AGENDA

PUBLIC HEALTH ADVISORY BOARD

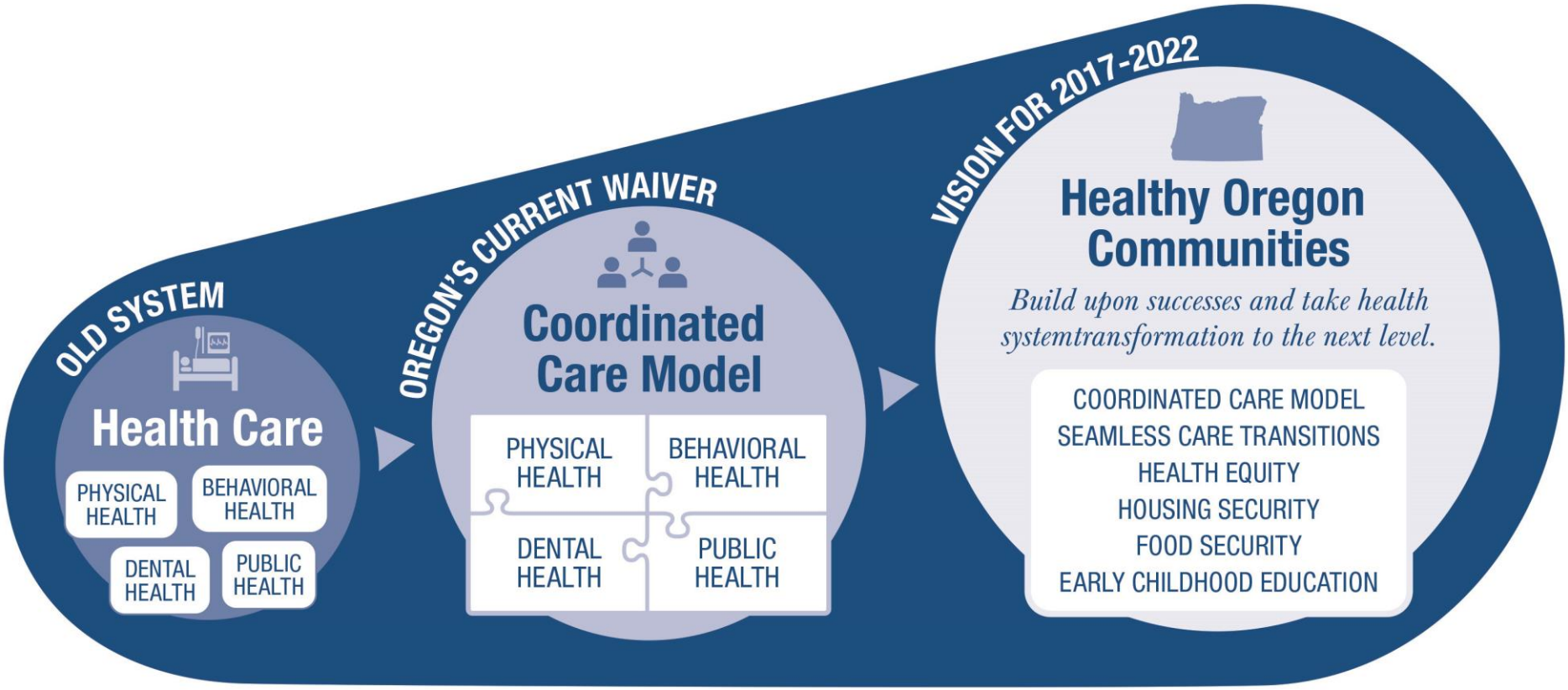
June 16, 2016
2:30-5:30 pm
Portland State Office Building, 800 NE Oregon St., Room 1E, Portland, OR 97232

Conference line: (877) 873-8017
Access code: 767068

PHAB Meeting Objectives

- Review and approve the work of the Public Health Advisory Board subcommittees
- Discuss the public health modernization assessment report and deliverables to Legislative Fiscal Office

2:30-2:40 pm	**Welcome** • Approve May 19, 2016 minutes • Approve June 3, 2016 webinar minutes	Jeff Luck, PHAB Chair
2:40-3:10 pm	**Public Health Advisory Board subcommittee reports** • Incentives and Funding Subcommittee • Accountability Metrics Subcommittee	PHAB Subcommittee members
3:10-4:40 pm	**Public health modernization assessment report and deliverables to Legislative Fiscal Office** • Discuss vision statement • Discuss modernization update report for Legislative Fiscal Office • Review public health modernization assessment report • Adopt public health modernization assessment report	Michael Hodgins, Jason Hennessy and Annie Saurwein, BERK Consulting
4:40-4:55 pm	**Break**	
4:55-5:15 pm	**Public health modernization briefing** • Discuss next steps for briefing on the report to Legislative Fiscal Office	Rosa Klein, OHA External Relations Division
5:15-5:30 pm	**Public comment**	
5:30 pm	**Adjourn**	Jeff Luck, PHAB chair



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Public Health Advisory Board (PHAB)
May 19, 2016
Portland, OR
Draft Meeting Minutes

Attendance:

Board members present: Carrie Brogoitti, Muriel DeLaVergne-Brown, Katrina Hedberg, Prashanthi Kaveti, Safina Koreishi, Jeff Luck, Alejandro Queral, Eva Rippeteau, Akiko Saito, Eli Schwarz, Lillian Shirley, Tricia Tillman, Jennifer Vines
Board members absent: Silas Halloran-Steiner, Teri Thalhofer
OHA Public Health Division staff: Sara Beaudrault, Cara Biddlecom, Dano Moreno, Angela Rowland
Members of the public: Morgan Cowling, Coalition of Local Health Officials and Charlie Fautin, Benton County Health Department

Changes to the Agenda & Announcements

No changes were made to the agenda.

Lillian announced that Joe Robertson resigned from the Public Health Advisory Board and that the Governor's Office will appoint a new Oregon Health Policy Board liaison within the next several weeks.

Approval of Minutes

A quorum was present so the Board was able to vote to approve the April 21, 2016 minutes. All members approved the minutes with the request to provide more high level summaries of discussions on subsequent meeting minutes and provide a link to the meeting video if recorded.

The Board voted to approve the May 10, 2016 webinar minutes with the addition of Eli Schwarz as an attendee.

Preventative Health & Health Services Block Grant Work Plan

– Lillian Shirley, OHA Public Health Division Director

Lillian presented the Preventative Health & Services (PHHS) Block grant work plan with a request from the Board to vote on its approval. In 2016 the Public Health

Division aligned the work plan with three additional Health People 2020 objectives and integrated work with Tribes throughout the work plan. The overall goal is to support planning and implementation of public health modernization.

The grant is federally funded with standardized amounts distributed each year. Funding remains flat.

Alejandro asked what framework was used to allocate these funds. The Block Grant goes to support infrastructure across the public health system, foundational responsibilities and enterprise-level work across the state.

Eli asked how counties gain access to the grant for programmatic activities. Muriel replied that the Block Grant supports the infrastructure for the entire public health system and largely does not support program-level work.

Eva commented that this block grant work could be reviewed by the Board with a health equity lens.

The Board voted on the work plan provided with all in favor.

Public Health Modernization Work Plan
– Cara Biddlecom, OHA PHD Interim Policy Officer

Cara provided an overview of the public health modernization timeline. This timeline was provided to the Board to review the scope of activities the PHAB, PHD and LPHAs will be working on in the upcoming months. PHD has received legislative guidance for the report due to Legislative Fiscal Office by June 30, 2016. The report should include a comprehensive yet flexible plan for how public health modernization should be implemented, including how to scale up over subsequent biennia.

PHD will co-host an opportunity with Representative Greenlick for legislators to learn about the modernization assessment report and modernization plan in early July. PHAB members can join this meeting, and Jeff suggested that PHAB could share information about the work of the Board with legislators at this time.

Key informant interviews are being held with public health leaders and champions to develop a public health modernization vision statement. PHAB will receive a draft in early June.

The partnership and outreach plan includes working with County Commissioners, legislators, CCOs and health system partners, early learning hubs and Tribes. For some of these groups, outreach plans are still being formulated but for others, like Boards of County Commissioners, outreach is already occurring.

PHD is consulting with local public health administrators for guidance on the most appropriate timeline and process for engaging with Boards of County Commissioners. Cara and Muriel reported that so far, outreach with Commissioners has been generally well-received, with many Commissioners expressing a willingness to support this work.

PHD is working with Innovator Agents for guidance on working with CCOs. Cara is hopeful that PHAB members will also help make connections with the early learning hubs. Muriel explained her approach will be to use any joint Commissioner meetings with the head of the Education Service District to provide a modernization presentation. She also suggested that public health modernization should be placed on the agenda for the Association of Oregon Counties annual meeting in November.

Eva asked how the modernization vision is being presented. To date, conversations have been framed in terms of healthy communities and fair access for everyone.

Board members asked about their role to act as spokespeople and requested that staff send board members a public health modernization PowerPoint slide deck and other available materials. Board members discussed opportunities for them to share information within their communities.

Alejandro suggested the Board should consider health equity and population disease burden in counties with a significant Tribal population.

Alejandro asked about the approval process for the funding formula. OHA must submit a funding formula to the Legislative Fiscal Office by June 30 of every even year to inform the State budget. In this first year, OHA and PHAB will likely need to revise the funding formula after any state funds have been allocated.

Cara reviewed the draft public health modernization report for Legislative Fiscal Office. The highlighted areas throughout the document are placeholders. The report includes a summary of the work completed so far, the draft funding formula, and information about the accountability measure framework. Jeff stated that this report provides the context for the assessment report, as was requested at the April PHAB meeting. Jeff requested that PHAB members review this document and provide comments.

