Oregon Health Authority

AGENDA

PUBLIC HEALTH ADVISORY BOARD

October 20, 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
Webinar link: https://attendee.gotowebinar.com/register/5310778978932156162

Meeting objectives

- Share information about the Public Health Advisory Board Incentives and Funding and Accountability Metrics Subcommittee meetings
- Hear from Representative Mitch Greenlick, District 33 and Senator Laurie Monnes Anderson about their vision for Oregon's public health system
- Share information from the Conference of Local Health Officials (CLHO) annual retreat and the Oregon Public Health Association (OPHA) annual conference
- Hear from the Public Health Division's (PHD) Health Equity Committee and discuss health equity definitions
- Discuss the timeline and process for developing the statewide modernization plan

2:30-2:40 pm	**Welcome** • Approve September 12, 2016 minutes	Jeff Luck, PHAB Chair
2:40-3:10 pm	**Subcommittee reports** • Share information and progress from September 13 and October 18 Incentives and Funding subcommittee meeting • Share information and progress from September 22 Accountability Metrics subcommittee meeting	Jeff Luck, Incentives and Funding subcommittee member Muriel DeLaVergne-Brown, Accountability Metrics subcommittee member
3:10-3:50 pm	**Advancing public health system change** • Discuss the vision for achieving an efficient and effective public health system in Oregon	Representative Greenlick, District 33 Senator Monnes Anderson, District 25
3:50-4:05	**Break**	
4:05-4:20 pm	**Updates from CLHO retreat and OPHA conference**	PHAB members

	• Share highlights and important considerations from the CLHO annual retreat (Sept 14-15) • Share highlights and important considerations from the Oregon Public Health Association annual conference (Oct 10-11)	
4:20-5:05 pm	**Health equity definition and framework** • Share information about the PHD Health Equity Committee • Review framework for health equity • Discuss health equity definitions	Kati Moseley and Tim Noe, Oregon Health Authority
5:05-5:15 pm	**Statewide modernization plan** • Review report outline • Discuss timeline and process for finalizing report	Sara Beaudrault, Oregon Health Authority
5:15-5:30 pm	**Public comment**	
5:30 pm	**Adjourn**	Jeff Luck, PHAB chair

Public Health Advisory Board (PHAB)
September 12, 2016
Portland, OR
Draft Meeting Minutes

Attendance:

Board members present: Carrie Brogoitti (by phone), Muriel DeLaVergne-Brown, Katrina Hedberg, Jeff Luck, Alejandro Queral, Eva Rippeteau, Akiko Saito, Eli Schwarz, Lillian Shirley, Teri Thalhofer, Tricia Tillman, and Jennifer Vines
OHA Public Health Division staff: Isabelle Barbour, Sara Beaudrault, Heather Gramp, Holly Heiberg, Rosa Klein, Tim Noe, Britt Parrott, Angela Rowland
Invited guests: Jerri Bohard, Oregon Department of Transportation
Members of the public: Morgan Cowling, Coalition of Local Health Officials; Jackie Leung, Oregon Department of Transportation

Changes to the Agenda & Announcements

There were no changes to the agenda.

-Rosa Klein, Oregon Health Authority

Rosa Klein, Public Health Legislative Coordinator, announced that Representative Mitch Greenlick will attend the next PHAB meeting to discuss his vision for public health modernization. The conceptual framework for implementing by waves has shifted, and we need to demonstrate structurally how local public health will be provided, moving forward. Representative Greenlick continues to support this work and the recommendations the Board has made thus far. He will use this time to provide direction to the PHAB and discuss the critical elements of the statewide modernization plan.

Eli recommended the Oregon Health Policy Board (OHPB) be informed of this meeting. PHAB members also requested to receive discussion points prior to meeting with Representative Greenlick.

-Morgan Cowling, Coalition of Local Health Officials

Morgan provided a schedule for the CLHO AIMHI meetings. These meetings are intended to engage local communities, health and education stakeholders, and local elected officials in moving forward Oregon's new model for public health.

This body of work is funded by the Robert Wood Johnson Foundation. See the Oregon CLHO website for more details. http://oregonclho.org/public-health-issues/aimhi-in-oregon/. PHAB members can help recruit for attendance at these meetings and are encouraged to attend.

Approval of Minutes

Eli made one edit to the August 18, 2016 meeting minutes.

A quorum was present. The Board unanimously voted to approve the edited August 18, 2016 minutes.

Subcommittee reports

-Teri Thalhofer, Accountability Metrics subcommittee member

Teri provided an update for the August 25th Accountability Metrics subcommittee. The subcommittee continued its process to review a long list of metrics. Subcommittee members have expressed that reviewing more than 300 measures is an overwhelming process. A proposal has been made to focus on measures that align with 2017-19 priority areas. In Cara's absence, Rebecca Pawlak will be staffing this subcommittee.

Lillian stated that identifying relevant public health measures is a problem nationally. In addition to providing accountability, the measures that are selected will help the broader community of Oregon understand the added value of public health practice. Muriel recommends picking measures at the local level that multiple agencies or sectors can work on to ensure the entire local system is working in alignment. At the same time, it is important to have common measures for the entire public health system to demonstrate progress statewide.

Akiko asked whether a scoring tool has been developed to help narrow down the selection of measures to consider. Alejandro asked how the measures relate to incentives.

Jeff made the following suggestions for this subcommittee over the coming months: focus on 2017-19 priority areas, identify those measures where public health has a clear role in improving outcomes and make sure this subcommittee

has sufficient staff support. Eli asked whether this subcommittee could meet in person. The subcommittee will discuss this at their next meeting.

-Tricia Tillman, Incentives and Funding subcommittee member

Tricia provided an overview of the August 31st Incentives and Funding subcommittee meeting. Subcommittee members have received questions about whether different versions of the funding formula will be applied to counties based on their self-assessment findings. Only one funding formula will be used; however, local public health authorities (LPHAs) will have some flexibility to apply funding based on local needs and priorities. The subcommittee will consider where gaps exist across the system in the 2017-19 priority areas to make sure the funding formula allocates sufficient funding to areas of the state with the largest needs. There was a suggestion to develop a list of frequently asked questions (FAQs) to be posted on the PHAB webpage.

The subcommittee also looked at three funding formula models and will continue to explore models at their next meeting. The subsequent meeting will focus on indicators to be included in the model. At a future meeting the subcommittee will discuss Measure 97 and its potential effects on public health funding, and other sources for funding public health.

Public health modernization updates

-Lillian Shirley, Oregon Health Authority

Lillian provided an overview of the OHA agency request budget which includes $30 million for the implementation of public health modernization in the 2017-19 biennium. The full report is available online and through an email sent to Board members on August 31, 2016.

The specific request was based on the assessment and priorities. For the first biennium $8.5 million of the $30 million would remain with OHA Public Health Division (PHD) to be used for building capacity system-wide. Of the $8.5 million, $2.25 million would be allocated for population health data; $3 million would go toward data systems upgrades. The health equity analysis is allotted for $1.5 million. And $600,000 would go toward accountability for health outcomes.

The $30 million is in addition to the current public health operating budget.

Tricia asked if the percentage of the $30 million that would remain with PHD is consistent with the resource needs identified in the modernization assessment. Lillian replied that the percent breakdowns are similar and over two-thirds of the funds will be distributed to the counties.

Public health modernization with Oregon tribes
-Tim Noe, Oregon Health Authority

HB3100 did not require, nor does the state have the authority to require, that tribes are involved in public health modernization. Information about public health modernization has been shared with the tribes over the past few months at the SB 770 Health Cluster meetings, a Tribal Consultation and the Tribal preparedness conference. Four tribes have expressed interest in being involved in modernization work. Danna Drum and Tim have met with the Cow Creek Band of Umpqua Tribe of Indians and the Coquille Indian Tribe. Meetings are scheduled with the Confederated Tribes of Warm Springs and the Confederated Tribes of the Umatilla Indian Reservation.

Sharon Stanphill, Health Services Officer for the Cow Creek Band of Umpqua Tribe of Indians and Kelle Little, Health and Human Services Administrator for the Coquille Indian Tribe will ask the tribes to be involved in public health modernization work. They have agreed to present at the next Northwest Portland Area Indian Health Board (NPAIHB) meeting to initiate this process. It is anticipated that LPHAs will be involved with ongoing work with the tribes.

Jeff asked for a state map of the nine federally recognized Tribes. Tricia inquired whether there should be tribal representation on the PHAB.

Tricia asked about implications for the funding structure for public health modernization. The tribal population gets included in the county population, but the tribes are often not served by the local health department. Teri stated that this is not the case in her area of the state, where tribal members do seek services from local public health.

Follow up on health equity resources

-PHAB members

PHAB members reviewed equity references in HB 3100 and the draft health equity review tool policy and procedure. This policy would require PHAB to apply the health equity review tool to all products and deliverables recommended or approved by the Board.

Alejandro stated a health equity review needs to be conducted before a document is finalized. He also stated populations who may be affected need to be engaged before decisions are made. Eva stated the Early Learning Council specifically looks at community engagement and provides documentation of who was or was not included in the conversation, and why. Eli suggests that the policy require that outcomes are tracked; did the decision have the intended consequence, and did it move us toward achieving health equity?

Jen struggles with seemingly conflicting language in HB3100 for "equitable provision of public health services" and "health equity as it relates to race, ethnicity, and sex." The first indicates the same level of services while the latter targets services for populations likely to experience health disparities. She proposes the two subcommittees use a health equity lens in all of their discussions. Muriel would like to see health equity embedded into all of the work of the Board. Tricia commented that the Multnomah County Public Health Advisory Board requires their presenters to highlight health equity in all presentations to their Board.

Tricia noted that the policy and procedure lacks a definition of health equity. She also commented that populations experiencing transient states or diagnoses that may lead to health disparities should not be conflated with gender, race, and ethnicity in the definition that is used by the Board. Katrina noted that REAL+D requires standards for data collection on health disparities and includes disability in its definition. Eva recommended also looking at definitions that include socioeconomic factors. Eli recommended a document from the Association of State and Territorial Health Officials: http://www.astho.org/Programs/Health-Equity/Health-Equity-Orientation-for-SHOs/

Board members note the need to take the time that is needed to work through equity discussions about all products and deliverables. Lillian stated that it is important to be clear as to what the Board is doing. The legislation instructs what the task is and we must complete the mandated deliverables.

Jeff summed up the next steps: there is a general Board consensus on using a tool for all of the policies, products and deliverables for PHAB, there should be a test to make sure the tool is effective; and the Board would like to discuss health equity definitions at the October meeting.

Oregon Department of Transportation and Oregon Health Authority partnership

-Jerri Bohard, Oregon Department of Transportation
-Heather Gramp, Oregon Health Authority

Jerri presented an overview of the Oregon Department of Transportation (ODOT) and Oregon Health Authority partnership. There are transportation linkages for the top five leading causes of death in Oregon; cancer, heart disease, chronic disease, stroke and unintentional injuries. Benefits for health in transportation decisions include increases in physical activity, decrease of greenhouse gases, increases in social coherence, increased capacity for natural disaster triage and access to jobs. This work also addresses health equity as communities of color rely more on transit, walking, and biking.

The ODOT/OHA Memorandum of Understanding (MOU) was created to integrate transportation and public health. This partnership addresses the Transportation Safety Action Plan, Statewide Transportation Improvement Program, Bicycle and Pedestrian Plan, Distracted Driving Task Force, and Public Transportation Plan. There is interest in involving transportation in work with CCOs, CACs and community health improvement plans to incorporate transportation's role to improve population health and reduce health disparities. Much of the transportation work will occur at the local level but public health modernization can help address the capacity issues.

Eli is interested in learning more about transportation barriers for older populations and for people who live outside urban areas, and the relationship with access to health care. Teri commented that local conversations about

medical transportation must address health equity. Tricia discussed mental illness and transportation. She also asked about diesel and health quality.

