AGENDA

PUBLIC HEALTH ADVISORY BOARD

July 20, 2017
2:30-5:30 pm
Portland State Office Building, 800 NE Oregon St., Room 1A, Portland, OR 97232

Join by https://www.youtube.com/watch?v=QyDRFUS4JsU
Conference line: (877) 873-8017
Access code: 767068

Meeting objectives

- Approve June meeting minutes
- Hear update on AIMHI grant activities
- Adopt Guiding Principles for Public Health and Health Care Collaboration
- Discuss state health improvement plan priorities for oral health and suicide prevention
- Hear update from PHAB Incentives and Funding subcommittee
- Discuss public health modernization implementation in 2017-19

2:30-2:45 pm	**Welcome and updates** • Approve June 15 meeting minutes • State Health Assessment • Local public health authority transitions	Jeff Luck, PHAB Chair
2:45-3:10 pm	**AIMHI grant update** • Review findings from local modernization meetings • Receive update on the development of tools and resources • Discuss public opinion polling results on public health in Oregon	Kathleen Johnson, Coalition of Local Health Officials
3:10-4:00 pm	**State Health Improvement Plan** • Discuss oral health and suicide priority areas • Highlight progress, achievements and barriers	Cate Wilcox, Bruce Austin and Amy Umphlett, Oregon Health Authority Lisa Millet, Oregon Health Authority
4:00-4:15 pm	**Break**	
4:15-4:35 pm	**Guiding Principles for Public Health and Health Care Collaboration** • Hear about Columbia Pacific CCO's framework for collaborating with local public health • Discuss feedback gathered by PHAB members	Jeff Luck, PHAB Chair

	• Vote to adopt guiding principles	
4:35-4:45 pm	**Subcommittee updates** • Incentives and Funding subcommittee: share information and updates from July 11 meeting	Jeff Luck, PHAB Chair
4:45-5:15 pm	**Public health modernization implementation updates** • Provide legislative update • Discuss timeline for implementation	Cara Biddlecom, Oregon Health Authority
5:15-5:30 pm	**Public comment**	
5:30 pm	**Adjourn**	Jeff Luck, PHAB chair

Public Health Advisory Board (PHAB)
June 15, 2017
Draft Meeting Minutes

Attendance:

Board members present: David Bangsberg, Muriel DeLaVergne-Brown, Jeff Luck, Diane Hoover, Safina Koreishi, Rebecca Pawlak, Akiko Saito, Eli Schwarz, Lillian Shirley, Teri Thalhofer, and Jennifer Vines

Oregon Health Authority (OHA) staff: Isabelle Barbour, Cara Biddlecom, Sara Beaudrault, Emily Elman, Christy Hudson, Helene Rimberg, and Angela Rowland

Members of the public: Kelly McDonald

Approval of Minutes

A quorum was present.

- Page 2 change $5 to $5M
- Page 7 the accountability metrics agenda item at the Metrics and Scoring Committee meeting will be moved to August due to a conflict

The Board unanimously voted to approve the edited May 18, 2017 minutes.

Welcome and updates

-Jeff Luck, PHAB chair

- David Bangsberg, Dean of OHSU-PSU School of Public Health has been appointed as the Oregon Health Policy Board liaison to the PHAB.
- The OHA budget passed out of the joint Ways and Means Human Services Subcommittee. There is a proposed $5M allocated for public health modernization for the 2017-2019 biennium.
- HB2310 should be scheduled for a hearing in the next few weeks.
- The proposed Public Health Rules Advisory Committee will consist of two workgroups, one for the delegation of local public health authority and subcontracting, and the second workgroup for the local public health funding formula, accountability metrics, and incentives. The workgroup meetings will be held July-August, the committee meetings will be August-September, and the public comment period will be October-November. The rules will go into effect January 2018. PHAB members can participate in this process since they offer valuable expertise.
- Eli inquired on the timeline for the PHAB Accountability Metrics Subcommittee. The next step for the subcommittee is to determine process measures that align with the outcome measures to be selected today, and to identify performance targets.

Subcommittee updates

Incentives and Funding Subcommittee
– *Akiko Saito*

Akiko provided an overview of the Incentives and Funding Subcommittee meeting held on June 13th. The subcommittee made a decision to continue with the previously proposed funding formula. If the legislature awards under $5M annually, funds will be allocated to pilot projects. If funds are above $10M annually it will be fully allocated to all local public health authorities (LPHA) through the funding formula.

The subcommittee suggests moving forward with regional demonstration projects so that all county size bands can participate in modernizing the public health system. The funding focus area was decided with guidance from the Joint Leadership Team (JLT) to specifically look at communicable disease control. There was a discussion about a scoring matrix for the projects that include health equity and community partnerships to ensure other foundational capabilities are utilized as a part of the project. Another recommendation was to build a learning environment by providing technical assistance in support of pilot projects including regularly scheduled conference calls. There was a discussion about ensuring that local public health authorities are supported with technical assistance for grant writing to eliminate any unfair advantage. Additional points could be awarded for creative partnerships.

Accountability Metrics Subcommittee
-*Jeff Luck*

The May 31st Accountability Metrics Subcommittee meeting discussed the stakeholder survey. The survey gathered input from a number of stakeholders by prioritizing modernization goals in a practical way. The subcommittee identified a recommended list of accountability measures for public health that will be discussed as a part of the following agenda item. The measures should allow an opportunity to collect data from a significant part of the state to show the legislature progress.

Public health accountability metrics

-*Myde Boles, Oregon Health Authority*

Myde presented the findings from the stakeholder survey and the recommendations for accountability metrics from the Accountability Metrics Subcommittee. She explained the background for the measure selection, which began with a list of outcome metrics proposed by PHD managers for each foundational program, was followed by webinars with the Conference of Local Health Officials (CLHO) and the Conference of Local Environmental Health Supervisors (CLEHS). Following these sessions, PHD launched a public stakeholder survey to obtain additional feedback on the initial list of measures. The survey engaged 201 respondents,

including local public health, coordinated care organizations, PHAB, etc. Twenty-four accountability metrics were included in the survey.

The selection criteria used for each measure includes how it promotes health equity, how it is respectful of local priorities, has transformative potential, its consistent with state and national quality measures, and how feasible it is to measure.

Communicable disease control

The subcommittee recommended *two-year vaccination rate* as the first choice measure and *gonorrhea rate* as the second choice. Although vaccination rates can be out of public health control it does align with its priorities.

David asked about the feasibility of Hepatitis C screening based on laboratory data. Myde said that screening is not a local public health activity and that prevention interventions, such as needle exchange programs, are emerging but not readily available in all areas of the state. Muriel stated the Hepatitis C screening is in the primary care wheelhouse but is an important issue. Lillian reaffirmed the purpose of these measures are for accountability for the entire state. The collection of Hepatitis C surveillance data is in the purview. David mentioned Indiana provides a good example with its statewide needle exchange program. These are important preventable diseases with a plethora of data available. It is an example of a public health emergency.

Safina understood that Hepatitis C wasn't chosen due to the lack of current capacity. Three years from now the infrastructure could be developed and it could be selected as an emerging issue that aligns with modernization. We are looking at capabilities and need to determine the possibility to be accountable at the state and local level for outbreaks.

Muriel commented that drug and alcohol prevention in primary care is integrated into public health work. Her county is looking at needle exchange as a public health responsibility. Jeff mentioned the goal is to identify measures for which health departments can make changes.

Eli anticipated this discussion from the subcommittee. The Metrics and Scoring Committee is in the same situation and has a desire to monitor many measures. Eli suggests that PHAB use the additional measures for monitoring to keep it them close in our minds. If conditions allow, then PHAB can adopt them as metrics rather than discard the ones that aren't selected this year.

Salmonella infections was chosen as a subsequent measure that is not under public health control but the subcommittee instead recommended *secondary Salmonella infections*.

Prevention and health promotion
Adults who smoke cigarettes was ranked as the first choice but the subcommittee preferred a *youth tobacco measure* including electronic cigarettes. There was concern about using a measure from the Oregon Health Teens (OHT) survey since not all Oregon school districts participate.

Opioid mortality ranked second since it is transformative, but the number of cases is small at the local level so the data must be combined over a few years. The subcommittee subsequently ranked *youth who smoke cigarettes, youth use of vaping/e-cigarettes,* and s*uicide deaths*. The subcommittee recommended removing *adult obesity* and *binge drinking* measures.

David inquired on the subcommittee's discussion between *opioid use* and *suicide*. Teri commented that LPHAs are not getting the funding to work on suicide prevention as it is typically allocated to mental health partners. Lillian said that local public health participates at the local level in suicide coalitions. Oregon is participating in the Zero Suicide initiative through community based organizations and other sectors.

Teri asked who at the state level is responsible for suicide prevention. Lillian stated that the state injury and violence prevention program provides the data and convenes suicide prevention workgroups. The grant money flows through the OHA Health Systems Division for prevention and behavioral health coalitions. Akiko remarked this is a good opportunity to bring in creative partnerships. Muriel is partnering with a hospital in her county to work on suicide prevention.

Rebecca questioned why adult obesity wasn't selected. Myde said that specific measure wasn't ranked highly.

Eli recommends the Board review the PHAB guiding principles for health care and public health collaboration. The practical implications of these measures could be discussed in collaboration with health care partners.

Environmental Health
The *active transportation* measure was ranked first by the subcommittees since it reflect land use planning and transportation planning work. This measures the percent of people who walk, ride a bike, or ride a bus to get to do things. Jeff says transportation is not just an urban issue. Teri commented how Wasco County is suffering from transportation issues due to poor sidewalks.

The *drinking water standards* measure was ranked second. It is more closely tied to health outcomes and is a priority for CLEHS. Lillian stated that Oregon has bypassed national standards so it can be hard to improve. She mentioned that the Public Health Division Strategic

Plan also includes targets for drinking water standards but they still need a policy change as OHA cannot test or certify private wells.

Access to clinical preventative services
The *effective contraceptive use* measure is recommended as the first choice since it aligns with the CCO metric and its priorities. Consider *dental visits for children 0-5*, *dental sealants in schools*, and *partner expedited therapy*. If communicable disease control uses the gonorrhea measure, *partner expedited therapy* isn't needed here.

Public health accountability metrics health equity review
Cara provided a summary of how the accountability metrics aligns in the PHAB health equity policy.

- Demonstrates progress
- The metrics require the promotion of health equity per the measure selection criteria
- The metrics do not address individuals but help to understand disparities
- The metrics don't address one area of health inequity over another
- The metrics don't directly address an equitable distribution of power
- The community was engaged through a stakeholder survey with cross-sector partners, transportation, early learning, CCOs, etc.

Eli mentioned there is an overlap with CCO metrics and that a race and ethnicity breakdown should be included. Teri mentioned that CCO data is collected through Medicaid clients and the accountability metrics will be used for the full state population, not just Medicaid.

Eli asked if the Board can work with CDC on small area analysis. Lillian mentioned the 50 largest cities data as a resource, which contains a lot of variables. This is a small piece of information to drive changes to the system and how it is funded and accountable. The challenge is in the analysis. Jeff mentioned there is variation across the state so we will want to see the numbers.

The Board adopted the prioritized accountability measures with a unanimous vote for:

Communicable disease control

1. *Two-year old vaccination rate*
2. *Gonorrhea rate*

Prevention and health promotion

1. *Adults who smoke cigarettes*
2. *Opioid mortality*

Environmental Public Health

1. *Active transportation*

2. *Drinking water measures*

Access to clinical preventative services

1. *Effective contraceptive use*
2. *Dental visits, children 0-5*

Action Item: Jeff will send the approved accountability metrics to the Health Plan Quality Metrics Committee to encourage the use of these measures.

Lillian mentioned an example of using a health equity lens in the case of colorectal cancer. Oregon's public health system has targeted African American men and mortality has decreased due to increased targeted screening. It is compelling to tell this clinical story with a health equity lens through a public health perspective.

Modernization Implementation Planning

-Cara Biddlecom, Oregon Health Authority

Cara provided the Incentives and Funding Subcommittee recommendations for funding regional projects, which include encouraging cross-jurisdictional sharing, targeting communicable disease control, and providing technical assistance. The CLHO-PHD Joint Leadership Team (JLT) reviewed the deliverables in the Public Health Modernization manual to provide recommendations for prioritizing capabilities and programs in specific order:

1. Communicable disease control
2. Health equity and cultural responsiveness
3. Leadership and organizational competencies
4. Assessment and epidemiology (primarily focused on state and regional public health work)
5. Environmental health
6. Emergency preparedness and response

Eli recommended using an adopted communicable disease accountability measure to hone in on communicable disease control. Cara stated that communicable disease risk is different within different areas of the state. Also, the soon to-be-determined state performance measures could help in the next biennium. Teri stated a measure should be chosen that could improve outcomes and is attainable. Muriel mentioned the challenge of reporting communicable diseases and working with partners to screen patients.

