AGENDA

PUBLIC HEALTH ADVISORY BOARD

May 17, 2018
Portland State Office Building
800 NE Oregon St., conference room 1B
Portland, OR 97232

Join by webinar: https://register.gotowebinar.com/rt/4888122320415752707
Conference line: (877) 873-8017
Access code: 767068

Meeting objectives:

- Discuss the role of public health in the vision for Oregon's health system transformation
- Discuss the 2019-21 local public health authority funding formula
- Learn about implementation of regional public health modernization initiatives

2:00-2:30 pm	**Welcome and updates** • Approve April 19 meeting minutes • Staffing updates	Rebecca Tiel, PHAB Chair
2:30-3:00 pm	**Health system transformation and a modern public health system** • Discuss the charge to the Public Health Advisory Board to advance public health modernization in Oregon • Discuss the role of the public health system in advancing health system transformation	Zeke Smith, Chair Oregon Health Policy Board
3:00-3:15 pm	**Break**	
3:15-4:00 pm	**Local public health authority funding formula** • Review 2019-21 local public health authority funding formula, including base, matching and incentive components	Akiko Saito, PHAB member
4:00-4:30 pm	**Public health modernization implementation** • Discuss progress towards implementing regional public health modernization initiatives	Muriel DeLaVergne-Brown, PHAB member Bob Dannenhoffer, PHAB member
4:30-4:45 pm	**Public comment**	Rebecca Tiel, PHAB Chair

4:45 pm	**Adjourn**	Rebecca Tiel, PHAB Chair

Public Health Advisory Board (PHAB)
April 19, 2018
Draft Meeting Minutes

Attendance:

Board members present: David Bangsberg, Carrie Brogoitti, Bob Dannenhoffer, Muriel M DeLaVergne-Brown, Katrina Hedberg, Rebecca Tiel, Kelle Adamek-Little, Jeff Luck, Eva Rippeteau, Eli Schwarz, Lillian Shirley, Teri Thalhofer, Tricia Mortell, Jen Vines

Oregon Health Authority (OHA) staff: Cara Biddlecom, Julia Hakes, Stephanie Jarem, Amanda Peden, Maria Castro, Tim Sweeney, Zintars Beldavs, Sean Schafer, Alison Dent, Aaron Dunn

Members of the public: Alexandra Phan, Holly Losli, Cynthia Boelling (OHSU School of Nursing); Morgan Cowling, Caitlin Hill (Coalition of Local Health Officials); Christina Bodamer (American Heart Association)

Approval of Minutes

A quorum was present. The Board moved to approve the March 15 minutes.

Welcome and updates

-Rebecca Tiel, PHAB Chair

Danna gave an update that the Wallowa County Board of Commissioners unanimously passed an ordinance transferring its local public health authority to the Oregon Health Authority. This is the first time in recent Oregon history that a county has decided to transfer public health authority to the state. While legally the transfer does not occur until Oct. 13, 2018, Wallowa County will no longer have a local public health administrator as of May 1, 2018. Therefore, OHA will assume responsibility for continuing the public health services the agency is required to provide by law.

During this transition, OHA's priority is to ensure the people in Wallowa continue to receive basic public health services, including:

- Monitoring communicable diseases and controlling outbreaks.
- Enforcing the Indoor Clean Air Act.
- Ensuring access to safe drinking water.
- Ensuring access to WIC services.
- Licensing and inspecting food, pool and lodging facilities.

All other governmental public health services will end in Wallowa County. Over the next six months, the Public Health Division will evaluate if there are other services it will take on to do or assure are covered by non-governmental partners.

Public Health Division staff have been working since December to compile the findings from the 2017 State Health Assessment. A draft of the State Health Assessment is now available for public comment and is open through May 11, 2018. Cara gave an overview of the SHA Timeline.

On May 1, the Public Health Advisory Board will be giving an update to the Oregon Health Policy Board. Rebecca shared she is taking the lead on this presentation and will focus on sharing the results from the public health accountability metrics baseline report. Zeke Smith will also be joining us at our May meeting to share his perspective on the role of public health with regard to the priorities of the Oregon Health Policy Board.

Subcommittee Updates
-Bob Dannenhoffer, PHAB Member

Bob gave an update to the PHAB about the special joint subcommittee meeting. Subcommittee members approved the incentives funding formula model. Subcommittee members also reviewed four options for allocating state matchings to county general fund investments in local public health and voiced support for option number one.

PHAB members expressed concern that the matching model only incentivizes increased funding. Bob echoed their concerns but clarified that the subcommittee worked hard to balance the statutory requirements and what is most defensible to county commissioners. Cara clarified that matching funds would also be available for local public health authorities that retain their investment in public health over time.

Bob also shared the allocations to funding formula components at a range of funding levels for 2019-21 biennium that were revised at the joint subcommittee meeting.

CCO 2.0 policy recommendations
Stephanie Jarem, Amanda Peden, Maria Castro, Tim Sweeney, OHA

OHA staff outlined a series of policy recommendations for the 2020-2024 CCO contracts.

Stephanie Jarem provided some background on the CCO 2.0 process.

Amanda Peden and Maria Castro presented the policy recommendations under the social determinants of health and equity area of the Governor's priorities for the Oregon Health Policy Board.

Tim Sweeney reviewed relevant components of the sustainable cost recommendations.

PHAB members gave the following feedback:

- Rural counties may encounter issues with broadband internet service when providing telehealth services.
- The equity assessment needs to be clearer about who is being assessed and recognize the role of public health in this body of work.
- Licensed providers are already required to receive cultural competency training and the enforcement of the training provision should be held at the licensing board level.
- There is a missed opportunity in calling out the need for a diversified workforce.
- There should be a call out to public health as the driver for relevant work to encourage compensation.
- Be specific with how CCOs must use seed money.

Tricia shared the Coalition of Local Health Officials CCO 2.0 recommendations:

1. Add a Local Public Health Administrator to the governing boards of CCOs.
2. Require CCOs to develop, financially invest, and implement shared Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) with Local Public Health Authorities and local Hospitals. Require the use of CHA/CHIP planning tools that meet the needs of LPHA and Hospitals.
3. Require a percentage of the quality pool to be shared with LPHA acknowledging the collective impact on meeting metrics.
4. Require one percent of the CCO global budget to be invested in the LPHA for community-based prevention and evidenced based strategies targeting:
   a) reducing rising obesity rates
   b) reducing adult tobacco use and preventing youth from getting addicted
   c) reducing the number of low-birth weight babies and supporting infants and children for growth and development
   d) reducing opioid and other substance abuse mis-use disorders
5. Require the creation of an Alternative Payment Method to the LPHA for providing quality and culturally appropriate clinical services to high-risk, Medicaid members through specialty clinics and other public health models including services in nonclinical settings and the use of nursing services and traditional health workers that are not easily reimbursable through a fee for service/ clinic model.

