AGENDA

PUBLIC HEALTH ADVISORY BOARD
Incentives and Funding Subcommittee

March 2, 2020
12:00-1:00 pm
Portland State Office Building, 800 NE Oregon St., Conference Room 915, Portland, OR 97232

Join Zoom Meeting
https://zoom.us/j/659735928
Meeting ID: 659 735 928
(669) 900 6833

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

Meeting Objectives
- Approve February 3 meeting minutes
- Finalize recommendations for changes to PHAB Funding Principles
- Discuss statement clarifying PHAB's expectations for use of Funding Principles.
- Review LPHA funding formula survey results and discuss changes to the funding formula's base component.

12:00-12:05 pm	**Welcome, introductions and updates** • Approve February 3, 2020 minutes	Sara Beaudrault, Oregon Health Authority
12:10-12:25 pm	**PHAB Funding Principles** • Review summary of 2019-21 legislative investment in public health modernization. • Finalize recommended changes to PHAB funding principles, which PHAB will vote to adopt at its March meeting. • Review draft statement clarifying PHAB's expectations that the funding principles be used in funding decisions.	All
12:25-12:45	**2021-23 public health modernization funding formula** • Review LPHA funding formula survey results • Discuss changes to the funding formula's base component based on survey results.	All
12:45-12:50 pm	**Subcommittee business** • The next meeting is scheduled for Monday, April 6 from 12:00-1:00	Sara Beaudrault

	• Select person to provide subcommittee update at March 19 PHAB meeting	
12:50-12:55 pm	**Public comment**	
12:55 pm	**Adjourn**	Sara Beaudrault

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
February 3, 2020
12:00 p.m. – 1:00 p.m.

PHAB members present: Carrie Brogoitti, Dr. Bob Dannenhoffer, Alejandro Queral, Akiko Saito
PHAB members absent: None
Oregon Health Authority (OHA) staff: Sara Beaudrault, Cara Biddlecom, Krasimir Karamfilov, Tracie Jacobs

Welcome, introductions, and updates

Ms. Beaudrault introduced the meeting. The subcommittee members introduced themselves.

A quorum was present. Dr. Dannenhoffer made a motion to approve the meeting minutes from the meeting on August 9, 2019. Ms. Brogoitti seconded the motion. The subcommittee approved the meeting minutes unanimously.

Subcommittee scope of work and deliverables

Ms. Beaudrault remarked that the main deliverable was the funding formula for 2021-2023, which needs to be completed by June. OHA needs to submit the funding formula to the Legislative Fiscal Office in June of every even-numbered year. The subcommittee will also make a recommendation on the Public Health Modernization Funding Report as a whole, providing recommendations and contributions to the framing around how the funding has been used and what is seen as a result of the funding, and needs moving forward.

Ms. Beaudrault added that the PHAB had a conversation at its January meeting about the funding principles the PHAB created in February 2018. The plan is to bring that back to the PHAB in its March meeting to finalize whether the PHAB wants to make any changes. The principles will be vetted through this subcommittee to continue the conversation started by the PHAB, in terms of whatever changes or tweaks the subcommittee wants to make to the funding principles. Also, OHA and CLHO leadership will be working on developing system-wide priorities and a scope of work for funding in the next biennium, OHA will share information about that process with the subcommittee to make sure it is in line with PHAB's priorities.

Ms. Beaudrault reviewed the scope of work and timeline for the subcommittee meetings through June 2020.

Mr. Queral asked about the instrument for getting feedback from the local public health authorities on the fund allocations and about the alignment with the objectives that the subcommittee had set.

Ms. Beaudrault answered that the plan was to do a survey of LPHAs between this meeting and the next meeting. There is a draft of the survey in the meeting packet.

Mr. Queral asked, in terms of the OHA and CLHO leadership developing systemwide priorities for 2021-2023, what was guiding that decision from these two bodies. What are the parameters and how do they align to the work of the subcommittee?

Ms. Beaudrault answered that at its January meeting, the PHAB voted on the funding priorities for the next biennium. The PHAB's recommendation was to keep prioritizing the work around communicable disease control, health equity, and, with more funding coming in, start building environmental health. Having these priorities in place gives OHA the framework to be able to begin developing the scope of work and a description of the resources that are needed. All of that will feed into OHA's policy option package or funding request for the next biennium, so it is very clear what the legislature will be purchasing and what outcomes it will expect to see as a result.

PHAB Funding Principles

Ms. Beaudrault stated that the funding principles were originally created by the PHAB in February 2018. They are not specific to public health modernization funding. The idea behind the principles was to have some guides in place that the public health system could use whenever new funds came into the system or whenever funds were lost. The ask for the subcommittee is to go back to the PHAB conversation and review the changes, based on the PHAB's conversation in January, and talk about whether there should be additional changes that the subcommittee would recommend back to the PHAB before its vote in March. The subcommittee should look for anything in the principles that the subcommittee needs to be strengthened or changed to support the subcommittee's work around the modernization funding formula.

Ms. Beaudrault presented the funding principles document with track changes. A few PHAB members suggested getting rid of the word *may* in principles #3 and #4. The only other change was a recommendation to change the word *coordinate* with *leverage* to strengthen the intention that we use multiple sources of funding in a cohesive way. Some of the other PHAB comments related to including funding to the tribes in the funding principles. One of the questions asked at the PHAB's January meeting was whether the board wanted to do any prioritization. Instead of including all seven principles equally, maybe there are a few principles that should be prioritized. There was not a strong sense from the PHAB that there was an obvious way to prioritize them.

Dr. Dannenhoffer remembered that the PHAB discussion in January never came to a final discussion or a vote, as it was more of an off-the-cuff discussion. The *may* in principle #4 is a bit softer. Deleting it and using *includes* means that, in principle #3, it will include cross-jurisdictional sharing, and, in principle #4, it will include directing funds. While this change works in principle #3, there could be some negative feedback on the change in principle #4,

because the jurisdictions are not ready to have cross-jurisdictional sharing for every funding. He recommended leaving the word *may* in principle #4.

Ms. Brogoitti remarked that during the conversation at the PHAB meeting about changing the word *may*, she almost objected for the same reasons Dr. Dannenhoffer suggested. Does the change mean that everything that is done with these funds will be including cross-jurisdictional sharing, or does it mean that part of LPHAs' body of work will include that, but not necessarily every piece of the work? Her understanding was that cross-jurisdictional sharing would be part of what LPHAs did with the funding, not the only thing they did with the funding.

Dr. Dannenhoffer added that the current language suggested that when LPHAs did environmental health, they had to have cross-jurisdictional sharing in environmental health. While this may work in certain small counties, but once a county is big enough to do it, cross-jurisdictional sharing is not helpful.

Mr. Queral pointed out that the original intent in softly naming cross-jurisdictional sharing was that the PHAB didn't want to lose the element of change in the way the system was being reformed. That's one of the reasons why that was explicitly called out in the principles, which is also why the PHAB used the word *may* to qualify it somewhat. In principle #4, the last line could read *which includes cross-jurisdictional sharing whenever in the discretion of the director makes strategic sense*. The language could be refined, but it should be something that gave leeway for jurisdictions to use it whenever they decided that that made sense.

Dr. Dannenhoffer noted that in some areas, LPHAs didn't use cross-jurisdictional sharing when they should have. At the last CLHO meeting, the conference approved a program element related to suicide prevention that cried out for cross-jurisdictional sharing, and yet, cross-jurisdictional sharing in that area was a tiny, *may* component. He couldn't see how cross-jurisdictional sharing would work in other areas, such as immunization school law. He agreed with Mr. Queral that *may* in principle #4 made sense, but it made it way too long for a principle when the phrase *at the discretion of the director* was included. That's why *may* is still the right word in principle #4.

