AGENDA

PUBLIC HEALTH ADVISORY BOARD

May 19, 2022, 2:00-4:30 pm

Join ZoomGov Meeting
https://www.zoomgov.com/j/1602414019?pwd=MWtPYm5YWmxyRnVzZW0vZkpUV0lEdz09

Meeting ID: 160 241 4019
Passcode: 577915
One tap mobile
+16692545252,,1602414019#

Meeting objectives:

- Approve April meeting minutes
- Discuss work of PHAB subcommittees
- Discuss Preventive Health and Health Services Block Grant
- Reflect on health equity capacity building sessions while reviewing PHAB charter and bylaws

2:00-2:20 pm	**Welcome, board updates, shared agreements, agenda review** • Welcome, board member introductions and icebreaker • Share group agreements and the Health Equity Review Policy and Procedure • Meeting format update • ACTION: Approve April meeting minutes	Veronica Irvin, PHAB Chair
2:20-2:45 pm	**Subcommittee updates** • Accountability Metrics • Incentives and Funding • Strategic Data Plan	Jocelyn Warren, Accountability Metrics Bob Dannenhoffer,

		Incentives & Funding Subcommittee Veronica Irvin, Strategic Data Plan
2:45-3:00 pm	**Preventive Health and Health Services Block Grant report out** • Share information about current work plan activities	Danna Drum, OHA
3:00-3:10 pm	**Break**	
3:10-3:55 pm	**Charter and bylaws review** • Determine goals, priorities, PHAB's role and next steps • Review PHAB membership and roles • Discuss workgroup for charter, bylaws and work plan update	Veronica Irvin, PHAB Chair All
3:55-4:15 pm	**PHAB member discussion** • Open time to discuss public health priorities • Member updates	Veronica Irvin, PHAB Chair
4:15-4:25 pm	**Public comment**	Veronica Irvin, PHAB Chair
4:25-4:30 pm	**Next meeting agenda items and adjourn**	Veronica Irvin, PHAB Chair

PUBLIC HEALTH ADVISORY BOARD (PHAB) MEETING MINUTES

April 21, 2022, 2:00-4:30 pm

Attendance

***Board members present*:**

Dr. Bob Dannenhoffer, Dr. Veronica Irvin, Dr. David Bangsberg, Sarah Poe, Dr. Sarah Present, Carrie Brogoitti, Rachael Banks, Jackie Leung, Dr. Jocelyn Warren, Nic Powers, Kelle Little, Dr. Jeanne Savage

Board members absent:

Erica Sandoval, Dr. Michael Baker, Dr. Ryan Petteway, Dr. Dean Sidelinger, Jawad Khan

***Oregon Health Authority (OHA) staff*:**

Cara Biddlecom, Sara Beaudrault, Tamby Moore, Victoria Demchak, Charina Walker

Meeting objectives:

- Approve March meeting minutes
- Discuss work of PHAB subcommittees
- Discuss outcomes of 2022 legislative session
- Reflect on health equity capacity building sessions and determine PHAB priorities

2:00-2:30 pm Welcome, board updates, shared agreements and agenda review

Veronica Irvin, *PHAB Chair*

- Welcome, board member introduction and icebreaker
  - PHAB's new Member at Large, Jawad Khan will be attending in May.
  - This is Sarah Poe's last PHAB meeting.
  - May will be Dr. David Bangsberg's last PHAB meeting.

- Oregon Health Policy Board (OHPB) retreat recap
  - Meeting was on April 5th. Members of OHPB committees, including PHAB, were invited to join discussions on committee work, challenges and strategies toward health equity. There are a lot of similarities with what is working and not working across Oregon Health Policy Board and its committees. Committee representatives expressed appreciation for OHA staff who support the committees, but also acknowledged a lack of understanding for how and where decisions are made.

- Review and discuss group agreements
  - Veronica reviewed the group agreements drafted by the Accountability Metrics Subcommittee and recommended that they be used in PHAB meetings.

- Discussion on PHAB purpose and decision-making
  - Veronica opened up a discussion to acknowledge concerns about lack of transparency about the role and decision-making authority of the Conference of Local Health Officials (CLHO) and PHAB. CLHO members have requested clarity.
  - PHAB had a discussion of what expectations are for the board and how the board can meet them.
  - The board discussed the challenges of providing public health in rural counties and how PHAB can support rural counties.
  - Discussed the need for an emphasis on tribal public health and how it is unique and has been underfunded.
  - PHAB members shared that meetings have a lot of presentation and discussion but no action.

- The point was brought up that we are doing what is listed in objectives as listed in the charter for PHAB and that it feels like people are bringing in things outside of the objectives. PHAB's objectives need to be revisited and revitalized as issues are being brought up.
    - Loss of transparency.
    - Lack of clarity where information is coming from.
    - Implications for modernization. Public health system shifts need to be created together.

- Meeting format discussion
    - Based on feedback from some members and the Health Resources in Action team, OHA will put together a survey to identify a new standing meeting time.

- ACTION: Approve March meeting minutes
    - The March minutes were approved unanimously.

2:30 – 2:45pm Subcommittee updates

Kat Mastrangelo, *Accountability Metrics*; Bob Dannenhoffer, *Incentives & Funding Subcommittee*; Cara Biddlecom, *Strategic Data Plan*

- Accountability Metrics Subcommittee
    - Last month Dr. Present shared an updated framework for public health accountability metrics that emphasizes governmental public health accountability. Currently focusing on identifying metrics for data and data systems.
    - Last meeting reviewed the metrics to see if they aligned with the updated framework that was presented in last month's meeting and to see if any changes needed to be made. Topics discussed but no decisions were made:
        - Data availability
        - Data comparability
        - Timeliness of reporting of data
        - Review some work with local health communicable diseases metrics of data access, completeness, utilization and workforce

        - Need to work toward more complete risk factor data, which could be accomplished through increased data sharing.
- Incentives and Funding Subcommittee
    - The last subcommittee meeting included a discussion about the funding formula changes needed to provide enough funding for FTEs for counties. The subcommittee discussed the challenges for smaller counties. Discussed three options for funding- status quo, every $10 million funded equals 1 FTE or (and recommended by subcommittee), 1 FTE at $20 million, and 2 FTE after $40 million funded.
    - Recommended that PHAB prioritize discussions on challenges providing public health in rural counties. These challenges are greater than lack of sufficient funding.
    - Will have final proposal by June PHAB meeting.
- Strategic Data Plan
    - No update as meeting was having technical issues and the committee was not able to meet.

2:45 – 3:00 pm Preventive Health and Health Services Block Grant Report out
Danna Drum, *OHA staff*

- Meeting item moved to next month's agenda.

3:00 – 3:10 pm Break

3:10 – 4:20 pm Health equity capacity building reflection and next steps
Veronica Irvin, *PHAB Chair*

- Discussed ideas, next steps and possible pathways to implement PHAB's health equity priorities.
    - PHAB reviewed the reflections and recommendations on page 27 of the packet that was sent out that was decided by Health Resources in Action and OHA.
    - PHAB discussed having a standing agenda item in the beginning for a recap of CLHO meeting due to information not being relayed to committee members in time for PHAB meeting.

- Meeting minutes from each breakout room:
    - Charter & Bylaws
        - Discussed making sure to review charter, bylaws and work plan annually.
        - Discussed forming a small task force to work on proposing charter updates.
        - Sarah Present shared that some of the goals and objectives are too large and require more specificity. What does oversight mean, and does it need to be removed?
        - Discussed the need to ensure the charter reflects the role of tribes.
        - The charter will need to help PHAB identify and prioritize its focus.
        - Bob shared that the charter needs to be updated to reflect better alignment with our equity priorities.
        - Discussed whether to add compliance with the PHAB Health Equity Review Policy and Procedure into the charter.
    - Subcommittees
        - Discussed the need for clarity on how subcommittees fit into PHAB's overall structure and who subcommittees report to.
        - Requested a visual of existing subcommittees and how their bodies of work fit together.
        - Recommended that subcommittees be included in PHAB's charter and/or bylaws.
        - Recommended expanding the scope of Incentives and Funding to address public health funding more broadly.
        - Recommended including community partners in all subcommittees.
        - Requested that OHA make connections when subcommittee work is connected to other initiatives. (For example, PHAB Accountability Metrics may be connected to community information exchange).
        - Discussed whether subcommittee participation should be required but did not make a recommendation.
    - Meeting processes
        - What could be other date/ time for meetings (evenings, weekends?) so the public can take part?

- Are there format changes that encourage participation of all in ways that they feel most comfortable with. Breakouts, chat, roll call giving everyone a chance to speak without having to jump in or interrupt. What are concrete steps/actions we can do personally to encourage participation? How can we support people in moving up?
- PHAB can recruit public members for funding subcommittee.
- PHAB members can work to invite members of the public to participate.
- Working toward quarterly in-person meetings (the rest could be virtual).
- Bringing meetings across the state could be valuable,
    - Some people may not feel safe across the state/ traveling across OR.
    - Value - it's good to have folks from all over the state participate
    - Aligns with OHPB and their previous work to take their meetings across the state.
- Virtual or non-virtual meetings:
    - Mostly virtual, maybe do an in-person quarterly and rotate the location?
    - It's nice to have the flexibility of the virtual format.
    - In a hybrid setting, it's easy to miss out on side conversations, pre/post conversation meetings. Want to make sure everyone can participate.
    - It was nice (as a PHAB member) to have all meetings on one day. But the world has changed.
    - Childcare and transportation are an issue that make in-person meetings more challenging
- Jargon and acronyms, welcoming setting:
    - We have to be mindful of acronyms.
    - Incentives and Funding Subcommittee hasn't had public members join; it would be helpful to have other voices in those discussions. Recommend to recruit.
    - Want to bring in more community voices - those who can't participate during the day, who can't make it to Portland.

