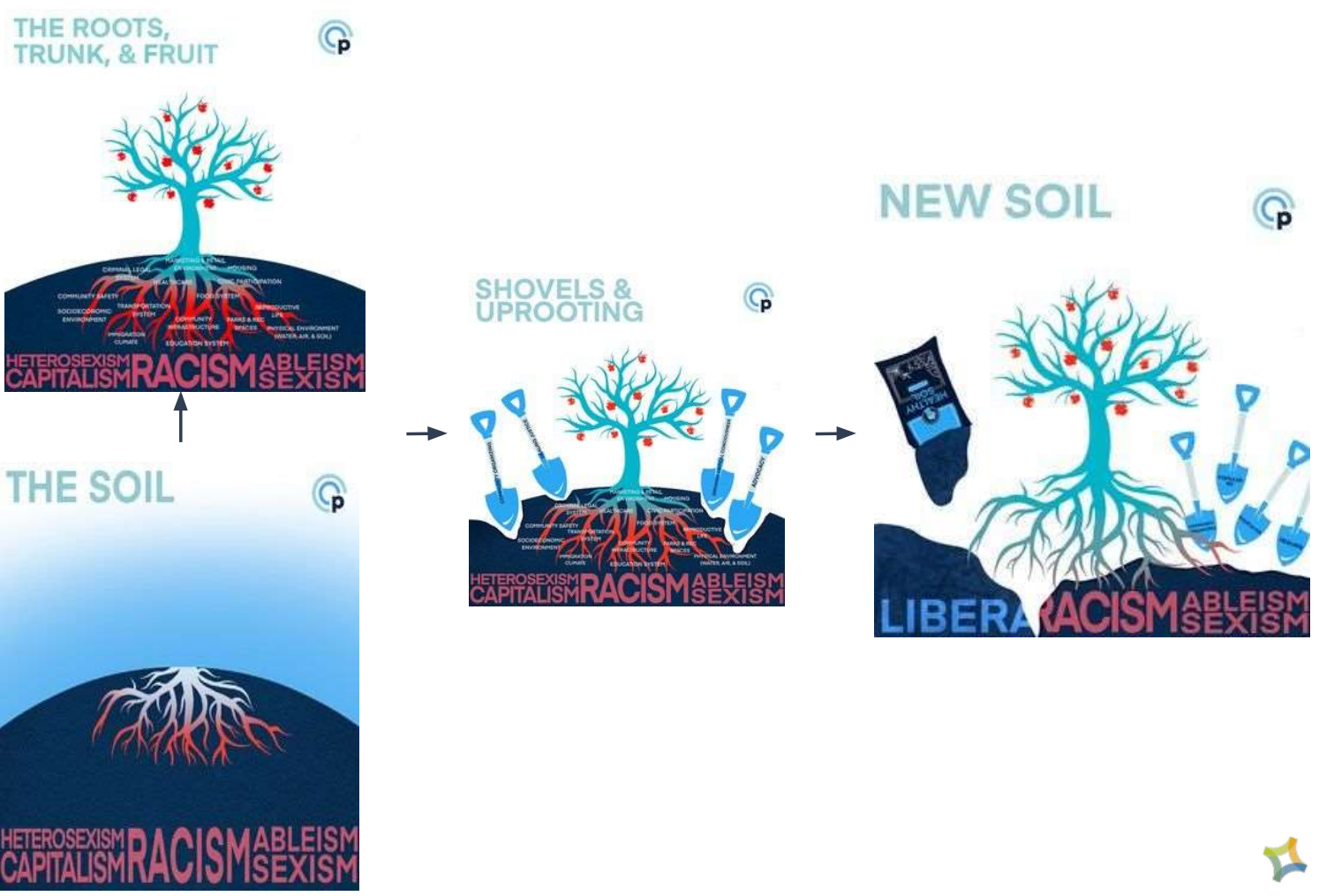
Getting to the Roots of Structural Change



[Social Determinants of Health — The Praxis Project](#)