Ms. Beaudrault shared that she didn't read principle #4 as stating that funding needed to go to cross-jurisdictional sharing, but that a conversation about whether that was an appropriate model was warranted, as well as thinking about system change that it should be part of the conversations as funds are coming into the system. Are there pieces of this work that can be done through sharing? If not, then the answer is no, and it really does need to be local. It is a question that we train ourselves as a system to be asking.

Ms. Biddlecom stated that the first half of the sentence was about increasing efficiency and improving health outcomes for which this was potentially one strategy, but how do we make sure that funds did that very work. The sentence can be restructured to emphasize efficiency and health outcomes.

Dr. Dannenhoffer remarked that the original wording was brilliant and he wouldn't change it.

Mr. Queral commented that he recognized that cross-jurisdictional sharing might make sense in some cases where the conditions warranted that kind of work across jurisdictions. But it could also potentially create a situation where there wasn't enough incentive or stake to say that this was going to be an option to consider. How do we ensure that LPHAs are not going to continue business as usual without considering cross-jurisdictional sharing whenever it was warranted? Maybe it's not in the principles. Maybe it's in the way the formula runs. To what extent can the subcommittee create that incentive to be much more explicit so that it gets the authorities thinking about that as an option? If it's too permissive, are we missing an opportunity here to incentivize that?

Dr. Dannenhoffer wondered if the subcommittee was arguing too much about a very small issue. There are other things besides cross-jurisdictional sharing. For example, there is modernization of information systems. There are lots of different things in there that OHA could fund to incentivize changes that would improve efficiency. If *may* is removed, it would mean that all these things would have cross-jurisdictional sharing, which would be ill-advised. The language changes in principles #3 and #5 are fine, but *may* should stay in principle #4.

Mr. Queral, Ms. Brogoitti, and Ms. Saito seconded Dr. Dannenhoffer's suggestion.

Ms. Beaudrault stated that two other questions that came up at the January PHAB meeting were around funding to tribes and whether or how that should be included in the principles, and whether any of the principles should be prioritized.

Dr. Dannenhoffer shared that the inclusion of the tribes was important and it could be welded into principle #1. The language could read *…by an individual local public health authority, through a tribe, through cross-jurisdictional sharing arrangements…*

Ms. Beaudrault asked if the other subcommittee members approved that change. Ms. Saito supported the change.

Ms. Beaudrault asked the subcommittee members if there were any other changes the subcommittee would recommend before the principles were brought back to the PHAB in March.

Dr. Dannenhoffer noted that prioritizing the principles felt like choosing among one's children, because all principles were important. It all depends on how the prioritization was done. In some cases, principle #5 would be most important. In areas dealing with health equity, principle #3 would be most important. Because it's impossible to decide which should be which, the conclusion is that the original writers did a beautiful job with the principles.

Ms. Beaudrault remarked that every funding stream and the work that needed to happen because of it required a different interpretation of these questions. Having the funding principles in place gives some sort of guideposts for making decisions. It doesn't necessarily mean that all seven principles can be fully accomplished every single time.

Ms. Biddlecom reminded the subcommittee that the funding principles were also operationalized in other funding over which the PHAB didn't have direct purview. The principles are operationalized in the Conference of Local Health Officials (CLHO) as well, which may add flexibility as to which principle shines for a particular body of work and allows a little bit more customization to happen based on the program that is available for it.

Dr. Dannenhoffer noted that when it came down to actual work, the principles were not followed. Over the last two months, different subcommittees have come up with a funding formula for TPEP, a funding formula for suicide prevention, and a funding formula for opioid overdose prevention, and those subcommittees ignored the PHAB funding principles when those funding formulas were put together.

Ms. Biddlecom asked if Dr. Dannenhoffer would recommend that CLHO had some process that would better reflect that the PHAB funding principles had been considered in making funding decisions.

Dr. Dannehoffer supported Ms. Biddlecom's idea. He gave an example with the suicide prevention funding formula. The suicide prevention grant is available, but it's not much money to give full funding to every county. A subcommittee decided to give funding to several counties and they are going to get a minimal amount of money to go ahead and do suicide prevention work in their counties, with suicide burden being taken into account. However, it is known that suicide is not a problem just for certain counties. Some counties have a higher burden than others, but even the mid counties still have a high burden, and yet, there is going to be almost no services in counties that didn't get the grant. Opioid overdose prevention was going to fund 5-6 areas in the state rather than the whole state. The advantage for people who are working together in counties is really minimal. On the suicide prevention grant, the way the subcommittee did it was to figure out the suicide rate for the fiscal agent county. It didn't follow any of the PHAB principles. There must be principles that should be followed, if not rigidly, very closely.

Ms. Beaudrault stated that part of the reason for updating the funding principles was because local public health leadership, and OHA through the joint leadership team, wanted to have conversations to address those issues. This conversation will continue through the Joint Leadership Team.

Ms. Biddlecom suggested that an explicit requirement from the PHAB in terms of what that should look like would be helpful. It doesn't mean that a specific format by which the principles

are responded to couldn't be developed by CLHO, but an explicit requirement from the PHAB would move this forward.

Implementation of 2019 public health modernization funding formula

Ms. Beaudrault explained that the task on this topic was to talk about the feedback the subcommittee wanted to hear from LPHAs and talk about how to structure working through funding formula changes over the next few months. She introduced Tracie Jacobs from the fiscal team and clarified that Chris Curtis, who had done all the work on the funding formula over the past few years, no longer works in the OHA Public Health Division. Ms. Jacobs and her colleague Mr. Monty Schindler are familiar with the funding formula and will be supporting the work over the next few meetings.

Ms. Beaudrault showed a spreadsheet with the funds allocated through the funding formula to each county. Seven million dollars went out through the funding formula across all LPHAs. All those funds went to the base component. No funds went to incentives or matching. Within the base component, there is the floor funding, which is a set amount that goes out to each LPHA based on the county population. Counties are grouped by size. The floor amounts were initially set by the Incentives and Funding subcommittee two years ago with the understanding that this would give a LPHA enough to move the work forward. The intention was that it would provide enough funding for the county to do something.

There was $10 million total to go out to LPHAs, with about $3 million going to regional partnerships. The floor payments favor the extra-small and smaller counties. All other indicators in the base component tend to favor larger counties, because it is tied not just to a county's ranking, but also to the population size. Some of the extra-small counties received just above 30K for the biennium. The most populated counties received hundreds of thousands, with one county receiving over $1 million.

Ms. Beaudrault noted that OHA funded seven regional partnerships, covering 32 out of 36 counties. Once the LPHAs received their local and regional allocations, some LPHAs moved some of their local funds to the regional partnership funds to support the regional partnership.

Dr. Dannenhoffer stated that the state retained some funding. During the meeting in August 2019, he asked about that amount. He hears a lot about that from other LPHAs. In August, the amount was not available because the budget was being developed. He asked if that information was available now.

Ms. Biddlecom answered that there were descriptions about the different bodies of work that OHA was doing with the funding.

Dr. Dannenhoffer noted that the descriptions were not the budget. What he hears from other administrators is that they have the budget down to the dollar, but don't have even a high-level budget for the state.