- Workplan
  - Workplan needs to reflect PHAB priorities for equity.
  - Discussed the need for communication between PHAB, Oregon Health Policy Board, CLHO and other relevant groups.
  - Creating priorities needs to be inclusive outside of OHA.
  - Workplan needs to include defining public health priorities.
  - Discussed sharing power/resources between boards/bodies.
  - Discussed the need more conversation and discussion around process and a mechanism on how we all work together on priorities.
  - Discussed the need to make sure Community Advisory Council and Local Public Health will work together in the development of CCO 2.0 to identify social determinants of health metrics.
  - Discussed the need to make sure we are advancing previous workplans.
  - Discussed the need to center health equity and identify how community, LPHAs, coordinated care organizations, and other partners achieve this together.

4:20 – 4:30 pm Public Comment

Veronica Irvin, *PHAB Chair*
Cara Biddlecom*, OHA Staff*

- No requests for public comments were made prior to the meeting or during this time. Public comments were closed.

4:20 pm Next meeting agenda items and adjourn

Veronica Irvin, *PHAB Chair*

- May's meeting recap for next steps, purpose to start with charter & bylaws discussion as it helps with rest of the topics discussed and block grant report out.
- Next meeting will be Thursday, May 19, from 2-4:30 pm.

Meeting adjourned at 4:30 p.m.

Minutes

draft

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

April 20, 2022
8:30-9:30 am

Subcommittee members present: Cristy Muñoz, Kat Mastrangelo, Dr. Sarah Present, Dr. Ryan Petteway

Subcommittee members absent: Olivia Gonzales, Jeanne Savage

OHA staff: Sara Beaudrault, Kusuma Madamala, Lisa Rau, Ann Thomas, Sandra Rice, Tim Menza, Heather Jamieson, June Bancroft

PHAB's Health Equity Policy and Procedure

Meeting Objectives

- Approve March meeting minutes
- Review and update metrics selection criteria, with focus on how accountability is demonstrated
- Hear updates and discuss measurement of data and data systems
- Discuss inclusion of indicators in metrics framework and process for identifying indicators

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Welcome and Introduction

Sara B. welcomed everyone and asked committee members to introduce themselves. She mentioned this was a public meeting and asked the public to hold comments until the end. This meeting is recorded for the purpose of writing minutes but not published.

Meeting minutes were passed unanimously.

Metrics selection criteria, how accountability is demonstrated

Sara B. began with referring back to last summer and fall when these metrics were created. We want to make sure selection criteria still remains true, since they will be used for the next few years.

Sara B. showed a slideshow (see PowerPoint presentation) outlining the current deliverables for the committee:

<u>April and May, 2022</u>

- Review recommendations from Coalition of Local Health Official (CLHO) committees.

<u>June 2022</u>

- Metrics recommendations for PHAB approval.

<u>July 2022 and beyond</u>

- Develop 2022 accountability metrics report
- Continue work to identify public health accountability metrics for additional programmatic areas, including developmental measures.

Sara B. noted that we have two more meetings before an OHA report is due to the Legislative Fiscal Office which will include progress made by the committee so far.

Sara B. presented a slideshow and stated that the metrics have been revised, with the overarching theme of focusing on **actionable** metrics. She suggested one statement change from "may" to "will."

- "Disease outcomes ~~**may**~~ **will** be used as indicators of progress but are secondary to process measures of public health system accountability."

Kat shared that is she is in the HIE group, which has similar statements and language. Will our work be added to what other groups are doing? Will common definitions be established or will they stay separate?

Sara B. answered that those connections will not be made unless there is an intention to align. OHA can work to draw connections, but you and others on this committee can do so as well.

Kat agreed that it made sense to pull all common definitions together; i.e. data and data systems. We should verify terms and at the very least confirm that they do not contradict each other.

Questions for discussion on metrics selection criteria:

- *Are additional changes needed to metrics selection criteria to align with the metrics framework?*
- *In what ways can accountability metrics be used to demonstrate accountability to communities and for system-wide improvements?*
- *What do we mean when we say accountability and accountability metrics, and who are we accountable to?*

Kat asked if there was support for traditional cultures? She will follow up with Sara on her HEI meeting and what they discussed about this topic.

Ryan commented:

1. We should have examples of what each metric should look like. An example is tobacco use, where most measures don't consider context like environment, advertising, tobacco retail...
2. What do we mean by actionable? Need to be concrete. Sample-based and cross-sectional is not actionable.
3. Data availability – No accountability if we are basing metrics on data that are already available, based on funding. We don't have the data we need to address population health inequity and lack of data by design and because it hasn't been deemed important. It doesn't address who is responsible. If we are not committed up-front to using financial and human resources to get the data we need, we will not be able to make this actionable and it will be a waste of time.
4. Data comparability – This should not be the core thing of what is collected. we should not collect the same data from each county. Each county should collect data that is most applicable to their situation. Otherwise, we are tying ourselves to needs that are outside our own community. In terms of macro needs across the state, this is valuable data to collect, but in terms of actionable needs, we should be careful about comparing one community's needs to anothers.

Kusuma stressed that the Survey Modernization team informed this new framing around having a lack of context in public health data. This is not currently in selection criteria. It should include lack of context and the need to address contextual factors. She agreed with Ryan and shared that the committee has discussed the need for flexibility in terms of measures that are locally tailored, but the standard around it should show that we are working toward the same thing. The subcommittee could include something about flexibility and locally tailored measures in the selection criteria. Kusuma noted that data availability is an important piece, but there has to be some acknowledgement of whether we have the workforce available to collect the data?

Cristy stated that her work is around community engagement and when it comes to metrics, data can become old. How long do we have before it becomes out-of-date? Do we need something that determines a timeline for gathering data--creating an expectation that we don't rely on data that are old?

Ryan pointed out in the chat that public health data may be 2-3 years old when finally made public, need to work more closely with community residents to collect and share real-time data.

Sarah P. acknowledged that there has been a lot of discussion about dismantling our current public health system and rebuilding it to meet community needs, but is still science and data driven, and the tension of doing this with an exhausted work force. There is tension around this issue, to be finding things that are truly doable and still create system change.

Sarah P. also pointed out that there is a lot of opportunity now for public and private partnerships, such as OSHU being a thought leader providing ideas and resources to the public health system. Public health encompasses more than just government public health system. Perhaps drawing on these partnerships can increase our capacity. Not sure if this should be a criteria or not.

Ryan added in the chat that it sounds like LHD capacity/workforce should be itself an accountability metric; for example, how do we do this work without first making investments in the resources needed to do it?

Kusuma wanted to go back to the charter and reviewing what local and state governmental health are actually accountable for. We should make sure we're learning from the past, like lessons learned in the Health Officer Caucus Report to the Covid Response and doing the basics well before we add other requirements.

Measurement of data and data systems

Questions for discussion:

- *What questions, ideas or concerns do subcommittee members have about discussions on measurement of data and data systems?*
- *Is this consistent with the direction provided by this subcommittee?*

Sara shared slides that showed the CLHO committee discussion which focused on communicable diseases with a subset of data and data systems for communicable disease within the government system. In the future we hope to add a set of metrics around community partnership and policy for communicable disease control. Then at a higher level, we would identify population indicators and why we would need to be making these improvements in our communicable disease data.

Ryan agreed that the data looks good from a communicable disease standpoint but not sure how it transfers to population and community health. Also, examples would be helpful here, especially explaining context issues: such as risk factors related to living wage or sick leave. If we don't have this kind of data, it makes it difficult to intervene and provide resources to those who need them. This data is very good but needs to be reworked to serve accountability purposes.

Kusuma asked Ryan if he thinks that integrating additional data sources into our communicable disease data would provide the additional context needed. Is there a possible measure for data use agreements with other agencies and integrating data sources?

Ryan replied that he's not sure of OHA's data use agreements but feels as public government, we should have access to such databases as: transportation indicators: wage, property ownership, and tax data; parks and rec data; school data; Medicare and Medicaid and other databases relevant to public health. Therefore, the first step should be to see what other data sources are out there. Then, we need to think about how to fill in the gaps for data that is not available or that we do not have access to.

June Bancroft added in the chat - We do have our communicable disease data in a mapping portal with the CDC social vulnerability index which includes minorities, unemployed, % below poverty.

Ryan added in the chat, "I also think we need to spend some time accounting for the (limited) role of data as form of evidence/testimony in context of policy/politics. It's an important piece in policy

decisions (or at least should be), but it's hardly ever the only piece or the most important piece. So we need to be asking ourselves which kinds/forms of data are most useful/valuable to complement other community health organizing/advocacy strategies."

Ann agreed with Ryan, and is curious if Ryan is referring to obtaining individual data or census-track data? She asked how he envisions this working.

Ryan added in the chat that this work will inevitably require making asks of private entities for data as well. Many may be available at an ecological, neighborhood level. Identified data are aggregated as individual points and geocoded.