There was no motion for the PHAB to adopt CLHO's CCO 2.0 recommendations.

Public Comment Period

Morgan Cowling from the Coalition of Local Health Officials (CLHO) provided public comment. Morgan stated that she disagrees with the PHAB's decision to not adopt CLHO's CCO 2.0 recommendations. Morgan shared CLHO will be putting forward their recommendations during the CCO 2.0 public comment period.

Oregon's State Health Improvement Plan: communicable disease and immunizations
Zintars Beldavs, Sean Schafer, Alison Dent, and Aaron Dunn, OHA

Aaron Dunn and Alison Dent reviewed the progress towards the immunization objectives in the State Health Improvement Plan.

Bob stated he is unsurprised by the low rates of HPV vaccinations and said vaccines should be held to a "burrito standard," meaning getting a vaccination should be as close and as simple as buying a burrito.

Zints Beldavs and Sean Schafer reviewed progress towards the communicable disease objectives in the State Health Improvement Plan.

Closing
The meeting was adjourned.

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

May 17, 2018
2-5 PM
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 Julia Hakes at (971) 673-2296 or Julia.a.hakes@state.or.us. For more information and meeting recordings please visit the website: healthoregon.org/phab

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
May 14, 2018
1-3 pm

Welcome and Introductions

PHAB members present: Bob Dannenhoffer, Jeff Luck, Akiko Saito, Alejandro Queral

Oregon Health Authority (OHA) staff: Sara Beaudrault, Cara Biddlecom, Danna Drum, Julia Hakes, Chris Curtis

The March and April minutes were approved.

LPHA expenditures and matching funds

Danna reviewed a proposed list of county general fund exclusions that would not be eligible for state matching funds and asked for subcommittee feedback.

Bob noted that incentives always have unintended consequences—which in this case could result in counties shifting funds to programs and activities that are eligible for matching funds.

Bob asked about in kind charges such as shared space and noted it would be difficult to separate these costs by items that are or aren't on the list. Danna clarified that that these exclusions relate to direct charges.

Akiko asked OHA staff how items ended up on the exclusion list. Sara said that OHA staff used guidance provided to LPHAs during the 2016 public health modernization assessment and Fiscal Year 2017 LPHA expenditures data. Generally excluded services and activities are those that target individuals, and those that are eligible for matching funds affect the entire population.

Jeff asked for clarity around what reproductive health client services means. Danna explained that the reproductive health program has gone through some changes and the direct client services are now being provided through a service agreement between OHA, LPHAs and other entities. The assurance of access to reproductive services would be included in the matching funds.

Danna shared that OHA will be pulling together a technical group with county fiscal to develop reporting mechanisms.

Bob expressed concern over potential administrative burden in implementing this framework for LPHAs, especially given the relatively small amount of funds LPHAs would receive. He asked about the timeline for rolling out matching funds. Danna said that OHA has taken direction from PHAB regarding the need to incorporate matching funds as soon and PHAB has recommended rolling out matching funds sooner rather than later. Cara will map out what the rollout process for matching funds for PHAB members.

Sara asked subcommittee members if any items on the list should be required for matching funds? Akiko noted immunization clinics, and noted the importance for having capacity for clinics in outbreak situations. Sara clarified that immunization clinics were excluded because it is another service some LPHAs contract out and OHA does not want to disincentivize LPHAs contracting out services.

Jeff stated he is okay with moving forward this exclusion list to PHAB with additional clarifications that subcommittee members requested. Jeff requested changes to the document itself to include source documents and rationale for why certain bodies of work are not eligible for matching funds.

Funding formula indicators

Sara asked subcommittee members to review three options for a new funding formula indicator related to geographic complexity. Subcommittee members agreed to add Rurality: Percentage of population living in a rural area. Rurality data come from U.S. Census Bureau Population Estimates.

Sara asked subcommittee members to review three options for funding formula indicator allocations. Subcommittee members recommended option one: spilt the total indicator pool evenly across indicators.

Funding formula review

Sara reviewed the description and methodology for the three components to the local public health funding formula and the allocations to funding formula components at a range of funding level for the 2019-21 biennium. Chris reviewed

the local public health funding formula model: $10 million and $15 million example.

Akiko recommended adding the PHAB funding principles and the statutory language in ORS 431.380 to the document.

Bob noted that the allocations to different counties generally seem to make sense. He asked whether, for the base component, PHAB should set a maximum floor payment for counties. Bob stressed that OHA needs to be clear that the figures in the funding formula for matching and incentive funds are not based on actual LPHA data and were arbitrarily assigned to show the functionality of the funding formula.

For matching funds, subcommittee members recommended splitting the total available matching funds evenly between maintenance funds for sustained county investment and additional allocations for increased county investments. Jeff recommended renaming the floor payment to maintenance payment.

For incentive funds, subcommittee members recommended allocating 20% of available incentive funds to the floor payment with a minimum threshold of $1,000 per county, and the remainder to the additional allocation that is based on county population.

Report to Legislative Fiscal Office

OHA must submit a report on the application of the LPHA modernization funding formula by June 30. Sara asked subcommittee members if they would like to meet in June to provide feedback on the report. Sara clarified that OHA will take feedback into consideration but it is ultimately OHA that writes the final report. Bob asked that Sara put the meeting on the calendar and send out the report. If there are no major revisions recommended then Sara will cancel the meeting to review comments.

Subcommittee business

Akiko will provide the subcommittee update at the May 17 PHAB meeting.

Public Comment

No public testimony.

PHAB Incentives and Funding subcommittee
Local public health funding formula description and methodology
May 15, 2018 *draft*

Background
ORS 431.380 requires that, from state moneys Oregon Health Authority (OHA) receives for funding foundational capabilities and programs, OHA shall distribute funds to local public health authorities (LPHAs) through a funding formula described in this section of statute. The full text of ORS 431.380 is included as **Appendix A**.

The Public Health Advisory Board (PHAB) is responsible for making recommendations to OHA on the development of and modification of plans for the distribution of funds to LPHAs under ORS 431.380. In addition to making recommendations for the 2017-19 and 2019-21 local public health funding formula, PHAB has also established a set of Funding Principles to be used as a resource in discussions about public health funding formulas. These Funding Principles are included as **Appendix B**. PHAB recommendations on the 2019-21 local public health funding formula should be considered in the context of these Funding Principles.