Tricia commented on a transportation legislative town hall held a month ago, during which transit justice was discussed. She also asked about a legislative transportation package and whether funds would become available for local health departments to work on transportation and health. Jerri responded that if there is a legislative package that passes, there are constitutional requirements that funds must be dedicated to transportation, which may include safe routes to schools.

Jerri proposed a future joint meeting of the Transportation Commission and PHAB. This was supported by Board members. Eva recommends including early learning in ongoing discussions.

OHA – ODOT Partnership website:
https://www.oregon.gov/ODOT/TD/Pages/ODOT-OHA.aspx

Public Comment Period
No public comments were made in person or on the phone.

Closing:
Tricia requested follow-up regarding the funding split for the state and local public health as it compares to the assessment gaps.

The meeting was adjourned.

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

October 20, 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
Incentives and Funding Subcommittee Meeting Minutes

September 13, 2016
1:00-2:00 pm

Portland State Office Building, 800 NE Oregon St., Room 1C, Portland, OR 97232
Conference line: (877) 873-8017
Access code: 767068

Meeting chair: Jeff Luck

PHAB subcommittee members present: Jeff Luck, Alejandro Queral, Akiko Saito, Tricia Tillman

PHAB subcommittee members absent: Silas Halloran-Steiner

OHA staff: Sara Beaudrault, Chris Curtis, Angela Rowland

Members of the public: Kathleen Johnson, *Coalition of Local Health Officials*

Welcome and introductions – Jeff Luck

Approval of minutes – Jeff Luck

Subcommittee members voted to approve the August 31, 2016 subcommittee meeting minutes. Akiko added a correction to the base amount in the HSPR funding formula. There are actually two base amounts.

All in favor to approve the edited minutes.

Discuss how the funding formula can be used to incentivize change – Jeff Luck

The subcommittee should think about what changes to incentivize through the funding formula. Oregon Health Authority staff provided an excerpt from Section 28 of HB 3100. This section states that the funding formula should provide for the equitable distribution of monies, and incentives are to be used to encourage the effective and equitable provision of public health services. This language is open to interpretation as it could mean distributing funds equitably to local public health departments or distributing funds equitably for all people in the state of Oregon. The funding formula can be used to incentivize a changed system.

Alejandro commented on the part of Section 28 related to state matching funds for county contributions. He suggested the subcommittee consider methods to incentivize county investments through the funding formula. Alejandro also suggested for the subcommittee to define equitable health outcomes. He proposed looking at disparities

and increasing payments above the baseline amount to target disadvantaged communities.

Tricia asked what the decision-making process is for the subcommittee to bring forward a recommendation to the Public Health Advisory Board (PHAB). The subcommittee favored working toward consensus, but if consensus is not reached, take the decision forward to be made by the full Board.

The subcommittee discussed the timeline for incorporating state matching funds for county investments and incentive payments for performance on accountability metrics. The subcommittee recommends targeting all funds available in 2017-19 to baseline payments. Akiko stated that the system needs to be built before incorporating incentive funds and matching funds. These components can be incorporated into the funding formula that will be submitted to legislative fiscal office in June 2018.

The subcommittee discussed how the funding formula can be used to drive the system to change to achieve outcomes and gain efficiencies. Jeff questioned whether regional approaches or cross jurisdictional sharing could be among the changes that are incentivized. Tricia stated that counties don't have current capacity to make decisions to regionalize or enter into cross jurisdictional sharing agreements today, which is why planning grants or a similar mechanism to target funding for these decisions may be a good option. Jeff suggested funding pilot tests.

Alejandro questioned the purpose of regionalization. Better access? Better health? There may be other routes for achieving improved health outcomes. Tricia stated that regionalization is a means to appropriate staffing and core capacity.

Akiko stated there is a difference between regional sharing and a regional system approach. She proposed using the funding formula to fund LPHAs to perform pilot projects around the 2017-19 priorities. The BERK public health modernization assessment report can provide insight on the capacity gaps in these areas. Based on the $210M gap in the BERK findings, Tricia does not think that $30M in requested funding is enough for LPHAs to reach full capacity in the 2017-19 priority areas.

Jeff proposed taking an amount off the top of the funds that become available in 2017 to use for planning grants or pilots. Sara stated there is a priority around leadership and competencies to be used around public health planning, which may include exploring regional approaches to sharing services. Tricia's understanding is that priority is focused on performance management and quality improvement. Tricia supported planning grants or pilot projects but suggests not putting a dollar amount on it now since the requested funding amount of $30M will not meet needs across the system.

Alejandro recommended using a matching funds approach to incentivize planning rather than a grant approach. This creates a planning approach to make improvements toward foundational capabilities and avoids a second grant. Tricia questioned the

implication for small counties that may not get county investments but that may have the greatest need to explore new service delivery models.

Discuss updated funding formula models– Subcommittee members
Postponed until the October meeting.

Subcommittee business– subcommittee members

Alejandro will chair the next meeting on October 18, 2016 from 2:00pm-4:00pm.

The group agreed to two hour meeting times for upcoming meetings.

Action Items:

- OHA will send subcommittee members “homework” to review the three models. Subcommittee members will review the models and come to the next meeting prepared to make an initial recommendation or rule a model out.
- Add time to the next agenda to review the methodology for developing the funding formula models.
- Consider updating county population estimates using PSU population estimates.
- Update indicators as discussed at the July subcommittee meeting.
- Extend meetings through 2016 to two hours.

Public comment – None

Adjournment – Jeff Luck
The meeting was adjourned.

PHAB Funding and Incentives Subcommittee

Subcommittee Members: Silas Halloran-Steiner, Jeff Luck, Alejandro Queral, Akiko Saito, Tricia Tillman

October 19, 2016

Model 1: equal base payment; all indicators tied to county population. The model includes a base payment for each county. Awards for each indicator are tied to county population.

County Group	Population[1]	Floor	County Population[1]	Burden of Disease[2]	Health Status[3]	Race/Ethnicity[4]	Poverty[5]	Limited English Proficiency[6]	Matching Funds[7]	Incentives[8]	Total Award[9]	Award Percentage	% of Total Population	Award Per Capita	
County 33	1,357	$ 50,000	$ 1,426	$ 276	$ -	$ 83	$ 312	$ 33	$ -	$ -	$ 52,130	0.5%	0.0%	$ 38.42	
County 31	6,893	$ 50,000	$ 7,246	$ 1,681	$ 536	$ 298	$ 1,201	$ 118	$ -	$ -	$ 61,080	0.6%	0.2%	$ 8.86	
County 12	7,253	$ 50,000	$ 7,624	$ 2,389	$ 2,272	$ 556	$ 1,924	$ 139	$ -	$ -	$ 64,904	0.6%	0.2%	$ 8.95	
County 11	7,325	$ 50,000	$ 7,700	$ 1,419	$ 844	$ 412	$ 1,420	$ 146	$ -	$ -	$ 61,942	0.6%	0.2%	$ 8.46	
County 18	7,854	$ 50,000	$ 8,256	$ 2,022	$ 1,033	$ 1,013	$ 1,756	$ 525	$ -	$ -	$ 64,606	0.6%	0.2%	$ 8.23	
County 24	11,217	$ 50,000	$ 11,791	$ 2,261	$ 3,809	$ 6,443	$ 2,721	$ 5,148	$ -	$ -	$ 82,173	0.8%	0.3%	$ 7.33	
County 1	16,049	$ 50,000	$ 16,871	$ 4,377	$ 3,238	$ 1,016	$ 3,696	$ 526	$ -	$ -	$ 79,723	0.8%	0.4%	$ 4.97	$ 12.17
County 7	20,798	$ 50,000	$ 21,863	$ 4,946	$ 4,014	$ 2,619	$ 5,432	$ 1,388	$ -	$ -	$ 90,261	0.9%	0.5%	$ 4.34	
County 15	21,830	$ 50,000	$ 22,947	$ 6,964	$ 5,663	$ 7,357	$ 5,719	$ 4,834	$ -	$ -	$ 103,484	1.0%	0.6%	$ 4.74	
County 8	22,341	$ 50,000	$ 23,485	$ 7,847	$ 7,083	$ 2,328	$ 4,314	$ 800	$ -	$ -	$ 95,857	1.0%	0.6%	$ 4.29	
County 13	22,620	$ 50,000	$ 23,778	$ 3,690	$ 4,082	$ 11,850	$ 4,451	$ 13,206	$ -	$ -	$ 111,057	1.1%	0.6%	$ 4.91	
County 28	25,334	$ 50,000	$ 26,631	$ 6,448	$ 5,778	$ 4,229	$ 5,611	$ 2,890	$ -	$ -	$ 101,586	1.0%	0.6%	$ 4.01	
County 30	25,736	$ 50,000	$ 27,053	$ 5,764	$ 5,386	$ 1,883	$ 6,080	$ 1,971	$ -	$ -	$ 98,137	1.0%	0.7%	$ 3.81	
County 26	29,103	$ 150,000	$ 30,593	$ 7,726	$ 8,023	$ 7,462	$ 6,003	$ 7,442	$ -	$ -	$ 217,250	2.2%	0.7%	$ 7.46	
County 22	30,740	$ 50,000	$ 32,314	$ 6,983	$ 10,208	$ 17,258	$ 10,964	$ 10,737	$ -	$ -	$ 138,462	1.4%	0.8%	$ 4.50	
County 4	37,236	$ 50,000	$ 39,142	$ 10,413	$ 8,119	$ 5,099	$ 7,378	$ 3,792	$ -	$ -	$ 123,943	1.2%	1.0%	$ 3.33	
County 20	46,138	$ 50,000	$ 48,500	$ 14,589	$ 11,043	$ 6,591	$ 9,917	$ 4,809	$ -	$ -	$ 145,449	1.5%	1.2%	$ 3.15	
County 5	49,325	$ 50,000	$ 51,850	$ 11,808	$ 12,980	$ 3,756	$ 8,148	$ 1,869	$ -	$ -	$ 140,412	1.4%	1.3%	$ 2.85	
County 6	62,678	$ 50,000	$ 65,886	$ 19,707	$ 14,138	$ 6,207	$ 14,176	$ 2,795	$ -	$ -	$ 172,910	1.7%	1.6%	$ 2.76	
County 17	65,985	$ 50,000	$ 69,363	$ 19,892	$ 19,349	$ 12,800	$ 15,409	$ 7,792	$ -	$ -	$ 194,605	1.9%	1.7%	$ 2.95	$ 4.09
County 27	76,464	$ 50,000	$ 80,378	$ 14,211	$ 14,660	$ 16,679	$ 16,364	$ 11,608	$ -	$ -	$ 203,902	2.0%	2.0%	$ 2.67	
County 29	76,645	$ 50,000	$ 80,568	$ 17,682	$ 21,034	$ 32,988	$ 16,449	$ 20,819	$ -	$ -	$ 239,540	2.4%	2.0%	$ 3.13	
County 16	83,021	$ 50,000	$ 87,271	$ 24,935	$ 18,102	$ 9,605	$ 20,523	$ 3,274	$ -	$ -	$ 213,710	2.1%	2.1%	$ 2.57	
County 2	86,034	$ 50,000	$ 90,438	$ 12,314	$ 16,172	$ 10,019	$ 24,494	$ 9,632	$ -	$ -	$ 213,068	2.1%	2.2%	$ 2.48	
County 34	100,486	$ 50,000	$ 105,630	$ 19,410	$ 18,385	$ 26,458	$ 21,089	$ 22,218	$ -	$ -	$ 263,189	2.6%	2.6%	$ 2.62	
County 10	107,156	$ 50,000	$ 112,641	$ 32,191	$ 32,630	$ 9,216	$ 26,483	$ 3,642	$ -	$ -	$ 266,803	2.7%	2.7%	$ 2.49	
County 21	118,270	$ 50,000	$ 124,324	$ 27,255	$ 27,715	$ 16,600	$ 28,961	$ 9,987	$ -	$ -	$ 284,842	2.8%	3.0%	$ 2.41	$ 2.62
County 9	163,141	$ 50,000	$ 171,492	$ 30,526	$ 20,035	$ 21,493	$ 30,771	$ 14,551	$ -	$ -	$ 338,868	3.4%	4.2%	$ 2.08	
County 14	206,583	$ 50,000	$ 217,158	$ 48,735	$ 48,669	$ 40,861	$ 46,186	$ 25,543	$ -	$ -	$ 477,151	4.8%	5.3%	$ 2.31	
County 23	320,448	$ 50,000	$ 336,852	$ 66,316	$ 85,534	$ 138,829	$ 76,768	$ 119,960	$ -	$ -	$ 874,258	8.7%	8.2%	$ 2.73	
County 19	354,764	$ 50,000	$ 372,924	$ 77,796	$ 73,354	$ 48,257	$ 90,776	$ 36,350	$ -	$ -	$ 749,458	7.5%	9.1%	$ 2.11	$ 2.31
County 3	384,697	$ 50,000	$ 404,389	$ 68,956	$ 69,902	$ 53,545	$ 47,115	$ 58,336	$ -	$ -	$ 752,242	7.5%	9.9%	$ 1.96	
County 32	547,451	$ 50,000	$ 575,475	$ 79,928	$ 90,556	$ 151,718	$ 81,322	$ 177,740	$ -	$ -	$ 1,206,740	12.1%	14.0%	$ 2.20	
County 25	757,371	$ 50,000	$ 796,141	$ 158,543	$ 155,651	$ 144,474	$ 176,070	$ 235,380	$ -	$ -	$ 1,716,259	17.2%	19.4%	$ 2.27	$ 2.14
Total	**3,900,343**	**$ 1,800,000**	**$ 4,100,000**	**$ 820,000**	**$ 820,000**	**$ 820,000**	**$ 820,000**	**$ 820,000**	**$ -**	**$ -**	**$ 10,000,000**	**100.0%**	**100.0%**	**$ 2.56**	