Rebecca stated that initial funding could be helpful to get modernization started. She says that Memoranda of Understanding (MOUs) and cross-jurisdictional sharing would be great examples for the legislature to see.

Diane stated that the leadership and organizational competencies work could be cross-jurisdictional sharing agreements. Applications shouldn't use the "jargon of the day" but instead provide specific outcomes.

Akiko stated that it isn't a county project but instead a regional project. A scoring matrix could award more points for health equity and cultural competency work. It is important to get that type of information at the beginning.

Teri stated that all LPHAs can be ask to be involved. This impacts the leadership of every public health administrator. The data on where the disparities are will show where LPHAs need to work together.

Eli stated that a considerable amount of time needs to be allocated to this work. He questions if two years is a reasonable timeline. Any funding allocated this year would be for the two-year biennium only.

Cara commented that it is difficult to have a concrete conversation with information we currently don't have. The funding mechanism should be made available to local jurisdictions as soon as possible after funding is determined by the legislature. She also mentioned the thought that some jurisdictions will have difficulties in hiring the right positions in a timely manner due to workforce shortages.

Action Item: Jeff requested a timeline of the necessary steps to distribute funds by January 2018 at the July PHAB meeting.

David summarized that there isn't enough money to spread across the state to develop competitive requests for proposals for communicable disease control, but proposals could be evaluated based on building leadership capacity and how that capacity could be related to environmental health or emergency preparedness. Teri stated that CLHO is not in favor of the competitive process but rather a collaborative process. The history is that the counties with the most resources tend to be awarded the competitive grants. David asked how to push an idea forward when more than one idea is on the table. Teri stated through consensus. Since the funding is limited it needs to be provided for more than one jurisdiction.

Jeff stated that the criteria must make it clear how this is different than ever done before to set the bar.

Eli stated the need to show legislators that the outcomes are being met. Rebecca stated that this needs to be a new way for doing business and need a collaborative way to push the state forward with limited resources. Teri identified the need to move the system forward. Jeff stated that the direction that PHAB and CLHO are moving are aligning. Cara stated there will be a need to develop infrastructure.

Eli asked if the Incentives and Funding Subcommittee could provide a different formula for less than $5M. Jeff mentioned that it wouldn't provide adequate resources to hone in on even a narrow set of capabilities.

Jen mentioned absence of the large county representative voice. Lillian stated that the existing Board members should fill in the holes to provide a large county voice. Teri stated that burden of disease has been a part of the considerations. For example, gonorrhea is a large problem in Multnomah County, but the Board is looking at the burden of disease need and not the specific county needs.

Public Comment Period

No public testimony was provided.

Closing

The meeting was adjourned.

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

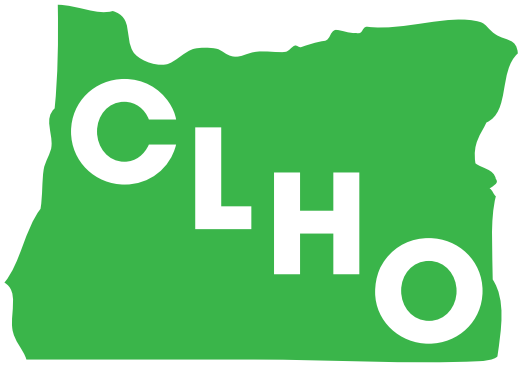
July 20, 2017
2:30pm – 5:30 p.m.
Portland State Office Building
800 NE Oregon St., Room 1A
Portland, OR 97232

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Angela Rowland at (971) 673-2296 or angela.d.rowland@state.or.us. For more information and meeting recordings please visit the website: healthoregon.gov/phab

ALIGNING INNOVATIVE MODELS for HEALTH IMPROVEMENT (AIMHI) UPDATES

Public Health Advisory Board
July 20, 2017

Presented By:
Kathleen Johnson
Coalition of Local Health Officials



JUNE 2017

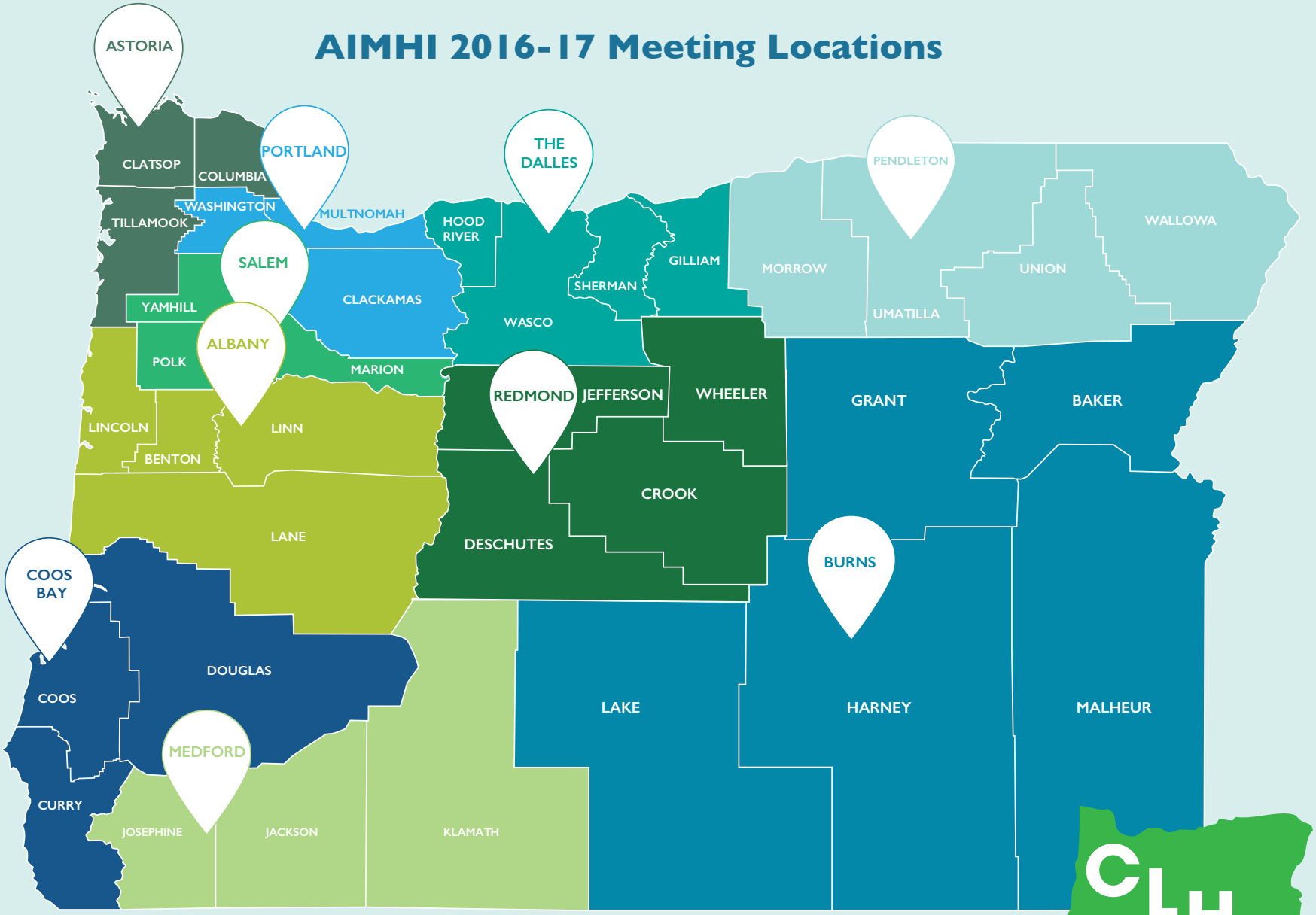
PUBLIC HEALTH MODERNIZATION

STATEWIDE REPORT

This report was prepared by the Rede Group in June 2017.

REDE GROUP
RESEARCH | ENGAGEMENT | STRATEGY
www.RedeGroup.co

AIMHI 2016-17 Meeting Locations



Coalition of Local Health Officials

Types of AIMHI Meeting Attendees by Sector

Types of Attendees by Sector	Attendance
Local Public Health Department Staff	172
Community Based Organization	56
Local Public Health Department Administrators	33*
CCO's	33
State Public Health Department Staff	22*
Local Government Elected Officials	28
Healthcare Providers	28
Other	24
Higher Education	19
Primary Education	9
Tribal Government	8
Local Public Health Advisory Board	6

*People who attended multiple AIMHI meetings were counted once.

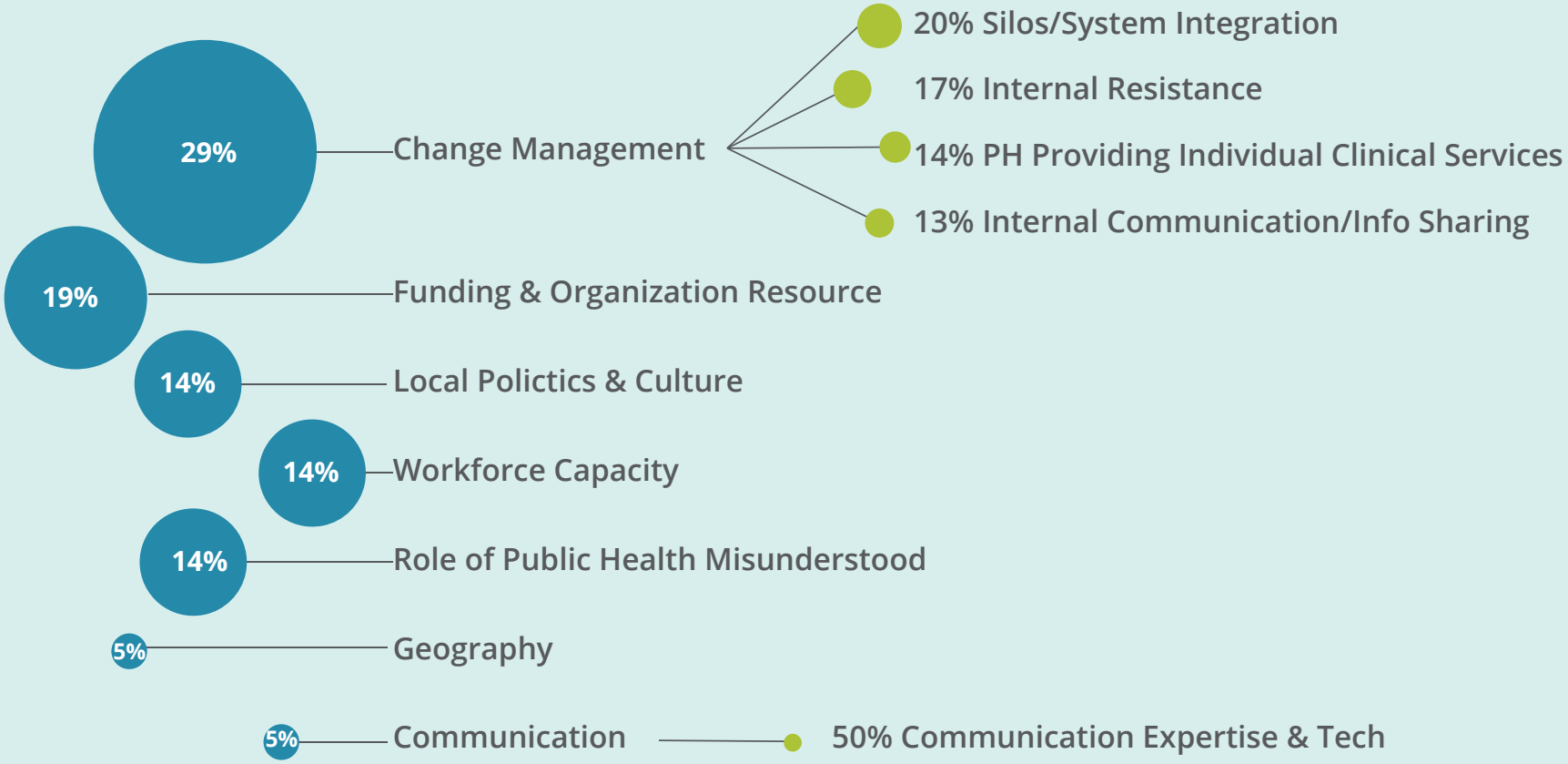
Coalition of Local Health Officials

AIMHI Meeting Information

Location	Date	Attendance
Burns, OR	10/21/2016	29
Redmond, OR	11/01/2016	61
The Dalles, OR	11/03/2016 & 11/21/2016	44
Salem, OR	1/20/2017	47
Albany, OR	1/25/2017	68
Medford, OR	1/27/2017	22
Coos Bay, OR	1/30/2017	30
Portland, OR	2/06/2017	84
Astoria, OR	2/10/2017	50
Pendleton, OR	2/17/2017	18
Total		453

Coalition of Local Health Officials

Challenges to Implementing Modernization



*The strength of this theme may be artificially low as attendees were encouraged not to focus solely on funding and resources.

