Oregon Health Authority
Public Health Division

Report to Legislative Fiscal Office
In fulfillment of ORS 431.139 and ORS 431.380

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1. Executive summary

Oregon's public health system has been on a path to modernize under the initial charge from the Oregon legislature in 2013. ORS 431.139 and 431.380 require the Oregon Health Authority (OHA) to submit the information included in this report to the Public Health Advisory Board (PHAB) and Legislative Fiscal Office by June 30 of every even-numbered year. This report is the second of such reports designed to both detail the use of the existing 2017-19 legislative investment and current progress toward accountability metrics, as well as describe the resources needed for public health modernization and how they would be distributed through the local public health authority funding formula in the 2019-21 biennium.

In 2017, OHA received an initial $5,000,000 investment to begin implementation of public health modernization in three areas detailed in the 2016 report to Legislative Fiscal Office: communicable disease control, health equity and cultural responsiveness, and assessment and epidemiology. Of this investment, $1,100,000 is being used by OHA to support collection of population health metrics and data and to provide support to local public health modernization grantees. The remaining $3,900,000 is being used by eight regions of local public health authorities, collectively supporting 33 of Oregon's 36 counties, to implement communicable disease control interventions focused on mitigating disease risks in their jurisdictions with a focus on reducing health disparities.

Also in 2017, the PHAB adopted a series of public health accountability measures which will be used to track progress of the public health system over time. These measures were first published in the baseline Public Health Accountability Metrics Report in March 2018. Moving forward, progress toward public health accountability measures will be reported annually.

Over the course of the last several months, OHA and PHAB have worked to develop the 2019-21 local public health authority funding formula which is detailed in this report. The 2019-21 funding formula addresses all three legislatively required components: base, matching and incentive funds, phased in at tiers of available funding for local public health authorities.

Finally, this report includes a description of the PHAB's recommended priorities for implementation of public health modernization in the 2019-21 biennium: expanded implementation of communicable disease control, health equity and cultural responsiveness, and assessment and epidemiology interventions; and, with additional resources, implementation of environmental health, emergency preparedness and response, and leadership and organizational competencies interventions. Given the level of work necessary to effectively protect the population from emerging disease risks that are a result of changes in the way we live and in our environment, OHA estimates that $47,700,000 of the total estimated biennial gap of $210,000,000 is necessary to implement work across these six areas in the 2019-21 biennium.

2. Introduction

Through legislative direction in the 2013 (HB 2348), 2015 (HB 3100) and 2017 (HB 2310) sessions, the Oregon Health Authority (OHA) and local public health authorities have been working to create a modern public health system. A modern public health system:

- Assures that basic public health protections are in place for every person in Oregon, regardless of where they live;
- Is effective and efficient; and
- Is accountable for improvements in health outcomes.

Over the course of the last five years, Oregon's state and local public health authorities have made tremendous strides towards achieving these aims. Notably:

- The new Oregon Public Health Advisory Board (PHAB) was appointed by Governor Brown, and became a formal committee of the Oregon Health Policy Board to assure alignment between health system and public health transformation.
- OHA and all local public health authorities completed a comprehensive public health modernization assessment in 2016. The assessment, based on the 2015 *Public Health Modernization Manual*, identified programmatic strengths and gaps across the state as well as the level of resources required to fully implement the foundational capabilities (ORS 431.131) and foundational programs (ORS 431.141) for state and local public health authorities.
- OHA and local public health authorities garnered an additional $250,000 investment from the Robert Wood Johnson Foundation to accelerate public health modernization. The Coalition of Local Health Officials has managed this grant spanning from 2016-2018.
- The PHAB adopted accountability metrics for state and local public health authorities. Oregon is leading the nation in developing and reporting on accountability metrics for the public health system.
- The Oregon legislature demonstrated its commitment to public health modernization through a $500,000 investment in planning during the 2015-17 biennium and a $5,000,000 initial investment in implementation during the 2017-19 biennium.
- Administrative rules pertaining to HB 3100 and HB 2310 became effective on January 1, 2018.

This report fulfills the OHA's requirements as described by ORS 431.139 and ORS 431.380. This report will both provide information on how the 2017-19 legislative investment is being used, and how a future investment in 2019-21 can be implemented to further Oregon's work to modernize its public health system.

3. 2017-19 legislative investment in public health modernization

Amount of funds received for foundational capabilities and programs, distribution of funds, and the level of work funded

In 2017, the Oregon legislature made an initial $5,000,000 investment in public health modernization. This investment was used to begin work focused on the communicable disease control foundational program and the health equity and cultural responsiveness and assessment and epidemiology foundational capabilities. In Spring 2017, the PHAB advised on how to best apply a new general fund investment to state and local public health authorities in these three areas.

Of the $5,000,000 investment, $1,100,000 remained with OHA in order to:

- Fund a repurposed, existing position to provide technical assistance to local public health authorities and develop a comprehensive approach to OHA's population health metrics and data collection systems; and
- Maintain basic population health data systems in order to deliver timely and accurate information for public health interventions. Specifically, this includes: partial funding for administration of the Behavioral Risk Factor Surveillance System (BRFSS) and the Oregon Healthy Teens surveys, maintenance and interoperability functions for the ALERT Immunization Information System, maintenance of the Oregon Public Health Assessment Tool, evaluation of the local public health modernization grants, and reporting of the new public health accountability measures.

The remaining $3,900,000 was invested in eight regions of local public health authorities working together on communicable disease priorities with an emphasis on addressing communicable disease-related health disparities. In May 2017, the PHAB determined that at a funding level of less than $20,000,000 per biennium, the local public health authority funding formula would not effectively allocate resources to have a meaningful impact. With that recommendation, the Oregon Health Authority released a competitive request for proposals in September 2017 that supplied funds to the eight regions covering 34 of 36 Oregon counties in a range between $100,000 and $700,000 for the remainder of the biennium. Local public health authorities were required to work with federally recognized tribes, regional health equity coalitions and other partners to address leading communicable disease issues in their jurisdiction.

