Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
June 17, 2019
12:00 p.m. – 1:00 p.m.

PHAB members present: Carrie Brogoitti, Dr. Jeff Luck, Alejandro Queral, Akiko Saito, Dr. Bob Dannenhoffer
PHAB members absent: None
Oregon Health Authority (OHA) staff: Sara Beaudrault, Katarina Moseley, Danna Drum, Krasimir Karamfilov, Dr. Ali Hamade

Welcome, introductions, and updates

Ms. Beaudrault introduced the meeting and announced that Dr. Dannenhoffer would chair the meeting. She invited Dr. Dannenhoffer to lead introductions and kick off the agenda.

Dr. Dannenhoffer invited the meeting attendees and the subcommittee members on the phone to introduce themselves.

A quorum was present. Dr. Dannenhoffer remarked that the meeting minutes from the meeting on May 14, 2019, were beautifully done and gave a sense of what happened at the meeting. He asked if the subcommittee would entertain a motion to approve the meeting minutes.

Ms. Saito made a motion to approve the meeting minutes. Dr. Luck seconded the motion. The subcommittee approved the meeting minutes unanimously.

Modernization funding for 2019-2021

Ms. Beaudrault expressed excitement about sharing news about the public health modernization budget for 2019-2021.

Last week, the Joint Ways and Means Human Services Subcommittee approved the OHA Public Health Division's budget. The budget included an additional $10 million for public health modernization, for a total of $15 million in the next biennium. The funding is not final yet, as it has to go through the full Ways and Means Committee.

Ms. Beaudrault added that this is a big success and a big accomplishment. During the hearing last week, legislators had some good insights in what they are learning about the public health system and understanding the direction we are going in a way they haven't before. It's positive.

Dr. Luck asked if the legislators said something that struck Ms. Beaudrault.

Ms. Beaudrault answered that she was struck by the numerous comments about the difficulty to understand public health and the public health work, but now the legislators understood it in a way they hadn't before. As the legislative session wraps up, OHA will be bringing information to the PHAB about all public health successes in this legislative session. If we look at them in whole, it's a very positive landscape for public health. We have a lot of support in the legislature. We see that for public health modernization, but also for a whole host of things that passed this session. Quite a few legislators gave their commitment to continue to hear about public health modernization and to continue to look for additional funding for it. That sets us up for upcoming sessions as well.

Ms. Beaudrault stated that OHA anticipates the public health modernization budget to be $15 million. At this point, OHA staff can't discuss the budget in any details yet. However, in addition to providing funds to LPHAs, OHA will also be proving funds to tribes for the first time. Moving forward, it will be a state-local-tribal effort. The focus in the next biennium will remain on communicable disease, health equity, and assessment and epidemiology. OHA doesn't have details for the subcommittee today and there's no clear timeline for when the details will be available, but OHA will be bringing information back to the PHAB in the coming weeks to give the PHAB more details on how those funds will be used to support state, local, and tribal public health to move the entire system forward.

Ms. Beaudrault pointed out that in terms of next steps, OHA has been hearing recommendations and getting direction from the PHAB for the better part of this year. The next steps will be working closely with local and tribal health authorities to develop the scope of work, down a level from what the PHAB typically works on, but getting into the specifics of how funds will go out and what they will be used to support. Last month at this meeting, the subcommittee talked about what funding to LPHAs could look like if it's more than $10 million going out to LPHAs. At that time, the subcommittee wanted to hear feedback from local public health officials.

Dr. Luck asked about the amount that will go to LPHAs, if the legislature appropriated $15 million for the biennium.

Ms. Beaudrault answered that OHA does not have those specific numbers yet. It's hard for her to ballpark.

Dr. Luck asked if the proportions will be as in prior years.

Ms. Beaudrault answered that the proportions will be similar, but it's a ballpark estimate right now. She explained that OHA convened calls with local administrators to get their feedback on what has worked with funding the LPHA partnerships and how they would envision using funding to support priorities and goals in the next biennium. She wanted to share their feedback with the subcommittee today, and discuss the direction OHA is going with funding to local public health based on discussions with this subcommittee and health administrators.

Ms. Beaudrault stated that many local health administrators attended the calls. Two different funding levels were discussed. The first one was funding to LPHAs between $5-10 million. Based on the recommendations, if the funding is between $5-10 million to LPHAs, the eight partnerships would continue to be funded. All LPHAs would receive some funding and the remainder would go to new partnerships or models to do some focused work on new service delivery models.

Ms. Beaudrault explained that administrators voiced a lot of support for shared or regional positions. A number of counties talked about the benefits of having regional positions that support a group of counties. A group of three counties has done the work to list out positions that they could share as a region, if they were to receive additional funding. With the current funding, they funded the first two positions on their list. With additional funding, they can talk about employing additional regional positions. That's the level of planning that some groups are doing right now. Others spoke about filling existing gaps by hiring local positions.

Ms. Beaudrault noted that administrators gave feedback that OHA should not emphasize new and innovative approaches because, in many cases, LPHAs don't have enough resources to do the core work. It's important to hear that. It is also important to make sure we are connecting whatever funding we have to building the modern infrastructure that we need to have in place to be able to address our priorities. Other groups said that if they received some funding, they would look at their community health assessment and the public health accountability metrics to help them target where to put those funds. The groups also talked about potential new partnership models with schools or CCOs, and about policy and communications.

Dr. Dannenhoffer asked how that correlated with what the subcommittee had talked about in the past. This is exactly coincident with the LPHA funding pyramid.

Ms. Beaudrault answered that it completely lined up. OHA gave the groups in these calls the PHAB recommendations as framing for the conversation. Local administrators provided additional details that OHA can use to hone the scope of work and develop contracts.