Ryan added a link in the chat:
Health affairs piece: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01489

Ann believes there is still a lot of data that we could get at the census-track level. She referenced CDC's social vulnerability index. OHA developed a COVID vulnerability index that took into account a lot of these other factors mentioned based on census level tract.

Sara B. chimed in that data use agreements could be a state-level metric. It is long-term work to get those in place. Community information exchange is another mechanism for risk factor and population health data.

Ann replied that statewide communicable disease databases include demographic data such as age, gender, race, ethnicity, and we geocode all of our data. Data can change according to the disease being tracked. She referenced proposed metrics she shared last fall, one part of which addressed decreasing disease transmissions in the houseless population.

Heather added in the chat: "OHA PHD ACDP : housing status, SOGI, REAL D, occupation *for reportable diseases that receive interview."

Tim Menza agreed with Ryan that there is plenty of opportunities to pull together and integrate information. CDC metrics don't necessarily explain Oregon context – they are made for national use and not for the local level. Took social vulnerability index from CDC and made one for Oregon specifically. We need to do more of this work. It is a complex process. Tim referenced a Health Affairs article, discussing measurement of structural racism in research or in explanatory data. This is a big question with great applications to public health, and not rely on things like race and ethnicity.

Cristy shared that there might be some states that are already working on improving the measurement of structural racism and added two resources in the chat:

1. Institute for the study for race and ethnicity : https://kirwaninstitute.osu.edu/
https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01489
2. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01489

Sara B. summarized that we need to create useful metrics that will be relevant over the next few years. These metrics can be used to leverage the changes we need to make to be an accountable and equity-centered public health system. This is long-term work.

Population Indicators

Questions to be asked:

- *In what ways would the subcommittee recommend including indicators within the framework for accountability metrics?*
- *What role does the subcommittee want to play in identifying metrics?*

This discussion will be carried over to the next subcommittee meeting in May.

Next steps

There were some changes suggested to the selection criteria.

- De-emphasizing that we already have data available and not wanted to lead with that.
- De-emphasizing data comparability
- Building in flexibility

Subcommittee business

Kat was chosen to present today's update to the 4/21 PHAB meeting.

Public Comment

None.

Adjourn

Next meeting is 5/18/22.

New framework for public health accountability metrics

Current accountability metrics	New metrics framework
Minimal context provided for disease risks and root causes of health inequities	Provides context for social determinants of health, systemic inequities and systemic racism
Focus on disease outcome measures	Disease outcomes may be used as indicators of progress, but are secondary to process measures of public health system accountability
Focus on programmatic process measures	Focus on data and data systems; community partnerships; and policy.
Focus on LPHA accountability	Focus on governmental public health system accountability.
Minimal connection to other state and national initiatives	Direct and explicit connections to state and national initiatives.

Minutes

draft

PUBLIC HEALTH ADVISORY BOARD
Incentives and Funding Subcommittee

April 15, 2022
1:00-2:0 p.m.

Subcommittee members present: Bob Dannenhoffer, Carrie Brogoitti, Michael Baker, Veronica Irvin, Nic Powers

OHA staff: Sara Beaudrault, Cara Biddlecom, Andrew Cohen, Ilana Kurtzig

Guest: Laura Daly, Coalition of Local Health Officials

PHAB's Health Equity Policy and Procedure

Welcome and introductions
March minutes were approved.

Public health modernization funding formula
Sara reviewed the subcommittee deliverables.

Sara shared some things that have happened since this group last met:

- The Conference of Local Health Officials Systems and Innovation committee reviewed notes from this subcommittee's March meeting and talked about some ways to operationalize the changes discussed. The CLHO committee doesn't make decisions but can help think through implications of funding formula changes made by PHAB. We are lucky that Mike Baker participates in both groups and can help facilitate sharing information back and forth.
- Sara and Drew have modeled some of the changes discussed, primarily to increase base funding that every LPHA receives to make sure small counties have the funding to make the changes necessary for public health modernization.

Sara reviewed the proposal and modeling, which includes funds for one FTE per LPHA at every $10 million increment, starting at $20 million. OHA estimated as a starting point $200,000 per biennium for a full time employee.

Mike said that CLHO Systems and Innovation also talked about the number of staff needed to complete the work, not necessarily what can be provided with current funding. We need to also

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think about the requirements that go along with funding. Often there is too much work for a single position to do.

Bob said that the per capita difference in the modeling between the extra small and extra large counties is not balanced. He pointed out that this funding formula is used for many other programs and it won't be feasible to provide an FTE for every program and it also isn't reasonable. Bob also noted that this modeling will negate any interest in regional efforts because there is no incentive to do so. There are many unintended consequences of moving to this updated formula.

Nic also commented on the imbalance in the modeling. He also said that if counties don't receive enough funding, instead of regional approaches counties might give up their public health authority. Nic asked about other funding to LPHAs.

Mike said that LPHAs rely on state and federal funding from OHA funding but they also rely on grants and county funding. OHA mandates services and LPHAs rely on the funds OHA provides to provide those services that they can't bill for.

Veronica asked whether there is still funding for regional work to pool across counties.

Sara said that there is still $4 million to fund regional partnerships or collaborations. We are funding eight partnerships currently. These funds don't show up in the funding formula; they are distributed through the proposals that are submitted. OHA has a table will all three modernization funding streams and will share it with the subcommittee.

Bob said the big issue is, how can public health be provided in counties with large geography and small populations, or areas without health care providers. The funding formula won't fix this, and he hopes PHAB will do some thinking of the future of public health in rural areas. The issues are not just money and PHAB should address the underlying issues.

Carrie thinks about, in order to focus on equity and eliminating health disparities, there need to be investments of resources and people. In a county like Union, around 10% of the population is non-White. She thinks they need even more resources to do what's needed to improve the health of everyone and eliminate health disparities. She noted that without having local staff to engage in partnership with regional staff, they are unable to take advantage of regional resources. She feels strongly that smaller counties need investments in addition to larger counties.

Bob agrees that there needs to be at least one person focused on modernization. He proposed that every health department gets at least one FTE and we revisit this in the next biennium.

Mike said that he sees a shift in how we talked about modernization in 2016, when we talked about how we make sure that every person in Oregon has access to public health services, to now when we talk about funding for positions to fulfill roles. For Mike, it is still about making sure that every person in his county can access public health. Even with the increase in funding for FTE, it does not get us to the original vision.

Sara said that the concept of every person being served by public health is grounded in the Modernization Manual, which applies to all of us. The positions hired don't only support modernization but also support programs across a health department.

Bob said that counties are giving up public health because there is not enough money to run the programs.

Mike said that without flexibility in how funds are used, it limits a health department's ability to fill gaps.

Carrie said the funding is pretty flexible. The application can be broad. She is hard-pressed to see how any health department couldn't use an FTE to support the work that is in the Program Element.

Veronica agrees with dedicated FTE. She noted that there are no large counties represented and asked what counterpoints they've shared about funding at least one FTE in each county.

Mike and Sara said that large counties have not disagreed with funding an FTE. Many extra large counties have voiced support.

Subcommittee members agreed to recommending funding for one FTE for every county. Bob recommended also including funding for two FTEs at the $40 million level. There will still be a discrepancy in per capita investments, but not as significant as what OHA modeled. Subcommittee members agreed.

Bob said that step two should be a deep discussion on how we're going to maintain public health in rural areas.

Laura Daly let the subcommittee members know that CLHO is developing a workforce development strategic plan and they would like to invite PHAB members as partners.

Subcommittee business

Bob will provide the subcommittee update at the April 21 PHAB meeting.

The subcommittee will meet again on May 5. At that meeting the subcommittee will discuss changes to funding formula indicators.

Public comment

No public comment was provided.

Adjourn

PHAB Incentives and Funding
LPHA funding formula FTE modeling
May 2022

Base funding modeling

1. Increases floor funding to provide a minimum FTE to every LPHA as follows:
    a. Includes funding for one FTE at $20 million.
    b. Includes funding for a second FTE at $40 million
2. One FTE estimated at $200,000/biennium.

	FTE modeling			Per capita range	
	Base funding for FTE*	Base funding for indicators	Incentives and matching funds	FTE modeling	Current funding formula
$20 million	$6,600,000 (1 FTE per LPHA)	$13,066,667	$333,333	Ex Sm: $28.98 Med: $4.87 Ex Lg: $2.86	Ex Sm: $11.69 Med: $4.95 Ex Lg: $3.57
$40 million	$13,200,000 (2 FTE per LPHA)	$24,400,000	$2,400,000	Ex Sm: $60.21 Med: $10.21 Ex Lg: $6.07	Ex Sm: $23.39 Med: $9.91 Ex Lg: $7.14

*Assumes 1 FTE equals $200,000/biennium

CLHO committee feedback:

- Support for this proposal.
- Recommend CLHO or OHA solicit feedback from LPHAs most impacted (extra small and extra large) prior to adoption.