Figure 1: The table below provides a brief description of $3,900,000 in awards that span from December 1, 2017 through June 30, 2019.

Regional partners	Project description	Award amount
Clatsop, Columbia and Tillamook counties	• Convene partners to assess regional data on sexually transmitted infections and develop priorities;	$100,000

	• Identify vulnerable populations and develop regional strategies to address population-specific needs.	

Deschutes, Crook and Jefferson counties; St. Charles Health System; Central Oregon Health Council	• Form the Central Oregon Outbreak Prevention, Surveillance and Response Team which will improve:
	  • Communicable disease outbreak coordination, prevention and response in the region;
	  • Communicable disease surveillance practices;
	  • Communicable disease risk communication to health care providers, partners and the public.
	• Funds will be directed to communicable disease prevention and control among vulnerable older adults living in institutional settings and young children receiving care in child care centers with high immunization exemption rates.
		$500,000

Douglas, Coos and Curry counties; Coquille and Cow Creek Tribes; Western Oregon Advanced Health CCO	• Improve and standardize mandatory communicable disease reporting. • Implement strategies for improving two year-old immunization rates. • Focus on those living in high poverty communities.	$468,323
Jackson and Klamath counties; Southern Oregon Regional Health Equity Coalition; Klamath Regional Health Equity Coalition	• Work with regional health equity coalitions and community partners to respond to and prevent sexually transmitted infections and Hepatitis C, focused on reducing health disparities and building community relationships and resources. • Promote HPV vaccination as an asset in cancer prevention.	$499,923

Lane, Benton, Lincoln and Linn counties; Oregon State University	• Establish a learning laboratory to facilitate cross-county information exchange and continuous learning.
	• Implement an evidence-based quality improvement program, AFIX, to increase immunization rates.
	• Pilot three local vaccination projects:
	  • Hepatitis A vaccination among unhoused people in Linn and Benton counties;
	  • HPV vaccination among adolescents attending school-based health centers in Lincoln County;
	  • Pneumococcal vaccination among hospital discharge patients in Lane County.
		$693,517

	• Establish an Academic Health Department model with Oregon State University to extend public health capacity and support evaluation.	
Marion and Polk counties; Willamette Valley Community Health CCO	• Focus on system coordination and disease- and population-specific interventions to control the spread of gonorrhea and chlamydia. • Increase HPV immunization rates among adolescents.	$463,238
North Central Public Health District; Baker, Grant, Harney, Hood River, Lake, Malheur, Morrow, Umatilla, Union and Wheeler counties; Eastern Oregon CCO; Mid-Columbia Health Advocates	• Establish a regional epidemiology team. • Create regional policy for gonorrhea interventions. • Engage community-based organizations to decrease gonorrhea rates through shared education and targeted interventions.	$495,000

Washington, Clackamas and Multnomah counties; Oregon Health Equity Alliance	• Develop an interdisciplinary and cross-jurisdictional communicable disease team. This team will focus on developing and strengthening surveillance and communications systems to facilitate the timely collection of data, create surge capacity and communicate about outbreaks.
	• With leadership and guidance from the Oregon Health Equity Alliance, this cross-jurisdictional team will develop culturally responsive strategies that:
	  • Identify and engage at-risk communities.
	  • Reduce barriers (e.g., language, stigma, access to care) to infectious disease control, prevention and response.
	• Both qualitative and quantitative evaluation methods are included in the overall design. Evaluation results will guide implementation of best practices across the region focused on reducing and eliminating the spread of communicable diseases.
		$679,999

It is important to note that with a funding level of $5,000,000, relative to the $32,382,000 estimated as the need for full implementation of communicable disease control, health equity and cultural responsiveness, and assessment and epidemiology alone per the 2016 *Public Health Modernization Assessment Report*[1], both the OHA and local public health authority deliverables were focused on the 1-2 most critical communicable diseases and most critical state level functions to support local priorities.

[1] Berk Consulting. (2016). State of Oregon Public Health Modernization Assessment Report. Available at http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/PHModernizationFullDetailedReport.pdf.

Progress toward accountability metrics

In 2017, PHAB adopted accountability metrics for Oregon's public health system. The framework for public health accountability metrics includes health outcome measures which reflect population health priorities in Oregon, and process measures that articulate the specific work of local public health authorities to achieve changes in health outcomes.

Oregon Health Authority published the baseline Public Health Accountability Metrics Report in March 2018. This report provides detailed information about Oregon's current status on population health priorities. Some notable findings include:

- **With 89% of public water systems meeting health-based standards in 2016, the public health system is close to meeting the statewide benchmark of 92%.** Oregon's public health system ensures clean drinking water for people across Oregon. State and local public health authorities inspect Oregon's 3,600 public water systems and take corrective actions when public water systems do not meet standards.
- **In 2016, the rate of gonorrhea infections was considerably higher than the statewide benchmark of 72 cases per 100,000 people.** In recent years, Oregon, like much of the rest of the nation, has experienced a large increase in gonorrhea cases, with significant disparities among certain populations. State and local public health authorities identify where outbreaks are occurring and make sure both the individual affected and their partners are properly treated. Oregon's public health system has already begun to improve its work on sexually transmitted infections and other communicable diseases using the 2017-19 legislative investment in public health modernization.
- **For most accountability metrics, health outcomes vary across racial and ethnic groups.** The report highlights variations across different racial and ethnic groups to better focus interventions on reducing the health disparities that exist in Oregon.

Moving forward, annual reports will provide the public health system, its partners, and the Legislature the information that is needed to understand where Oregon is making progress toward population health goals, and where new approaches or additional focus are needed. The full report is available in **Appendix B**.