Public Health Advisory Board subcommittee reports
– Alejandro Queral, Incentives and Funding Subcommittee chair

The funding formula has three components: baseline amount, method for awarding matching funds, and the use of incentives. The subcommittee is looking at how to target limited dollars to have the greatest impact and use funds in an equitable way. The next subcommittee meeting is June 15th. The funding formula will be presented to PHAB at the June 16th meeting.

PHAB members discussed the table showing county general fund contributions for public health, grouped by quartiles. Tricia cautioned against making assumptions about which counties provide more or less general funds for public health (i.e., rural, frontier, urban or suburban) and requested that counties be identified. Carrie stated that counties have to make decisions about what to fund, and a lack of funding for public health does not mean that public health isn't valued.

Alejandro stated that the task is to incentivize counties that have low distribution of general funds for public health. PHAB members discussed whether health outcomes can be tied to spending. County Health Rankings could be used to compare spending and health outcomes. Tricia stated that there should be careful messaging around tying spending to health outcomes. There are nuances within

each county that influence the health of the community outside of spending. Jeff stated the social determinants of health will need to be considered.

– Cara Biddlecom, OHA PHD Interim Policy Officer

The Accountability Metrics Subcommittee held their first meeting on May 12. Cara explained how the measure criteria questions were used to guide the discussion to develop this framework. The subcommittee recommends focusing on outcome measures first, and then process measures. Measures will be framed around foundational capabilities and programs. The subcommittee also discussed setting performance targets for each health department based on current rates. The subcommittee also discussed having a core measure set for state and local health departments in addition to locally selected measures based on community health improvement plans.

Tricia noted that health equity is a theme for the work of both subcommittees and expressed concern about the timeline for the subcommittees to submit deliverables while addressing the complexities and data gaps related to health equity. Board members discussed forming a standing health equity workgroup that would include PHAB members and external members. Eli recommended that Office of Equity and Inclusion (OEI) present to the Board at an upcoming meeting. The health equity committee work group proposal could be placed on next month's PHAB meeting agenda.

Public health modernization assessment

-Annie Saurwein, BERK Consulting

Annie provided a detailed look at the methodology for preparing the draft Public Health Modernization Assessment Report. The report was created to determine to what extent the roles and responsibilities of public health modernization are being met today and the resources needed to fully implement public health modernization.

Jeff suggested creating a map of how the Public Health Modernization Manual is tied to the functional areas in the Public Health Modernization Assessment Report. Annie stated there is a table for each foundational area that includes the

roles and deliverables from the Public Health Modernization Manual that fall under that functional area. The functional areas are defined in Appendix B.

Eli stated that this assessment is very detailed and asked how this will be presented to legislators. Annie commented that BERK Consulting will develop an executive summary with key findings, and the full report could be used as an additional reference for the executive summary.

BERK Consulting determined the self-assessment scoring across two dimensions: provider level of implementation and population level of service. Each score was placed in six categories based on expertise and capacity. Alejandro asked about the mid-range categories: partially implemented with low capacity and partially implemented with low expertise. Annie stated that the differences for these categories are primarily in how the gaps would be filled. Jeff requested that examples be included in the report to describe what different colors on the grid mean.

Tricia asked if this report includes findings for both the state and local public health departments and if the funding gaps for state and local are similar. The report does include findings for both state and local public health and shows the interdependencies between the state and local departments.

Safina asked about how local public health authorities responded on the assessment for areas where community organizations provide assistance to fill a gap. Tricia stated that her county accounted for services they provide or contract for and did not address what other organizations provide. Muriel stated that there are few community-based organizations in her county.

PHAB members discussed the need for clear communication about these results. Annie stated that BERK is developing a decision-making framework so report findings can be used moving forward with changing conditions and available funding. Jeff stated that this report makes clear that public health modernization is not one item with one price tag, but a set of needs. Annie replied that while this could be seen as menu of options, the functional areas and resource needs are highly interdependent.

PHAB members stated that the resource need graphics are not intuitive and requested that this information be presented differently. They would like to see the relationship between state and local gaps in order to look at the system as a whole.

The text in the Public Health Division sections of the report detail the scale of the activities provided in relationship to the entire system, with a detailed breakdown of the less implemented state roles and deliverables. The local public health authority text presents the scale of the gap between current level of service and future need and the proportion of the population served. This local public health authority sections were also used to share non-financial barriers to implementation. The roles and deliverables tables explains every role and deliverable by degree of implementation and by population of service.

Alejandro commented that the non-financial barriers should not be provided at this stage of the modernization presentation process because it is difficult to discern if a response was provided by one local public health authority or many, and barriers may be subjective.

Jeff asked what type of information the Board should provide about this report. Cara stated that BERK would like concrete feedback on the presentation of the results in the draft report.

Eli commented that this information is very detailed and suggested that BERK create a concise executive summary for the report. Jeff commented that the schedule is very aggressive and the date the information is due to Legislative Fiscal Office is fixed. Tricia asked what is the minimum information needed to the legislators by June 30th. She wants this to be created carefully and thoughtful of the message. Cara stated that the policy implications coming forward from the assessment results need to be determined by the PHAB and reflected in the report to Legislative Fiscal Office.

Annie recommended the Board provide details on the overall cost analysis and how it should be presented and policy implications that are powerful and should be in the forthcoming executive summary.

Jeff stated that one global comment was that non-financial barriers could be subjective versus representative of the entire system. Annie stated she will change the non-financial barriers that have been summarized or appear to be generalizable to all local public health authorities.

Cara proposed sharing a summary of the draft report findings and proposed policy implications for discussion at a webinar to be scheduled during the first week of June. Discussion at the webinar can formulate the executive summary to accompany the report.

Public Comment Period

No public comments were made.

Closing:

The next Public Health Advisory Board meeting will be held on:

June 16, 2016
2:30pm – 5:30 p.m.
Portland State Office Building
800 NE Oregon St., Room 1E
Portland, OR 97232

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Angela Rowland at (971) 673-2296 Or angela.d.rowland@state.or.us. For more information and meeting recordings please visit the website: healthoregon.gov/phab

Public Health Advisory Board (PHAB)
June 3, 2016
Portland, OR
Draft Meeting Minutes

Attendance:

Board members present: Carrie Brogoitti, Muriel DeLaVergne-Brown, Prashanthi Kaveti, Jeff Luck, Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Tricia Tillman, Jennifer Vines

Board members absent: Silas Halloran-Steiner, Safina Koreishi, Alejandro Queral, Akiko Saito, Lillian Shirley, Katrina Hedberg

Oregon Health Authority staff: Sara Beaudrault, Cara Biddlecom, Steven Fiala, Dano Moreno, Angela Rowland

Guest presenters: Jason Hennessy, Michael Hodgins, and Annie Saurwein, BERK Consulting

Members of the public: Jan Johnson, The Lund Report, Catie Thiesen, Oregon Nurses' Association, Morgan Cowling, Coalition of Local Health Officials, Kellie DeVore, Planned Parenthood of Southwest Oregon, MaiKia Moua, Benton County Health Department, Rebekah Bally, Oregon Health Care Quality Corporation, Katherine McGinness, Oregon Health Authority, Kelly McDonald, Kelly McDonald LLC, Abdirahman Omar, Estela Gomez, Oregon Health Authority, Laura McKeane, AllCare Health Plan, Pat Luedtke, Lane County Health Department, Belle Shepherd, Oregon Health Authority, Lynn Knox, Oregon Food Bank

Welcome and Introductions

This meeting was designed to be an informational webinar for Public Health Advisory Board members. No motions were put forward during the meeting for a vote.

Steven Fiala provided an update on the key informant interviews. The stakeholders included PHAB members, the legislature, local public health, and health systems. They were asked to provide feedback on draft communications

materials. Five interviews have been completed. Some preliminary findings were as follows: 1. Need for a concise vision to see modernization of public health in a tangible way by calling out language related to foundational programs; 2. Need to change a few key phrases, i.e. bedrock, fair shake; 3. Need to reference current issues, e.g. Zika virus, Cascadia Subduction Zone planning.
Next steps will involve finishing up the last few key informant interviews, revising the vision statement with the OHA communications officer, and setting up a conference call with all interviewees to further discuss the vision statement.

Eli asked where members can find the vision statement. Cara informed that it was sent out on May 20th via email.

Eva provided the Early Learning Council design team's goal statement from 2011, "Ensure that every Oregon child enters school ready and able to learn and is reading in first grade. Integrate and align state resources with outcome structures and expectations to meet these goals." She commented that this statement is simple and the Modernization vision statement could mirror this concept.

Jeff inquired when will PHAB members expect to see the updated version of the vision statement that reflects the stakeholder input and edits. Cara replied that it will be provided at the next PHAB meeting on June 16th for discussion. OHA will then take written board member comments via email thereafter.

Public Health Modernization Assessment Report

Jason Hennessy, Michael Hodgins, and Annie Saurwein, BERK Consulting

Annie provided an overview of the updates and edits made to the public health modernization assessment report. The assessment will be made up of three areas:

1. The executive summary will be only a few pages, highlighting key findings, policy implications, and phasing that can be used as a standalone document.
2. The summary report will include the background, assessment overview, overall results, policy implications, and phasing considerations.

3. The full detailed assessment report will catalog all results from the report. BERK is in the process of streamlining writing, rewriting the barriers section, and will update the graphics according to the feedback received so far.

Annie noted a correction made to the Public Health Division's current spending. In the full report draft, a $21M communicable disease control program that shouldn't have been counted as a part of public health modernization was inadvertently included. Removal of that $21M decreased the Public Health Division's current spending in communicable disease control accordingly. Additional refinements led to the total additional need dropping by $1.5M.

