

# AGENDA

## PUBLIC HEALTH ADVISORY BOARD Incentives and Funding Subcommittee

**April 9, 2019**

**1:00-2:00 pm**

Portland State Office Building, 800 NE Oregon St., Conference Room 915, Portland, OR 97232

Webinar: <https://attendee.gotowebinar.com/register/3531740595390230274>

Conference line: (877) 873-8017

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

### Meeting Objectives

- Approve March 12 meeting minutes
- Make recommendations for distributing funds to local public health authorities at a funding range of \$5-10 million

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<b>1:00-1:10 pm</b>	<b>Welcome, introductions and updates</b> <ul style="list-style-type: none"><li>• Approve March 12 meeting minutes</li><li>• Hear update on OHA planning for distributing modernization funds to LPHAs</li><li>• Hear updates from subcommittee members</li></ul>	Akiko Saito, Meeting Chair
<b>1:10-1:45 pm</b>	<b>LPHA funding between \$5-10 million - planning scenario</b> <ul style="list-style-type: none"><li>• Discuss and make recommendations on distribution of funding to LPHAs at a funding range of \$5-10 million</li></ul>	Akiko Saito, Meeting Chair
<b>1:45-1:50 pm</b>	<b>Subcommittee business</b> <ul style="list-style-type: none"><li>• Confirm that Akiko will provide subcommittee update at April 18 PHAB meeting.</li><li>• Confirm that Carrie will chair the May 14 subcommittee meeting.</li></ul>	Akiko Saito, Meeting Chair
<b>1:50-1:55 pm</b>	<b>Public comment</b>	
<b>1:55 pm</b>	<b>Adjourn</b>	

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Public Health Advisory Board (PHAB)  
Incentives and Funding Subcommittee meeting minutes  
March 12, 2019  
1:00 p.m. - 2:00 p.m.

PHAB members present: Carrie Brogoitti, Dr. Jeff Luck, Alejandro Queral, Akiko Saito, Dr. Bob Dannenhoffer

PHAB members absent: None

Oregon Health Authority (OHA) staff: Sara Beaudrault, Katarina Moseley, Karen Girard, Krasimir Karamfilov

*Welcome and Introductions*

Mr. Queral invited the subcommittee members and members of the public to introduce themselves. Members of the public on the call included Wendy Zieker (Marion County Health Department), Mr. Bowen (Coalition for a Healthy Oregon), Angela Johnson (Linn County Public Health), and Glenna Hughes (Linn County Public Health).

A quorum was present. Mr. Queral moved for approval of the February 12, 2019, meeting minutes. Dr. Luck seconded the motion. The subcommittee approved the meeting minutes unanimously.

*Increasing Funding through Tobacco Tax Revenue*

Ms. Beaudrault reminded the subcommittee that the Governor's budget for 2019-2021 included funding for public health modernization. That was the first time public health modernization funding showed up in the Governor's budget. The Governor's budget builds on the existing \$5 million for the current biennium with an additional \$13.6 million for the next biennium.

Ms. Beaudrault added that the Governor's budget is not our final budget. The final budget is developed and put in place by the legislature. The additional funding for public health modernization would come from increased tobacco tax revenue that Oregon would have if the tobacco tax increase passed. If that happens, these funds would be allocated for the final six months of this biennium (January-June 2021) and those funds would be in place for future biennia.

Ms. Beaudrault noted that, in terms of the Governor's budget, and what Governor Brown would like to see happen with increased tobacco tax revenue, the majority of those funds will go to Oregon Public Health (OHP). Ninety percent of those increased dollars would go to OHP, with 10% coming for public health modernization, including tobacco prevention. It will be important, as we move forward, to show how our current efforts of building capacity in communities across the state support our current direction for public health modernization,

and also support the work that can happen around tobacco prevention. These are not distinct things. We use the same tools and rely on the same skills and strategies whether we are talking about communicable disease control or tobacco prevention.

Dr. Luck asked if, according to the funding allocation graph in the packet, the new proposal would not have any tobacco tax going to the General Fund and all will go to the Oregon Health Plan or Modernization and Tobacco Prevention.