4. 2019-21 proposed legislative investment

Local public health authority funding formula

The 2014 Task Force for the Future of Public Health Services (Task Force) envisioned an approach for funding local public health authorities designed to increase accountability for achieving population health goals and sustain local investment in public health, while ensuring a sufficient state investment for foundational public health programs. The vision of the Task Force was supported in the 2015 Oregon legislature and is implemented through ORS 431.380, which directs OHA to distribute state moneys for public health modernization to local public health authorities through a funding formula that includes three components:

1. Base funds: Allocated to local public health authorities based on population, health status, burden of disease, and ability of the local public health authority to invest in local public health;

2. Matching funds: Awarded for county investment in local public health services and activities above the base funding amount;

3. Incentive funds: Awarded for achieving accountability metrics.

<u>Public Health Advisory Board recommendations</u>

The PHAB provides recommendations to OHA on the development and modification of plans to distribute funds to local public health authorities under ORS 431.380. The model recommended by PHAB and submitted in this report shows how state funds would be allocated through the funding formula in 2019-21 but is not a commitment of funding to local public health authorities. Final decisions about local public health authority funding allocations through the funding formula will be made following legislative decisions about total public health modernization funding for the 2019-21 biennium.

In addition to its recommendations on the funding formula required under ORS 431.380, in 2018 PHAB developed a set of funding principles that can be applied to other state and federal public health funding streams. These funding principles are intended to maximize the benefit of available resources, support system-wide approaches to providing foundational public health programs, and increase transparency and understanding about state and local public health authority roles and funding. PHAB's funding principles are included in **Appendix C**.

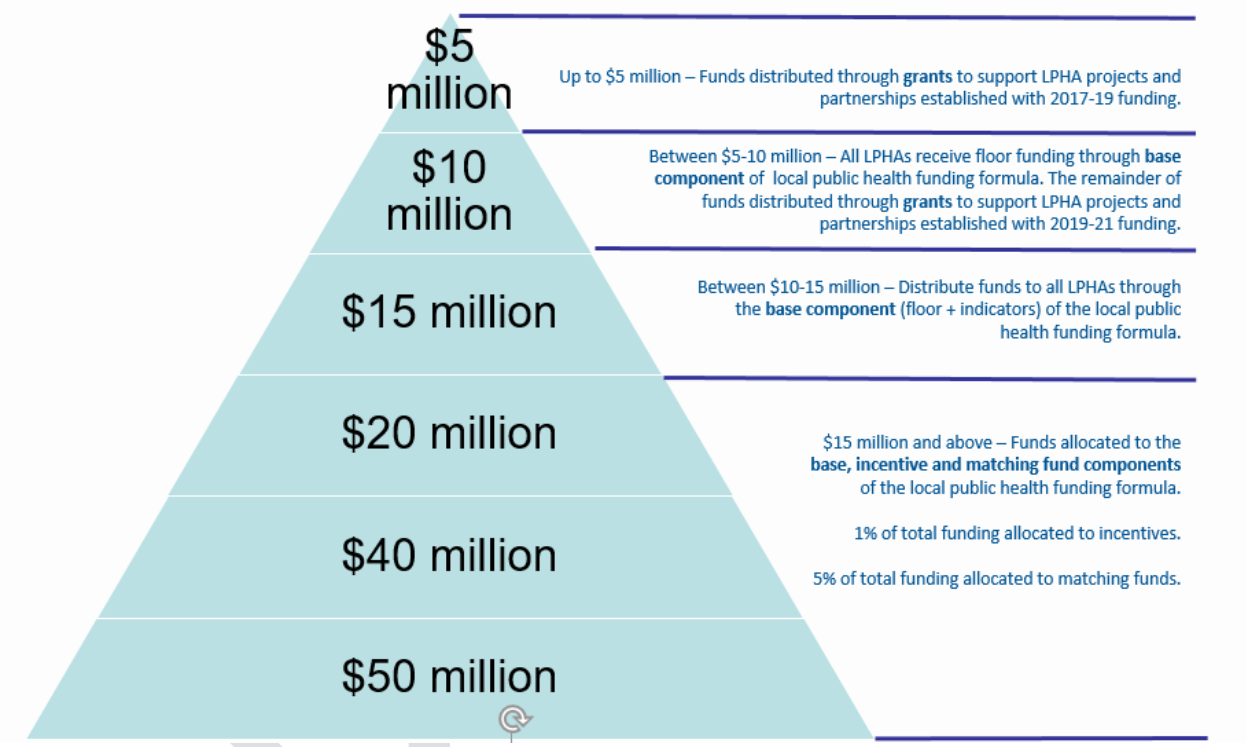
The PHAB has provided the following broad recommendations for allocating public health modernization funds to local public health authorities:

- A tiered approach should be used to allocate funds to each component of the funding formula at different funding levels. PHAB recommends that funds be distributed to all local public health authorities through the funding formula starting at the $10 million biennial funding level for local public health authorities. At levels below this threshold, funds should be awarded through alternative mechanisms intended to support new or

innovative models of public health service delivery, like regional grants. See **Figure 2** for a complete description of PHAB's funding threshold recommendations.

- At all funding levels at or above $10 million to local public health authorities for the biennium, extra-small and small counties should receive a proportionally larger per capita allocation, and large and extra-large counties should receive a proportionally larger dollar amount. This is consistent with the resource gaps identified in the 2016 public health modernization assessment.
- The local public health authority funding formula should be used to advance health equity by directing funds to a set of indicators that measure health outcomes and county demographics.

Figure 2: Allocations to funding formula components at a range of local public health authority funding levels for the 2019-21 biennium*.