Three components to the local public health funding formula

1. Base funds awarded for population, health status, burden of disease, and ability of LPHA to invest in local public health. Includes floor payments (based on five tiers of county size bands);
2. Matching funds for county investment in local public health services and activities above the base funding amount;
3. Incentive funds for achieving accountability metrics.

A 30,000-foot view of the 2019-21 local public health funding formula

The funding formula described in this document is a model for how funds would be allocated through the funding formula in 2019-21. The PHAB Incentives and Funding subcommittee will convene in 2019 to review and make final recommendations for the funding formula model, and the Conference of Local Health Officials will be consulted, when actual funding levels for 2019-21 are known.

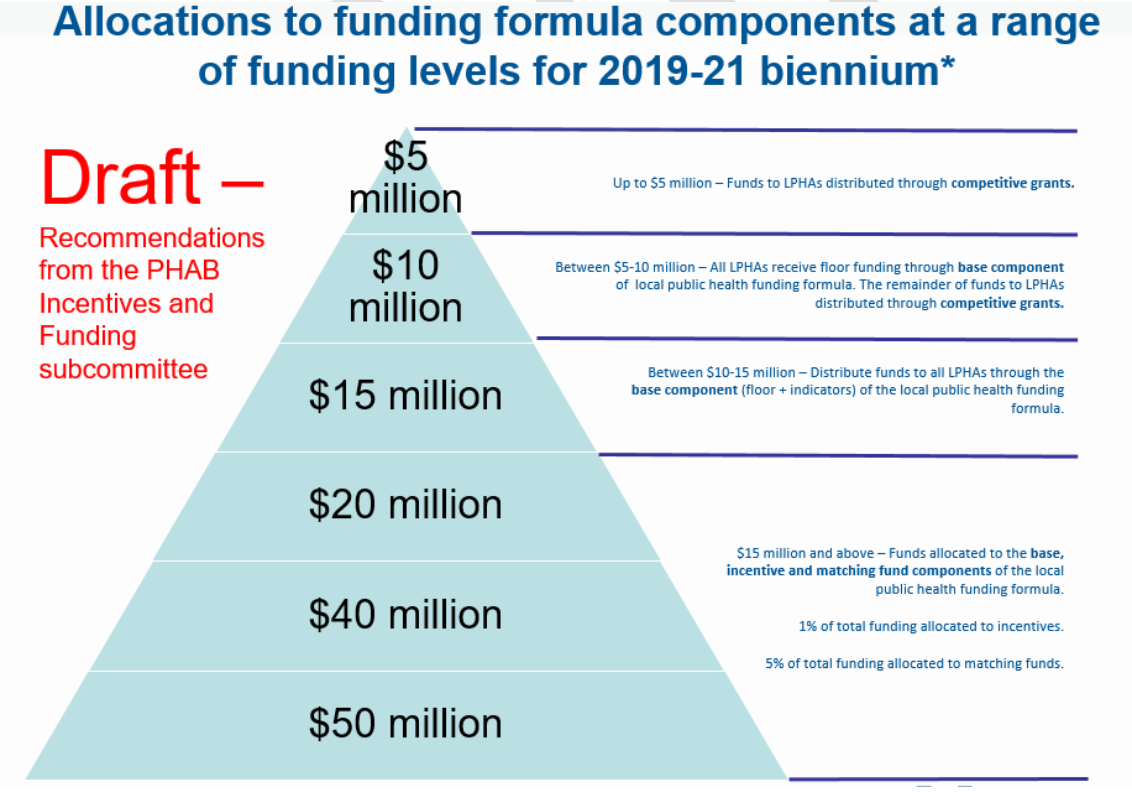
- Each component includes a floor payment, plus an additional method for allocating funds to counties.

- Floor payments favor extra-small and small counties. Additional methods are tied to county population and favor large and extra-large counties.
- In all components, extra-small and small counties receive a proportionally larger per capita allocation, and large and extra-large counties receive a proportionally larger dollar amount. This is consistent with the resource gaps identified in the 2016 public health modernization assessment.
- The funding formula advances health equity by directing funds to a set of indicators that measure health outcomes and county demographics.

Allocations to funding formula components at a range of funding levels for the 2019-21 biennium*

The Public Health Advisory Board's Incentives and Funding subcommittee made the following recommendations to OHA on allocating funds to each of the funding formula components at different total funding levels. These recommendations are incorporated into the local public health funding formula model for 2019-21.

Figure 1:



* Funding levels reflect total allocations to LPHAs (two years)

Figure 2: Description of funding formula components at the $15 million biennial funding level for LPHAs in 2019-21. See **Appendix C** for a complete description and methofology of the funding formula components.

Total LPHA biennial funding level	$15 million					
Funding formula compoent	Base funds ($14.1 million)		Matching funds ($750,000)		Incentive funds ($150,000)	
How funds are allocated	Floor payment to all counties based on county size band	Additional allocation to all counties based on funding formula indicators	Maintenance payment to counties that sustain county investment	Additional payment to counties that increase county investment	Floor payment to counties that achieve an accountability metric	Additional allocation to counties that achieve an accountability metric
Percent of funding	18.45% of base funds	81.55% of base funds	50% of matching funds	50% of matching funds	20% of incentive funds, minimum threshold = $1,000	80% of incentive funds
Funding amount	$2,767,500 (Size band range = $45,000-$135,000)	$11,332,500 (County award based on indicator ranking and county population)	$375,000 divided evenly among qualifying counties	$375,000 divided among qualifying counties based on percent funding increase and county population	$30,000, minimum of $1,000 to qualifying counties	$120,000 divided among qualifying counties based on county population

PHAB Incentives and Funding subcommittee

Appendix A – Oregon Revised Statutes 431.380

May 15, 2018 *draft*

FUNDING OF LOCAL PUBLIC HEALTH AUTHORITIES

431.380 Distribution of funds; rules. (1) From state moneys that the Oregon Health Authority receives for the purpose of funding the foundational capabilities established under ORS 431.131 and the foundational programs established under ORS 431.141, the Oregon Health Authority shall make payments to local public health authorities under this section. The Oregon Health Authority shall each biennium submit to the Oregon Public Health Advisory Board and the Legislative Fiscal Office a formula that provides for the equitable distribution of moneys. The Oregon Health Authority shall incorporate into the formula:

(a) A method for distributing to local public health authorities a base amount of state moneys received by the Oregon Health Authority pursuant to this subsection, taking into consideration the population of each local public health authority, the burden of disease borne by communities located within the jurisdiction of each local public health authority, the overall health status of communities located within the jurisdiction of each local public health authority and the ability of each local public health authority to invest in local public health activities and services;

(b) A method for awarding matching funds to a local public health authority that invests in local public health activities and services above the base amount distributed in accordance with paragraph (a) of this subsection; and

(c) A method for the use of incentives as described in subsection (3) of this section.