Ms. Girard confirmed that 90% of the tobacco tax funds will go to the OHP and 10% will go to Modernization and Tobacco Prevention. Also included in that are some very small amounts that would hold the existing programs funded by tobacco taxes harmless, because, if tobacco consumption goes down, the statutes in the graph that denote Counties, Cities, and ODOT will see a decrease in their funding.

Ms. Girard stated that the Governor's office is convening representatives from communities experiencing inequities and disparities in tobacco use, such as communities of color, lower income communities and organizations that represent them, and tribes to talk about the importance of a tobacco tax, both in funding prevention through the Oregon Health Plan and in providing services to reduce inequities in tobacco use. The Governor's office has held one meeting a couple of weeks ago, with another meeting coming up next week to continue these discussions.

Ms. Beaudrault clarified that the subcommittee is not talking about a course change from communicable disease control to tobacco prevention. It is talking about foundational capabilities. That is, building the local and state-wide capacity for partnership development and working with communities and groups that are most affected by health disparities. These are the things we are investing in with public health modernization. Right now, the initial dollars have been going to communicable disease control, but the work is setting the stage to enhance tobacco prevention as well.

Mr. Queral asked about the framing of communicable disease within the context of the foundational capabilities, whether it is epidemiology or several of the foundational capabilities.

Ms. Beaudrault referred Mr. Queral to the modernized framework for government public health services in the packet that showed all foundational capabilities and foundational programs. The foundational capabilities are the foundation for the programs that need to be in place. The ones we have been focusing on for the initial investment in communicable disease control have been Health Equity and Cultural Responsiveness and Assessment and Epidemiology. We have not called out Community Partnership Development explicitly, but the work is founded in strengthening community partnerships.

Ms. Moseley remarked that what we are experiencing in the Public Health Division as we are looking at health and working on enhancing our capacity in health equity and cultural

responsiveness is that it has pulled in other foundational capabilities. Community partnership development is one capability that is naturally attached to health equity and cultural responsiveness. One of the things that is helpful to think about are examples in the division, programmatically, as to where infection (STD) and HIV work cross with tobacco prevention work, is seeing these foundational capabilities rise and become attached to each other, and pull each other along, as those areas of interest come together. It is becoming harder and harder to draw lines around the foundational capabilities and say that we are doing just one or another.

Mr. Queral asked about the sustainability component of the foundational capabilities. For example, when we talk about the communicable disease and HIV prevention program, aren't we talking about not only building on the program, but also creating the foundational pieces that one would presume would stay in place even if the program is not being deployed?

Ms. Moseley responded that the foundational capabilities are how we do our work. We use the same capabilities around communicable disease, as well as around tobacco prevention, or environmental health, or access to clinical preventive services. The benefit that that starts to have is that we start to see where the populations that bear greater burden of – fill in the blank – cross over each other and become the same populations. When we start to think about communicable disease and tobacco prevention, there are examples where these are the same humans.

Mr. Queral asked if Ms. Brogoitti and Dr. Dannenhoffer could share their perspective on this, based on their experience or observation of the foundational capabilities and how they can be established beyond the life of the program. This is important because a percentage of the additional dollars would likely be linked to tobacco and there needs to be a nexus between modernization and tobacco prevention. Could we make the same case that by applying the elements of the Tobacco Prevention and Education program, we are also building on the foundational capabilities of those LPHAs that are implementing it?

Dr. Dannenhoffer noted that we are a little shy, because the last time we got money from the federal tobacco settlement, many states, including Oregon, used the money for things other than tobacco prevention, such as roads, and prisons, and whatever else. We are always cautious when we have tobacco tax money that is being spent for anything other than tobacco prevention. In the past, we focused narrowly on programs, and had to spend all our money on programs, so that there was no money to be spent on other important things. For example, in the last few biennia, Douglas County had very little money for chronic disease and no money for suicide prevention, which are two of the big issues on the State Health Improvement Plan. Because of all this, Dr. Dannenhoffer is torn about this and does not have good advice.

Ms. Brogoitti agreed with Dr. Dannenhoffer. In the absence of a clear answer or path and considering that local health departments have been working in an under-resourced system for so long, there are needs everywhere. It is hard to pick and choose and prioritize. While we do have needs in tobacco prevention, and we know how much tobacco impacts the health of our

communities, there are also other needs that we have identified in our communities where we don't get any resources to support them. There is no one right or wrong answer.

