AGENDA

PUBLIC HEALTH ADVISORY BOARD

November 17, 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

Meeting objectives

- Review and provide feedback on work to date by the Public Health Advisory Board Incentives and Funding and Accountability Metrics Subcommittee meetings.
- Discuss draft statewide public health modernization plan

2:30-2:40 pm	**Welcome** • Approve October 20, 2016 minutes	Jeff Luck, PHAB Chair
2:40-2:50 pm	**Updates** • CLHO public health modernization meetings • Public Health National Center for Innovations meeting (11/10-11/11)	Morgan Cowling, Coalition of Local Health Officials Sara Beaudrault, Oregon Health Authority
2:50-3:50 pm	**Subcommittee reports** • Review work-to-date to develop a funding formula model. Bring forward a funding formula model recommendation for consideration by the Board. • Review work-to-date to develop a set of accountability metrics.	Eli Schwarz, Accountability Metrics subcommittee member Akiko Saito, Incentives and Funding subcommittee member
3:50-4:05	**Break**	
4:05-4:35 pm	**Review draft statewide public health modernization plan** • Review elements of the plan • Review feedback received from local public health administrators • Discuss recommended changes by PHAB members	Sara Beaudrault, Oregon Health Authority

4:35-4:45 pm	**Public comment**	
4:45 pm	**Adjourn**	Jeff Luck, PHAB chair

Public Health Advisory Board (PHAB)
October 20, 2016
Portland, OR
Draft Meeting Minutes

Attendance:

Board members present: Carrie Brogoitti, Muriel DeLaVergne-Brown, Silas Halloran-Steiner (by phone), Jeff Luck, Eva Rippeteau, Eli Schwarz, Lillian Shirley, Teri Thalhofer, Tricia Tillman (by phone), and Jennifer Vines

Oregon Health Authority (OHA) Public Health Division (PHD) staff: Sara Beaudrault, Rosa Klein, Tim Noe, Angela Rowland

Invited guests: Representative Mitch Greenlick, Senator Laurie Monnes Anderson, Carlos Crespo, Oregon Health Policy Board

Members of the public: Morgan Cowling, Coalition of Local Health Officials; Jan Johnson, The Lund Report; and Justin Freeman, State Representative Mitch Greenlick's Legislative Director.

Changes to the Agenda & Announcements

There were no changes to the agenda.

There are four PHAB member appointments expiring at the end of this year. OHA is working with current Board members whose terms are expiring to submit reappointment forms if members are interested in doing so. OHA will share the recruitment announcement with Board members when it goes out. Please share it with individuals who may be interested in filling one of the seats.

The PHAB Special Webinar to review the PDES *Health and Economic Benefits of Public Health Modernization* Report will be on October 27, 2016.

Morgan Cowling with the Coalition of Local Health Officials (CLHO) gave an update on the Aligning Innovative Models for Health Improvements in Oregon (AIMHI) meetings that CLHO is holding across the state. PHAB members are strongly encouraged to attend. Please visit: http://oregonclho.org/public-health-issues/aimhi-meetings/ for more information and to register.

Approval of Minutes

A quorum was present. The Board unanimously voted to approve the edited September 12, 2016 minutes.

Subcommittee reports

-Muriel DeLaVerge-Brown, Accountability Metrics subcommittee member

The subcommittee met on September 22, 2016. Jeff Luck joined this meeting, and the subcommittee agreed to focus in on measures for communicable disease, environmental health, and preparedness. Greg Whitman with the Public Health Activities & Services Tracking (PHAST) will join the subcommittee's next meeting on Oct 27 to review the PHAST measure set. The group discussed communicable disease measures and identified those that are in public health's wheelhouse, like STDs, foodborne illness and tuberculosis. The subcommittee agreed to do "homework" to continue to review which measures are appropriate to demonstrate progress toward modernization and focus on the assessment gap analysis.

-Jeff Luck, Incentives and Funding subcommittee member

The Incentives and Funding subcommittee has met twice since the last PHAB meeting.

At the September meeting the subcommittee discussed how to use the funding formula to incentivize change, including by incentivizing sharing services through cross-jurisdictional sharing agreements or other mechanisms. The group has discussed the use of grants for pilot projects for exploration and adoption of innovative sharing mechanisms.

At the October meeting the subcommittee got into details about the funding formula. Jeff reviewed the three versions of the funding formula that were shared with Board members. The subcommittee would like to hear feedback from the Board on these models.

Representative Greenlick asked what the cost per person is to deliver foundational public health services. The modernization assessment determined by county how much money was needed per year to implement the foundational services, but it wasn't calculated per capita. Representative Greenlick suggested starting with what's needed rather than focusing on what we could do with monies made available. Based on the $105M gap and ~4 million residents in Oregon, the annual per capita need is approximately $26.60. Board members stated that there is enough information in the assessment report and the *Health and Economic Benefits of Public Health Modernization* report to determine a rough estimate. Representative Greenlick reminded the Board that the public health system's task is to deliver a plan over the next decade of how we will get where we need to be, and it is the legislature's task to figure out how to fund it.

Senator Monnes Anderson encouraged local health departments to engage local policy makers – CCOs, health systems, early learning and other community partners - to incorporate public health modernization in their communities. She discouraging continuing this work in silos.

Advancing public health system change

-Representative Mitch Greenlick- District 33
-Senator Laurie Monnes Anderson, District 25

Representative Greenlick encouraged the Board to create a comprehensive map for all counties over the next decade. The map can be used to display an agreement county by county on how each county will achieve the goals of public health modernization. This may include regionalization in some counties. The model would help the Ways and Means committee make funding decisions based on the long-term picture and the steps needed to get there. Legislators need to be aware of what will happen for their constituents and when.

Representative Greenlick envisioned a plan coming out of HB 3100 that would fund a set of local health departments to modernize, expanding to additional sets of local health departments in each biennium. Senator Monnes Anderson concurred.

PHAB members spoke about how this implementation model and the current proposal to implement across all health departments simultaneously may impact counties.

Muriel shared that discussions about the model for how public health services can be provided locally have begun. One concern about funding some, but not all, counties will lead to haves and have nots. One finding from the assessment is that there are gaps across the entire system, in all foundational capabilities and programs, and for all local health departments. In order to work toward equity the model should be implemented across the entire system.

Teri stated that there may be missed opportunities of cross-jurisdictional sharing if all communities aren't moving forward in the same direction simultaneously.

Silas expressed that implementing by county waves may present a risk if funding does not become available to spread the model to other counties. He also raised an ethical question of improving capacity for work like communicable disease prevention while leaving other communities at higher risk. If modernization is implemented across the entire system with an initial focus on a subset of foundational capabilities and programs, local communities could identify where the investment goes, with a measurable plan to address the community's needs.

Carlos suggested looking at different levels of readiness across counties and said that some counties have a different level of readiness. If a county is in an urgent need, could be funded first through a different formula.

Tricia commented that the self-assessment looked at lack of capacity or expertise and not at health outcomes. It can be tricky to correlate investment with health outcomes; individual community challenges should also be considered.

Muriel stated that all local health departments are engaged and are working toward modernization. The counties are excited to move forward at the same time. Also, things like communicable diseases cross county lines, so this should be viewed as a true systems approach.

Carrie acknowledged that there are varying levels of readiness across counties. When counties come together to talk about something like communicable disease, it is a mechanism to start having the broader conversations.

Eva feels that implementing an initial set of foundational capabilities and programs across the entire system will build collaboration and prevent competition that may occur if some counties are funded but others are not.

Rep. Greenlick recommended communicating clearly with local health officials, county judges, and county board members. Each county representative should talk to their own senators and representatives. He encouraged the Board to continue working toward a clear vision of what it will take to modernize the public health system. He will support an implementation plan that moves the entire system forward simultaneously but needs the Board and public health authorities to give him the information he will need to take this forward.

Sen. Monnes Anderson stated that public health needs to be in the forefront and she continues to support modernization. She also wants to see county by county information about what is needed to become modernized.

Muriel stated it is easier for her to talk to her elected officials when she can say this is for everyone, not just for certain counties.

Eli stated that based on the assessment report one could determine the readiness by county. Counties do not want their specific information made public in that way since it is not scientific enough. Will continue to use the county size bands and prioritize the gaps in the next biennium. Teri is concerned of funding by readiness by county, as it eliminates the spirit of this work to collaborate. Should not be looking at county by county service delivery or state vs. local and instead look at innovative partnerships across the system.

Updates from CLHO Retreat and OPHA conference
-PHAB Members

Muriel provided an overview of the CLHO retreat.