county size bands
- extra small
- small
- medium
- large
- extra large

[1] Source: American Community Survey population 5-year estimate, 2009-2014.

[2] Source: Oregon State Health Profile. Premature death, 2010-14.

[3] Source: Oregon State Health Profile. Good or excellent health, 2010-2013.

[4] Source: American Community Survey population 5-year estimate, 2009-2014.

[5] Source: Oregon State Health Profile. Combined (adult and children) population below FPL, 2010-2014.

[6] Source: American Community Survey population 5-year estimate, 2012

[7] Limitations exist for calculating current county contributions for public health. An updated process will be developed to address these limitations. Matching funds will be awarded based on actual, not projected expenditures, and will be limited to county contributions that supoprt public health modernization. Given the change in process, matching funds will not be awarded until 2019.

[8] The Accountability Metrics subcommittee will define a set of accountability metrics. Following selection of accountability metrics, baseline data will be collected. Funds will not be awarded for achievement of accountability metrics until 2019.

PHAB Funding and Incentives Subcommittee

Subcommittee Members: Silas Halloran-Steiner, Jeff Luck, Alejandro Queral, Akiko Saito, Tricia Tillman

October 19, 2016

Model 1, variation 1: equal base payment; 20% weight for 5 indicators. The model includes an equal base payment for each county. Funds are not awarded for county population directly; however, awards for each of the other five indicators on the model are tied to county population.

County Group	Population[1]	Floor	County Population[1]	Burden of Disease[2]	Health Status[3]	Race/Ethnicity[4]	Poverty[5]	Limited English Proficiency[6]	Matching Funds[7]	Incentives[8]	Total Award[9]	Award Percentage	% of Total Population	Award Per Capita	
County 33	1,357	$ 50,000	$ -	$ 551	$ -	$ 166	$ 624	$ 66	$ -	$ -	$ 51,407	0.5%	0.0%	$ 37.88	
County 31	6,893	$ 50,000	$ -	$ 3,363	$ 1,071	$ 595	$ 2,402	$ 237	$ -	$ -	$ 57,668	0.6%	0.2%	$ 8.37	
County 12	7,253	$ 50,000	$ -	$ 4,778	$ 4,545	$ 1,111	$ 3,847	$ 278	$ -	$ -	$ 64,559	0.6%	0.2%	$ 8.90	
County 11	7,325	$ 50,000	$ -	$ 2,838	$ 1,689	$ 824	$ 2,841	$ 292	$ -	$ -	$ 58,484	0.6%	0.2%	$ 7.98	
County 18	7,854	$ 50,000	$ -	$ 4,044	$ 2,067	$ 2,025	$ 3,513	$ 1,050	$ -	$ -	$ 62,699	0.6%	0.2%	$ 7.98	
County 24	11,217	$ 50,000	$ -	$ 4,523	$ 7,619	$ 12,885	$ 5,442	$ 10,295	$ -	$ -	$ 90,764	0.9%	0.3%	$ 8.09	
County 1	16,049	$ 50,000	$ -	$ 8,754	$ 6,476	$ 2,032	$ 7,392	$ 1,052	$ -	$ -	$ 75,706	0.8%	0.4%	$ 4.72	$ 11.99
County 7	20,798	$ 50,000	$ -	$ 9,891	$ 8,027	$ 5,238	$ 10,864	$ 2,776	$ -	$ -	$ 86,797	0.9%	0.5%	$ 4.17	
County 15	21,830	$ 50,000	$ -	$ 13,928	$ 11,325	$ 14,713	$ 11,438	$ 9,668	$ -	$ -	$ 111,072	1.1%	0.6%	$ 5.09	
County 8	22,341	$ 50,000	$ -	$ 15,695	$ 14,166	$ 4,656	$ 8,627	$ 1,600	$ -	$ -	$ 94,744	0.9%	0.6%	$ 4.24	
County 13	22,620	$ 50,000	$ -	$ 7,381	$ 8,164	$ 23,700	$ 8,901	$ 26,412	$ -	$ -	$ 124,557	1.2%	0.6%	$ 5.51	
County 28	25,334	$ 50,000	$ -	$ 12,896	$ 11,556	$ 8,457	$ 11,222	$ 5,780	$ -	$ -	$ 99,911	1.0%	0.6%	$ 3.94	
County 30	25,736	$ 50,000	$ -	$ 11,528	$ 10,772	$ 3,767	$ 12,160	$ 3,941	$ -	$ -	$ 92,168	0.9%	0.7%	$ 3.58	
County 26	29,103	$ 150,000	$ -	$ 15,453	$ 16,047	$ 14,924	$ 12,007	$ 14,883	$ -	$ -	$ 223,314	2.2%	0.7%	$ 7.67	
County 22	30,740	$ 50,000	$ -	$ 13,965	$ 20,416	$ 34,515	$ 21,927	$ 21,474	$ -	$ -	$ 162,298	1.6%	0.8%	$ 5.28	
County 4	37,236	$ 50,000	$ -	$ 20,826	$ 16,238	$ 10,199	$ 14,755	$ 7,584	$ -	$ -	$ 119,602	1.2%	1.0%	$ 3.21	
County 20	46,138	$ 50,000	$ -	$ 29,177	$ 22,086	$ 13,183	$ 19,834	$ 9,619	$ -	$ -	$ 143,899	1.4%	1.2%	$ 3.12	
County 5	49,325	$ 50,000	$ -	$ 23,615	$ 25,961	$ 7,512	$ 16,296	$ 3,739	$ -	$ -	$ 127,123	1.3%	1.3%	$ 2.58	
County 6	62,678	$ 50,000	$ -	$ 39,415	$ 28,276	$ 12,414	$ 28,351	$ 5,591	$ -	$ -	$ 164,047	1.6%	1.6%	$ 2.62	
County 17	65,985	$ 50,000	$ -	$ 39,783	$ 38,698	$ 25,601	$ 30,818	$ 15,584	$ -	$ -	$ 200,485	2.0%	1.7%	$ 3.04	$ 4.16
County 27	76,464	$ 50,000	$ -	$ 28,422	$ 29,321	$ 33,359	$ 32,729	$ 23,217	$ -	$ -	$ 197,047	2.0%	2.0%	$ 2.58	
County 29	76,645	$ 50,000	$ -	$ 35,363	$ 42,069	$ 65,977	$ 32,897	$ 41,638	$ -	$ -	$ 267,944	2.7%	2.0%	$ 3.50	
County 16	83,021	$ 50,000	$ -	$ 49,870	$ 36,205	$ 19,210	$ 41,046	$ 6,549	$ -	$ -	$ 202,879	2.0%	2.1%	$ 2.44	
County 2	86,034	$ 50,000	$ -	$ 24,628	$ 32,344	$ 20,037	$ 48,987	$ 19,263	$ -	$ -	$ 195,259	2.0%	2.2%	$ 2.27	
County 34	100,486	$ 50,000	$ -	$ 38,820	$ 36,770	$ 52,915	$ 42,177	$ 44,436	$ -	$ -	$ 265,118	2.7%	2.6%	$ 2.64	
County 10	107,156	$ 50,000	$ -	$ 64,382	$ 65,261	$ 18,431	$ 52,965	$ 7,285	$ -	$ -	$ 258,323	2.6%	2.7%	$ 2.41	
County 21	118,270	$ 50,000	$ -	$ 54,511	$ 55,430	$ 33,200	$ 57,922	$ 19,974	$ -	$ -	$ 271,036	2.7%	3.0%	$ 2.29	$ 2.59
County 9	163,141	$ 50,000	$ -	$ 61,051	$ 40,070	$ 42,986	$ 61,542	$ 29,102	$ -	$ -	$ 284,751	2.8%	4.2%	$ 1.75	
County 14	206,583	$ 50,000	$ -	$ 97,469	$ 97,338	$ 81,721	$ 92,372	$ 51,085	$ -	$ -	$ 469,985	4.7%	5.3%	$ 2.28	
County 23	320,448	$ 50,000	$ -	$ 132,631	$ 171,067	$ 277,658	$ 153,535	$ 239,921	$ -	$ -	$ 1,024,812	10.2%	8.2%	$ 3.20	
County 19	354,764	$ 50,000	$ -	$ 155,592	$ 146,708	$ 96,514	$ 181,553	$ 72,699	$ -	$ -	$ 703,067	7.0%	9.1%	$ 1.98	$ 2.30
County 3	384,697	$ 50,000	$ -	$ 137,912	$ 139,803	$ 107,090	$ 94,229	$ 116,672	$ -	$ -	$ 645,706	6.5%	9.9%	$ 1.68	
County 32	547,451	$ 50,000	$ -	$ 159,857	$ 181,113	$ 303,435	$ 162,645	$ 355,481	$ -	$ -	$ 1,212,530	12.1%	14.0%	$ 2.21	
County 25	757,371	$ 50,000	$ -	$ 317,087	$ 311,303	$ 288,947	$ 352,141	$ 470,761	$ -	$ -	$ 1,790,238	17.9%	19.4%	$ 2.36	$ 2.09
Total	**3,900,343**	**$ 1,800,000**	**$ -**	**$ 1,640,000**	**$ 1,640,000**	**$ 1,640,000**	**$ 1,640,000**	**$ 1,640,000**	**$ -**	**$ -**	**$ 10,000,000**	**100.0%**	**100.0%**	**$ 2.56**	

county size bands
- extra small
- small
- medium
- large
- extra large

[1] Source: American Community Survey population 5-year estimate, 2009-2014.

[2] Source: Oregon State Health Profile. Premature death, 2010-14.

[3] Source: Oregon State Health Profile. Good or excellent health, 2010-2013.

[4] Source: American Community Survey population 5-year estimate, 2009-2014.

[5] Source: Oregon State Health Profile. Combined (adult and children) population below FPL, 2010-2014.

[6] Source: American Community Survey population 5-year estimate, 2012

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PHAB Funding and Incentives Subcommittee

Subcommittee Members: Silas Halloran-Steiner, Jeff Luck, Alejandro Queral, Akiko Saito, Tricia Tillman

October 19, 2016

Model 1, variation 2: tiered base payments; 20 weight for 5 indicators. The model includes a tiered base payment for each county. Funds are not awarded for county population directly; however, awards for each of the other five indicators on the model are tied to county population.

