AGENDA

PUBLIC HEALTH ADVISORY BOARD

June 16, 2022, 2:00-4:30 pm

Join ZoomGov Meeting
https://www.zoomgov.com/j/1602414019?pwd=MWtPYm5YWmxyRnVzZW0vZkpUV0lEdz09

Meeting ID: 160 241 4019
Passcode: 577915
One tap mobile
+16692545252,,1602414019#

Meeting objectives:

- Approve May meeting minutes
- Approve accountability metrics, funding formula and recommend submission of the public health modernization biennial report to Legislative Fiscal Office
- Recommend Preventive Health and Health Services Block Grant work plan for Fiscal Year 2023
- Discuss PHAB charter and bylaws

2:00-2:20 pm	**Welcome, board updates, shared agreements, agenda review** • Welcome, board member introductions and icebreaker • Share group agreements and the Health Equity Review Policy and Procedure • Meeting format update • ACTION: Approve May meeting minutes	Veronica Irvin, PHAB Chair
2:20-3:25 pm	**Biennial report to Legislative Fiscal Office** • Discuss health equity review • Review final accountability metrics • Review final funding formula • Discuss 2023-25 funding request	TBD, Accountability Metrics

	• ACTION: Approve funding formula, approve accountability metrics, recommend report submission	Veronica Irvin, Incentives & Funding Subcommittee Sara Beaudrault, OHA
3:25-3:35 pm	**Break**	
3:35-3:50 pm	**Preventive Health and Health Services Block Grant proposed work plan** • Share information about proposed work plan activities • Discuss health equity review • Recommend work plan	Danna Drum, OHA
3:50-4:15 pm	**Charter and bylaws review** • Summarize the last meeting discussions about PHAB charter • Propose updates to language on PHAB scope • Determine next steps for a small working group to update objectives or work on the charter in ongoing PHAB meetings	Veronica Irvin, PHAB Chair All
4:15-4:25 pm	**Public comment**	Veronica Irvin, PHAB Chair
4:25-4:30 pm	**Next meeting agenda items and adjourn**	Veronica Irvin, PHAB Chair

PHAB Accountability Metrics
Group agreements

- Stay engaged
- Speak your truth and hear the truth of others
- Expect and accept non-closure
- Experience discomfort
- Name and account for power dynamics
- Move up, move back
- Confidentiality
- Acknowledge intent but center impact: ouch / oops
- Hold grace around the challenges of working in a virtual space
- Remember our interdependence and interconnectedness
- Share responsibility for the success of our work together

PUBLIC HEALTH ADVISORY BOARD (PHAB) MEETING MINUTES

May 19, 2022, 2:00-4:30 pm

Attendance

***Board members present*:**

Dr. Bob Dannenhoffer, Dr. Veronica Irvin, Dr. David Bangsberg, Sarah Poe, Dr. Sarah Present, Carrie Brogoitti, Rachael Banks, Jackie Leung, Dr. Jocelyn Warren, Nic Powers, Kelle Little, Dr. Jeanne Savage

Board members absent:

Erica Sandoval, Dr. Michael Baker, Dr. Ryan Petteway, Dr. Dean Sidelinger, Jawad Khan

***Oregon Health Authority (OHA) staff*:**

Cara Biddlecom, Sara Beaudrault, Tamby Moore, Victoria Demchak, Charina Walker

Meeting objectives:

- Approve April meeting minutes
- Discuss work of PHAB subcommittees
- Discuss outcomes of 2022 legislative session
- Reflect on health equity capacity building sessions and determine PHAB priorities

2:00-2:30 pm Welcome, board updates, shared agreements and agenda review

Veronica Irvin, *PHAB Chair*

- Welcome, board member introduction and icebreaker

- Group discussion on whether to bring in an external facilitator for PHAB meetings. Members voiced support for Veronica's facilitation. Others noted that an external facilitator would allow the Chair to participate more fully in discussions. Another option would be to share facilitation among PHAB members. OHA staff will continue to look into an external facilitator as an option for PHAB to consider.

- ACTION: Approve April meeting minutes
    - The April minutes were approved unanimously.

2:30 – 2:45pm Subcommittee updates

Kat Mastrangelo, *Accountability Metrics*; Bob Dannenhoffer, *Incentives & Funding Subcommittee*; Cara Biddlecom, *Strategic Data Plan*

- Accountability Metrics Subcommittee. The subcommittee has continued to work on finalizing an updated framework for accountability metrics and corresponding selection criteria for new metrics. The subcommittee heard about a new approach to communicable disease indicators that centers communities at higher risk instead of centering individual diseases. It is critical to involve the community more thoroughly in data collection. Need to think about accountability beyond health agencies; lack of improvements is because there's no policy or political will. There are different levels of accountability for PHAB, who PHAB reports to and the legislature.
- Incentives and Funding Subcommittee. The subcommittee has continued to discuss changes to the funding formula that will provide sufficient funding for every LPHA to hire additional staff as funding allocations continue to increase. The subcommittee has begun discussing the funding formula indicators, including whether to weight some more heavily and whether it is possible to find Oregon data sources that may be more reflective of changes in Oregon's population.

- Strategic Data Plan. The subcommittee discussed community-led data systems and reviewed a summary of survey modernization activities and lessons learned. There may be an opportunity to align the work of the Accountability Metrics and Strategic Data Plan subcommittees.

2:45 – 3:00 pm Preventive Health and Health Services Block Grant Report out
Danna Drum, *OHA staff*

- PHAB heard an overview of the Preventive Health and Health Services Block Grant, and PHAB's oversight role. Currently funding supports implementation of Healthier Together Oregon, the state health improvement plan; training consultation and technical assistance for LPHAs and Tribes; contract compliance, workforce development and primary sexual violence prevention. These funds are used by OHA to provide support, infrastructure and technical assistance across the public health system.

3:00 – 3:10 pm Break

3:10 – 4:20 pm Health equity capacity building reflection and next steps
Veronica Irvin, *PHAB Chair*

PHAB charter

- Must consider PHAB's scope in statute.
- What groups talk about the future of public health, if not PHAB? LPHAs have a lot of public health authority, but there are significant challenges that jeopardize the public health system, especially in rural areas.
- The future of public health was at the heart of the 2014 Task Force on the Future of Public Health.
- Equity and addressing structural racism at the forefront.
- PHAB should go beyond planning and operationalizing to being proactive.
- PHAB needs to communicate priorities up to PHPB. PHAB doesn't necessarily have authority to make changes.
- It is important for Tribes to be at the table for all these conversations and should be included throughout the charter.
- Charter should also reflect work with CBOs.

- Are objectives in alignment with reflecting PHAB's work to be an antiracist branch and provide antiracist oversight? Perhaps organize PHAB's work into three buckets: public health system, structural racism, holding policymakers and the legislature accountable.
- Would like to see more intentional connections with CCOs and the health care delivery system.
- The charter, once updated, will go to OHPB for approval.
- Suggestion to continue to focus on scope at June meeting. Then work on other sections of charter, bylaws and workplan.

4:20 – 4:30 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 were closed.

4:20 pm Next meeting agenda items and adjourn

Veronica Irvin, *PHAB Chair*

- May's meeting recap for next steps, purpose to start with charter & bylaws discussion as it helps with rest of the topics discussed and block grant report out.
- Next meeting will be Thursday, June 16, from 2-4:30 pm.

Meeting adjourned at 4:30 p.m.

Draft Minutes

PUBLIC HEALTH ADVISORY BOARD
Strategic Data Plan Subcommittee

May 17, 2022
1:00 - 2:00 PM

Subcommittee members: Jackie Leung, Hongcheng Zhao and Veronica Irvin,

OHA staff: Victoria Demchak, Cara Biddlecom, Diane Leiva

Welcome and introductions

- **Overview:**
  - Have waited some time to meet with modernization partners. Making sure that we are centering modernization in how we collect data. In March PHAB meeting, discussed pulling group back together, PHAB recommended we continue to meet given the importance of data being collected, use of the data, and applying the recommendations that have come out.
- **What we've learned:**
  - Veronica - In depth review from surveys, great reach, comments and ideas that came back from surveys about wording and reach.
  - Hongcheng – lots of challenges we've been facing during the pandemic. Public Health department courage to face it and means to do it.
  - Look how we ground ourselves & surveys are relevant and brings up community. Started with behavioral risk factor surveillance survey, telephone survey. It has some issues and challenges of reaching people as well.
  - Working with several groups to collab with to use community identified priorities to guide analysis, interpretation contextualization data. Community led data collection.
- **PHAB role:**
  - What type of guidance for guiding OHA?
  - More systematic approach.
  - How we move these goals forward
    - Community led data collection systems

- State data systems for population based statewide estimates.
- Federally funded population-based surveys
- Local complementary surveys

Diane – requirement for federal funding but able to recommend. Complements modernization documents, innovation network participatory analysis, help develop and grow participation.