- Discussion on public health modernization themes such as priorities
- Talked about accountability by choosing measures that showed success.
- Discussion about equity across the system
- Robust conversation with state staff on how to work together
- Job shadowing across departments / state and local
- Reorganizing CLHO committees.
- Locals provide technical assistance to the state as well

Jeff provided a quick overview of OPHA conference:

- Oregon Public Health Association (OPHA) Annual meeting was last week in Corvallis.
- The closing plenary session was about public health modernization. The slides are included in today's meeting packet.
- Provided history of public health modernization
- Good crowd and energy

Health equity definition and framework

-Tim Noe, Oregon Health Authority

Tim provided an overview of the PHD Health Equity Committee, which was formed, in part, in response to needs identified in the PHD modernization assessment. Tim reviewed criteria the committee has used to select a definition, as well as the committee's draft definition.

> *The Public Health Division defines health equity as the absence of unfair, avoidable, or remediable difference in health among social groups.*
> *Meaningful engagement with social groups. Interesting to define it by the absence of something.*
>
> *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.*

Eli noted that health equity is being framed as an absence of conditions. The group discussed what it means to remove these conditions.

Tricia shared information about Multnomah County's work in health equity. She stated the need to dismantle institutional white dominance. Health should not be compromised because society is organized to disadvantage certain groups of people. This could be incorporated into the definition by calling out societal prejudice, racism and discrimination, by a certain individual group. She offered a second look at the second paragraph to redistribute existing resources and power now versus later. Using a restorative justice approach requires looking back, not only forward.

-Kati Moseley, Oregon Health Authority

Kati reviewed the PHD conceptual framework for health equity. Kati shared a modified version of a framework developed by the World Health Organization (WHO) framework and the Bay Area Regional Health Inequities (BARHI) Initiative framework. PHD's version of the framework is helpful at a system level but is less useful when thinking about individual jobs or responsibilities. It seeks to define a broader lane for public health practice.

Lillian explained this work will be embedded in the division and will require PHD to work as a system rather than program by program.

Tricia asked how to build communication across the state and local level. How do we build the whole system as we learn about and engage in equity? Is PHD's committee informed by external partners? Lillian responded that we don't have that platform yet; it is aspirational and we can work toward it. Lillian recommends a deliberate approach with a work plan with actionable steps.

Statewide modernization plan

-Sara Beaudrault, Oregon Health Authority

The statewide modernization plan will be completed by the end of 2016. It will be built upon the report to legislative fiscal office and will demonstrate how public health modernization will be scaled up over the next 10 years. Sara reviewed an outline for the plan and steps that will be taken to complete this plan by the end of the year.

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 departments as it compares to the assessment gaps.

The meeting was adjourned.

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

November 17, 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
DRAFT Accountability Metrics Subcommittee Meeting Minutes

October 27 2016
2:00 – 3:00pm

PHAB Subcommittee members in attendance: Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Jennifer Vines

PHAB Subcommittee members absent: Muriel DeLaVergne-Brown

OHA staff: Sara Beaudrault, Myde Boles, Rebecca Pawlak, Angela Rowland

Members of the public: Kelly MacDonald

Welcome and introductions

The September 22 draft meeting minutes were unanimously approved by the subcommittee.

Public Health Activities & Services Tracking (PHAST) measures

Betty Beckmeier and Greg Whitman from the University Of Washington School Of Nursing provided an overview of the PHAST measures.

The beginning measure set started with the Multi-network Practice and Outcome Variation Examination (MPROVE) measures. The purpose is to identify high value public health service measures across jurisdictions and collect the evidence based data. They were sorted in three core public health domains: Communicable Disease Control, Environmental Health Protection, and Chronic Disease Prevention. They are working with states to adopt these measures and use them for public health practice.

Eli asked if there are any national groups working with this criteria and Greg stated that a crosswalk is included in the presentation materials.

In May 2015 the MPROVE measures evolved to correct errors, provide clarity, and add responsibility questions.

Jennifer commented that these are process outcomes and inquired if there are any cause and effect outcomes. Betty stated this is activity data and do have some outcome data with behavior changes. She did work on existing data and did some matching of health department data with health outcomes to demonstrate the local public health contribution of services. She found the data was very limited across the states. Jen cautions the cause and effect of these findings and to be explicit with what is known and unknown.

Betty explained the obesity prevention data findings showing that prevalence of obesity is lower and physical activity is higher in all LHD groups with population-based interventions compared to LHDs with no apparent activities. Also, population-based interventions are more strongly linked to positive outcomes in literature when compared to individual-level interventions.

Eli questioned whether there is currently a standardized instrument to collect data at a county level. Betty stated that PHAST has received funding from the Robert Wood Johnson Foundation to provide a standardized instrument to collect these data at a local level.

Betty also presented the cross-jurisdictional sharing and immunization completeness study. Health departments that were sharing services had higher immunization completeness rates for toddlers.

For more information: http://phastdata.org

Subcommittee business

The next subcommittee meeting will be a two-hour in-person meeting held on November 15th. The materials will be sent out ahead of time to allow for committee members to review and come back with decisions to put forward. The group will work to prioritize environmental health and communicable disease PHAST measures as well as state health profile indicators.

Eli recommended a crosswalk of the measures be provided.

Public comment
No public testimony.

Adjournment

The meeting was adjourned.

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
DRAFT
November 8th, 2016
1:00-3:00 pm

Welcome and roll call

Meeting Chair: Silas Halloran-Steiner

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

Oregon Health Authority (OHA) staff: Sara Beaudrault, Chris Curtis, Angela Rowland

Members of the public: Morgan Cowling

The October 18th PHAB Incentives and Funding meeting minutes were approved.

Debrief Oct 20th PHAB discussion

Silas led a discussion to debrief the October 20th PHAB discussion with Representative Greenlick and Senator Monnes Anderson. One stand out was that Representative Greenlick stated his ongoing support for public health modernization. While Representative Greenlick and Senator Monnes Anderson have continued to think about implementation occurring by county waves, PHAB members explained the rationale for implementing by foundational capabilities and programs across the entire public health system in terms of equity, ethics and logistics for how to operationalize. Subcommittee members agreed to continue developing a funding formula model that is in line with this implementation approach.

Jeff stated that Representative Greenlick encourages PHAB to develop a 10-year plan and acknowledge the investment that will be needed to fully implement public health modernization over the next 10 years.

Review data sources for funding formula indicators

Subcommittee members held a consensus around including the following six indicators in the funding formula model: county population, burden of disease, health status, racial/ethnic diversity, limited English proficiency, and poverty.

OHA staff have compiled a list of data sources for county population and the other funding formula indicators. The subcommittee needs to determine if the funding formula should use Portland State University (PSU) population estimates or U.S. Census Bureau American Community Survey (ACS) data for county population.

The subcommittee agreed to use the PSU population estimates. Since the PSU estimates are not generated for race/ethnicity, limited English proficiency or poverty, ACS estimates will be used to determine a proportional percentage that will be applied to the PSU estimates. Subcommittee members

requested that the subcommittee continue to explore options to account for projected population growth in the funding formula.

The poverty indicator is currently calculated from American Community Survey and looks at both children and adults living under the federal poverty level. It is a commonly used measure but doesn't factor in socioeconomic factors that directly impact poverty, like education or employment. Jeff recommended to review the supplemental poverty measure from the U.S. Census Bureau as a potential data source prior to the December meeting. This measure takes into account local variations in housing costs, transfer payments, and other governmental programs. It is not known whether this is calculated at the county level. Subcommittee members agreed to look at this measure at the December meeting. If these data are not available at the county level the subcommittee will continue to discuss alternative poverty measures that look at income inequality or educational attainment at the December meeting.

Subcommittee members questioned whether the Behavioral Risk Factor Surveillance System survey BRFSS) has an acceptable reach into communities of color to be used as a data source for health status. Generally subcommittee members did not feel that BRFSS is adequate, although alternative data sources were not proposed.

Action Item: Explore U.S. Census Bureau supplemental poverty measure. If reported at the county level, bring county rates to the December meeting, to compare with income inequality.

Action Item: Subcommittee members and OHA staff should identify alternative data sources for the health status indicator prior to the December meeting.

Discuss funding formula models and make initial recommendations

OHA staff updated the three funding formula models after the October meeting.

Silas recommends to narrow the model options by removing model #1 (Equal base; county population; five indicators tied to county population) as it doesn't seem too modern. Model 2 and 3 differ in the structure for base/floor payments (equal across all counties or tiered).