Tricia made a comment that the slide Annie presented for Updated Cost of Full Implementation had a numerical error. Annie determined that it was due to a sorting issue and will be corrected and sent out before the June 16th meeting.

A global edit made was to remove the second waffle chart which was replaced by a bar chart. Eli commented that it would make more sense to him if all 3 bars had the same scale in percentages. Tricia stated that local public health authorities may be ranking themselves as less than half on a 1-10 scale. It overestimates the capacity and expertise for local health authorities. The 5/5 area shows partial implementation when it should not. Annie added that the scale has been updated with the degree of implementation and population service language. Jason commented that less than 4% of the responses ranked at 5/5 out of the 10 scale, so if you moved this it would not show an overrepresentation in either group. Jeff requested that Jason's comment be added to the report text.

The next global edit made was that the resource graphics were contextualized to make them more intuitive. Jeff asked if the grey boxes will be same on each page. Annie stated that for each state page they will be the same and for each local public health authority page will have the same amount of boxes. This represents overall current spending and full implementation and additional increment with the share of each program out of the overall. Eli inquired on what the figure at the bottom of each set of grey boxes represents. Annie informed that in this example on slide 8, it represents the state share of current spending, full implementation, and additional increment. Tricia stated that this graphic adds

confusion. Annie stated that each box equals to $500,000. Annie offered to add a legend that explains what each grey box means.

Annie explained that BERK added to the overall assessment results to compare the foundational capabilities and programs to see trends. She also displayed a new graph on page 17 of the draft summary assessment report. There it explains the distribution of unmet costs across all foundational programs and capabilities for the state and local public health authorities. Annie stated they will add a legend to explain the different shades of teal. Eli asked that a description of the percentages of funding be added to the graphic. Jeff recommended adding the dollar amounts to this graph. Tricia pointed out a potential risk to showing what the state's unmet need is versus the local public health authority's unmet need, in that the initial investment might go towards the state level instead of the local level if it is split out. Tricia requested a narrative around the large gap in capacity at the local level versus the state level. Teri expressed the need to articulate a full public health system perspective. Eva suggested that the unmet costs be placed side by side to what is currently being spent. The Incentives and Funding subcommittee could discuss this topic at the next meeting on June 15.

Eli pointed out that the graph on page 16 states Cost of Additional Increment of Service and on page 18 it is described as unmet costs. Eli would like to see consistent language to make the report more intuitive. Jeff asks that the narrative includes that PHAB recommends funding towards local public health departments and not just the state.

Annie proceeded to explain the level of implementation graph on page 18. This graph displays the patchwork quilt concept – that there are different needs in each public health authority. Each public health authority is a column. The determination was made to add size bands to these graphics so more detail could be provided without naming specific local public health authorities.

Annie discussed the three new graphs on pages 19, 20 and 21. She provided an example of the communicable disease control and environmental public health share of activities graphics on page 22. Eli asked clarifying questions on the percentages. Annie stated they will need to be updated.

Annie then explained the summary findings on page 28. Jeff commented that the remaining pages from 29-37 are the summary in text of what BERK thought were the important policy implications. PHAB members should provide feedback on these pages with as much review as possible. These comments should be provided via email by the end of the day Monday, June 6. Tricia asked about placing the summary findings in the front of the document. Annie stated that the executive summary is forthcoming. Tricia and Jennifer felt hat the executive summary should be closer to two pages. Jennifer stated that the summary findings discussed process was light on conclusions. For example, that there is a large unmet need at the local level and for the state most of the unmet need is at the program level. Also, the size of the jurisdiction doesn't necessarily determine capacity. Jeff encouraged these types of conclusions and comments to be put in writing. Eva clarified the full implementation cost is annual rather than biennial. Eli commented that biennia and biennium need to be used in the correct context.

Annie discussed the phasing considerations from pages 34 and 35. Eli noticed that the planning for the assessment and the initial implementation is not calculated in the estimated unmet needs. Cara states that these costs could go into the leadership and organizational competencies foundational capability. Eli suggests to add case studies of examples of how the work is getting done and how phasing could take place. Jeff added that in addition to the BERK report the Public Health Division will have their own narrative document. Tricia shared that Multnomah County was asked to assess capacity around environmental health, and since then there have been many additional unanticipated environmental health needs. The assessment was based on what they currently knew, but not the unknown. Tricia asked if there is a way to see in the triennial review process what gaps the counties are having. Cara will connect with Danna Drum to see what key triennial review findings are for the state.

Cara requests input from the board on the phasing considerations. Please send all written input to PublicHealth.Policy@dhsoha.state.or.us.

Public Comment Period

Les Ruark, Written Testimony

The planned webinar access notwithstanding, for the public to have any *real* opportunity to review and offer *meaningfully arrived at* comment on the draft policy recommendations the PHAB is to consider Friday, the draft recommendations needed to be posted yesterday, actually last week.

Here it is three days away from the meeting and the draft recommendations, as best I can tell, are still not posted. And, if they've been disseminated to board members the same communication hasn't been made known or available to interested persons.

For what it's worth (and said with an understanding of the need to keep the momentum of interest in gear, as well as a genuine respect for staff's work) I believe the PHAB is just plain moving this front along too fast.

From this point forward, the board needs to slow the pace down a little and ensure there *truly is* actual time for interested persons to a) obtain and review future draft recommendations, and b) prepare and submit comment on them.

I ask that this communication be made a part of the PHAB's meeting record Friday.

Closing:

The next Public Health Advisory Board meeting will be held on:

June 16, 2016
2:30pm – 5:30 p.m.
Portland State Office Building
800 NE Oregon St., Room 1E
Portland, OR 97232

If you would like these minutes in an alternate format please contact Angela Rowland at (971) 673-2296 or angela.d.rowland@state.or.us. The handouts from this meeting as well as the minutes will be posted on our website: healthoregon.org/phab.

PUBLIC HEALTH ADVISORY BOARD
DRAFT Incentives and Funding Subcommittee Meeting Minutes

May 17, 2016
2:00-3:00 pm

Portland State Office Building, 800 NE Oregon St., Room 918, Portland, OR 97232
Conference line: (877) 873-8017
Access code: 767068

Meeting chair: Alejandro Queral

PHAB subcommittee members present: Silas Halloran-Steiner, Jeff Luck, Alejandro Queral, Akiko Saito, Tricia Tillman

PHAB subcommittee members absent: none

OHA staff: Sara Beaudrault, Cara Biddlecom, Chris Curtis

Members of the public: Morgan Cowling, Coalition of Local Health Officials and Stacy Michaelson, Association of Oregon Counties

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Welcome and introductions - Cara Biddlecom, OHA Public Health Division

Approval of minutes – Alejandro Queral
Subcommittee members voted to approve the April 18, 2016 subcommittee meeting minutes.

Subcommittee work plan – Alejandro Queral
Alejandro reviewed the activities and deliverables for future meetings. A draft funding formula will be submitted to Legislative Fiscal Office by June 30, 2016, and developing the funding formula is the main deliverable for this subcommittee over upcoming meetings.

PHD staff provided clarification for work plan activities related to the Program Design and Evaluation Services economic analysis and health outcomes report, expected to be published in September. This report will look at health outcomes that could be expected if foundational capabilities and programs are fully implemented. When this report is available, the subcommittee will review the funding formula to determine whether changes should be made as a result of the economic analysis and health outcomes report.

PHD staff also provided clarification on subcommittee activities following the 2017 legislative session. Currently there is a placeholder on the work plan in case there is a need for the subcommittee to review the funding formula after it is known whether funding will be allocated by the legislature to support public health modernization.

Tricia asked why the work plan does not include activities related to seeking additional sources of funding, as was discussed during the April subcommittee meeting. Since the April meeting, OHA has received guidance from the legislature about the specific deliverables that need to be completed this summer. The funding formula needs to be submitted to Legislative Fiscal Office by June 30. Given this guidance, the subcommittee needs to focus on developing the funding formula over upcoming meetings. It was requested that activities related to seeking additional funding sources be added to the work plan.

Action item:

- Add seeking additional funding sources to the work plan as an activity for this subcommittee, pending guidance from PHAB.

Funding formula guidance document and supporting materials – Subcommittee members

Per House Bill 3100 Section 28, each biennium OHA must submit a funding formula that provides for the equitable distribution of moneys to local public health authorities for foundational capabilities and programs. The funding formula must include a baseline amount, a method for awarding matching funds and the use of incentives.

This subcommittee will make recommendations for how funds will be allocated across each of these three components, appropriate data sources, and mechanisms for awarding matching funds and incentives. The subcommittee will consider the interplay among each component as it relates to equity.

Alejandro asked whether the PHAB Accountability Metrics subcommittee will also be making recommendations for data sources. The Accountability Metrics subcommittee will focus on the incentives component of the funding formula and will develop a set of accountability metrics. The two subcommittees may work together to make recommendations for a mechanism to award incentive payments to local public health authorities.

Health equity

Tricia asked whether the subcommittee has the latitude to look at equity more broadly across all components of the funding formula, and not just where it is referenced in the bill. Nothing in the bill precludes using equity as a factor in decisions made for other areas of the funding formula.

Alejandro proposed including health equity as a driver for baseline funding. Burden of disease and health outcomes are areas where disparities are seen that are most likely to affect health.

HB 3100 does not define equity. Equity is referenced in terms of incentives, health outcomes, workforce, service provision and funding. The subcommittee will also look to the definition of health equity that is included in the Public Health Modernization Manual.

Other funding sources
Subcommittee members asked whether this funding formula is to be used for existing Program Element funding. This funding formula is intended for new monies allocated by the legislature for foundational capabilities and programs. This funding formula could be used for other funding sources; however, OHA would need to be cognizant of specific federal funding requirements for different funding sources and adhere to those requirements. A more detailed process is required to individually examine how aspects of the funding formula could apply to federal funding streams.