Coalition of Local Health Officials

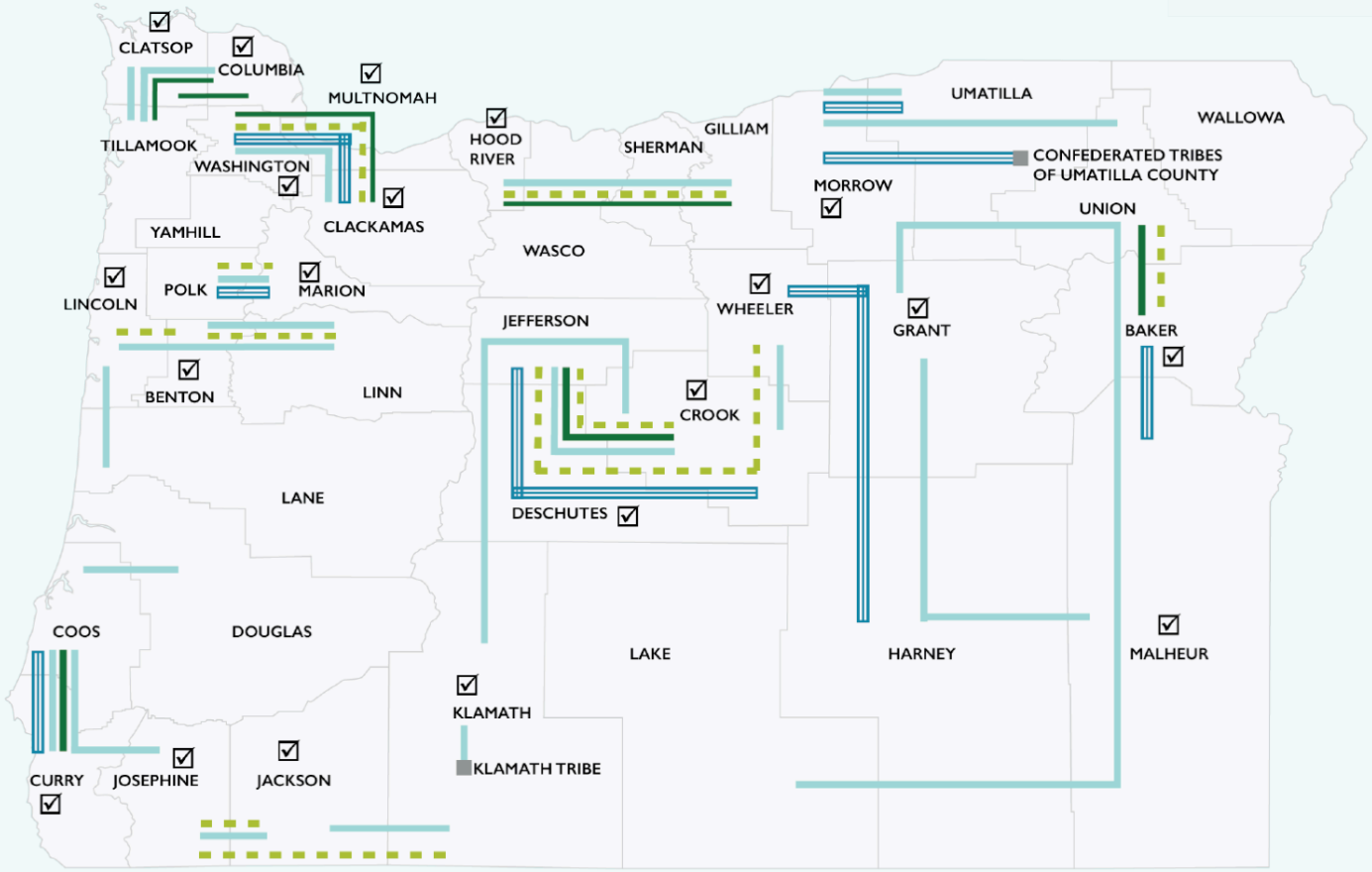
Opportunities in Cross-Jurisdictional Sharing

CLHO
Coalition of Local Health Officials

DRAFT

*At least one county in the depicted arrangement has responded to the excel spreadsheet and confirmed that the CJS is happening. If there is not a check mark in your county then we have not received an updated CJS spreadsheet from you.

Cross-Jurisdictional Sharing: Foundational Public Health Programs March 2017



Overview

78 Total Sharing Arrangements

29 Counties/tribes Engaged

11 Environmental Public Health Arrangements

41 Prevention & Health Promotion Arrangements

14 Communicable Disease Control Arrangements

12 Access To Clinical Preventive Services Arrangements

Description:

This map depicts all confirmed cases of cross-jurisdictional sharing occurring between local health departments in the state of Oregon. This map does not represent every instance of CJS happening in the state, instead it puts a single line to represent all sharing arrangements which fall into a single foundational program category. Therefore, there will be more numbers in the overview than there are lines on the map. For example, if Polk and Marion have two sharing arrangements that fall under Environment Public Health, both arrangements will be accounted for in the overview but there will only be one line for that foundational program on the map.

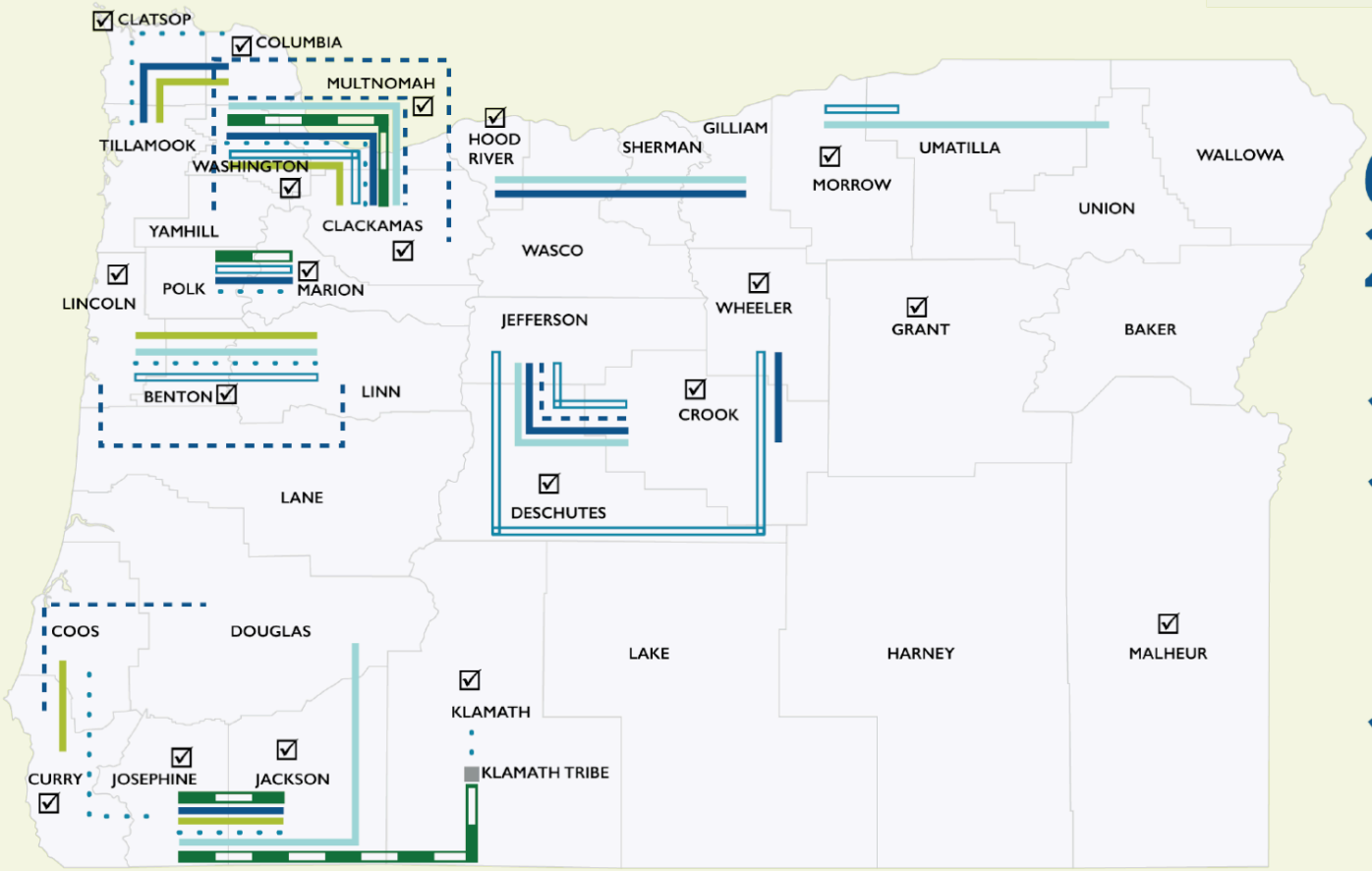
Legend

- Environmental Public Health
- Prevention & Health Promotion
- Communicable Disease Control
- Access to Clinical Preventive Services

DRAFT

*At least one county in the depicted arrangement has responded to the excel spreadsheet and confirmed that the CJS is happening. If there is not a check mark in your county then we have not received an updated CJS spreadsheet from you.

Cross-Jurisdictional Sharing: Foundational Public Health Capabilities March 2017



Overview

64 Total sharing Arrangements

29 Counties/Tribes Engaged

4 Community Partnership Arrangements

13 Leadership & Organizational Competencies Arrangements

13 Policy & Planning Arrangements

8 Assessment & Epidemiology Arrangements

7 Emergency Preparedness & Response Arrangements

16 Health Equity & Cultural Responsiveness Arrangements

3 Communications Arrangements

Description:

This map depicts all confirmed cases of cross-jurisdictional sharing occurring between local health departments in the state of Oregon. This map does not represent every instance of CJS happening in the state, instead it puts a single line to represent all sharing arrangements which fall into a single foundational capability category. Therefore, there will be more numbers in the overview than there are lines on the map. For example, if Polk and Marion have two sharing arrangements that fall under Communications, both arrangements will be accounted for in the overview but there will only be one line for that foundational capability on the map.

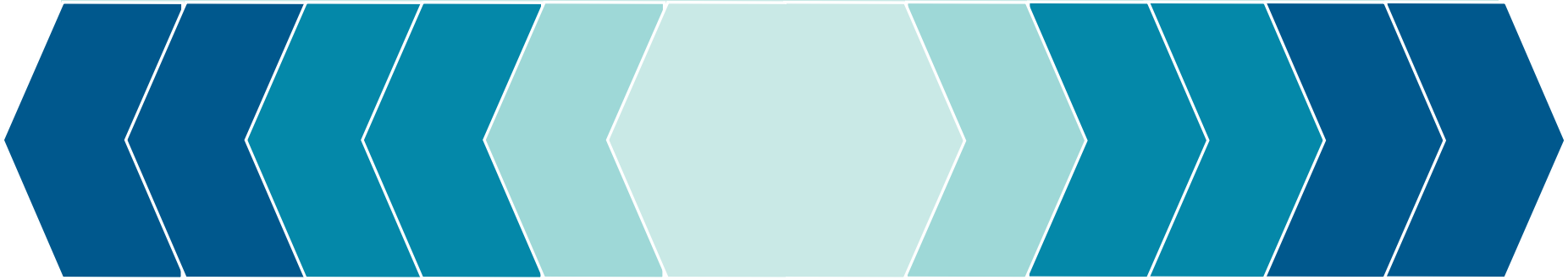
Legend

- Community Partnerships
- Leadership & Organizational Competencies
- Policy & Planning
- Assessment & Epidemiology
- Emergency Preparedness & Response
- Health Equity & Cultural Responsiveness
- Communications

Cross-Jurisdictional Sharing Spectrum

DRAFT

Informal & Customary Arrangements	Service-Related Arrangements	Shared Functions with Joint Oversight	Regionalization
48	29	28	1
Instances in OregonI	nstances in OregonI	nstances in OregonI	nstance in Oregon
SPArC tobacco prevention grant (Benton, Lincolon, Lane) Columbia provides medications to a Clatsop worksite that is closer to Columbia (Columbia, Clatsop) Health alerts during outbreaks (Marion, Polk)	Malheur Environmental Health Specialists contractionally shared (Malheur, Baker) Grant County provides Environmental Inspections (Wheeler, Harney, Grant) Formalized Health Officer Sharing (Linn, Benton)	Regional Health Assessment, all counties pay equally for staffing and support (Linn, Benton, Lincoln) Tri-County Mental Health Promotion (Crook, Deschutes, Jefferson) Healthcare Coalition of Southern Oregon (Jackson, Josephine, Douglas)	