Tricia recommends comparing model #1 and model #3, as model #2 does not represent the needs of large and extra-large counties. Model #3 seems to best address the needs across the system that have been voiced.

Sara reviewed a spreadsheet showing per capita resource gaps identified in the public health modernization assessment. Per capita gaps were displayed for foundational capabilities and programs, and for county size bands.

Jeff stated that it is important to compare per capita gaps with the funding formula to make sure the formula matches the solution pattern in the models.

Tricia stated that the assessment looked at capacity and expertise but not burden of disease. She stated that overall health and burden of disease is a small portion of the measure in the funding formula. ,

A motion was made to recommend model #3 (Model 1, Variation 2 – Tiered base; five indicators tied to county population) to PHAB at the November 17 meeting. Subcommittee members expressed agreement; this is the most equitable approach. This motion was approved.

Action Item: Bring subcommittee recommendation of model #3 (Model 1, Variation 2 – Tiered base; five indicators tied to county population) to the Nov 17th PHAB.

Subcommittee Business

Akiko volunteered to report out at the Nov 17th PHAB meeting and will chair the next subcommittee meeting. Subcommittee members requested that OHA staff cross-reference questions that were asked at the October 20 PHAB meeting to identify whether any questions would remain unresolved with this funding formula.

Sara provided the Local Public Health Funding Formula section of the Statewide Modernization report for subcommittee feedback. The PHAB will review at the Nov 17th meeting.

- The baseline amount could include a health equity bullet.
- The report should explain that the subcommittee hasn't spent much time on state matching funds.
- Keep the baseline funding section a different color to indicate that this is where the subcommittee's work-to-date has focused.
- Describe alignment with the PHAB Accountability Metrics subcommittee.
- Summarize the model recommendation from the subcommittee.
- Performance based incentives for equitable public health services.
- Explain why the model ties the indicators to population.

Action Item: The subcommittee again requests a joint meeting with the Accountability Metrics subcommittee. This could be at the beginning of 2017. Incentives and Funding subcommittee members may join an upcoming accountability Metrics meeting.

Next subcommittee agenda item: Determine how to use this model for performance based incentives to provide equitable public health services.

Public Comment

Morgan Cowling, Executive Director of Coalition of Local Health Officials

Morgan appreciates that the PHAB has set a path for thoughtful deliberation on modernization. She remarked that it could pose a challenge to only provide one funding formula model. She is unable to determine if the incentives piece is for performance based metrics or structural in HB 3100. She encourages the subcommittee to incentivize different models through the funding formula. More outreach will be needed to local public health authorities to get their take on funding formula recommendations. She encourages the subcommittee to focus on the incentives work. She also encourages the subcommittee to continue to look at HB 3100 guidance on the ability of counties to invest in public health.

Accountability Metrics

In 2014, the Task Force on the Future of Public Health Services called for a set of state and local metrics to track improvements and changes to the public health system. These metrics would be established and monitored by the Public Health Advisory Board.

House Bill 3100 requires the use of incentive payments as a component of the local public health funding formula to encourage the effective and equitable provision of public health services. Through this requirement, local public health authorities (LPHAs) will be eligible to receive performance-based incentive payments for achieving a set of accountability metrics.

Oregon Health Authority and the Public Health Advisory Board will establish a comprehensive set of accountability metrics that will be used to monitor improvements across Oregon's public health system for all foundational capabilities and programs. A subset of these metrics will be selected as performance-based incentive measures for LPHAs. LPHAs will be eligible to receive incentive payments with a portion of monies made available in the 2019-21 biennium. [1]

The Public Health Advisory Board Accountability Metrics subcommittee

The Public Health Advisory Board formed a subcommittee to develop a set of accountability metrics that will demonstrate progress toward achieving improved health and system outcomes. This Accountability Metrics subcommittee has met monthly since June 2016.

Key activities to date

The PHAB Accountability Metrics subcommittee has completed the following key activities:

- Developed criteria for measure selection
- Reviewed existing state measure sets to identify areas for alignment
- Identified measures for 2017-19 priority areas *(in process)*

Measure selection criteria

The subcommittee applied the following criteria to proposed measures to determine whether each would be an appropriate measure of a modernized public health system:

Must pass criteria	Additional criteria to be considered
a. Promotes health equity	f. Consumer engagement

[1] The Public Health Advisory Board's Incentives and Funding subcommittee has recommended that all monies made available to implement foundational capabilities and programs in the 2017-19 biennium be directed toward base funding for local public health authorities. This will allow LPHAs to develop capacity and make changes to their current operating structure before being eligible to receive incentive payments. Also, this will allow time to set up data collection and reporting systems and collect baseline data.

b. Respectful of local priorities	g. Relevance
c. Transformative potential	h. Attainability
d. Consistency with state and national quality measures, with room for innovation	i. Accuracy
e. Feasibility of measurement	j. Reasonable accountability
	k. Range/diversity of measures

The subcommittee will develop a recommended measure set that balances the following:

- Process and outcome measures
- Measures that monitor our current, core work and aspirational measures that we will work toward
- Measures that monitor the progress of the entire public health system and measures of LPHAs that will be used to award performance-based incentive payments

The final set of recommended accountability metrics will require each state and local public health authority to work toward a common set of accountability metrics. LPHAs may select additional metrics that align with local priorities identified in the community health improvement plan.

Timeline for establishing and implementing accountability metrics

The PHAB Accountability Metrics committee will continue to meet in 2017. Additional work to be completed includes:

Solicit input through a survey of partners on recommended measures for the 2017-19 biennium	Q1 2017
Identify and recommend accountability metrics for foundational capabilities and programs that will be implemented in 2019 or later	Q1 2017
Work with the PHAB Incentives and Funding subcommittee to develop a structure for local public health performance-based incentives through the funding formula	Q1 2017
Develop process for collecting and reporting on metrics annually. This includes developing or modifying existing data collection methods	Q2 2017
Collect baseline data on accountability metrics for 2017-19; set statewide benchmark and LPHA improvement targets	Q3 2017
Issue annual accountability report	Q4 2017, and annually thereafter
Review and make changes to measures and targets	Q1 2018, and biannually thereafter

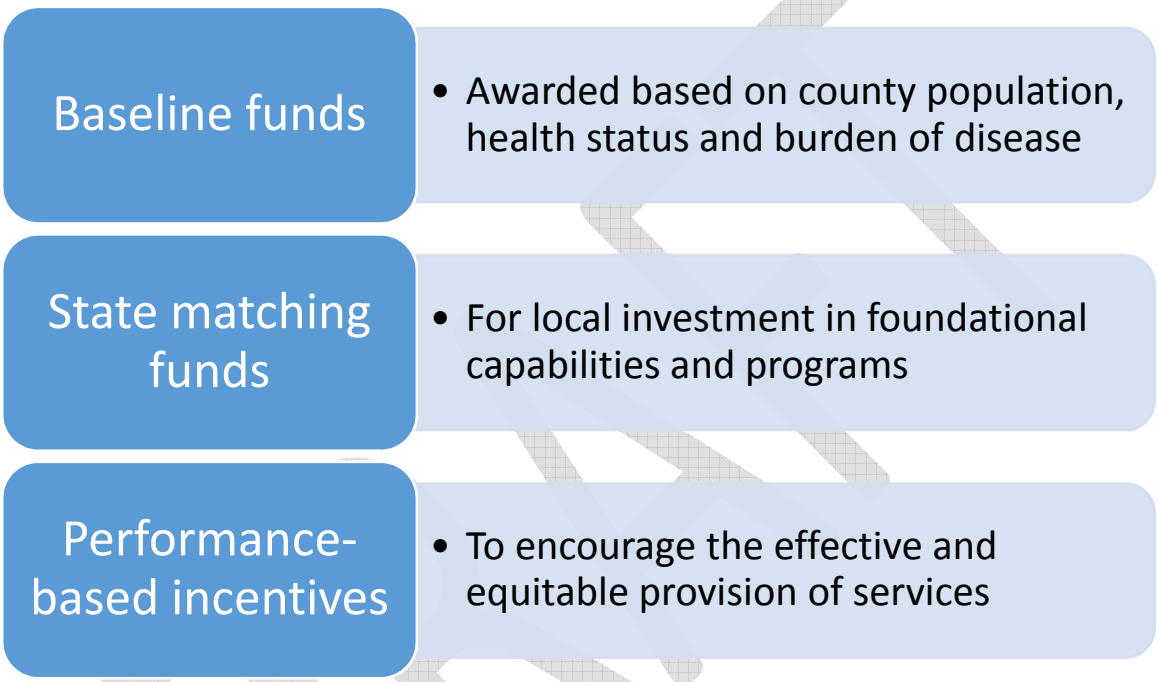
Recommended accountability metrics for 2017-19	
Communicable disease control	*(available in December 2016)*
Environmental health	*(available in December 2016)*
Emergency preparedness	*(available in December 2016)*
Health equity	**Reduce health disparities by ensuring that measure sets for all 2017-19 priority areas include a focus on achieving health equity.** **Increase capacity for state and local public health authorities for advancing health equity. This will be measured by:** - Evidence of increased workforce recruitment from communities adversely impacted by health disparities *(NACCHO measure)* - Increased percent of state and local public health authorities with policies for training, engagement and recruitment *(Public Health Modernization Manual)* - Increased percent of state and local public health authorities with health equity fully integrated into strategic plan and SHIP/CHIP *(Public Health Modernization Manual)*
Public health system change	**Increase public health leadership, expertise and involvement in state and local policy that may affect health. This will be measured by:** - Prepared issue briefs and recommendations for policymakers *(NACCHO measure)* - Technical assistance provided to legislative, regulatory or advocacy groups *(NACCHO measure)* - Evidence of Health in all Policies **Increase the efficiency and effectiveness of the public health system through cross jurisdictional sharing. This will be measured by:** - Increased percent of LPHAs with MOUS or contracts with other LPHAs or the Public Health Division for cross jurisdictional sharing **Increase the impact of health interventions by forming cross-sector partnerships and collaborations. This will be measured by:** - Increased percent of state and local public health authorities with MOUs, contracts or shared work plans in place with health care and early learning providers, CCOs and other community partners - Evidence of evaluation of shared projects or initiatives