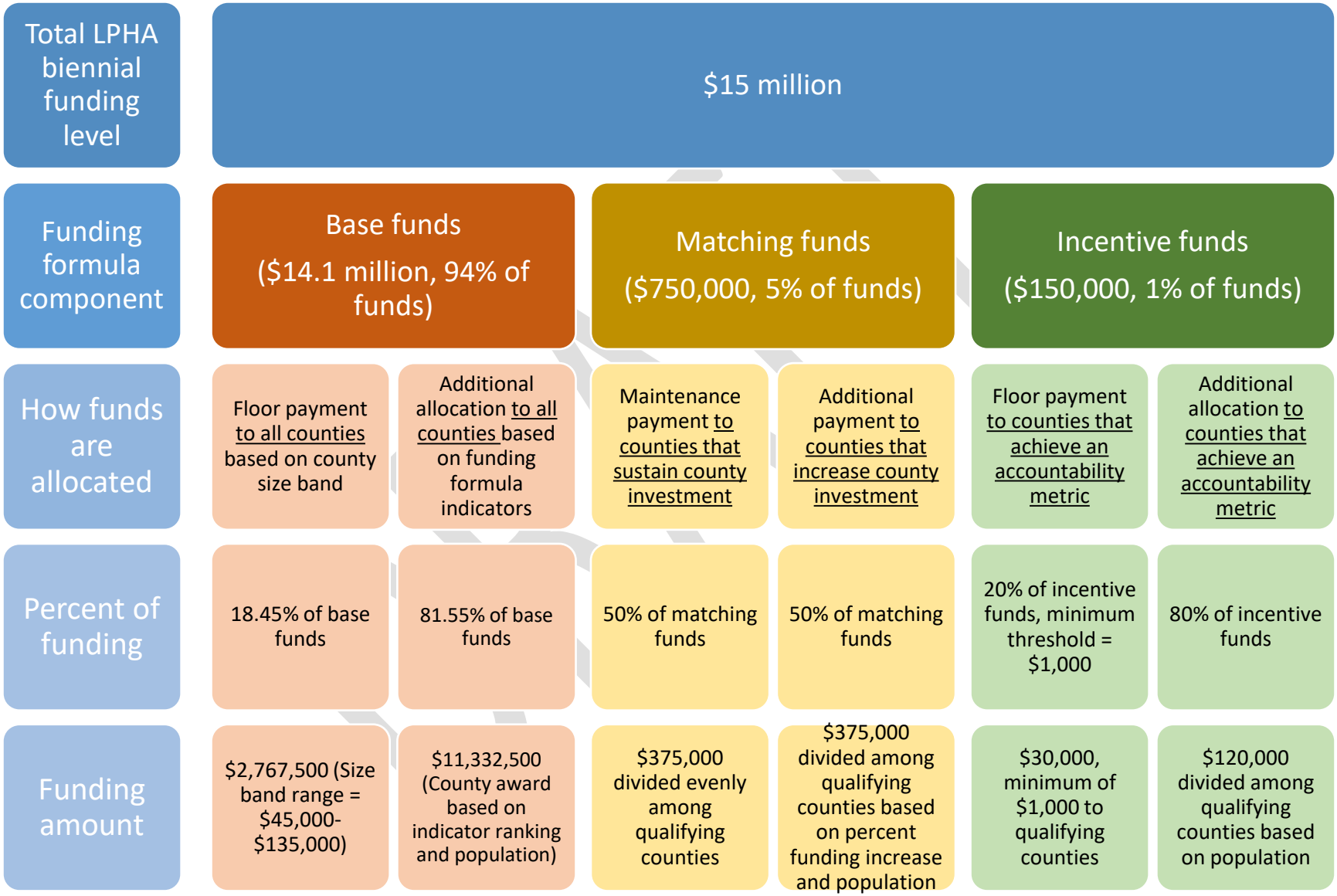


* The funding levels in this diagram represent the public health modernization biennial allocation to local public health authorities, which is a portion of total public health modernization funding for the biennium given that resources are also needed at OHA for state-level public health functions.

<u>The local public health authority funding formula model</u>

Using PHAB's recommendations for a tiered funding approach, **Figure 3** provides an overview of how funds would be allocated across each component of the funding formula at the funding level of $15 million to local public health authorities for the 2019-21 biennium. This is the level at which all local public health authorities would be eligible to receive base, matching and incentive funds. Each component in this model has been carefully designed to fulfill legislative intent and the original vision of the 2014 Task Force. See **Appendix D** for a complete description and methodology of each funding formula component.

Figure 3: Description of funding formula components at the $15 million biennial funding level for local public health authorities in 2019-21.

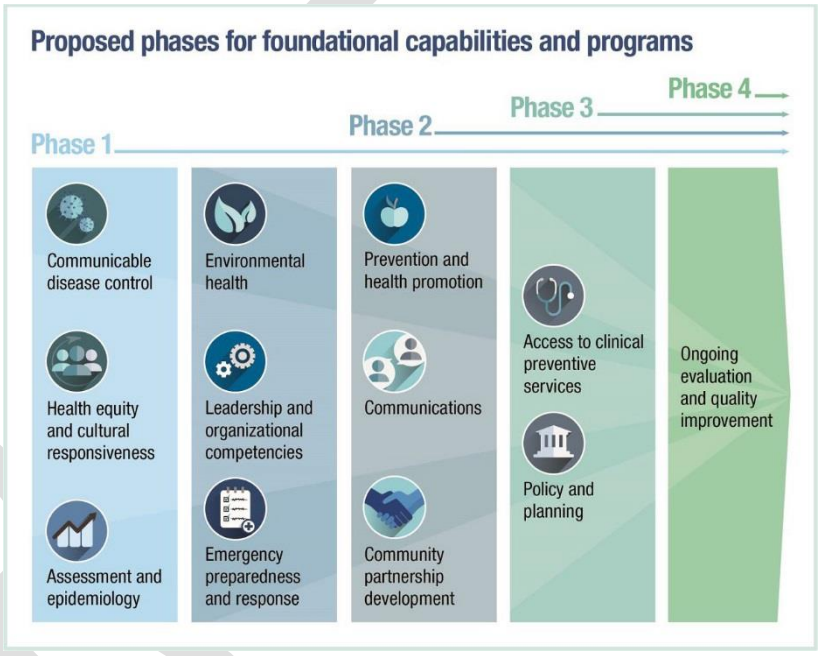


Estimate of the amount of state general fund needed for public health modernization

In February 2018, the PHAB provided its recommendation to OHA for implementing foundational capabilities and programs in the 2019-21 biennium. PHAB recommended that:

1. The public health system continue to focus on communicable disease control, health equity and cultural responsiveness, and assessment and epidemiology; and,
2. With additional funding, expand its focus to include environmental health, emergency preparedness and response, and leadership and organizational competencies.