Work on a framework for the four ways that OHA partners with federal and local governments to collect and manage data and increase the way that those systems are focused on community

- Hongcheng - On right track with community led and working with communities of color. A way to lower the price tag. Concerned about only a small portion of east Asian included with Pacific Islanders. Should be just Asian & Pacific Islanders.
- Community-led research and bring that piece in. Time and cycles to be aware of it. How is this shared or not shared and process [for working with community members]. Concerns about communication through state. Be more upfront of benefits and how this help.
- Look at one system each for framework, rather than all 4 due to complexity of all. Will be more tangible.

Minutes

draft

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

June 14, 2022
3:00-4:00

Subcommittee members present: Cristy Muñoz, Jeanne Savage, Jocelyn Warren

Subcommittee members absent: Kat Mastrangelo, Sarah Present, Ryan Petteway

OHA staff: Sara Beaudrault, Kusuma Madamala, Lisa Rau, Diane Leiva

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Welcome and Introduction
Sara B. welcomed everyone and asked subcommittee members to introduce themselves.

The subcommittee unanimously approved May meeting minutes. The April minutes will need to be approved at a meeting with additional subcommittee members present.

Metrics selection criteria
Sara B. presented the metrics selection criteria and reminded everyone that these are the same items we've been working on, with the focus today being on finalizing metrics selection criteria for PHAB to review on Thursday.

Sara B. described indicators as data points that draw attention to priority communicable diseases and environmental health issues that affect the people of Oregon. Indicators will change over time, but rarely in a two-year funding cycle. Indicators are different from accountability metrics, which reflect changes the government makes to move the needle on any of these indicators. We've been talking about public health data, community partnership development and the work around policy.

Jeanne asked, when we say accountability metrics, are we focusing on the public health system and the work it is doing? Do the metrics need to reflect the strategic work that public health is doing around public health modernization?

Sara B. agreed with this and said the focus is on the work that governmental health does, related to foundational capabilities.

Kusuma clarified that we are talking about local and state government for accountability metrics.

Jeanne asked whether this is in alignment with PHAB's charter. PHAB has responsibility to the public health system and reports to the Oregon Health Policy Board. We need to have metrics in place that reflect the drive and strategies, and the groups for whom PHAB helps to direct work.

Kusuma shared that larger contextual factors play into the indicators, but this is not necessarily where the accountability for governmental public health lies.

Sara B. said these are tough conversations, trying to focus in on what governmental public health is accountable for, which is described in the Public Health Modernization Manual. Some subcommittee conversations also seem to be about how to keep the state of Oregon, beyond public health, accountable. This can include political and societal factors that are much bigger than public health. It is hard to thread the needle on these.

Jocelyn asked about CBOs and their accountability for public funding. What is the accountability for CBOs if they are working on the same priorities for public health modernization?

Cristy said that for disaster resilience, CBO partners have been on the frontline and are doing a lot of work to create the new programming that is needed. She noted that her organization is receiving public health modernization funds and works with other funded organizations. These funds are helping CBOs create the new programming that is needed for moving forward. When we talk about accountability, she wants to be sure we are talking about the public sector and not CBOs. The requirements and expectations are different.

Kusuma thought back to last summer and discussions about what governmental public health was not able to do in its core functions for the COVID response. She believes that focus on governmental public health helps to not have the same issues that came up during the ongoing COVID response, in part through having infrastructure in place. She noted tat CBOs are accountable for areas of work outside of public health.

Jeanne said she doesn't know if it is within the purview of PHAB to look at the accountability of CBOs. Those are relationships that OHA has set up, and the way they've gone about funding CBOs and the structure that they are creating is lending to abrasion and friction amongst organizations that received different funding levels for different things. It is the same as when public health said it needed to have contracts with CCOs, which also created frictions. OHA in general needs to look at their own strategy and go back to that. But in this subcommittee, she doesn't think CBO accountability is within the purview of this subcommittee. If it is within purview, then we need to go back to the framework.

Sara agreed that it is out of scope. OHA funding to CBOs is something that is in the Public Health Modernization Manual as a core function for state public health. OHA is accountable for doing it. But she doesn't see how it carries through to organizations that do not have the public health authority or governmental functions of state and local public health authorities.

Jocelyn said that she thought that was true as well. But in hearing presentations from OHA In the past year, she sees that CBOs, OHA and LPHAs comprise the public health system, that the public health system has been redefined by OHA and that governmental public health was redefined to include CBOs. She is trying to understand what the system is now and how the parts work together.

Kusuma asked, if CBOs are considered to be governmental public health, then what about all the other types of partners that public health works with, like schools?

Jeanne said that her CCO funds both LPHAs and CBOs. Do we need to answer this question in order to answer the accountability metrics question?

Kusuma said she believes we do. She notes the metrics selection criteria for public health system accountability, and the specific item for alignment with the Public Health Modernization Manual which only addresses state and local public health authorities. If this is changing, we need to talk about it.

Sara B. agreed that this is important for the subcommittee to discuss. Sara said that she continues to see the governmental public health system as OHA, LPHAs and Tribes. The investments in CBOs are investing in the larger community health system, but it is not governmental. OHA needs to do more to differentiate the essential role of LPHAs, which is very different from what CBOs provide. OHA needs to do more to communicate how and why we are using funding to bring these parts of the system together.

Jocelyn said she agrees with this and hasn't heard it before from OHA. How does LPHA and CBO funding complement each other to leverage differing roles and maximize impact through the specific work that they do.

Jeanne reiterated what she heard, which is that governmental public health is OHA, LPHA and tribes. Are CBOs considered extensions of LPHAs?

Sara said no, they are not extensions of LPHAs. They are part of the broader community health or public health system. OHAs, LPHAs and tribes have statutory authority for protecting health and wellbeing. There are no similar laws for CBOs.

Cristy said that CBOs are their own separate entities and sector with really different expectations for how they meet community need. They are often small and grassroot. CBOs don't work <u>for</u> governmental entities; they work <u>with</u> governmental entities. There is a power dynamic between CBOs and governmental agencies, which the modernization funds start to address. Most CBOs don't apply for large governmental grants because of the bureaucracy and education gap in understanding how to navigate partnerships and relationships with CBOs that work with marginalized groups. This is where reparations are happening between large agencies like OHA and small organizations. Some CBOs work in the Ven diagram of public health, advocacy and policy, and direct frontline services.

Kusuma noted how this contributes to CHAs and CHIPs that are the foundation of so much in public health.

Kusuma asked whether, based on the discussion, the group agrees that the public health accountability measures were not intended to be used as a mechanism for BCO accountability.

Subcommittee members agreed.

Kusuma returned the group to looking at the metrics selection criteria.

Sara B. said that we are moving toward a framework with two levels of measures: indicators and accountability metrics. It is similar to the existing public health accountability measures, which include health outcome measures and local public health process measures. There has been talk about only including the accountability metrics that look at the granular work of state and local public health related to public health data, community partnerships and policy. Sarah Present has shared that health officers across the state feel it is important to have indicators because it shows the "so what"? Why does it matter to improve data systems? We need to be able to demonstrate a connection to long-term health improvements. Ryan has talked about the importance of articulating the community context that affects the indicators, to demonstrate that the differences in health outcomes are rooted in injustice and are the responsibility of the systems that are set up around people.

Sara asked whether the framework with two levels of measures makes sense.

Jocelyn said it makes sense and said we've been struggling with this for years. Public health is a long game and we won't see changes in indicators from year to year. Having indicators is important to show the goals and what we're aiming for. She appreciates the attention to process metrics. It is challenging to find the right ones that are convincing and important. This is a place where CBOs could come in. As we widen public health modernization, the involvement of more and more organizations in public health is important and helps create a greater understanding at the community level about where public health system is headed and why.

Cristy asked about feedback loops. Will there be a feedback loop with community once measures are identified through community listening sessions?

Sara said that determining how to get community feedback is within the scope of work for this subcommittee. She asked how we can use feedback gathered through community feedback processes for Healthier Together Oregon or other similar efforts? Will the subcommittee want to ask the community to provide feedback on more granular public health process measures? The subcommittee will need to work through questions like this as we start to identify measures.

Jeanne thought if we are looking at measures already informed by communities that have been marginalized recently, and through actively an antiracist data collection manner, then yes, it would be great to look at feedback already collected. For process measures, can we count on PHAB,

representing different sectors, as a decent representative to look at process measures, or would it need to go out for community input? She doesn't know the answers.

Kusuma asked the subcommittee to what extent indicators and accountability metrics need to be connected. She hopes to see direct alignment. As we walk through selection criteria, it would be helpful to think about indicators and accountability metrics as they relate to each other.

Sara said the CLHO communicable disease committee chairs will be invited to the next subcommittee meeting. They are thinking about data measures like completeness of REALD data, how state-level data are made available to LPHAs and workforce. Next month we'll be able to start seeing what measures could look like. Identifying indicators sits with this committee, and OHA will be bringing more content experts to talk with the subcommittee about what potential indicators could be.

Sara said we will keep the metrics selection criteria in draft form. It will be important to continue to look at it once the subcommittee is reviewing proposed measures.