The Local Public Health Authority Funding Formula

Legislative requirements

HB 3100, Section 28 requires Oregon Health Authority to submit a funding formula to Legislative Fiscal Office by June 30 of every even numbered year.

The local public health funding formula is comprised of three components, listed below. This funding formula is intended to provide for the equitable distribution of monies made available to fund implementation of foundational capabilities and programs.



Baseline funds. This component awards funding to LPHAs based on their county population, health status and burden of disease. Counties with a larger population will receive a larger portion of the pool of available funding. Similarly, counties with a greater burden of disease or worse health status will receive a proportionally larger portion of the pool of available funding.

State matching funds for county investments. This component awards state matching funds for local public health authority investment in foundational programs and capabilities.

Performance-based incentives. This component uses performance-based incentives to encourage the effective and equitable provision of public health services by local public health authorities.

Oregon Health Authority submitted an initial framework for the funding formula to Legislative Fiscal Office on June 30, 2016. The funding formula described below was built from this framework. This funding formula will continued to be developed over the coming months and will be finalized at the conclusion of the 2017 legislative session.

The Public Health Advisory Board has formed an Incentives and Funding subcommittee that meets monthly to develop the funding formula.

Guiding principles

The Incentives and Funding subcommittee has applied the following guiding principles to decisions made about the funding formula:

- The funding formula should advance equity in Oregon, both in terms of health equity and building an equitable public health system.
- The funding formula should be designed to drive changes to the public health system intended to increase efficiencies and effectiveness.
- Decisions made about the funding formula will be compared with findings from the public health modernization assessment to ensure funds will adequately address current gaps in implementation of foundational public health services.

Funding formula recommendations

The Incentives and Funding subcommittee makes the following recommendations:

- All monies made available for implementing foundational capabilities and programs in the 2017-19 should be directed to the baseline component of the funding formula. Monies will be used to fill critical gaps that result from the historical un- or under-funding for foundational public health work.
- Payments to local public health authorities for the other two components of the funding formula, state matching funds and performance-based incentives, will be incorporated into the funding formula in the 2019-21 biennium.
- This funding formula dictates how state funds will be distributed to local public health authorities and does not inform how funds are split between state and local public health authorities. OHA and the Public Health Advisory Board intend for the majority of funds to be distributed to local public health authorities to address gaps and priorities locally. Dollars that remain with OHA Public Health Division will be specifically used to address statewide needs that are necessary to support local improvements, and to monitor implementation and accountability.
- The funding formula must provide for the equitable distribution of moneys. This means that some counties may receive proportionally more or less than an “equal” share based on need. While extra small and small counties will receive a proportionally larger per capita payment, extra-large and large counties will receive a proportionally larger total dollar amount of funding. This is consistent with the financial resource gaps identified in the public health modernization assessment.
- The subcommittee recommends adding three additional indicators to the baseline funds component of the funding formula: racial/ethnic diversity, poverty and limited English proficiency. These indicators may be linked to poorer health outcomes and also indicate increased demand for LPHA resources.

- The subcommittee recommends incorporating a floor, or base, payment per county into the funding formula. This floor payment is intended to ensure that each LPHA has resources needed to implement the modernization framework and drive toward greater efficiencies and improved health outcomes. The subcommittee recommends using a tiered floor amount, based on county population.
- The subcommittee recommends allocating all remaining funds across the six indicators included in the baseline funds component. The subcommittee recommends weighting all indicators equally in 2017-19.
- The subcommittee will revisit all decisions made about the funding formula at the conclusion of the 20127 legislative session before finalizing payment amounts for each local public health authority.

Funding formula example:

(add excel table for funding formula)

Next steps

- The Incentives and Funding subcommittee has reviewed and made initial recommendations for data sources for the six indicators used to calculate baseline funds for each local public health authority. The subcommittee will continue to look at alternative data sources and will finalize its recommendations in 2017.
- Currently, there is no mechanism to collect standardized information on county expenditures for foundational programs and capabilities. The Public Health Division and local public health authorities will develop a standardized method and timeline, and PHD is also developing a method to validate this information.
- The PHAB Incentives and Funding subcommittee will continue to explore how to use matching funds to incentivize increased local funding while ensuring that the funding formula does not penalize counties that are currently unable to invest in public health.
- A second PHAB subcommittee is developing a set of performance-based metrics to ensure accountability in the public health system and progress toward improved health outcomes. This mechanism will be similar to metrics established for Coordinated Care Organizations, whereby the entire state is accountable for a set of accountability metrics. CCOs are additionally accountable for a subset of these metrics and receive incentive payments annually for achieving improvement targets or benchmarks. These two subcommittees will work closely in 2017 to ensure that the metrics that are selected are achievable with funds made available through the funding formula.

See Appendix XXX for funding formula methodology and a list of data sources used for funding formula indicators.

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. Oregon death certificate data.

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

[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. American Community Survey.

[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.

Local Public Health Administrator Review of Public Health Modernization
Statewide Modernization Plan
DRAFT
Nov. 14, 2016

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Executive summary

Background

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. To the extent Oregon's Health system transformation has achieved some level of success~~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 have changed over time: 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.

The public health modernization framework

Through House Bill 3100 (2015), a new framework for state and local health departments was adopted for every community across Oregon. The public health modernization framework depicts the core services that must be available to ensure critical protections for every individual in Oregon.

Oregon's modernized public health system is built upon seven foundational capabilities and four foundational programs. Foundational capabilities are the knowledge, skills and abilities needed to successfully implement foundational programs.

Foundational capabilities are:

- Leadership and organizational competencies
- Health equity and cultural responsiveness
- Community partnership development
- Assessment and epidemiology
- Policy and planning

- Communications
- Emergency preparedness and response

Foundational programs include topic- and disease-specific work to improve health outcomes, such as a decrease in the prevalence of a particular disease or health risk behavior. Foundational programs are:

- Communicable disease control
- Environmental health
- Prevention and health promotion
- Access to clinical preventive services

Implementation of public health modernization will need to be somewhat flexible and consider the existing strengths and needs of different public health authorities. Movement towards a common set of health outcomes will be the focus for Oregon's public health system over the next three biennia.

Successful implementation of public health modernization will require deliberate and sustainable changes over the next three to five biennia. By scaling up public health modernization over the next several years, Oregon's governmental public health system will be able to:

- Improve the capacity of the governmental public health workforce to take on new community health challenges.
- Engage community members in creating a public health system that meets their needs.
- Identify and implement new ways of delivering public health services that are more effective and efficient.
- Develop partnerships with traditional and non-traditional partners in order to improve the delivery of public health services.
- Move from an activity-based public health system to one to one that is outcomes-driven.
- Slowly and sustainably scale up public health services over time.

Key findings from public health modernization assessment

In 2016, state and local public health authorities completed an assessment of the existing 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?