These areas fall under "Phase 1" for implementation of foundational capabilities and programs, as described in the December 2016 Statewide Public Health Modernization Plan.

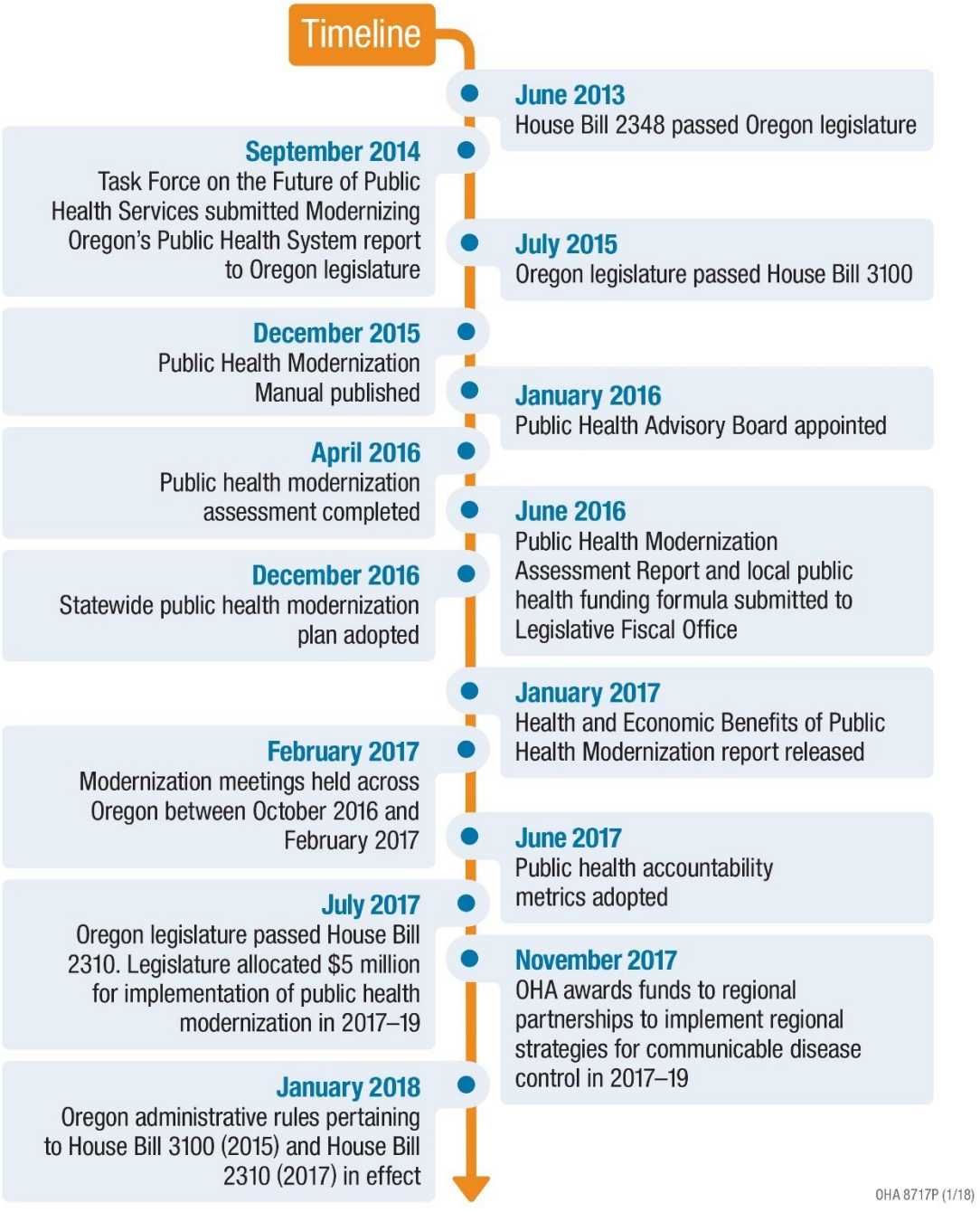


These recommendations from PHAB recognize that human health is interconnected with the environment, and the way people live, work and travel have all changed the landscape of public health priorities in recent years. Environmental changes are resulting in new and changing health threats, like emerging communicable diseases and health impacts of poor air quality due to wildfires. The public health system needs to address emerging issues with comprehensive strategies that include working with communities to prepare for emerging environmental health and communicable disease threats. The emphasis will remain on working with vulnerable communities to help them prepare for events like wildfires or drought, and emerging diseases.

The 2016 Public Health Modernization Assessment found a $105,000,000 annual, or $210,000,000 biennial gap in public health spending in order to fully implement all four foundational programs and seven foundational capabilities included in Oregon's public health modernization statutes.

The Oregon Health Authority estimates that $47,700,000 is necessary to implement the priorities included in Phase 1 above as identified by PHAB for the 2019-21 biennium. These funds would be deployed at the state and local level in order to achieve the deliverables included in the Public Health Modernization Manual.