County Group	Population[1]	Floor	County Population[1]	Burden of Disease[2]	Health Status[3]	Race/Ethnicity[4]	Poverty[5]	Limited English Proficiency[6]	Matching Funds[7]	Incentives[8]	Total Award[9]	Award Percentage	% of Total Population	Award Per Capita	
County 33	1,357	$ 30,000	$ -	$ 548	$ -	$ 165	$ 620	$ 65	$ -	$ -	**$ 31,399**	**0.3%**	**0.0%**	**$ 23.14**	
County 31	6,893	$ 30,000	$ -	$ 3,344	$ 1,065	$ 592	$ 2,389	$ 236	$ -	$ -	**$ 37,626**	**0.4%**	**0.2%**	**$ 5.46**	
County 12	7,253	$ 30,000	$ -	$ 4,752	$ 4,520	$ 1,105	$ 3,826	$ 277	$ -	$ -	**$ 44,479**	**0.4%**	**0.2%**	**$ 6.13**	
County 11	7,325	$ 30,000	$ -	$ 2,822	$ 1,680	$ 819	$ 2,825	$ 291	$ -	$ -	**$ 38,437**	**0.4%**	**0.2%**	**$ 5.25**	
County 18	7,854	$ 30,000	$ -	$ 4,022	$ 2,056	$ 2,014	$ 3,493	$ 1,044	$ -	$ -	**$ 42,629**	**0.4%**	**0.2%**	**$ 5.43**	
County 24	11,217	$ 30,000	$ -	$ 4,498	$ 7,577	$ 12,814	$ 5,412	$ 10,239	$ -	$ -	**$ 70,540**	**0.7%**	**0.3%**	**$ 6.29**	
County 1	16,049	$ 30,000	$ -	$ 8,706	$ 6,440	$ 2,021	$ 7,351	$ 1,046	$ -	$ -	**$ 55,565**	**0.6%**	**0.4%**	**$ 3.46**	**$ 7.88**
County 7	20,798	$ 45,000	$ -	$ 9,837	$ 7,983	$ 5,209	$ 10,805	$ 2,760	$ -	$ -	**$ 81,595**	**0.8%**	**0.5%**	**$ 3.92**	
County 15	21,830	$ 45,000	$ -	$ 13,852	$ 11,263	$ 14,632	$ 11,375	$ 9,615	$ -	$ -	**$ 105,737**	**1.1%**	**0.6%**	**$ 4.84**	
County 8	22,341	$ 45,000	$ -	$ 15,609	$ 14,088	$ 4,631	$ 8,580	$ 1,591	$ -	$ -	**$ 89,499**	**0.9%**	**0.6%**	**$ 4.01**	
County 13	22,620	$ 45,000	$ -	$ 7,340	$ 8,119	$ 23,570	$ 8,852	$ 26,267	$ -	$ -	**$ 119,148**	**1.2%**	**0.6%**	**$ 5.27**	
County 28	25,334	$ 45,000	$ -	$ 12,825	$ 11,493	$ 8,411	$ 11,160	$ 5,748	$ -	$ -	**$ 94,637**	**0.9%**	**0.6%**	**$ 3.74**	
County 30	25,736	$ 45,000	$ -	$ 11,465	$ 10,713	$ 3,746	$ 12,093	$ 3,919	$ -	$ -	**$ 86,936**	**0.9%**	**0.7%**	**$ 3.38**	
County 26	29,103	$ 105,000	$ -	$ 15,368	$ 15,959	$ 14,842	$ 11,941	$ 14,802	$ -	$ -	**$ 177,912**	**1.8%**	**0.7%**	**$ 6.11**	
County 22	30,740	$ 45,000	$ -	$ 13,889	$ 20,304	$ 34,326	$ 21,807	$ 21,356	$ -	$ -	**$ 156,681**	**1.6%**	**0.8%**	**$ 5.10**	
County 4	37,236	$ 45,000	$ -	$ 20,712	$ 16,149	$ 10,143	$ 14,674	$ 7,542	$ -	$ -	**$ 114,220**	**1.1%**	**1.0%**	**$ 3.07**	
County 20	46,138	$ 45,000	$ -	$ 29,017	$ 21,965	$ 13,111	$ 19,725	$ 9,566	$ -	$ -	**$ 138,384**	**1.4%**	**1.2%**	**$ 3.00**	
County 5	49,325	$ 45,000	$ -	$ 23,486	$ 25,818	$ 7,471	$ 16,207	$ 3,718	$ -	$ -	**$ 121,700**	**1.2%**	**1.3%**	**$ 2.47**	
County 6	62,678	$ 45,000	$ -	$ 39,198	$ 28,121	$ 12,346	$ 28,196	$ 5,560	$ -	$ -	**$ 158,421**	**1.6%**	**1.6%**	**$ 2.53**	
County 17	65,985	$ 45,000	$ -	$ 39,565	$ 38,486	$ 25,460	$ 30,649	$ 15,499	$ -	$ -	**$ 194,659**	**1.9%**	**1.7%**	**$ 2.95**	**$ 3.88**
County 27	76,464	$ 60,000	$ -	$ 28,266	$ 29,160	$ 33,176	$ 32,549	$ 23,089	$ -	$ -	**$ 206,240**	**2.1%**	**2.0%**	**$ 2.70**	
County 29	76,645	$ 60,000	$ -	$ 35,169	$ 41,838	$ 65,615	$ 32,717	$ 41,409	$ -	$ -	**$ 276,748**	**2.8%**	**2.0%**	**$ 3.61**	
County 16	83,021	$ 60,000	$ -	$ 49,596	$ 36,006	$ 19,105	$ 40,820	$ 6,513	$ -	$ -	**$ 212,040**	**2.1%**	**2.1%**	**$ 2.55**	
County 2	86,034	$ 60,000	$ -	$ 24,493	$ 32,166	$ 19,927	$ 48,718	$ 19,158	$ -	$ -	**$ 204,462**	**2.0%**	**2.2%**	**$ 2.38**	
County 34	100,486	$ 60,000	$ -	$ 38,607	$ 36,568	$ 52,625	$ 41,946	$ 44,192	$ -	$ -	**$ 273,937**	**2.7%**	**2.6%**	**$ 2.73**	
County 10	107,156	$ 60,000	$ -	$ 64,029	$ 64,903	$ 18,330	$ 52,674	$ 7,245	$ -	$ -	**$ 267,180**	**2.7%**	**2.7%**	**$ 2.49**	
County 21	118,270	$ 60,000	$ -	$ 54,212	$ 55,126	$ 33,017	$ 57,604	$ 19,864	$ -	$ -	**$ 279,823**	**2.8%**	**3.0%**	**$ 2.37**	**$ 2.69**
County 9	163,141	$ 75,000	$ -	$ 60,716	$ 39,850	$ 42,750	$ 61,204	$ 28,942	$ -	$ -	**$ 308,463**	**3.1%**	**4.2%**	**$ 1.89**	
County 14	206,583	$ 75,000	$ -	$ 96,934	$ 96,804	$ 81,273	$ 91,865	$ 50,805	$ -	$ -	**$ 492,681**	**4.9%**	**5.3%**	**$ 2.38**	
County 23	320,448	$ 75,000	$ -	$ 131,903	$ 170,129	$ 276,134	$ 152,692	$ 238,604	$ -	$ -	**$ 1,044,462**	**10.4%**	**8.2%**	**$ 3.26**	
County 19	354,764	$ 75,000	$ -	$ 154,738	$ 145,903	$ 95,985	$ 180,557	$ 72,300	$ -	$ -	**$ 724,483**	**7.2%**	**9.1%**	**$ 2.04**	**$ 2.39**
County 3	384,697	$ 90,000	$ -	$ 137,155	$ 139,036	$ 106,503	$ 93,712	$ 116,031	$ -	$ -	**$ 682,437**	**6.8%**	**9.9%**	**$ 1.77**	
County 32	547,451	$ 90,000	$ -	$ 158,979	$ 180,119	$ 301,770	$ 161,752	$ 353,530	$ -	$ -	**$ 1,246,150**	**12.5%**	**14.0%**	**$ 2.28**	
County 25	757,371	$ 90,000	$ -	$ 315,347	$ 309,594	$ 287,361	$ 350,208	$ 468,177	$ -	$ -	**$ 1,820,688**	**18.2%**	**19.4%**	**$ 2.40**	**$ 2.15**
Total	**3,900,343**	**$ 1,845,000**	**$ -**	**$ 1,631,000**	**$ 1,631,000**	**$ 1,631,000**	**$ 1,631,000**	**$ 1,631,000**	**$ -**	**$ -**	**$ 10,000,000**	**100.0%**	**100.0%**	**$ 2.56**	

county size bands
- extra small
- small
- medium
- large
- extra large

[1] Source: American Community Survey population 5-year estimate, 2009-2014.

[2] Source: Oregon State Health Profile. Premature death, 2010-14.

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PHAB Funding and Incentives Subcommittee

Subcommittee Members: Silas Halloran-Steiner, Jeff Luck, Alejandro Queral, Akiko Saito, Tricia Tillman

October 19, 2016

Models assume a $10M investment. This is an example only.

This table shows the average award per capita for three variations of a funding formula model for each county size band.

Each row represents a county size band. Each row has a green, yellow and red cell to show which model awards the largest, middle and smallest per capita award for each size band:

largest award for county size band
middle award for county size band
smallest award for county size band

County Group	Model 1 - Equal base; county population; five indicators tied to county pop Award Per Capita	Model 1, Variation 1 - Equal base; five indicators tied to county pop Award Per Capita	Model 1, Variation 2 - Tiered base; five indicators tied to county pop Award Per Capita
Extra Small	$ 12.17	$ 11.99	$ 7.88
Small	$ 4.09	$ 4.16	$ 3.88
Medium	$ 2.62	$ 2.59	$ 2.69
Large	$ 2.31	$ 2.30	$ 2.39
Extra Large	$ 2.14	$ 2.09	$ 2.15
Total			

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics Subcommittee Meeting Minutes

September 22, 2016
2:00 – 3:00pm

PHAB Subcommittee members in attendance: Muriel DeLaVergne-Brown, Jeff Luck, Eva Rippeteau, Eli Schwarz, Jennifer Vines

PHAB Subcommittee members absent: Teri Thalhofer,

OHA staff: Sara Beaudrault, Myde Boles, Joey Razzano, Angela Rowland

Members of the public: None

Welcome and introductions

The August 25 draft meeting minutes were unanimously approved by the subcommittee.

Accountability and Metrics Subcommittee Staffing and work-plan review

Sara provided an update on staffing. While Cara is on family leave, Sara will staff the PHAB and Incentives and Funding subcommittee meetings. Rebecca Pawlak will staff the Accountability Metrics subcommittee. Myde Boles will provide expertise to this subcommittee for metrics selection.

Jeff joined today's subcommittee meeting to speak to the importance of this subcommittee's work to identify the health outcomes we will work toward with additional investments in public health, and to discuss the timeline for having a list of measures in place. There is a need to have an initial list by the end of the year, and the Board recommends that this subcommittee focus on areas that have been prioritized for the 2017-19 biennium, specifically communicable disease, environmental health, and preparedness.

Eli questioned whether there is a good way to measure the impact of public health. Jeff said there are many established public health measures, and this subcommittee can work to determine the best measure to fit systematic changes in Oregon. Muriel stated that measuring public health impacts is different than measuring the impacts of the CCO system, which can often be measured using data collected in the electronic health record. This is not the case for public health, where we may track process measures like preparedness exercises or tobacco prevention plans and policies.

At the September 12 PHAB meeting, Eli proposed holding a longer, in person meeting for this subcommittee to complete its deliverable for an initial list of measures before the end of the year. Subcommittee members were supportive of this proposal, or of holding

a longer meeting by phone. Jen proposed that subcommittee members complete homework to review public health measure sets before the next meeting.