The assessment found gaps between our current public health system and a fully modernized system that meets the health protection, prevention and promotion needs of Oregonians in every part of the state. The assessment identified that, in more than one third of Oregon communities, foundational public health services are limited or minimal.

Overall, there are gaps in all state and local public health authorities. These gaps are not uniform and do not appear in the same foundational capability or program in each public health authority. Some governmental public health authorities have larger gaps than others. However, there are needs across governmental public health authorities of all sizes.

There is not one foundational capability or program that is implemented across every public health authority. There are some foundational programs and capabilities with a higher concentration of limited and minimal implementation, such as health equity and cultural responsiveness and prevention and health promotion.

The public health modernization assessment found an additional $105M is needed annually for the public health system to fully implement a modernized public health system. This represents a 50% increase over current spending levels. This is a planning-level estimate and it will be refined over time as the system changes and efficiencies are gained. However, we know that the system is underfunded, and upgrading the system to implement foundational public health services will require significant, sustainable funding.

Increased funding in the 2017-19 biennium will be used to make significant progress in a subset of foundational capabilities and programs across the state and to drive the system toward change and innovation. The Public Health Advisory Board and state and local public health authorities have identified that significant progress could be made with an initial investment of $30M. The level of implementation provided by state and local public health authorities will be scaled based on available funding in 2017. Information about how state funds will be allocated to local public health authorities is available in the funding formula section of this plan.

Roadmap for modernizing Oregon's public health system

The following five strategies are critical to achieving a modern public health system that protects and improves the health of every person in Oregon. Comprehensively implementing these five strategies will ensure we meet the outcomes listed below by 2023.

Public Health Modernization Roadmap

Outcome 1: ~~Local modernization plans by 2023~~ Improved health outcomes in 5-10 years

Outcome 2: An efficient, effective and equitable public health system

Outcome 3: Improved public health services for all people in Oregon

Outcome 4: ~~Improved health outcomes in 5-10 years~~ Local modernization plans by 2023

Strategy 1: Increase capacity across the entire public health system to provide foundational public health programs.

Strategy 2: Adopt new and innovative service delivery models, including cross jurisdictional sharing, to increase the efficiency and effectiveness of Oregon's public health system.

Strategy 3: Work with the health care system, early learning and other sectors to provide evidence-based, upstream interventions in a way that best meets the needs and priorities of each community.

Strategy 4: Work with Oregon's federally recognized tribes to align tribal public health services with the governmental public health system.

Strategy 5: Establish accountability metrics to demonstrate improved health outcomes and public health system change. ~~an accountability system to demonstrate progress toward achieving improved health outcomes.~~

Commented [BS1]: The roadmap has been reorganized so that outcomes are listed before strategies.

Comment from 11/7 webinar: roadmap should talk more about the people who will be the beneficiaries of these strategies and outcomes.

Recommendation to add increasing funding to strategy 1 and/or 3.

Commented [BS2]: Morgan and Kathleen will provide alternate language for this outcome, based on Public Health Modernization Manual.

Strategy 1: Increase capacity across the entire public health system to provide foundational public health programs.

Justification: The 2016 public health modernization assessment found that one third of Oregon communities – or 1.3 million people – are in an area of the state where foundational public health programs are limited or minimal. Gaps exist in all areas of the state and for all communities. Foundational public health programs protect people from communicable diseases, prepare for and respond to emergencies and prevent environmental health threats. Increasing capacity across the system will, over time, narrow the gaps that exist among communities and move the entire system forward toward modernization.

Key Activities:

- Use findings from the public health modernization assessment to develop a timeline for implementing foundational capabilities and programs. All foundational capabilities and programs will be implemented across the public health system by 2023.
- Develop a local public health funding formula. The funding formula will consider differences in population, burden of disease and health status in awarding funding to each local public health authority.
- Each biennium develop a scope of work for state and local public health authorities that includes system-wide interventions to make improvements across the entire system and local interventions to close gaps among public health authorities.
- Each biennium, report on progress toward implementing foundational capabilities and programs.
- Implement all foundational capabilities and programs by 2023.

Strategy 2: Adopt new and innovative service delivery models, including cross jurisdictional sharing, to increase the efficiency and effectiveness of Oregon's public health system.

Justification: Cross jurisdictional sharing is demonstrated to increase efficiency and effectiveness in how public health programs are delivered. Cross jurisdictional sharing exists on a spectrum, from informal agreements between local public health authorities to regionalization. Local public health authorities will explore where cross jurisdictional sharing is already occurring and spread effective models to other areas of the state. Public health modernization also presents an opportunity to examine which public health services and activities are centralized in the Public Health Division or decentralized across local public health authorities, and to make changes based on the functional needs of the public health system. Cross jurisdictional sharing and changes to which services are done at the state and local level will close gaps identified in the public health modernization assessment.

Key activities:

- Create opportunities for local public health authorities and local governments to discuss current sharing models and identify additional opportunities for sharing.
- Develop a set of tools to facilitate adoption of new cross jurisdictional sharing opportunities.
- Create learning opportunities and other mechanisms to spread innovation across the system.
- Use the funding formula to incentivize exploration and adoption of new services delivery models.
- Report annually on new and innovative service delivery models that increase the provision of foundational public health services.

Strategy 3: Work with the health care system, early learning and other sectors to provide evidence-based, upstream interventions in a way that best meets the needs and priorities of each community.

Justification: Public health modernization is an essential component of health system transformation in Oregon. A public health system that emphasizes evidence-based, population-level interventions to improve health will advance our shared work toward achieving Oregon's Triple Aim. A modernized public health agency will convene the local CCO(s), early learning hubs and other organizations to develop cross-sector community approaches for prevention and health promotion.

Key Activities:

- Convene CCO and early learning leadership and others in discussions about local population health needs and priorities.
- Use results from the local public health modernization assessment to identify barriers to collaboration across sectors.
- Identify opportunities for collaboration.
- Develop a set of tools to facilitate adoption of cross-sector approaches to prevention and health promotion.

Strategy 4: Work with Oregon's federally recognized tribes to align tribal public health services with the governmental public health system.

Justification: Oregon's federally recognized tribes provide services critical to the health of their members and in many cases provide services to protect and improve the health of other community members.

Key activities:

- Work with tribes to conduct assessments of current foundational public health services.
- Facilitate opportunities for tribes to be involved in local decision-making about how to most effectively provide public health services.

Strategy 5: Establish an accountability system to demonstrate progress toward achieving improved health outcomes.

Justification: As with coordinated care organizations and hospitals, the public health system must demonstrate accountability for public investments to implement evidence-based population health interventions. The public health system will demonstrate accountability through a set of metrics to measure improvements in population health and changes to the structure of the public health system.

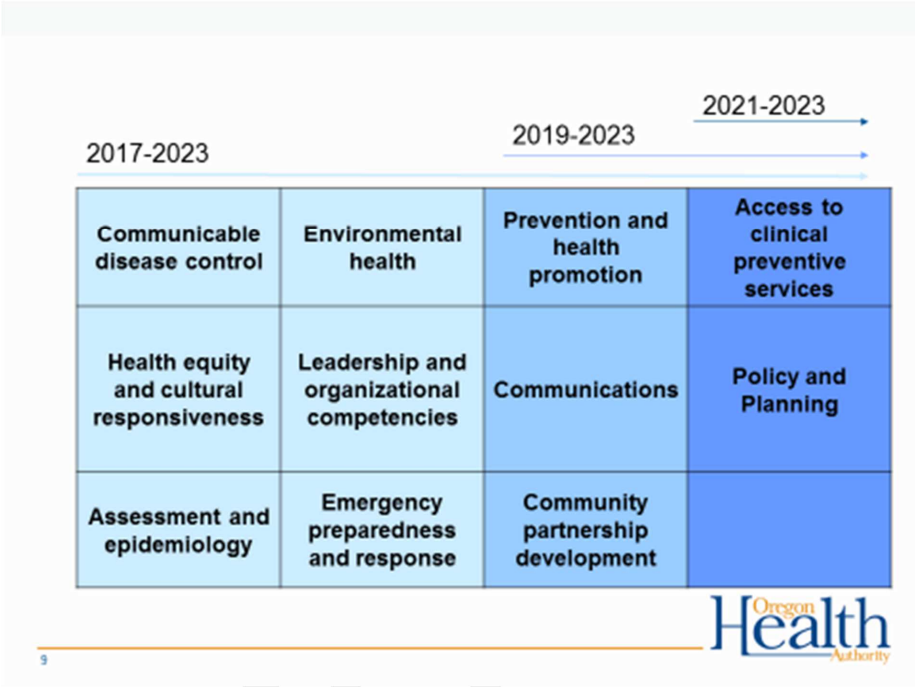
Key activities:

- Develop a set of system-wide accountability metrics and a subset to be used to measure local public health authority progress toward meeting metrics. Accountability metrics will include health outcomes and metrics to demonstrate system change and increased efficiency.