(2) The Oregon Health Authority shall submit the formula adopted under subsection (1) of this section to the Oregon Public Health Advisory Board and the Legislative Fiscal Office no later than June 30 of each even-numbered year. At the same time that the Oregon Health Authority submits the formula, the Oregon Health Authority shall submit to the Oregon Public Health Advisory Board and the Legislative Fiscal Office an estimate of the amount of state moneys necessary to fund in part or in whole the foundational capabilities established under ORS 431.131 and the foundational programs established under ORS 431.141.

(3) The Oregon Health Authority shall adopt by rule incentives and a process for identifying, updating and applying accountability metrics, for the purpose of encouraging the effective and equitable provision of public health services by local public health authorities.

(4) Nothing in this section prohibits the Oregon Health Authority from distributing state moneys that the Oregon Health Authority receives for the purpose of funding the foundational capabilities established under ORS 431.131 and the foundational programs established under ORS 431.141 to local public health authorities on an individual basis as opposed to a statewide basis, or through a competitive grant or contract process or on the basis of need, if the state moneys received are insufficient to adequately fund local public health authorities on a statewide basis. [1983 c.398 §2; 2009 c.595 §560; 2015 c.736 §28; 2017 c.627 §4]

PHAB Incentives and Funding subcommittee
Appendix B – PHAB Funding Principles
May 15, 2018 *draft*

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

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

Public health system approach to foundational programs

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

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

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

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

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

Transparency across the public health system

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

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

PHAB Incentives and Funding subcommittee

Appendix C – Detailed description of funding formula components

May 15, 2018 *draft*

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

The base component

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

Floor payments

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

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

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

Indicator pool

Every county receives additional allocations through the indicator pool based on the county's ranking on a set of health and demographic indicators[2]. A description of each indicator, measure and data source is included as **Attachment D**. Each of the health and demographic indicators receives an equal percentage of available indicator pool dollars.

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

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

Methodology

Base funding = floor payment + indicator pool payment

Floor payment = based on county size band

Indicator pool payment = all remaining base component funds

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

LPHA weight = LPHA population * LPHA indicator percentage

The matching funds component

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

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

Methodology

Compares county general fund investment over two years[3].

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

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

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

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

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

LPHA weight = LPHA population * percent county funding increase

The incentive funds component

- Each county that achieves an accountability metric will receive an incentive fund floor payment and an additional allocation.
  - All qualifying counties receive the same floor payment. Twenty percent of incentive funds will go to floor payments, with a minimum threshold of $1,000
  - Additional allocations are proportionally distributed to qualifying counties based on county population.
- One percent of funds will be allocated to incentive funds at or above the $15 million level. (At the $15 million, $150,000 would be allocated to incentive funds.
  - Available funds will be split across incentivized accountability metrics

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

Methodology

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

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

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

Figure 3: Local public health funding formula model - $15 million example

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

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

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

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

[1] Source: American Community Survey population 5-year estimate, 2012-2016.

[2] Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon death certificate data, 2012-2016.

[3] Source: Quality of life: Good or excellent health, 2012-2015.

[4] Source: Portland State University Certified Population estimate July 1, 2017

[5] Source: U.S. Census Bureau, Population estimates,2010

County Size Bands

Extra Small	Small	Medium	Large	Extra Large

PHAB Incentives and Funding subcommittee
Appendix D – Funding formula indicators
May 15, 2018 *draft*

The following indicators are included in the base component of the funding formula. The Public Health Advisory Board recommends that the total indicator pool be split evenly across seven indicators.

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

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

The Central Oregon Public Health Modernization Experience

Muriel DeLaVergne-Brown, RN, MPH
Health & Human Services Director
Crook County Health Department

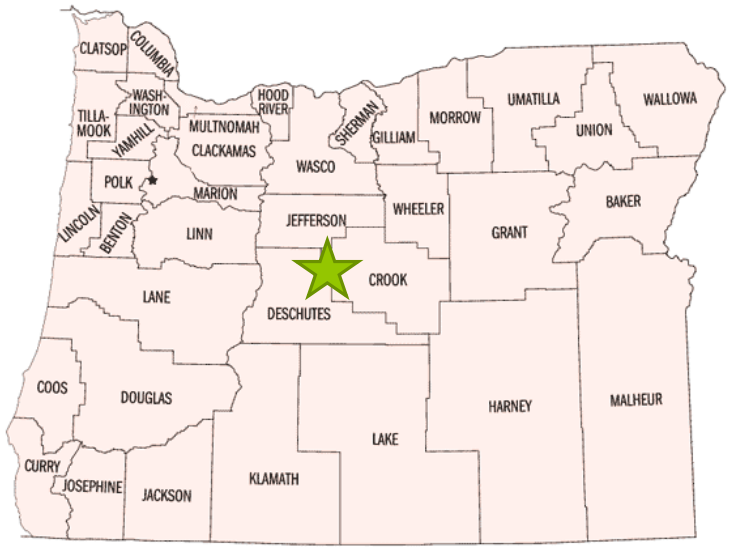







Central Oregon

- 7,833 Square Miles – Center of Oregon
- Population – 213,578 (2014 Estimate)
- Economy: Timber, Ranching, Agriculture, Outdoor Recreation



The Need

- Central Oregon Responses to day-to-day
- Gonorrhea rates increased by over 450% over 10 years compared to 232% statewide
- 70% of all norovirus outbreaks - long term care facilities
- Children's Immunization Rates – four outbreaks since 2012
- Limited Capacity and Surge Capacity to address outbreaks and emerging threats
- Public Health Gap Analysis ranked from 20% to 60% in Communicable Disease

Our Project Goals

Increase public health capacity to prevent, respond to, analyze and communicable disease outbreaks, health inequities, and emerging threats through a Response Team.

PREVENTION STRATEGIES

- Training in Long Term Care Facilities (LTCF)
- Increase % of nursing facility staff who receive flu vaccine
- Develop infection prevention trainings for LTCF and Child Care Facilities
- Annual Report on Communicable Disease/Providers
- Develop policies based on annual report

Our Project Goals

Conduct regional surveillance on communicable diseases, and produce and share timely information with health care providers, partner agencies, and the public.

SURVEILLANCE STRATEGIES

- Analyze data incorporating **a health equity lens**
- **Analyze Communicable Disease Population Disparities**
- Participate in regional meetings with partners
- Educate health care providers on reporting requirements
- Timely communication to the public/providers
- Organize and lead outbreak investigations in collaboration with partners

Our Project Goals

Assess and evaluate communicable disease response efforts and recommend change/improvements in practice.