Appendix A: Public health modernization milestones



Appendix B: Public Health Accountability Metrics Report

http://www.oregon.gov/oha/PH/ABOUT/Documents/phab/Accountability-metrics-baseline-report.pdf

Appendix C: PHAB Funding Principles

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

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

Public health system approach to foundational programs

1. Ensure that public health services are available to every person in Oregon, whether they are provided by an individual local public health authority, through cross-jurisdictional sharing arrangements, and/or by the Oregon Health Authority.

2. Align funding with burden of disease, risk, and state and community health assessment and plan priorities, while minimizing the impact to public health infrastructure when resources are redirected.

3. Use funding to advance health equity in Oregon, which may include directing funds to areas of the state experiencing a disproportionate burden of disease or where health disparities exist.

4. Use funding to incentivize changes to the public health system intended to increase efficiency and improve health outcomes, which may include cross-jurisdictional sharing.

5. Align public health work and funding to coordinate resources with health care, education and other sectors to achieve health outcomes.

Transparency across the public health system

6. Acknowledge how the public health system works to achieve outcomes, and direct funding to close the identified gaps across the system in all governmental public health authorities.

7. Improve transparency about funded work across the public health system and scale work to available funding.

Appendix D: Detailed description of funding formula components

This appendix provides additional detail and describes the methodology for each of the funding formula components. An example of the funding formula model at the $15 million biennial funding level for LPHAs is available at the end of this section.

The base component

- Includes a floor payment for each county and additional allocations through the indicator pool.

Floor payments

- Floor payments are based on five tiers of county size bands. At the $10 million level, floor payments range from $30,000-90,000 and total $1.845 million.
  - Floor payments increase proportionally at funding levels above $10 million (remaining at 18.45% of total base component funds).
  - Floor payments are intended to ensure stable funding for a basic level of public health staffing and operations.

Total funds	Range of floor payments[2]	Floor payment total	Indicator pool total
$10 million	$30,000-90,000	$1,845,000	$8,155,000
$15 million	$45,000-135,000	$2,767,500	$11,332,500
$20 million	$60,000-180,000	$3,690,000	$15,110,000

- All remaining base component funding is distributed through the indicator pool.

Indicator pool

Every county receives additional allocations through the indicator pool based on the county's ranking on a set of health and demographic indicators[3]. A description of each indicator, measure and data source is included below. Each of the health and demographic indicators receives an equal percentage of available indicator pool dollars.

[2] In the future PHAB may consider whether to establish a cap for the maximum dollar amount going to base component floor payments.

[3] Indicators include health status, burden of disease, racial and ethnic diversity, poverty, educational attainment, population density, limited English proficiency and rurality.

	Measure	Indicator required by statute?	Data source	Percent allocation
Burden of disease	Premature death: Leading causes of years of potential life lost before age 75.	Yes	Oregon death certificate data	16.67%%
Health status	Quality of life: Good or excellent health.	Yes	Behavioral Risk Factor Surveillance System	16.67%
Racial and ethnic diversity	Percent of population not categorized as "White alone".	No	U.S. Census Bureau, American Community Survey population five-year estimate	16.67%
Poverty**	Percent of population living below 150% of the federal poverty level in the past 12 months.	No	U.S. Census Bureau, American Community Survey population five-year estimate	8.33%
Education**	Percent of population age 25 years and over with less than a high school graduate education level.	No	U.S. Census Bureau, American Community Survey population five-year estimate	8.33%
Limited English proficiency	Percent of population age 5 years and over that speaks English less than "very well".	No	U.S. Census Bureau, American Community Survey population five-year estimate	16.67%
Rurality New for 2019-21	Percent of population living in a rural area	No	U.S. Census Bureau Population estimates	16.67%
Total				100%

**PHAB recommended including two measures under one indicator for socioeconomic status.

Methodology

Base funding = floor payment + indicator pool payment

Floor payment = based on county size band

Indicator pool payment = all remaining base component funds

Indicator pool payment = (LPHA weight/sum of all LPHA weights) * Total indicator pool

LPHA weight = LPHA population * LPHA indicator percentage

The matching funds component

- Matching funds will be awarded for sustained or increased county general fund investments over time.
- Five percent of funds will be allocated to matching funds at or above the $15 million level. (At the $15 million, level $750,000 would be allocated to matching funds.
- Of the total funds allocated to matching funds, 50% will be awarded for sustained county general fund investments, and 50% will be awarded for increased county investment.
    - Maintenance payment: Awarded to counties that demonstrate sustained county general fund investment. Available funds awarded equally to all qualifying counties.
    - Additional allocation: Awarded to counties that demonstrate increased county general fund investment. Allocations for increased investment are determined based on the available pool, percent funding increase, and county population.

Total funds	Total matching funds	Maintenance payments	Additional allocation
$10 million	$0	$0	$0
$15 million	$750,000	$375,000	$375,000
$20 million	$1,000,000	$500,000	$500,000

Methodology

Compares county general fund investment over two years[4].

Matching funds = maintenance payment for sustained investment + additional allocation for increased investment

Maintenance payment = All counties eligible to receive the same floor payment.

Additional allocation = Based on percent county funding increase, county population and total funds available to counties with funding increases

Additional allocation = (LPHA weight/sum of all LPHA weights) * total available pool for counties with funding increases

LPHA weight = LPHA population * percent county funding increase

The incentive funds component

Structure for public health accountability metrics

- Public health accountability metrics are comprised of the set of health outcomes measures and local public health process measures that have been adopted by PHAB.
- Public health accountability metrics will become incentivized when there is base funding going out to LPHAs through the funding formula for a foundational program. For example, if 2019-21 public health modernization funds are directed to communicable disease control, the public health accountability metrics for communicable disease control will be incentivized.
- Incentive funds will be awarded based on performance on the local public health process measures.
- Performance includes meeting a benchmark or improvement target.
- PHAB is responsible for establishing benchmarks and improvement targets.
- Public health accountability metrics will be collected and reported on annually.