- Use the local public health funding formula to incentivize progress toward achieving accountability metrics.
- Report on metrics annually

Scaling up public health modernization over the next three biennia		
Biennium	**Foundational capabilities and programs**	**Key actions**
2017-2019	• Communicable disease control • Environmental health • Emergency preparedness • Health equity and cultural responsiveness • Assessment and epidemiology • Leadership and organizational competencies	• Develop initial public health modernization plans, addressing the priorities listed to the left. • Ensure sufficient funding to support priorities. • Identify effective and efficient public health governance structures. • Finalize accountability measures for state and local public health authorities. • Distribute available funding to local public health authorities using the funding formula required in House Bill 3100. • Report on baseline accountability metrics. • Collect and report on year one accountability metrics.
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*	• Utilize established 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. • Update the public health modernization assessment.
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*	• Utilize established 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.
2023 and beyond	• *Continue the foundational capabilities and programs implemented in 2017-2023*	• Collect and report on accountability metrics. • Update the public health modernization assessment.

Timeline for implementation of foundational capabilities and programs



Monitoring and accountability

Accountability – for ensuring an efficient and effective public health system and for achieving improved health outcomes – is a central tenet of public health modernization. The public health system has in place a number of mechanisms to ensure system-wide accountability.

The Public Health Advisory Board

The Public Health Advisory Board (PHAB) is established by House Bill 3100 (2015), Sections 5-7 as a body that reports to the Oregon Health Policy Board. The purpose of the PHAB is to be the accountable body for governmental public health in Oregon. This includes oversight of public health modernization, development and implementation of accountability measures for state and local health authorities and development of a funding formula that builds an equitable governmental public health system.

PHAB meets monthly and convenes subcommittees as needed.

Accountability metrics

Accountability metrics will function both as an assurance that state and local public health authorities are providing foundational public health services to all people in Oregon, and as an incentive to encourage LPHAs to transform the local public health service delivery model to best provide foundational capabilities and programs to community members.

Accountability metrics for the public health system will be established for the 2017-19 biennium and will evolve over each biennium as the public health system changes and addresses new priorities. It is understood that data on accountability metrics will be collected and reported on annually.

As with the statewide performance measures established under HB 3650 (2011), a set of accountability metrics will be used to monitor the progress of the entire public health system toward increased efficiencies and improved health outcomes. As with Coordinated care Organizations, a subset of these metrics will be used to monitor progress of each local public health authority. Each local public health authority will be eligible to receive incentive payments based on achievement of accountability metrics.

Incentive payments to local public health authorities will be incorporated into the 2019-21 funding formula. Until that time, state and local public health authorities will:

- Finalize system-wide accountability metrics;
- Finalize the subset of accountability metrics to be used as LPHA incentive measures;
- Establish data collection mechanisms;
- Establish data validation mechanisms;
- Develop a reporting timeline; and
- Collect and report on baseline data.

The OHA Public Health Division will be an active partner with LPHAs to support achievement of incentive measures. In this capacity, OHA Public Health Division will do the following:

- Provide accurate and timely population health data;
- Convene learning opportunities to discuss best practices and innovation that can be spread across local public health jurisdictions;
- Provide technical assistance

The Coalition of Local Health Officials will also actively support LPHAs to achieve incentive measures through convening learning opportunities and providing technical assistance.

Evaluation of implementation

OHA Public Health Division will explore opportunities for initial and ongoing evaluation of implementation of public health modernization.

State and local public health authorities will update the public health modernization assessment during the 2019-21 biennium. This update will demonstrate changes in the public health system, including whether we have increased capacity and expertise in communities across Oregon, and any changes to the financial resources needed to implement the public health modernization model.

Annual work plans and progress reports

As part of the contracting process with LPHAs to receive public health modernization funding through OHA, each local public health authority will submit an annual work plan. Progress reports will be submitted annually.

Rationale for system approach to implementing foundational capabilities and programs

HB 3100 described waves up implementation across local public health authorities, whereby an initial group of LPHAs would adopt the complete modernization framework in the 2017-19 biennia, additional LPHAs would adopt the framework in 2019-21, and all LPHAs would move toward the modernization framework by 2023 (with the submission of comprehensive modernization plans). This implementation plan was recommended by the Future of Public Health Services Task Force and is based on the idea that modernization could begin as a pilot that would expand across the system over subsequent biennia.

The public health modernization assessment showed risks of following this implementation model due to:

- Risk of creating a two-tiered system
- Potential impacts to health equity, where individuals living in a "modernized" area of the state would receive a higher level of service than those living in other areas of the state.

The assessment also indicated challenges to implementing by foundational capability or program across the entire state because current level of implementation varies across LPHAs. Some LPHAs are closer to fully implementing foundational capabilities and programs, while gaps are larger for other LPHAs. This will be addressed by building a system that requires system-wide focus on a set of foundational capabilities and programs but allowing for local flexibility in determining the best way to meet the unique needs of the local community. We will "rise all boats" while narrowing the largest implementation gaps that exist today.

This implementation strategy is critical for other reasons. Focusing resources on a handful of counties will reduce opportunities for innovation across county lines, but spreading resources across the system will drive all areas of the public health system toward innovation. Also, many of the health issues we face in public health – like disease outbreaks or natural disasters - cross county lines. Counties need to be equally equipped to address these issues. Finally, the public health system is poised to move forward in unison. Conversations about how we could do our work differently have already begun, and changes are being made. We need to encourage and sustain these conversations rather than build a system where most counties will need to wait years to receive resources to do this work.

Approach for exploring and adopting new models within the public health system

Cross-jurisdictional sharing

Current Sharing in Oregon

In 2016 the Coalition of Local Health Officials deployed a survey that asked local health departments (LHDs) to provide detail on the types of collaboration, shared services, and other partnerships that allow them to deliver essential public health services. Most LHDs reported some level of collaboration and sharing with other jurisdictions. Some of the most commonly cited partnerships include:

- **Community health assessments**. Cross-jurisdictional partnering for community health assessments occurs in many regions throughout the state. These efforts also include partnerships with Coordinated Care Organizations (CCOs), Early Learning Hubs, local hospitals, and other community organizations.

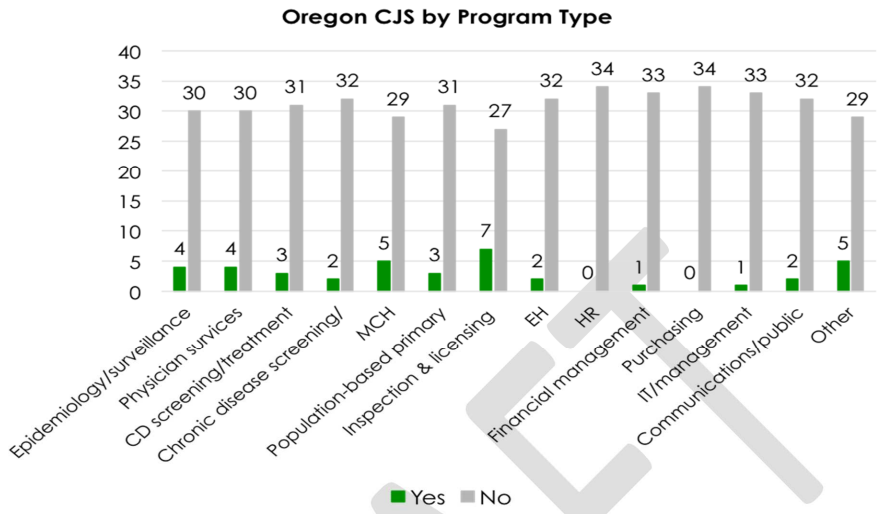
- **Communicable disease surveillance and sharing**. Some of these partnerships include formal agreements to share access to Orpheus, an electronic disease surveillance system, for case investigation and follow up.

- **Environmental health sharing**. Several rural jurisdictions share environmental health staff to ensure that mandated restaurant, water, and other inspections are carried out as required.

- **Technical assistance and other support**. LHDs offer varying levels of assistance to each other on a regular basis, including general programmatic or operational advice, resource sharing, partnering for staff training, or job shadowing for new staff.