Greg Whitman from Washington State University was scheduled to attend the September subcommittee meeting to speak with the subcommittee about Public Health Activities & Service Tracking (PHAST) measures. The PHAST measures fall into three domains (chronic disease, communicable disease and environmental health). PHAST materials are available online: http://phastdata.org/. Mr. Whitman will be invited to a future meeting.

Review Communicable Disease Control measures

The subcommittee reviewed communicable disease measures included in the state health improvement plan. The subcommittee reviewed the measure criteria questions developed by the subcommittee over the summer. The subcommittee agreed that the following criteria should be "must pass" for any measures selected: promotes health equity, is respectful of local health priorities, has transformative potential, is consistent with state and national quality measures and feasibility of measurement.

Oregon State Health Improvement Plan – Communicable Disease Control

Hospital-onset Clostridium difficile infections
Rate of Gonorrhea infections in Oregon residents
Proportion of people living with HIV in Oregon that have a suppressed viral load within the previous 12 months
HIV infections in Oregon residents
Infections caused by Shiga toxin-producing Escherichia O157
Rate of early syphilis infections in Oregon residents (primary, secondary and early latent infections)
Incidence of TB disease among U.S born persons

Clostridium difficile: The group did not support including this measure.

STIs: the group supported including an STI measure. Local public health is responsible for prevention, testing, follow up, ensuring treatment, and sometimes for providing expedited partner therapy. An appropriate measure might be number/percent of women who are screened, since increasing screening may lead to an increase in identified cases. However, it's not clear what would be measured for health departments that do not offer screening or testing. Should the denominator include clients of the health department or the entire population? Muriel states the largest gaps are in the ability to follow up and treatment of contacts. Jen stated that among the state and large counties, there is an artificial separation between communicable disease and STI programs that we should work to eliminate. Muriel suggests referring back to the Public Health Modernization Manual to develop appropriate measures

Foodborne illness: The group supported including foodborne illness measures. Subcommittee members stated these are things communities often take for granted,

and it is core public health work. However, one outbreak can cause a spike in cases. Tracking the number of inspections is not a priority. Oftentimes an outbreak is caused by something in the supply chain or an ill worker that would not have been addressed through an inspection. Muriel says that her county is focusing on environmental hazards as well as the built environment. Muriel noted the complexity of measuring the work of public health as response organizations.

Tubercolosis: Subcommittee felt like community interest is low. Eva asked how TB work at the local level is funded and how local work connects to proposed measures. Eli stated that TB is related to socioeconomic factors such as poverty and homelessness. These basic factors should be addressed.

Jen suggested placeholders for TB, STIs, and foodborne illness measures. Subcommittee members agreed.

Public comment
No public testimony.

Adjournment

The meeting was adjourned.

Public Health Modernization means everyone in Oregon can expect public protections critical to their health and the health of future generations— these include clean air, safe food and water, health promotion and prevention of diseases, and responding to new health threats.

Public Health Modernization in Oregon

Leaders in education, health care, and early learning, join public health leaders in 10 meetings throughout the state to talk about improving the public health in Oregon!

presented by:

CLHO
COALITION OF LOCAL HEALTH OFFICIALS

Leaders in every county around the state are meeting to work towards advancing public health modernization in our communities.

In 2015, the Oregon legislature passed House Bill 3100, which will **bring our public health system into the 21st Century** to better identify and address community heath issues. Public Health Modernization aims to increase the efficiency and effectiveness of Oregon's public health system while ensuring a basic level of public health service for every person in Oregon.

At our meetings we will discuss:

- **What is public health modernization and recent progress**
- **How can we work together for sustained success?**
- **Opportunities to increase the efficiency and effectiveness of the public health system**

Please visit the registration link below to find the time and place of the meeting/s you would like to join

9:30am to 12:15pm (lunch included) Health, education, coordinated care and early learning partners come together with public health and elected officials.

12:30pm to 3:30pm Key public health officials and planning with commissioners

You must register in order to attend

Register Here

For more information please contact:
Hannah Zyirek
hannah.zyirek@redegroup.co

Visit http://oregonclho.org/public-health-issues/aimhi-meetings/ to join the meeting!

Oregon
Public Health Modernization
Draft Meeting Agenda

Time	Topic
All Partners	
9:30—9:45	Welcome & introductions
9:45—10:10	What is a modernized public health system?
10:10—10:45	What are the benefits of Public Health Modernization?
10:45—11:15	What do we need in order to modernize?
11:15—11:45	What's working in Oregon?
11:45—11:50	Conclusion, All Partners Meeting
11:50—12:15	Lunch
Key Planning Partners (CHDs, commissioners, and other invited guests)	
12:30—1:30	High level overview of assessment findings Efficiencies and value of cross-jurisdictional sharing and other types of partnerships: Specific examples from each region, retrospective and prospective
1:30—2:15	Challenges to implementing a Public Health Modernization framework: Community, system, other
2:15—2:30	BREAK
2:30—3:30	Addressing challenges Next steps in the planning and implementation process

COALITION OF LOCAL HEALTH OFFICIALS

RESEARCH | ENGAGEMENT | STRATEGY
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CLHO AIMHI meeting schedule
(as of 10/12/16)

The AIMHI meetings will address:

- What is public health modernization and recent progress
- How can local health departments, community partners and the public health division work together for sustained success
- Opportunities to increase the efficiency and effectiveness of the public health system

	PHAB members close to this area* *
October 21, 2016 **Location:** Burns, Oregon **Local Health Department Hosts:** Baker, Grant, Harney, Lake and Malheur	
November 1, 2016 **Location:** Redmond, Oregon **Local Health Department Hosts:** Crook, Deschutes, Jefferson, Wheeler	**Muriel**
November 3, 2016 **Location:** The Dalles, Oregon **Local Health Department Hosts:** Hood River, North Central Public Health District	**Teri**
December 14, 2016 **Location:** Portland, Oregon **Local Health Department Hosts:** Clackamas, Multnomah, Washington	**Eli, Tricia, Jennifer, Eva, Alejandro**
December 16, 2016 **Location:** Albany, Oregon **Local Health Department Hosts:** Benton, Lane, Lincoln, Linn	**Jeff**
January 12, 2017 **Location:** Astoria, Oregon **Local Health Department Hosts:** Clatsop, Columbia, Tillamook	**Safina**

January 17, 2017 **Location:** Pendleton, Oregon **Local Health Department Hosts:** Morrow, Umatilla, Union, Wallowa	**Carrie**
January 26, 2017 **Location:** Coos Bay, Oregon **Local Health Department Hosts:** Douglas, Coos, Curry	
January 27, 2017 **Location:** Medford, Oregon **Local Health Department Hosts:** Jackson, Josephine, Klamath	
To be scheduled **Location:** Salem, Oregon **Local Health Department Hosts:** Salem, Polk, Yamhill	**Prashanthi, Silas**

**** Local public health administrators will be representing their county, not PHAB, while participating in the meeting in their area of the state.**

AIMHI in Oregon Travel Reimbursement Request

Between October 2016 and February 2017 ten meetings will take place across Oregon to help identify challenges, needs and opportunities for our public health system to implement Modernization.

To ensure that public health administrators are able to attend these important meetings CLHO will reimburse mileage costs (0.54 cents/mile) for travel to and from the meetings.

CLHO will reimburse either you, or your health department depending on who assumed the costs for mileage, please be sure to indicate this below.

Please submit to CLHO within one month of the AIMHI meeting.

Will this reimbursement be to the local health department or the individual?

_____ Individual _____ Local health department _____ Organization

Name: _____

Organization / Local Health Department:
_____

Address to send payment to:

_____

If billed to the Local Health Department, please indicate who to send the reimbursement to.

Attention:

_____

Mileage Costs:

Travel from _____ to _____ = _____Total round-trip miles

_____Total miles x 0.54 cents = $ _____

Please send reimbursement request to kathleen@oregonclho.org

21st Century Public Health – Progress Update on Oregon Modernization

OPHA Annual Conference & Meeting
July 6, 2016

Oregon Health Authority
PUBLIC HEALTH DIVISION
Office of the State Public Health Director

Panel Members

Jeff Luck, MBA, PhD
OSU College of Public Health and Human Sciences &
Oregon Public Health Advisory Board

Kaye Bender, PhD, RN, FAAN
Public Health Accreditation Board

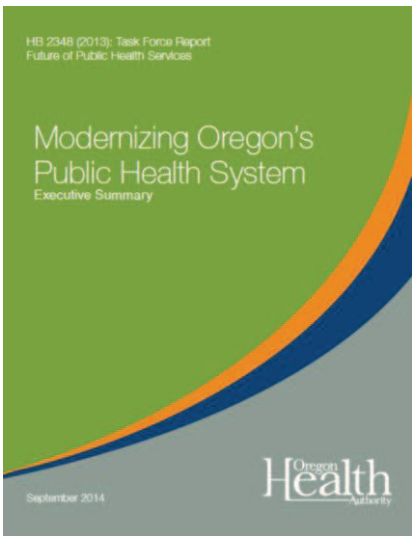
Sara Beaudrault, MPH
Oregon Health Authority, Public Health Division

Morgan Cowling, MPA
Coalition of Local Health Officials

Charlie Fautin, RN, MPH
Benton County & Conference of Local Health Officials

Oregon Health Authority

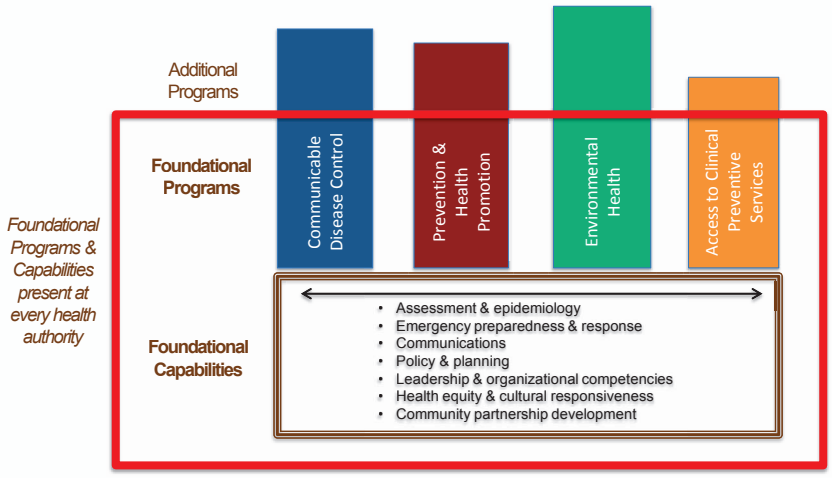
Task Force on the Future of Public Health Services



Oregon Health Authority

4

Public Health Modernization Framework



5

Moving Toward Modernization

Legislators used the recommendations from the *Modernizing Oregon's Public Health System* report to introduce House Bill 3100, which :

- Adopted the foundational capabilities and programs for governmental public health
- Changed the composition and role of the Public Health Advisory Board on January 1, 2016
- Required an assessment of how foundational capabilities and programs are provided and what additional resources are needed
- Laid out modernization planning requirements for 2016 and the next 3 biennia, through 2023

6

Timeline

June 2013
House Bill 2348 passed Oregon legislature

January-September 2014
Task Force on the Future of Public Health Services met monthly

September 2014
Modernizing Oregon's Public Health System report submitted to Oregon legislature

July 2015
Oregon legislature passed House Bill 3100

December 2015
Public Health Modernization Manual published; Public Health Advisory Board appointed

January 2016
Public Health Advisory Board begins meeting monthly

April 2016
State and local public health authorities complete individual public health modernization assessments

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

Oregon Health Authority

7

For more information, visit:

www.healthoregon.org/modernization

Oregon Health Authority

8

Public Health National Center for Innovations (PHNCI) at the Public Health Accreditation Board (PHAB)