LPHA funding above $10 million – planning scenario

In the last month's subcommittee meeting, the subcommittee discussed that when funding reached the $10 million threshold to LPHAs, the funding formula switches on, which means that all funds are distributed through the funding formula and no funds would be directed to the eight partnerships that are funded now. Part of the discussion during the subcommittee meeting last month was that there were questions about whether there would be support for making modifications to the funding formula, so that some funds can continue to fund those eight partnerships. There was also a discussion about which approach is better and which approach is going to get us to where we want to get to.

Ms. Beaudrault stated that, by and large, administrators on the call were supportive of using a portion of funding to continue the LPHA partnerships in areas of the state where the model is working. It was not a consensus, but there was a lot of support for making sure that we don't lose the gains and the momentum from the last two years. One administrator commented that it was hard to say what the best approach was without modeling. This was getting at the point that we need to put numbers into the funding formula and look at different scenarios. OHA will be doing that over the coming weeks. With a finite amount of money, OHA is trying to make it have as big an impact as possible and making sure all areas of the state are benefiting equally.

Ms. Beaudrault mentioned that the group also talked about establishing some baselines across the system. The idea that was discussed was using funding to support regional epidemiologists. This has been one of the big successes in many of the areas of the state that have hired regional epidemiologists. These positions don't take over the local functions for communicable disease investigation, but it adds on top of what LPHAs are doing. Comments were that it would raise the bar for all counties and it would put some sort of baseline. OHA would be making sure that all areas of the state had epidemiological capacity to be doing some of the forward-looking work. A larger county that would receive proportionally more of the funding through the funding formula commented that at the funding level they would receive, it would allow them to start focusing on prevention of communicable disease, because they would be able to hire several employees and really work with partners around prevention. A smaller county stated that it wouldn't be able to do as much, because it would be receiving proportionally a much smaller amount of money. This asks the question: How do we ensure that we are creating a core everywhere rather than allowing some areas of the state to go much further than other areas of the state can go?

Dr. Luck asked, if he heard correctly, that one county, maybe more, realized that if they got money via the formula, they would get less than they are getting from the current partnership.

Ms. Beaudrault answered that local administrators looked at that. They compared the amount of money going into areas of the state through the LPHA partnerships and they compared that to the amount of money that would be distributed through the funding formula. Just because of the way the formula was built, some counties would get much more money through the funding formula, whereas other counties would get about the same amount that they get through the LPHA partnerships, even though within that we are moving from $3.9 million up to $10 million to LPHAs.

Dr. Dannenhoffer remarked that in the Douglas County partnership with Coos County and Curry County, they had 460K total for three counties. In the new funding formula with $10 million, Curry County would get about 40K or 50K, which is less than they are getting now through the partnership. It's hard to know, because it's sort of spread. It's difficult to know how much they are actually getting, because some of the services are provided centrally and they go out to the

counties. The smaller counties do have the possibility, if the partnerships are gone, of having less services.

Dr. Luck stated that he didn't remember the subcommittee discussing that in previous meetings.

Dr. Dannenhoffer agreed. He felt uncertain as to how all this would play out. For example, how do we calculate how much Curry County is getting now? Because the process is done as a partnership and it is done locally, it is hard to figure out how much of Douglas County's staff time they are getting. This is a little troubling.

Dr. Luck noted that it wouldn't be good for a county to feel that it was worse off when the overall pot was much larger.

Ms. Beaudrault stated that this was an important thing to be considering right now. The funding formula was developed initially back in 2016, and it's a really good funding formula, but, as it is built, it doesn't take into account the work that has happened in the last two years. We don't want to erase all the progress that has been made. If the funding formula, as it is built, means that some areas of the state move forward faster than others, then we need to look at that. In terms of the focus on prevention, LPHAs do a lot around investigating and monitoring communicable disease outbreaks and stopping the spread of disease once it's occurring. A big gap has been having the resources to do prevention. LPHAs are working with partners to make it so that disease outbreaks don't occur in the first place. Some areas of the state have been doing some of that through the LPHA partnerships. When one area of the state was saying, "We could really focus on prevention," and others are saying, "We still wouldn't be at a place where we can get to prevention," that is something OHA is trying to balance out.

Ms. Beaudrault noted that some administrators stated that funding all LPHAs individually with no incentives for regional models would result in disparities for the regional projects. This is giving support to somehow incentivizing or continuing funding to the LPHA partnerships, just to make sure that for areas that want to continue, they are not penalized through the funding formula. An administrator commented that in her area of the state the counties do a lot of work regionally without requirements from OHA, and OHA does not need to put requirements for regional work with modernization funding because they do it on their own. The final two comments were about the ability for counties to pool funds for regional work. One administrator commented that the ability to pool resources in that way actually requires resources to be able to do that work, because it does take a lot of local and regional planning. Finally, the ability to pool funds for regional positions depends on local politics. This is the feedback OHA received on these calls.

Dr. Dannenhoffer asked to go back to the funding pyramid. If the subcommittee changes anything from the pyramid, we are going to get a lot of guff, because this is what people have

been dealing with. Between $10 and $15 million, which it looks like where we are going to be, was spelled out. It was in the graphics that everybody saw.

Ms. Beaudrault agreed with Dr. Dannenhoffer. The pyramid came out of this subcommittee a year ago, with a lot of CLHO feedback at the time. Above $10 million, all funds go out to LPHAs through the funding formula.

Dr. Luck added that the subcommittee may have been thinking that if we got above $10 million, it would be significantly above $10 million. But if we just go a little above $10 million, it's not such a clear phase.

Ms. Beaudrault explained that part of what OHA was proposing to administrators on the call was trying to get a sense of whether they would support if OHA held some money aside to fund the partnerships that want to be funded and want to continue their work and then everything else goes out through the funding formula. That was the question posed to them.