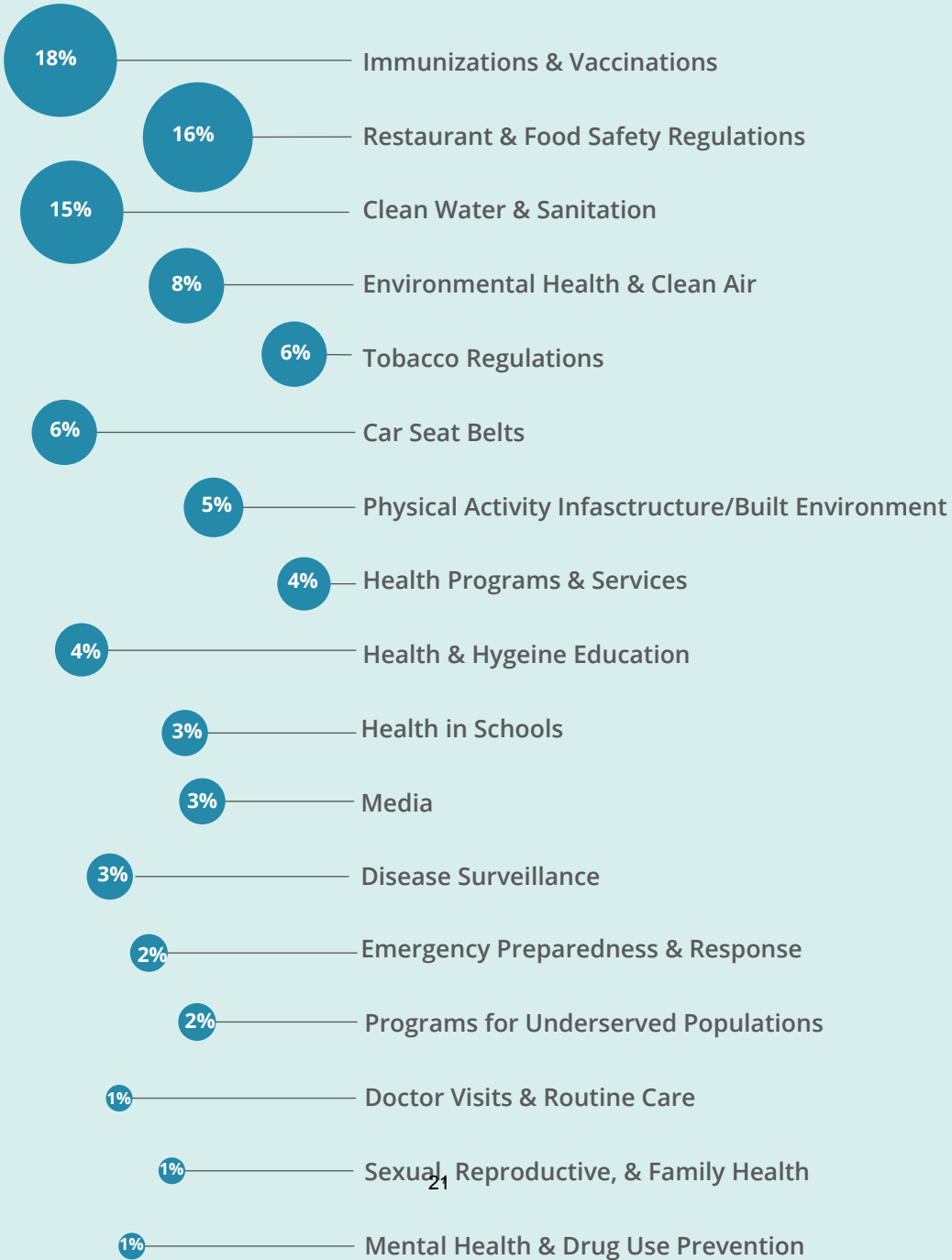


Looser Integration

Tighter Integration

Source: Center for Sharing Public Health Services. Adapted from: Kaufman N. (2010) which was adapted from: Ruggini,

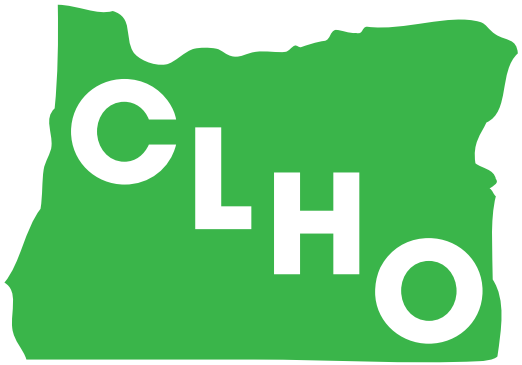
Public Health Question Data



CLHO
Coalition of Local Health Officials

PUBLIC HEALTH NATIONAL CENTER for INNOVATION (PHNCI)

OREGON POLLING DATA



Coalition of Local Health Officials

Methodology

Public Opinion Strategies conducted a statewide telephone survey in Oregon among N=500 registered voters from May 1-4, 2017.

The margin of error on a sample of this size is ±4.4%.

The survey was designed to explore:

- Voters' perceptions about public health departments
- How confident voters are in the effectiveness of public health departments
- The perceived value of different services provided by public health departments

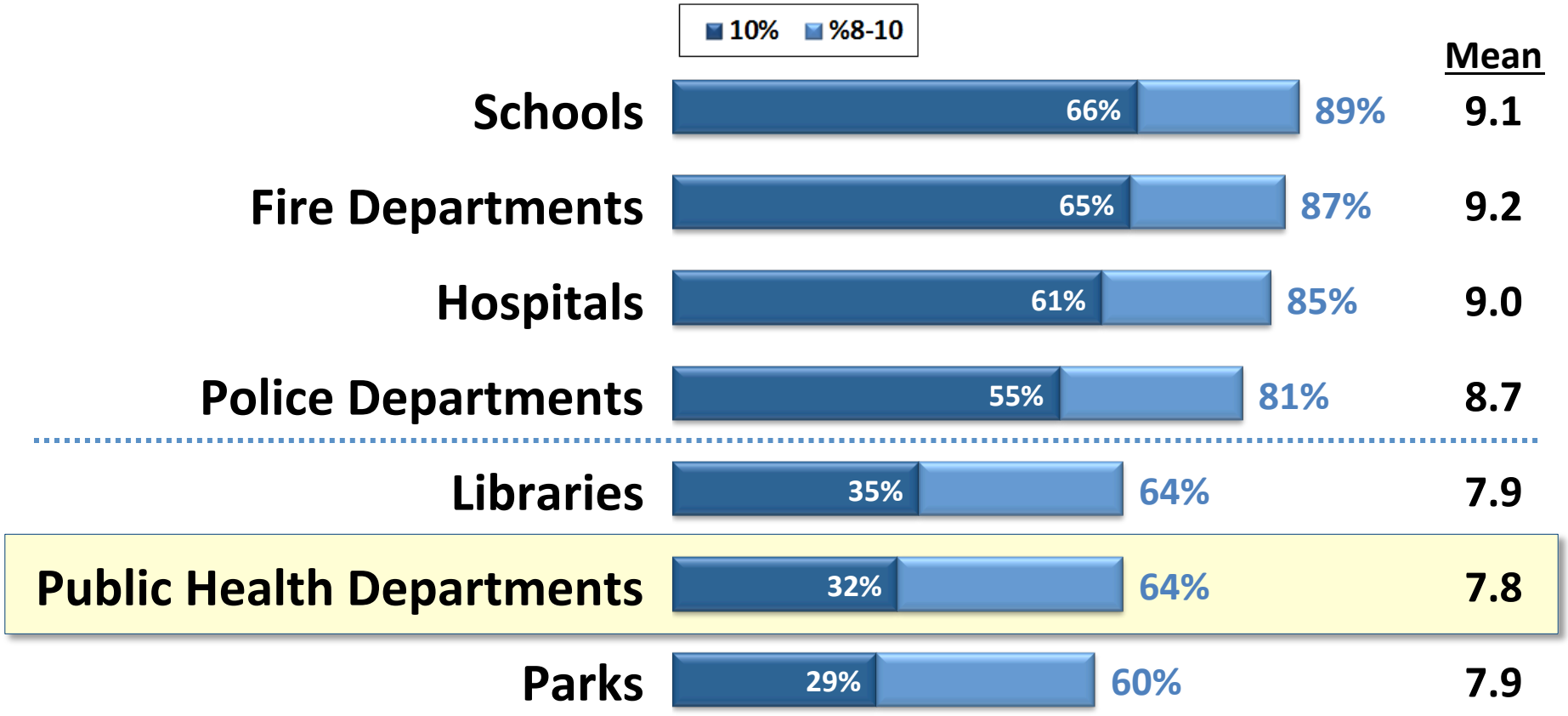
Demographic Profile

	Registered Voter/ Census Population Statistics	Survey*
Male	**49%**	**48%**
Female	**51%**	**52%**
Ages 18-44	**44%**	**41%**
Ages 45+	**56%**	**59%**
White	**88%**	**87%**
Total Non-White	**12%**	**11%**

* In the survey respondents are able to "decline to answer" when asked a question therefore ethnicity does not add to 100%.

All of the organizations we tested are viewed as having an important role in creating a healthy community. Public health departments rank in the second tier of organizations we tested.

Various Organizations Importance In Creating A Healthy Community Ranked by % 10



I am going to read you a list of some different types of organizations or things that can help create a healthy community. For each, please tell me how important of a role you think it has in creating a healthy community for you and your family? Please use a one to ten scale, with one meaning it is NOT AT ALL important in creating a healthy community and ten meaning it is VERY important in creating a healthy community.

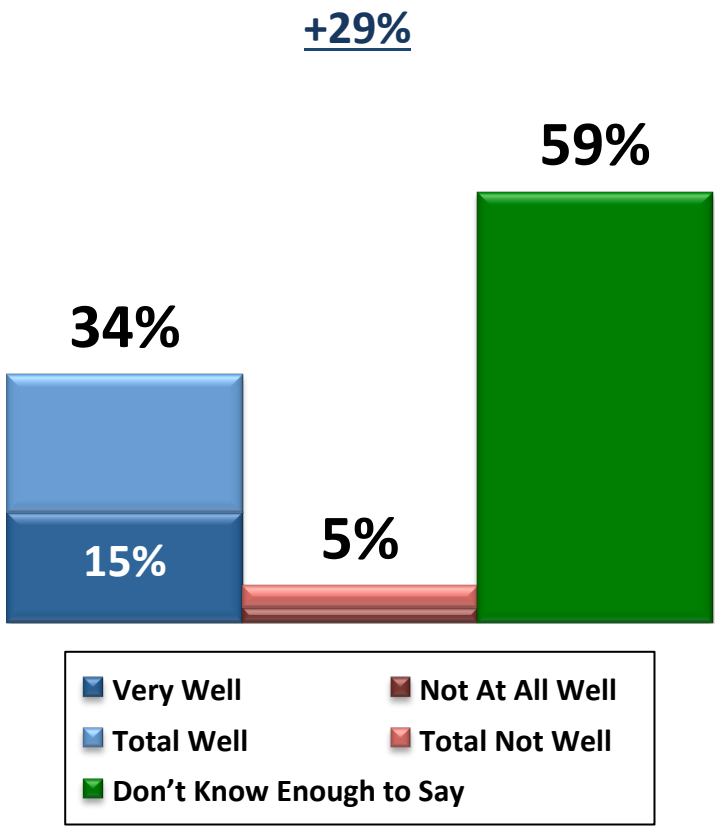
If a friend or neighbor asked you to explain what your local public health department does, what might you tell them?

- Track and collect data about diseases/outbreaks
- Provide immunizations/vaccinations
- Inform and educate the community about health issues
- Provide medical/health care for those in the community who are low income or can't afford health care
- Provide mental health services
- Provide basic medical care to all members of the community
- Test water quality and safety
- Inspect restaurants, food quality, and enforce health code regulations
- Regulate doctors and hospitals
- Encourage healthy lifestyles and physical wellness in the community
- Ensure a clean/healthy environment
- STD testing and treatment
- Provide access to birth control/ contraceptives/family planning
- Set health policy in the state

Coalition of Local Health Officials

A majority of voters say they do not know enough to say one way or the other how well their local public health department is doing its job.

Assessment of Public Health Department Job Performance



Top Sub-groups: Total Well (34%)	
Yes, HH Works in Health Care	51%
Moms	47%
Upper Economic Class/Well-To-Do	45%
Public Health Depts. Importance - (%10)	44%
Independent Women	41%
Eugene Media Market	40%
Democratic Men	40%
Men College +	40%
Ages 65+	39%
Women Ages 50+	39%
College +	39%
Public Health Depts. Importance - (%8-10)	39%
Parents	39%

Top Sub-groups: Don't Know (59%)	
Independent Men	68%
Men Less Than College	65%
Middle Class	65%
Women Ages 18-49	64%
Republicans	64%
Public Health Depts. Importance - (%1-7)	64%

How well do you think your local public health department does its job? Does your local public health department do its job very well, somewhat well, not too well, or not at all well or do you not know enough to say one way or the other?