Ms. Biddlecom agreed to provide that information. Ms. Beaudrault added that the slides she presented did not show the funding that was going out to the tribes. About $1.2 million is going out to seven tribes, NARA (Native American Rehabilitation Association), and NPAIHB (Northwest Portland Area Indian Health Board). They will receive funds directly. The reason for focusing on funding going out to LPHAs in this subcommittee is because that is what is in statute (i.e., the PHAB needs to develop the funding formula for distribution to LPHAs).

Ms. Beaudrault presented a draft of a survey that OHA can use to collect information from every LPHA and be able to provide to the subcommittee responses on how the funding formula was working, based on county size and population. The questions are around understanding how the funding formula has worked for different county sizes and how the regional partnership funding has worked. She asked the subcommittee members what they specifically would like to hear from local public health administrators.

Dr. Dannenhoffer responded that this was a good start. Any survey like this one done in the state harms Multnomah County, which has only one vote out of 35, while representing over one quarter of the people.

Ms. Beaudrault added that a survey was good because it allowed everyone to have the same voice. What comes back to the subcommittee won't be who speaks loudest. There are fewer counties that fall into the large and extra-large group than in the small and extra-small county size groups.

Mr. Queral remarked that some of the questions in the survey had more to do with feedback about a program and not about how effective was a program. For example, in question #3, why is it important to know whether LPHAs thought that the funding formula favored extra small counties or whether the funding was fairly distributed? What is the intent? Some of these questions don't quite get the intent of understanding how counties have used those dollars and whether that allocation formula works for them from their perspective. Asking individual LPHAs what they think about the system is useful feedback, but it's unclear if that is the intent of the work the subcommittee is trying to do. He recommended developing more questions about whether the funding helped or hurt, and how to make it better so it helps.

Ms. Beaudrault explained that OHA had an ongoing evaluation that got a little more to the impact of the legislative funding, but the timeline for the evaluation and the process didn't allow for quick feedback to the subcommittee. Maybe it makes sense to ask some of the questions that will come out of the evaluation in more of a quick-and-dirty form: What is your sense of these things? Has it helped? Do you have more capacity? What's the impact on your work? Some of these questions can be put into the survey.

Ms. Beaudrault added that OHA was also interested in asking some questions about the PHAB's decision to hold some of the funds for regional partnership. Anecdotally, there are areas of the

state that tell OHA how much they rely on that funding. Having those funds set aside is what allows them to work as a regional partnership. If the funds weren't held aside in that way, they might not have the support of their leadership to come together and do that work. That's one side of it. Anecdotally, OHA also hears from partnerships that feel like either they would be able to do this work without having the funds explicitly set aside or they just don't feel like it's the right model and that OHA should not continue to push funds in that direction. She asked the subcommittee members what were the questions that would help them decide how to continue to support those groups where the funding was working.

Dr. Dannenhoffer asked if there was going to be a place for review of how things were working – what worked, what didn't.

Ms. Beaudrault answered that that review would happen through the evaluation. Through the evaluation process, Program Design and Evaluation Services will be collecting some information, beginning in March. They will be producing a first evaluation report around August-September and a final evaluation toward the end of the funding cycle. to question #7.

Mr. Queral asked Dr. Dannenhoffer and Ms. Brogoitti if there were things that they wanted to share with the subcommittee from their experience so that the subcommittee could ask the LPHAs to dig deeper in those areas.

Ms. Saito supported Dr. Dannenhoffer's suggestion that if the PHAB felt confident about the funding principles, they should be seen in other areas and become more institutional. It would be good if the letter came from the PHAB.

Ms. Beaudrault stated that the OHA team would be cleaning up the survey and working with LPHAs and would have information to share back with the subcommittee at the March meeting.

Subcommittee business

Ms. Beaudrault informed the subcommittee that the next subcommittee meeting was scheduled on March 2, 2020, at 12:00-1:00 p.m. Previously the subcommittee had used rotating chairs to facilitate meetings where the subcommittee members took turns facilitating. She asked the subcommittee members if they wanted to continue using that model and, if yes, who would like to chair the March meeting.

Dr. Dannenhoffer remarked that today's meeting worked great.

Ms. Saito informed that subcommittee that she would miss the meeting in March.

Dr. Dannenhoffer pointed out that the way Ms. Beaudrault conducted the meeting was fabulous.

Ms. Beaudrault thanked Dr. Dannenhoffer and noted that the other PHAB subcommittee did not have a chair. It is fine to not have a chair. It's up to whatever the subcommittee members are comfortable with.

Mr. Queral shared that he was comfortable with this arrangement, because he wouldn't be able to do much prep work ahead of meetings in February and March.

Ms. Saito agreed that OHA staff could do the meeting without a chair and praised Ms. Beaudrault for her facilitation.

Ms. Beaudrault said that the subcommittee meeting would continue to run in the way today's meeting ran. If, at any point, something came up and the subcommittee wanted to make a change, that would be fine. She informed the subcommittee that the OHA team is making great progress in bringing new PHAB members onboard. Two appointments came through late last week.

Ms. Biddlecom added that a third new PHAB member would come through this week.

Ms. Beaudrault remarked that as those new PHAB members came onboard, the OHA team would be reaching out to all of them to see if they wanted to join either subcommittee and fill a seat. The Incentives and Funding subcommittee will have a new member and more perspectives and a little bit of bandwidth for when members can't attend.

Public comment

Ms. Beaudrault invited members of the public to ask questions and provide comments. There was no public comment.

Closing

Ms. Beaudrault adjourned the meeting at 12:47 p.m.

PHAB Incentives and Funding subcommittee
Scope of work and timeline for 2020
January 2020, draft

Subcommittee members: Carrie Brogoitti, Bob Dannenhoffer, Alejandro Queral, Akiko Saito

Deliverables:

- **Public health modernization funding formula for 2021-23**
- Recommendations on Public Health Modernization Funding Report to Legislative Fiscal Office
- PHAB Funding Principles

Scope of work and timeline for subcommittee meetings

February	- Discuss PHAB funding principles. - Discuss implementation of 2019 public health modernization funding formula.
March	- Review feedback from LPHAs on 2019 funding allocations. - Discuss changes to base component of funding formula, based on LPHA and OHA feedback. - Hear update on OHA and CLHO Leadership work to develop system-level priorities for 2021-23.
April	- Finalize base component of funding formula. - Review methodology for incentives and matching funds components.
May	- Final review of funding formula and recommendations for regional partnership or cross-jurisdictional sharing funding.
June	- Review funding formula section of June 2020 Public Health Modernization Funding Report to Legislative Fiscal Office

Public health modernization LPHA funding formula - FINAL
2019-21 biennium
August, 2019