Dr. Dannenhoffer asked whether, if there is $15 million, some of the funding would go to OHA.

Ms. Beaudrault confirmed that that was correct.

Dr. Dannenhoffer calculated that if the funding is $15 million and $2 million goes to OHA, $13 million will remain. Is the idea that $10 million would go to LPHAs and $3 million would be held back for the partnerships?

Ms. Beaudrault recalled that what was discussed on the calls with the administrators was just assuming $10 million to LPHAs total. What if some of those funds were held off for LPHA partnerships, for regional positions or regional infrastructure?

Dr. Dannenhoffer asked if some funding would come out from above the $10 million.

Ms. Beaudrault answered that funding for the partnerships would come out of that $10 million. It would be a chunk of that $10 million.

Ms. Saito asked Ms. Beaudrault to remind the subcommittee how much it would be to do the base funding.

Ms. Beaudrault stated that if every LPHA partnership wanted to continue and they wanted to fund everything they are funding now, then that would be about $5 million.

Ms. Saito clarified that she meant the base, when the funding formula was used. She thought it was about $2.6 million.

Ms. Beaudrault answered that at $10 million, everything would go to the base, which is the floor funding and the indicators.

Dr. Luck remarked that, according to the pyramid, $5-$7 million would allow us to do the partnerships, plus the floor payments.

Ms. Beaudrault clarified that, above $10 million, the base component is a floor payment to each LPHA that ranges from 30K for the extra small counties up to 90K for the extra large counties. Everything else goes to the indicators (racial and ethnic diversity, burden of disease, etc.); those six indicators that are in the funding formula. The way the funding formula works is that the majority of the funds go to those indicators. If we had $10 million for LPHAs, it means that our extra small counties would be getting somewhere in the range of 40K for the biennium and our largest county would be getting a couple of million dollars for the biennium. That's the range of what individual counties would receive, if all money goes out to LPHAs through the funding formula. Extra small counties would be put in a position of having to pool their money if they want to keep any of the regional work going and they would be very challenged to do the same level of work individually because of the amount of money that they would be getting. Extra large counties would presumably be in a different position because they would be getting much more than they are getting through their partnership.

Ms. Beaudrault remarked that what OHA proposed during these calls was that if we had $10 million going out to LPHAs that we make sure some of that funding go to support the partnerships that want to continue the work. It could be that we pull money aside and we fund that first and everything else goes out through the funding formula, or it could be that we look at how to incentivize regional work. There are different ways we could get it, but generally the group was supportive of OHA moving in that direction and giving each area of the state the leeway to figure out whether they want to continue the regional work or whether they don't want to.

Dr. Luck asked if the amount available for the partnerships be set at a fixed amount or would the counties that want to continue with the partnership request how much they want to keep for the partnerships and then the balance left over would be allocated according to the formula.

Ms. Beaudrault answered that there would be a maximum amount that the LPHA partnerships could request. That's how it's set up now. Each group would need to look at, functionally, what they need to have in place. Do they want to continue all the regional positions that are working now? Do they want to continue all the contracts that are in place? They would need to figure out the different pieces that are critical to continue their regional work. And then everything else. It wouldn't be a fixed amount. Functionally, groups need to look at what they need and what they want.

Dr. Dannenhoffer commented that if OHA was going to do this, and let's just say that the first $10 million went through the funding formula, the difference, for example, in the Douglas County region, would be that… there would still be money coming into the region. What about the possibility of distributing the $10 million according to LPHA exactly as we said we would, and then to use the difference between the $10 million and the amount that we have to spend to additionally fund partnerships? And, presumably, they could be funded at a much lower level

because the counties already have some base funding. Instead of funding a whole structure, it would really just need to fund the project.

Dr. Luck added that it would be topping up whatever the gap might be.

Dr. Dannenhoffer stated that, for example, in the Douglas County region, because Douglas County has more population than the other two regions, it would have a base there, but then there might be a smaller grant for the three counties to work together on a project like AFIX or something like that. The county could work on AFIX and the other money could be spent on other modernization elements. Once we go with less than $10 million through the funding formula, we are going to get endless heartache on that.

Ms. Beaudrault asked if the endless heartache would come from administrators.

Dr. Dannenhoffer said yes. According to the comments, it looks like the administrators thought that the LPHAs were going to get both. The administrators probably weren't thinking, "Cut back my base funding formula, so you can fund the partnerships." That's not what he heard through the grapevine. It sounded like LPHAs were going to get both.

Dr. Luck stated that the impact of the funding could depend on how much more than $10 million we are talking about. Spending $12 million that way would cause less discomfort than spending, say, $10.1 million that way.

Dr. Dannenhoffer noted that in the case of Douglas County region, some regional staff has been hired. If the county gets the base funding, it may continue to employ these staff, partially through regional funding and partly through county base funding. Because LPHAs are getting the base funding, the partnerships could be funded at a much lower level and still get the good work done.

Ms. Beaudrault agreed with Dr. Dannenhoffer and added that that's why OHA has been thinking about doing that first – letting LPHAs figure out what they need first and then figuring out what happens with everything that's remaining.

Dr. Dannenhoffer remarked that the other possibility was to give the counties the base funding and say, "If a county is in a regional situation, it will get a bonus of extra 10% of what it would get from the funding formula, if it did this as a region." Maybe. Ten percent may not be enough of a sweetener.

Dr. Luck pointed out that Dr. Dannenhoffer's idea was at variance with all the effort that was put into developing the funding formula. The concept was attractive, but some counties might object to the process.

Dr. Dannenhoffer agreed with Dr. Luck.