Tricia asked whether the requirement for OHA to work with CLHO committees to change funding formulas is still in place. Morgan replied that the requirement was removed in HB 3100.

Tricia asked whether competitive grants are still allowable. Yes, this is covered in Section 28(5).

State/local split
Silas asked what HB 3100 includes related to state/local split for new monies allocated to foundational capabilities and programs. This is not included in the sections of the bill pertaining to the local public health funding formula and is not a piece of the funding formula to be submitted to Legislative Fiscal Office in June.

The subcommittee reviewed the document showing FY15 county general fund contributions to support public health by quartile. Subcommittee members requested more detail, either by county, or including population size. Silas noted the potential impacts of applying a different percent match for different quartiles.

Tricia requested the total annual amount of funding to counties by PHD, and the amount or percent that stays at the state. Some of this information will be included in the draft Public Health Modernization Assessment Report.

Action items:
- Provide definition of health equity that is included in the Public Health Modernization Manual.
- Tricia and Jeff to explore equity definitions or frameworks that might be applicable.
- Talk with BERK Consulting about modernization assessment drivers. Explore feasibility and usefulness of incorporating BERK assessment report drivers in funding formula.
- Provide additional detail for county general fund contributions.
- Provide information about total amount currently distributed to local public health authorities through Program Elements and include information about state/local split from the draft Public Health Modernization Assessment Report.

Funding formula framework
The subcommittee reviewed a framework for the funding formula which includes the three components: baseline, matching funds and incentives.

Jeff noted that the percent allocated to each of the three components of the funding formula could be changed over time and referenced how incentive payments to CCOs are increased each year.

When looking at a method for awarding matching funds, the subcommittee should consider the impact on small/large or urban/rural counties.

Alejandro requested additional factors to be considered for baseline funding: for example, primary language, health disparities, housing, disability.

Silas commented that the subcommittee should be considering all sources of funding, not limited to new moneys allocated by the legislature.

The subcommittee requested that a set of principles be developed to guide the development of the funding formula.

Action items:
- Add guiding principles to funding formula guidance document
- Explore whether population drivers included in the public health modernization assessment can be applied to the baseline component of the funding formula; are there algorithms that could be applied?
- Remove sample percentages from the funding formula framework; instead, use __% to indicate where percentages need to be filled in.

5/19 PHAB meeting
The subcommittee agreed to share the funding formula guidance document, funding formula framework and county general fund contributions to support public health during the subcommittee update at the 5/19 PHAB meeting.

Alejandro will give the subcommittee update.

Organizational business
Silas will chair the June meeting.

Public comment
none

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics Subcommittee Meeting Minutes

June 9, 2016
1:00 – 2:00pm

PHAB Subcommittee members in attendance: Muriel DeLaVergne-Brown, Eva Rippeteau, Eli Schwarz, Teri Thalhofer

PHAB Subcommittee members absent: Jennifer Vines

OHA staff: Sara Beaudrault**,** Cara Biddlecom, Angela Rowland, Joey Razzano

Members of the public: Kelly McDonald, Kelly McDonald, LLC, Laura Moses, Multnomah County Health Department, Kathleen Johnson, Coalition of Local Health Officials.

Welcome and introductions: The May 12 draft meeting minutes were unanimously approved by the subcommittee.

Review measurement structure proposal from May 12 meeting
Cara reviewed the decisions on the measure criteria questions discussed at the last meeting.

Eva asked if there had been process measures identified. An example of a process measure is the number of policies determined. Identification of actual measures will be the next step in our process

Teri commented that process measures are used for county work plans because health outcomes change very slowly. For example: reduce tobacco use by 3% is a large undertaking so the process measures help move the outcomes along the way.

The subcommittee agreed it was important to use both process and outcome measures.

The subcommittee agreed that the framework should align with the foundational programs and capabilities.

Cara reviewed the list of criteria for measure selection. Eli is concerned with the large number of measurement principles. The subcommittee decided to break the principles into two categories: “must pass” and “additional principles”. In lieu of “flexible”, wording was changed to “respectful of local health priorities”. The subcommittee placed the following criteria in “must pass”: promotes health equity; respectful of local health priorities; transformative potential; consistency with state and national quality measures; and feasibility of measurement. The remaining were retained as “additional principles”.

Cara reviewed the discussion from the May 12 meeting about measure application. Subcommittee members agreed that measures should be applied with individual improvement targets based on current data. Subcommittee members agreed that there

should be a core measure set for the state and local health departments with locally selected measures derived from community health improvement plan priorities.

Existing measure sets to be used to populate measure matrix

Cara presented the list of existing measure sets for state and local health authorities.

Muriel shared that County Health Rankings are not helpful since the measure specifications change every year and not all counties get ranked. This makes it difficult to track progress over time. Muriel reiterated that data that Oregon already has are used for County Health Rankings, so it would be possible to use similar measures but calculate them the same way over time.

Teri shared that the University of Washington has a set of measures for chronic disease, communicable disease and environmental health: http://phastdata.org/measures.

Cara asked if the county health rankings should be removed from the list, and suggested that the subcommittee review the state health profile indicators compared to the county health rankings data in a future meeting.

Coordinated care organization incentive measures include 18 measures but only a small number are related to the role of public health. Eli has reviewed the coordinated care organization incentive measures for what would be applicable to public health will send his thoughts on these measures to Cara. Muriel stated that a lot of these measures are clinical in nature.

The subcommittee discussed the large number of measures being collected and reported and the need to be mindful of this context as measures are selected.

The subcommittee agreed to start by identifying what health care and education measures are relevant for public health at the next meeting, before populating state and national public health measures.

Review measure matrix

Cara reviewed the measure matrix created for the subcommittee. Eli requested adding a label to the foundational capabilities and programs.

Public comment
Kathleen Johnson, Coalition of Local Health Officials

Kathleen shared information about public health activities and services tracking (PHAST) data. There is a lot of crossover between public health accreditation and these process and outcome measures. Washington State is going through a similar

modernization process with this research performed by the University of Washington. The measures can compare county by county. This data could help compare our process with another state. The components include: physical activity, communicable disease, environmental health, obesity, and maternal health measures.

For more information please reach out to Dr. Betty Bekemeier who serves as the lead on this project. Kathleen can send out research studies that have looked at the effectiveness of public health delivery as it relates to cross jurisdictional sharing. http://phastdata.org/measures

Adjournment

Eva has agreed to report back to the Board on June 16 regarding today's meeting.

The meeting was adjourned.

Oregon Public Health Advisory Board – Accountability Metrics Subcommittee

Measure selection criteria

June 9, 2016

1. **At what level should measures be selected?**
    a. Outcome: impacts of the public health system's activities on health
    b. Process: activities the public health system does

2. **How should the measures be framed?**
    a. Foundational programs
    b. Foundational capabilities

3. **What principles should be applied to measure selection? *(adapted from coordinated care organization measurement principles)***

    Must pass principles:
    a. Promotes health equity
    b. Respectful of local health priorities
    c. Transformative potential
    d. Consistency with state and national quality measures, with room for innovation
    e. Feasibility of measurement

    Additional principles:
    f. Consumer engagement
    g. Relevance
    h. Attainability
    i. Accuracy
    j. Reasonable accountability
    k. Range/diversity of measures

4. **How should measures be applied to state and local public health authorities?**
    a. Individual performance targets based on the jurisdiction with incremental improvement over time for all
    b. Core measure set for the state with locally selected measures derived from community health improvement plan priorities

OREGON'S PATH TO PUBLIC HEALTH MODERNIZATION

Oregonians believe in fairness. We want good health for ourselves and our families. Fairness means a healthy life is within reach for all of us—whether we live in small towns or big cities, east or west of the Cascades.

"I believe that every citizen in Oregon has the right to be covered by a public health system that includes all the elements of a modern public health system and that is true in downtown Portland and in Enterprise and in Coos Bay. Right now it's not true, there is great variation in what's available to protect the health of people in different parts of the state. We all deserve to have a government that protects us when we need protecting."

Eighty percent of the factors that shape our health happen outside of a doctor's office. This is the domain of public health, and right now, our communities are not equally equipped to support our health where we live, work, learn and play. We need to upgrade our public health system in ways that recognize how our physical environment, social and economic conditions, and health behaviors affect us. Because together, these day-to-day realities play the biggest role in determining how healthy we can be.

Modernizing public health in Oregon requires a full-system upgrade. This effort must capitalize on partnerships in order to equip every community with the same essential skills and programs to:

- protect all people in Oregon from communicable disease,
- keep our air and water clean,
- counter the harmful impact of chronic disease,
- and, ensure that everyone has access to quality health care.

Modernized public health is critical to Oregon's movement toward health system transformation: better health and better care at a lower cost. But for people in Oregon, it's even simpler than that: **A healthy life, within our reach.**

PHASE ONE: THE ROAD SO FAR

2015

JULY	DECEMBER
State and local public health officials define the bedrock skills and programs critical for a modernized public health system.	Public Health Modernization Manual published. This defines the core roles and deliverables for state and local public health authorities and will guide day-to-day work.