Total biennial funds available to LPHAs through the funding formula = $7 million

		Base component									Matching and Incentive fund components		Total county allocation				
County Group	Population[1]	Floor	Burden of Disease[2]	Health Status[3]	Race/ Ethnicity[4]	Poverty 150% FPL[4]	Rurality[5]	Education[4]	Limited English Proficiency[4]		Matching Funds	Incentives	Total Award	Award Percentage	% of Total Population	Award Per Capita	Avg Award Per Capita
Wheeler	1,450	$ 30,000	$ 292	$ 543	$ 138	$ 202	$ 1,588	$ 107	$ 5		$ -	$ -	$ 32,876	0.5%	0.0%	$ 22.67	
Wallowa	7,175	$ 30,000	$ 1,751	$ 1,076	$ 411	$ 725	$ 7,858	$ 530	$ 223		$ -	$ -	$ 42,576	0.6%	0.2%	$ 5.93	
Harney	7,380	$ 30,000	$ 2,492	$ 2,394	$ 846	$ 947	$ 3,581	$ 791	$ 511		$ -	$ -	$ 41,561	0.6%	0.2%	$ 5.63	
Grant	7,400	$ 30,000	$ 1,527	$ 1,661	$ 527	$ 797	$ 8,105	$ 786	$ 282		$ -	$ -	$ 43,684	0.6%	0.2%	$ 5.90	
Lake	8,115	$ 30,000	$ 2,172	$ 1,316	$ 1,043	$ 1,228	$ 5,626	$ 1,292	$ 505		$ -	$ -	$ 43,183	0.6%	0.2%	$ 5.32	
Morrow	11,885	$ 30,000	$ 2,449	$ 3,609	$ 4,055	$ 1,370	$ 5,975	$ 3,055	$ 6,496		$ -	$ -	$ 57,010	0.8%	0.3%	$ 4.80	
Baker	16,765	$ 30,000	$ 4,308	$ 2,719	$ 1,295	$ 1,905	$ 7,528	$ 1,727	$ 754		$ -	$ -	$ 50,237	0.7%	0.4%	$ 3.00	$ 5.17
Crook	22,710	$ 45,000	$ 5,711	$ 6,592	$ 2,287	$ 2,857	$ 11,939	$ 2,860	$ 943		$ -	$ -	$ 78,189	1.1%	0.5%	$ 3.44	
Curry	22,915	$ 45,000	$ 7,925	$ 6,624	$ 2,626	$ 2,642	$ 9,713	$ 2,409	$ 1,110		$ -	$ -	$ 78,048	1.1%	0.5%	$ 3.41	
Jefferson	23,560	$ 45,000	$ 6,835	$ 5,431	$ 8,140	$ 3,201	$ 16,282	$ 3,507	$ 4,157		$ -	$ -	$ 92,552	1.3%	0.6%	$ 3.93	
Hood River	25,310	$ 45,000	$ 4,092	$ 6,112	$ 7,866	$ 2,547	$ 14,470	$ 5,374	$ 13,834		$ -	$ -	$ 99,295	1.4%	0.6%	$ 3.92	
Tillamook	26,395	$ 45,000	$ 6,762	$ 6,245	$ 3,506	$ 2,855	$ 20,121	$ 2,775	$ 2,648		$ -	$ -	$ 89,912	1.3%	0.6%	$ 3.41	
Union	26,885	$ 45,000	$ 6,215	$ 4,722	$ 2,497	$ 3,619	$ 12,397	$ 2,043	$ 1,581		$ -	$ -	$ 78,073	1.1%	0.6%	$ 2.90	
Gilliam, Sherman, Wasco	30,970	$ 105,000	$ 8,070	$ 5,930	$ 6,184	$ 3,151	$ 14,077	$ 4,250	$ 6,106		$ -	$ -	$ 152,768	2.2%	0.7%	$ 4.93	
Malheur	31,925	$ 45,000	$ 7,354	$ 11,175	$ 10,615	$ 5,113	$ 16,923	$ 6,280	$ 9,277		$ -	$ -	$ 111,737	1.6%	0.8%	$ 3.50	
Clatsop	39,200	$ 45,000	$ 10,524	$ 7,410	$ 4,764	$ 4,027	$ 16,744	$ 3,468	$ 3,661		$ -	$ -	$ 95,600	1.4%	0.9%	$ 2.44	
Lincoln	48,210	$ 45,000	$ 15,049	$ 12,112	$ 7,157	$ 6,125	$ 19,853	$ 5,319	$ 4,169		$ -	$ -	$ 114,785	1.6%	1.1%	$ 2.38	
Columbia	51,900	$ 45,000	$ 11,869	$ 12,217	$ 4,911	$ 4,809	$ 24,784	$ 5,132	$ 2,514		$ -	$ -	$ 111,235	1.6%	1.2%	$ 2.14	
Coos	63,275	$ 45,000	$ 19,268	$ 16,978	$ 7,910	$ 8,278	$ 26,612	$ 6,915	$ 3,283		$ -	$ -	$ 134,243	1.9%	1.5%	$ 2.12	
Klamath	67,960	$ 45,000	$ 19,971	$ 17,820	$ 12,567	$ 9,346	$ 27,987	$ 8,913	$ 7,523		$ -	$ -	$ 149,126	2.1%	1.6%	$ 2.19	$ 2.88
Umatilla	80,765	$ 60,000	$ 17,350	$ 21,671	$ 23,138	$ 10,058	$ 25,741	$ 15,131	$ 29,336		$ -	$ -	$ 202,425	2.9%	1.9%	$ 2.51	
Polk	82,100	$ 60,000	$ 15,355	$ 14,519	$ 15,039	$ 8,262	$ 17,894	$ 7,947	$ 14,484		$ -	$ -	$ 153,500	2.2%	2.0%	$ 1.87	
Josephine	86,395	$ 60,000	$ 26,611	$ 20,126	$ 9,450	$ 12,498	$ 42,580	$ 9,801	$ 3,885		$ -	$ -	$ 184,952	2.6%	2.1%	$ 2.14	
Benton	93,590	$ 60,000	$ 12,962	$ 16,209	$ 15,194	$ 11,498	$ 19,271	$ 4,481	$ 13,598		$ -	$ -	$ 153,211	2.2%	2.2%	$ 1.64	
Yamhill	107,415	$ 60,000	$ 20,129	$ 25,022	$ 20,888	$ 9,954	$ 26,588	$ 13,081	$ 20,065		$ -	$ -	$ 195,727	2.8%	2.6%	$ 1.82	
Douglas	111,735	$ 60,000	$ 34,639	$ 31,888	$ 11,252	$ 12,931	$ 50,419	$ 12,327	$ 4,638		$ -	$ -	$ 218,095	3.1%	2.7%	$ 1.95	
Linn	125,575	$ 60,000	$ 28,856	$ 28,946	$ 15,589	$ 14,374	$ 43,461	$ 12,809	$ 9,122		$ -	$ -	$ 213,158	3.0%	3.0%	$ 1.70	$ 1.84
Deschutes	188,980	$ 75,000	$ 33,149	$ 26,275	$ 20,180	$ 16,006	$ 57,126	$ 12,785	$ 13,728		$ -	$ -	$ 254,249	3.6%	4.5%	$ 1.35	
Jackson	219,200	$ 75,000	$ 52,080	$ 49,191	$ 34,824	$ 25,275	$ 48,255	$ 24,412	$ 25,023		$ -	$ -	$ 334,061	4.8%	5.2%	$ 1.52	
Marion	344,035	$ 75,000	$ 68,536	$ 82,241	$ 100,653	$ 40,535	$ 49,361	$ 54,070	$ 128,532		$ -	$ -	$ 598,927	8.6%	8.2%	$ 1.74	
Lane	375,120	$ 90,000	$ 80,869	$ 73,659	$ 56,665	$ 45,770	$ 71,898	$ 33,187	$ 33,739		$ -	$ -	$ 485,786	6.9%	8.9%	$ 1.30	$ 1.48
Clackamas	419,425	$ 90,000	$ 74,842	$ 75,197	$ 62,993	$ 26,028	$ 83,146	$ 29,685	$ 60,938		$ -	$ -	$ 502,829	7.2%	10.0%	$ 1.20	
Washington	606,280	$ 90,000	$ 83,945	$ 98,345	$ 173,166	$ 44,487	$ 37,185	$ 54,900	$ 190,854		$ -	$ -	$ 772,881	11.0%	14.5%	$ 1.27	
Multnomah	813,300	$ 90,000	$ 162,706	$ 160,691	$ 208,288	$ 84,912	$ 11,580	$ 76,185	$ 239,142		$ -	$ -	$ 1,033,506	14.8%	19.4%	$ 1.27	$ 1.26
Total	**4,195,300**	**$ 1,860,000**	**$ 856,667**	**$ 856,667**	**$ 856,667**	**$ 428,333**	**$ 856,667**	**$ 428,333**	**$ 856,667**		$ -	$ -	**$ 7,000,000**	**100.0%**	**100.0%**	**$ 1.67**	**$ 1.67**