Ms. Moseley wondered if it might be helpful in thinking this through and in the discussion to try to get regrounded in health improvement and health outcomes and approach the discussion of

how local public health and local services and the overall governmental public health system is funded from that perspective. Ms. Beaudrault mentioned earlier that at this allocation, there is also opportunity to really strengthen and deepen the governmental public health system work locally, statewide, and with tribal public health authorities. We might get to a place where we can be able to speak to those outcomes, if we try to move the conversation back to that direction and think about outcomes and the infrastructure we need for the outcomes that we are seeking.

Ms. Beaudrault asked if Ms. Brogoitti could share perspectives from her area of the state.

Ms. Brogoitti shared that she was struggling with her own thinking about this, because it would be a shame to lose the capacity that has been built with the regional partnership. If the partnerships weren't fully funded by the state and the individual counties in the region received funding through the base funding formula, it is unclear whether the funding would go back to the partnership. The reason being that some of the health departments in the Union County partnership really need that funding. They are at the point where they are either existing or not existing. As per Ms. Moseley's comment about the outcomes, although we have this great regional partnership that is working on system's outcomes, but if we don't have a health department in one of the counties doing this work, which is also a system issue… Here we are, again, having a really difficult conversation about funding public health. It's unclear if that is the direction to go. Because Union County is a smaller county, the base funding would be amazing, but it doesn't radically change the county's ability to do the work of modernization. Maybe the partnerships have more capacity to change the system versus a small infusion into each health department.

Dr. Luck pointed out that Ms. Brogoitti's last sentence was important.

Dr. Luck agreed that this was especially true for the smaller counties.

Ms. Beaudrault remarked that another layer of this is what the legislature is expecting. While we all identified that most counties don't have enough to do the basics, we cannot use these funds from the legislature just to keep the doors open or to fill gaps in current funding. We really do need to be demonstrating that we are improving the public health system and setting ourselves up in a way that we are not set up right now.

Ms. Saito remarked that, based on the comments from the 18 LPHAs that were represented on the calls, it sounded like they were still willing to put some funding and possibly have OHA pull out some funding for the regional projects. If OHA agrees to that, because that's sort of what OHA had done between $5-$10 million, but if maybe we pulled out $2.5 million instead of the $5 million and left the other $7.5 million for doing the base funding plus the funding formula. It's unclear if LPHAs would think that would be enough money or if that would be enough incentive.

Dr. Dannenhoffer asked what would happened with the amount between $10-$15 million.

Ms. Saito answered that we know that there is $15 million total, and we know that at least $2 million will come to OHA for administrative expenses. That leaves $13 million. The tribes are going to be receiving funds, too. If it was $11 million or $12 million, we could take a percentage, we could still take the $2.5 million, which is half of the $5 million, or we could take a higher number. But at least we need to do that from the start, so we are doing both.

Dr. Dannenhoffer asked if we had a sense of what the OHA requirement would be and what the tribes would be funded at.

Ms. Beaudrault stated that she didn't have budget information that she could share right now.

Dr. Dannenhoffer remarked that those differences were critical. If that's $5 million, it changes the position of LPHAs very much. If it was $3 million or $2 million, that does make a difference.

Dr. Luck asked Ms. Beaudrault if in the previous biennium about 20% of the total amount went to the state and about 80% went to LPHAs.

Dr. Dannenhoffer calculated that 78% went to the LPHAs and 22% went to the state.

Ms. Beaudrault added that, going back to Ms. Saito's suggestion, the PHAB doesn't need to say how much it would go to the LPHA partnerships. That is work that OHA would do with local administrators. The concept of scaling back the funding to LPHA partnerships to figure out the critical components that should be funded regionally and then everything else up to the total amount going out to LPHAs would go out through the funding formula.

Dr. Luck stated that the general concept makes sense. What's crystalizing in his mind from this discussion is that the funding formula inherently gives the majority of the dollars to the larger counties, just because a lot of it is population-based.

Ms. Beaudrault noted that this was correct.

Dr. Luck added that we got a small amount of funding from the legislature and the recommendation of this subcommittee, supported by the PHAB, was to try and give all LPHAs an opportunity to get some of it. The result of that was inherently to give relatively more money to small counties and relatively less to large counties than it would have come through the funding formula. That was the right decision. If we went over a threshold amount of total funding and therefore switched from a model that inherently benefits small counties back to a model that benefits large counties, that would be troubling as a condition.

Dr. Dannenhoffer asked about the timeframe of knowing the OHA budget numbers and the funding allocation to the tribes.

Ms. Beaudrault answered that she couldn't give Dr. Dannenhoffer an exact week that OHA would have this information. We need to wait for the legislative session to end and we need to wait for any additional guidance from the legislature that is going to come with this funding. OHA has done some planning and it did some planning with the executive leadership from

CLHO last fall. OHA has got a starting place for what this would look like. OHA is really committed to getting this information out as quickly as possible. For Dr. Dannenhoffer and Ms. Brogoitti, there is a lot of work that needs to be done to get to the scope of work and a program element to get these dollars out. It's a months-long process. We'll need to be moving quickly over the next couple of weeks to get this started.

Ms. Drum commented that it takes some time from when the legislature adjourns and the budget information makes its way to the OHA director's budget office and to the Public Health Division's budget office. It's a process.

Ms. Beaudrault announced that she moved to the 14th slide of the presentation. From what we have heard from local administrators, it does seem like, by and large, there is support for making sure that there are some funds to support regional models or regional infrastructure to keep the work going where it is going. That is the direction that OHA is going to be moving down. OHA will be working closely with local administrators over the next few weeks to start developing the specifics around this.

Dr. Dannenhoffer noted that this was consistent with what we have heard. The devil in this one will be in the details. It would be a shame to lose some of the regional work that the counties have done before. There are a couple of nuances with that – some of the regions might want to regroup or focus on something else, some of the regions might want to go with a different county.