Getting to the Roots of Structural Change



Getting to the Roots of Structural Change



Practicing Equity-Focused Shifts



Proposed Internal Actions Expressed by the PHAB

- 1 Practice self-evaluation, dialogue, feedback**
Create time and processes for PHAB to practice self-evaluation, dialogue, feedback from all members, from the public, and from OHA/PHD.
- 2 Set its own agenda**
Create the conditions necessary for the PHAB to set its own agenda, informed by but not always led by OHA/PHD.
- 3 Inclusive, equitable participation**
Create opportunity for all PHAB members to participate in PHAB activities and discussions equitably and fully through intentional onboarding and regular check-ins with all members.
- 4 Definition of community**
Develop consensus on a working definition of community for the PHAB (who is the PHAB community?).



Proposed Internal Actions Expressed by the PHAB

5

Definition of community participation

Develop a process of defining community participation along a continuum for PHAB activities (from community informed to community led) and to include accountability processes.

6

Process for community engagement

Develop a process to define which actions of the PHAB require community engagement and at what level on the continuum.

7

Charter and bylaws

Revise the PHAB charter and bylaws if constraining any desired actions.



Proposed External Actions Expressed by the PHAB

1

Stronger connection between PHAB, OHA & other state agencies

Develop a process for PHAB members to participate in and have representation at other OHA and state agency meetings (especially those with influence over SDOH).

2

Communication messages and approaches

Develop and implement communication messages and approaches to make the role and work of PHAB more compelling/understandable (why should people care and participate?).

3

Address public health mistrust

Create a role for PHAB to address the critically important issue of mistrust in information and public health.



Proposed External Actions Expressed by the PHAB

4

Baseline and equitable funding

Revisit the LPHA funding formula to account for baseline and equitable funding that provides adequate capacity, support for community-centered work, and support for evaluation and reporting on outcomes.

5

Public health cost assessment

Create a new public health cost assessment that more fully recognizes the cost of delivering equitable public health services.

6

Accountability to community need

Support LPHAs, OHA and others serving the community with redefining accountability to community need



Spotlight: Connections across agencies

1

Stronger connection between PHAB, OHA & other state agencies

Develop a process for PHAB members to participate in and have representation at other OHA and state agency meetings (especially those with influence over SDOH).



Spotlight: Connection across agencies

Defining the issue

1) **What is the inequity we are trying to resolve? Why does it matter? What are the root causes?**

SDOH factors drive health and hold inequities in place. Need to come to a common understanding of structural racism (and other systems of oppression) as a root cause of inequity and partner with other agencies to cultivate new soil.

Expand representation on other state agencies.

Public health issues require collaboration

Efficiency. What is being done, what is working and what is not

Public health is siloed. It is pragmatic.

Formal role is limited but voices not

avoid unintended consequences of other policies and investments, eg infrastructure, taxes, education

Who has the power,



Spotlight: Connection across agencies

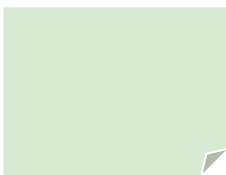
Defining the issue

2) What is our vision for change?

PHAB will become go-to partners for state agencies to explore the connection between SDOH and health outcomes and partner together to envision policies, practices, and resource flows that advance health, justice, and racial equity.

a standing Health/Equity in All Policies committee/council staffed w/ various agency folks and community/public health folks that reviews all existing legislation/policy for health/equity impacts and all proposed legislation

Do folks have to come to us, or are we already integrated (someone employed at all agencies and making connections)



Spotlight: Connecting across agencies

To make progress in shifting PHAB practice:

1) What mental models need to be challenged?

Public health needs to be more than service delivery, we need to consider all the SDOH.

2) Who needs to be involved? Who has not yet been involved, but should be?

3) What power dynamics are at play? What needs to be shifted?

4) What is the next practical step that needs to be taken (e.g., policies, practices, and/or resource flows)?

- The role of the PHAB related to the Oregon Health Policy Board
- The role of the PHAB related to OHA
- Identifying how these conversations will continue

Small group discussion notes [here](#).