[1] Source: Portland State University Certified Population estimate July 1, 2018
[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: American Community Survey population 5-year estimate, 2013-2017.
[5] Source: U.S. Census Bureau, Population estimates,2010

County Size Bands

Extra Small	Small	Medium	Large	Extra Large
up to 20,000	20,000-75,000	75,000-150,000	150,000-375,(	above 375,000

Program Element 51: Public Health Modernization award amounts to LPHAs
Funding period: October 1, 2019 through June 30, 2021
December, 2019

		Subsection 1: LPHA Leadership, Governance and Program Implementation			Subsection 2: Regional Partnership Implementation (Funding to Fiscal Agent)			
County Group	Population[1]	Original Award	Modifications	Final Subsection 1 Award Amount	Subsection 2: Regional Partnership Award 10/1/19-6/30/21[2]	Subsection 2: requested award modifications	Final Subsection 2 Award Amount	Total/Final Award (Subsection 1 + Subsection 2)
Wheeler[4]	$ 1,450	$ 32,876	$ (2,000)	$ 30,876				**$ 30,876**
Wallowa[3]	$ 7,175	$ -		$ -				**$ -**
Harney[4]	$ 7,380	$ 41,561	$ (2,000)	$ 39,561				**$ 39,561**
Grant[4]	$ 7,400	$ 43,684	$ (2,000)	$ 41,684				**$ 41,684**
Lake[4]	$ 8,115	$ 43,183	$ (2,000)	$ 41,183				**$ 41,183**
Morrow[4]	$ 11,885	$ 57,010	$ (2,000)	$ 55,010				**$ 55,010**
Baker[4]	$ 16,765	$ 50,237	$ (2,000)	$ 48,237				**$ 48,237**
Crook	$ 22,710	$ 78,189		$ 78,189				**$ 78,189**
Curry	$ 22,915	$ 78,048		$ 78,048				**$ 78,048**
Jefferson[5]	$ 23,560	$ 92,552	$ (46,276)	$ 46,276				**$ 46,276**
Hood River[4]	$ 25,310	$ 99,295	$ (2,000)	$ 97,295				**$ 97,295**
Tillamook	$ 26,395	$ 89,912		$ 89,912				**$ 89,912**
Union[4]	$ 26,885	$ 78,073	$ (2,000)	$ 76,073				**$ 76,073**
Gilliam, Sherman, Wasco[4]	$ 30,970	$ 152,768	$ (6,000)	$ 146,768	$ 466,637	$ 24,000	$ 490,637	**$ 637,405**
Malheur[4]	$ 31,925	$ 111,737	$ (2,000)	$ 109,737				**$ 109,737**
Clatsop	$ 39,200	$ 95,600		$ 95,600	$ 376,637		$ 376,637	**$ 472,237**
Lincoln	$ 48,210	$ 114,785		$ 114,785				**$ 114,785**
Columbia	$ 51,900	$ 111,235		$ 111,235				**$ 111,235**
Coos	$ 63,275	$ 134,243		$ 134,243				**$ 134,243**
Klamath	$ 67,960	$ 149,126		$ 149,126				**$ 149,126**
Umatilla	$ 80,765	$ 202,425		$ 202,425				**$ 202,425**
Polk	$ 82,100	$ 153,500		$ 153,500				**$ 153,500**
Josephine	$ 86,395	$ 184,952		$ 184,952				**$ 184,952**
Benton	$ 93,590	$ 153,211		$ 153,211				**$ 153,211**
Yamhill	$ 107,415	$ 195,727		$ 195,727				**$ 195,727**
Douglas	$ 111,735	$ 218,095		$ 218,095	$ 399,137		$ 399,137	**$ 617,232**
Linn	$ 125,575	$ 213,158		$ 213,158				**$ 213,158**
Deschutes[5]	$ 188,980	$ 254,249	$ 46,276	$ 300,525	$ 466,637		$ 466,637	**$ 767,162**
Jackson	$ 219,200	$ 334,061		$ 334,061				**$ 334,061**
Marion	$ 344,035	$ 598,927		$ 598,927	$ 354,137		$ 354,137	**$ 953,064**
Lane	$ 375,120	$ 485,786		$ 485,786	$ 444,137		$ 444,137	**$ 929,923**
Clackamas	$ 419,425	$ 502,829		$ 502,829				**$ 502,829**
Washington	$ 606,280	$ 772,881		$ 772,881				**$ 772,881**
Multnomah	$ 813,300	$ 1,033,506		$ 1,033,506	$ 435,137		$ 435,137	**$ 1,468,643**
Total	**$ 4,195,300**	**$ 6,957,424**		**$ 6,933,424**	**$ 2,942,459**	**$ 24,000**	**$ 2,966,459**	**$ 9,899,883**

[1] Source: Portland State University Certified Population estimate July 1, 2018
[2] A portion of the $3 million in funding to Regional Partnerships was allocated for the 7/1/19-9/30/19 quarter. Unspent funds from this quarter were distributed to Regional Partnerships
[3] The Wallowa County allocation of 42,576 is used by OHA-PHD to provide communicable disease services.
[4] Most counties that participate in the EOMC regional partnership transferred a portion of its Sub-1 funds to NCPHD Sub-2. The amount of funds transferred ranged from $2,000 to $6,000
[5] Jefferson County transferred a portion ($46,276) of its Sub-1 funds to Deschutes County Sub-1

County Size Groups
Extra Small
Small
Medium
Large
Extra Large

PUBLIC HEALTH DIVISION
Office off the State Public Health Director
Kate Brown, Governor

Oregon Health Authority

800 NE Oregon St., Suite 930
Portland, OR 97232
Voice: (971) 673-1222
FAX: (971) 673-1229
www.healthoregon.org

February 2020

2019-21 Legislative Investment in Public Health Modernization

In 2019, the Oregon legislature allocated a total of $15.6M to advance public health modernization through local and tribal public health authorities and the Oregon Health Authority, Public Health Division (OHA-PHD). These funds have been allocated as follows.

Local public health modernization - $10.3M

- All 33 local public health authorities (LPHAs) are receiving a total of $7M in funding through the Public Health Advisory Board's local public health authority funding formula.
- Seven LPHAs are receiving an additional $3.3M to continue and expand on innovative regional communicable disease prevention and control work that began during the 2017-19 biennium.

Tribal public health modernization - $1.1M (additional $100,000 included from other Federal funds)

- At least seven federally-recognized Tribes and NARA (Urban Indian Program) are receiving funds to assess, plan and implement work related to public health modernization.
- The Northwest Portland Area Indian Health Board is receiving funds to provide technical assistance to tribes and to evaluate the tribal public health modernization investment.