RESPONSE STRATEGIES

- Utilize the ***10 Steps of an Outbreak*** to conduct outbreak investigations in Central Oregon
- Work with LTCFs to mitigate the spread of disease
- Provide ongoing regional peer support, assistance, and training to regional CD staff
- Provide assistance and back-up on day-to-day communicable disease investigations in individual counties as needed (particularly in under-resourced counties)

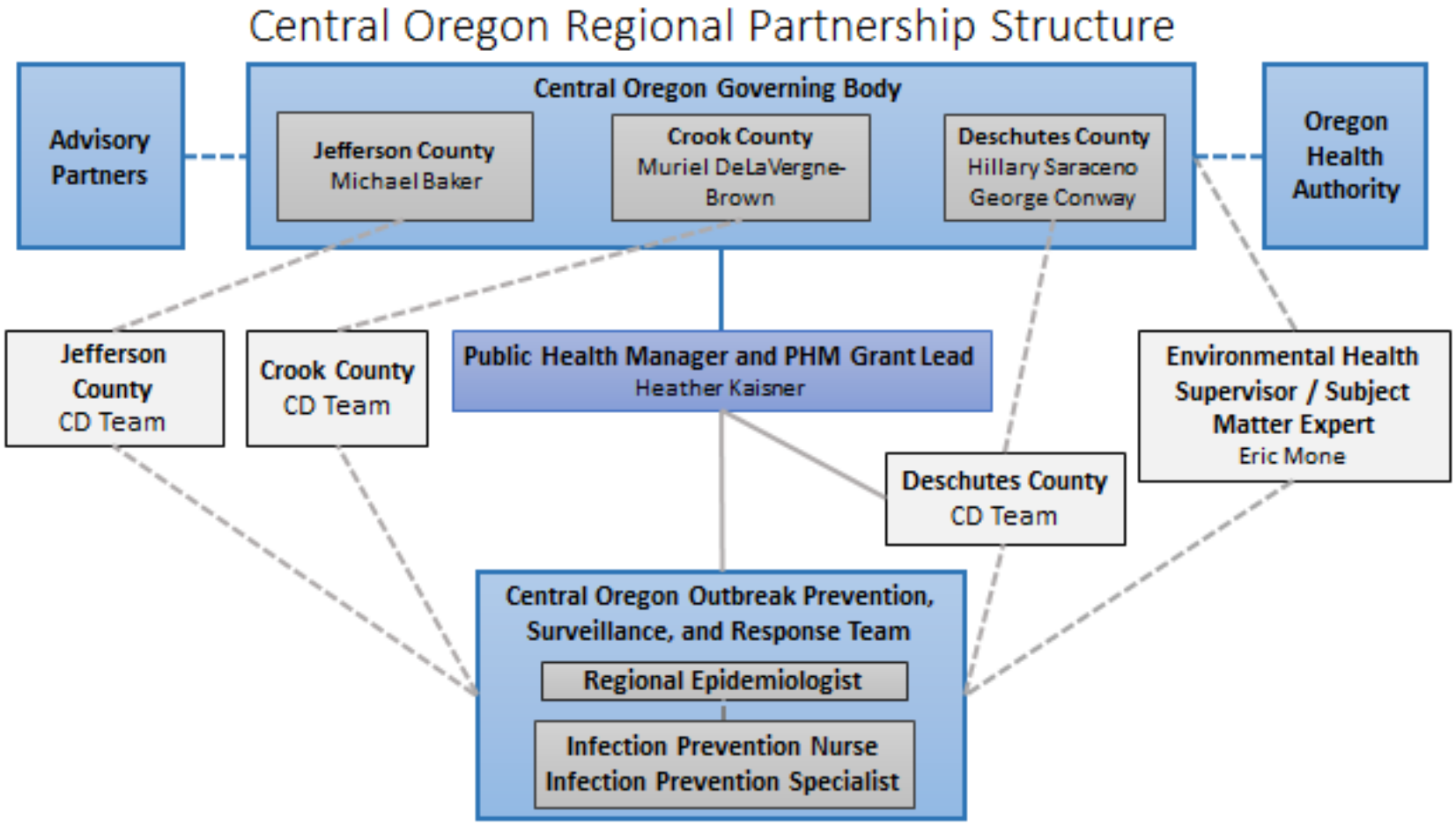
What Success Looks Like!

- The Regional Team – ability to hire highly qualified team
- Improved Communication/Risk Communication
- Improved Capacity
- Health Equity Assessment
- CJS is used to improve service delivery, not to replace or outsource services
- More efficient as a team

What Success Looks Like!

- Collaboration allows communities to solve problems that cannot be solved—or easily solved— by single organizations or jurisdictions.
- Quality Improvement - Metrics

Fill the Gap/Build Capacity



The Road - CJS

Challenges

- Local Identities
- Building Trust
- The Need in the Community
- Large Medical Community
- Need Lots of Communication Time

Barriers

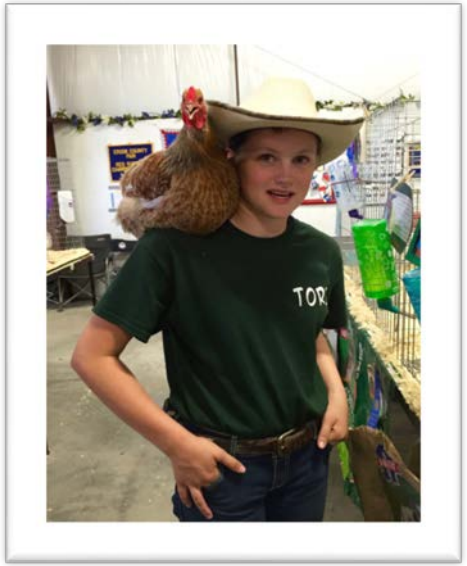
- More requests from partners than able to fulfill
- Distances for Travel Time
- No Other Barriers Determined
- It doesn't work for all PH programs

Foundation for 2019-2021

- Continue funding for Communicable Disease and Health Equity (Disparities)
- Build on current system
- Evaluate the amount of work local health departments do to support the primary care system (follow-up for Communicable Disease, Tuberculosis (DOT)
- Continuity for our local public health systems

Questions?

mdelavergnebrown@h.co.crook.or.us
541-416-1980



Central Oregon Public Health Quarterly

Communicable Disease Update for Crook, Deschutes, and Jefferson Counties
2018: Quarter 1

24/7 Communicable Disease reporting lines:	Crook County: 541-447-5165	Deschutes County: 541-322-7418	Jefferson County: 541-475-4456

2017 Communicable Diseases Year-in-Review

The table below summarizes 2017 case counts and estimated rates for select reportable communicable diseases with Central Oregon regional case counts of 5 or higher.