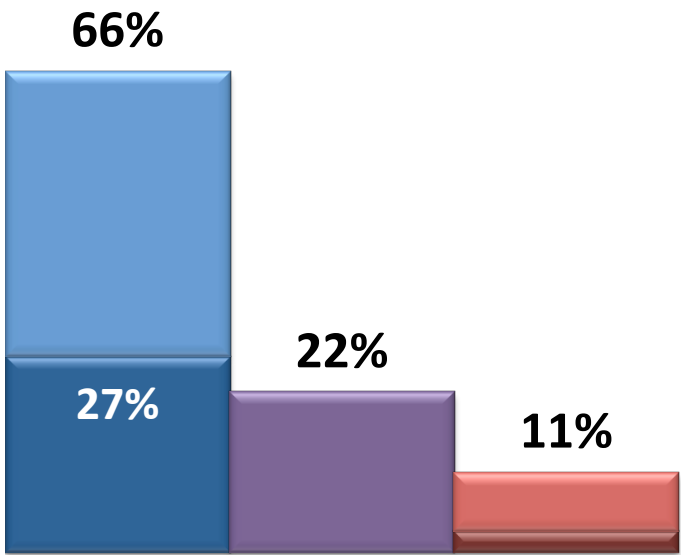
The most important services were viewed as:

Public Health Department Services Personal Importance Ranked by % 10	% 10	% 8-10	Mean
Support women's and children's health, such as pre-natal care and appropriate nutritional assistance.	**50%**	**75%**	**8.4**
Help stop the spread of communicable diseases, such as Meningitis, Salmonella, and the flu.	**47%**	**78%**	**8.5**
Bring others in government, like police and fire departments and state authorities, together to respond to public health emergencies, such as those resulting from natural and human caused disasters, and rebuild afterward.	**47%**	**74%**	**8.4**

For each item, please tell me how important it is to you personally that your local health department does this in your community. Using a scale of one to ten, with one meaning it is NOT AT ALL important to you and ten meaning it is VERY important to you that your local public health department does this in your community.

Two-thirds of voters believe ensuring that every community in Oregon receives all of these public health services should be a high priority for the state's government.

Priority Level State Government Ensure Every Community Receives ALL Services



Top Sub-groups: Very High (27%)		Total High (66%)
Public Health Depts. Importance - (%10)	48%	85%
Democratic Women	40%	80%
Moms	39%	80%
Democrats	37%	80%
Women College +	36%	74%
Public Health Depts. Importance - (%8-10)	36%	81%
Women Ages 18-49	34%	74%
Eugene Media Market	34%	72%
Parents	33%	70%
Democratic Men	33%	79%
Ages 65+	33%	66%
Rural Residents	32%	71%
Middle Economic Class or Higher Women	32%	70%

Thinking again about ALL of these services that your local public health department could do in your community that we just discussed, how high of a priority do you think it is for the state government to ensure that every community in Oregon receive ALL of these public health services?

The Bottom Line

- Of the nine local public health department services we tested, voters view the most important services as:
  - Supporting women's and children's health, such as pre-natal care and appropriate nutritional assistance.
  - Helping to stop the spread of communicable diseases.
  - Bringing others in government, like police and fire departments and state authorities, together to respond to public health emergencies, such as those resulting from natural and human caused disasters, and rebuild afterward.

The least important service was working with partners to help create strong local policies that support health, such as smoke-free workplace laws.

Coalition of Local Health Officials

The Bottom Line

- Two-thirds of voters believe ensuring that every community in Oregon receives all nine of the public health services we tested should be a high priority for the state's government.

- When asked to choose, voters are divided about whether it is more important for their local public health department to provide direct services to individuals, children, and families that improve their health and safety or to track and prevent threats to public health and safety in Oregon.

Coalition of Local Health Officials

NEXT STEPS in AIMHI

- The Rede Group and CLHO with the help of LPHAs have developed a concept/framework for the AIMHI Roadmap
- The Rede Group will be convening a "user panel" to assist in finalizing the Roadmap
- The Roadmap will be debuted at the CLHO Retreat in September
- The Rede Group and CLHO are working to develop a TA plan to support LHDs
- The PHD, CLHO and LPHAs are working together on communications outlined in a shared communications plan

Coalition of Local Health Officials

Suicide & Oral Health

Prevent deaths from suicide

Measure	Baseline	Current Data	2020 Target	Data Source
Rate of suicide	18.7	17.7	16.0 per 100,000	CDC WISQRS
Suicide attempts among 8th graders	7.9%	8.2%	7%	Oregon Healthy Teens Survey
Emergency department visits for suicide attempts	14,423	15,132	16,000	ESSENCE

Successes

- All CCOs met their incentive benchmark for depression screening & follow-up.
- Oregon bill passed related to suicide training for health professionals
- Established data dashboard
- Expansion of Zero Suicide Initiative

Suicide in Oregon

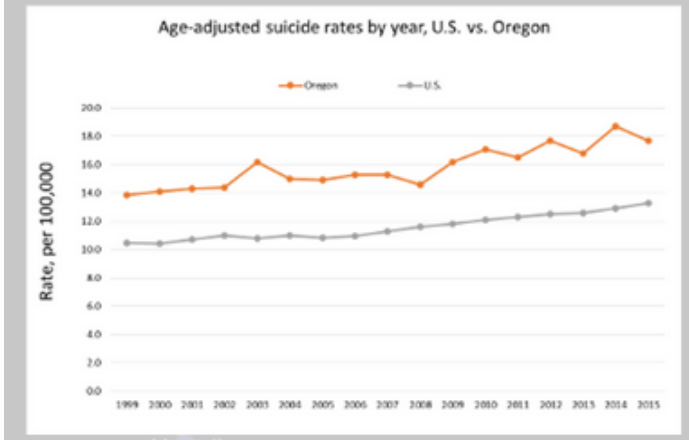
OHA- Suicide in Oregon

US Suicide Rates by State | Suicide in Oregon | Oregon Suicide Rate by County: Ages 10-24

Overview of Suicide

Suicide is a serious public health problem that affects individuals, families, and communities. In 2015 alone, more than 44,000 Americans died by suicide and almost half a million Americans received medical care for self-inflicted injuries.

Oregon's suicide rate has been higher than the national average for the past three decades. Oregon's age-adjusted suicide rate of 17.7 per 100,000 residents in 2015 was **33 percent higher than the national average** and Oregon ranked 13th place among all US states in suicide incidence. Suicide rates for Oregon and U.S. states have increased since 2000. Click on any state to display the suicide rate.



Source: CDC WISQARS.

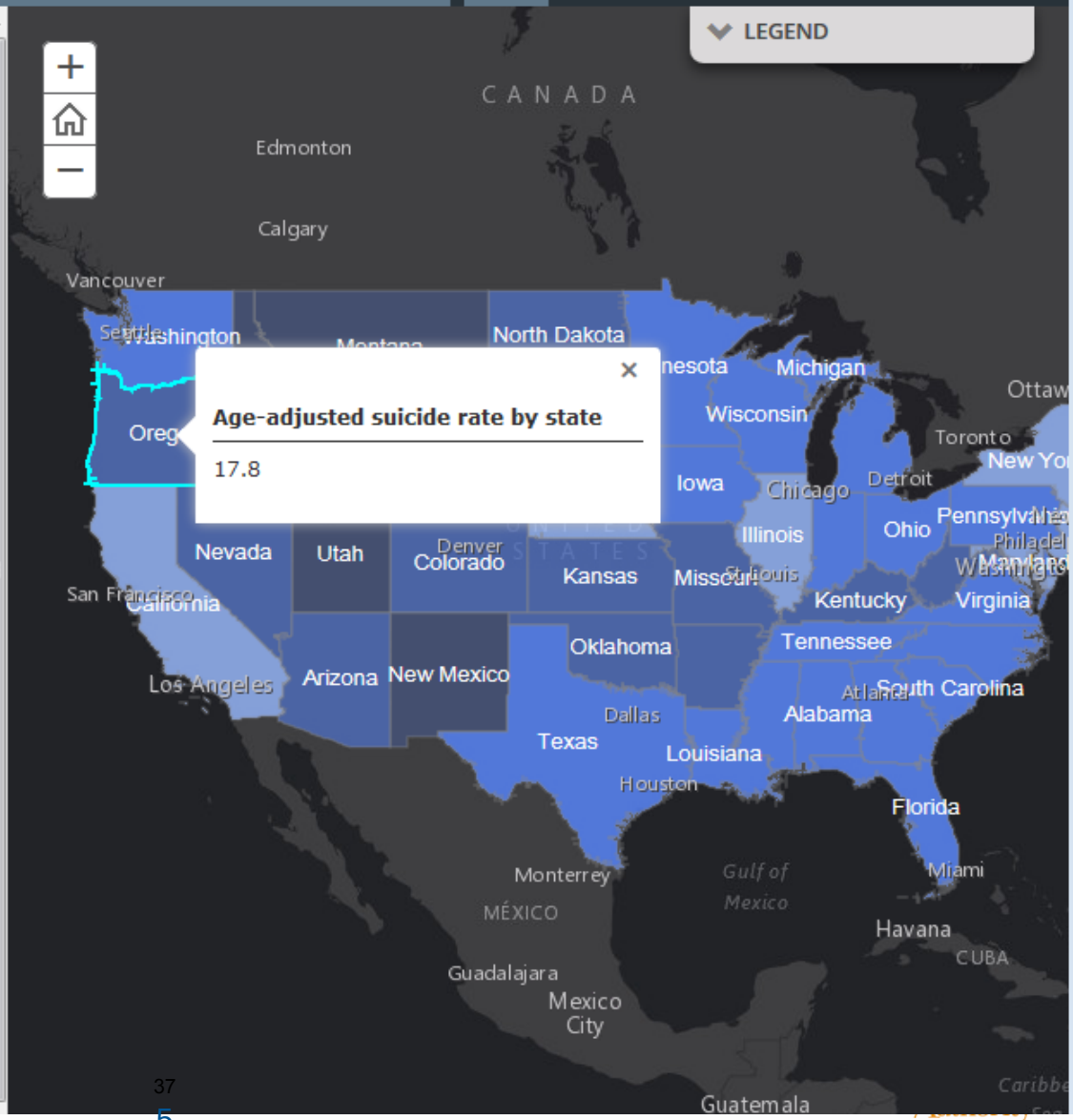
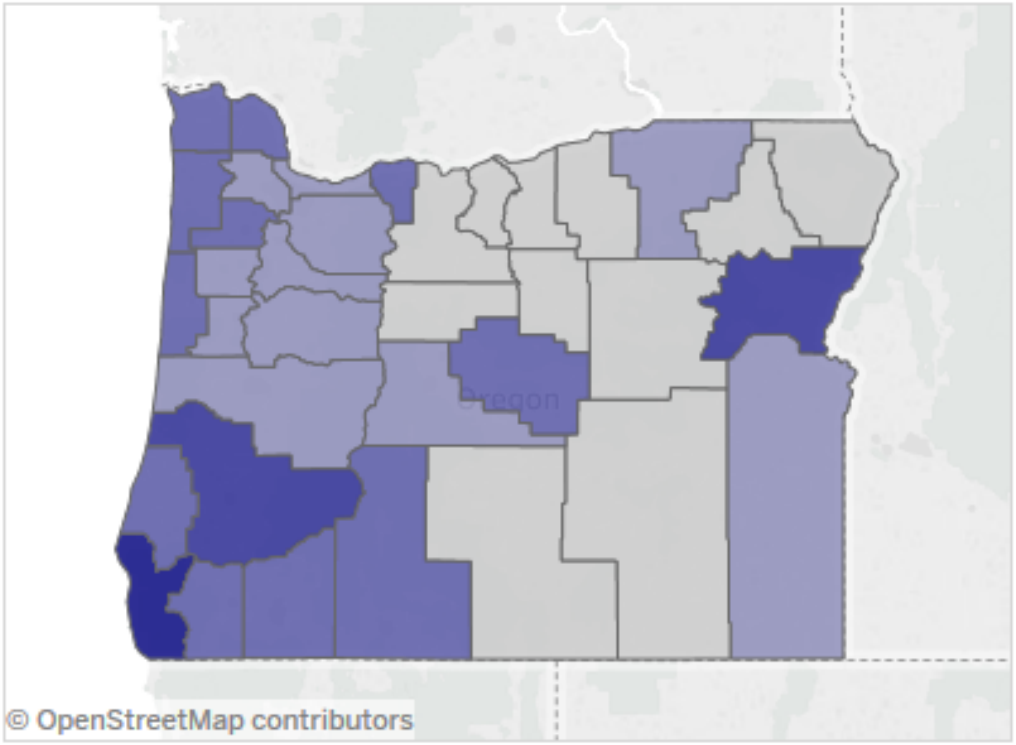


Table of Contents | Suicide | Firearms | Technical Notes

Oregon Suicide Data Dashboard

Oregon Suicide Death Map, 2003-2015



Map Year

2015

Hover mouse pointer over counties for rates and counts

Suicide Rate per 100,000 Population

0.00 50.00

Sentinel Event Alert

Detecting and treating suicide ideation

Suicide is the 10th leading cause of death in the U.S., claiming more lives than traffic accidents and more than twice as many as homicides.