OHA-PHD - $4.2M

- Staffing ($1.45M)
    - Maintains 2.10 FTE in existing staff from the 2017-19 biennium and adds 4.0 FTE in new staff to support the legislative investment at the state and local levels: Health Equity Coordinator (hired); Surge Epidemiologist (in recruitment); Emerging Environmental Health Risks Lead (in recruitment); Office of Information Services Information Specialist (in recruitment).
- Technology, hardware and software maintenance and upgrades ($762,000)
    - Includes functions for laboratory interface with electronic medical records; ALERT Immunization Information System and whole genome sequencing technology.
- Data collection, evaluation and reporting ($1.5M)
    - Collection of Student Health and Behavioral Risk Factor Surveillance System surveys
    - Community-based participatory data collection and research briefs with four communities of color
    - Culturally responsive survey of Asian/Pacific Islander adults
    - Literature review and plan for transition to other survey data collection methods beyond random digit dial telephone surveys for adults
    - Small area estimates data files for communities
    - Annual data collection and reporting of public health accountability metrics
    - Evaluation of the public health modernization investment
- Public health modernization learning collaborative and contracted technical assistance for the public health system ($405,000)
- Translation and interpretation services for communicable disease outbreak response and prevention initiatives ($100,000)

Public Health Advisory Board
Funding principles for state and local public health authorities
~~February 15, 2018~~Updated January 2020

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, a tribal 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~~ includes 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~~ leverage 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.

Commented [BS1]: PHAB I&F subcommittee recommends keeping the "may".

To:
From:
Date:

In 2018, Oregon's Public Health Advisory Board (PHAB) developed a set of funding principles, which were established to guide decisions for maximizing public health funding to eliminate health disparities and improve health outcomes.

PHAB acknowledges significant challenges to public health funding, including insufficient funds to fully address many population health priorities and categorical, siloed funding streams. However, Oregon's public health system is uniquely positioned to address these and other challenges by thoughtfully and strategically making decisions to maximize the benefit of available resources to achieve desired outcomes.

It is PHAB's expectation that Oregon Health Authority and Conference of Local Health Officials will use the set of funding principles to make decisions about how public health funding is allocated. These principles do not dictate any single solution for allocating public health funding, but the same set of principles should be applied to the decision-making process. This could include:

- Reviewing funding principles when funding formulas are being changed, and coming to agreement on which funding principles are most relevant to the work to be completed with available funding;
- Including a statement with each finalized funding formula for which funding principles were prioritized;
- Using funding principles to support discussions about how to maximize resources across multiple funding streams.

Respectfully,

PHAB Chair

LPHA funding formula survey results

- How did the distribution of 2019-21 public health modernization funding affect LPHAs across county size bands?
- What changes, if any, should the subcommittee discuss making for the next funding formula?

PHAB Incentives and Funding subcommittee
LPHA funding formula survey results
March 2, 2020

Purpose: The Oregon Health Authority, on behalf of the PHAB Incentives and Funding subcommittee, fielded a survey of local public health administrators between February 14-24 to hear feedback on:

- 2019-21 distribution of funding to every LPHA through the public health modernization funding formula; and
- 2019-21 allocation of funds to regional partnerships.

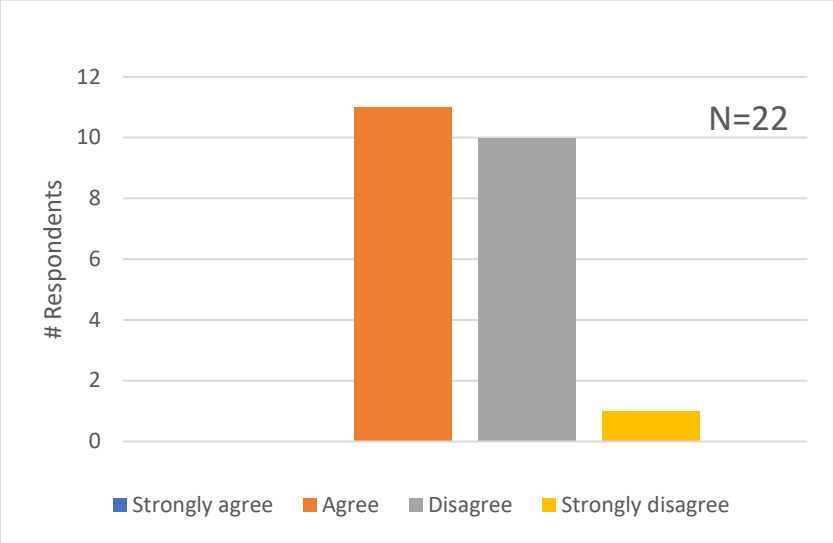
Results from this survey can be used by the subcommittee to make recommendations for changes to the public health modernization funding formula for2021-23.

Summary of respondents

22 of 33 LPHAs completed the survey. The breakdown of responses by county size band is as follows:

	# of responses
Extra-small and small counties	11 of 19
Medium counties	4 of 7
Large and Extra-large counties	7 of 7
Overall	22 of 33

Question 1: The total amount of funding my LPHA received through the funding formula (for both floor funding and indicators) was enough to conduct the work included in Program Element 51.



	Strongly agree	Agree	Disagree	Strongly disagree
Small/Extra-small	0	4	7	0
Medium	0	2	2	0
Large/Extra large	0	5	1	1
Overall	0	11	10	1

Key points:

1. Overall, LPHAs were evenly divided between agreeing and disagreeing.
2. More extra-small and small respondents disagreed than agreed that funding was sufficient.
3. More extra-large and large respondents agreed than disagreed that funding was sufficient.

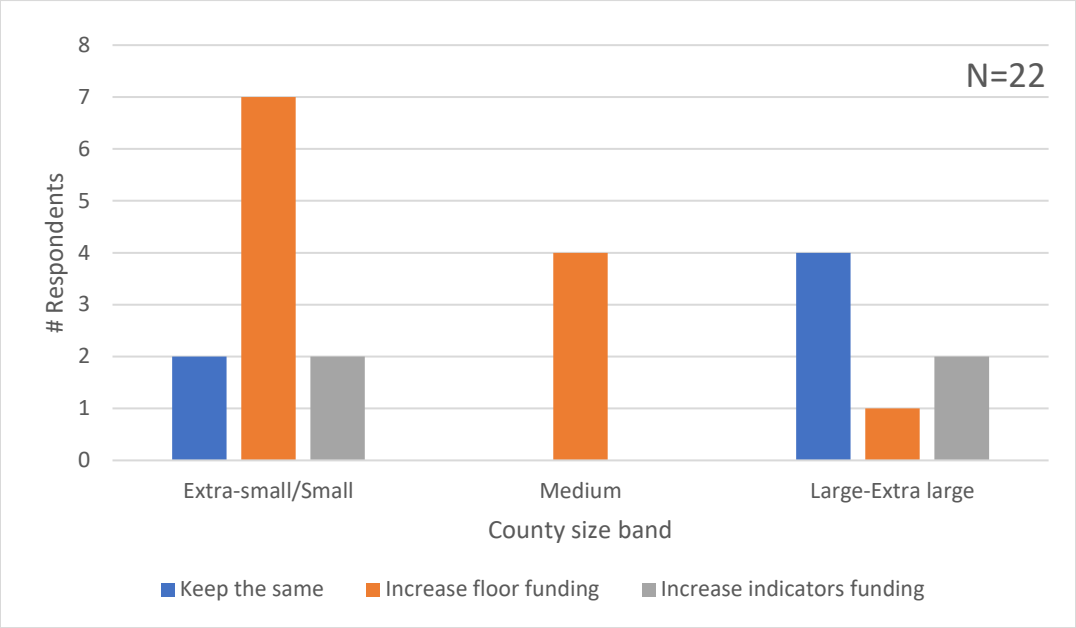
Comments from LPHAs:

- The amount of funding received was a little frustrating as it is not enough to increase capacity (enough to support an increase in FTE) and yet it resulted in an increase in the workplan/workload.
- With (a small amount of funding), we are adding work to the workload of employees who already had full time jobs. That is often what we do - adding something here and there. Over time it adds up and gets to be too much.