2017 Communicable Disease Annual Case Counts and Rates

Reportable Disease or Condition	Oregon		Crook Co.		Deschutes Co.		Jefferson Co.	
	Case count	Rate per 100,000 population	Case count	Rate per 100,000 population	Case count	Rate per 100,000 population	Case count	Rate per 100,000 population
Campylobacteriosis	1,059	25.6	14	63.3	67	36.6	7	30.2
Chlamydia	18,723	452.1	91	411.7	675	369.0	161	694.3
Cryptosporidium	274	6.6	<5	--	10	5.5	<5	--
E.Coli (STEC)	211	5.1	<5	--	12	6.6	<5	--
Giardiasis	339	8.2	<5	--	17	9.3	<5	--
Gonorrhea	5,039	121.7	14	63.3	65	35.5	49	211.3
Hepatitis B (Chronic)	492	11.9	<5	--	8	4.4	<5	--
Hepatitis C (Chronic)	6,007	145.1	37	167.4	232	126.8	62	267.4
Elevated Blood Lead Level	975	23.5	<5	--	15	8.2	<5	--
Salmonellosis (non-typhoidal)	483	11.7	<5	--	14	7.7	<5	--
Shigellosis	122	2.9	<5	--	<5	--	<5	--
Syphilis	861	20.8	<5	--	11	6.0	<5	--
Vibriosis	32	0.8	<5	--	9	4.9	<5	--
Yersiniosis	48	1.2	<5	--	5	2.7	<5	--

Case counts include both confirmed and presumptive cases. Case counts are preliminary as of February 1, 2018. When case counts are <5, county-level data is suppressed and county-level rates are unreliable. Rates calculated using 2017 mid-year population estimates from the Population Research Center at Portland State University.

Central Oregon Year-in-Review Highlights

- The total number of chlamydia and gonorrhea cases in Central Oregon increased by 21.2% and 33.3%, respectively, since 2016.
- The highest number of chlamydia and gonorrhea cases in Central Oregon were in Deschutes County; however, the largest rates of chlamydia and gonorrhea (cases per 100,000 population) were in Jefferson County. *(Details can be found on the next page.)*
- Giardiasis cases (n=24) decreased 36.8% from 2016 (n=38).
- Salmonellosis cases (n=17) decreased 32% from 2016 (n=25).
- The number of cases of cryptosporidium, chronic hepatitis C, and syphilis in 2017 were similar to the number of cases in 2016.

Disease Spotlight: Chlamydia

Chlamydia cases are on the rise in Central Oregon.

The increase in cases over time is partially due to our increase in population; however, rates of chlamydia (# of cases per population size) peaked in 2017 (406.2 cases per 100,000 population for the Central Oregon region).

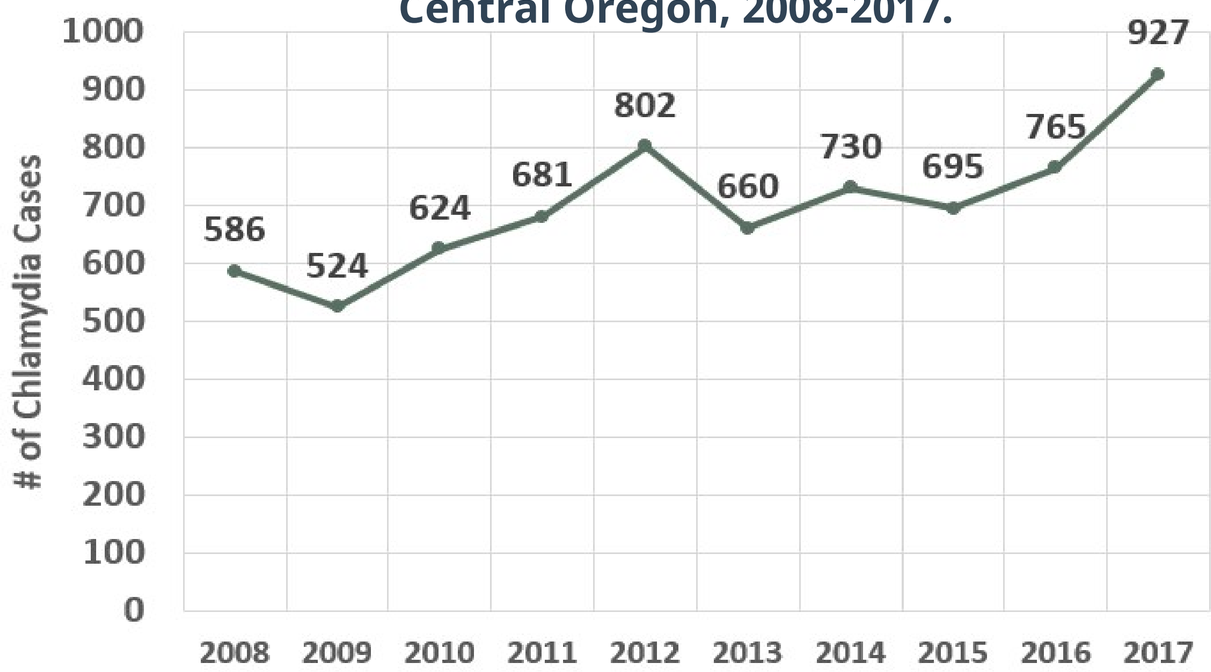
In 2017, the largest number of cases in Central Oregon were in Deschutes County (675), followed by Jefferson County (161) and Crook County (91).

Of the three Central Oregon counties, Jefferson County had the highest rate of chlamydia in 2017 (694.3 per 100,000 population), followed by Crook County (411.7 per 100,000 population) and Deschutes County (369.0 per 100,000 population).