Dr. Dannenhoffer pointed out the three funding questions shown on a slide and invited the subcommittee to comment on the questions.

Ms. Beaudrault stated that the subcommittee has discussed the questions in various ways throughout this discussion. More comments are welcome.

Dr. Luck remarked that his feeling about question number one (i.e., Is this approach consistent with discussions and feedback to-date?) was that the answer is yes.

Dr. Dannenhoffer agreed. Ms. Saito agreed. Ms. Brogoitti agreed. Mr. Queral agreed.

Dr. Dannenhoffer asked the second funding question: Is this approach consistent with PHAB's funding principles? He thought that it was consistent.

Ms. Saito agreed. She shared that she was looking at the questions, going back and forth during the conversation.

Dr. Dannenhoffer asked the third funding question: What are the subcommittee's high-level expectations for system changes the PHAB would expect to see? He invited Ms. Beaudrault to elaborate on that question.

Ms. Beaudrault remarked that this was a very open question to hear from the subcommittee members about the most important things they want OHA to be emphasizing. For example, Dr.

Luck mentioned earlier that OHA should ensure that the extra small counties are not penalized through the funding formula and trying to equalize between the extra small and extra large counties. We have talked a little bit about local-tribal-state and making sure that each area of the governmental public health system is working together.

Mr. Queral shared that the series of discussions over the last few months have reinforced for him the notion that the subcommittee's expectations, whether high level or not, for system changes that the PHAB would like to see are so beholden to the funding and the capriciousness of the legislature to fund or not fund public health that he would love to see the PHAB engage in a conversation around a viable approach to consistent and sustainable sources of funding. Does public health throughout the state and the public health system itself have to be and stay beholden to whatever legislators want to do? Are there alternatives that would give potential control to local jurisdictions (for example, property taxes), or are there other ways of thinking about sustainably funding public health for the long run (for example, through government-issued bonds)? This is not the purview of this subcommittee and maybe it is not even the purview of the PHAB, but if we never talk about this, any high-level system change is always going to be two or three steps away.

Ms. Beaudrault noted that Mr. Queral just set the subcommittee up for its next conversation when it reconvened after the summer.

Ms. Drum proposed for Mr. Queral to facilitate the conversation.

Mr. Queral admitted that he would love to engage in that conversation. If it takes his facilitation of the conversation to happen, he would be happy to do it.

Dr. Dannenhoffer added that Mr. Queral's suggestion was very timely, because there are several counties that are really struggling.

Subcommittee business

Dr. Dannenhoffer stated that there would be no subcommittee update to the PHAB in June because of the OTC/PHAB meeting on June 20, 2019. Although the subcommittee will be on hiatus through the summer, does that allow it to make the decisions? Now it is early, and we don't know what is in the budget. Would there be more information in August about some of the discussed things? Is September too late to make that? There is the July, August, September extension for modernization, but if the subcommittee waited until September and the PHAB didn't get this until September, it's very late in the game.

Ms. Beaudrault agreed and noted that the next body of work is going to be a little bit down in the details and it's going to be between OHA and local administrators. It's going to be at a level a little bit more down in the weeds than what the PHAB normally works on. There may be a need to convene the subcommittee on the fly some time over the summer. We do need a couple of months for state and local [administrators] to work through all nuances the

subcommittee has been talking about today. That said, as soon as OHA has the specifics of the budget, they will be shared with the PHAB.

Dr. Luck noted that, as a member of the subcommittee, he would appreciate hearing the details when they become available. He would be interested to talk about them, if other subcommittee members would.

Dr. Dannenhoffer proposed to hold a meeting date on the calendar in August, in case the details are available then. He noted that backing from the subcommittee would be tremendously useful in later discussions.

Ms. Beaudrault agreed. OHA would be happy to do that.

Public comment

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

Dr. Jim Gaudino introduced himself as a prevention specialist, who used to be a part of the governmental public health system. He has been tracking this issue and talking to legislators for the last few years, especially this year. According to him, Oregon's legislators still view public health as a stepchild of healthcare and the healthcare system. He thought that we had to really work on changing that perception. He liked what Mr. Queral said: we need to broaden our scope of thinking about funding public health and local communities. He's heard that from legislators. According to him, we haven't reached out and made our case to the public about why public health is different and an added value to their communities as well. Next time, we have to rethink things and this subcommittee is starting to figure out what's the best way of distributing money that, hopefully, we will get from the legislature. He applauded the subcommittee for its creative thinking. He agreed with Dr. Dannenhoffer's suggestion of separating out the funding formula and the partnership money a little bit more clearly to get local health departments the most flexibility to do their work in their communities.

Closing

Dr. Dannenhoffer thanked Dr. Gaudino for his comments and asked if there were more public comments. Hearing none, he called for a motion to adjourn the meeting.

Dr. Luck made a motion to adjourn the meeting. Ms. Brogoitti seconded the motion. The meeting was adjourned unanimously at 1:04 p.m.

Dr. Dannenhoffer stated that the subcommittee would stand adjourned and expect the timeline from Ms. Beaudrault.

The next Public Health Advisory Board Incentives and Funding subcommittee meeting will be held in August 2019.

AGENDA

PUBLIC HEALTH ADVISORY BOARD
Incentives and Funding Subcommittee

August 9, 2019
12:00-1:00 pm
Portland State Office Building, 800 NE Oregon St., Conference Room 915, Portland, OR 97232

Webinar: https://attendee.gotowebinar.com/register/3531740595390230274
Conference line: (877) 873-8017
Access code: 767068
Please do not put your phone on hold – it is better to drop the call and rejoin if needed.