2016

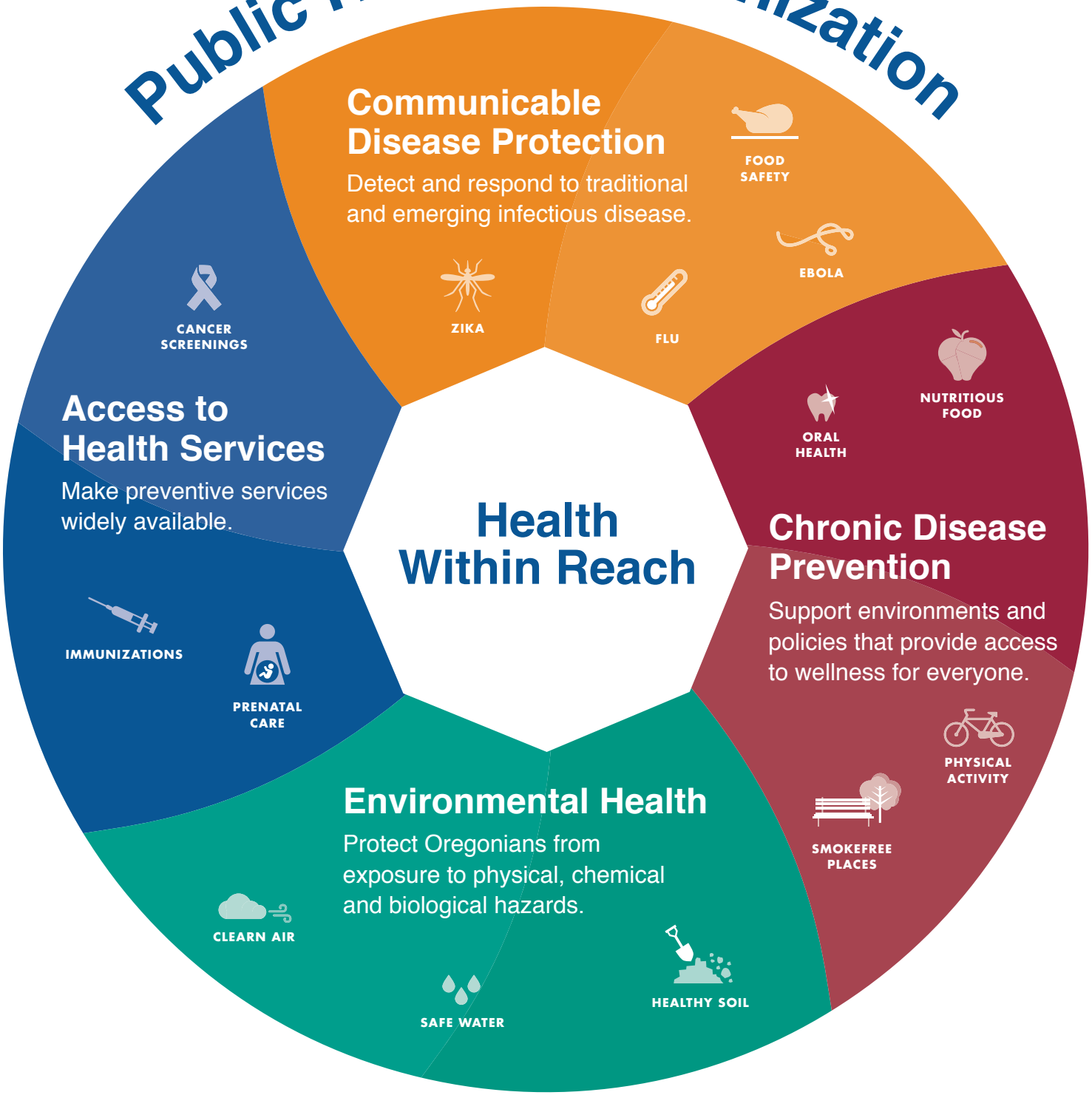
JANUARY	FEBRUARY	APRIL
Public Health Advisory Board is established to advise on statewide public health policy.	Oregon is awarded a grant from the Robert Wood Johnson Foundation to fund regional meetings, tool development and technical assistance to develop local modernization plans.	State and local health departments assess how many modernized public health skills and programs they currently provide.

PHASE TWO: WHAT'S NEXT

2016-2023

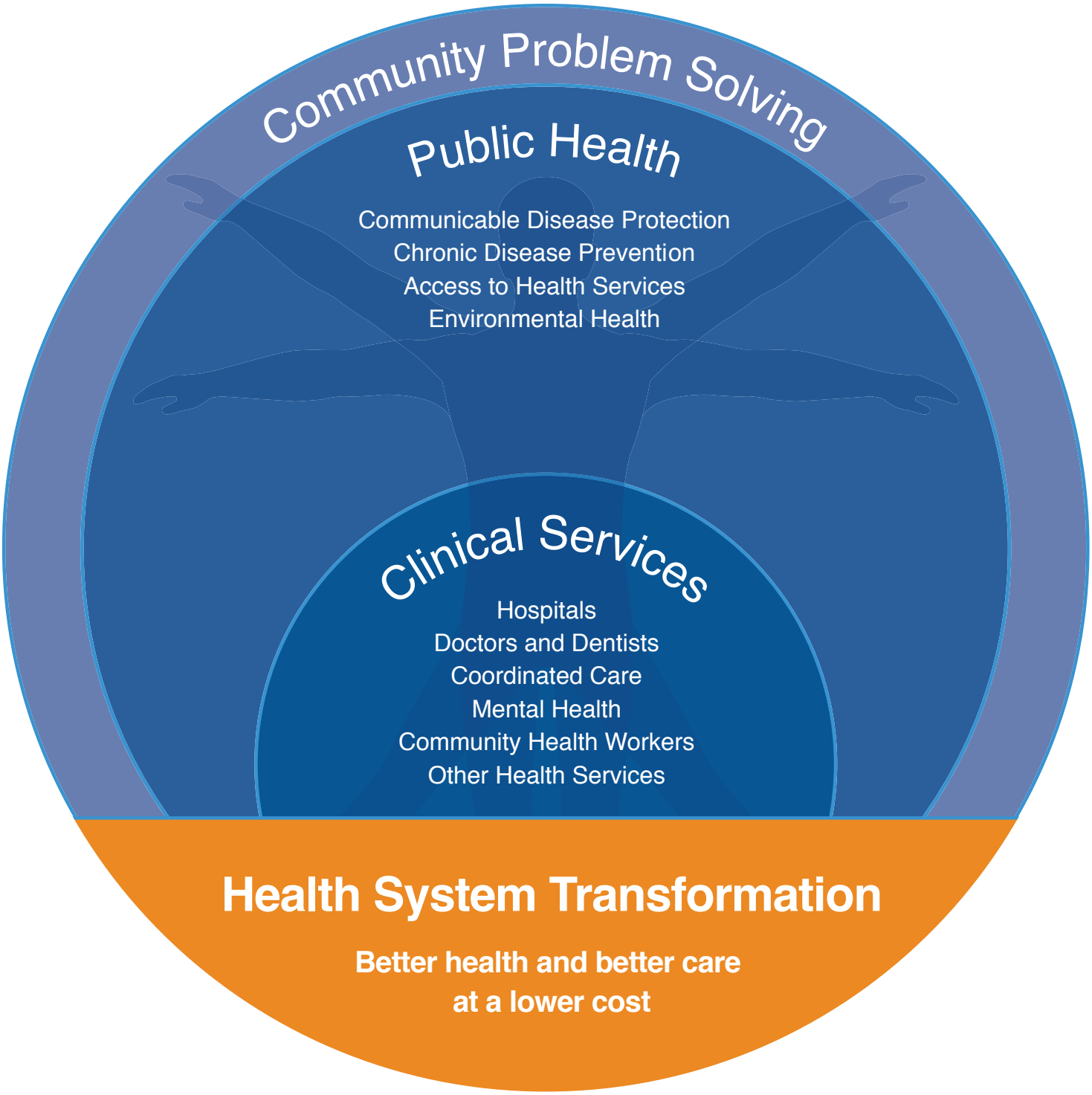
JUNE 2016-SUMMER 2017	2017-2023
Local public health departments to engage local policy makers, CCOs, health systems, early learning organizations and other community partners in regional meetings.	Each local public health department to submit a modernization plan to the Oregon Health Authority by 2023.

Public Health Modernization



Public Health Foundational Capabilities:

Policy and Planning, Community Partnership Development, Leadership and Organizational Competencies, Health Equity and Cultural Responsiveness, Assessment and Epidemiology, Emergency Preparedness and Response, and Communications.