Looking forward: Leading with Equity

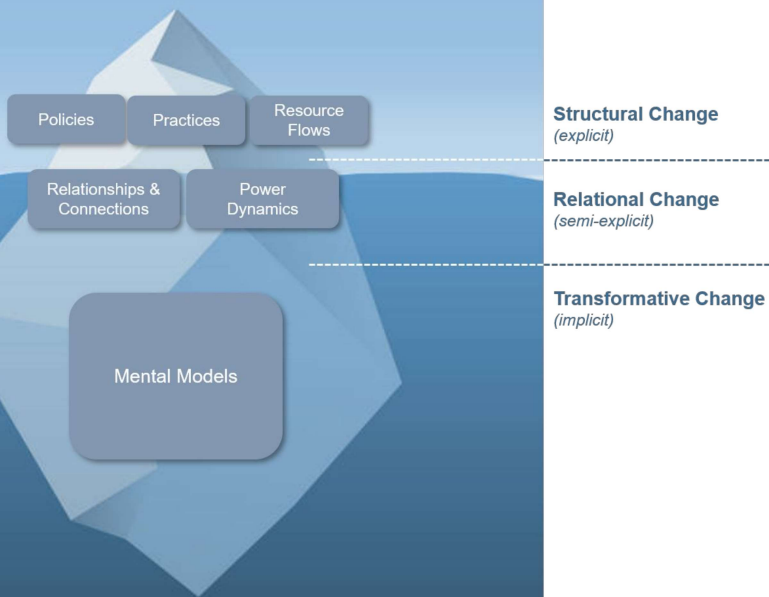


What's Next for PHAB

Centering equity in the:

- PHAB Charter Review
- Health Equity Review Policy and Procedure

Six Conditions of Systems Change



Key Questions

- *What mental models need to be challenged?*
- *Who needs to be involved? Who has not yet been involved, but should be?*
- *What power dynamics are at play? What needs to be shifted?*
- *What is the next practical step that needs to be taken (e.g., policies, practices, and/or resource flows)?*