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

Meeting Objectives
- Approve June 17 meeting minutes
- Discuss allocation and use of 2019-21 legislative investment in public health modernization

12:00-12:05 pm	**Welcome, introductions and updates** • Approve June 17 meeting minutes • Hear updates from subcommittee members	Sara Beaudrault, Oregon Health Authority
12:05-12:35	**Modernization funding for 2019-21** • Provide overview for how legislative investment will be allocated and used across the governmental public health system • Provide overview for how funds will be allocated to local public health authorities, based on recommendations from this subcommittee	Cara Biddlecom and Sara Beaudrault, Oregon Health Authority
12:35-12:40 pm	**Subcommittee business** • Next PHAB meeting is scheduled for August 15. Cara Biddlecom will provide overview of legislative investment. • Unless additional needs arise, this subcommittee is on hiatus through the summer.	Sara Beaudrault, Oregon Health Authority
12:40-12:45 pm	**Public comment**	
12:45 pm	**Adjourn**	Sara Beaudrault, Oregon Health Authority

2019-21 public health modernization investment

August 9, 2019

Public Health Advisory Board

Incentives and Funding Subcommmittee

Oregon Health Authority

PUBLIC HEALTH DIVISION

Office of the State Public Health Director

Goals, objectives and inputs for the work

- Goal: Utilize state general funds to build on existing investment while positioning the public health system to ensure that *all* essential public health services are *available* to every person in Oregon.
- Inputs
  - Public Health Advisory Board (PHAB) funding principles
  - PHAB guidance on use of funds, June 2019
  - Public Health Modernization Manual
  - 2016 Public Health Modernization Assessment

$15 million investment in public health modernization

- Continue and leverage the work that started in the 2017-19 biennium.
- Additional resources to continue putting public health modernization into practice and build a *public health system* for the future.

$15M public health modernization legislatively-approved budget, 2019-21

- Funding to local public health authorities: $10M
- Funding to federally-recognized tribes and NARA: $1.2M
- Funding to the OHA Public Health Division: $3.8M

OHA Public Health Division investment

- Targets the following areas:
  - Health equity and cultural responsiveness: Implements policy initiatives within PHD and implementation of LPHA health equity plans
  - Leadership and organizational competencies: Provides co-learning opportunities for PHD and LPHAs to identify new business models that advance public health modernization
  - Assessment and epidemiology: Expands data collection and reporting capacity, including data visualization; funds program evaluation and collection and reporting of public health accountability metrics
  - Communicable disease control and environmental health: Provides technical assistance to LPHAs and leverages the communicable disease response system to monitor and respond to environmental health threats

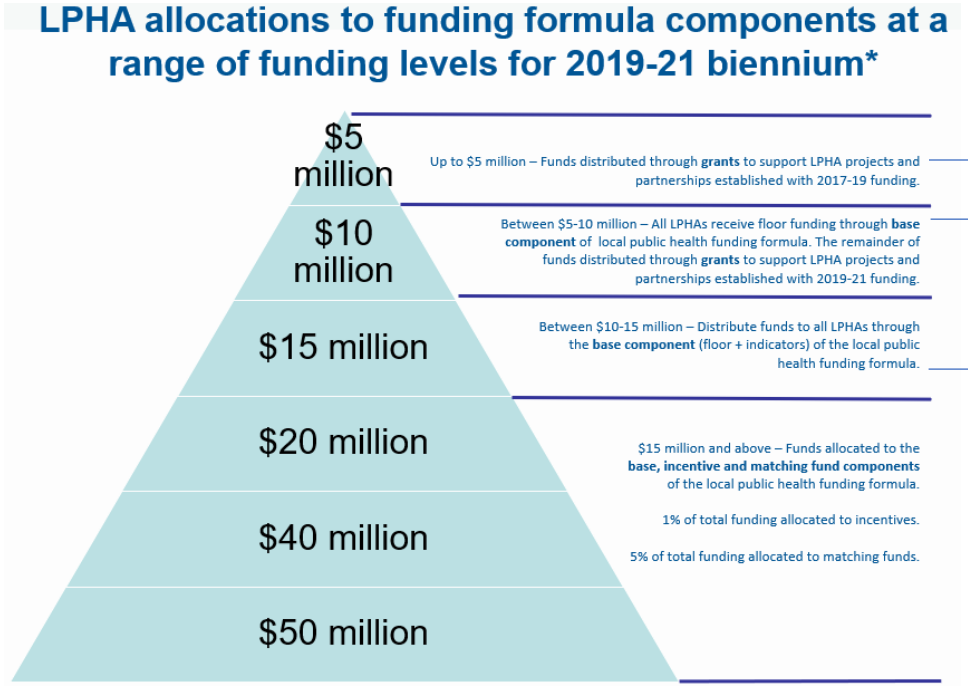
Local public health modernization investment

- $3 million will be used to continue funding Regional Partnerships.
  - Funds will support regional positions, contracts, partnerships, and infrastructure that includes and benefits all counties.
  - Existing Regional Partnerships will be prioritized.
  - Existing Regional Partnerships can change configurations, and new Partnerships can also request funding.
  - The same definition of Regional Partnerships from 2017-19 will apply (two or more LPHAs and one partner).
- The remaining $7 million will be allocated to each LPHA through the public health modernization LPHA funding formula.

PHAB Incentives and Funding subcommittee

Recommendations for public health modernization funding to LPHAs, 2019-21

June 17, 2019



PHAB recommendations for use of funding

Up to $5 million in funding to LPHAs:

1. Continue LPHA Partnerships that are currently funded.
2. Allow LPHAs that were not involved in 2017-19 to join an existing group.

Between $5-10 million in funding to LPHAs:

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

Above $10 million in funding to LPHAs:

1. Use a portion of funding to continue LPHA Partnerships established with 2017-19 funding.
2. Direct all remaining funds to each LPHA through the public health modernization funding formula.