- We have provided the minimum of services with a Director that is also our nurse. We get the job done .... at the basic service level. We could do so much more with additional funding.
- It is too early to see how things will finish out, but the projected budgets require in kind support to complete the work outlined in PE 51.

Question 2: For the 2021-23 funding formula, I would like PHAB to

- Keep the proportion of funds allocated to floor funding and indicators the same as in 2019-21.
- Increase the proportion of funds allocated to floor funding, so that the minimum amount received by each LPHA is increased.
- Increase the proportion of funds allocated to demographic and health status indicators so that more funding is directed to areas of the state where the population may experience greater need or where there are likely to be greater demands on the public health system.



Key points:

1. Extra-small, small and medium counties favor increasing the proportion of funds allocated to floor funding.
2. Large and extra-large counties favor keeping proportions the same or increasing the proportion of funding allocated to indicators.

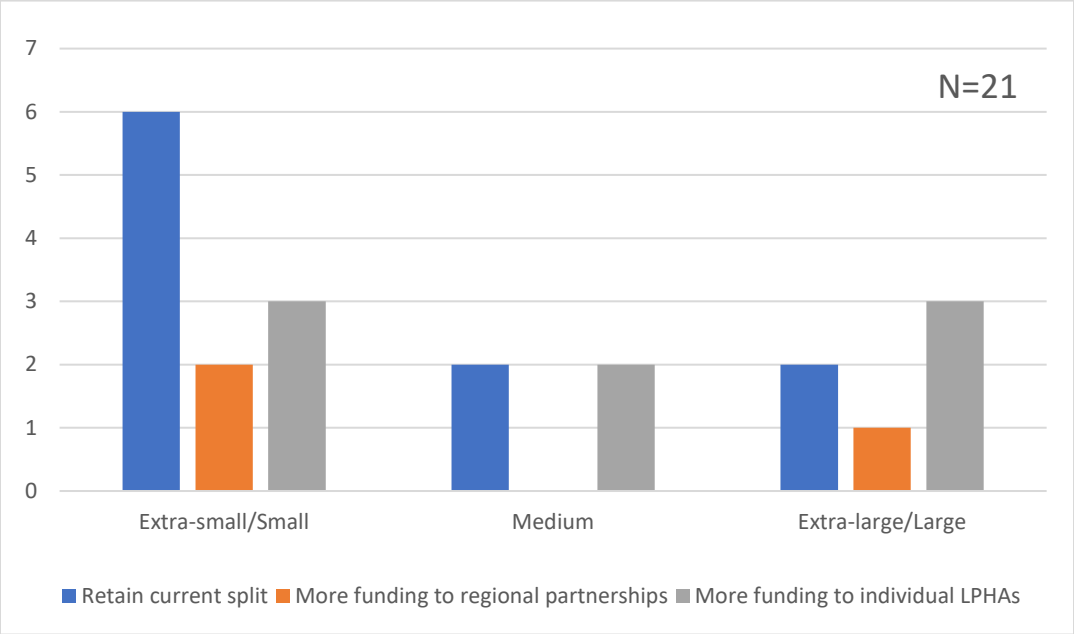
Comments from LPHAs:

- I would like to see the modernization funding shift to being more foundation and less programmatic. This should be the "base" funding to provide the foundation capabilities of public health. Because different geographic areas have different disease burdens and greater needs, greater demands, etc. for different types of public health issues, funding based on those burdens should be specific to funding for specific issues and not the broader modernization funds.

- It is important the funds are not distributed based on "indicators" because rural areas cannot compete typically and for something like modernization, it is impossible to create equitable services with far fewer staff, resources, and funding.
- Allocations based on health indicators rely on past data to determine the need, and do not allow for increased capacity to address emerging issues or trends. Providing more floor funding to each LPHA allows the autonomy to direct funding towards these emerging issues in a more proactive manner, and also allows for a more stable funding status.

Question 3: If a similar amount of funding is available in 2021-23, I recommend that PHAB

- Retain the current split of funding across individual LPHAs and regional partnerships. (Approximately 2/3 to individual LPHAs and 1/3 to regional partnerships).
- Direct more funding to regional partnerships, cross-jurisdictional sharing, or other shared service delivery models.
- Direct more funding to individual LPHAs.



Key point:

1. The majority of respondents recommend retaining the current split of funding between regional partnerships and individual LPHAs, closely followed by increasing funding to individual LPHAs.

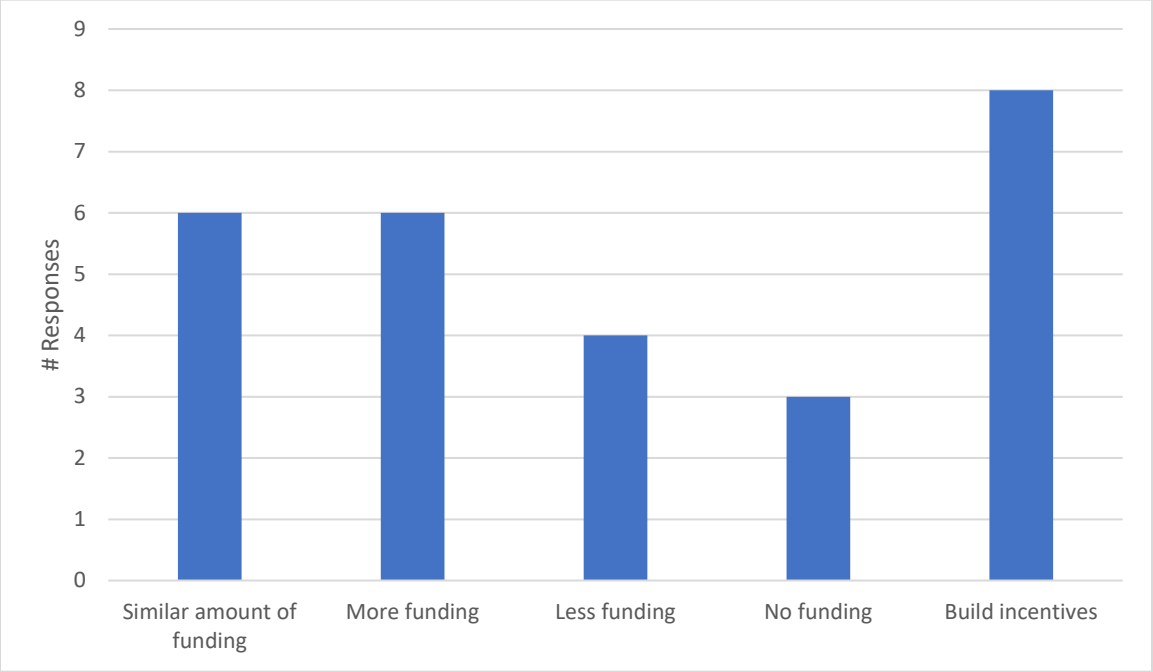
Comments from LPHAs:

- In order to continue and expand the regional partnership work and costs associated with shared staffing, we need to continue to increase investment in this model.
- We understand there is a finite amount of funds to be shared. That being said, we would prefer more funding to the Regional partnerships to provide the needed support and resources so that the entire region benefits from the workplan/work through cross jurisdictional sharing, increasing capacity across the region. without increasing the workload at the local level.
- If regional partnerships are workable and efficient for areas they can pool resources and make this happen vs. a forced approach via the funding formula.