Public Health Modernization LPHA Funding Formula

Updated March, 2021

LPHA allocations using FTE allocation model **$20,000,000**

		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	1,456	$ 200,000	$ 666	$ 1,309	$ 262	$ 479	$ 3,511	$ 271	$ 8			**$ 206,506**	**1.1%**	**0.0%**	**$ 141.83**	
Gilliam	2,039	$ 200,000	$ 972	$ 818	$ 419	$ 480	$ 4,917	$ 463	$ 436			**$ 208,505**	**1.1%**	**0.0%**	**$ 102.26**	
Wallowa	7,433	$ 200,000	$ 3,544	$ 2,981	$ 1,072	$ 1,808	$ 17,924	$ 1,310	$ 632			**$ 229,272**	**1.2%**	**0.2%**	**$ 30.85**	
Harney	7,537	$ 200,000	$ 5,059	$ 2,475	$ 2,001	$ 2,021	$ 8,051	$ 1,809	$ 891			**$ 222,307**	**1.2%**	**0.2%**	**$ 29.50**	
Grant	7,226	$ 200,000	$ 4,017	$ 3,014	$ 1,123	$ 1,934	$ 17,425	$ 1,906	$ 353			**$ 229,772**	**1.2%**	**0.2%**	**$ 31.80**	
Lake	8,177	$ 200,000	$ 5,333	$ 3,939	$ 2,138	$ 2,594	$ 12,482	$ 2,517	$ 1,140			**$ 230,142**	**1.2%**	**0.2%**	**$ 28.15**	
Morrow	12,635	$ 200,000	$ 5,896	$ 10,609	$ 4,209	$ 3,606	$ 13,985	$ 7,328	$ 15,030			**$ 260,663**	**1.4%**	**0.3%**	**$ 20.63**	
Baker	16,860	$ 200,000	$ 10,195	$ 8,576	$ 3,479	$ 4,369	$ 16,669	$ 4,115	$ 1,800			**$ 249,202**	**1.3%**	**0.4%**	**$ 14.78**	**$ 28.98**
Crook	25,482	$ 200,000	$ 14,938	$ 15,773	$ 5,372	$ 6,660	$ 29,495	$ 7,446	$ 2,551			**$ 282,235**	**1.5%**	**0.6%**	**$ 11.08**	
Curry	23,662	$ 200,000	$ 16,410	$ 12,991	$ 6,409	$ 5,542	$ 22,082	$ 6,085	$ 2,415			**$ 271,934**	**1.4%**	**0.6%**	**$ 11.49**	
Jefferson	24,889	$ 200,000	$ 14,993	$ 9,177	$ 21,032	$ 7,339	$ 37,871	$ 8,188	$ 9,593			**$ 308,193**	**1.6%**	**0.6%**	**$ 12.38**	
Hood River	23,888	$ 200,000	$ 7,952	$ 10,543	$ 9,352	$ 4,806	$ 30,069	$ 10,631	$ 28,748			**$ 302,102**	**1.6%**	**0.6%**	**$ 12.65**	
Tillamook	27,628	$ 200,000	$ 15,917	$ 12,566	$ 6,060	$ 6,828	$ 46,369	$ 6,284	$ 6,755			**$ 300,779**	**1.6%**	**0.6%**	**$ 10.89**	
Union	26,295	$ 200,000	$ 14,348	$ 7,501	$ 6,100	$ 7,782	$ 26,695	$ 4,751	$ 3,292			**$ 270,470**	**1.4%**	**0.6%**	**$ 10.29**	
Sherman, Wasco	28,489	$ 400,000	$ 16,303	$ 10,581	$ 9,954	$ 6,602	$ 28,510	$ 9,045	$ 12,090			**$ 493,086**	**2.6%**	**0.7%**	**$ 17.31**	
Malheur	31,995	$ 200,000	$ 17,329	$ 23,335	$ 10,212	$ 11,352	$ 37,342	$ 14,360	$ 19,506			**$ 333,437**	**1.8%**	**0.7%**	**$ 10.42**	
Clatsop	41,428	$ 200,000	$ 23,745	$ 16,724	$ 10,645	$ 9,234	$ 38,961	$ 8,211	$ 9,882			**$ 317,402**	**1.7%**	**1.0%**	**$ 7.66**	
Lincoln	50,903	$ 200,000	$ 34,890	$ 29,180	$ 17,568	$ 13,894	$ 46,153	$ 11,258	$ 7,836			**$ 360,779**	**1.9%**	**1.2%**	**$ 7.09**	
Columbia	53,014	$ 200,000	$ 26,712	$ 29,248	$ 11,094	$ 10,838	$ 55,738	$ 11,940	$ 5,566			**$ 351,136**	**1.9%**	**1.2%**	**$ 6.62**	
Coos	65,154	$ 200,000	$ 44,930	$ 37,524	$ 22,238	$ 18,920	$ 60,331	$ 17,071	$ 7,513			**$ 408,526**	**2.2%**	**1.5%**	**$ 6.27**	
Klamath	69,822	$ 200,000	$ 47,372	$ 32,696	$ 24,487	$ 22,519	$ 63,307	$ 20,661	$ 18,175			**$ 429,217**	**2.3%**	**1.6%**	**$ 6.15**	**$ 8.99**
Umatilla	80,463	$ 200,000	$ 39,952	$ 39,845	$ 34,117	$ 23,038	$ 56,462	$ 33,688	$ 65,911			**$ 493,014**	**2.6%**	**1.9%**	**$ 6.13**	
Polk	88,916	$ 200,000	$ 37,431	$ 43,791	$ 31,218	$ 20,268	$ 42,668	$ 19,981	$ 35,419			**$ 430,777**	**2.3%**	**2.1%**	**$ 4.84**	
Josephine	88,728	$ 200,000	$ 61,681	$ 52,057	$ 20,603	$ 28,895	$ 96,282	$ 20,411	$ 9,062			**$ 488,990**	**2.6%**	**2.1%**	**$ 5.51**	
Benton	93,976	$ 200,000	$ 26,780	$ 28,579	$ 39,425	$ 25,453	$ 42,604	$ 10,067	$ 34,885			**$ 407,793**	**2.2%**	**2.2%**	**$ 4.34**	
Yamhill	108,261	$ 200,000	$ 47,674	$ 53,610	$ 36,958	$ 22,684	$ 59,000	$ 29,880	$ 44,541			**$ 494,348**	**2.6%**	**2.5%**	**$ 4.57**	
Douglas	111,694	$ 200,000	$ 78,996	$ 66,733	$ 24,416	$ 30,128	$ 110,968	$ 28,579	$ 10,316			**$ 550,136**	**2.9%**	**2.6%**	**$ 4.93**	
Linn	130,440	$ 200,000	$ 68,257	$ 63,540	$ 36,534	$ 32,414	$ 99,396	$ 30,916	$ 24,498			**$ 555,556**	**3.0%**	**3.1%**	**$ 4.26**	**$ 4.87**
Deschutes	203,390	$ 200,000	$ 76,604	$ 74,991	$ 38,669	$ 37,085	$ 135,366	$ 30,917	$ 33,429			**$ 627,060**	**3.3%**	**4.8%**	**$ 3.08**	
Jackson	223,827	$ 200,000	$ 119,609	$ 110,838	$ 56,446	$ 58,329	$ 108,487	$ 54,545	$ 61,276			**$ 769,531**	**4.1%**	**5.2%**	**$ 3.44**	
Marion	347,182	$ 200,000	$ 154,738	$ 179,398	$ 192,113	$ 92,477	$ 109,673	$ 120,226	$ 281,532			**$ 1,330,157**	**7.1%**	**8.1%**	**$ 3.83**	**$ 3.52**
Lane	382,647	$ 200,000	$ 182,702	$ 170,948	$ 145,331	$ 106,806	$ 161,476	$ 77,460	$ 76,890			**$ 1,121,613**	**6.0%**	**9.0%**	**$ 2.93**	
Clackamas	425,316	$ 200,000	$ 168,769	$ 165,973	$ 148,639	$ 57,070	$ 185,635	$ 67,198	$ 135,445			**$ 1,128,730**	**6.0%**	**10.0%**	**$ 2.65**	
Washington	605,036	$ 200,000	$ 180,818	$ 245,876	$ 421,715	$ 95,989	$ 81,703	$ 119,317	$ 427,200			**$ 1,772,619**	**9.4%**	**14.2%**	**$ 2.93**	
Multnomah	820,672	$ 200,000	$ 357,799	$ 355,593	$ 531,922	$ 186,422	$ 25,727	$ 167,831	$ 538,717			**$ 2,364,011**	**12.6%**	**19.2%**	**$ 2.88**	**$ 2.86**
Total	**4,266,560**	**$ 7,200,000**	**$ 1,933,333**	**$ 1,933,333**	**$ 1,933,333**	**$ 966,667**	**$ 1,933,333**	**$ 966,667**	**$ 1,933,333**	$ 1,000,000	$ 200,000	**$ 18,800,000**	**100.0%**	**100.0%**	**$ 4.41**	**$ 4.41**

[1] Source: Portland State University Certified Population estimate July 1, 2021

[2] Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon death certificate data, 2014-2018

[3] Source: Quality of life: Good or excellent health, 2014-2017

[4] Source: American Community Survey population 5-year estimate, 2014-2018

[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	150,000-375,0	above 375,000

Public Health Modernization LPHA Funding Formula

Updated March, 2021

Total biennial funds available to LPHAs through the funding formula = $40,000,000