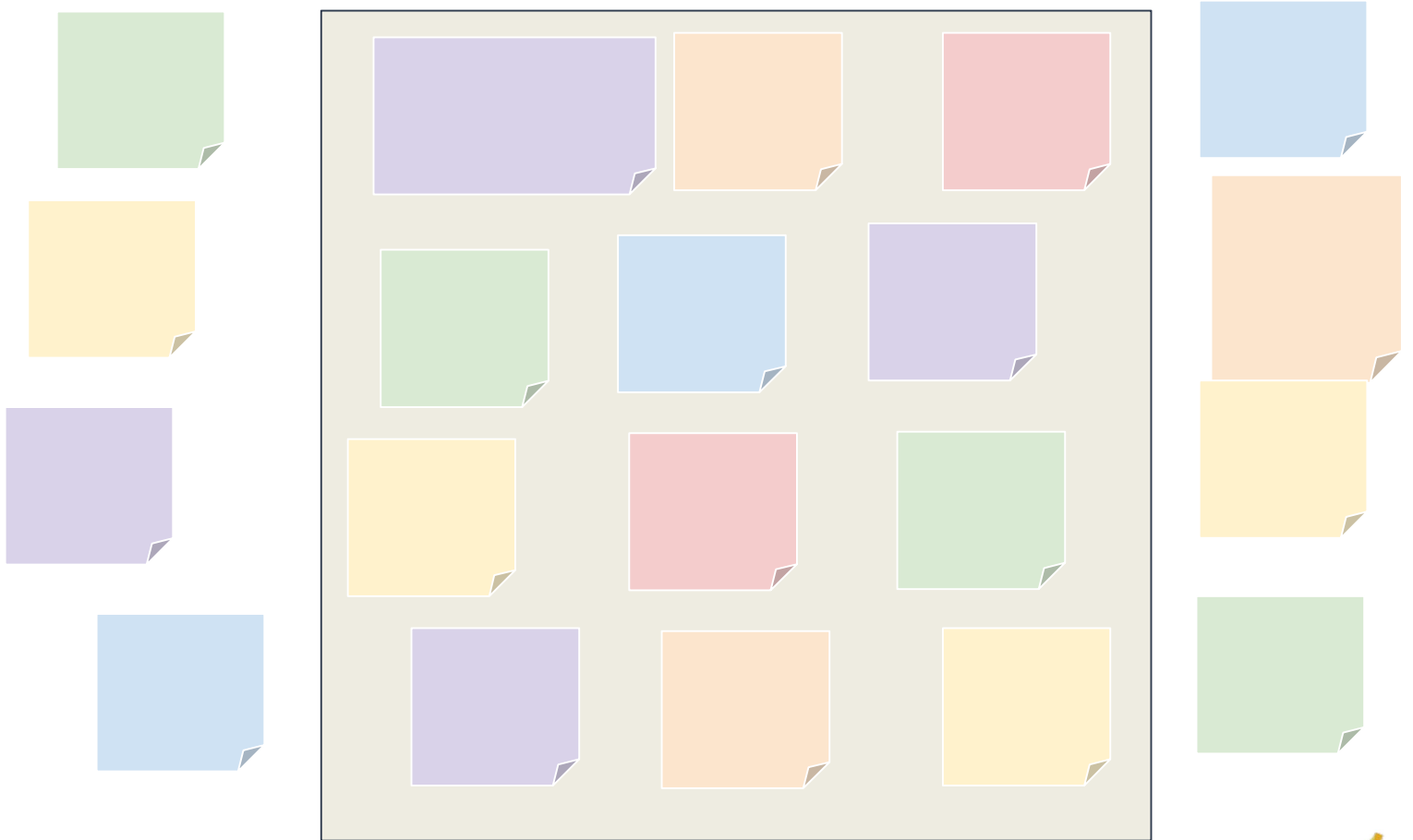


Reflection and Action



Geometric reflection

Something that squared with your understanding

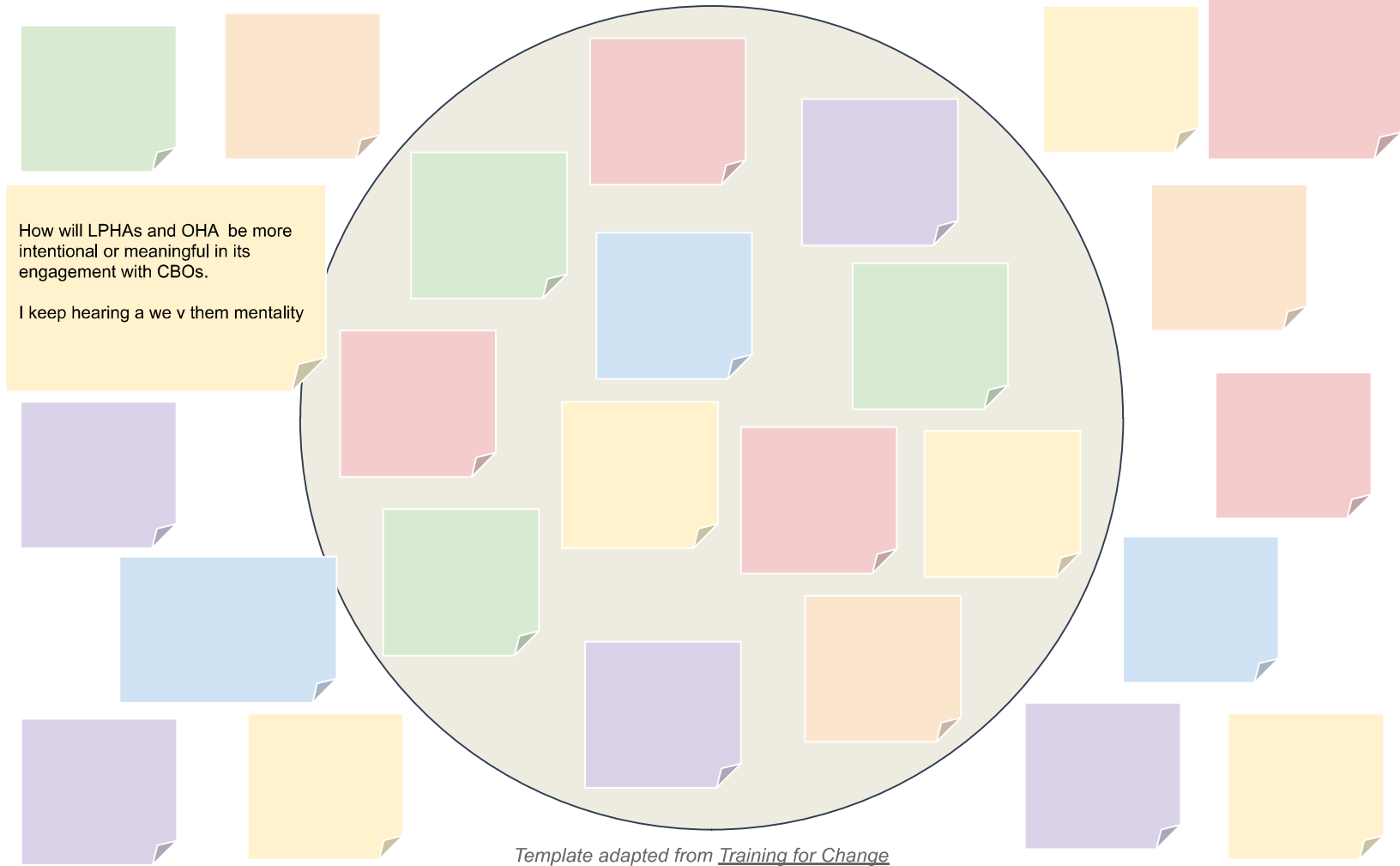


Template adapted from [Training for Change](#)



Geometric reflection

Something that is still circling around



Template adapted from Training for Change

Geometric reflection

Something that made you look at things from a new angle



Template adapted from [Training for Change](#)



Geometric reflection

One new action you'd like to take

continue this

conversation with my board. Health Equity is not their daily focus, but they are community leaders

Invest in relationship

bring a good/concrete summary to the Health Officer Caucus...whom I'm representing but have not engaged with well.

Recognizing privilege

Template adapted from Training for Change



Feedback and Close



Thank you!



Public Health Advisory Board

I. Authority

The Public Health Advisory Board (PHAB) is established by ORS 431.122 as a body that reports to the Oregon Health Policy Board (OHPB).

The purpose of the PHAB is to be the accountable body for governmental public health in Oregon. The role of the PHAB includes:

- A commitment to racial equity to drive public health outcomes.
- Alignment of public health priorities with available resources.
- Analysis and communication of what is at risk when there is a failure to invest resources in public health.
- Oversight for Oregon Health Authority, Public Health Division strategic initiatives, including the State Health Assessment and State Health Improvement Plan.
- Oversight for governmental public health strategic initiatives, including the implementation of public health modernization.
- Support for state and local public health accreditation.

This charter defines the objectives, responsibilities, and scope of activities of the PHAB. This charter will be reviewed no less than annually to ensure that the work of the PHAB is aligned with statute and the OHPB’s strategic direction.

II. Deliverables

The duties of the PHAB as established by ORS 431.123 and the PHAB’s corresponding objectives include:

PHAB Duties per ORS 431.123	PHAB Objectives
a. Make recommendations to the OHPB on the development of statewide public health policies and goals.	<ul style="list-style-type: none"> • Participate in and provide oversight for Oregon’s State Health Assessment. • Regularly review state health data such as the State Health Profile to identify ongoing and emerging health issues. • Use best practices and an equity lens to provide recommendations to OHPB on policies needed to address priority health issues, including the social determinants of health.
b. Make recommendations to the OHPB on how other statewide priorities, such as the provision of early learning services and the delivery of health care services, affect and are affected by	<ul style="list-style-type: none"> • Regularly review early learning and health system transformation priorities. • Recommend how early learning goals, health system transformation priorities, and statewide public health goals can best be aligned.