Kusuma asked whether the selection criteria align with the new framework and where do they not align. It seems like we've been talking about accountability metrics first, but the metrics slection criteria lists indicators first. Are the metrics selection criteria phases necessary? She noted that the framework addresses the importance of context and on accountability metrics for data, community partnerships and policy, but she doesn't see those reflected in the metrics selection criteria.

Sara noted that the metrics selection criteria could be organized to line up with the framework, but we don't have that right now. We can add data, partnerships, and policy into the selection criteria, noting that PHAB has prioritized these three areas.

Subcommittee members agreed.

Sara asked about how to incorporate use of context to the metrics selection criteria.

Kusuma said this fits with selection of indicators more than in the accountability metrics.

Sara asked how it could be used to determine whether an indicator is a good fit to be adopted by PHAB.

Kusuma thinks about using data from other data systems or data use agreements as ways that governmental public health can be accountable.

Jeanne said she thinks of it as, is the indicator reflective of the populations that have been marginalized and suffering from a faulty system. If we pick an indicator and we look the context of social determinants of health, systemic inequities and systemic racism, does the indicator help us improve the conditions of people who have been marginalized? If it does not, then it is useless. We need indicators that reflect the populations we want to serve and provide reparations for.

Jocelyn wondered whether we could think about indicator points less as individual level outcomes and instead look at something like differences in life expectancy among racial and ethnic groups as the things we're trying to change. It may be too general and broad. The focus should be on context and not focus on the individual. Maybe what we're interested in are differences between groups that are not attributable to individual behavior, but are influenced by the context in which people live. It could be differences in infections between racial groups or based on other risk factors like housing status. The differences themselves are attributable to systemic oppression and differences in opportunity, among other things.

Sara and Kusuma will clean up the metrics criteria for PHAB but keep them as a draft and label them as preliminary. This has been an important conversation and more conversation is needed.

Health equity review questions for PHAB discussion
Cristy wrote in the chat that the document reflects our commitments to equity.

Jeanne noted that it is clear that we're challenged by identifying the correct indicators and accountability metrics and the subcommittee is still trying to figure this out. She is okay with sharing the health equity review questions.

Public Comment
None.

Adjourn
Next meeting is currently scheduled for 7/20. OHA staff are still trying to find a recurring meeting time that works for all subcommittee members.

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 will 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.

PHAB Accountability Metrics Subcommittee
Metrics selection criteria
June 2022, preliminary

Purpose: Provide standard criteria used to evaluate metrics for inclusion in the set of public health accountability metrics.

Definitions:

See graphic on next page

Indicators

- Data points that draw attention to priority communicable disease and environmental health issues that affect the health and wellbeing of people in Oregon.
- Over time, changes in indicator data show whether Oregon is making progress toward eliminating inequities and whether health outcomes are improving as a result of investments in the governmental public health system and other sectors.
- The core public health functions reflected in selected accountability metrics are necessary for achieving improvements in the indicators.
- When possible, indicator data are reported by race, ethnicity and other demographic and risk factor data.

Accountability metrics

- Process measures of the governmental public health system's core functions for which the system is accountable.
- These core public health functions are necessary for achieving improvements in communicable disease and environmental health indicators.
- Over time, changes in accountability metrics show whether the governmental public health system is increasing capacity for providing core functions.
- Accountability metrics are not reported at a population level and are not reported by race, ethnicity and other demographic factors.
- Examples may include completeness of communicable disease risk factor data or provision of data to community partners for decision-making.

Public health accountability metrics

Indicators Communicable disease control and environmental health	Public health accountability metrics Public health data, partnerships and policy
Bring attention to priority issues that affect health and wellbeing.	Measures of governmental public health system core functions for which the system is accountable.
Context provided for societal, political and systemic factors.	Focus on core functions for public health data, community partnerships and policy.
When possible, reported by race, ethnicity and other demographic and risk factor data.	Not reported at a population level or by race, ethnicity, or other demographic or risk factors.
Over time, show whether Oregon is making progress toward eliminating health inequities through public health modernization investments	Within the control of state and local public health authorities

Notes

- Core system functions, roles and deliverables are defined in the Public Health Modernization Manual.
- Refer to Metrics Selection Criteria for additional measure definitions

Metrics criteria can be applied in three areas.

1. Indicators of population health priorities
2. Community priorities and acceptance
3. Suitability of measurement and public health sphere of control

Indicators of population health priorities	
Selection criteria	Definition
Population health priority	Indicator has been identified as a population health priority by community members and/or public health professionals Information is available to provide the community, societal, systemic, and political context that creates and upholds inequities.
Data relevance	Data are reportable at the county level or for similar geographic breakdowns, which may include census tract or Medicare Referral District Data provide context for health outcomes, which includes systemic issues that result in poorer health outcomes for certain groups. Updated data are routinely available to ensure that the public health system does not rely on data that are old, outdated or no longer relevant. When applicable, data are reportable by race and ethnicity, gender, sexual orientation, age, disability, income level, insurance status or other relevant risk factor data.
Community leadership and community-led metrics	Communities have provided input and have demonstrated support Measure is of interest from a local perspective Measure is acceptable to communities represented in public health data
Alignment with strategic initiatives	Measure aligns with State Health Indicators or priorities in state or community health improvement plans or other plans

	Measure is locally, nationally or internationally validated; with awareness of the existence of white supremacy in validated measures. ~~National or other benchmarks exist for performance on this measure~~

Community priorities and acceptance	
Selection criteria	Definition
Actively advances health equity and an antiracist society	Measure addresses an area where health inequities exist Measure demonstrates zero acceptance of racism, xenophobia, violence, hate crimes or discrimination Measure is actionable, which may include policies or community-level interventions
Transformative potential	Measure is actionable and would drive system change Opportunity exists to triangulate and integrate data across data sources ~~Measure aligns with core public health functions in the Public Health Modernization Manual~~
~~**Alignment with other strategic initiatives**~~	~~Measure aligns with State Health Indicators or priorities in state or community health improvement plans or other local health plans~~ ~~Measure is locally, nationally or internationally validated; with awareness of the existence of white supremacy in validated measures.~~ ~~National or other benchmarks exist for performance on this measure~~

Suitability of measurement and public health sphere of control	
Feasibility of measurement	Data are already collected, or a mechanism for data collection has been identified, which could include establishing data sharing agreements with other sectors.

	Updated data available on an annual basis
Public health system accountability	State and local public health authorities have some control over the measure Measures focus on public health data and data systems, community partnerships policy. These foundational capabilities have been prioritized as measurement areas by PHAB for the coming years Measure successfully communicates what is expected of the governmental public health system, specifically state and local. Measure aligns with core system functions in the Public Health Modernization Manual Allows for each public health authority to tailor how work toward achieving the metric is implemented in order to be responsive to local context and priorities. Context provided shows how locally tailored metrics are working toward common goals.
Resourced or likely to be resourced	Funding is available or likely to be available Local public health expertise exists
Accuracy	Changes in public health system performance will be visible in the measure Measure is sensitive enough to capture improved performance or sensitive enough to show difference between years

minutes

PUBLIC HEALTH ADVISORY BOARD
Incentives and Funding Subcommittee

June 10, 2022
1:00-2:00 p.m.

Subcommittee members: Bob Dannenhoffer, Carrie Brogoitti, Michael Baker, Nic Powers, Veronica Irvin, Jackie Leung

OHA staff: Sara Beaudrault, Andrew Cohen, Maria Castro, Oliver Vera, Ilana Kurtzig

PHAB's Health Equity Policy and Procedure

Welcome and introductions
May minutes were unanimously approved.

Migrant and seasonal farmworker data
Sara introduced Maria Castro and Oliver Vera. Their teams work extensively with migrant and seasonal farmworkers, employers and community partners.

Oliver reviewed slides that provide a snapshot of OHA's COVID-19 response strategies with migrant and seasonal farmworkers. He described the Protecting Oregon Farmworkers grant program. The program served migrant and seasonal farmworkers through education, resources, COVID wraparound supports, access to testing and vaccine, communications, partnerships with FQHCs. The program also provided air purifiers, N95 masks, gators, towels, water bottles to protect against heat and poor air quality due to wildfire smoke. Oliver shared numbers on people and families served.

Maria discussed data and noted that it is challenging to have accurate data for this population. There are many different data sources. The enumeration studies are comprehensive and use data from multiple sources. The most recent update was in 2018. The OHA primary care office uses this information to determine MSFW designations that are assigned by the federal government for the purpose of opening new migrant health centers. Oregon has eight migrant health centers, and most FQHCs also collect information on migrant and seasonal farmworkers. OHA partners with Oregon Department of Agriculture because they have information on where migrant and seasonal farmworkers are, and with Oregon Department of Education's migrant program. Often the worker is counted but not the family that usually comes with them, and this is why it is important to supplement data through partnerships.

Sara noted that the slides convey the level of complexity from a state perspective. While not represented in the slides, an LPHA's work to serve MSFWs is equally intensive.