- **Emergency preparedness**. Regions throughout the state partner to hold preparedness exercises and to ensure that critical resources will be available in the event of a large-scale bioterrorism event or natural disaster.

Commented [BS3]: Add local example of CJS.



Source: Cross-jurisdictional sharing for local public health services. 2015. J. Marlowe, B. Bekemeier. Funded by RWJF.

Future Sharing in Oregon

The CLHO survey asked LHDs to identify opportunities for future shared services that could potentially create efficiencies and improve effectiveness across jurisdictions. Some of the most commonly cited potential future shared services include:

- **Assessment and epidemiology**. Several LPHAs identified a regional approach to data collection and analysis as the most efficient and effective method of fulfilling the elements listed in the new modernization framework.

- **Prescription drug overdose grant**. Six regions throughout the state will be collaborating on prevention efforts related to prescription drug and heroin overdose.

- **Environmental health**. Shared environmental health specialists to prevent, assess, and address emerging environmental public health issues.

- **Emergency preparedness.** Regional efforts to ensure that communities are prepared and able to respond to and recover from public health threats and emergencies.

There is great potential for future cross-jurisdictional sharing that moves LHDs towards more a formalized arrangement. What that arrangement looks like is up to the LHDs to decide; it could be shared capacity with joint oversight or outright consolidation of local public health agencies. The public health modernization legislation outlined several pathways for local public health authorities to meet the Foundational Capabilities and Programs, all of which are intended to allow for significant local flexibility.

From October 2016 through January 2017, ten meetings will take place across Oregon to discuss opportunities and barriers to cross-jurisdictional sharing.

(Add information from recent studies that demonstrate increased efficiencies).

State and local service delivery models

The Public Health Modernization Manual demonstrates that the distinct roles for state and local public health are each essential to fulfill the core system functions. For example, it is necessary to collect and analyze data on health behaviors and outcomes at the state level to understand where health disparities exist. And it is necessary to use this data at the local level to work closely with those populations experiencing disparities to close those gaps in health outcomes.

The public health system will continue to identify areas where the state public health authority can perform its core functions more effectively to support local public health, or where local public health authorities can perform their core functions more efficiently to achieve statewide goals. In some cases this may mean transferring functions that are currently done at the local level to the state if they could be performed more efficiently and effectively under a centralized model. The reverse may also occur.

The state public health authority may also form cross-sector relationships with individual local health authorities to conduct some functions for the LPHA, as indicated by gaps and available resources.

Commented [BS4]: Add example of inter-reliance on state-local roles to fulfill a core system function.

Approach for building collaborations across sectors

The public health system serves a critical function in a transformed health system. Its focus on assessment, assurance and policy builds communities that support and promote health; these policy, system and environmental changes directly complement clinical care. Public health also plays a key role to convene partners and stakeholders and to work toward health in policies.

There are many examples of cross sector innovation occurring across Oregon where public health, the local CCO(s) and others are each working from their own realm to achieve shared outcomes. Innovative funding models that allow public health to fulfill its functions for prevention and for reaching underserved communities.

Commented [BS5]: Add local example of how an LPHA works with the CCO and other local orgs to address the community's needs.

Approach for working with Oregon's federally recognized tribes

Commented [BS6]: Add example describing a tribe's role in providing foundational public health services to the community.

(Add information about current work with tribes to identify how tribal public health fits with state and local public health. Discuss next steps, which may include a modified version of the public health modernization assessment for tribes. Many tribes are interested in working with LPHAs and PHD to provide foundational programs and capabilities).

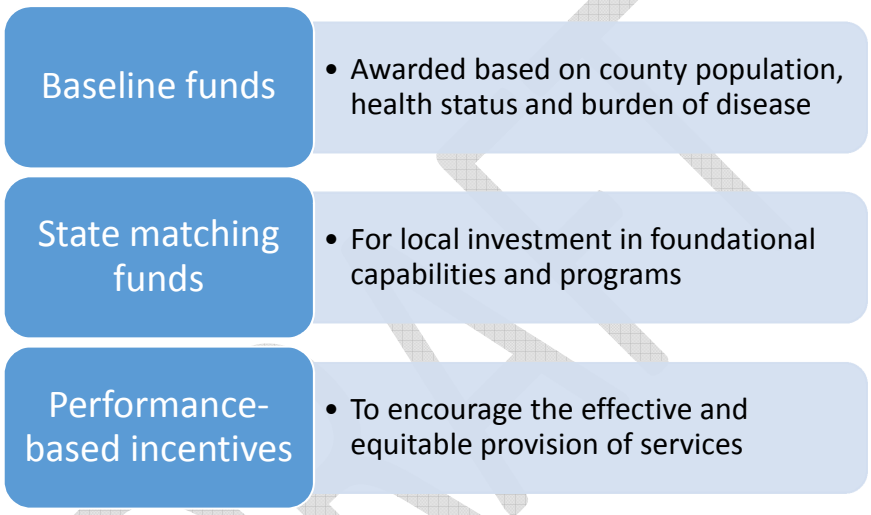
The Local Public Health Authority Funding Formula

Commented [BS7]: This section has been updated

Legislative requirements

HB 3100, Section 28 requires Oregon Health Authority to submit a funding formula to Legislative Fiscal Office by June 30 of every even numbered year.

The local public health funding formula is comprised of three components, listed below. This funding formula is intended to provide for the equitable distribution of monies made available to fund implementation of foundational capabilities and programs.



Baseline funds. This component awards funding to LPHAs based on their county population, health status and burden of disease. Counties with a larger population will receive a larger portion of the pool of available funding. Similarly, counties with a greater burden of disease or worse health status will receive a proportionally larger portion of the pool of available funding.

State matching funds for county investments. This component awards state matching funds for local public health authority investment in foundational programs and capabilities.

Performance-based incentives. This component uses performance-based incentives to encourage the effective and equitable provision of public health services by local public health authorities.

Oregon Health Authority submitted an initial framework for the funding formula to Legislative Fiscal Office on June 30, 2016. The funding formula described below was built from this framework. This funding formula will continued to be developed over the coming months and will be finalized at the conclusion of the 2017 legislative session.

The Public Health Advisory Board has formed an Incentives and Funding subcommittee that meets monthly to develop the funding formula.

Guiding principles

The Incentives and Funding subcommittee has applied the following guiding principles to decisions made about the funding formula:

- The funding formula should advance equity in Oregon, both in terms of health equity and building an equitable public health system.
- The funding formula should be designed to drive changes to the public health system intended to increase efficiencies and effectiveness.
- Decisions made about the funding formula will be compared with findings from the public health modernization assessment to ensure funds will adequately address current gaps in implementation of foundational public health services.

Funding formula recommendations

The Incentives and Funding subcommittee makes the following recommendations:

- All monies made available for implementing foundational capabilities and programs in the 2017-19 should be directed to the baseline component of the funding formula. Monies will be used to fill critical gaps that result from the historical un- or under-funding for foundational public health work.
- Payments to local public health authorities for the other two components of the funding formula, state matching funds and performance-based incentives, will be incorporated into the funding formula in the 2019-21 biennium.
- This funding formula dictates how state funds will be distributed to local public health authorities and does not inform how funds are split between state and local public health authorities. OHA and the Public Health Advisory Board intend for the majority of funds to be distributed to local public health authorities to address gaps and priorities locally. Dollars that remain with OHA Public Health Division will be specifically used to address statewide needs that are necessary to support local improvements, and to monitor implementation and accountability.
- The funding formula must provide for the equitable distribution of moneys. This means that some counties may receive proportionally more or less than an "equal" share based on need. While extra small and small counties will receive a proportionally larger per capita payment, extra-large and large counties will receive a proportionally larger total dollar amount of funding. This is consistent with the financial resource gaps identified in the public health modernization assessment.
- The subcommittee recommends adding three additional indicators to the baseline funds component of the funding formula: racial/ethnic diversity, poverty and limited English proficiency. These indicators may be linked to poorer health outcomes and also indicate increased demand for LPHA resources.

- The subcommittee recommends incorporating a floor, or base, payment per county into the funding formula. This floor payment is intended to ensure that each LPHA has resources needed to implement the modernization framework and drive toward greater efficiencies and improved health outcomes. The subcommittee recommends using a tiered floor amount, based on county population.
- The subcommittee recommends allocating all remaining funds across the six indicators included in the baseline funds component. The subcommittee recommends weighting all indicators equally in 2017-19.
- The subcommittee will revisit all decisions made about the funding formula at the conclusion of the 20127 legislative session before finalizing payment amounts for each local public health authority.