Mr. Queral reminded the subcommittee that during its last meeting the subcommittee came up with a recommendation to the PHAB to stay the course with respect to the first \$5 million dollars that are going to be allocated towards modernization. Is it correct that there is \$5 million allocated from the General Fund, plus the \$13.6 million coming from tobacco tax increase, if the bill passes and survives a challenge at the ballot?

Ms. Beaudrault responded that that was correct. We feel confident the \$5 million that is currently in the OHA budget for public health modernization will be there going into the next biennium, although there is no guarantee. The \$13.6 million would be new money coming into the system. The subcommittee already discussed the challenges of handling the money, as it will hit the system fast, with a very short amount of time (i.e., six months) to spend the first chunk of money at the end of this biennium.

Ms. Beaudrault added that public health modernization sets up the PHAB to have a large role in setting the direction for how the system is scaled up, which also includes a component of how funding is directed. It is important that new money coming into the system remain flexible enough to honor the role of the PHAB. To the extent that we can, we want to avoid being prescriptive about how funding is used for categorical public health programs, because that would keep us in the system in which we already exist.

Ms. Queral stated that the LPHAs that received funding in the first round would be informed that we would stay the course with those \$5 million. In addition, we would have another \$5 million. Could the PHAB frame this second round as work on any of these foundational capabilities through the application of their program? If it's tobacco, they could say that they would work on health equity and cultural responsiveness to build their capacity of, for example, health equity and cultural responsiveness, community partnership development, and communications, which are three key elements of TPEP. It can be expressed in such a way that regardless of what the program is, their focus is on building their foundational capabilities. In a sense, the program becomes the money vehicle. Would that be an approach that allows us enough flexibility and, at the same time, sets up LPHAs to receive the additional funding from the tobacco tax, if that comes through?

Ms. Beaudrault clarified that we have \$5 million in the current biennium. We are looking at the same, flat funding in the next biennium. That is what is sitting in the budget right now. It would not be an additional \$5 million. It would be the same level of funding (i.e., \$5 million) in the next biennium, with the potential for increased funding through tobacco tax.

Mr. Queral noted that the PHAB could inform LPHAs to stay the course, without altering the recommendation from last time. If they are working on communicable disease and feel that they need more money, they should keep working on that. But if they feel that they can

develop any of the foundational capabilities, anticipating additional funding from the tobacco tax, that scenario would be Option B.

Ms. Beaudrault remarked that OHA puts funding out to LPHAs through program elements, which are contracts that spell out the requirements. The requirements for the current funding are not specifically focused just on communicable disease control. The requirements include engaging local organizations, building partnerships with tribes and recs, providing culturally responsive interventions within in the community, and working towards health equity. The contractual requirements already set up the work to build capacity for the foundational capabilities.

Mr. Queral ensured that all PHAB members were clear about what the subcommittee was being asked to recommend to the PHAB. The subcommittee already made a recommendation. Now the subcommittee needs to reaffirm it and then the PHAB will vote on it during the March 21, 2019, PHAB meeting.

Mr. Queral asked for questions from the subcommittee members about how to set up the programs if there was an additional \$13.6 million from tobacco taxes, and how that money would be spent or distributed.

Dr. Luck confirmed that the options are clear. Because the \$13.6 million is uncertain, he did not feel that the subcommittee should be too prescriptive about how the money should be spent.

Mr. Queral noted that, to some extent, the subcommittee has to be prescriptive with the tobacco tax revenue. Some portion of that would need to go directly to TPEP implementation at the local level. The subcommittee has to be flexible enough so that LPHAs can work on the foundational capabilities and building that capacity, while, at the same time, being aware that there may be additional dollars that would allow them to further work on their foundational capabilities, but through the implementation of TPEP, not something else that they decide.

Mr. Queral stated that, in a sense, that could be the subcommittee's recommendation: Stay the course. Keep working on foundational capabilities, with the anticipation of additional dollars coming to continue working on foundational capabilities; and emphasizing TPEP.