Bob noted a concern that while this is a priority population, we may not have a sufficient data source. Data may not be apportioned by county the way it is for other indicators. There is also a concern about whether data are regularly updated.

Maria offered to share a link to FQHC UDS data. There are data sources that are updated annually, but they do not provide a complete count of agricultural workers.

Sara suggested two options to continue this discussion, noting that PHAB likely does not have a sufficient data source or a deep enough understanding of the data to add an indicator this month. The subcommittee could continue data discussions with Maria and Oliver this summer. Or this topic could go to the full Board for a discussion and include presentations from LPHAs in addition to OHA staff.

Bob agreed with bringing this to PHAB in June and saying that the subcommittee thinks this is an important indicator and hear direction from the Board about whether this should be prioritized.

Veronica agreed with not making a change now but making this a priority for the next biennium. She also thought bringing this as a topic to PHAB is warranted.

Public health modernization funding formula

Sara said that the three versions of funding formula in the meeting packet have been updated with the most current years' data for indicators.

Sara reminded the subcommittee of the proposal from last month to weight the two required indicators at a lesser value (5%) and increase the weight for all other indicators.

Drew modeled this out using the $20 million funding formula in the spreadsheet that was provided to subcommittee members. The spreadsheet shows allocations for each indicator using the current method and proposed method. The far righthand columns show overall differences, with funding increasing for some LPHAs and decreasing for others with no clear patterns. Percent-wise and per capita, the differences are relatively small.

Veronica noted some larger changes that would result in decreased funding for some LPHAs.

Sara said if we were to end the next legislative session with the same amount of funding, PHAB should discuss whether to implement this change since it would result in funding reductions for some LPHAs. But with increased funding, all LPHAs would presumably get increased allocations, even while making changes to indicator weights that prioritize the indicators added by PHAB.

Bob noted that these changes will make a relatively small difference.

Bob asked about feedback provided by LPHAs during listening sessions.

Sara said the feedback was positive. LPHAs support the changes PHAB is proposing and did not express concerns. No one provided feedback on the idea of weighting some indicators ore heavily.

Mike said that trying to come up with a perfect formula is impossible. These changes accurately capture what we're trying to do.

Nic agreed with changes to indicator weights and said the changes make sense. The changes reinforce the good work that the subcommittee started years ago and helps us look toward the future.

Sara proposed that the subcommittee go to PHAB with a recommendation for changing indicator weights but request feedback from PHAB members. The subcommittee may state that changes wouldn't be implemented if there were no additional funding from the legislature, which would result in some LPHAs receiving smaller allocations. Subcommittee members agreed.

As requested, OHA staff have looked into options for Oregon data sources to replace some of the federal data sources that have been used in past years. There are some options available, to discuss in the future.

Public health modernization funding report and PHAB health equity review questions
Sara reviewed draft responses to the PHAB health equity review questions.

Veronica recommended clearly stating that the FTE infrastructure funding happens through increasing floor funding to LPHAs.

Bob suggested adding that, for the question about which health inequities are addressed, it is all of them.

Veronica suggested adding a note about the listening sessions with LPHAs.

Jackie asked about adding more detail about what we mean by recruiting community partners to join this subcommittee. Is it health system partners or nonprofit?

Subcommittee business
Veronica will provide the subcommittee update at the June 16 PHAB meeting.

The subcommittee will take a break for summer and meet again in September to continue discussing data sources for indicators. OHA will recruit for community partners to join this subcommittee.

Public comment
No public comment was provided.

Adjourn

Public Health Modernization LPHA Funding Formula

Updated June, 2022

Total biennial funds available to LPHAs through the funding formula = $10,000,000

Funding formula for LPHA allocations up to $19,999,999

		Base component									Matching and Incentive fund components		Total county allocation				
County Group	Population[1]	Floor	Burden of Disease[2]	Health Status[3]	Race/ Ethnicity[4]	Poverty 150% FPL[4]	Rurality[5]	Education[4]	Limited English Proficiency[4]		Matching Funds	Incentives	Total Award	Award Percentage	% of Total Population	Award Per Capita	Avg Award Per Capita
Wheeler	1,456	$ 29,758	$ 105	$ 276	$ 263	$ 669	$ 2,666	$ 377	$ 134		$ -	$ -	$ 34,247	0.3%	0.0%	$ 23.52	
Gilliam	2,039	$ 29,758	$ 216	$ 172	$ 445	$ 955	$ 3,733	$ 510	$ 21		$ -	$ -	$ 35,810	0.4%	0.0%	$ 17.56	
Wallowa	7,433	$ 29,758	$ 642	$ 629	$ 921	$ 2,213	$ 13,609	$ 1,649	$ 389		$ -	$ -	$ 49,810	0.5%	0.2%	$ 6.70	
Harney	7,537	$ 29,758	$ 983	$ 522	$ 1,387	$ 2,715	$ 6,113	$ 2,460	$ 436		$ -	$ -	$ 44,375	0.4%	0.2%	$ 5.89	
Grant	7,226	$ 29,758	$ 924	$ 636	$ 920	$ 2,962	$ 13,230	$ 3,033	$ 606		$ -	$ -	$ 52,069	0.5%	0.2%	$ 7.21	
Lake	8,177	$ 29,758	$ 1,134	$ 831	$ 1,321	$ 4,040	$ 9,477	$ 3,821	$ 1,400		$ -	$ -	$ 51,782	0.5%	0.2%	$ 6.33	
Morrow	12,635	$ 29,758	$ 1,234	$ 2,238	$ 4,111	$ 6,794	$ 10,618	$ 10,692	$ 10,468		$ -	$ -	$ 75,913	0.8%	0.3%	$ 6.01	
Baker	16,860	$ 29,758	$ 2,186	$ 1,809	$ 2,590	$ 7,101	$ 12,656	$ 5,724	$ 1,036		$ -	$ -	$ 62,859	0.6%	0.4%	$ 3.73	$ 6.42
Crook	25,482	$ 44,637	$ 2,940	$ 3,327	$ 3,509	$ 8,709	$ 22,394	$ 10,556	$ 890		$ -	$ -	$ 96,961	1.0%	0.6%	$ 3.81	
Curry	23,662	$ 44,637	$ 3,479	$ 2,740	$ 4,879	$ 8,603	$ 16,766	$ 7,264	$ 1,963		$ -	$ -	$ 90,330	0.9%	0.6%	$ 3.82	
Jefferson	24,889	$ 44,637	$ 3,609	$ 1,935	$ 15,116	$ 10,297	$ 28,754	$ 11,257	$ 7,897		$ -	$ -	$ 123,503	1.2%	0.6%	$ 4.96	
Hood River	23,888	$ 44,637	$ 1,605	$ 2,224	$ 7,216	$ 5,899	$ 22,830	$ 16,173	$ 22,407		$ -	$ -	$ 122,992	1.2%	0.6%	$ 5.15	
Tillamook	27,628	$ 44,637	$ 3,361	$ 2,650	$ 4,844	$ 8,959	$ 35,206	$ 10,364	$ 7,068		$ -	$ -	$ 117,090	1.2%	0.6%	$ 4.24	
Union	26,295	$ 44,637	$ 3,116	$ 1,582	$ 4,302	$ 11,062	$ 20,268	$ 7,261	$ 1,991		$ -	$ -	$ 94,220	0.9%	0.6%	$ 3.58	
Sherman, Wasco	28,489	$ 74,395	$ 3,394	$ 2,232	$ 6,728	$ 10,339	$ 21,646	$ 13,500	$ 10,410		$ -	$ -	$ 142,645	1.4%	0.7%	$ 5.01	
Malheur	31,995	$ 44,637	$ 3,720	$ 4,921	$ 8,490	$ 18,461	$ 28,352	$ 23,173	$ 14,311		$ -	$ -	$ 146,066	1.5%	0.7%	$ 4.57	
Clatsop	41,428	$ 44,637	$ 4,917	$ 3,527	$ 8,916	$ 14,539	$ 29,581	$ 12,242	$ 6,455		$ -	$ -	$ 124,815	1.2%	1.0%	$ 3.01	
Lincoln	50,903	$ 44,637	$ 7,191	$ 6,154	$ 12,985	$ 21,309	$ 35,042	$ 15,254	$ 6,473		$ -	$ -	$ 149,045	1.5%	1.2%	$ 2.93	
Columbia	53,014	$ 44,637	$ 5,589	$ 6,169	$ 8,869	$ 14,998	$ 42,319	$ 18,942	$ 2,240		$ -	$ -	$ 143,764	1.4%	1.2%	$ 2.71	
Coos	65,154	$ 44,637	$ 9,086	$ 7,914	$ 14,675	$ 29,518	$ 45,807	$ 25,303	$ 5,627		$ -	$ -	$ 182,567	1.8%	1.5%	$ 2.80	
Klamath	69,822	$ 44,637	$ 10,572	$ 6,896	$ 21,329	$ 36,139	$ 48,066	$ 33,269	$ 14,749		$ -	$ -	$ 215,658	2.2%	1.6%	$ 3.09	$ 3.55
Umatilla	80,463	$ 59,516	$ 9,163	$ 8,403	$ 27,836	$ 33,954	$ 42,870	$ 52,893	$ 44,114		$ -	$ -	$ 278,750	2.8%	1.9%	$ 3.46	
Polk	88,916	$ 59,516	$ 7,814	$ 9,236	$ 23,820	$ 28,288	$ 32,396	$ 29,059	$ 22,524		$ -	$ -	$ 212,652	2.1%	2.1%	$ 2.39	
Josephine	88,728	$ 59,516	$ 12,821	$ 10,979	$ 15,280	$ 45,785	$ 73,103	$ 31,515	$ 7,804		$ -	$ -	$ 256,802	2.6%	2.1%	$ 2.89	
Benton	93,976	$ 59,516	$ 5,337	$ 6,028	$ 30,860	$ 39,609	$ 32,347	$ 13,900	$ 27,772		$ -	$ -	$ 215,369	2.2%	2.2%	$ 2.29	
Yamhill	108,261	$ 59,516	$ 9,759	$ 11,307	$ 29,500	$ 33,506	$ 44,796	$ 43,378	$ 36,694		$ -	$ -	$ 268,457	2.7%	2.5%	$ 2.48	
Douglas	111,694	$ 59,516	$ 16,226	$ 14,074	$ 18,701	$ 44,944	$ 84,253	$ 40,880	$ 8,060		$ -	$ -	$ 286,654	2.9%	2.6%	$ 2.57	
Linn	130,440	$ 59,516	$ 14,643	$ 13,401	$ 28,915	$ 48,766	$ 75,467	$ 51,192	$ 22,857		$ -	$ -	$ 314,758	3.1%	3.1%	$ 2.41	$ 2.61
Deschutes	203,390	$ 74,395	$ 15,654	$ 15,816	$ 32,005	$ 57,118	$ 102,778	$ 48,838	$ 26,153		$ -	$ -	$ 372,757	3.7%	4.8%	$ 1.83	
Jackson	223,827	$ 74,395	$ 24,472	$ 23,376	$ 43,427	$ 88,623	$ 82,370	$ 82,844	$ 43,318		$ -	$ -	$ 462,825	4.6%	5.2%	$ 2.07	
Marion	347,182	$ 74,395	$ 32,787	$ 37,836	$ 149,002	$ 142,626	$ 83,270	$ 198,299	$ 216,514		$ -	$ -	$ 934,729	9.3%	8.1%	$ 2.69	$ 2.29
Lane	382,647	$ 89,274	$ 39,104	$ 36,054	$ 108,316	$ 168,016	$ 122,602	$ 111,212	$ 52,667		$ -	$ -	$ 727,246	7.3%	9.0%	$ 1.90	
Clackamas	425,316	$ 89,274	$ 35,148	$ 35,005	$ 120,038	$ 88,620	$ 140,945	$ 103,569	$ 111,844		$ -	$ -	$ 724,443	7.2%	10.0%	$ 1.70	
Washington	605,036	$ 89,274	$ 38,251	$ 51,857	$ 317,088	$ 140,651	$ 62,034	$ 172,826	$ 327,927		$ -	$ -	$ 1,199,907	12.0%	14.2%	$ 1.98	
Multnomah	820,672	$ 89,274	$ 76,567	$ 74,996	$ 389,293	$ 281,114	$ 19,533	$ 254,671	$ 402,682		$ -	$ -	$ 1,588,131	15.9%	19.2%	$ 1.94	$ 1.90
Total	**4,266,560**	**$ 1,845,000**	**$ 407,750**	**$ 407,750**	**$ 1,467,900**	**$ 1,467,900**	**$ 1,467,900**	**$ 1,467,900**	**$ 1,467,900**		$ -	$ -	**$ 10,000,000**	**100.0%**	**100.0%**	**$ 2.34**	**$ 2.34**