Kaye Bender, PhD, RN, FAAN, PHAB President/CEO
Oregon Public Health Association Annual Conference
October 11, 2016

phnci

Sparking innovation in public health

PHNCI supports the development, testing and dissemination of models of innovation and will serve as the coordinating body for a number of allied, national initiatives being applied at health departments across the country. These innovations will serve as pathways for the nation's health departments as they work to be conveners, providers and strategists that our communities need to improve health and well-being.

www.phnci.org

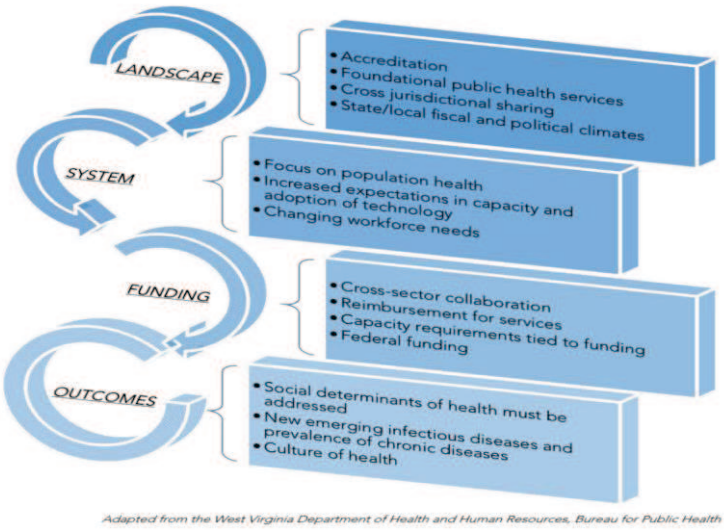
"What if we don't change at all ...
and something magical just happens?"

phnci PHAB

PHNCI Advisory Committee

TERRY ALLAN, Cuyahoga County Board of Health (OH)	**JOHN AUERBACH**, Centers for Disease Control and Prevention
LESLIE BEITSCH, Center for Medicine/Public Health at the Florida State University College of Medicine	**BETTY BEKEMEIER**, Northwest Center for Public Health Practice at the University of Washington
LIZA CORSO, Centers for Disease Control and Prevention	**CHARLIE FAUTIN**, Oregon Conference of Local Health Officials
PAUL HALVERSON, Fairbanks School of Public Health at the University of Indiana	**LAMAR HASBROUCK**, National Association of County and City Health Officials
HEATHER HOWARD, Princeton University Woodrow Wilson School of Public and International Affairs	**PAUL KUEHNERT**, Robert Wood Johnson Foundation
PATRICK LIBBEY, Center for Sharing Public Health Services	**GENE MATTHEWS**, Network for Public Health Law
GLEN MAYS, University of Kentucky	**CAROL MOEHRLE**, Idaho North Central District Public Health
PAMELA RUSSO, Robert Wood Johnson Foundation	**PAMELA SCHWARTZ**, Kaiser Permanente Community Benefit Program
JOSHUA SHARFSTEIN, Johns Hopkins Bloomberg School of Public Health	**JENNIFER TEBALDI**, Washington State Department of Health
CRAIG THOMAS, Centers for Disease Control and Prevention	**LISA WADDELL**, Association of State and Territorial Health Officials

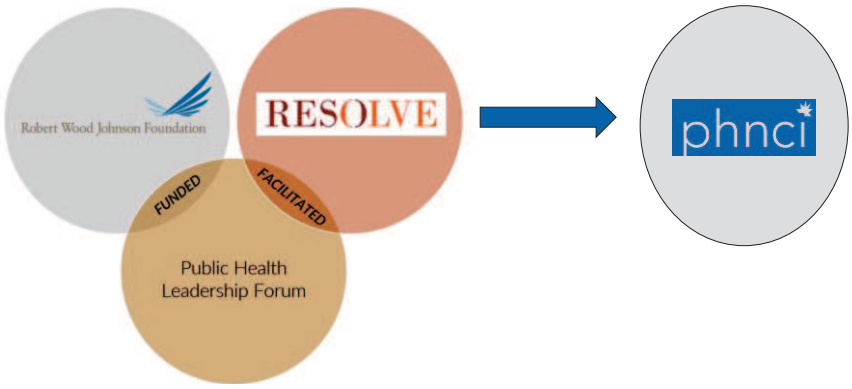
phnci PHAB



Adapted from the West Virginia Department of Health and Human Resources, Bureau for Public Health

phnci PHAB

Foundational Public Health Services



phnci PHAB

Foundational Public Health Services Model

Version 1.0, March 2014

Public Health National Center for Innovations at the Public Health Accreditation Board

PHAB

PHNCI is leading a national effort to foster alignment and spread of innovations in public health practice that will advance a culture of health.

- Division of PHAB, launched in November 2015
- Informed by an **Advisory Committee**
- **Coordinating hub** for allied initiatives
- Leading the national work around the **foundational public health services** model
- Supporting a **Learning Community** through funding, education/TA and peer learning. Current grantees/members include:


Ohio

Oregon


Washington

phnci

Commonalities

- Policy driven strategy
- Interest in systems/structural change and sustainable funding
- Strategic thinking and timelines
- Learning from others
- S/L collaboration
- Provision of tools and resources

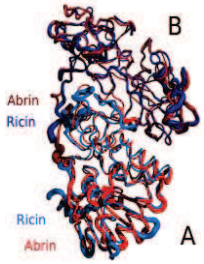
phnci PHAB

FPHS	Accreditation
Capacities	Standards
Skills and capacities	Implementation of skills and capabilities
Minimum	Stretch/QI
Created to make the case for sustainable funding and describe what is needed for public health to function anywhere/everywhere	Created to improve quality
Pilot testing underway today	Validated through implementation and evaluation
Prescribe mandatory services	Prescribe mandatory processes (i.e. CHA/CHIP)
Developed by the field	
For health departments, as the backbone to the public health system	

Alignment document now available!

What About OR Modernization and Accreditation?

- Accreditation is nicely aligned with transformation
- Accreditation is nicely aligned with the FPHS
- Examples from the transformation work should work nicely for accreditation examples
- Think of it all as one process to move your health department forward
- Don't hesitate to ask PHAB for advice along the way!



PHAB

PHNCI's Future

- Defining innovation in public health: think tank
- How to get there
- Educational opportunities
- Website with library of resources and examples
- Fostering innovative practice, dissemination
- FPHS model revision

phnci

PHAB

Public Health National Center for Innovations
at the
Public Health Accreditation Board
1600 Duke Street, Suite 200
Alexandria, VA 22314
703-778-4549

www.phaboard.org* or *www.phnci.org

PHAB

Findings from Oregon's public health modernization assessment

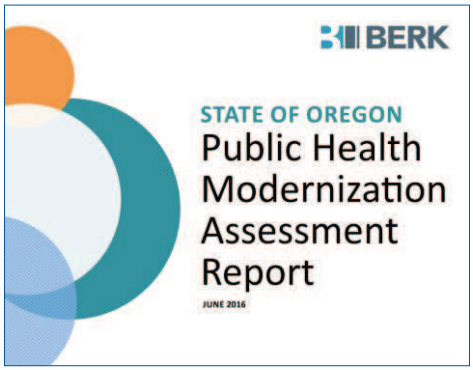
Sara Beaudrault
Oregon Health Authority, Public Health Division
Office of the State Public Health Director

Oregon Health Authority
PUBLIC HEALTH DIVISION
Office of the State Public Health Director

Public health modernization assessment

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?



Oregon Health Authority

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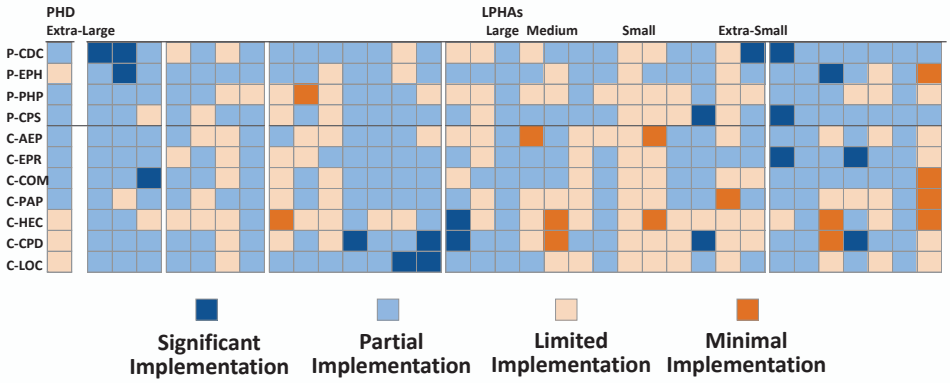
Programmatic gaps in current governmental public health system

implementation is uneven across the system.



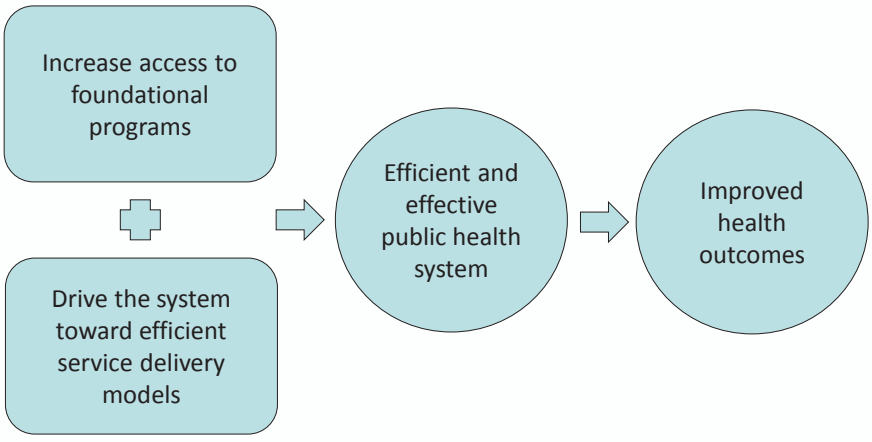
Oregon Health Authority

24

In more than one third of Oregon communities – **over 1.3 million people** – foundational programs are limited or minimal.

25

Strategy for modernizing the public health system



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Where do we begin?