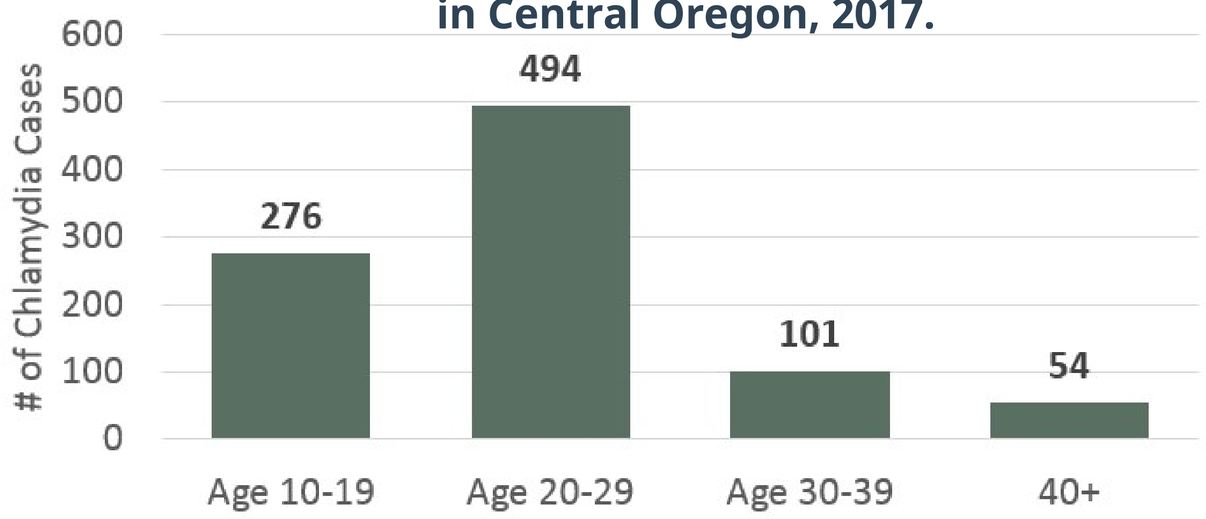
Chlamydia affects young adults and females the most.

Most (53%) chlamydia cases in Central Oregon in 2017 were among those aged 20-29. Most (68%) cases were female.

# of chlamydia cases per year in Central Oregon, 2008-2017.



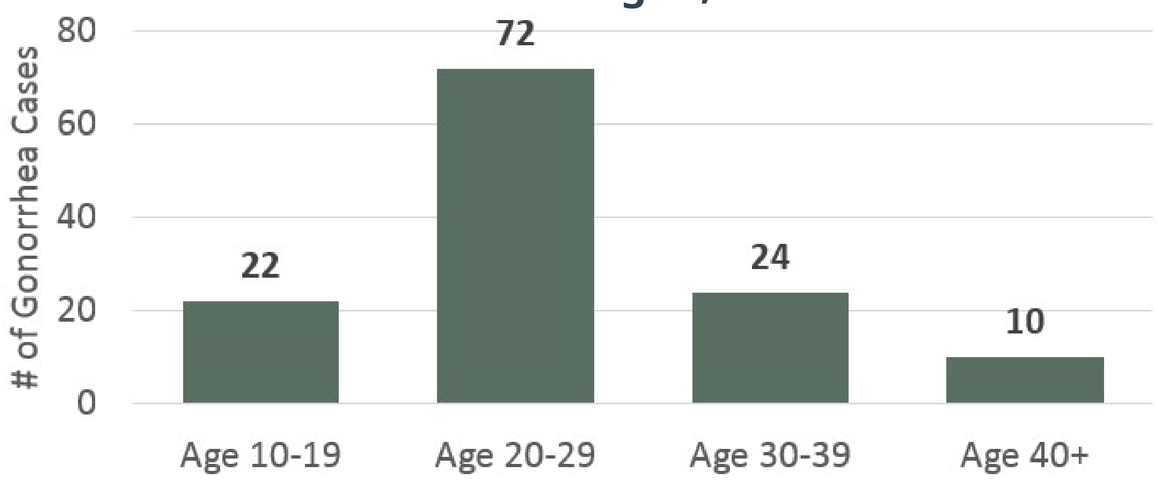
# of chlamydia cases by age group in Central Oregon, 2017.



Disease Spotlight: Gonorrhea

# of gonorrhea cases per year in Central Oregon, 2008-2017.

# of gonorrhea cases by age group in Central Oregon, 2017.



The number of annual gonorrhea cases has rapidly increased in Central Oregon.

Gonorrhea rates have increased from 3.5 per 100,000 population in 2008 to 56.1 per 100,000 population in 2017 in the Central Oregon region. Rates have more than doubled since 2014.

In 2017, the largest number of cases seen in Central Oregon were in Deschutes County (65), followed by Jefferson County (49) and Crook County (14).

Of the three Central Oregon counties, Jefferson County had the highest rate of gonorrhea in 2017 (211.3 per 100,000 population), followed by Crook County (63.3 per 100,000 population) and Deschutes County (35.5 per 100,000 population).

Gonorrhea affects young adults and males the most.

Most (56%) gonorrhea cases in Central Oregon in 2017 were among those aged 20-29. Slightly more than half (55%) of all cases were male.

Why are STD cases increasing in Central Oregon?

- Sex is more readily available and anonymous, partially due to dating apps. This makes tracking and partner notification more difficult.
- Use of condoms has decreased.
- Infections are spreading more broadly and into populations not traditionally affected by STDs.
- We have become better at detecting cases. This is due to many factors including changes in national screening guidelines, more sensitive tests, and increased access to healthcare services, including STD services.
- Our local health departments have experienced decreased funding for STD services.

What can be done to slow or stop the increase?

- **Providers:** make STD screening and timely treatment a standard part of medical care, especially for pregnant women, MSM, and young adults.
- **Local health departments**: increase prevention efforts through targeted outreach and messaging, and use innovative methods to conduct partner services.
- **Everyone**: talk openly about STDs, get tested regularly, and reduce risk by using condoms or practicing mutual monogamy if sexually active.