[1] Source: Portland State University Certified Population estimate July 1, 2021

[2] Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon Death Certificate data, 2016-2020.

[3] Source: Quality of life: OHA, Oregon Behavioral Risk Factor Surveillance System (BRFSS), county file 2014-2017

[4] Source: U.S. Census Bureau, American Community Survey (ACS), 5-year estimates, Table B02001, B15002, C16001, C17002, 2016-2020.

[5] Source: U.S. Census Bureau, Decennial Census, SF1 Table P2, 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,(	above 375,000

Public Health Modernization LPHA Funding Formula
Updated June, 2022
Total biennial funds available to LPHAs through the funding formula = $20,000,000

Funding formula for LPHA allocations between $20,000,000-39,999,999

		Base component								Matching and Incentive fund components		Total county allocation				
County Group	Population[1]	Floor	Burden of Disease[2]	Health Status[3]	Race/ Ethnicity[4]	Poverty 150% FPL[4]	Rurality[5]	Education[4]	Limited English Proficiency[4]	Matching Funds	Incentives	Total Award	Award Percentage	% of Total Population	Award Per Capita	Avg Award Per Capita
Wheeler	1,456	$ 200,000	$ 150	$ 393	$ 373	$ 951	$ 3,792	$ 536	$ 190			$ 206,385	1.1%	0.0%	$ 141.75	
Gilliam	2,039	$ 200,000	$ 307	$ 245	$ 633	$ 1,358	$ 5,310	$ 726	$ 30			$ 208,609	1.1%	0.0%	$ 102.31	
Wallowa	7,433	$ 200,000	$ 914	$ 894	$ 1,310	$ 3,148	$ 19,358	$ 2,346	$ 553			$ 228,523	1.2%	0.2%	$ 30.74	
Harney	7,537	$ 200,000	$ 1,398	$ 742	$ 1,972	$ 3,862	$ 8,696	$ 3,500	$ 620			$ 220,791	1.2%	0.2%	$ 29.29	
Grant	7,226	$ 200,000	$ 1,315	$ 904	$ 1,308	$ 4,214	$ 18,819	$ 4,314	$ 862			$ 231,736	1.2%	0.2%	$ 32.07	
Lake	8,177	$ 200,000	$ 1,612	$ 1,182	$ 1,879	$ 5,747	$ 13,480	$ 5,436	$ 1,991			$ 231,327	1.2%	0.2%	$ 28.29	
Morrow	12,635	$ 200,000	$ 1,756	$ 3,183	$ 5,848	$ 9,664	$ 15,104	$ 15,209	$ 14,890			$ 265,653	1.4%	0.3%	$ 21.03	
Baker	16,860	$ 200,000	$ 3,109	$ 2,573	$ 3,684	$ 10,101	$ 18,003	$ 8,142	$ 1,473			$ 247,085	1.3%	0.4%	$ 14.66	$ 29.04
Crook	25,482	$ 200,000	$ 4,182	$ 4,732	$ 4,991	$ 12,388	$ 31,854	$ 15,015	$ 1,266			$ 274,428	1.5%	0.6%	$ 10.77	
Curry	23,662	$ 200,000	$ 4,949	$ 3,897	$ 6,941	$ 12,237	$ 23,848	$ 10,332	$ 2,792			$ 264,996	1.4%	0.6%	$ 11.20	
Jefferson	24,889	$ 200,000	$ 5,134	$ 2,753	$ 21,502	$ 14,647	$ 40,901	$ 16,013	$ 11,233			$ 312,182	1.7%	0.6%	$ 12.54	
Hood River	23,888	$ 200,000	$ 2,284	$ 3,163	$ 10,264	$ 8,391	$ 32,475	$ 23,005	$ 31,873			$ 311,455	1.7%	0.6%	$ 13.04	
Tillamook	27,628	$ 200,000	$ 4,781	$ 3,770	$ 6,891	$ 12,743	$ 50,079	$ 14,742	$ 10,054			$ 303,060	1.6%	0.6%	$ 10.97	
Union	26,295	$ 200,000	$ 4,432	$ 2,250	$ 6,119	$ 15,736	$ 28,830	$ 10,328	$ 2,833			$ 270,528	1.4%	0.6%	$ 10.29	
Sherman, Wasco	28,489	$ 400,000	$ 4,828	$ 3,174	$ 9,571	$ 14,707	$ 30,791	$ 19,203	$ 14,808			$ 497,082	2.6%	0.7%	$ 17.45	
Malheur	31,995	$ 200,000	$ 5,292	$ 7,001	$ 12,077	$ 26,260	$ 40,329	$ 32,962	$ 20,357			$ 344,277	1.8%	0.7%	$ 10.76	
Clatsop	41,428	$ 200,000	$ 6,994	$ 5,017	$ 12,683	$ 20,680	$ 42,078	$ 17,414	$ 9,182			$ 314,048	1.7%	1.0%	$ 7.58	
Lincoln	50,903	$ 200,000	$ 10,229	$ 8,754	$ 18,470	$ 30,311	$ 49,845	$ 21,698	$ 9,207			$ 348,515	1.9%	1.2%	$ 6.85	
Columbia	53,014	$ 200,000	$ 7,950	$ 8,775	$ 12,616	$ 21,334	$ 60,197	$ 26,944	$ 3,187			$ 341,002	1.8%	1.2%	$ 6.43	
Coos	65,154	$ 200,000	$ 12,924	$ 11,257	$ 20,875	$ 41,988	$ 65,158	$ 35,992	$ 8,004			$ 396,197	2.1%	1.5%	$ 6.08	
Klamath	69,822	$ 200,000	$ 15,039	$ 9,809	$ 30,340	$ 51,405	$ 68,371	$ 47,323	$ 20,980			$ 443,267	2.4%	1.6%	$ 6.35	$ 8.97
Umatilla	80,463	$ 200,000	$ 13,034	$ 11,953	$ 39,596	$ 48,297	$ 60,979	$ 75,238	$ 62,750			$ 511,848	2.7%	1.9%	$ 6.36	
Polk	88,916	$ 200,000	$ 11,114	$ 13,137	$ 33,882	$ 40,237	$ 46,082	$ 41,334	$ 32,039			$ 417,826	2.2%	2.1%	$ 4.70	
Josephine	88,728	$ 200,000	$ 18,237	$ 15,617	$ 21,735	$ 65,126	$ 103,984	$ 44,828	$ 11,100			$ 480,627	2.6%	2.1%	$ 5.42	
Benton	93,976	$ 200,000	$ 7,592	$ 8,574	$ 43,897	$ 56,342	$ 46,012	$ 19,771	$ 39,503			$ 421,691	2.2%	2.2%	$ 4.49	
Yamhill	108,261	$ 200,000	$ 13,882	$ 16,083	$ 41,962	$ 47,660	$ 63,720	$ 61,703	$ 52,195			$ 497,206	2.6%	2.5%	$ 4.59	
Douglas	111,694	$ 200,000	$ 23,081	$ 20,020	$ 26,601	$ 63,930	$ 119,845	$ 58,149	$ 11,464			$ 523,091	2.8%	2.6%	$ 4.68	
Linn	130,440	$ 200,000	$ 20,829	$ 19,062	$ 41,130	$ 69,366	$ 107,348	$ 72,818	$ 32,513			$ 563,066	3.0%	3.1%	$ 4.32	$ 4.86
Deschutes	203,390	$ 200,000	$ 22,266	$ 22,497	$ 45,525	$ 81,247	$ 146,195	$ 69,470	$ 37,201			$ 624,402	3.3%	4.8%	$ 3.07	
Jackson	223,827	$ 200,000	$ 34,810	$ 33,251	$ 61,772	$ 126,061	$ 117,166	$ 117,841	$ 61,617			$ 752,519	4.0%	5.2%	$ 3.36	
Marion	347,182	$ 200,000	$ 46,638	$ 53,819	$ 211,946	$ 202,876	$ 118,447	$ 282,068	$ 307,979			$ 1,423,773	7.6%	8.1%	$ 4.10	$ 3.62
Lane	382,647	$ 200,000	$ 55,623	$ 51,284	$ 154,074	$ 238,993	$ 174,394	$ 158,193	$ 74,916			$ 1,107,476	5.9%	9.0%	$ 2.89	
Clackamas	425,316	$ 200,000	$ 49,996	$ 49,792	$ 170,747	$ 126,057	$ 200,486	$ 147,321	$ 159,091			$ 1,103,489	5.9%	10.0%	$ 2.59	
Washington	605,036	$ 200,000	$ 54,409	$ 73,763	$ 451,039	$ 200,067	$ 88,240	$ 245,834	$ 466,457			$ 1,779,808	9.5%	14.2%	$ 2.94	
Multnomah	820,672	$ 200,000	$ 108,912	$ 106,678	$ 553,746	$ 399,867	$ 27,785	$ 362,254	$ 572,792			$ 2,332,034	12.4%	19.2%	$ 2.84	$ 2.83
Total	**4,266,560**	**$ 7,200,000**	**$ 580,000**	**$ 580,000**	**$ 2,088,000**	**$ 2,088,000**	**$ 2,088,000**	**$ 2,088,000**	**$ 2,088,000**	$ 1,000,000	$ 200,000	**$ 18,800,000**	**100.0%**	**100.0%**	**$ 4.41**	**$ 4.41**