<p>statewide public health policies and goals.</p>	<ul style="list-style-type: none"> • Identify opportunities for public health to support early learning and health system transformation priorities. • Identify opportunities for early learning and health system transformation to support statewide public health goals.
<p>c. Make recommendations to the OHPB on the establishment of foundational capabilities and programs for governmental public health and other public health programs and activities.</p>	<ul style="list-style-type: none"> • Participate in the administrative rulemaking process which will adopt the Public Health Modernization Manual. • Verify that the Public Health Modernization Manual is still current at least every two years. Recommend updates to OHPB as needed.
<p>d. Make recommendations to the OHPB on the adoption and updating of the statewide public health modernization assessment.</p>	<ul style="list-style-type: none"> • Review initial findings from the Public Health Modernization Assessment. (completed, 2016) • Review the final Public Health Modernization Assessment report and provide a recommendation to OHPB on the submission of the report to the legislature. (completed, 2016) • Make recommendations to the OHPB on processes/procedures for updating the statewide public health modernization assessment.
<p>e. Make recommendations to the OHPB on the development of and any modification to the statewide public health modernization plan.</p>	<ul style="list-style-type: none"> • Review the final Public Health Modernization Assessment report to assist in the development of the statewide public health modernization plan. (completed, 2016) • Using stakeholder feedback, draft timelines and processes to inform the statewide public health modernization plan. (completed, 2016) • Develop the public health modernization plan and provide a recommendation to the OHPB on the submission of the plan to the legislature. (completed, 2016) • Update the public health modernization plan as needed based on capacity.
<p>f. Establish accountability metrics for the purpose of evaluating the progress of the Oregon Health Authority (OHA) and local public</p>	<ul style="list-style-type: none"> •

<p>health authorities in achieving statewide public health goals.</p>	
<p>g. Make recommendations to the Oregon Health Authority (OHA) and the OHPB on the development of and any modification to plans developed for the distribution of funds to local public health authorities, and the total cost to local public health authorities of implementing the foundational capabilities programs.</p>	<ul style="list-style-type: none"> • Identify effective mechanisms for funding the foundational capabilities and programs. • Develop recommendations for how the OHA shall distribute funds to local public health authorities. • Review the Public Health Modernization Assessment report for estimates on the total cost for implementation of the foundational capabilities and programs. (completed, 2016) • Support stakeholders in identifying opportunities to provide the foundational capabilities and programs in an effective and efficient manner.
<p>h. Make recommendations to the Oregon Health Policy Board on the incorporation and use of accountability metrics by the Oregon Health Authority to encourage the effective and equitable provision of public health services by local public health authorities.</p>	<ul style="list-style-type: none"> • Develop and update public health accountability metrics and local public health authority process measures. • Provide recommendations for the application of accountability measures to incentive payments as a part of the local public health authority funding formula.
<p>i. Make recommendations to the OHPB on the incorporation and use of incentives by the OHA to encourage the effective and equitable provision of public health services by local public health authorities.</p>	<ul style="list-style-type: none"> • Develop models to incentivize investment in and equitable provision of public health services across Oregon. • Solicit stakeholder feedback on incentive models.
<p>j. Provide support to local public health authorities in developing local plans to apply the foundational capabilities and implement the foundational programs for governmental public health.</p>	<ul style="list-style-type: none"> • Provide support and oversight for the development of local public health modernization plans. • Provide oversight for Oregon’s Robert Wood Johnson Foundation grant, which will support regional gatherings of health departments and their stakeholders to develop public health modernization plans.
<p>k. Monitor the progress of local public health authorities in meeting statewide public health goals, including employing the</p>	<ul style="list-style-type: none"> • Provide oversight and accountability for Oregon’s State Health Improvement Plan by receiving quarterly updates and providing feedback for improvement.

foundational capabilities and implementing the foundational programs for governmental public health.	<ul style="list-style-type: none"> • Provide support and oversight for local public health authorities in the pursuit of statewide public health goals. • Provide oversight and accountability for the statewide public health modernization plan. • Develop outcome and accountability measures for state and local health departments.
l. Assist the OHA in seeking funding, including in the form of federal grants, for the implementation of public health modernization.	<ul style="list-style-type: none"> • Provide letters of support and guidance on federal grant applications. • Educate federal partners on public health modernization. • Explore and recommend ways to expand sustainable funding for state and local public health and community health.
m. Assist the OHA in coordinating and collaborating with federal agencies.	<ul style="list-style-type: none"> • Identify opportunities to coordinate and leverage federal opportunities. • Provide guidance on work with federal agencies.