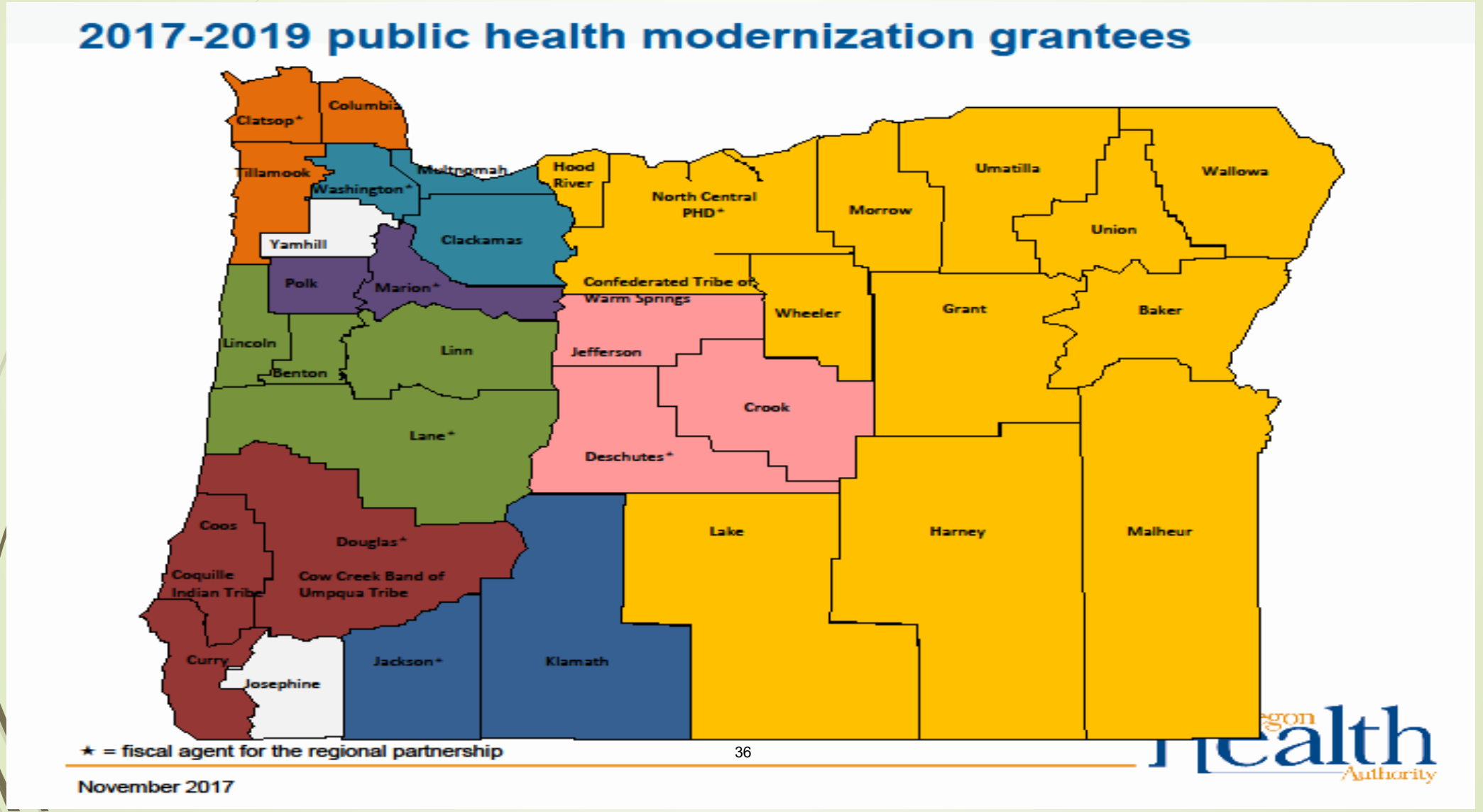
Modernization

Bob Dannenhoffer, MD

Douglas County Health Officer and Administrator

May 17, 2018

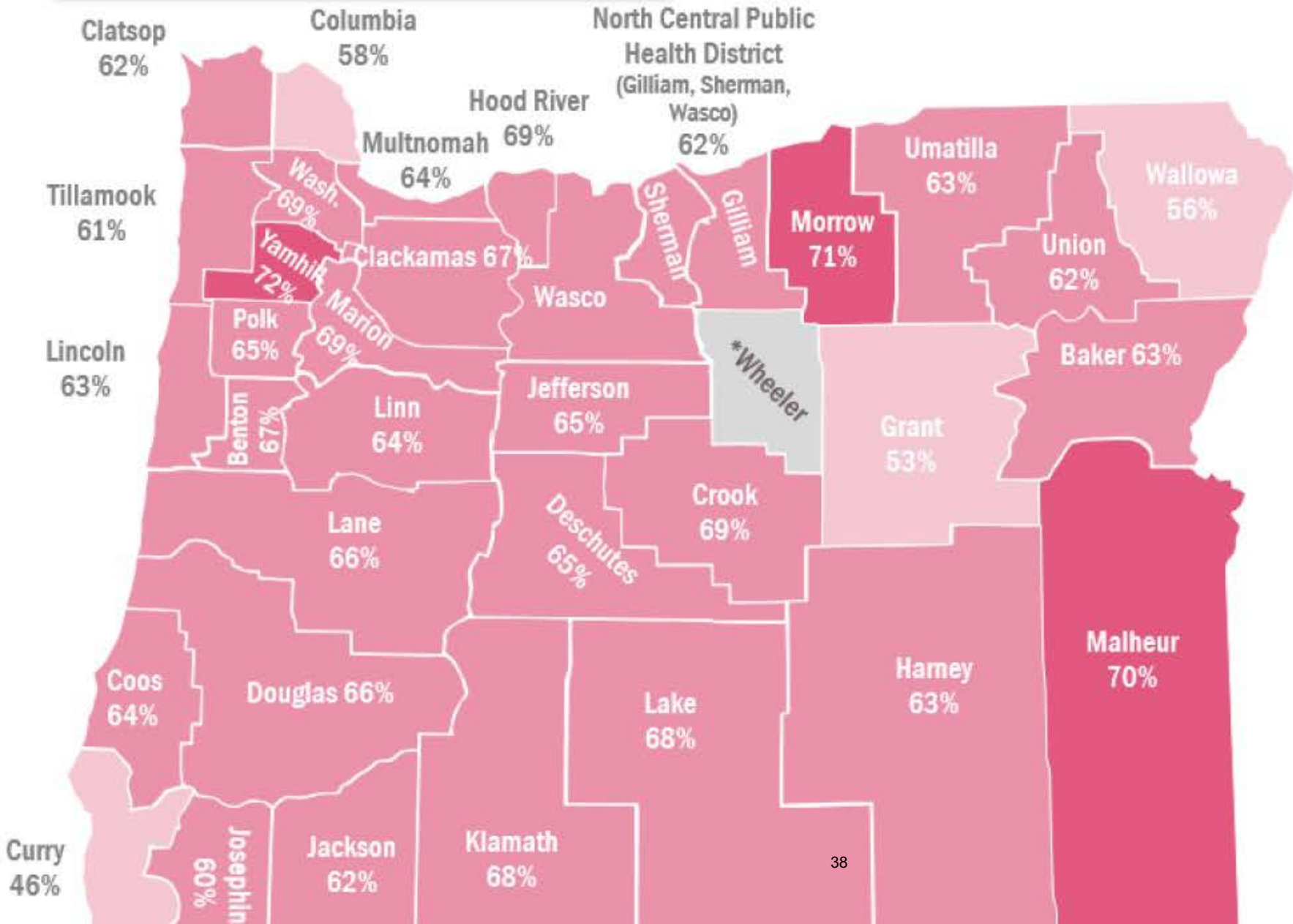
South West Regional Health Collaborative



EQUITY

By county

Oregon 2016



Benchmark:

80%

Legend

- 0-59%
- 60-69%
- 70-79%
- 80-100%
- *No data

Improve Communicable disease reporting