		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	1,456	$ 400,000	$ 1,333	$ 2,618	$ 525	$ 957	$ 7,022	$ 542	$ 17	$ -	$ 2,770	**$ 415,783**	**1.0%**	**0.0%**	**$ 285.57**	
Gilliam	2,039	$ 400,000	$ 1,945	$ 1,635	$ 837	$ 961	$ 9,834	$ 926	$ 872	$ -	$ 2,812	**$ 419,822**	**1.0%**	**0.0%**	**$ 205.90**	
Wallowa	7,433	$ 400,000	$ 7,089	$ 5,961	$ 2,145	$ 3,616	$ 35,848	$ 2,620	$ 1,264	$ -	$ 3,196	**$ 461,740**	**1.2%**	**0.2%**	**$ 62.12**	
Harney	7,537	$ 400,000	$ 10,119	$ 4,949	$ 4,002	$ 4,041	$ 16,103	$ 3,619	$ 1,782	$ 29,630	$ 3,204	**$ 477,449**	**1.2%**	**0.2%**	**$ 63.35**	
Grant	7,226	$ 400,000	$ 8,034	$ 6,029	$ 2,245	$ 3,869	$ 34,850	$ 3,812	$ 706	$ -	$ 3,182	**$ 462,726**	**1.2%**	**0.2%**	**$ 64.04**	
Lake	8,177	$ 400,000	$ 10,666	$ 7,878	$ 4,276	$ 5,187	$ 24,963	$ 5,034	$ 2,280	$ 28,404	$ 3,249	**$ 491,938**	**1.2%**	**0.2%**	**$ 60.16**	
Morrow	12,635	$ 400,000	$ 11,793	$ 21,219	$ 8,418	$ 7,212	$ 27,970	$ 14,656	$ 30,059	$ 28,365	$ 3,567	**$ 553,259**	**1.4%**	**0.3%**	**$ 43.79**	
Baker	16,860	$ 400,000	$ 20,390	$ 17,152	$ 6,957	$ 8,738	$ 33,338	$ 8,229	$ 3,599	$ 30,267	$ 3,868	**$ 532,538**	**1.3%**	**0.4%**	**$ 31.59**	**$ 60.21**
Crook	25,482	$ 400,000	$ 29,876	$ 31,546	$ 10,744	$ 13,320	$ 58,990	$ 14,891	$ 5,102	$ 40,252	$ 4,482	**$ 609,204**	**1.5%**	**0.6%**	**$ 23.91**	
Curry	23,662	$ 400,000	$ 32,820	$ 25,982	$ 12,818	$ 11,084	$ 44,163	$ 12,170	$ 4,831	$ 56,687	$ 4,353	**$ 604,908**	**1.5%**	**0.6%**	**$ 25.56**	
Jefferson	24,889	$ 400,000	$ 29,985	$ 18,353	$ 42,065	$ 14,677	$ 75,742	$ 16,376	$ 19,186	$ -	$ 4,440	**$ 620,825**	**1.6%**	**0.6%**	**$ 24.94**	
Hood River	23,888	$ 400,000	$ 15,905	$ 21,087	$ 18,704	$ 9,613	$ 60,138	$ 21,262	$ 57,496	$ -	$ 4,369	**$ 608,573**	**1.5%**	**0.6%**	**$ 25.48**	
Tillamook	27,628	$ 400,000	$ 31,834	$ 25,132	$ 12,120	$ 13,655	$ 92,738	$ 12,569	$ 13,511	$ -	$ 4,635	**$ 606,194**	**1.5%**	**0.6%**	**$ 21.94**	
Union	26,295	$ 400,000	$ 28,697	$ 15,003	$ 12,200	$ 15,564	$ 53,390	$ 9,502	$ 6,585	$ 28,253	$ 4,540	**$ 573,733**	**1.4%**	**0.6%**	**$ 21.82**	
Sherman, Wasco	28,489	$ 800,000	$ 32,606	$ 21,161	$ 19,908	$ 13,205	$ 57,020	$ 18,090	$ 24,180	$ 87,080	$ 7,363	**$ 1,080,615**	**2.7%**	**0.7%**	**$ 37.93**	
Malheur	31,995	$ 400,000	$ 34,659	$ 46,670	$ 20,424	$ 22,705	$ 74,684	$ 28,720	$ 39,012	$ -	$ 4,946	**$ 671,820**	**1.7%**	**0.7%**	**$ 21.00**	
Clatsop	41,428	$ 400,000	$ 47,489	$ 33,448	$ 21,290	$ 18,469	$ 77,922	$ 16,422	$ 19,764	$ 28,232	$ 5,618	**$ 668,654**	**1.7%**	**1.0%**	**$ 16.14**	
Lincoln	50,903	$ 400,000	$ 69,780	$ 58,359	$ 35,136	$ 27,788	$ 92,306	$ 22,517	$ 15,672	$ 88,064	$ 6,294	**$ 815,916**	**2.0%**	**1.2%**	**$ 16.03**	
Columbia	53,014	$ 400,000	$ 53,423	$ 58,497	$ 22,189	$ 21,677	$ 111,475	$ 23,880	$ 11,131	$ 82,440	$ 6,444	**$ 791,156**	**2.0%**	**1.2%**	**$ 14.92**	
Coos	65,154	$ 400,000	$ 89,860	$ 75,049	$ 44,475	$ 37,839	$ 120,663	$ 34,141	$ 15,025	$ 138,595	$ 7,309	**$ 962,956**	**2.4%**	**1.5%**	**$ 14.78**	
Klamath	69,822	$ 400,000	$ 94,743	$ 65,393	$ 48,973	$ 45,038	$ 126,614	$ 41,322	$ 36,350	$ 57,277	$ 7,642	**$ 923,352**	**2.3%**	**1.6%**	**$ 13.22**	**$ 19.36**
Umatilla	80,463	$ 400,000	$ 79,905	$ 79,690	$ 68,234	$ 46,077	$ 112,925	$ 67,375	$ 131,821	$ 37,403	$ 8,400	**$ 1,031,830**	**2.6%**	**1.9%**	**$ 12.82**	
Polk	88,916	$ 400,000	$ 74,862	$ 87,583	$ 62,437	$ 40,537	$ 85,336	$ 39,962	$ 70,837	$ 32,164	$ 9,002	**$ 902,720**	**2.3%**	**2.1%**	**$ 10.15**	
Josephine	88,728	$ 400,000	$ 123,362	$ 104,113	$ 41,206	$ 57,790	$ 192,563	$ 40,822	$ 18,123	$ 50,354	$ 8,989	**$ 1,037,323**	**2.6%**	**2.1%**	**$ 11.69**	
Benton	93,976	$ 400,000	$ 53,560	$ 57,159	$ 78,851	$ 50,907	$ 85,207	$ 20,133	$ 69,769	$ -	$ 9,363	**$ 824,948**	**2.1%**	**2.2%**	**$ 8.78**	
Yamhill	108,261	$ 400,000	$ 95,349	$ 107,221	$ 73,916	$ 45,368	$ 118,000	$ 59,761	$ 89,082	$ 75,280	$ 10,380	**$ 1,074,356**	**2.7%**	**2.5%**	**$ 9.92**	
Douglas	111,694	$ 400,000	$ 157,993	$ 133,466	$ 48,831	$ 60,255	$ 221,936	$ 57,158	$ 20,633	$ -	$ 10,625	**$ 1,110,897**	**2.8%**	**2.6%**	**$ 9.95**	
Linn	130,440	$ 400,000	$ 136,514	$ 127,080	$ 73,068	$ 64,829	$ 198,792	$ 61,832	$ 48,997	$ 70,607	$ 11,961	**$ 1,193,679**	**3.0%**	**3.1%**	**$ 9.15**	**$ 10.21**
Deschutes	203,390	$ 400,000	$ 153,208	$ 149,982	$ 77,338	$ 74,169	$ 270,732	$ 61,834	$ 66,858	$ 46,135	$ 17,159	**$ 1,317,414**	**3.3%**	**4.8%**	**$ 6.48**	
Jackson	223,827	$ 400,000	$ 239,218	$ 221,676	$ 112,892	$ 116,659	$ 216,975	$ 109,091	$ 122,553	$ 199,732	$ 18,615	**$ 1,757,409**	**4.4%**	**5.2%**	**$ 7.85**	
Marion	347,182	$ 400,000	$ 309,476	$ 358,795	$ 384,227	$ 184,954	$ 219,346	$ 240,452	$ 563,064	$ 155,128	$ 27,404	**$ 2,842,846**	**7.1%**	**8.1%**	**$ 8.19**	**$ 7.64**
Lane	382,647	$ 400,000	$ 365,404	$ 341,896	$ 290,662	$ 213,612	$ 322,951	$ 154,920	$ 153,780	$ 190,540	$ 29,931	**$ 2,463,696**	**6.2%**	**9.0%**	**$ 6.44**	
Clackamas	425,316	$ 400,000	$ 337,538	$ 331,946	$ 297,279	$ 114,140	$ 371,271	$ 134,397	$ 270,890	$ 236,842	$ 32,971	**$ 2,527,274**	**6.3%**	**10.0%**	**$ 5.94**	
Washington	605,036	$ 400,000	$ 361,636	$ 491,752	$ 843,430	$ 191,979	$ 163,407	$ 238,634	$ 854,400	$ 182,269	$ 45,777	**$ 3,773,284**	**9.4%**	**14.2%**	**$ 6.24**	
Multnomah	820,672	$ 400,000	$ 715,598	$ 711,187	$ 1,063,845	$ 372,844	$ 51,453	$ 335,662	$ 1,077,433	$ -	$ 61,141	**$ 4,789,163**	**12.0%**	**19.2%**	**$ 5.84**	**$ 6.07**
Total	**4,266,560**	**$ 14,400,000**	**$ 3,866,667**	**$ 3,866,667**	**$ 3,866,667**	**$ 1,933,333**	**$ 3,866,667**	**$ 1,933,333**	**$ 3,866,667**	$ 2,000,000	$ 400,000	**$ 40,000,000**	**100.0%**	**100.0%**	**$ 9.38**	**$ 9.38**

[1] Source: Portland State University Certified Population estimate July 1, 2021

[2] Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon death certificate data, 2014-2018

[3] Source: Quality of life: Good or excellent health, 2014-2017

[4] Source: American Community Survey population 5-year estimate, 2014-2018

[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	150,000-375,0	above 375,000

Program Design and Evaluation Services

OHA | MCHD

Update on Survey Modernization Activities and Lessons Learned

April 2022

Background

The Oregon Legislature's Modernization funding for the 2019-2021 biennium included funding to update the adult (BRFSS) and youth (OHT/SHS) survey systems to address these challenges and gather better data for specific communities. The Office of the State Public Health Director (OSPHD) directed Program Design and Evaluation Services (PDES) [1] to lead this project, and the Oregon Public Health Division (OPHD) Science and Epidemiology Council (SEC) provided scientific oversight.