This information can help providers prepare for and know what to do when a patient with suicidal thoughts comes to them for help.

DETECTING SUICIDE IDEATION IN NON-ACUTE OR ACUTE CARE SETTINGS

Who: Primary, emergency and behavioral health clinicians

1. Review each patient's personal and family medical history for suicide risk factors.

While suicide may affect certain demographics – such as military veterans –

Zero Suicide Initiative

Lead: Make an explicit commitment to reduce suicide deaths.

Train: Develop a confident, competent, and caring workforce.

Identify: Identify every person at risk for suicide.

Engage: Engage clients in a Suicide Care Management Plan.

Treat: Treat suicidal thoughts and behaviors directly.

Transition: Follow patients through every transition in care.

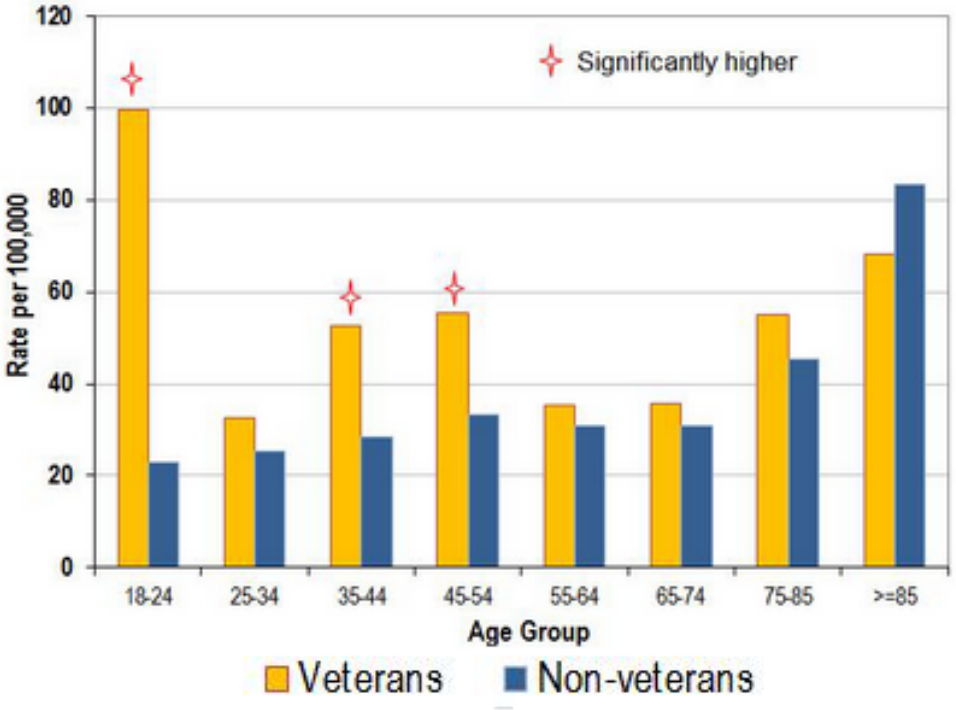
Improve: Apply data-driven quality improvement.

Challenges

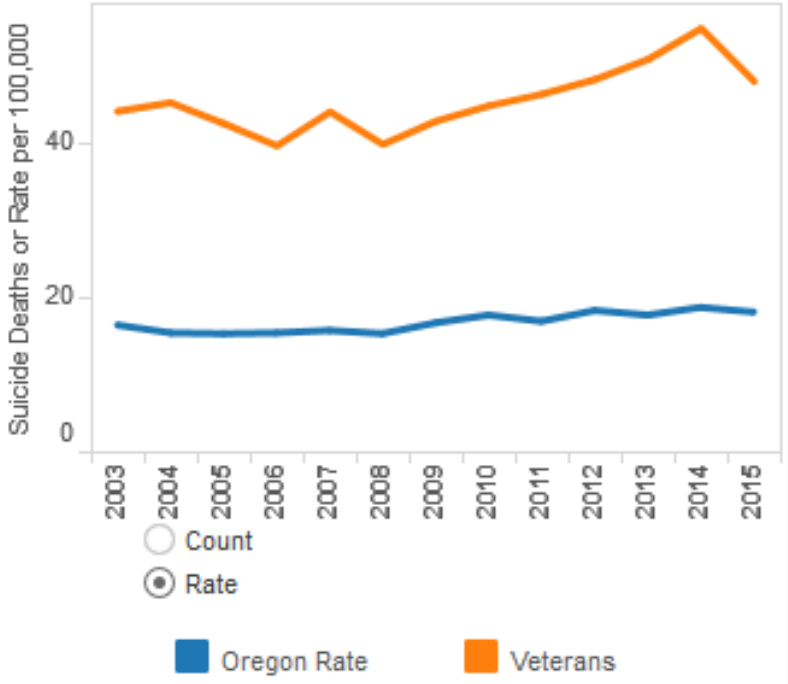
- Access to complete data
- Ensuring community implementation of services and programs to promote safe and nurturing environments
- Disparities persist, especially among veterans

Suicide Among Veterans, Oregon, 2003-2015

Suicide Rates Among Male Veterans and Non-Veterans, Oregon, 2003-2012

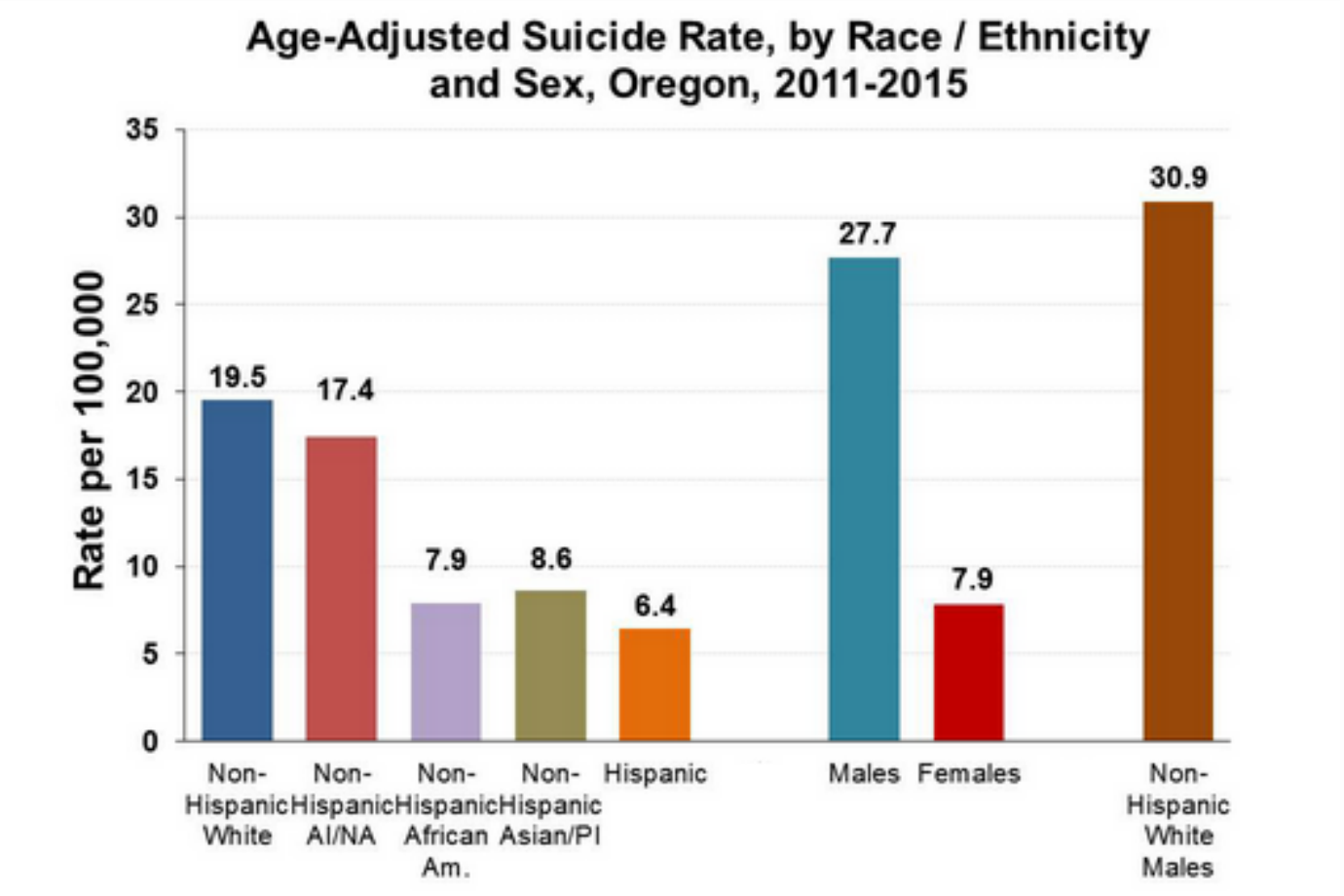


Veteran and General Population Suicide, Oregon, 2003-2015



Oregon Health Authority

Attention to Health Disparities



Feedback & Discussion

- What suggestions do you have for engaging health care providers (CCOs, LHDs, and others) to implement the Zero Suicide initiative?

Lisa Millet
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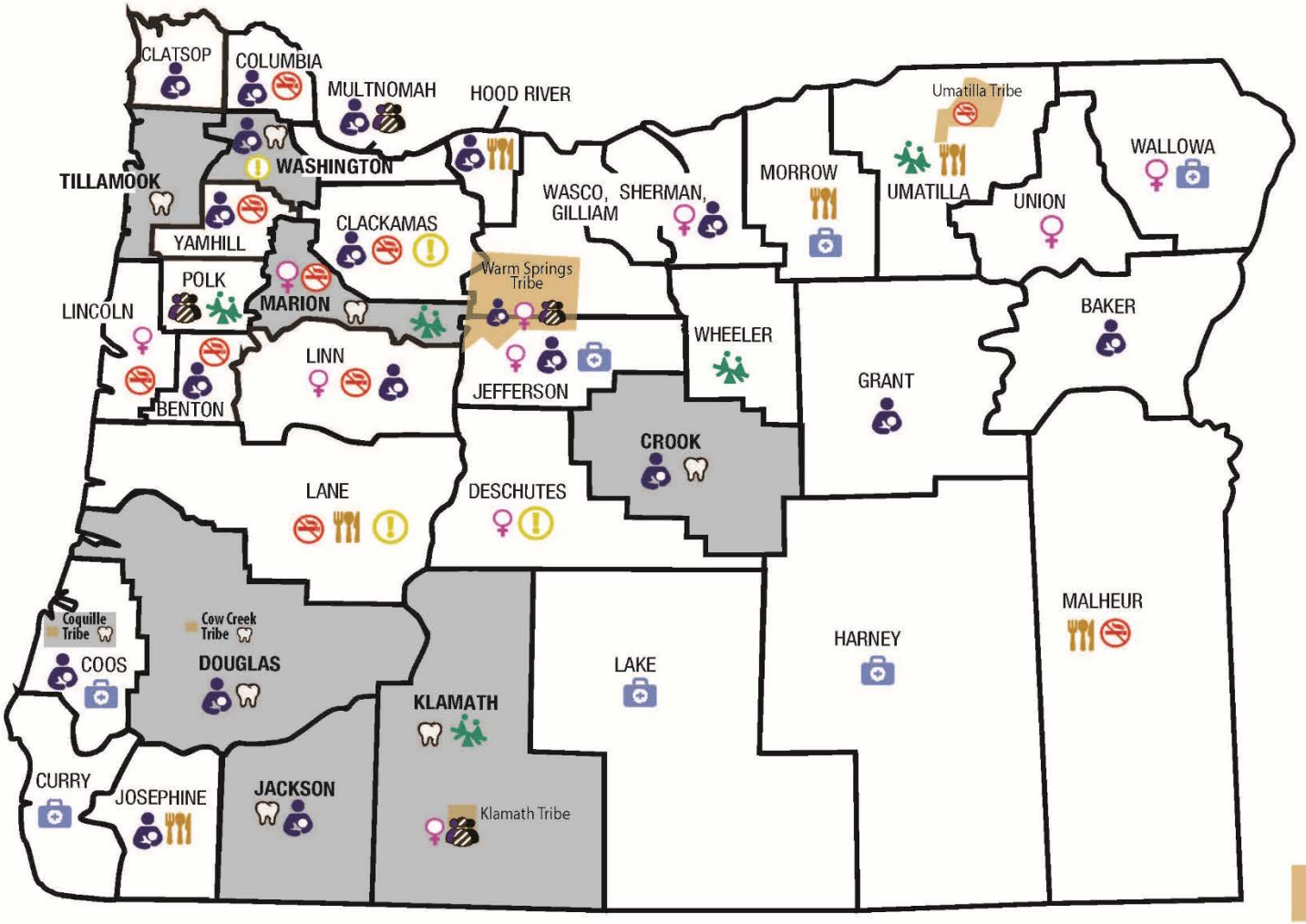
Improve oral health