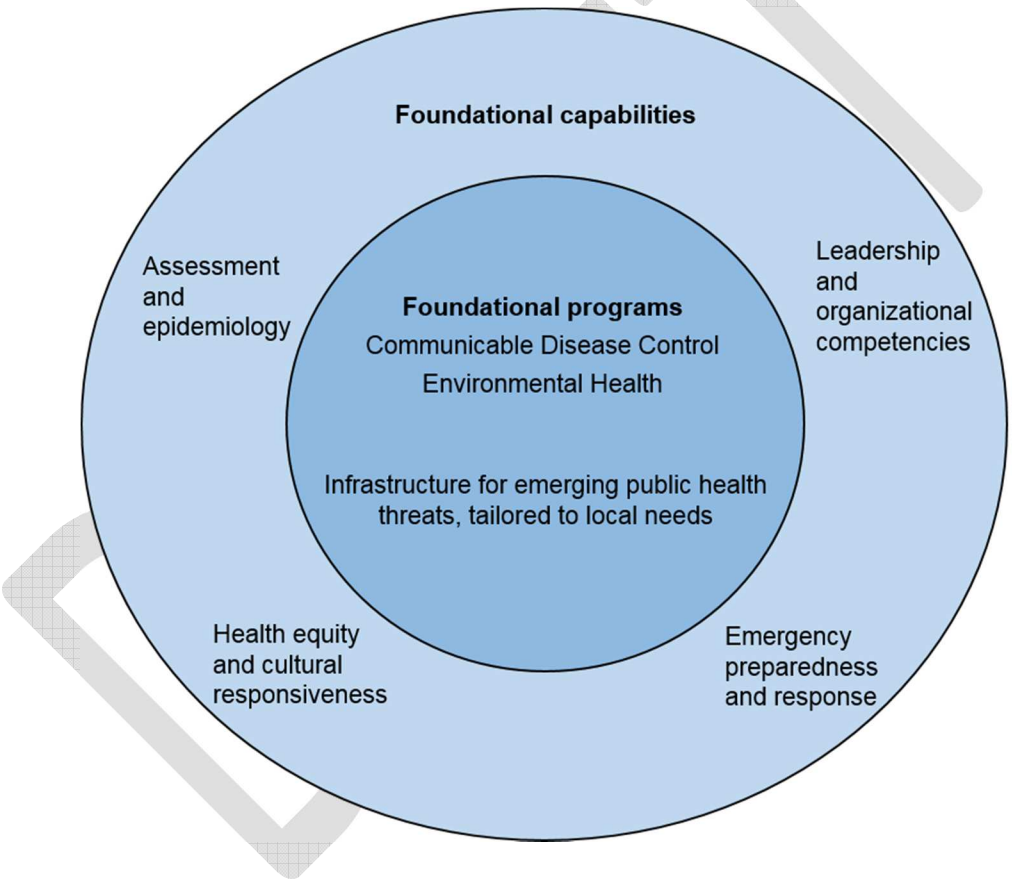

Community Problem Solving
Public Health
Communicable Disease Protection
Chronic Disease Prevention
Access to Health Services
Environmental Health
Clinical Services
Hospitals
Doctors and Dentists
Coordinated Care
Mental Health
Community Health Workers
Other Health Services
Health System Transformation
Better health and better care
at a lower cost

Public Health Modernization
2017-19 Priorities
Draft for Discussion, June 9, 2016

General considerations

1. There are meaningful gaps across the system in all foundational capabilities and programs.
2. There are meaningful gaps across the system in all governmental public health authorities. These gaps are not uniform, nor do they appear in the same places in every public health authority.
3. Many of the foundational capabilities and programs support one another.

Recommendations for initial 2017-19 investment



In 2017-19, state and local public health authorities can begin by focusing resources in **targeted foundational capabilities and programs**. An initial subset of priority roles for each foundational capability and program will be identified, as investments in each foundational capability and program will be **tailored to local needs**. Tailoring will allow state and local public health authorities to **build upon existing capacity while filling identified gaps**.

- **Emerging health threats.** Protect the health of Oregonians by ensuring adequate capacity throughout the public health system to address emerging health threats. This priority addresses

gaps identified in the public health system modernization assessment in the areas of Environmental Health, Communicable Disease Control and Emergency Preparedness and Response, and can be customized to meet local needs.

- **Health equity.** Ensure that every state and local public health authority has the capacity to engage communities that experience an excess burden of death and disease. This priority addresses the significant gaps identified across the public health system for Health Equity and Cultural Responsiveness.
- **Population health data**. Lack of access to timely, accurate and meaningful data was identified as a barrier in most areas of the public health system modernization assessment. Oregon's public health system has limited data available to help local communities identify and respond to health inequities. Monitoring and reporting on disease trends, health risk behaviors and environmental health threats is a core function of the governmental public health system. This priority addresses the needs identified in Assessment and Epidemiology.
- **Public health modernization planning.** Provide ongoing support to state and local public health authorities to identify strategies to build an efficient public health system. This will include working with elected officials, the health care delivery system, early learning partners and community-based organizations to identify how public health services should be provided in the community, and working with other public health authorities to identify opportunities to share services across jurisdictions. This priority addresses a subset of needs identified in Leadership and Organizational Competencies.

Public Health Advisory Board

Comparison of Public Health Modernization Reports

June 16, 2016

Report Comparison

	Public Health Modernization Assessment Report	Report for Legislative Fiscal Office (LFO)	Report on Health Outcomes and Cost Savings	Statewide Public Health Modernization Plan
Who develops the report?	Developed by BERK Consulting	Developed by the Oregon Health Authority (OHA)	Developed by Program Design and Evaluation Services	Developed by OHA
When is the report due?	To be included as an addendum to the Report for LFO	To be submitted to LFO by June 30, 2016	To be completed by September 2016	To be completed by January 1, 2017
What does the report include?	Reports results from the public health modernization assessment	Provides an update on public health activities and milestones, July 2015-June 2016	Quantifies the estimated health outcomes and cost savings attributable to public health modernization	Builds upon the June 30, 2016 report to LFO
	Identifies policy implications and implementation strategies	Identifies the 2017-2019 priorities for public health modernization implementation		Describes the completed framework for allocating funds to LPHAs and the completed framework for accountability measurement
	Identifies the total cost to implement public health modernization under the existing system	Identifies the baseline for 2017-19 priorities		Describes the process for approving local public health modernization plans
	Three parts: 1) executive summary, 2) summary report, and 3) full report	Describes the funding formula and accountability measurement frameworks intended to ensure the equitable distribution of funds across the system		Includes additional context for the implementation of public health modernization

Roles for Report Development and Submission

OHA

- Adopt and update as necessary a statewide public health modernization assessment.
- Submit to the Public Health Advisory Board (PHAB) and Legislative Fiscal Office by June 30 of each even-numbered year a formula that provides for the equitable distribution of funds to local public health authorities.
- Develop and modify as necessary plans for the distribution of funds to local public health authorities.
- Develop and modify a statewide public health modernization plan.

PHAB

- Make recommendations to OHPB on the adoption and updating of the statewide public health modernization assessment.
- Make recommendations to OHPB on the development and modification of plans for the distribution of funds to LPHAs and the total cost to LPHAs to apply and implement foundational capabilities and programs.
- Make recommendations to OHPB on the use of incentives by OHA to encourage the effective and equitable provision of public health services by LPHAs.
- Make recommendations to OHPB on the development and modification of the statewide public health modernization plan.

Oregon Health Policy Board (OHPB)

- Provide advice to OHA based on recommendations made by PHAB as noted above.

House Bill 3100 (2015)
Public Health Modernization:
Report to Legislative Fiscal Office

June 9, 2016 DRAFT

healthoregon.org/modernization

In 2015, the legislature passed House Bill 3100, which creates changes to increase the efficiency and effectiveness of Oregon's public health system and ensures a basic level of public health services is available for every person in Oregon. This report provides an update on the progress of the Oregon Health Authority (OHA) toward fulfilling the requirements of House Bill 3100 and outlines OHA's strategy for modernizing the governmental public health system in the coming years.

This report is provided by the Oregon Health Authority, in collaboration with the Public Health Advisory Board. The Public Health Advisory Board, a committee of the Oregon Health Policy Board, advises and makes recommendations to the Oregon Health Authority and Oregon Health Policy Board on statewide public health policy and goals. Special thanks go to the members of the Public Health Advisory Board for their contributions to this report.

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EXECUTIVE SUMMARY

Oregon is a leader in its approach to health system transformation, which aims to provide better health and better care at a lower cost. The governmental public health system plays a critical role in health system transformation to monitor, protect and improve the health of every person in Oregon. The Oregon legislature has demonstrated its commitment to building a modern public health system that can fulfill its role in health system transformation through the passage of House Bill 2348 (2013) and House Bill 3100 (2015).

In 2016, state and local public health authorities completed an assessment of the governmental public health system, as required under House Bill 3100. This assessment was intended to answer two questions: To what extent is the existing system able to meet the requirements of a modern public health system? What resources are needed to fully implement public health modernization?

This assessment demonstrated significant gaps in the public health system's current ability to meet public health modernization requirements in all areas of the state, and no single public health authority is currently providing all necessary programs and services. Addressing system-wide and local gaps and achieving an equitable public health system across the state will be the focus of the public health system now and into the future.

Based on findings from the public health modernization assessment, OHA recommends the following priorities for the 2017-19 biennium:

- **Emerging health threats.** Protect the health of Oregonians by ensuring adequate capacity throughout the public health system to address emerging health threats.
- **Health equity.** Ensure that every state and local public health authority has the capacity to engage communities that experience an excess burden of death and disease.
- **Population health data**. Ensure that every state and local public health authority has access to timely, accurate and meaningful data needed to understand the health of the community and drive decision-making.
- **Public health modernization planning.** Ensure ongoing support to state and local public health authorities to identify strategies to build an equitable and efficient public health system.

Modernizing public health in Oregon requires a full system upgrade that will scale up over time. But by committing to building a modern public health system, we demonstrate our commitment to ensuring that a healthy life is within reach for every Oregonian.

OREGON'S PATH TO PUBLIC HEALTH MODERNIZATION

Oregonians believe in fairness. We want good health for ourselves and our families. Fairness means a healthy life is within reach for all of us—whether we live in small towns or big cities, east or west of the Cascades.

Every citizen in Oregon has the right to be covered by a public health system that includes all the elements of a modern public health system and that is true in downtown Portland and in Enterprise and in Coos Bay. Right now it's not true, there is great variation in what's available to protect the health of people in different parts of the state. We all deserve to have a government that protects us when we need protecting.

80 percent of the factors that shape our health happen outside of a doctor's office. Right now, our communities are not equally equipped to support the health of Oregonians where they live, work, learn and play. We need to upgrade our public health system in ways that recognize how our physical environment, social and economic conditions, and health behaviors affect us. Because together, these day-to-day realities play the biggest role in determining how healthy we can be.

Modernizing public health in Oregon requires a full-system upgrade. This effort must connect all the players and capitalize on partnerships in order to equip every community with the same essential skills and programs to protect Oregonians from communicable disease, keep our air and water clean, counter the debilitating impact of chronic disease, and ensure that everyone has access to quality health care.