The need and approach for modernizing Oregon's population wide surveys came in several ways including our previous work with communities in various projects, work with African American, Pacific Islander, Alaska Native and other communities, academics, and practice partners. Our approach was informed by the literature and over 30 key informant interviews with local community-based organizations.

The Behavioral Risk Factor Surveillance System (BRFSS) is a telephone survey to collect state-specific data from individual adults on preventive health practices and risk behaviors that are linked to chronic diseases, injuries, and preventable infectious diseases in the adult population. The BRFSS is partially funded by the Centers for Disease Control (CDC). Health departments are dependent on BRFSS data for a variety of purposes, such as targeting services, securing funding, and measuring progress toward public health objectives.

The BRFSS has problems of equity, data quality, and sustainability: (1) the BRFSS is increasingly not representative of all Oregonians, especially for BIPOC communities[2], (2) there are growing concerns about the validity of BRFSS data given the lack of context and sensitivity of many questions, and (3) the BRFSS is expensive to conduct -- BRFSS costs close to $1 million annually and the last racial and ethnic oversample cost over $500 per completed survey and was still not representative of certain major racial and ethnic groups (e.g., Pacific Islanders).

[1] PDES is an interagency applied public health research and evaluation unit, within OPHD and Multnomah County Health Department, and currently coordinates the BRFSS and school-based youth surveys for OPHD.

[2] BRFSS implementation methods (random phone call) exclude communities who are generally mistrustful of government. BFRSS questions are often seen by communities as invasive and lacking the contextual questions to make them meaningful.

Oregon's Student Health Survey (SHS) is a collaborative effort with the Oregon Department of Education to improve the health and well-being of all Oregon students. The SHS is a comprehensive, school-based, anonymous, and voluntary health survey of 6th, 8th and 11th graders that provides key data for OPHD and ODE for program planning and policy efforts. Prior to 2020, student health data was collected through the Oregon Healthy Teens Survey, the Student Wellness Survey, and the Youth Risk Behavior Survey.

Survey Modernization Efforts: 2019-2021 Biennium

Rather than investing in an expensive and limited use racial oversample that would only update the content of the surveys, PDES decided to take an approach that examined the root design and implementation of the surveys. PDES invested in two complementary approaches: 1) piloting innovative statewide survey methods that incorporated the most recent scientific advances and (2) collaborating with Oregon tribes and BIPOC and communities to collect, analyze, and contextualize culturally specific survey data. Oregon is one of the few states to engage communities in modernizing our public health data surveys. We are sharing this information about extensive collaboration with communities in the design of public health surveys to offer a model for how such collaborations can be valuable and feasible in public health systems.

The work included:

1) Collaborating with and funding the Coalition of Communities of Color and the Northwest Portland Area Indian Health Board to form and facilitate community-specific data project teams for the Latinx, Black/African American/African Immigrant & Refugee, and American Indian/Alaskan Native communities. Each team included 5–6 members including community researchers and leadership from community-based organizations (CBOs). They used community-identified priorities to guide the analysis, interpretation, and contextualization of BRFSS (4-year aggregate 2015-2018), and OHT (2019) data. Some partners also led community-driven data collection on topics and methods of their choice. Their critique and recommendations are summarized in two reports: Engaging Communities in Public Health Survey Modernization and NPAIHB Survey Mod Report to OHA FINAL MARCH 2022.

2) Funding Pacific Islander researchers, community organizers, individuals, and CBOs to conduct community-led data collection and build capacity within Pacific Islander communities around research and data. The Pacific Islander community is particularly underrepresented on statewide surveys. Using a community-led research model, a Pacific Islander core team of researchers worked with PDES and sought guidance from various advisory groups including the Oregon Pacific Islander Coalition. The Pacific Islander-led core team identified priorities for this project, co-designed the data collection methods that would work best with their communities, and developed a community health assessment tool. They analyzed both the qualitative and quantitative

data using a participatory approach[3]. with a broader team of Community Research Workers. The core team co-wrote the final report, which includes results and recommendations in the report: PI HEAL Report 2021.

Detailed results and recommendations can be found in each of the reports. Taken together, the overall results from these community collaborations and the statewide BRFSS pilot of innovative methods highlight that OPHD needs to revamp its community health data collection systems.

Ongoing Survey Modernization Efforts: 2021–2023 Biennium

The results and lessons learned from the initial survey modernization efforts have led to the following ongoing work this biennium:

- Disseminating the survey modernization results to the Oregon Public Health Advisory Board, Oregon Public Health Division and survey leadership, state health programs, community partners, and federal government.

- Facilitating discussions with the Oregon BRFSS leadership about developing the infrastructure and processes to engage communities in designing statewide, locally funded adult surveys (e.g., state BRFSS).

- Establishing and engaging a youth-led, diverse, statewide Youth Data Council to improve the 2022 Student Health Survey, with support from community partners. The Youth Data Council will receive training; make recommendations to improve the survey process, content, messaging, and reporting (e.g., interactive data dashboard); and explore other data sources to provide context and actionable data.

- Coordinating with the Epidemiology and Laboratory Capacity (ELC) funded work examining the broader impact of COVID-19. For that project, OPHD has $1 million to fund BIPOC community researchers and public health leaders to lead the development of a state data system for tracking a broader set of measures (e.g., social determinants of health, mental health) in a culturally responsive way to be prepared for future pandemics and to inform the statewide health improvement plan. Such a system might use existing data sources, as well as include primary data collection.

Key Lessons Learned for Future Efforts

Working with community-based individuals, leaders and researchers on modernization taught us several lessons that are important for OPHD to considers as it moves forward in further engaging communities in modernization efforts:

[3] Pankaj V. et.al. "Participatory Analysis" 2011 accessed at https://www.innonet.org/media/innovation_network-participatory_analysis.pdf on 5/13/22

- Collaborate with community partners through all phases of the data life cycle. This is essential for improving the representativeness and validity of our data systems and reporting.
- Fund community partners directly and sufficiently for their time and expertise. This includes compensation for adult and youth partners.
- Build budgets and timelines to allow sufficient staff time and resources for relationship building and maintenance. Account for staff time for such activities as facilitating continuous communication among partners, organizing meetings, disseminating materials.
- Communicate regularly and be transparent with community partners (e.g., share datasets, budgets, internal decision-making processes, legal responsibilities).
- Share power with community partners at every possible step. (e.g., share datasets and budgets, cede project review for participant compensation to community research partners.)
- Be flexible, willing to recognize mistakes and change course.
- Avoid overburdening community partners.
- Build organization-wide commitment and infrastructure to support staff and programs to advance equity and undo structural racism reflected in data systems by collaborating with community partners through all phases of the data life cycle. Examples of needed infrastructure include:
    - Training, technical assistance, and ongoing coaching for staff (e.g., conflict resolution, power dynamics, data sovereignty and data justice, decolonizing research, and data, and facilitating difficult conversations) to support program and staff commitment to community engagement.
    - Agency-wide infrastructure for sustained partnerships with the communities to engage in all phases of the data life cycle from design through collection, analysis, and dissemination (e.g., funding, contracts, relationships).
    - Agency-wide assessment and coordination of community engagement activities around data (e.g., how many youth councils/advisory groups are there?).
    - Clear vision for the outcome of data equity efforts.
        - Articulation of the public health system's future state for data infrastructure that centers communities in all phases of the data lifecycle.
        - Universal understanding of public health data systems now, and where communities are asking public health data to go, with the understanding that some public health surveys will need to continue but have opportunities to improve.
    - Communication
        - Clear guidance on channels of communication within OPHD and with community partners.
        - Campaigns or structures to communicate and coordinate all OPHD community equity activities and to align with related OHA activities.

        - Plan to disseminate knowledge and activities, including roles of communities and OPHD, and strategies for clear, consistent, and effective messaging
    - IT support for software and platforms for collaborating across agencies and with communities. (e.g., Google Docs works for many partners but not state staff, not all parties can use Zoom before IT approval at Multnomah County level).

A Possible Model of Modernized Community Health Data System

In contemplating a model for a modernized community health data system, it is important to consider the system as not a group of individual surveys (e.g., BRFSS, SHS), but as a diverse and integrated set of data sources that inform one another, such as:

- Community-led data collection systems for specific-community data and reporting of those data. In this approach, communities identify priorities and play a lead role in design, data collection, analysis, and contextualization of results.