Incentive funds

- Each county that achieves an accountability metric will receive an incentive fund floor payment and an additional allocation.
    - All qualifying counties receive the same floor payment. Twenty percent of incentive funds will go to floor payments, with a minimum threshold of $1,000

[4] If funding for matching funds is available in 2019-21, OHA may recommend an initial matching funds award based on one year of county general fund data.

- Additional allocations are proportionally distributed to qualifying counties based on county population.

- One percent of funds will be allocated to incentive funds at or above the $15 million level. (At the $15 million, $150,000 would be allocated to incentive funds.
    - Available funds will be split across incentivized accountability metrics

Total funds	Total incentive funds	Floor payment (20%)	Additional Allocation (80%)
$10 million	$0	$0	$0
$15 million	$150,000	$30,000 (minimum payment to qualifying counties is $1,000)	$120,000
$20 million	$200,000	$40,000	$160,000

Methodology

Incentive funds = floor payment plus additional allocation based on county population

Floor payment = All qualifying counties receive the same floor payment.

Additional allocation = All qualifying counties receive proportion of remaining incentive funds based on county population

Local public health authority funding formula model - $15 million example

Total biennial funds available to LPHAs: $15 million
Base component: $14.1 million
Matching funds component: $750,000
Incetnive funds component: $150,000

Local public health funding formula model: At the $15 million level, the majority of funds are allocated to the base component of the funding formula, with 5% allocated to matching funds and 1% allocated to incentive funds. The data for matching and incentive funds are not based on actual LPHA data and are included for demonstration purposes only.