Dr. Luck asked if the 10% of the tobacco revenue equal the \$13.6 million, and if the \$13.6 million has to be allocated to both modernization and tobacco prevention.

Ms. Beaudrault responded that that is approximately 10%.

Ms. Girard remarked that all this is assuming that the tobacco tax goes into effect in the last six months of the biennium. Roughly, it is a fourth of what we would expect the tobacco tax increase to bring in over a biennium.

Ms. Beaudrault recommended not focusing too heavily on the \$13.6 million. In the first full biennium (2021-23), it would be a large increase in funding coming to public health to support modernization and tobacco prevention.

Dr. Luck calculated that to estimate that for a biennium, we roughly multiply 13 by 4.

Ms. Girard confirmed the accuracy of the rough calculation.

Ms. Saito suggested that one of the subcommittee's recommendations should be to not separate public health modernization from tobacco prevention, because tobacco prevention is part of the foundational program Prevention and Health Promotion. If we are talking about modernization dollars, we should be talking about more of what Ms. Beaudrault mentioned. Namely, what we want these funds to be, not necessarily what program we want them to go to. For instance, whatever this money comes for, whether it is for tobacco prevention or communicable disease, we should be focusing on making sure there is leadership and organizational competencies, making sure that there is a focus on health equity and communities that experience health inequities, and making sure that there is a policy piece.

Ms. Saito added that if we are saying 10%, and that some of it will go to tobacco prevention and the other part will go to modernization, that is not the message we want to send. We want to say that everything is going to modernization, and because tobacco prevention is one of the foundational programs that really helps, we want to make sure that even tobacco prevention dollars that we use is within the modernization perspective and using all modernization pieces.

Mr. Queral agreed with Ms. Saito and invited comments from the subcommittee members. Dr. Luck, Dr. Dannenhoffer, and Ms. Brogoitti liked Ms. Saito's suggestion.

Ms. Beaudrault pointed out that OHA is not asking for well-developed recommendations from this subcommittee on additional funds coming through tobacco tax revenue at this point in time. There is way too much activity, and we are early in the conversation. It has been very helpful to hear the subcommittee's thinking on it, and to hear that there is some understanding and agreement about how we can move these conversations.

Mr. Queral agreed that there was a consensus and that it was a good time to go back to the PHAB and report the subcommittee's perspective. Will the PHAB vote and formalize the recommendations during its March 21, 2019, meeting?

Ms. Beaudrault remarked that we are going to ask the PHAB through this subcommittee to vote just on the \$5 million. That is, use of the \$5 million that we have now and that should be in place at the beginning of the next biennium. This is the only piece we want to get formalized.

*Sustaining 2017-2019 investment in LPHA partnerships*



Ms. Beaudrault presented the subcommittee's recommendations from its February 12, 2019, meeting for distributing funds to LPHAs if funding remained at \$5 million. It is important to have the recommendations captured exactly as the subcommittee members defined them. The reason we want to get firm on the use of the \$5 million, assuming we have flat funding going into the next biennium, is because we at OHA need to start doing the planning work to make sure we can get these dollars out immediately to LPHAs. That work needs to start now, so we want to make sure that the PHAB is settled on these recommendations.

Mr. Queral read the four recommendations. Although he did not recall discussing one of the recommendations (#3), he invited the subcommittee members to comment on the recommendations, ask questions, or propose changes.

Ms. Saito remembered discussing recommendation #3 because there were a couple of counties that were not involved initially and the subcommittee wanted to give them an opportunity to join another group. Some of counties in eastern Oregon (e.g., Wallowa) did not apply initially. Ms. Saito approved the four recommendations moving forward and asked if the other subcommittee members were ready for a motion.

Ms. Beaudrault commented that the subcommittee does not need to make a motion as long as its members come to an agreement. We do want the PHAB to take some sort of action toward approval.

Mr. Queral invited Ms. Brogoitti, Dr. Luck, and Dr. Dannenhoffer to express any concerns or thoughts.

Dr. Dannenhoffer informed the subcommittee that he presented the four recommendations to the CHLO meeting in February and they were well accepted.

Ms. Brogoitti stated that she felt strongly about allowing all local health departments to participate. The whole intent behind what we are doing is to raise everybody up. It would be good if LPHAs that have not participated were allowed to join an existing group.