[1] Source: Portland State University Certified Population estimate July 1, 2021
[2] Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon Death Certificate data, 2016-2020.
[3] Source: Quality of life: OHA, Oregon Behavioral Risk Factor Surveillance System (BRFSS), county file 2014-2017
[4] Source: U.S. Census Bureau, American Community Survey (ACS), 5-year estimates, Table B02001, B15002, C16001, C17002, 2016-2020.
[5] Source: U.S. Census Bureau, Decennial Census, SF1 Table P2, 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,(	above 375,000

Public Health Modernization LPHA Funding Formula

Updated June, 2022

Total biennial funds available to LPHAs through the funding formula = $40,000,000

Funding formula for LPHA allocations at or above $40,000,000

		Base component									Matching and Incentive fund components		Total county allocation				
County Group	Population[1]	Floor	Burden of Disease[2]	Health Status[3]	Race/ Ethnicity[4]	Poverty 150% FPL[4]	Rurality[5]	Education[4]	Limited English Proficiency[4]		Matching Funds	Incentives	Total Award	Award Percentage	% of Total Population	Award Per Capita	Avg Award Per Capita
Wheeler	1,456	$ 400,000	$ 300	$ 785	$ 747	$ 1,903	$ 7,584	$ 1,073	$ 380				$ 412,771	1.1%	0.0%	$ 283.50	
Gilliam	2,039	$ 400,000	$ 614	$ 491	$ 1,266	$ 2,716	$ 10,620	$ 1,451	$ 59				$ 417,217	1.1%	0.0%	$ 204.62	
Wallowa	7,433	$ 400,000	$ 1,828	$ 1,788	$ 2,620	$ 6,296	$ 38,716	$ 4,692	$ 1,106				$ 457,047	1.2%	0.2%	$ 61.49	
Harney	7,537	$ 400,000	$ 2,797	$ 1,485	$ 3,945	$ 7,724	$ 17,391	$ 7,000	$ 1,241				$ 441,582	1.2%	0.2%	$ 58.59	
Grant	7,226	$ 400,000	$ 2,629	$ 1,809	$ 2,616	$ 8,427	$ 37,638	$ 8,628	$ 1,725				$ 463,471	1.2%	0.2%	$ 64.14	
Lake	8,177	$ 400,000	$ 3,225	$ 2,364	$ 3,758	$ 11,495	$ 26,960	$ 10,872	$ 3,982				$ 462,654	1.2%	0.2%	$ 56.58	
Morrow	12,635	$ 400,000	$ 3,511	$ 6,366	$ 11,697	$ 19,328	$ 30,207	$ 30,418	$ 29,779				$ 531,306	1.4%	0.3%	$ 42.05	
Baker	16,860	$ 400,000	$ 6,218	$ 5,146	$ 7,369	$ 20,202	$ 36,005	$ 16,284	$ 2,946				$ 494,169	1.3%	0.4%	$ 29.31	$ 58.08
Crook	25,482	$ 400,000	$ 8,363	$ 9,464	$ 9,982	$ 24,775	$ 63,709	$ 30,029	$ 2,533				$ 548,856	1.5%	0.6%	$ 21.54	
Curry	23,662	$ 400,000	$ 9,898	$ 7,795	$ 13,881	$ 24,474	$ 47,697	$ 20,664	$ 5,583				$ 529,992	1.4%	0.6%	$ 22.40	
Jefferson	24,889	$ 400,000	$ 10,268	$ 5,506	$ 43,004	$ 29,294	$ 81,802	$ 32,026	$ 22,465				$ 624,364	1.7%	0.6%	$ 25.09	
Hood River	23,888	$ 400,000	$ 4,567	$ 6,326	$ 20,529	$ 16,782	$ 64,949	$ 46,011	$ 63,745				$ 622,909	1.7%	0.6%	$ 26.08	
Tillamook	27,628	$ 400,000	$ 9,562	$ 7,540	$ 13,782	$ 25,487	$ 100,157	$ 29,484	$ 20,109				$ 606,120	1.6%	0.6%	$ 21.94	
Union	26,295	$ 400,000	$ 8,864	$ 4,501	$ 12,238	$ 31,471	$ 57,661	$ 20,656	$ 5,665				$ 541,057	1.4%	0.6%	$ 20.58	
Sherman, Wasco	28,489	$ 800,000	$ 9,656	$ 6,348	$ 19,142	$ 29,414	$ 61,581	$ 38,405	$ 29,617				$ 994,163	2.6%	0.7%	$ 34.90	
Malheur	31,995	$ 400,000	$ 10,583	$ 14,001	$ 24,154	$ 52,521	$ 80,659	$ 65,924	$ 40,713				$ 688,554	1.8%	0.7%	$ 21.52	
Clatsop	41,428	$ 400,000	$ 13,987	$ 10,034	$ 25,365	$ 41,361	$ 84,156	$ 34,828	$ 18,364				$ 628,095	1.7%	1.0%	$ 15.16	
Lincoln	50,903	$ 400,000	$ 20,458	$ 17,508	$ 36,940	$ 60,623	$ 99,691	$ 43,395	$ 18,414				$ 697,029	1.9%	1.2%	$ 13.69	
Columbia	53,014	$ 400,000	$ 15,901	$ 17,549	$ 25,231	$ 42,669	$ 120,393	$ 53,888	$ 6,373				$ 682,004	1.8%	1.2%	$ 12.86	
Coos	65,154	$ 400,000	$ 25,848	$ 22,515	$ 41,750	$ 83,976	$ 130,316	$ 71,983	$ 16,007				$ 792,394	2.1%	1.5%	$ 12.16	
Klamath	69,822	$ 400,000	$ 30,077	$ 19,618	$ 60,679	$ 102,810	$ 136,743	$ 94,647	$ 41,960				$ 886,534	2.4%	1.6%	$ 12.70	$ 17.95
Umatilla	80,463	$ 400,000	$ 26,069	$ 23,907	$ 79,191	$ 96,595	$ 121,959	$ 150,475	$ 125,499				$ 1,023,695	2.7%	1.9%	$ 12.72	
Polk	88,916	$ 400,000	$ 22,229	$ 26,275	$ 67,764	$ 80,475	$ 92,163	$ 82,669	$ 64,077				$ 835,652	2.2%	2.1%	$ 9.40	
Josephine	88,728	$ 400,000	$ 36,473	$ 31,234	$ 43,471	$ 130,253	$ 207,969	$ 89,655	$ 22,200				$ 961,255	2.6%	2.1%	$ 10.83	
Benton	93,976	$ 400,000	$ 15,184	$ 17,148	$ 87,794	$ 112,684	$ 92,024	$ 39,542	$ 79,007				$ 843,382	2.2%	2.2%	$ 8.97	
Yamhill	108,261	$ 400,000	$ 27,764	$ 32,166	$ 83,924	$ 95,321	$ 127,440	$ 123,406	$ 104,390				$ 994,411	2.6%	2.5%	$ 9.19	
Douglas	111,694	$ 400,000	$ 46,161	$ 40,040	$ 53,203	$ 127,859	$ 239,691	$ 116,299	$ 22,929				$ 1,046,181	2.8%	2.6%	$ 9.37	
Linn	130,440	$ 400,000	$ 41,658	$ 38,124	$ 82,261	$ 138,733	$ 214,695	$ 145,636	$ 65,025				$ 1,126,132	3.0%	3.1%	$ 8.63	$ 9.72
Deschutes	203,390	$ 400,000	$ 44,533	$ 44,995	$ 91,051	$ 162,493	$ 292,390	$ 138,939	$ 74,402				$ 1,248,803	3.3%	4.8%	$ 6.14	
Jackson	223,827	$ 400,000	$ 69,620	$ 66,503	$ 123,543	$ 252,121	$ 234,333	$ 235,682	$ 123,234				$ 1,505,037	4.0%	5.2%	$ 6.72	
Marion	347,182	$ 400,000	$ 93,275	$ 107,639	$ 423,892	$ 405,753	$ 236,893	$ 564,136	$ 615,957				$ 2,847,546	7.6%	8.1%	$ 8.20	$ 7.23
Lane	382,647	$ 400,000	$ 111,246	$ 102,569	$ 308,147	$ 477,985	$ 348,787	$ 316,386	$ 149,832				$ 2,214,952	5.9%	9.0%	$ 5.79	
Clackamas	425,316	$ 400,000	$ 99,991	$ 99,584	$ 341,493	$ 252,114	$ 400,973	$ 294,641	$ 318,182				$ 2,206,978	5.9%	10.0%	$ 5.19	
Washington	605,036	$ 400,000	$ 108,819	$ 147,526	$ 902,078	$ 400,134	$ 176,479	$ 491,668	$ 932,913				$ 3,559,617	9.5%	14.2%	$ 5.88	
Multnomah	820,672	$ 400,000	$ 217,825	$ 213,356	$ 1,107,493	$ 799,735	$ 55,570	$ 724,507	$ 1,145,583				$ 4,664,068	12.4%	19.2%	$ 5.68	$ 5.66
Total	**4,266,560**	**$ 14,400,000**	**$ 1,160,000**	**$ 1,160,000**	**$ 4,176,000**	**$ 4,176,000**	**$ 4,176,000**	**$ 4,176,000**	**$ 4,176,000**		$ 2,000,000	$ 400,000	**$ 37,600,000**	**100.0%**	**100.0%**	**$ 8.81**	**$ 8.81**

[1] Source: Portland State University Certified Population estimate July 1, 2021

[2] Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon Death Certificate data, 2016-2020.

[3] Source: Quality of life: OHA, Oregon Behavioral Risk Factor Surveillance System (BRFSS), county file 2014-2017

[4] Source: U.S. Census Bureau, American Community Survey (ACS), 5-year estimates, Table B02001, B15002, C16001, C17002, 2016-2020.