Criteria for identifying priorities for the 2017-19 biennium

1. Population health impact
2. Service dependency
3. Equity
4. Population coverage

27

Recommended priorities for 2017-19

- Communicable diseases
- Environmental health
- Emergency preparedness
- Health equity
- Population health data (assessment and epidemiology)
- Public health modernization planning (leadership and organizational competencies)

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Scaling up public health modernization

2017-2023 public health modernization priorities	
Biennium	**Foundational capabilities and programs**
2017-2019	• Communicable disease control • Environmental health • Emergency preparedness • Health equity and cultural responsiveness • Assessment and epidemiology • Leadership and organizational competencies
2019-2021	• Prevention and health promotion • Communications • Community partnership development • Continue and expand on work on the foundational capabilities and programs implemented in 2017-2019
2021-2023	• Access to clinical preventive services • Policy and planning • Continue and expand on work on the foundational capabilities and programs implemented in 2017-2021

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Modernization at the Local Level

Coalition of Local Health Officials (CLHO)

Morgan Cowling – Executive Director

Charlie Fautin – Board Chair

www.oregonclho.org

Moving theory into practice

- Identify opportunities for local departments
  - Local
  - Cross-Jurisdictional
  - With the State
- Engage with communities and build understanding of and support for Public Health Modernization
- Build support from state and local elected officials

Coalition of Local Health Officials

Improving the Health of Oregonians – Communicable Disease

Figure 1. Chlamydia incidence,
Oregon 2006–2015

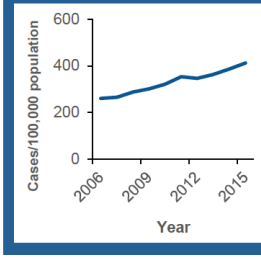
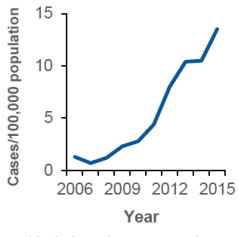
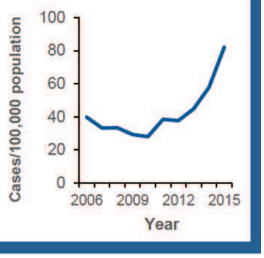


Figure 3.
Early syphilis* incidence,
Oregon 2015



* includes primary, secondary and early latent stage infection

Figure 7.Gonorrhea incidence,
Oregon 2006– 2015

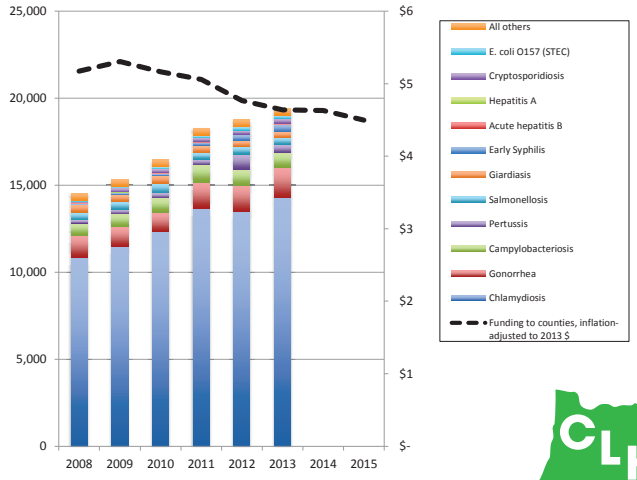


Coalition of Local Health Officials

Communicable Disease Workload and Funding

Communicable disease, TB and STD funding to counties, in $ millions

Number of cases of select notifiable conditions



Coalition of Local Health Officials

Addressing Environmental Health

- Public environmental health issues we have only just begun to address systematically
  - ~18,000 Oregon school age children have asthma
  - Air & Water contamination
  - Climate Health

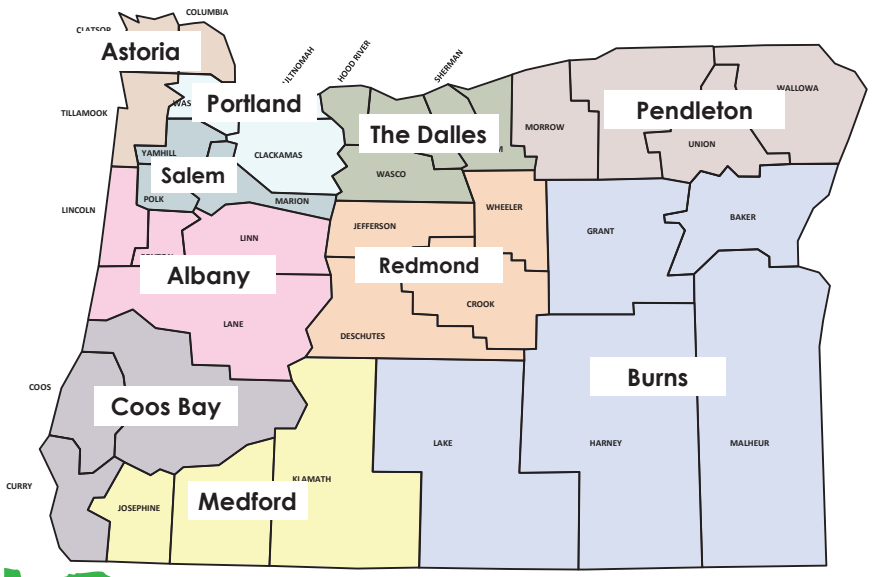
Coalition of Local Health Officials

Foundational Capabilities

- **Health Equity** is a major social determinant
- **Population health data** must become more timely, meaningful, and accessible
- **PH system leadership** (and workforce) need better knowledge of modernization & integrate it into strategies and operations

Build Understanding and Support

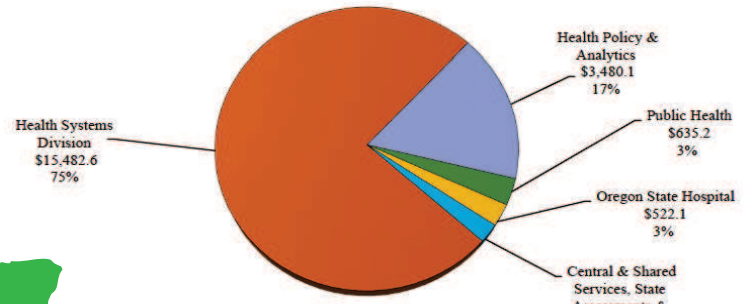
- Robert Wood Johnson Foundation / Public Health National Center for Innovation identified Oregon
- 10 Meetings across Oregon covering the whole state
- Health care delivery partners, early learning partners and local elected officials participate

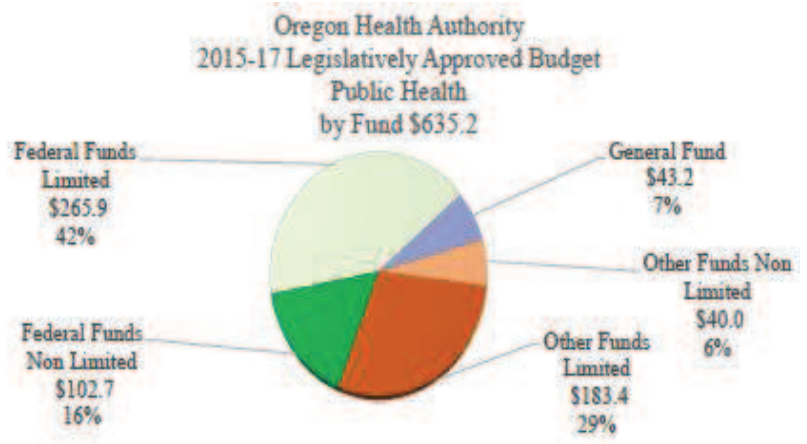


AIMHI Statewide Meetings

Engaging State Leaders in Supporting Public Health

Oregon Health Authority
2015-17 Legislatively Approved Budget
Total Funds by Program Area
$20,574.1





Coalition of Local Health Officials

How you can help?

- **Educate** – talk to people about Public Health
- **Engage** – with your local – city, county, state elected officials
- **Advocate** – get involved with organizations like OPHA
- **Endorse** – if you are part of an organization help us by endorsing the budget request

www.oregonclho.org

Coalition of Local Health Officials

Audience Questions and Discussion

PHD Health Equity Working Committee
Referenced Health Equity Definitions
DRAFT October 20, 2016 – Shared with PHAB

1. Health equity exists when all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance. (CDC) http://www.cdc.gov/nchhstp/socialdeterminants/definitions.html

2. Health equity means all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions. (National Collaborating Centre for Determinants of Health (2014). http://nccdh.ca/resources/glossary

3. Health equity asserts that all people can reach their full health potential and should not be disadvantaged from attaining it because of their social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance. (Braveman, P, (2006). Health Disparities and Health Equity: Concepts and Measurement. Annual Review of Public Health 27: 167-94.

4. Health equity means that all persons have fair opportunities to attain their health potential to the fullest extent possible. (LaVeist, T., Issac, L. (2011). Race, Ethnicity and Health: A Public Health Reader. Centers for Disease Control.

5. Health equity is defined as the absence of unfair, avoidable or remediable differences in health among social groups. World Health Organization, Commission on Social Determinants of Health, (2007). A Conceptual Framework for Action on the Social Determinants of Health

6. Health equity means that everyone has a fair opportunity to live a long, healthy life. It implies that health should not be compromised or disadvantaged because of an individual or population group's race, ethnicity, gender, income, sexual orientation, neighborhood or other social condition. Achieving health equity requires creating fair opportunities for health and eliminating gaps in health outcomes between different social groups. It also requires that public health professionals look for solutions outside of the health care system, such as in the transportation or housing sectors, to improve the opportunities for health in communities. (Boston Public Health Commission. http://www.bphc.org/whatwedo/health-equity-social-justice/what-is-health-equity/Pages/what-is-health-equity.aspx)

Health Equity Working Committee DRAFT Health Equity Definition (as of 10.14.2016)

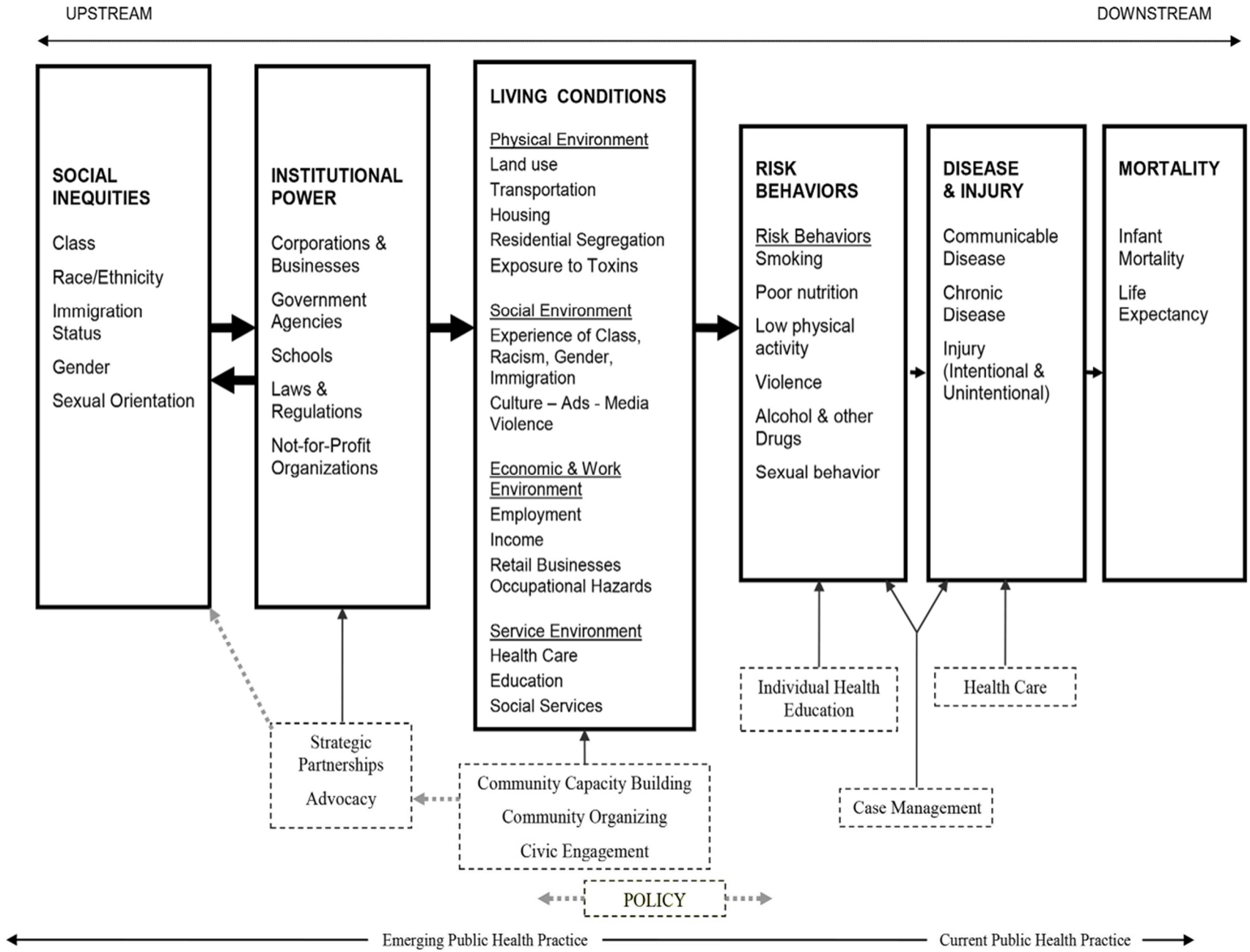
Health Equity Work Committee criteria for a definition:

- Definition must express and explicit value for social justice
- Definition must be explicit about the equitable distribution of power
- Definition must be make explicit that action can increase health equity

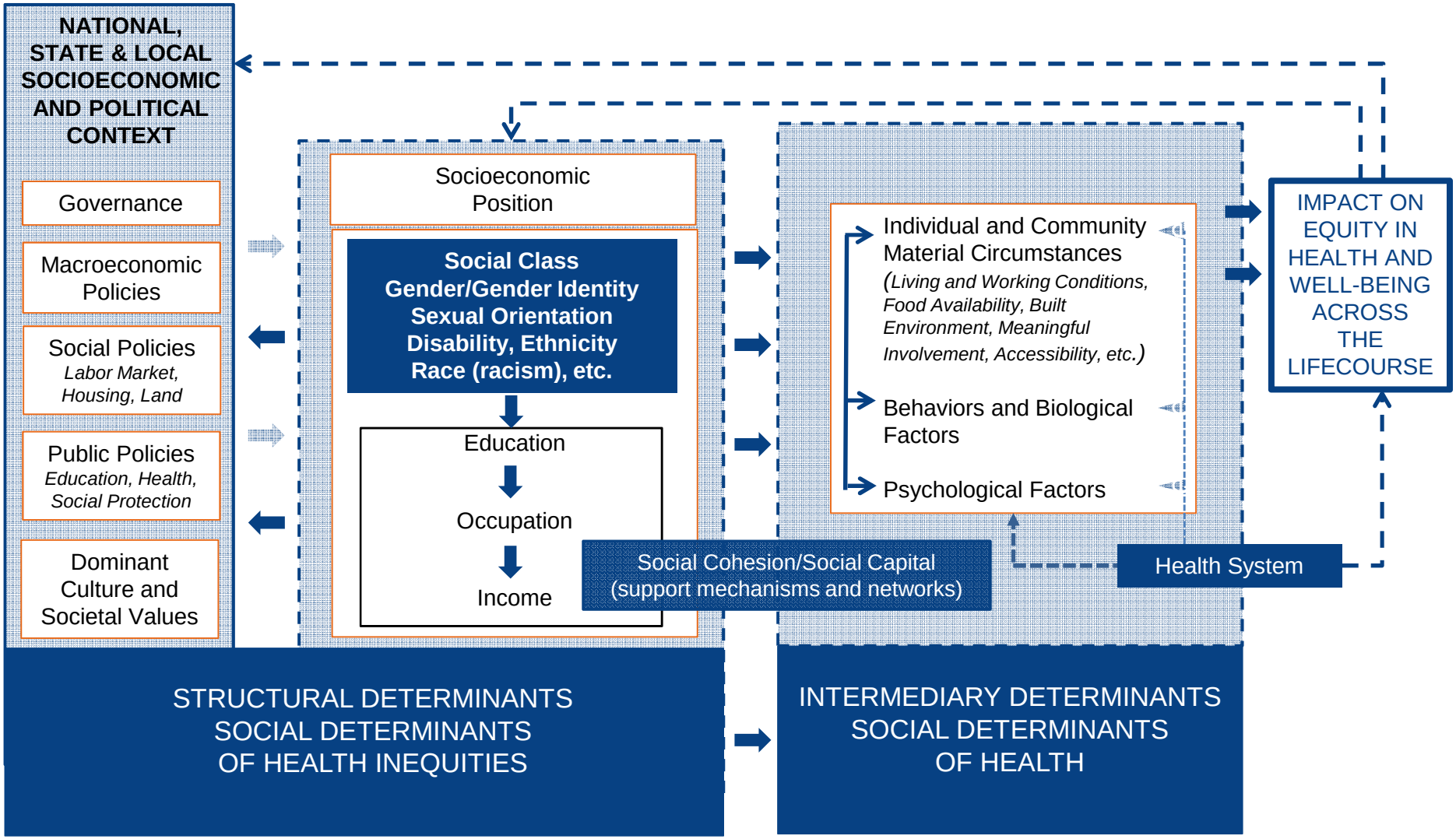
Health Equity Work Committee draft definition:

The Public Health Division defines health equity as the absence of unfair, avoidable, or remediable difference in health among social groups.

> Health equity implies that health should not be compromised or disadvantaged because of an individual or population group's race, ethnicity, disability, gender, income, sexual orientation, neighborhood, or other social condition.
>
> Achieving health equity requires the equitable distribution of resources and power for health and the elimination of gaps in health outcomes between different social groups.
>
> Health equity also requires that public health professionals look for solutions outside of the health care system, such as in the transportation or housing sectors and through the distribution of power and resources, to improve health with communities.


UPSTREAM
DOWNSTREAM
SOCIAL INEQUITIES
Class
Race/Ethnicity
Immigration Status
Gender
Sexual Orientation
INSTITUTIONAL POWER
Corporations & Businesses
Government Agencies
Schools
Laws & Regulations
Not-for-Profit Organizations
LIVING CONDITIONS
Physical Environment
Land use
Transportation
Housing
Residential Segregation
Exposure to Toxins
Social Environment
Experience of Class, Racism, Gender, Immigration
Culture – Ads - Media Violence
Economic & Work Environment
Employment
Income
Retail Businesses
Occupational Hazards
Service Environment
Health Care
Education
Social Services
RISK BEHAVIORS
Risk Behaviors
Smoking
Poor nutrition
Low physical activity
Violence
Alcohol & other Drugs
Sexual behavior
DISEASE & INJURY
Communicable Disease
Chronic Disease
Injury (Intentional & Unintentional)
MORTALITY
Infant Mortality
Life Expectancy
Individual Health Education
Health Care
Strategic Partnerships
Advocacy
Community Capacity Building
Community Organizing
Civic Engagement
Case Management
POLICY
Emerging Public Health Practice
Current Public Health Practice

Framework for Action on Social Determinants of Health



Adapted from the World Health Organization, Commission on Social Determinants of Health, Framework for Action on Social Determinants of Health (2007).

Statewide modernization plan outline
October 2016, DRAFT

1. **Table of contents**

2. **Executive summary**

3. **Background**
    a. The need for a modern public health system
    b. The modernization framework
    c. Progress to date

4. **Key findings from public health modernization assessment**

5 **Implementing the public health modernization model over the next three biennia**
    a. Implementation will happen through:
        i. Increasing capacity throughout the public health system to provide foundational services and programs to all people in Oregon. This will increase protection from communicable diseases, limit environmental health risks and prepare for emergencies.
        ii. Driving system change by allocating resources toward exploring and establishing alternative service delivery models.
        iii. This two-pronged approach will create a more efficient and effective system and ensure all people in Oregon have access to the same level of public health services.
    b. Methods/opportunities to explore new service delivery models
        i. Meetings, materials, etc.
        ii. Description of cross jurisdictional sharing that is already occurring, or examples of where it could occur
            1. Sharing services between counties
            2. Exploring state/local service delivery
            3. Collaborating across sectors (CCOs, early learning, etc)
    c. Planned phase in of foundational capabilities and programs
        i. Description of phased approach
        ii. Full implementation by 2023
    d. 2017-19 priorities
        i. Description of the six priority areas
        ii. Resources needed ($30M)
    e. Implementation contingent upon available funding

6 Implementation plan for coming years

a. Contracting mechanism and scope of work development
    i. Considerations for establishing a new performance based funding mechanism *(What does the funding mechanism need to do? What needs to be different from existing funding mechanisms)?*
    ii. Process for developing scope of work
    iii. Scope of work to include:
        1. Shared set of roles, deliverables and outcomes
        2. Local flexibility to focus resources on local priorities
        3. Exploration of new service delivery models
    iv. Discuss the need to balance shared set of roles/deliverables with local flexibility
    v. Discuss the need to align scope of work with available funding
    vi. Scope of work to be finalized after the 2017 legislative session
b. Local Public Health Authority funding formula
    i. Description of funding formula
    ii. Initial payments to LPHAs anticipated for late 2017/early 2018. Funding for 2017-19 will go toward baseline components of the funding formula to fill critical gaps that have been un- or underfunded.
    iii. Funding formula components for state matching funds for local investments and incentive payments for performance on accountability measures to be incorporated into funding formula in FY2020 (tentative; this is the recommendation of the PHAB Incentives and Funding subcommittee).
    iv. Steps to finalize and implement state matching funds for local investments
    v. Steps to finalize and implement incentive payments for performance on accountability measures
    vi. Updated funding formula to be submitted to LFO by June 30 of each even-numbered year
c. LPHA modernization work plans for 2017-19 priorities
    i. Will be required to receive funding
    ii. OHA to develop local modernization plan template
    iii. Technical assistance to be made available
    iv. OHA to develop process for reviewing and approving plans
d. Comprehensive local modernization plans by 2023
    i. Roadmap and other tools available
    ii. Criteria for these comprehensive plans to be established
e. CLHO cross-jurisdictional meetings and technical assistance
    i. Description of RWJF grant and how grant funds are being used in Oregon

ii. Opportunity to begin discussions on regional needs and explore alternative service delivery models

f. Oregon Administrative Rules
    i. Timeline for convening RAC and finalizing rules

7 Monitoring and accountability

a. PHAB – accountable body for public health system
b. Annual reporting
    i. Accountability metrics
    ii. Evaluation of implementation
c. Annual work plans and progress reports
d. Ongoing technical support (What mechanisms will be in place for LPHAs to share what's working)?
e. Public health modernization assessment update – to gauge changes in the system, including financial resources needed to fully implement the public health modernization model

8 Implementation timeline

a. Table describing key activities and deliverables for 6a-f

9 Appendices

Statewide modernization plan timeline
October 2016

This timeline lists PHAB and CLHO meeting times during which work will occur on key components of the statewide modernization plan (i.e., funding formula and accountability metrics), or during which the statewide modernization plan will be reviewed. Red font indicates final opportunities for review.

October	PHAB Incentives and Funding subcommittee meeting - Make recommendation for which funding formula model to continue to develop	Oct 18, 2016 2:00-4:00
	CLHO meeting - Provide overview for statewide modernization plan - Share outline	Oct 20, 2016 9:30-2:00
	PHAB meeting - Provide overview for statewide modernization plan - Share outline	Oct 20, 2016 2:30-5:30
	PHAB Accountability Metrics subcommittee meeting - Review PHAST measures	Oct 27, 2016 2:00-3:00
November	CLHO Special Webinar - Review draft statewide modernization plan - Solicit feedback (11/7-11/17)	Nov 7, 2016 3:30-4:30
	PHAB Incentives and Funding subcommittee meeting - Finalize data sources - Finalize percent allocations for indicators	Nov 8, 2016 1:00-3:00
	PHAB Accountability Metrics subcommittee meeting - Develop measure set for communicable disease, environmental health and emergency preparedness - Final review and approval by subcommittee members of accountability metrics structure to be included in statewide modernization plan	Nov 15, 2016 2:00-4:00
	CLHO meeting *(to be held in Eugene)* - Review draft statewide modernization plan, including feedback received following 11/7 CLHO special webinar	Nov 17, 2016 9:30-2:00
	PHAB meeting - Review draft statewide modernization plan - Review funding formula - Review accountability metrics	Nov 17, 2016 2:30-5:30

December	PHAB Incentives and Funding subcommittee meeting - Final review and approval by subcommittee members of initial funding formula to be included in statewide modernization plan	Dec 13, 2016 1:00-3:00
	CLHO meeting - Final review of statewide modernization plan	Dec 15, 2016 9:30-2:00
	PHAB meeting - Final review and approval of statewide modernization plan	Dec 15, 2016 2:30-5:30
	PHAB Accountability Metrics subcommittee meeting - *Agenda tbd*	Dec 19, 2016 10:00-11:00
	OHA clearance	Dec 16-31, 2016
	Statewide modernization plan complete	Dec 31, 2016