Dr. Dannenhoffer noted that this was discussed during the last CLHO meeting. Yes, LPHAs should be able to come in at the same level as everybody else could, but not as a single country, but as a group. If people wanted to form their own group, or join an existing group, that would be acceptable.

Dr. Luck asked how many LPHAs are not participating now.

Dr. Dannenhoffer responded that there are three counties: Josephine, Yamhill, and Wallowa.

Ms. Beaudrault clarified that there are two, as Wallowa County does not have a local public health authority.



Dr. Dannenhoffer remarked that the two counties that have health departments and are not participating are Josephine County and Yamhill County. Both counties are between groups that are already existing.

Mr. Queral concluded that the subcommittee is clear on the recommendations and can move forward.

Ms. Beaudrault stated that the recommendations will be included in the agenda for the PHAB meeting on March 21, 2019, for formal discussion and vote. The reason we want to have the PHAB vote on this is because, in order to get the dollars out to LPHAs, beginning in July 2019, we need to start doing the planning work now. We heard loud and clear that we needed to take whatever efforts we could to minimize break in funding, protect the staff that have been hired, and protect the ongoing partnerships that have been developed.

Ms. Beaudrault emphasized the goals: No interruptions in work, and allowing the eight LPHA partnerships time to identify whatever course corrections and natural progressions they want to start building in in 2019-2021, which would include bringing in Yamhill and Josephine counties, if they want to join. In addition, we will be working with CLHO through our regular processes to make updates to the program element to reflect the changes that we need to make. We are planning to do a 3-month continuation of current workplans and budgets to get us through the first quarter of the next biennium, since we won't have the final OHA budget as of July 1. This is the way we have figured out to get the funds out and allow the work to continue, while we are still sorting out some of the details of the biennium.

Mr. Queral asked if Ms. Saito could chair the subcommittee meeting on April 9, 2019.

Ms. Saito responded that she could, and thanked Ms. Queral for chairing two subcommittee meetings in a row.

### Public Comment

Mr. Queral invited members of the public to ask questions and provide comments.

There was no public comment.

### Closing

Mr. Queral adjourned the meeting at 1:46 p.m.

The next Public Health Advisory Board Incentives and Funding subcommittee meeting will be held on April 9, 2019, at 1:00 p.m.