Public health modernization LPHA funding formula - draft
2019-21 biennium
July, 2019

Total biennial funds available to LPHAs through the funding formula = $7 million

		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	1,450	$ 30,000	$ 292	$ 543	$ 138	$ 202	$ 1,588	$ 107	$ 5		$ -	$ -	$ 32,876	0.5%	0.0%	$ 22.67	
Wallowa	7,175	$ 30,000	$ 1,751	$ 1,076	$ 411	$ 725	$ 7,858	$ 530	$ 223		$ -	$ -	$ 42,576	0.6%	0.2%	$ 5.93	
Harney	7,380	$ 30,000	$ 2,492	$ 2,394	$ 846	$ 947	$ 3,581	$ 791	$ 511		$ -	$ -	$ 41,561	0.6%	0.2%	$ 5.63	
Grant	7,400	$ 30,000	$ 1,527	$ 1,661	$ 527	$ 797	$ 8,105	$ 786	$ 282		$ -	$ -	$ 43,684	0.6%	0.2%	$ 5.90	
Lake	8,115	$ 30,000	$ 2,172	$ 1,316	$ 1,043	$ 1,228	$ 5,626	$ 1,292	$ 505		$ -	$ -	$ 43,183	0.6%	0.2%	$ 5.32	
Morrow	11,885	$ 30,000	$ 2,449	$ 3,609	$ 4,055	$ 1,370	$ 5,975	$ 3,055	$ 6,496		$ -	$ -	$ 57,010	0.8%	0.3%	$ 4.80	
Baker	16,765	$ 30,000	$ 4,308	$ 2,719	$ 1,295	$ 1,905	$ 7,528	$ 1,727	$ 754		$ -	$ -	$ 50,237	0.7%	0.4%	$ 3.00	$ 5.17
Crook	22,710	$ 45,000	$ 5,711	$ 6,592	$ 2,287	$ 2,857	$ 11,939	$ 2,860	$ 943		$ -	$ -	$ 78,189	1.1%	0.5%	$ 3.44	
Curry	22,915	$ 45,000	$ 7,925	$ 6,624	$ 2,626	$ 2,642	$ 9,713	$ 2,409	$ 1,110		$ -	$ -	$ 78,048	1.1%	0.5%	$ 3.41	
Jefferson	23,560	$ 45,000	$ 6,835	$ 5,431	$ 8,140	$ 3,201	$ 16,282	$ 3,507	$ 4,157		$ -	$ -	$ 92,552	1.3%	0.6%	$ 3.93	
Hood River	25,310	$ 45,000	$ 4,092	$ 6,112	$ 7,866	$ 2,547	$ 14,470	$ 5,374	$ 13,834		$ -	$ -	$ 99,295	1.4%	0.6%	$ 3.92	
Tillamook	26,395	$ 45,000	$ 6,762	$ 6,245	$ 3,506	$ 2,855	$ 20,121	$ 2,775	$ 2,648		$ -	$ -	$ 89,912	1.3%	0.6%	$ 3.41	
Union	26,885	$ 45,000	$ 6,215	$ 4,722	$ 2,497	$ 3,619	$ 12,397	$ 2,043	$ 1,581		$ -	$ -	$ 78,073	1.1%	0.6%	$ 2.90	
Gilliam, Sherman, Wasco	30,970	$ 105,000	$ 8,070	$ 5,930	$ 6,184	$ 3,151	$ 14,077	$ 4,250	$ 6,106		$ -	$ -	$ 152,768	2.2%	0.7%	$ 4.93	
Malheur	31,925	$ 45,000	$ 7,354	$ 11,175	$ 10,615	$ 5,113	$ 16,923	$ 6,280	$ 9,277		$ -	$ -	$ 111,737	1.6%	0.8%	$ 3.50	
Clatsop	39,200	$ 45,000	$ 10,524	$ 7,410	$ 4,764	$ 4,027	$ 16,744	$ 3,468	$ 3,661		$ -	$ -	$ 95,600	1.4%	0.9%	$ 2.44	
Lincoln	48,210	$ 45,000	$ 15,049	$ 12,112	$ 7,157	$ 6,125	$ 19,853	$ 5,319	$ 4,169		$ -	$ -	$ 114,785	1.6%	1.1%	$ 2.38	
Columbia	51,900	$ 45,000	$ 11,869	$ 12,217	$ 4,911	$ 4,809	$ 24,784	$ 5,132	$ 2,514		$ -	$ -	$ 111,235	1.6%	1.2%	$ 2.14	
Coos	63,275	$ 45,000	$ 19,268	$ 16,978	$ 7,910	$ 8,278	$ 26,612	$ 6,915	$ 3,283		$ -	$ -	$ 134,243	1.9%	1.5%	$ 2.12	
Klamath	67,960	$ 45,000	$ 19,971	$ 17,820	$ 12,567	$ 9,346	$ 27,987	$ 8,913	$ 7,523		$ -	$ -	$ 149,126	2.1%	1.6%	$ 2.19	$ 2.88
Umatilla	80,765	$ 60,000	$ 17,350	$ 21,671	$ 23,138	$ 10,058	$ 25,741	$ 15,131	$ 29,336		$ -	$ -	$ 202,425	2.9%	1.9%	$ 2.51	
Polk	82,100	$ 60,000	$ 15,355	$ 14,519	$ 15,039	$ 8,262	$ 17,894	$ 7,947	$ 14,484		$ -	$ -	$ 153,500	2.2%	2.0%	$ 1.87	
Josephine	86,395	$ 60,000	$ 26,611	$ 20,126	$ 9,450	$ 12,498	$ 42,580	$ 9,801	$ 3,885		$ -	$ -	$ 184,952	2.6%	2.1%	$ 2.14	
Benton	93,590	$ 60,000	$ 12,962	$ 16,209	$ 15,194	$ 11,498	$ 19,271	$ 4,481	$ 13,598		$ -	$ -	$ 153,211	2.2%	2.2%	$ 1.64	
Yamhill	107,415	$ 60,000	$ 20,129	$ 25,022	$ 20,888	$ 9,954	$ 26,588	$ 13,081	$ 20,065		$ -	$ -	$ 195,727	2.8%	2.6%	$ 1.82	
Douglas	111,735	$ 60,000	$ 34,639	$ 31,888	$ 11,252	$ 12,931	$ 50,419	$ 12,327	$ 4,638		$ -	$ -	$ 218,095	3.1%	2.7%	$ 1.95	
Linn	125,575	$ 60,000	$ 28,856	$ 28,946	$ 15,589	$ 14,374	$ 43,461	$ 12,809	$ 9,122		$ -	$ -	$ 213,158	3.0%	3.0%	$ 1.70	$ 1.84
Deschutes	188,980	$ 75,000	$ 33,149	$ 26,275	$ 20,180	$ 16,006	$ 57,126	$ 12,785	$ 13,728		$ -	$ -	$ 254,249	3.6%	4.5%	$ 1.35	
Jackson	219,200	$ 75,000	$ 52,080	$ 49,191	$ 34,824	$ 25,275	$ 48,255	$ 24,412	$ 25,023		$ -	$ -	$ 334,061	4.8%	5.2%	$ 1.52	
Marion	344,035	$ 75,000	$ 68,536	$ 82,241	$ 100,653	$ 40,535	$ 49,361	$ 54,070	$ 128,532		$ -	$ -	$ 598,927	8.6%	8.2%	$ 1.74	
Lane	375,120	$ 90,000	$ 80,869	$ 73,659	$ 56,665	$ 45,770	$ 71,898	$ 33,187	$ 33,739		$ -	$ -	$ 485,786	6.9%	8.9%	$ 1.30	$ 1.48
Clackamas	419,425	$ 90,000	$ 74,842	$ 75,197	$ 62,993	$ 26,028	$ 83,146	$ 29,685	$ 60,938		$ -	$ -	$ 502,829	7.2%	10.0%	$ 1.20	
Washington	606,280	$ 90,000	$ 83,945	$ 98,345	$ 173,166	$ 44,487	$ 37,185	$ 54,900	$ 190,854		$ -	$ -	$ 772,881	11.0%	14.5%	$ 1.27	
Multnomah	813,300	$ 90,000	$ 162,706	$ 160,691	$ 208,288	$ 84,912	$ 11,580	$ 76,185	$ 239,142		$ -	$ -	$ 1,033,506	14.8%	19.4%	$ 1.27	$ 1.26
Total	**4,195,300**	**$ 1,860,000**	**$ 856,667**	**$ 856,667**	**$ 856,667**	**$ 428,333**	**$ 856,667**	**$ 428,333**	**$ 856,667**		$ -	$ -	**$ 7,000,000**	**100.0%**	**100.0%**	**$ 1.67**	**$ 1.67**