Funding formula example:

(add excel table for funding formula)

Next steps

- The Incentives and Funding subcommittee has reviewed and made initial recommendations for data sources for the six indicators used to calculate baseline funds for each local public health authority. The subcommittee will continue to look at alternative data sources and will finalize its recommendations in 2017.
- Currently, there is no mechanism to collect standardized information on county expenditures for foundational programs and capabilities. The Public Health Division and local public health authorities will develop a standardized method and timeline, and PHD is also developing a method to validate this information.
- The PHAB Incentives and Funding subcommittee will continue to explore how to use matching funds to incentivize increased local funding while ensuring that the funding formula does not penalize counties that are currently unable to invest in public health.
- A second PHAB subcommittee is developing a set of performance-based metrics to ensure accountability in the public health system and progress toward improved health outcomes. This mechanism will be similar to metrics established for Coordinated Care Organizations, whereby the entire state is accountable for a set of accountability metrics. CCOs are additionally accountable for a subset of these metrics and receive incentive payments annually for achieving improvement targets or benchmarks. These two subcommittees will work closely in 2017 to ensure that the metrics that are selected are achievable with funds made available through the funding formula.

See Appendix XXX for funding formula methodology and a list of data sources used for funding formula indicators.

Additional steps for implementation in the coming years

Contracting mechanism and scope of work development

State and local public health authorities are working to develop a new contracting mechanism for new moneys made available for public health modernization. State and federal funds are currently distributed through Program Elements, which are deliverables-based contracts. OHA will establish a performance-based contracting model whereby each local public health authority would be contractually obligated to develop a strategy and plan for achieving a set of outcomes. However, each local public health authority would have the flexibility to design its own strategy, thereby accounting for local needs, assets and priorities.

Next steps:

Comprehensive local modernization plans by 2023

HB 3100 requires each local public health authority to submit a modernization plan by 2023 that includes how the authority will apply foundational capabilities and implement foundational programs. These plans will demonstrate the structure and governance for how local public health will be provided locally, including how it will be aligned with local health care and early learning to maximize outcomes and align resources. The Coalition of Local Health Officials will develop a roadmap and a set of tools for local public health authorities to use as they develop comprehensive local modernization plans. OHA, in consultation with local public health authorities and the Public Health Advisory Board, will develop requirements and a review and approval process for these plans.

Next steps:

Public health modernization and accreditation

(Describe alignment between public health modernization and accreditation. Describe how the public health system can support local public health authorities to move both initiatives forward and potential benefits).

The national perspective

(Describe national focus on FPHS and Public Health 3.0. Describe Oregon's RWJF grant and work with PHNCI)

Oregon Administrative Rules

Describe timeline for convening RAC and finalizing rules

Progress to date

Define foundational capability and programs – completed, 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. 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 comprehensive public health modernization assessment between January and April 2016.

Publish the Public Health Modernization Assessment Report – completed, June 2016
The findings from each state and local public health authority's modernization assessment was compiled into a summary report. The findings from this assessment were used to identify the timing and sequence of work over future biennia to fully modernize Oregon's governmental public health system.

Develop public health modernization funding formula – initial draft completed, December 2016
The Public Health Advisory Board developed the initial funding formula for the distribution of funds to local public health authorities as outlined in House Bill 3100, Section 28. Based on available funds, the formula may be updated in July 2017.

Expanded statewide public health modernization plan – completed, December 2016
The statewide public health modernization plan is included in this document.

Establish metrics to ensure accountability and improved health outcomes - measure selection to be completed in March 2017
The Public Health Advisory Board has developed an initial list of accountability metrics for state and local public health authorities, as well as measure selection criteria. Accountability measures will be finalized by March 2017.

Conduct Tribal Consultations in order to identify their interest in engaging in Public Health Modernization - ongoing: The Oregon Health Authority is conducting tribal consultations with Oregon Tribes interested in pursuing opportunities for public health modernization.[1]

[1] Tribes, as sovereign nations, define their own service populations and are not obligated by state statute to provide public health services. Historically, tribes have not been funded for public health. Under HB 3100, the

public health system (state and local government) is required to meet certain standards of capacity and expertise related to the public health foundational capabilities and programs. Given tribal sovereignty, the state is not and cannot mandate tribes to act. Thus, the public health modernization requirements outlined in HB 3100 apply only to the state and county public health system. Tribes are not required to complete the modernization assessment and are not required to demonstrate sufficient capacity on the public health foundational capabilities and programs. However, tribes are committed to promoting and protecting the health and well-being of members and all people residing within their self-defined service populations. Therefore, as local public health authorities begin to develop their plans to build capacity and expertise to fulfill the requirements of Modernization, it may be helpful for local public health authorities, in collaboration with OHA, to participate in consultation with tribes regarding any potential impact upon tribes and to gauge tribes' interest in engaging in capacity building related to modernization of their individual public health efforts and determine what assistance can be provided. In order to initiate a potential tribal consultation process related to public health modernization, OHA participated in the SB770 Tribal Consultation meeting on June 20, 2016. During this meeting, a brief presentation and discussion of public health modernization was presented to tribes, opportunities for questions and answered were provided and a process outlined for initiating consultation with interested tribes.

Appendices

PHAB Funding and Incentives Subcommittee

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

November 8, 2016

Per capita analysis based on current spending and resources needed in public health modernization report

Public Health Modernization Assessment Report (information in this table is copied directly from the report)				per capita[1] annual additional increment of cost	2017-19 priority areas			
	total estimated cost of full implementation	**current spending**	**additional increment of cost**		**per capita annual additional increment**	**total annual additional increment**	**PHD annual additional increment**	**LPHA annual additional increment**
foundational programs	**$ 184,714,000**	**$ 129,616,000**	**$ 55,098,000**	**$ 14.13**				
environmental public health	$ 59,647,000	$ 45,214,000	$ 14,433,000	$ 3.70	$ 3.70	$ 14,433,000	$ 3,150,000	$ 10,500,000
prevention and health promotion	$ 58,351,000	$ 40,908,000	$ 17,443,000	$ 4.47				
communicable disease control	$ 38,322,000	$ 25,404,000	$ 12,918,000	$ 3.31	$ 3.31	$ 12,918,000	$ 2,100,000	$ 10,500,000
access to clinical preventive services	$ 28,394,000	$ 18,090,000	$ 10,304,000	$ 2.64				
foundational capabilities	**$ 129,068,000**	**$ 79,602,000**	**$ 49,464,000**	**$ 12.68**				
leadership and org. competencies	$ 47,860,000	$ 34,959,000	$ 12,901,000	$ 3.31	$ 3.31	$ 12,901,000	$ 2,100,000	$ 10,500,000
assessment and epidemiology	$ 31,984,000	$ 17,504,000	$ 14,479,000	$ 3.71	$ 3.71	$ 14,479,000	$ 7,350,000	$ 7,350,000
emergency preparedness and response	$ 12,214,000	$ 8,966,000	$ 3,247,000	$ 0.83	$ 0.83	$ 3,247,000	$ 1,050,000	$ 2,100,000
community partnership development	$ 9,941,000	$ 5,974,000	$ 3,967,000	$ 1.02				
policy and planning	$ 9,617,000	$ 4,415,000	$ 5,202,000	$ 1.33				
health equity and cultural responsiveness	$ 9,396,000	$ 4,411,000	$ 4,985,000	$ 1.28	$ 1.28	$ 4,985,000	$ 1,050,000	$ 4,200,000
communications	$ 8,056,000	$ 3,373,000	$ 4,683,000	$ 1.20				
total	**$ 313,782,000**	**$ 209,218,000**	**$ 104,562,000**	**$ 26.81**	**$ 16.14**	**$ 62,963,000**	**$ 16,800,000**	**$ 45,150,000**

Average gap per capita for 2017-19 priorities by county size band	
extra small	$44.27
small	$17.94
medium	$11.47
large	$12.19
extra large	$9.27

[1] Oregon's population based on U.S. Census Bureau, American Community Survey estimates, 2009-14. Oregon's estimated population was 3,900,243.

County size bands:
Extra small: Baker, Grant, Harney, Lake, Morrow, Wallowa, Wheeler
Small:Clatsop, Columbia, Coos, Crook, Curry, Hood River, Josephine, Klamath, Lincoln, Malheur, NCPHD, Tillamook, Union
Medium: Benton, Douglas, Joesphine, Linn, Polk, Umatilla, Yamhill
large: Deschutes, Jackson, Lane, Marion
extra large: Clackamas, Multnomah, Washington