**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.

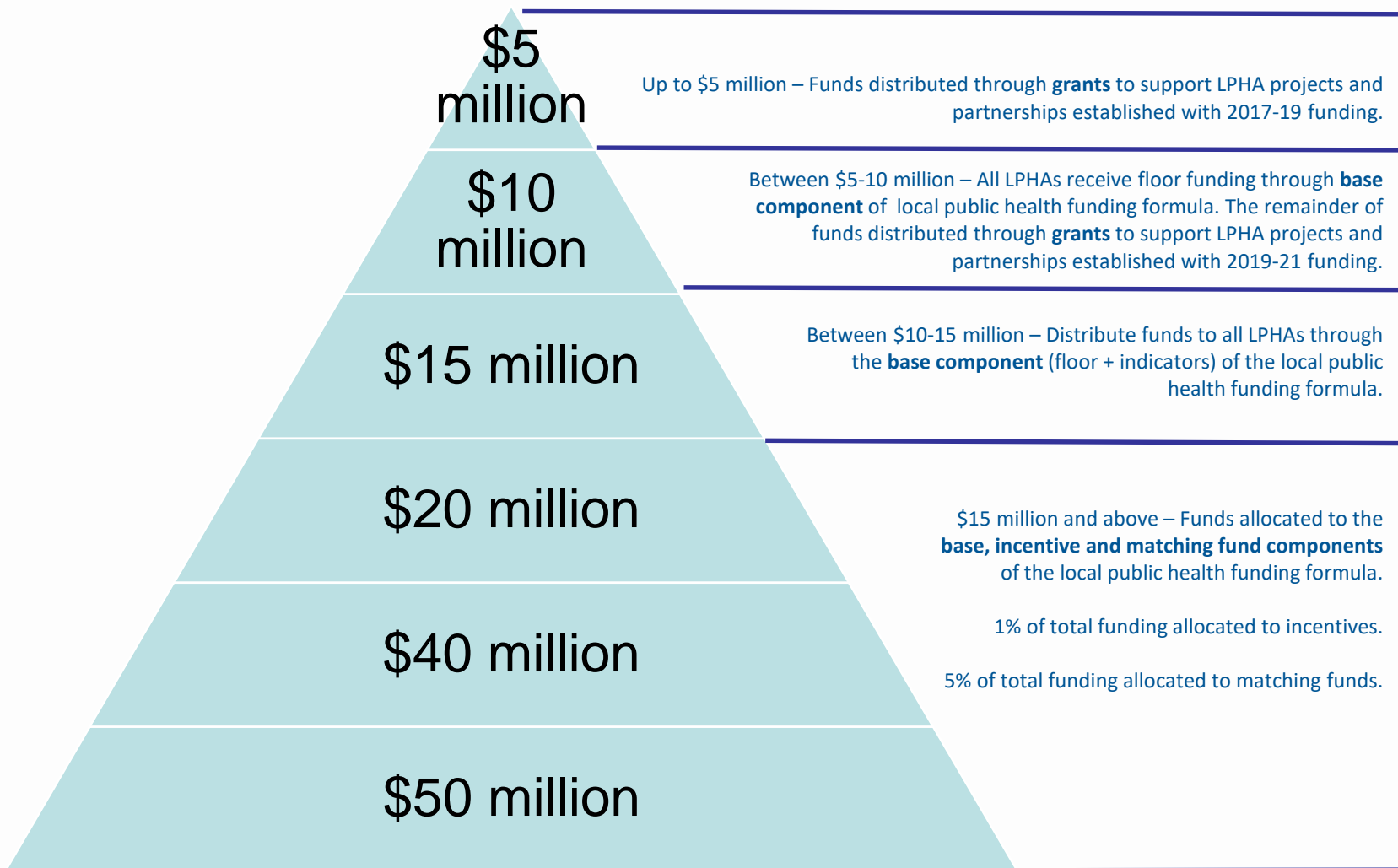
**Public health system approach to foundational programs**

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.

# LPHA allocations to funding formula components at a range of funding levels for 2019-21 biennium\*



\* The funding levels in this diagram represent the public health modernization biennial allocation to LPHAs, which is a portion of total public health modernization funding for the biennium.

# Planning for 2019-21 funding to LPHAs between \$5-10 million – funding breakdown

OHA seeks the subcommittee's input on funding mechanism for remaining funds (in red font)

Funding category	Funding amount
LPHA Partnerships	\$3.9 million
Base funding to each LPHA (Range = \$30,000-\$90,000)	\$1.845 million
<b>Remaining funds</b> <ul style="list-style-type: none"><li>- Additional funding for LPHA partnerships</li><li>- New partnerships that do not meet the criteria for currently-funded LPHA partnerships</li><li>- Cross-jurisdictional service delivery models</li></ul>	Remainder

# Planning for 2019-21 funding to LPHAs between \$5-10 million – funding purpose

OHA seeks the subcommittee's input on purpose and goals of funding (in red font)

Funding category	Purpose of funding
LPHA Partnerships \$3.9 million	Regional systems for communicable disease control; elimination of health disparities
Base funding to each LPHA \$1.845 million	<ul style="list-style-type: none"><li>- Increase local capacity to improve accountability metrics CD process measures</li><li>- Implement health equity action plan</li><li>- Increase local capacity to participate in LPHA Partnership</li></ul>
Remaining funds	<ul style="list-style-type: none"><li>- Address gaps in modernization assessment</li><li>- Increase capacity for foundational capabilities</li></ul>

# Planning for 2019-21 funding to LPHAs between \$5-10 million - recommendations

- What are PHAB's priorities and goals for increased funding?
- What are PHAB's recommendations on distribution of funding to LPHAs at a funding range of \$5-10 million?
  - Goals for base funding to each LPHA
  - Goals for funding new partnerships or service delivery models

# Subcommittee business

- Confirm that Akiko will provide subcommittee update at April 18PHAB meeting.
- Confirm that Carrie will chair the May 14 subcommittee meeting.



# Public comment

# Adjourn