Additionally, the Public Health Advisory Board is responsible for the following duties which are not specified in ORS 431.123:

Duties	PHAB Objectives
a. Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters.	<ul style="list-style-type: none"> • Provide guidance and recommendations on statewide public health issues and public health policy.
b. Act as formal advisory committee for Oregon’s Preventive Health and Health Services Block Grant.	<ul style="list-style-type: none"> • Review and provide feedback on the Preventive Health and Health Services Block Grant work plan priorities.
c. Provide oversight for the implementation of health equity initiatives across the public health system <u>by leading with racial equity.</u>	<ul style="list-style-type: none"> • Receive progress reports and provide feedback to the Public Health Division Health Equity Committee. • Participate in collaborative health equity efforts.

III. Dependencies

PHAB has established two subcommittees that will meet on an as-needed basis in order to comply with statutory requirements:

1. Accountability Metrics Subcommittee, which reviews existing public health data and metrics to propose biannual updates to public health accountability measures for consideration by the PHAB.
2. Incentives and Funding Subcommittee, which develops recommendations on the local public health authority funding formula for consideration by the PHAB.

PHAB shall operate under the guidance of the OHPB.

IV. Resources

The PHAB is staffed by the OHA, Public Health Division, as led by the Policy and Partnerships Director. Support will be provided by staff of the Public Health Division Policy and Partnerships Team and other leaders, staff, and consultants as requested or needed.

PHAB Executive Sponsor: Lillian Shirley, Public Health Director, Oregon Health Authority, Public Health Division

Staff Contact: Cara Biddlecom, Director of Policy and Partnerships, Oregon Health Authority, Public Health Division

PUBLIC HEALTH ADVISORY BOARD BYLAWS

~~November 2017~~ April 2020

ARTICLE I

The Committee and its Members

The Public Health Advisory Board (PHAB) is established by ORS 431.122 for the purpose of advising and making recommendations to the Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB).

The PHAB consists of the following 14 members appointed by the Governor.

1. A state employee who has technical expertise in the field of public health;
2. A local public health administrator who supervises public health programs and public health activities in Benton, Clackamas, Deschutes, Jackson, Lane, Marion, Multnomah or Washington County;
3. A local public health administrator who supervises public health programs and public health activities in Coos, Douglas, Josephine, Klamath, Linn, Polk, Umatilla or Yamhill County;
4. A local public health administrator who supervises public health programs and public health activities in Clatsop, Columbia, Crook, Curry, Hood River, Jefferson, Lincoln, Tillamook, Union or Wasco County;
5. A local public health administrator who supervises public health programs and public health activities in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Wallowa or Wheeler County;
6. A local health officer who is not a local public health administrator;
7. An individual who represents the Conference of Local Health Officials created under ORS 431.330;
8. An individual who is a member of, or who represents, a federally recognized Indian tribe in this state;
9. An individual who represents coordinated care organizations;
10. An individual who represents health care organizations that are not coordinated care organizations;
11. An individual who represents individuals who provide public health services directly to the public;
12. An expert in the field of public health who has a background in academia;
13. An expert in population health metrics; and
14. An at-large member.

Governor-appointed members serve four-year terms and are eligible for reappointment. Members serve at the pleasure of the Governor.

PHAB shall also include the following nonvoting, ex-officio members:

1. The Oregon Public Health Director or the Public Health Director's designee;
2. If the Public Health Director is not the State Health Officer, the State Health Officer or a physician licensed under ORS chapter 677 acting as the State Health Officer's designee;
3. If the Public Health Director is the State Health Officer, a representative from the Oregon Health Authority who is familiar with public health programs and public health activities in this state; and
4. An OHPB liaison.

Members are entitled to travel reimbursement per OHA policy and are not entitled to any other compensation.

Members who wish to resign from the PHAB must submit a formal resignation letter. Members who no longer meet the statutory criteria of their position must resign from the PHAB upon notification of this change.