Measure	Baseline	Current Data	2020 Target	Data Source
3rd graders with cavities in permanent teeth	15.5% (2012)	Available 2018	14%	Oregon Smile Survey
Adolescents who have ever had one or more cavities	8th: 70.1% 11th: 74.0% (2013)	8th: 68.7% 11th: 75.1% (2015)	8th: 66.6% 11th: 70.3%	Oregon Healthy Teens Survey
Prevalence of older adults who have lost all their natural teeth	17.7% (2010)	15.1% (2015)	14%	BRFSS

Successes

- Expansion of school oral health services:
  - Eligible middle schools with school dental sealant programs increased from 8% (2014–15 school year) to 47% (2015–16 school year)
  - School-Based Health Centers (SBHCs) with routine access to an onsite dental provider increased from 5 in 2014 (7.4%) to 15 in the 2015–16 school year (19.7%)
- Oral health is a priority area within the Maternal & Child Health (MCH) Title V Block Grant
  - Approximately $200,000 is being spent at the state and local level for FY2018

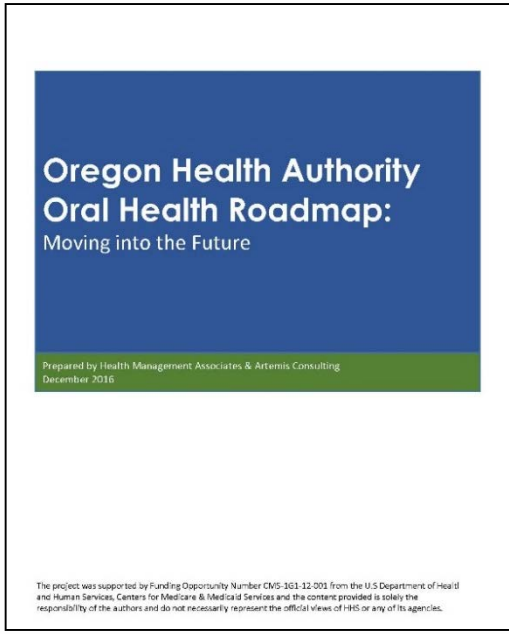
Title V Grantees and Priorities



Well Woman Care | Breastfeeding | Adolescent Well Care | Physical Activity in Children | Oral Health | Smoking | Toxic Stress & Trauma | Nutrition and Food Insecurity | CLAS Standards

Success & Future Goal

- Oral health integration in PHD and across OHA:
  - Community water fluoridation workgroup
  - Monthly OHA Oral Health Team meetings
  - OHA oral health work plan and evaluation plan that aligns with the SHIP
- Challenges:
  - Slow progress
  - Limited capacity of staff within other OHA divisions to work on oral health



Challenges

- Community Water Fluoridation – going backwards slowly
  - 22.6% in 2012
  - 22.2% in 2014
  - Preliminary data suggests 21.9% in 2016

- Resources and funding to focus on adult and senior oral health care issues
  - Limited Duration (LD) position is mapping the dental insurance landscape and service delivery in Oregon for adults 65+
  - LD only available until August 31, 2018

Attention to Health Disparities

- Reduces dental cavities & disease across the entire population, regardless of age, race or ethnicity, insurance coverage, access to a dentist, or the ability to pay for care

- Project #100 – Oregon Tribes Dental Health Aide Therapist Pilot Project
  - Testing a dental mid-level provider similar to a nurse practitioner
- Project #200 – Training Dental Hygienists to Place Interim Therapeutic Restorations

Attention to Health Disparities

- OHA Certification requires local school dental sealant programs to:
  - Target first 40% FRL elementary and middle schools
  - Offer dental sealant services to all students regardless of insurance status, race, ethnicity or socio-economic status
- Only 20-25 schools

2017 Oregon Smile & Healthy Growth Survey

Region	Required	Recruited	% Recruited
1	17	6	35.3%
2	17	13	76.5%
3	17	12	70.6%
4	17	12	70.6%
5	28	11	39.3%
6	20	11	55.0%
7	19	11	57.9%
Total	**135**	**76**	**56.3%**

Feedback & Discussion

1. How can we keep making improvements when dental benefit coverage is expected to change at the federal level and potentially the state level?
    - Pediatric dental care as an essential health benefit
    - OHP continuing to offer comprehensive dental care for adults
2. PHAB has prioritized dental visits for children 0-5. What are your thoughts around this focus area?
3. Community water fluoridation – how can we be more bold when no one wants to touch it?

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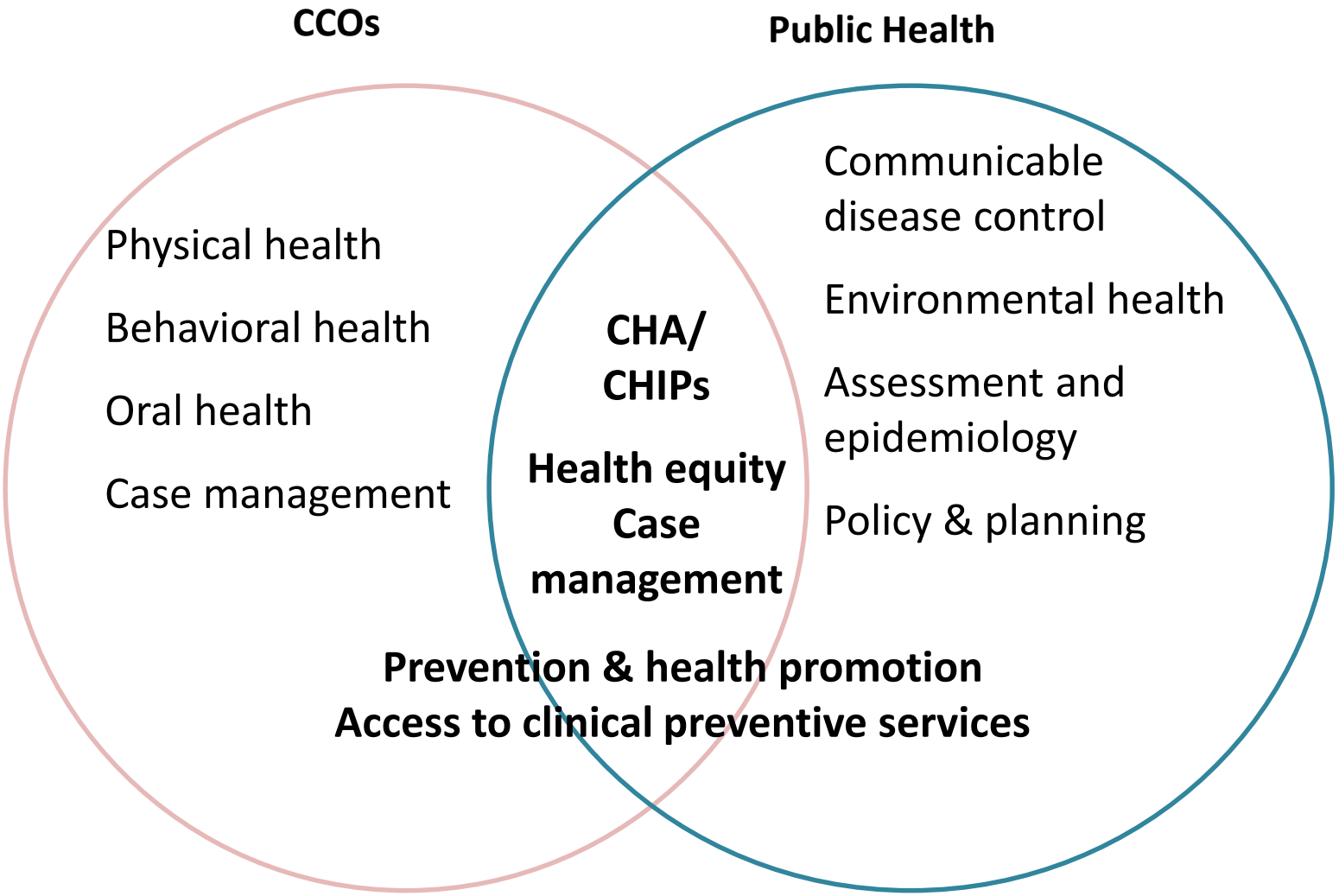
CPCCO framework for collaboration with local public health

Safina Koreishi, MD MPH

Opportunities for partnership



Collaboration

- Shared meeting with 3 PH directors and CCO leadership
- Discussed shared priorities
- Used ease and impact scale to determine focus areas

Collaboration framework

Priority: Increase <2y/O & Decrease School Exclusions

Goal: minimum increase of 5% for each county:

Immunizations

Public Health Work
Outreach/homevisits
- Imms assessment
- Patient Education
- Administration
- Reporting
- Promotion
- School exclusion

SHARED
- Advocacy
- Pt Education
- Promotion
- Data: Access, Actionable, Timely
- Key community stakeholders

CPCCO Work: (Clinical)
- Education: provider & member
- Workflows
- Messaging
- Advocacy
- Incentives
- Analytics/QI
- *Barrier: Access*

Timelines and deadlines…

Reporting

PH/CPCCO Leads:

Public Health Advisory Board
Draft: Guiding principles for public health and health care collaboration

~~May 19~~July 10, 2017

1. Purpose

This set of guiding principles is a tool that professionals can use to build collaborations between public health and the health care sector. This tool is a starting place for ideas that public health and health care can implement to reach common goals.

2. Guiding Principles

Value statement: We will not see meaningful improvement in population health without cross-sector collaboration. (Statewide Public Health Modernization Plan).

- Ensure broad, cross-sector collaboration between public health; coordinated care organizations (CCOs), hospitals and other groups within the health care sector; early learning and education; and community-based organizations to improve population health.
- Leverage existing opportunities for cross sector collaboration (i.e., community health assessments and community health improvement plans). (Public Health Modernization Manual)

Value statement: Direct services to individuals, including clinical interventions, are supported by~~The expertise that~~ the public health system's focus on ~~holds in~~ prevention; policy, systems and environmental change; and evidence-based strategies to improve population health. ~~supports direct services to individuals, including clinical interventions.~~ (Statewide Public Health Modernization Plan, CDC 6|18 Initiative)

- Ensure a comprehensive spectrum of strategies are in place for assessing, developing and implementing shared priorities.

Value statement: Public health and health care must work together to ensure that every community member has access to high quality, culturally appropriate health care. This requires jointly developing and implementing solutions to address access and quality barriers. (Public Health Modernization Manual)

- Ensure health care and public health collaborations are outcomes-oriented, sustainable, and allow for transformation and flexibility in implementation.

3. Strategies that align with guiding principles

- Leadership and governance: Include health care and public health perspectives on one another's governing and/or leadership boards and/or decision-making. Ensure that governing and/or leadership boards reflect the composition of the community being served. Ensure there are regular opportunities to solicit and include community input in the decision-making of the governing and/or leadership board. Leverage health care and public health funding to improve population health outcomes. (Public Health 3.0)
- Aligned metrics and data: Implement metrics that can be analyzed and reported by race, ethnicity, primary language and disability, that move health care and public health towards improvement in community health outcomes and elimination of health disparities (e.g., tobacco use prevalence). Identify what health care and public health contribute to individual measures and what could be done in the future. Tie performance payment to improved health outcomes that are shared across health care and public health partners. Develop systems to share data in

order to develop community health assessments, identify emerging health issues, and evaluate the effectiveness of new policies designed to improve health. (Public Health 3.0)

- Evidence-based practices: Collect and disseminate information on evidence-based clinical and population health strategies. Ensure that resources are invested in the implementation of practices that are grounded in scientific evidence, including promising culturally-specific practices. (Public Health Modernization Manual)
- Community health assessments and community health improvement plans: Ensure the continuation of partnerships across health care and public health to develop shared community health assessments and community health improvement plans; ensure assessments and plans meet all state, local and federal requirements. Utilize evidence-based and promising culturally-specific practices in the development of community health improvement plans. (Public Health Modernization Manual, Next Generation of Community Health)
- Access to care: Ensure that health care and public health organizations work collaboratively to collect data on access to care; review data to identify barriers to care; and develop solutions to improve access to care that are grounded in community needs. Ensure that health care and public health organizations work collaboratively to plan for and respond to emergencies. (Public Health Modernization Manual)
- Policy: Partner on the development and implementation of public policies that promote health and prevent disease.
- Workforce development: Collaboratively build the capacity of the health care and public health system so both are better equipped to address health outcomes and manage change. Ensure that the health care and public health workforce reflects the community being served.