		Base component								Matching and Incentive fund components		Total county allocation				
County Group	Population[4]	Floor	Burden of Disease[2]	Health Status[3]	Race/ Ethnicity[1]	Poverty 150% FPL[1]	Rurality[5]	Education[1]	Limited English Proficiency[1]	Matching Funds	Incentives	Total Award	Award Percentage	% of Total Population	Award Per Capita	Avg Award Per Capita
Wheeler	1,480	$ 45,000	$ 666	$ 1,237	$ 167	$ 433	$ 3,614	$ 282	$ 11	$ 10,555	$ 1,041	$ 63,005	0.4%	0.0%	$ 42.57	
Wallowa	7,195	$ 45,000	$ 3,920	$ 2,409	$ 898	$ 1,671	$ 17,568	$ 1,110	$ 440	$ -	$ 1,198	$ 74,212	0.5%	0.2%	$ 10.31	
Harney	7,360	$ 45,000	$ 5,546	$ 5,329	$ 1,866	$ 1,908	$ 7,961	$ 1,736	$ 956	$ 11,103	$ 1,203	$ 82,607	0.6%	0.2%	$ 11.22	
Grant	7,415	$ 45,000	$ 3,415	$ 3,714	$ 1,175	$ 1,922	$ 18,105	$ 1,749	$ 453	$ 11,108	$ 1,204	$ 87,844	0.6%	0.2%	$ 11.85	
Lake	8,120	$ 45,000	$ 4,851	$ 2,940	$ 2,315	$ 2,440	$ 12,550	$ 2,965	$ 1,550	$ 11,174	$ 1,224	$ 87,008	0.6%	0.2%	$ 10.72	
Morrow	11,890	$ 45,000	$ 5,468	$ 8,059	$ 9,135	$ 2,847	$ 13,325	$ 6,714	$ 14,530	$ 11,525	$ 1,327	$ 117,931	0.8%	0.3%	$ 9.92	
Baker	16,750	$ 45,000	$ 9,605	$ 6,064	$ 2,853	$ 4,146	$ 16,768	$ 3,647	$ 1,279	$ 11,978	$ 1,461	$ 102,802	0.7%	0.4%	$ 6.14	$ 10.22
Crook	22,105	$ 67,500	$ 12,407	$ 14,321	$ 4,990	$ 6,066	$ 25,907	$ 6,216	$ 1,182	$ 12,478	$ 1,609	$ 152,675	1.0%	0.5%	$ 6.91	
Curry	22,805	$ 67,500	$ 17,601	$ 14,712	$ 5,735	$ 5,665	$ 21,549	$ 5,327	$ 2,090	$ 12,543	$ 1,628	$ 154,351	1.0%	0.6%	$ 6.77	
Jefferson	23,190	$ 67,500	$ 15,014	$ 11,931	$ 18,323	$ 6,655	$ 35,728	$ 8,678	$ 8,148	$ 12,579	$ 1,638	$ 186,194	1.2%	0.6%	$ 8.03	
Hood River	25,145	$ 67,500	$ 9,074	$ 13,552	$ 17,676	$ 5,570	$ 32,048	$ 11,234	$ 27,848	$ 12,761	$ 1,692	$ 198,956	1.3%	0.6%	$ 7.91	
Tillamook	26,175	$ 67,500	$ 14,966	$ 13,823	$ 7,723	$ 6,432	$ 44,482	$ 6,055	$ 4,798	$ 12,857	$ 1,721	$ 180,356	1.2%	0.6%	$ 6.89	
Union	26,900	$ 67,500	$ 13,877	$ 10,544	$ 5,487	$ 7,985	$ 27,652	$ 4,514	$ 2,876	$ 12,[illegible]	[illegible]741	$ 155,101	1.0%	0.6%	$ 5.77	
Gilliam, Sherman, Wasco	30,895	$ 157,500	$ 17,967	$ 13,203	$ 13,822	$ 7,204	$ 31,306	$ 9,424	$ 13,099	[illegible]	[illegible]51	$ 301,506	2.0%	0.7%	$ 9.76	
Malheur	31,845	$ 67,500	$ 16,371	$ 24,878	$ 23,963	$ 11,024	$ 37,633	$ 14,372	$ 22,37[illegible]	[illegible]	[illegible]7	$ 233,380	1.6%	0.8%	$ 7.33	
Clatsop	38,820	$ 67,500	$ 23,260	$ 16,379	$ 10,608	$ 9,017	$ 36,966	$ 7,131	$ 8,59[illegible]	[illegible]	[illegible]	$ 195,565	1.3%	0.9%	$ 5.04	
Lincoln	47,960	$ 67,500	$ 33,412	$ 26,893	$ 16,240	$ 12,904	$ 44,030	$ 11,638	$ 11,356	[illegible]	[illegible]	$ 241,182	1.6%	1.2%	$ 5.03	
Columbia	51,345	$ 67,500	$ 26,206	$ 26,975	$ 10,778	$ 10,775	$ 54,660	$ 11,179	$ 5,490	[illegible]	[illegible]	$ 231,179	1.5%	1.2%	$ 4.50	
Coos	63,310	$ 67,500	$ 43,024	$ 37,914	$ 18,053	$ 18,169	$ 59,359	$ 15,937	$ 7,253	[illegible]	[illegible]	$ 286,272	1.9%	1.5%	$ 4.52	
Klamath	67,690	$ 67,500	$ 44,392	$ 39,615	$ 27,747	$ 19,730	$ 62,144	$ 19,035	$ 15,510	$ [illegible]	[illegible]	$ 315,264	2.1%	1.6%	$ 4.66	$ 5.92
Umatilla	80,500	$ 90,000	$ 38,594	$ 48,208	$ 51,967	$ 21,514	$ 57,197	$ 31,766	$ 63,943	$ [illegible]	[illegible]216	$ 424,328	2.8%	1.9%	$ 5.27	
Polk	81,000	$ 90,000	$ 33,809	$ 31,971	$ 33,202	$ 17,652	$ 39,357	$ 16,533	$ 27,221	$ [illegible]	[illegible]3,230	$ 310,944	2.1%	2.0%	$ 3.84	
Josephine	85,650	$ 90,000	$ 58,878	$ 44,531	$ 20,862	$ 27,423	$ 94,108	$ 21,755	$ 7,850	$ [illegible]	[illegible]3,358	$ 387,165	2.6%	2.1%	$ 4.52	
Benton	92,575	$ 90,000	$ 28,614	$ 35,783	$ 33,364	$ 25,156	$ 42,495	$ 10,497	$ 27,576	$ 19,048	$ 3,548	$ 316,082	2.1%	2.2%	$ 3.41	
Yamhill	106,300	$ 90,000	$ 44,457	$ 55,267	$ 46,310	$ 23,547	$ 58,658	$ 28,929	$ 43,842	$ 20,327	$ 3,926	$ 415,264	2.8%	2.6%	$ 3.91	
Douglas	111,180	$ 90,000	$ 76,920	$ 70,818	$ 24,658	$ 28,816	$ 111,843	$ 27,483	$ 10,190	$ 20,782	$ 4,061	$ 465,572	3.1%	2.7%	$ 4.19	
Linn	124,010	$ 90,000	$ 63,597	$ 63,800	$ 34,134	$ 31,808	$ 95,682	$ 28,968	$ 19,890	$ 21,979	$ 4,414	$ 454,271	3.0%	3.0%	$ 3.66	$ 3.91
Deschutes	182,930	$ 112,500	$ 71,610	$ 56,766	$ 43,831	$ 37,241	$ 123,276	$ 29,040	$ 27,944	$ 27,472	$ 6,036	$ 535,717	3.6%	4.4%	$ 2.93	
Jackson	216,900	$ 112,500	$ 115,010	$ 108,637	$ 76,453	$ 56,995	$ 106,449	$ 54,601	$ 57,982	$ 30,639	$ 6,971	$ 726,237	4.8%	5.2%	$ 3.35	
Marion	339,200	$ 112,500	$ 150,805	$ 180,972	$ 222,330	$ 90,045	$ 108,495	$ 114,620	$ 274,618	$ 42,041	$ 10,338	$ 1,306,764	8.7%	8.2%	$ 3.85	
Lane	370,600	$ 112,500	$ 178,303	$ 162,417	$ 124,024	$ 101,372	$ 158,354	$ 74,802	$ 79,256	$ 44,969	$ 11,202	$ 1,047,199	7.0%	8.9%	$ 2.83	$ 3.26
Clackamas	413,000	$ 135,000	$ 164,469	$ 165,260	$ 137,396	$ 56,300	$ 182,521	$ 62,754	$ 138,794	$ 48,922	$ 12,369	$ 1,103,785	7.4%	10.0%	$ 2.67	
Washington	595,860	$ 135,000	$ 184,123	$ 215,723	$ 381,120	$ 98,862	$ 81,474	$ 124,322	$ 432,349	$ 65,971	$ 17,403	$ 1,736,347	11.6%	14.4%	$ 2.91	
Multnomah	803,000	$ 135,000	$ 358,519	$ 354,104	$ 459,545	$ 185,080	$ 25,488	$ 169,362	$ 527,450	$ 85,283	$ 23,106	$ 2,322,937	15.5%	19.4%	$ 2.89	$ 2.85
Total	**4,141,100**	**$ 2,767,500**	**$ 1,888,750**	**$ 1,888,750**	**$ 1,888,750**	**$ 944,375**	**$ 1,888,750**	**$ 944,375**	**$ 1,888,750**	**$ 750,000**	**$ 150,000**	**$ 15,000,000**	**100.0%**	**100.0%**	**$ 3.62**	**$ 3.62**

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

[1] Source: American Community Survey population 5-year estimate, 2012-2016.
[2] Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon death certificate data, 2012-2016.
[3] Source: Quality of life: Good or excellent health, 2012-2015.
[4] Source: Portland State University Certified Population estimate July 1, 2017
[5] Source: U.S. Census Bureau, Population estimates,2010

County Size Bands

Extra Small	Small	Medium	Large	Extra Large