[1] Source: Portland State University Certified Population estimate July 1, 2018
[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: American Community Survey population 5-year estimate, 2013-2017.
[5] Source: U.S. Census Bureau, Population estimates,2010

County Size Bands

Extra Small	Small	Medium	Large	Extra Large
up to 20,000	20,000-75,000	75,000-150,000	150,000-375,(	above 375,000

Public health modernization investment to all LPHAs

- Includes requirements and menu options in three areas:
  - Leadership and governance
  - Health equity and cultural responsiveness
  - Communicable disease control

Leadership and Governance

- All LPHAs are required to participate in learning communities focused on governance.
- LPHAs must choose from one of the following menu items:
  - Developing a plan for full implementation of public health modernization
  - Developing and/or enhancing partnerships to build a sustainable public health system
  - Implementing workforce and leadership development initiatives
  - Developing and implementing technology improvements that support effective and efficient public health operations

Health Equity & Cultural Responsiveness

- Each LPHA must complete a health equity assessment and action plan.
- If the LPHA has already completed an assessment but does not have a plan, they must complete the action plan and select one additional menu item.
- If the LPHA has already completed an assessment and plan, they must select one or more additional menu items.
- LPHAs that have completed the health equity assessment may choose from the following:
  - Developing and/or enhancing partnerships
  - Co-creating strategies with communities
  - Staff training/workforce development
  - Collecting and maintaining data that reveal inequities and social conditions that influence health
  - Workforce diversity

Communicable Disease Control

- Each LPHA must conduct jurisdiction-specific communicable disease control and prevention activities, with focus on developing infrastructure.
- Each LPHA must select one additional menu item:
  - Work with partners on communicable disease control prevention
  - Workforce development
  - Utilizing communicable disease investigation and emergency preparedness systems to begin planning for environmental health threats

Tribal public health modernization investment

- Will support tribes that have not completed a public health modernization assessment in doing so, and moving towards planning.
- Will support tribes that have completed a public health modernization assessment in updating those and moving towards planning and implementation.
- Goal is to bring tribes that would like to be a part of public health modernization to the point of implementation by the end of the biennium.
- Collaborating with a tribal work group to develop scope of work and funding model

Discussion and Questions

- Is the funding approach consistent with the direction provided by this subcommittee?
- What level and type of information should be brought back to this subcommittee when it reconvenes?
- What questions do you have for OHA?

Subcommittee business

- Next PHAB meeting is scheduled for August 15. Cara Biddlecom will provide overview of legislative investment.
- Unless additional needs arise, this subcommittee is on hiatus through the summer.

Public Comment

Adjourn