4. Source documents

Oregon's Action Plan for Health
Public health modernization assessment
Statewide public health modernization plan
Public Health Modernization Manual
Public Health 3.0
CDC 6|18 Initiative
Next Generation of Community Health
Public Health Accreditation Board Standards and Measures
Coalition of Local Health Officials
Equity of Care

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes DRAFT
July 11, 2017
1:00-2:00 pm

Welcome and roll call

Meeting Chair: Jeff Luck

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

Oregon Health Authority (OHA) staff to the subcommittee: Sara Beaudrault, Cara Biddlecom, Chris Curtis, Angela Rowland

June meeting minutes

A quorum was present. The June 13th meeting minutes were unanimously approved.

Legislative update

Jeff announced that the legislature allocated $5M for public health modernization in the OHA budget for the 2017-19 biennium.

The modernization of public health House Bill 2310 passed unanimously. It makes small changes to how public health modernization will be implemented. Of note to PHAB:

- OHA must submit a biannual report to Legislative Fiscal Office that includes an estimated cost to implement public health modernization fully, on how state funds were used, and reports on accountability metrics.
- HB 2310 adds a seat to PHAB for a member of a federally recognized tribe, or an individual who represents federally recognized tribes.

Concept for scope of work and funding allocation

Jeff reminded subcommittee members that the original funding recommendation from PHAB for 2017-19 was $30M. Over the past few months the subcommittee has made recommendations for how smaller funding amounts would be allocated to local public health. PHAB reviewed this subcommittee's recommendations in June and did not recommend any changes.

Tricia asked whether the entire $5M would be allocated to local public health. Approximately $1.1M will remain with OHA. The scope of work document for review today provides additional information. Cara stated that the work should be planned based on a year and a half of implementation since funds will not be allocated until 1/1/18.

Sara provided an overview of the guidance and recommendations for how limited funds should be used in 2017-19.

PHAB recommendation: (from May 18 meeting)

- Oregon Health Authority Public Health Division funds should be focused on the local public health system.
- Request for proposals for pilot sites should not allow a disadvantage for smaller or less resourced counties.
- Funds be allocated to a group of counties that self-identify as working together.
- Funds should go to all local public health authorities to implement cross-jurisdictional sharing.
- Identify a key capability.

CLHO and JLT recommendation: (from June 8 meeting)

- Funds should address a specific health outcome to demonstrate process
- Prioritize capacity building and planning.
- Ensure all LPHAs are able to move forward with an investment.
- Limit a possible have/have not scenario by directing funds to all size bands.
- Support regional approaches.
- Limit specific requirements for the delivery of foundational capabilities and programs

- Utilize OHA resources to increase capacity across the public health system.

Sara reviewed the concept for the scope of work and funding allocation. Under this concept, local public health could receive funding under two tracks.

Track 1 Regional partnership implementation

The majority of funds will be awarded to regional partnerships that will implement a regional strategy for communicable disease control and reducing health disparities.

Track 2 Regional partnership capacity building

A small portion of available funds will be awarded to applicants for building capacity for regional partnerships and strategies. Applicants under this track will focus funding on developing a regional partnership and are not required to implement regional strategies for communicable disease control and reducing health disparities. OHA wanted to make sure that less resourced counties have an opportunity to receive funding.

Alejandro inquired how to avoid a situation where smaller counties apply for Track 2 as a default and how to determine when a small local public health authority be ready for Track 1. Sara suggested that LPHAs that qualify would likely aim for Track 1 since more funding will be available. Track 2 should help prepare health departments for Track 1 in the future.

Sara provided more details about the scope of work for Track 1. The Joint Leadership Team will determine the specific work LPHAs would be doing in the following areas.

Track 1 Scope of work concept:

- Form a regional partnership of LPHAs and other stakeholders
- Implement regional strategies to control communicable disease
- Implement regional strategies to reduce health disparities
- Develop and monitor a regional work plan
- Participate in learning communities and ongoing evaluation
- Develop initial public health modernization sustainability plans to ensure continuity of regional strategies after the 2017-19 biennium

Tricia asked if the funds will be allocated for every county. Sara said that there is not an intent to fund every county necessarily as counties need to work together to develop regional partnerships. OHA will distribute all funds that are available with the broadest reach and impact.

Alejandro suggested that health equity needs a stronger focus in this scope of work. Cara said that JLT looked at the deliverables in the Public Health Modernization Manual for health equity and cultural responsiveness and prioritized some deliverables for this scope of work. She thinks it will be useful to look at data by race and ethnicity in the partnership to identify and plan regional strategies.

Tricia also suggested that the health equity language be made stronger. She appreciated the partnership focus and recommends incorporating how decisions are made and how power is distributed. She recommended combining the communicable disease and health equity pieces of the scope of work, rather than having them listed as separate sections.

Tricia and Jeff inquired about whether JLT made recommendations for health outcomes to work toward. Tricia suggested that the scope of work should focus on strategy development specifically intended to move the needle on health outcomes. Cara stated that JLT discussed concentrating on STD prevention. However, due to local context and regional differences in communicable disease a more broad focus on communicable disease tailored to local need. Also, the PHD HIV, STD, and TB program will be releasing a grant to concentrate specifically on HIV and STD prevention for the state. Cara sees this as a way to build capacity to address any communicable disease strategies. With the $5M investments public health will need to change the way services are being delivered at the local level.

Track 2 Scope of work concept
1. Explore formation of a regional partnership of LPHAs and other stakeholders
2. Explore regional strategies for communicable disease control and reducing health disparities
3. Develop and monitor a work plan
4. Participate in learning communities and ongoing evaluation

Jeff would like the deliverables to be stronger, #2 instead of “explore”, say “identify” or “develop” regional strategies. Tricia recommends requiring a

partnership as an outcome of funding with at least one memorandum of understanding. Track 2 LPHAs should be expected to develop and adopt a regional strategy. Alejandro clarified that if one LPHA receives funding and subsequently partners with another LPHA, the fiscal agent could share or redistribute funds. He recommended clarifying this in the RFP. Track 2 should be a building block for Track 1.

Tricia recommended two resources for informing this capacity-building track: Office of Equity and Inclusion's Year 1 funding for RHECs, and the Kaiser Permanente Community Fund.

Alejandro asked about the concept of learning communities that has been previously discussed. He recommends tying learning communities to the scope of work under the two tracks.

Concept for funding allocation

In all, $3.9M will be allocated to LPHAs. The majority ($3.6M in this concept proposal) would be allocated to Track 1. PHAB members recommended using ranges to allow for flexibility in case more LPHAs apply under Track 2.

Cara clarified that these dollars cannot be used to supplant existing funding.

OHA is required to specify how proposals are scored and how decisions are made to award funding before an RFP is released. This is a formal process, and OHA will convene a panel of reviewers.

Cara asked subcommittee members whether they are in support of including Track 2 funding, which has not been discussed until this point. Subcommittee members expressed their support.

Subcommittee Business

Jeff will lead this discussion at the July 20th PHAB meeting.

Public Comment

No public testimony.

Public Health Advisory Board
Incentives and Funding subcommittee
July 11, 2017

Public health modernization funding: Concepts for scope of work and funding allocation

PHAB guidance for allocating new funding for public health modernization
(Discussed at May 18 PHAB meeting)

- Public health modernization **funding that remains with OHA should be focused on meeting the needs of the local public health system**, especially small local health departments. Examples may be assessment and epidemiology work and technical support.
- If funding is to be used for pilot sites, **an RFP should be structured so that larger, more resourced counties do not have an advantage** over smaller or less resourced counties.
- **Allocate funds for groups of counties** who self-identified as working together to improve a need or capability.
- **Identify a key capability** to focus on and identify which counties need more improvement based on the public health modernization assessment.
- Allocating funds for planning to all LPHAs will **give LPHAs resources to implement cross-jurisdictional sharing and strategic partnerships** with other organizations and to leverage additional funding.

Conference of Local Health Officials and OHA Public Health Division Joint Leadership Team (JLT) discussion, based on PHAB recommendations
(Discussed at June 8 JLT meeting)

1. Initial funds should be focused on specific health outcomes to demonstrate progress.
2. Capacity building and planning are critical; this will be emphasized in the approach to meeting the improved health outcomes.
3. Ensure all LPHAs are able to move forward with an investment in public health modernization.
4. Limit a possible have/have-not scenario by directing funds to all LPHA size bands.
5. Support/incentivize regional approaches to service provision.
6. Utilize available funding to fill gaps identified in the public health modernization assessment. Gaps are not uniform across the public health system.
7. Limit specific requirements for the delivery of foundational capabilities and programs, in lieu of common outcomes across the public health system.
8. Utilize OHA resources to increase capacity across the entire public health system, provide technical assistance, and perform state-level functions, such as assessment and epidemiology.

9. Invest in areas that can produce outcomes while also absorb any future funding shocks to the public health system.

Scope of work concept –for discussion and feedback

Public health modernization funds will be used to develop regional approaches for identifying, responding to and preventing the transmission of communicable disease. These funds will be used to support regional public health infrastructure and the development of new partnerships that are essential for meeting regional goals. These funds will also support improvements in health equity as it relates to communicable disease.

Public health modernization funds will be allocated to LPHAs along two tracks:

1. **Track 1 Regional partnership implementation:** The majority of funds will be awarded to regional partnerships that will implement a regional strategy for communicable disease control and reducing health disparities.
2. **Track 2 Regional partnership capacity building:** A small portion of available funds will be awarded to applicants for building capacity for regional partnerships and strategies. Applicants under this track will focus funding on developing a regional partnership and are not required to implement regional strategies for communicable disease control and reducing health disparities.

Track 1: Regional partnership implementation

Scope of work concept

1. Form a regional partnership of LPHAs and other stakeholders
    a. Focus on regional structure; project leadership and governance; and decision-making
2. Implement regional strategies to control communicable disease and reduce health disparities
    a. Focus on deliverables prioritized by JLT and CLHO
~~3. Implement regional strategies to reduce health disparities~~
    ~~a. Focus on deliverables prioritized by JLT and CLHO~~
~~4.~~3. Develop and monitor a regional work plan
    a. Focus on work plan monitoring and reporting
~~5.~~4. Participate in learning communities and ongoing evaluation
    a. Fulfills JLT and PHAB recommendation for convening LPHAs for joint learning, sharing successes, and developing solutions to barriers
~~6.~~5. Develop initial public health modernization sustainability plans to ensure continuity of regional strategies after the 2017-19 biennium
    a. Focus on ongoing partnership development and leveraging additional resources

Minimum qualifications

1. Partnership includes at least three LPHAs, as demonstrated by signed memoranda of understanding or formal letter of commitment
2. Partnership includes at least one additional partner organization, as demonstrated by signed memoranda of understanding or formal letter of commitment

Track 2: Regional partnership capacity building

Scope of work concept

1. Explore and form~~formation of~~ a regional partnership of LPHAs and other stakeholders
   a. Focus on exploring and developing a regional partnership
2. Identify and develop~~Explore~~ regional strategies for communicable disease control and reducing health disparities
   a. Focus on a subset of deliverables prioritized by JLT and PHAB related to identification of local and regional communicable disease risks and communities experiencing disproportionate burden of communicable disease
3. Develop and monitor a work plan
   a. Focus on work plan monitoring and reporting
4. Participate in learning communities and ongoing evaluation
   a. Fulfills JLT and PHAB recommendation for convening LPHAs for joint learning, sharing successes, and developing solutions to barriers

Minimum qualifications

1. Applicant may be a single LPHA that will take the lead on exploring the development of a regional partnership, or two or more LPHAs that will explore the development of a regional partnership~~.~~.

~~1.~~2. Proposal must include at least one letter of support from an LPHA or strategic partner that may engage with the applicant to form a strategic partnership. An established partnership is not a prerequisite for applying.

Concept for funding ranges/not to exceed – for discussion and feedback

Approximately $3.9 million will be allocated to LPHA regional partnerships

Track 1: Regional Partnership Implementation

- Available funding: $3.3-3.6 million
- Each regional partnership will be categorized as small, medium or large, based on the population size served in the region. This may incentivize including more counties in the partnership.
    - Large: not to exceed $700,000
    - Medium: not to exceed $500,000
    - Small: not to exceed $350,000
- JLT and PHAB have expressed concern about a competitive process that will favor counties with greater capacity. Rather than capping the number of projects that will be funded, OHA can include overarching language that proposals will be scored, ranked and funded in such a way that all funds are distributed and we have the greatest statewide reach.

Regional partnership size (based on total population served in the region)	Not to exceed
Large (>500,000 people served)	$700,000
Medium (100,000-499,000 people served)	$500,000
Small (<100,000 people served)	$350,000

Track 2: Regional Partnership Capacity-Building

- Available funding: $300,000-600,000

Public health modernization funding timeline

Activity	Timeline
PHAB and JLT provide feedback on scope of work and funding concept	July
OHA finalizes Request for Proposal (RFP)	August
RFP released	Late August-September
Proposals submitted	October (45-60 day response period)
Proposal review panel meets	Late October
Notices to award issued	Early November
Finalize contracts	November-December
Funds allocated	Jan 1, 2018