If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

ARTICLE II

Committee Officers and Duties

PHAB shall elect ~~one~~two of its voting members to serve as the chair ~~and vice chair~~. Elections shall take place ~~no later than January of~~within the first quarter of each even-numbered year and must follow the requirements for elections in Oregon's Public Meetings Law, ORS 192.610-192.690. Oregon's Public Meetings Law does not allow any election procedure other than a public vote made at a PHAB meeting where a quorum is present.

The chair ~~and vice chair~~ shall serve a ~~two~~two-year terms. The chair ~~and vice chair are~~is eligible for one additional two-year reappointment.

If the chair were to vacate their position before their term is complete, ~~the vice chair shall become the new chair to a chair election will take place to~~ complete the term. ~~If a vice chair is unable to serve, or if the vice chair position becomes vacant, then a new election is held to complete the remainder of the vacant term(s).~~

The PHAB chair shall facilitate meetings and guide the PHAB in achieving its deliverables. The PHAB chair shall represent the PHAB at meetings of the OHPB as directed by the OHPB designee. The PHAB chair may represent the PHAB at meetings with other stakeholders and partners, or designate another member to represent the PHAB as necessary.

~~Should the PHAB chair not be available to facilitate a meeting, the PHAB chair shall identify a voting member to facilitate the meeting in their place.~~

~~The PHAB vice chair shall facilitate meetings in the absence of the PHAB chair. The PHAB vice chair shall represent the PHAB at meetings of the OHPB as directed by the OHPB designee when the PHAB chair is unavailable. The PHAB vice chair may represent the PHAB at meetings with other stakeholders and partners when the PHAB chair is unavailable or under the guidance of the PHAB chair, or may designate another member to represent the PHAB as necessary.~~

Both the PHAB chair ~~and vice chair~~ shall work with OHA Public Health Division staff to develop agendas and materials for PHAB meetings. The PHAB chair shall solicit future agenda items from members at each meeting.

ARTICLE III

Committee Members and Duties

Members are expected to attend regular meetings and are encouraged to join at least one subcommittee.

Absences of more than 20% of scheduled meetings that do not involve family medical leave may be reviewed.

Date approved: ~~November 17, 2017~~

In order to maintain the transparency and integrity of the PHAB and its individual members, PHAB members must comply with the PHAB Conflict of Interest policy as articulated in this section, understanding that many voting members have a direct tie to governmental public health or other stakeholders in Oregon.

All PHAB members must complete a standard Conflict of Interest Disclosure Form. PHAB members shall make disclosures of conflicts at the time of appointment and at any time thereafter where there are material employment or other changes that would warrant updating the form.

PHAB members shall verbally disclose any actual or perceived conflicts of interest prior to voting on any motion that may present a conflict of interest. If a PHAB member has a potential conflict related to a particular motion, the member should state the conflict. PHAB will then make a decision as to whether the member shall participate in the vote or be recused.

If the PHAB has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member and afford an opportunity to explain the alleged failure to disclose. If the PHAB determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate corrective action including potential removal from the PHAB.

Members must complete required Boards and Commissions training as prescribed by the Governor's Office.

PHAB members shall utilize regular meetings to propose future agenda items.

ARTICLE IV

Committee and Subcommittee Meetings

PHAB meetings are called by the order of the chair or vice chair, if serving as the meeting facilitator. A majority of voting members constitutes a quorum for the conduct of business.

PHAB shall conduct its business in conformity with Oregon's Public Meetings Law, ORS 192.610-192.690. All meetings will be available by conference call, and when possible also by either webinar or by livestream.

The PHAB strives to conduct its business through discussion and consensus. The chair or vice chair may institute processes to enable further decision making and move the work of the group forward.

Voting members may propose and vote on motions. The chair and vice chair will use Robert's Rules of Order to facilitate all motions. Votes may be made by telephone. Votes cannot be made by proxy, by mail or by email prior to the meeting. All official PHAB action is recorded in meeting minutes.

Meeting materials and agendas will be distributed one week in advance by email by OHA staff and will be posted online at www.healthoregon.org/phab.

ARTICLE V

Amendments to the Bylaws

Bylaws will be reviewed annually. Any updates to the bylaws will be approved through a formal vote by PHAB members.