[5] Source: U.S. Census Bureau, Decennial Census, SF1 Table P2, 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,(	above 375,000

PHAB Incentives and Funding
Health equity review for public health accountability metrics

What are the primary changes to public health accountability metrics?

1. The PHAB Accountability Metrics subcommittee is making revisions to center community priorities and the role of governmental public health to address systemic racism and oppression.
2. Revisions will bring attention to economic and social injustices that result in health inequities and whether Oregon is taking steps to rectify injustices through policy and resources.
3. Public health accountability metrics will focus on state and local public health authority core functions for public health data, partnerships and policy for communicable disease prevention and environmental justice.
4. PHAB expected to vote to adopt new metrics in the second half of 2022.

What health inequities exist among which groups? Which health inequities does the work product, report or deliverable aim to eliminate?

PHAB is focusing on metrics for communicable disease control and prevention and environmental health.

As the PHAB subcommittee discusses indicators, the subcommittee will identify health inequities and use annual reports to bring attention to the economic, social and systemic causes for inequities.

Corresponding accountability metrics will measure the actions that state and local public health authorities are taking to eliminate health inequities through core functions for data, community partnerships and policy.

The PHAB subcommittee has spent much of the last year developing metrics selection criteria that they will use to evaluate potential indicators and accountability metrics to ensure that metrics actively advance health equity and an antiracist public health system and society.

How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?

Indicators and the explicit inclusion of context that describes the reasons for health inequities brings attention to the responsibilities of government agencies, beyond public health.

The PHAB subcommittee has not directly engaged with other sectors.

How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?

Central to the revised framework is that indicators and accountability metrics reflect community priorities and are acceptable to the communities represented in measures. The PHAB subcommittee continues to discuss opportunities to align with Healthier Together Oregon and other state and local plans that are community-led, and the subcommittee is building from lessons shared with PHAB by survey modernization partners.

The PHAB subcommittee has not engaged broadly with community partners. Three community partners have been members of the PHAB Accountability Metrics subcommittee since April 2021.

PHAB Incentives and Funding
Health equity review for public health modernization funding formula

What are the primary changes to the public health modernization funding formula for 2023-25?

1. Provides staffing infrastructure funding to LPHAs through increased floor funding, starting when $20 million or more is allocated through the funding formula. Staffing infrastructure funding ensures that every LPHA has funding to hire one or more positions, including specialized positions, that are necessary for fulfilling core work for public health modernization.
2. Allocates a larger portion of funding to certain health and demographic indicators. This means that additional funds are allocated to LPHAs where there is greater need for the community to access public health services, or where there may be added complexities for serving the community.
3. Discussions about adding an indicator related to migrant and seasonal farmworkers and for updating data sources for existing indicators are ongoing.

What health inequities exist among which groups? Which health inequities does the work product, report or deliverable aim to eliminate?
All of them. The funding formula is intended to leverage public health funding to eliminate health inequities, but it does not direct funds to address specific health inequities. The indicators in the funding formula address areas where inequities exist, including socioeconomic status and educational attainment, English language proficiency, and rurality. The base funding is intended to ensure that local public health authorities can establish the workforce and infrastructure needed for working directly with communities to address community priorities.

How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?
The funding formula s not used as a mechanism for engaging other sectors.

How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?

The community has not been engaged in the development of the public health modernization funding formula for local public health authorities. As recommended by the PHAB Chair, OHA will recruit community partners, including nonprofits and community-based organizations, to join the Incentives and Funding subcommittee in the future.

OHA staff held a listening session with local public health administrators and PHAB subcommittee members regularly solicited feedback on proposed changes to the funding formula.

Health equity review for Public Health Modernization Funding Report to Legislative Fiscal Office

What is the primary purpose for the report?

1. Describes how a $60.6 million legislative investment for the 2021-23 biennium has been allocated and used to make progress toward public health system priorities.
2. Estimates an additional investment of $300 million is needed in the 2023-25 biennium to continue developing a modern public health system that is equity-focused, community-centered and responsive to changing needs.

What health inequities exist among which groups? Which health inequities does the work product, report or deliverable aim to eliminate?