- State data systems for population-based statewide estimates and reporting that include a sustainable, coordinated system for authentic community engagement to ensure the communities are represented in the surveys and questions are culturally appropriate. For example, a state BRFSS could provide statewide estimates and improve on the CDC BRFSS methods based on community input, the BRFSS statewide pilot, and scientific research, and meeting community-led standards for reporting race, ethnicity, language, disability, sexual orientation, and gender identity (REALD & SOGI).

- Federally funded population-based surveys required for federal reporting (e.g., CDC BRFSS) and useful for supplementing local data systems (e.g., Household Pulse Survey). While OPHD does not have the power to change these systems, they can provide recommendations to our federal funders and their advisors.

- State/local complementary surveys (e.g., panel surveys, Facebook surveys) that are quick to implement and less expensive, but not necessarily representative of all adults in Oregon. Data from such surveys can aid in assessment and understanding of emerging issues.

Preventive Health & Health Services Block Grant

Oregon Public Health Advisory Board

May 19, 2022

OFFICE OF THE STATE PUBLIC HEALTH DIRECTOR
Public Health Division

Background

- Non-competitive grant through Centers for Disease Control and Prevention
- Issued to all states and territories to address state determined public health priorities
- Work plan tied to Healthy People 2030 Objectives
  - Oregon has typically used for infrastructure and tied to
    - PHI-16: Quality improvement
- Portion of funding allocation for rape prevention and victim services
  - Oregon Coalition Against Domestic Violence and Sexual Violence
    - PHI-40: Rape Prevention

Funding

Available funding for work plan implementation:

- October 2019 – September 2020: $1,033,083 available for work plan implementation
- October 2020 – September 2021: $1,046,084 available for work plan implementation
- October 2021 – September 2022: $1,016,267 available for work

- Annually $85,660 of allocation for rape prevention and victim services

Funding Supports

- Implementation of Healthier Together Oregon (State Health Improvement Plan)
- Training, consultation and technical assistance for LPHAs and Tribes
- Contract compliance reviews of LPHAs
- Partnership development and support
- Workforce development for public health system
- Primary sexual violence prevention

Role of Public Health Advisory Board

- Acts as block grant advisory board as required by federal code
- Must meet at least two times/year to exercise its duties as the block grant advisory board
- Provide input into the work plan prior to submission to CDC

Next Steps

- May or June – Public hearing
- May or June PHAB meeting – Overview of draft work plan, provide input
- June – Submit work plan to CDC

Questions or Comments

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Policy & Partnerships
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Preventive Health & Health Services Block Grant (Block Grant)
October 2021 – September 2022 Work Plan

Background

- Non-competitive grant issued to all states and territories to address state/territory determined public health priorities.
- The Public Health Advisory Board (PHAB) is designated as the Block Grant Advisory Committee which makes recommendations regarding the development and implementation of the work plan.
- Federal code states that a portion of the allocation (pre-determined) be used for rape prevention and victim services. This funding currently goes to the Oregon Coalition Against Domestic and Sexual Violence.
- Work plan must be tied to Healthy People 2030 objectives. Oregon has historically used the block grant to support infrastructure, including public health modernization. Healthy People 2030 objectives in the 2021-22 work plan:
    - Public health infrastructure (PHI-R07 Explore the use and impact of quality improvement as a means for increasing efficiency and/or effectiveness outcomes in health departments)
    - Sexual Violence (Reduce sexual violence)

Proposed October 2021-September 2022 Work Plan

- Support SHIP implementation – Healthier Together Oregon
  - Support reformed PartnerSHIP for implementation
  - Prioritized strategies list will inform OHA's policy and partnership development and investments
  - PartnerSHIP will make decisions about budget allocations moving forward
- Implement statewide public health modernization plan
  - Align OHA-PHD's processes, structures and systems with foundational programs and capabilities
  - Local public health investment and accountability metrics data collection and reporting
  - Workforce development to support impact objective
  - Tribal public health modernization assessment, planning and implementation
- Public Health Partnership Coordination, Training, Technical Assistance and Performance Management
  - Compliance Reviews
  - Contract administration and coordination for LPHAs and Tribes
  - Coordinate and support OHA-PHD work with Conference of Local Health Officials and Tribes
  - Technical assistance and training for LPHAs and Tribes
  - Tribal Consultation Policy Implementation

- The Oregon Coalition Against Domestic and Sexual Violence (OCADSV) Primary Prevention:
    - Fund one to three local, culturally specific organizations and/or Tribal sexual/domestic violence programs to build capacity for sexual violence primary prevention, implement sexual violence primary prevention programming.
    - Fund 0.8 FTE position to provide to funded and non-funded organizations online and in person (as able) sexual violence primary prevention technical assistance and training.

<u>Funding</u>

- Total PHHS Block Grant funding for October 2020 through September 2021 is $1,101,927 with $85,660 designated for sexual assault prevention and services.
- Funding by Health Objective:
    - Quality improvement – $1,016,267
    - Reduce sexual violence -- $85,660
    - Indirect costs (capped at 10%) -- $101,627
- Funding for OHA-PHD Staff:
    - FTE Strategic Partnerships Lead
    - 2.0 FTE Public Health Systems Consultant
    - FTE Strategic Initiatives Coordinator

Public Health Advisory Board

I. Authority

The Public Health Advisory Board (PHAB) is established by ORS 431.122 as a body that reports to the Oregon Health Policy Board (OHPB).
The purpose of the PHAB is to be the accountable body for governmental public health in Oregon. The role of the PHAB includes:

- A commitment to racial equity to drive public health outcomes.
- Alignment of public health priorities with available resources.
- Analysis and communication of what is at risk when there is a failure to invest resources in public health.
- Oversight for Oregon Health Authority, Public Health Division strategic initiatives, including the State Health Assessment and State Health Improvement Plan.
- Oversight for governmental public health strategic initiatives, including the implementation of public health modernization.
- Support for state and local public health accreditation.

This charter defines the objectives, responsibilities, and scope of activities of the PHAB. This charter will be reviewed no less than annually to ensure that the work of the PHAB is aligned with statute and the OHPB's strategic direction.

II. Deliverables

The duties of the PHAB as established by ORS 431.123 and the PHAB's corresponding objectives include:

PHAB Duties per ORS 431.123	**PHAB Objectives**
a. Make recommendations to the OHPB on the development of statewide public health policies and goals.	• Participate in and provide oversight for Oregon's State Health Assessment. • Regularly review state health data such as the State Health Profile to identify ongoing and emerging health issues. • Use best practices and an equity lens to provide recommendations to OHPB on policies needed to address priority health issues, including the social determinants of health.
b. Make recommendations to the OHPB on how other statewide priorities, such as the provision of early learning services and the delivery of health care services, affect and are affected by	• Regularly review early learning and health system transformation priorities. • Recommend how early learning goals, health system transformation priorities, and statewide public health goals can best be aligned.

statewide public health policies and goals.	• Identify opportunities for public health to support early learning and health system transformation priorities. • Identify opportunities for early learning and health system transformation to support statewide public health goals.
c. Make recommendations to the OHPB on the establishment of foundational capabilities and programs for governmental public health and other public health programs and activities.	• Participate in the administrative rulemaking process which will adopt the Public Health Modernization Manual. • Verify that the Public Health Modernization Manual is still current at least every two years. Recommend updates to OHPB as needed.
d. Make recommendations to the OHPB on the adoption and updating of the statewide public health modernization assessment.	• Review initial findings from the Public Health Modernization Assessment. (completed, 2016) • Review the final Public Health Modernization Assessment report and provide a recommendation to OHPB on the submission of the report to the legislature. (completed, 2016) • Make recommendations to the OHPB on processes/procedures for updating the statewide public health modernization assessment.
e. Make recommendations to the OHPB on the development of and any modification to the statewide public health modernization plan.	• Review the final Public Health Modernization Assessment report to assist in the development of the statewide public health modernization plan. (completed, 2016) • Using stakeholder feedback, draft timelines and processes to inform the statewide public health modernization plan. (completed, 2016) • Develop the public health modernization plan and provide a recommendation to the OHPB on the submission of the plan to the legislature. (completed, 2016) • Update the public health modernization plan as needed based on capacity.
f. Establish accountability metrics for the purpose of evaluating the progress of the Oregon Health Authority (OHA) and local public	•

health authorities in achieving statewide public health goals.	
g. Make recommendations to the Oregon Health Authority (OHA) and the OHPB on the development of and any modification to plans developed for the distribution of funds to local public health authorities, and the total cost to local public health authorities of implementing the foundational capabilities programs.	• Identify effective mechanisms for funding the foundational capabilities and programs. • Develop recommendations for how the OHA shall distribute funds to local public health authorities. • Review the Public Health Modernization Assessment report for estimates on the total cost for implementation of the foundational capabilities and programs. (completed, 2016) • Support stakeholders in identifying opportunities to provide the foundational capabilities and programs in an effective and efficient manner.
h. Make recommendations to the Oregon Health Policy Board on the incorporation and use of accountability metrics by the Oregon Health Authority to encourage the effective and equitable provision of public health services by local public health authorities.	• Develop and update public health accountability metrics and local public health authority process measures. • Provide recommendations for the application of accountability measures to incentive payments as a part of the local public health authority funding formula.
i. Make recommendations to the OHPB on the incorporation and use of incentives by the OHA to encourage the effective and equitable provision of public health services by local public health authorities.	• Develop models to incentivize investment in and equitable provision of public health services across Oregon. • Solicit stakeholder feedback on incentive models.
j. Provide support to local public health authorities in developing local plans to apply the foundational capabilities and implement the foundational programs for governmental public health.	• Provide support and oversight for the development of local public health modernization plans. • Provide oversight for Oregon's Robert Wood Johnson Foundation grant, which will support regional gatherings of health departments and their stakeholders to develop public health modernization plans.
k. Monitor the progress of local public health authorities in meeting statewide public health goals, including employing the	• Provide oversight and accountability for Oregon's State Health Improvement Plan by receiving quarterly updates and providing feedback for improvement.