- If funding goes directly to LPHAs, there is nothing to prevent those LPHAs for which collaboration is effective and efficient from continuing their partnerships or creating new ones.
- The regional partnerships are critical to the communicable disease work.
- It is important that continued funding be directed to the regional partnerships experiencing success in their regional structure. However, it is equally important that there is recognition that a regional structure is not feasible in every county or in every circumstance. This funding structure supports LPHAs to work towards a modernized public health system in a structure that works for them.

Question 4: If additional funding is available in 2021-23, how could PHAB improve funding for regional partnerships, cross-jurisdictional sharing, or other shared service delivery models? (check all that apply)

- PHAB should continue to direct a similar amount of funding to regional partnerships, cross-jurisdictional sharing, or other shared service delivery models.
- PHAB should make more funding available to support ongoing and new regional partnerships, cross-jurisdictional sharing, or other shared service delivery models.
- PHAB should make less funding available for regional partnerships, cross jurisdictional sharing, or other shared service delivery models.
- PHAB should not direct any portion of modernization funding to regional partnerships, cross-jurisdictional sharing, or other shared service delivery models.
- PHAB should build incentives into the funding formula for regional partnerships, cross-jurisdictional sharing, or other shared service delivery models.



Key points:

1. LPHAs support building incentives for regional partnerships into the funding formula.
2. Slightly more LPHAs recommend increasing the amount of funding for regional or keeping funding the same than reducing or eliminating funding for regional partnerships.

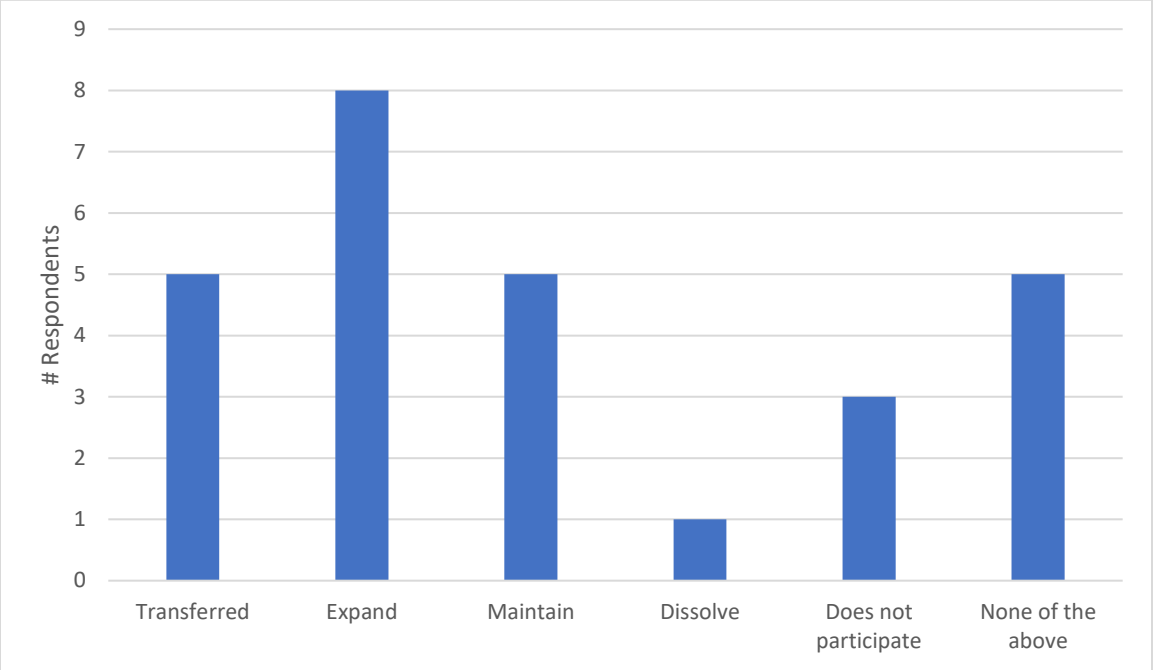
Comments from LPHAs:

- I like regional partnerships. But our "region" is so large. Sometimes we don't benefit from a regional partnership.

- There still needs to be regional funding for the projects. These add value to the entire dollars for the smaller counties.
- Funding should be provided to individual counties, and counties can initiate their own regional partnerships as appropriate for them.
- Each of the partnerships are unique. I would like them to have the option to continue, and potentially expand d as funding allows, but I am wary of any requirement for them to do so.
- I do not understand why partnerships and cross-jurisdictional sharing are perceived to have innate value. Their value depends entirely on the context (the counties involved, the work itself, etc.). These last two biennia have been an opportunity to test models; some tests are successful and some are not. Compelling continued partnerships does not strengthen the system, rather, it limits the ability of some counties to respond to local needs and can have the effect of drawing attention and resources from already-underresourced areas in large counties.
- The small counties cannot go back to lack of infrastructure prior to the regional funding.
- Regional efforts would be best supported by a less prescriptive approach to how partnerships, collaboration, and regional efforts can look. It is critical that county administrators are trusted to determine how best to use regional funding in a way that achieves maximum efficiency and effectiveness.
- If large counties could help small counties that could be helpful. They have the resources, small counties do not.

Question 5: My LPHA and other LPHAs that participate in the same regional partnership have (check all that apply)

- Transferred a portion of individual LPHA funding (from PE51-01 or other sources) to support the regional partnership or have committed to doing so in the future.
- Discussed opportunities to expand the regional partnership or implement other cross-jurisdictional sharing arrangements or shared service delivery models, if more funding were to become available.
- Discussed maintaining the current regional partnership at its current level if funds continue to be available, but we do not have plans to expand the regional partnership or implement new cross-jurisdictional sharing arrangements.
- Discussed dissolving the regional partnership if, in the future, PHAB does not direct funds directly to regional partnerships.
- My LPHA does not participate in a regional partnership in 2019-21.
- None of the above.



Key point:

1. More LPHAs have planned for expanding or maintaining the regional partnership than have discussed dissolving the partnership.

Comments from LPHAs:

- Our current regional partnership and cross-jurisdictional sharing of staff has been very successful and our region is committed to keeping that going as long as we receive regional funding. There has also been discussions of possible cross jurisdictional sharing

within other foundational programs and capabilities if there was increased regional funds (not at current level of funding).

- It is highly likely we would not enter into a regional partnership with this limited funding, except for the fact that if we don't we lose out on potential funds. It is a forced process.
- It's hard to have this discussion since regional money cannot support local positions. We are hanging onto our 1.5 CD nurse positions by our thumbs! I think all the rules around how to use regional money is not helpful.

Additional comments provided for PHAB:

- We cannot express enough how valuable the EOMC has been regarding the support (and resources) provided to the small (with very limited resources) counties throughout eastern Oregon.
- I think it's important for PHAB to know that we are seeing declines in other funding areas… Messaging modernization with staff and commissioners and talking about systems improvement is challenging when the system is failing in some areas but strong in others, and we still do not have the flexibility locally to allocate funding in the way that best meets local need. Thank you for all your efforts, PHAB!
- The work for modernization is different for the regional projects vs. local work required for modernization. We could not duplicate the regional work even if we had additional funding for each LPHA for the CD work.
- There must be far more support to small rural counties if the expectation is to have equitable services in public health from county to county.
- Inequities seem to be growing instead of resolving.

Subcommittee business

- The next subcommittee meeting is scheduled for April 6 from 12:00-1:00
- Decide who will provide subcommittee update at March 19 PHAB meeting. This update will cover both the 2/3 and 3/2 meetings.

Public Comment

Adjourn