Public health modernization investments broadly address health inequities. Systemic racism and historical and contemporary injustices create health inequities, and inequities can be exacerbated by policies that create unequal conditions for health for communities of color, Tribal communities and people with lower incomes.

Across the public health system, important progress has been made with current investments. Additional investments will build critical capacity within the governmental public health system and with community-based organizations to continue progress toward eliminating health inequities.

How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?

Achieving health equity requires governmental health and partners to work across sectors. State and local public health authorities work closely with other sectors, and increased investments increase capacity for cross sector initiatives that leverage resources, create shared responsibility and elevate community priorities.

How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?

OHA works closely with local public health authority leaders, Tribal health directors and leaders from community-based organizations to make decisions on use of funds and to develop recommendations for future investments.

Increased investments will have a positive effect on communities through enhanced responses to emerging public health threats, public health interventions that are responsive to community priorities and are co-created with communities, and by building and retaining a public health workforce with the skills and resources necessary for eliminating health inequities.

Preventive Health & Health Services Block Grant
October 2022 – September 2023 Work Plan

Background

- Non-competitive grant issued to all states and territories to address state/territory determined public health priorities.
- The Public Health Advisory Board (PHAB) is designated as the Block Grant Advisory

Committee which makes recommendations regarding the development and implementation of
the work plan.

- Federal code states that a portion of the allocation (pre-determined) be used for rape

prevention and victim services. This funding currently goes to the Oregon Coalition Against
Domestic and Sexual Violence.

- Work plan must be tied to Healthy People 2030 objectives. Oregon has historically used the

block grant to support infrastructure, including public health modernization and the state health improvement plan. Healthy People 2030 objectives in the 2022-23 work plan:

  - Healthier Together Oregon development and implementation (PHI-R04 Increase the proportion of state and territorial that have developed a health improvement plan)
  - Public Health Modernization support (PHI-R08 Explore financing of public health infrastructure, including the core/foundational capabilities in health departments)
  - Sexual Violence primary prevention (PHI-D05 Reduce contact sexual violence by anyone across the lifespan)

Proposed October 2022-September 2023 Work Plan

- Support SHIP implementation – Healthier Together Oregon (HTO)
    - PartnerSHIP will make decisions about budget allocations moving forward
    - Ongoing support for PartnerSHIP to guide strategy prioritization and implementation, including meeting facilitation, member compensation and travel
    - Implementation support for HTO prioritized strategies (may include mini grants, communications tools, training, etc.)
        - Increase affordable housing that is co-located with active transportation options
        - Increase access to affordable, healthy and culturally appropriate foods for people of color and low-income communities
        - Build a resilient food system that provides access to healthy, affordable and culturally appropriate food for all communities
        - Reduce systemic barriers to receiving behavioral health services, such as transportation, language and assessment
        - Provide culturally and linguistically responsive trauma informed, multi-tiered behavioral health services and supports to all children and families
        - Improve integration between behavioral health and other types of care
        - Increase affordable access to high-speed internet in rural Oregon
- Support Public Health Modernization
    - Support for Public Health Advisory Board
    - Training for Local PH Authorities, Tribes, and/or Community-based Organizations to support Public Health Modernization implementation

- Support for Conference of Local Health Officials for ongoing meetings to support state/local governmental public health system work
- Staff support for Public Health Modernization operations, including accountability metrics development and reporting, annual Legislative Fiscal Office report, coordination with local and state partners

- Sexual Violence Primary Prevention:
  - Oregon Coalition Against Domestic and Sexual Violence
  - Fund one to three local, culturally specific organizations and/or Tribal sexual/domestic violence programs to continue to build capacity for and implementation of sexual violence primary prevention and programs.
  - Fund 0.8 FTE position to provide to funded and non-funded organizations online and in person (as able) sexual violence primary prevention technical assistance and training.

<u>Funding</u>

- Total PHHS Block Grant funding for October 2020 through September 2021 is $1,111,737 with $88,458 designated for sexual assault prevention and services.
- Funding by Health Objective:
  - State Health Improvement Plan – $670,200
  - Financing Public Health Infrastructure -- $353,079
  - Reduce sexual violence -- $88,458
  - Indirect costs (capped at 10%) -- $102,327
- Funding for OHA-PHD Staff:
  - 1.0 FTE Public Health Modernization and Strategic Initiatives Lead (Block Grant Coordinator)
  - 1.0 FTE Cross Sector and Strategic Initiatives Coordinator
  - 1.0 FTE Safety Net and Policy Coordinator
  - Healthier Together Oregon Intern

Charter and Bylaws Review

1: Authority & Purpose of PHAB

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.

2: PHAB Duties (pt 1)

Make recommendations to the OHPB on

a) the development of statewide public health policies and goals.

b) how other statewide priorities, such as the provision of early learning services and the delivery of health care services, affect and are affected by statewide public health policies and goals.

c) the establishment of foundational capabilities and programs for governmental public health and other public health programs and activities.

d) the adoption and updating of the statewide public health modernization assessment

e) the development of and any modification to the statewide public health modernization plan

Oregon Health Authority

Charter and Bylaws Review

3: PHAB duties (pt 2)

f) Establish accountability metrics for the purpose of evaluating the progress of the Oregon Health Authority (OHA) and local public health authorities in achieving statewide public health goals.

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.

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.

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.

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

k) Monitor the progress of local public health authorities in meeting statewide public health goals, including employing the foundational capabilities and implementing the foundational programs for governmental public health.

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.	• 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	• 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.

statewide public health policies and goals.	• 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.
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.	• 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.
d. Make recommendations to the OHPB on the adoption and updating of the statewide public health modernization assessment.	• 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.
e. Make recommendations to the OHPB on the development of and any modification to the statewide public health modernization plan.	• 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.
f. Establish accountability metrics for the purpose of evaluating the progress of the Oregon Health Authority (OHA) and local public	•

health authorities in achieving statewide public health goals.	
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.	• 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.
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.	• 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.
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.	• Develop models to incentivize investment in and equitable provision of public health services across Oregon. • Solicit stakeholder feedback on incentive models.
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.	• 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.
k. Monitor the progress of local public health authorities in meeting statewide public health goals, including employing the	• 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.	• 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.	• 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.	• 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.	• 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.	• 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 by leading with racial equity.~~.~~	• 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~~-~~-year term~~s~~. 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.

Date approved: ~~November 17, 2017~~

Public Comment
Submitted June 3, 2022

Revised Statement for Oregon's Public Health Advisory Board - request to be added to the agenda

Dear Dr Irvin,

I am one of the board member of the Oregon Health Authority's Childhood Blood Lead Poisoning Prevention Program (CLPPP). I am contacting you because you are the chair of the Oregon's Public Health Advisory Board and I would like to make a public comment at your committee's June meeting regarding the addition of childhood blood lead screening as a metric to the Oregon Health Plan.

All children who are covered by the Oregon Health Plan are required to have their blood tested for lead at 12 and/or 24 months, and it is highly recommended for all children who may be exposed to lead. OHA, in collaboration with local public health departments, has an excellent childhood blood lead program that facilitates surveillance and follow up interventions for children who have blood lead levels that are above 5 ug/dL.

At our last board meeting, we learned that Oregon has one of the lowest childhood blood lead screening rates in the U.S. A review of the OHA CLPPP surveillance data from 2015-2021) indicates that **on average only 6.2% of children who are on the Oregon Health Plan had their blood tested for lead in 2020 and that decreased to 5.5% in 2021**. This is an all-time low and a serious problem that needs to be addressed. While it is understandable that blood lead screening may not have been a priority during this time when the medical community was fully engaged with managing the first wave of the COVID-19 pandemic, this trend is troubling because childhood lead exposure has long term consequences on children's health and well-being. There is considerable evidence that shows that elevated childhood blood lead levels damage the brain and central nervous system which manifests as decreased intelligence, decreased ability to pay attention, and diminished academic achievement. Chronic lead exposure in early childhood is also linked to slowed growth and development, hearing and speech problems, and learning and behavioral problems that persist

throughout life. Thus, early detection and early intervention is crucial to prevent further exposure and reduce damage to child health and well-being.

I would like to make a public comment that would ask your committee to consider making childhood blood lead testing a metric for the Oregon Health Plan. There have been many recent policy changes that would make the addition of this metric incredibly timely that I would like to bring to the attention of the Oregon's Public Health Advisory Board. Namely, the CDC has lowered the blood lead screening level of concern to 3.5 ug/dL and Oregon is considering adopting this new criteria which would identify more children who should receive interventions. Additionally, Ryan Barker who leads the OHA CLPPP has secured increased funding for local public health agencies who conduct case investigations which means the resources are in place for this important prevention work. A long-standing policy regarding the ability to recommend early childhood educational interventions will sunset in in January 2023 which opens up a new intervention to help children who have elevated blood lead. And finally, the CDC has made increasing blood lead screening a priority in Western States and currently Oregon has the lowest rate in the region.

Thank you for your consideration and I look forward to hearing from you.

Sincerely,
Molly Kile

Molly Kile
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Lifelong health and well-being for every person, every family, every community in Oregon and beyond