foundational capabilities and implementing the foundational programs for governmental public health.	• Provide support and oversight for local public health authorities in the pursuit of statewide public health goals. • Provide oversight and accountability for the statewide public health modernization plan. • Develop outcome and accountability measures for state and local health departments.
l. Assist the OHA in seeking funding, including in the form of federal grants, for the implementation of public health modernization.	• Provide letters of support and guidance on federal grant applications. • Educate federal partners on public health modernization. • Explore and recommend ways to expand sustainable funding for state and local public health and community health.
m. Assist the OHA in coordinating and collaborating with federal agencies.	• Identify opportunities to coordinate and leverage federal opportunities. • Provide guidance on work with federal agencies.

Additionally, the Public Health Advisory Board is responsible for the following duties which are not specified in ORS 431.123:

Duties	**PHAB Objectives**
a. Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters.	• Provide guidance and recommendations on statewide public health issues and public health policy.
b. Act as formal advisory committee for Oregon's Preventive Health and Health Services Block Grant.	• Review and provide feedback on the Preventive Health and Health Services Block Grant work plan priorities.
c. Provide oversight for the implementation of health equity initiatives across the public health system by leading with racial equity.~~.~~	• Receive progress reports and provide feedback to the Public Health Division Health Equity Committee. • Participate in collaborative health equity efforts.

III. Dependencies

PHAB has established two subcommittees that will meet on an as-needed basis in order to comply with statutory requirements:

1. Accountability Metrics Subcommittee, which reviews existing public health data and metrics to propose biannual updates to public health accountability measures for consideration by the PHAB.
2. Incentives and Funding Subcommittee, which develops recommendations on the local public health authority funding formula for consideration by the PHAB.

PHAB shall operate under the guidance of the OHPB.

IV. Resources

The PHAB is staffed by the OHA, Public Health Division, as led by the Policy and Partnerships Director. Support will be provided by staff of the Public Health Division Policy and Partnerships Team and other leaders, staff, and consultants as requested or needed.

PHAB Executive Sponsor: Lillian Shirley, Public Health Director, Oregon Health Authority, Public Health Division
Staff Contact: Cara Biddlecom, Director of Policy and Partnerships, Oregon Health Authority, Public Health Division

PUBLIC HEALTH ADVISORY BOARD BYLAWS
~~**November 2017**~~**April 2020**

ARTICLE I
The Committee and its Members
The Public Health Advisory Board (PHAB) is established by ORS 431.122 for the purpose of advising and making recommendations to the Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB).

The PHAB consists of the following 14 members appointed by the Governor.

1. A state employee who has technical expertise in the field of public health;
2. A local public health administrator who supervises public health programs and public health activities in Benton, Clackamas, Deschutes, Jackson, Lane, Marion, Multnomah or Washington County;
3. A local public health administrator who supervises public health programs and public health activities in Coos, Douglas, Josephine, Klamath, Linn, Polk, Umatilla or Yamhill County;
4. A local public health administrator who supervises public health programs and public health activities in Clatsop, Columbia, Crook, Curry, Hood River, Jefferson, Lincoln, Tillamook, Union or Wasco County;
5. A local public health administrator who supervises public health programs and public health activities in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Wallowa or Wheeler County;
6. A local health officer who is not a local public health administrator;
7. An individual who represents the Conference of Local Health Officials created under ORS 431.330;
8. An individual who is a member of, or who represents, a federally recognized Indian tribe in this state;
9. An individual who represents coordinated care organizations;
10. An individual who represents health care organizations that are not coordinated care organizations;
11. An individual who represents individuals who provide public health services directly to the public;
12. An expert in the field of public health who has a background in academia;
13. An expert in population health metrics; and
14. An at-large member.

Governor-appointed members serve four-year terms and are eligible for reappointment. Members serve at the pleasure of the Governor.

PHAB shall also include the following nonvoting, ex-officio members:

1. The Oregon Public Health Director or the Public Health Director's designee;
2. If the Public Health Director is not the State Health Officer, the State Health Officer or a physician licensed under ORS chapter 677 acting as the State Health Officer's designee;
3. If the Public Health Director is the State Health Officer, a representative from the Oregon Health Authority who is familiar with public health programs and public health activities in this state; and
4. An OHPB liaison.

Members are entitled to travel reimbursement per OHA policy and are not entitled to any other compensation.

Members who wish to resign from the PHAB must submit a formal resignation letter. Members who no longer meet the statutory criteria of their position must resign from the PHAB upon notification of this change.

If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

ARTICLE II

Committee Officers and Duties

PHAB shall elect one~~two~~ of its voting members to serve as the chair ~~and vice chair~~. Elections shall take place ~~no later than January of~~within the first quarter of each even-numbered year and must follow the requirements for elections in Oregon's Public Meetings Law, ORS 192.610-192.690. Oregon's Public Meetings Law does not allow any election procedure other than a public vote made at a PHAB meeting where a quorum is present.

The chair ~~and vice chair~~ shall serve a two~~-~~-year term~~s~~. The chair ~~and vice chair are~~is eligible for one additional two-year reappointment.

If the chair were to vacate their position before their term is complete, ~~the vice chair shall become the new chair to~~a chair election will take place to complete the term. ~~If a vice chair is unable to serve, or if the vice chair position becomes vacant, then a new election is held to complete the remainder of the vacant term(s).~~

The PHAB chair shall facilitate meetings and guide the PHAB in achieving its deliverables. The PHAB chair shall represent the PHAB at meetings of the OHPB as directed by the OHPB designee. The PHAB chair may represent the PHAB at meetings with other stakeholders and partners, or designate another member to represent the PHAB as necessary.

Should the PHAB chair not be available to facilitate a meeting, the PHAB chair shall identify a voting member to facilitate the meeting in their place.

~~The PHAB vice chair shall facilitate meetings in the absence of the PHAB chair. The PHAB vice chair shall represent the PHAB at meetings of the OHPB as directed by the OHPB designee when the PHAB chair is unavailable. The PHAB vice chair may represent the PHAB at meetings with other stakeholders and partners when the PHAB chair is unavailable or under the guidance of the PHAB chair, or may designate another member to represent the PHAB as necessary.~~

Both the PHAB chair ~~and vice chair~~ shall work with OHA Public Health Division staff to develop agendas and materials for PHAB meetings. The PHAB chair shall solicit future agenda items from members at each meeting.

ARTICLE III

Committee Members and Duties

Members are expected to attend regular meetings and are encouraged to join at least one subcommittee.

Absences of more than 20% of scheduled meetings that do not involve family medical leave may be reviewed.

Date approved: ~~November 17, 2017~~

In order to maintain the transparency and integrity of the PHAB and its individual members, PHAB members must comply with the PHAB Conflict of Interest policy as articulated in this section, understanding that many voting members have a direct tie to governmental public health or other stakeholders in Oregon.

All PHAB members must complete a standard Conflict of Interest Disclosure Form. PHAB members shall make disclosures of conflicts at the time of appointment and at any time thereafter where there are material employment or other changes that would warrant updating the form.

PHAB members shall verbally disclose any actual or perceived conflicts of interest prior to voting on any motion that may present a conflict of interest. If a PHAB member has a potential conflict related to a particular motion, the member should state the conflict. PHAB will then make a decision as to whether the member shall participate in the vote or be recused.

If the PHAB has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member and afford an opportunity to explain the alleged failure to disclose. If the PHAB determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate corrective action including potential removal from the PHAB.

Members must complete required Boards and Commissions training as prescribed by the Governor's Office.

PHAB members shall utilize regular meetings to propose future agenda items.

ARTICLE IV
Committee and Subcommittee Meetings
PHAB meetings are called by the order of the chair or vice chair, if serving as the meeting facilitator. A majority of voting members constitutes a quorum for the conduct of business.

PHAB shall conduct its business in conformity with Oregon's Public Meetings Law, ORS 192.610-192.690. All meetings will be available by conference call, and when possible also by either webinar or by livestream.

The PHAB strives to conduct its business through discussion and consensus. The chair or vice chair may institute processes to enable further decision making and move the work of the group forward.

Voting members may propose and vote on motions. The chair and vice chair will use Robert's Rules of Order to facilitate all motions. Votes may be made by telephone. Votes cannot be made by proxy, by mail or by email prior to the meeting. All official PHAB action is recorded in meeting minutes.

Meeting materials and agendas will be distributed one week in advance by email by OHA staff and will be posted online at www.healthoregon.org/phab.

ARTICLE V
Amendments to the Bylaws
Bylaws will be reviewed annually. Any updates to the bylaws will be approved through a formal vote by PHAB members.

Date approved: ~~November 17, 2017~~