This work is critical to Oregon's movement toward health system transformation: better health and better care at a lower cost. But for Oregonians in every community, it's even simpler than that: **A healthy life, within our reach.**

THE NEED FOR A MODERN PUBLIC HEALTH SYSTEM

Oregon is a leader in its approach to health system transformation, which aims to provide better health and better care at a lower cost. The vision for how public health should support Oregon's health system in shifting its focus to prevention of disease was outlined in the 2010 *Oregon's Action Plan for Health*:

> *We need a health system that integrates public health, health care and community-level health improvement efforts to achieve a high standard of overall health for all Oregonians, regardless of income, race, ethnicity or geographic location. To achieve this, we must stimulate innovation and integration among public health, health systems and communities to increase coordination and reduce duplication.*[1]

As Oregon's health system transformation has achieved success, the role of governmental public health in providing safety net services has changed over time. At the same time, a growth in the volume of new and emerging health threats has exposed the need for a governmental public health system that can systematically collect and report on population health risks and health disparities; implement needed policy changes to improve health and protect the population from harms; and leverage partnerships across the health system to ensure maximum efficiency and effectiveness of services delivered. There are many recent examples of how demands for governmental public health services change: the response to the international Zika virus outbreak; preparation for a possible Cascadia Subduction Zone earthquake; and the need to address environmental threats to human health through regulation and mitigation of heavy metals in air and water.

Although there is broad recognition that Oregon's governmental public health system must modernize in order to fulfill its role for everyone in Oregon, the governmental public health system has been hindered by its reliance on county general funds and federal categorical grants. There is wide variation among county general fund contributions to support local public health, and in some cases these contributions have been reduced over the years. Federal categorical grants are limited in flexibility and not always responsive to local needs. At the same time, federal spending on public health has remained below pre-recession levels.[2] Oregon's state per capita spending currently ranks below all other states in the region.[3] As a result, Oregon's governmental public health system is often challenged to focus strategically on

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[1] Oregon Health Authority. (2010). Oregon's Action Plan for Health. Available at https://www.oregon.gov/oha/action-plan/rpt-2010.pdf.

[22] Trust for America's Health. (2016). Investing in America's Health: A State-by-State Look at Public Health Funding and Key Facts. Available at http://healthyamericans.org/assets/files/TFAH-2016-InvestInAmericaRpt-FINAL.pdf.

[3] Ibid.

the types of public health programs and services that can help everyone in Oregon achieve optimal health.

State	State Per Capita Investment in Public Health	National Ranking[4]
Idaho	$94.70	7th
California	$56.20	10th
Washington	$38.20	23rd
Oregon	$26.60	31st

Recommendations from the 2014 Task Force on the Future of Public Health Services
The Task Force on the Future of Public Health Services, created by House Bill 2348 (2013), developed a set of recommendations to modernize Oregon's governmental public health system to meet the needs of the population in years to come. The Task Force recommended that:

1. A set of foundational capabilities and programs be adopted to ensure a core set of public health services is available in every area of the state;
2. Significant and sustained state funding be allocated to support implementation of the foundational capabilities and programs;
3. Implementation of the foundational capabilities and programs should occur in waves over a set timeline;
4. Local public health authorities should have the flexibility to determine the best method to implement the foundational capabilities and programs in order to meet each community's unique needs;
5. A set of accountability metrics should be developed to ensure improvements and progress toward established goals.

The 2015 legislature passed House Bill 3100 (2015), which operationalized the Task Force recommendations and established a set of planning activities to be completed during the 2015-17 biennium.

PUBLIC HEALTH MODERNIZATION TIMELINE

- June 2013: House Bill 2348 passes Oregon legislature
- January-September 2014: Task Force on the Future of Public Health Services meets monthly
- September 2014: *Modernizing Oregon's Public Health System* report submitted to Oregon legislature
- July 2015: Oregon legislature passes House Bill 3100

[4] Ibid.

- December 2015: Public Health Modernization Manual published; Public Health Advisory Board appointed
- January 2016: Public Health Advisory Board begins meeting monthly
- March 2016: Oregon receives Robert Wood Johnson Foundation grant to advance public health modernization implementation.
- April 2016: State and local public health authorities complete public health modernization assessment
- June 2016: Public Health Modernization Assessment Report, funding formula framework and framework for accountability metrics submitted to Legislative Fiscal Office
- September 2016: Report on estimated health outcomes and cost savings attributable to public health modernization released
- December 2016: Initial statewide public health modernization plan adopted

KEY MILESTONES AND DELIVERABLES

Define foundational capability and programs – completed, December 2015
From June-December 2015, measurable definitions for each foundational capability and program for governmental public health were developed and included in the Public Health Modernization Manual, published in December 2015. The Public Health Modernization Manual outlines the core functions of the governmental public health system and articulates the separate but mutually-supportive roles for state and local public health authorities.

Establish the Public Health Advisory Board – completed, January 2016
The Public Health Advisory Board has oversight for Oregon's governmental public health system and reports to the Oregon Health Policy Board. Board members began their terms in January 2016. The Board has established two subcommittees: the Incentives and Funding Subcommittee, which is charged with informing the development of an equitable funding formula for local public health authorities; and the Accountability Metrics Subcommittee, which is leading the development of quality measures to track the progress of state and local public health authorities in meeting population health goals over time.

Conduct statewide public health modernization assessment – completed, April 2016
Each state and local public health authority completed a public health modernization assessment between January-April 2016. The findings from this assessment will be used to identify the timing and sequence of events over upcoming biennia to fully modernize Oregon's governmental public health system. Priorities for 2017-19 are outlined below. For detail on the findings of the public health modernization assessment, see Appendix A: Public Health Modernization Assessment Summary Report.

Develop public health modernization funding formula – draft complete June 2016
The Public Health Advisory Board informed the development of a funding formula for local public health authorities for monies available to the Oregon Health Authority for the purpose of funding foundational capabilities and programs, as outlined in House Bill 3100, Section 28. For additional information on the funding formula, see the Funding Formula Framework section below.

Establish metrics to ensure accountability and improved health outcomes: measurement framework completed; measure selection to be completed in early 2017
The Public Health Advisory Board has developed a framework for accountability metrics for state and local public health authorities. For additional information on accountability metrics, see the Accountability Measurement Framework section below.

Expanded statewide public health modernization plan – anticipated date for completion: December 2016
The statewide public health modernization plan will include key components for implementation of public health modernization:

- Process and criteria to approve local public health modernization plans;
- Completed framework for allocating funds to local public health authorities;
- Completed framework for accountability measurement;
- Established waves for the implementation of local modernization plans.

SUCCESSES TO DATE

Oregon was one of three states to receive a Robert Wood Johnson Foundation grant administered through the Public Health National Center for Innovations. Oregon received a two-year grant totaling $250,000 in March 2016 to advance work to implement public health modernization. The Coalition of Local Health Officials is the fiscal agent for the grant, with OHA serving in a co-Principal Investigator role. The Robert Wood Foundation grant will:

- Convene 10 regional meetings across Oregon to engage stakeholders in discussions about how to structure local public health systems so that public health modernization is implemented efficiently and effectively.
- Provide technical assistance to state and local public health authorities with the goal of working toward fulfillment of the local public health modernization plan submission requirements included in House Bill 3100.

Oregon was invited to participate in the Public Health National Center for Innovations National Advisory Group to build a national knowledge base for foundational public health work. As a part of the Robert Wood Johnson Foundation grant, Oregon will provide technical assistance to ten new jurisdictions that will be brought on over the next year to explore implementation of the foundational capabilities and programs for governmental public health.

PRIORITIES FOR THE 2017-19 BIENNIUM

The public health system modernization assessment answered two questions: To what extent are the roles and deliverables associated with public health modernization being implemented today? What resources are needed to fully implement public health modernization? This assessment was completed by OHA and every local public health authority between January and April 2016.

The Public Health Modernization Assessment Report identified the following criteria for determining priorities for public health modernization, including:

1. Population health impact: the degree to which meaningful improvements in health can be expected.
2. Service dependencies: the degree to which OHA is dependent on local public health authorities to implement a specific function or vice versa. A gap in either state or local public health authorities could lead to the entire public health system not being able to meet its duty.
3. Equity: the degree to which underserved areas or populations of the state can gain access to a public health service.
4. Population coverage: the percent of the population receiving a public health service.

The public health modernization assessment demonstrated that there are significant gaps in the public health system's current ability to meet foundational capabilities and programs in all areas of the state, and overall no single public health authority is currently providing all necessary programs. At the same time, programs are currently provided in such a way that some public health authorities are providing different functions within a specific area than another. For example, one public health authority may have greater capacity for providing one program but have limited capacity for providing another, while the exact opposite may be true in a neighboring county. This key finding makes flexibility for implementation within foundational capability and program critical to building upon existing infrastructure. Addressing these gaps and achieving an equitable public health system across the state will be the focus of the public health system beginning now, and into the future.

Based on findings from the public health modernization assessment, OHA recommends the following priorities for the 2017-19 biennium:

- **Emerging health threats.** Protect the health of Oregonians by ensuring adequate capacity throughout the public health system to address emerging health threats. This priority addresses gaps identified in the public health system modernization assessment in the areas of Environmental Health, Communicable Disease Control and Emergency Preparedness and Response, and can be customized to local needs.

- **Health equity.** Ensure that every state and local public health authority has the capacity to engage communities that experience an excess burden of death and disease. Meaningful improvements in health cannot be achieved without reducing and eliminating health disparities. This priority addresses the significant gaps identified across the public health system for Health Equity and Cultural Responsiveness.
- **Population health data**. Lack of access to timely, accurate and meaningful data was identified as a barrier in most areas of the public health system modernization assessment. Oregon's public health system has limited data available to help local communities identify and respond to health disparities. Monitoring and reporting on disease trends, health risk behaviors and environmental health threats is a core function of the governmental public health system. This priority addresses the needs identified in Assessment and Epidemiology.
- **Public health modernization planning.** Provide ongoing support to state and local public health authorities to identify strategies to build an equitable and efficient public health system. This will include working with elected officials, the health care delivery system, early learning partners and community-based organizations to identify how public health services should be provided in the community, and working with other public health authorities to identify opportunities to share services across jurisdictions. This priority addresses a subset of needs identified in Leadership and Organizational Competencies.

Tasks associated with these priorities will be defined throughout 2017 as state and local public health authorities continue to analyze findings from the public health modernization assessment, assess the current system and identify strategies to build equity and efficiencies into the governmental public health system.

Additional information about how public health modernization will be implemented over upcoming biennia is available in the following section.

PROCESS FOR IMPLEMENTING PUBLIC HEALTH MODERNIZATION

Oregon's public health system is effective and efficient to the extent that roles for state and local public health authorities are clear and mutually-supportive through public health modernization. The process to implement public health modernization over subsequent biennia is intended to continue to build efficiencies in the following ways:

- Understand and build upon state and local governmental public health interdependencies;
- Remove financial and non-financial barriers to implementation;
- Encourage sharing of service delivery across the system.

Based on the findings of the public health modernization assessment, OHA and the Public Health Advisory Board recommend that the following actions take place over the next several biennia in order to efficiently and effectively implement public health modernization.

Biennium	Actions
Phase 1: 2017-2019	• Develop initial public health modernization plans, addressing the priorities listed in the previous section. • Ensure sufficient funding to support priorities. • Identify effective and efficient public health governance structures. • Finalize accountability measures for state and local public health authorities. • Finalize funding formula for local public health authorities. Distribute available funding to local public health authorities. • Enhance statewide public health modernization plan. • Report on baseline accountability metrics. • Collect and report on year one accountability metrics.
Phase 2: 2019-2021	• Utilize decision-making criteria to identify additional priority areas for 2019-2021. Ensure funding is available to support additional priorities. • Identify effective and efficient public health governance structures. • Collect and report on year two and year three accountability metrics. • Conduct public health modernization assessment.
Phase 3: 2021-2023	• Utilize decision-making criteria to identify additional priority areas for 2021-23. Ensure sufficient funding to support additional priorities. • Collect and report on year four and year five accountability metrics. • Ensure all local public health authorities have submitted a local modernization plan.
Phase 4: 2023-2025	• Utilize decision-making criteria to identify additional priority areas for 2023-2025. Ensure sufficient funding to support additional priorities. • Collect and report on year six and year seven accountability metrics. • Conduct public health modernization assessment.

FUNDING FORMULA FRAMEWORK

House Bill 3100 requires OHA to submit a funding formula to the Public Health Advisory Board and the Legislative Fiscal Office which provides for the equitable distribution of funds to local public health authorities. OHA shall:

- Establish a baseline amount to be invested in public health activities and services by the state;
- Establish a method for awarding matching funds to a local public health authority that invests in public health activities and services above the baseline amount established by OHA for that local public health authority;

- Consider the population of each local public health authority, burden of diseases, total overall health status and the ability of each local public health authority to invest in public health activities and services in its baseline amount; and
- Adopt by rule incentives to encourage the effective and equitable provision of public health services by local public health authorities.

OHA, with guidance from the Public Health Advisory Board, has drafted the following funding formula for the distribution of state funds to local public health authorities for the purposes of implementing the foundational capabilities and programs.

Funding formula criteria	**Percentage**
Population size • As measured by the current American Community Survey population estimate for the jurisdiction	placeholder
Disease burden • As measured by annual County Health Rankings	placeholder
Overall health status • As measured by annual County Health Rankings	placeholder
Racial/ethnic diversity • As measured by the current American Community Survey population estimate for the jurisdiction	placeholder
Poverty • As measured by the current American Community Survey population estimate for the jurisdiction	placeholder
Matching funds for county contributions to support public health	To be incorporated in 2019
Performance on accountability measures*	To be incorporated in 2019
Total	

*The Public Health Advisory Board is currently working to identify the measure set for which state and local public health authorities will be accountable. The funding formula allocates a percentage of funding to be held back and paid to local public health authorities based on their performance. The final set of accountability measures will be selected in early 2017.

Over the course of the next several months, the Public Health Advisory Board will continue working on the funding formula draft articulated above. Of particular importance are the following considerations:

1. Equity must be considered in all decisions made about the funding formula. This includes considering how the funding formula contributes to equitable funding for local public health authorities, the equitable provision of services, and health equity.
2. Any dollar amount made available to local public health authorities will need to be considered within the domains of the draft funding formula, so that there is a sufficient

incentive for local governments to invest in public health and for local public health to focus on achieving accountability measures.

3. There is a need to create a new system for collecting information on local investment in public health. Currently, local public health authorities submit information on their annual projected revenues; in order to match local general fund investment, actual revenues would need to be collected and validated.
4. Should funding be allocated to local public health authorities for public health modernization, matching funds would need to start being paid in Fiscal Year 2019, because state funds would not be allocated until after local governments have already made their budget decisions for Fiscal Year 2018.

Additional information on the methodology used to build the funding formula is available in Appendix B: Funding Formula Framework.

ACCOUNTABILITY MEASUREMENT FRAMEWORK

The Public Health Advisory Board is charged with developing a set of accountability metrics for state and local public health authorities. These measures will align with the foundational capabilities and programs adopted in House Bill 3100 for state and local public health:

- Leadership and organizational competencies
- Health equity and cultural responsiveness
- Community partnership development
- Assessment and epidemiology
- Policy and planning
- Communications
- Emergency preparedness and response
- Communicable disease control
- Environmental health
- Prevention and health promotion

When selecting appropriate measures for each of the above-listed categories, the Public Health Advisory Board will apply the following criteria:

Must pass criteria:

a. Promotes health equity
b. Respectful of local health priorities
c. Transformative potential
d. Consistency with state and national quality measures, with room for innovation
e. Feasibility of measurement

Additional criteria:

f. Consumer engagement
g. Relevance
h. Attainability
i. Accuracy
j. Reasonable accountability

k. Range/diversity of measures

The initial list of measures to select from within each foundational capability and program area will be developed using the following data sources:

- Oregon's State Health Improvement Plan – OHA
- Oregon State Health Profile Indicators – OHA
- Public Health Activities and Services Tracking – University of Washington
- Healthy People 2020 – US Department of Health and Human Services
- Winnable Battles – Centers for Disease Control and Prevention
- Coordinated Care Organization Incentive Measures – OHA
- Quality and Access Test Measures – OHA
- Child and Family Well-Being Measures – OHA
- Hospital Performance Measures - OHA

NEXT STEPS

OHA and the Public Health Advisory Board will be working diligently between now and summer 2017 to achieve the deliverables for public health modernization set forward in House Bill 3100. Deliverables include:

- Finalize the report to quantify estimated health outcomes and cost savings attributable to public health modernization;
- Implement the Robert Wood Johnson Foundation grant;
- Support the development of local public health modernization plans;
- Update the statewide public health modernization plan;
- Select accountability metrics for the governmental public health system; and
- Finalize the local public health funding formula.

FOR MORE INFORMATION

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APPENDIX A: PLACEHOLDER

APPENDIX B: PLACEHOLDER

Draft: June 9, 2016

Oregon's Public Health Modernization Assessment

Final Draft Assessment Report Review

BERK

Revised Assessment Review Purpose

- Our objective is to:
  - Review
    - PHAB Charge related to the Assessment Report
    - Final Draft Assessment Report
  - Discuss
    - Section 1, Executive Summary
    - Section 2.5, Phasing Considerations

PHAB Charter

- Make recommendations to the Oregon Health Policy Board on the adoption and updating of the statewide public health modernization assessment:
  - Review initial findings from the Public Health Modernization Assessment.
  - Review the final Public Health Modernization Assessment report and provide a recommendation to OHPB on the submission of the report to the legislature.
  - Make recommendations to the OHPB on processes/procedures for updating the statewide public health modernization report.

Report Design

Designed for legislative and lay audiences.

Designed for policy audiences.

Designed for governmental public health audiences.

Section 1	**Executive Summary**
Section 2	**Summary and Key Findings**
1. Background 2. Assessment Overview 3. Overall Results 4. Policy Implications 5. Phasing Considerations	
Section 3	**Detailed Assessment Results**
1. How to Read Results 2. Individual Foundational Programs and Capabilities	
Section 4	**Appendices**
A. Glossary and Acronyms B. Functional Area Definitions	

Review Final Draft Assessment Report

[Switch to Final Draft Assessment Report]

Phasing Considerations

Phasing should be designed to consider how:

- Implementation can build on the success of the existing system
- Future phases can be set up for success
- Early successes can be accomplished to demonstrate the value in the initiative to stakeholders, and to create momentum for long term implementation
- Initial phasing decisions can support meaningful change
- To maximize efficiency and effectiveness of activities

Phasing Considerations

- An efficient, effective implementation strategy should be flexible and allow for ongoing decision making that is responsive to iterative learning and individual governmental public health authority contexts.
- We have identified preliminary criteria for this decision-making framework to support this kind of robust implementation strategy, including:
  - Population Health Impacts
  - Service Dependencies
  - Coverage Maximization
  - Service Equity

Phasing Considerations

2017-19 Biennium

1. Support additional planning and work related to Public Health Modernization implementation for all governmental public health authorities, recognizing that executing implementation will require non-trivial resources as it is phased in.
2. Allow for flexible funding to support LPHAs in funding their "patchwork quilt" gaps based on locally-identified priorities.
3. Reduce gaps in state activities related to service dependencies to remove barriers to implementation of the dependent local activities in the future.
4. Invest in high priority population health initiatives with potential for the highest population health impacts.