AGENDA

PUBLIC HEALTH ADVISORY BOARD

May 18, 2017
2:30-5:15 pm
Portland State Office Building, 800 NE Oregon St., Room 1A, Portland, OR 97232

Join by Livestream
Conference line: (877) 873-8017
Access code: 767068

Meeting objectives

- Approve April meeting minutes
- Hear updates from PHAB subcommittees
- Plan for public health modernization implementation in 2017-19
- Adopt Guiding Principles for Public Health and Health Care Collaboration

2:30-3:00 pm	**Welcome and updates** • Approve April 20 meeting minutes • Legislative session updates	Jeff Luck, PHAB Chair
3:00-3:20 pm	**Subcommittee updates** • Accountability Metrics subcommittee: share information and updates from April 26 meeting • Incentives and Funding subcommittee: share information and updates from May 9 meeting	Muriel DeLaVergne-Brown, PHAB member Jeff Luck, PHAB Chair
3:20-4:10 pm	**Modernization implementation planning** • Identify the need for guidance on three scenarios for public health modernization funding in 2017-19 • Prioritize implementation of foundational capabilities and programs based on ranges of funding • Discuss governance criteria for implementation of public health modernization	Cara Biddlecom, Oregon Health Authority
4:10-4:25 pm	**Break**	
4:25-5:00 pm	**Guiding principles for Public Health and Health Care Collaboration** • Use PHAB Health Equity Policy questions to review guiding principles document	Cara Biddlecom, Oregon Health Authority

	• Debrief discussions with stakeholders about guiding principles • Adopt guiding principles document	
5:00-5:15 pm	**Public comment**	
5:00 pm	**Adjourn**	Jeff Luck, PHAB chair

Public Health Advisory Board (PHAB)
April 20, 2017
Draft Meeting Minutes

Attendance:

Board members present: Carrie Brogoitti, Muriel DeLaVergne-Brown, Katrina Hedberg, Jeff Luck, Alejandro Queral, Rebecca Pawlak, Akiko Saito, Eli Schwarz

Oregon Health Authority (OHA) staff: Cara Biddlecom, Sara Beaudrault, Christy Hudson, Angela Rowland

Members of the public: Kathleen Johnson, Kelly McDonald, Cate Theisen

Approval of Minutes

A quorum was present. The Board unanimously voted to approve the edited March 16, 2017 minutes.

Welcome and updates

-Carrie Brogoitti, PHAB co-chair

- Diane Hoover was announced as the new local public health administrator PHAB member. She has worked primarily in the military hospital setting and as the Josephine County public health administrator since 2011.
- Tricia Tillman and Eva Rippeteau are taking temporary family leave from the PHAB. The Incentives and Funding subcommittee membership will be re-evaluated.
- There is an open position for a local public health administrator PHAB member in the State Health Assessment steering committee.
- Carrie and Jeff presented the PHAB charter at the Oregon Health Policy Board (OHPB) meeting. The Board requested to add a qualifier to the Charter which states all changes are not effective until the OHPB approves. The OHPB liaison should be appointed to the PHAB soon. In the meantime, Zeke Smith will represent the PHAB during OHPB discussions.
- HB2310: Testimony on April 7th, Work session on April 17th.
    - -1 amendment was put forward by partners, it requires implementation of prioritized work on or before June 30, 2019 including assessment and epidemiology, leadership and organizational competencies, health equity and cultural responsiveness, communicable disease control, and environmental health. It did not include preparedness and response. There is an estimated $49M fiscal impact.
    - -2 and -3 amendments clarify the language in the bill, gives OHA authority to distribute funds if state dollars are insufficient in the funding formula, calls for a

biannual report with accountability metrics, and adds a PHAB member from Oregon's federally recognized tribes.
    - HB 2310 passed unanimously out of the House Health Care Committee with adoption of the -1 and -3 amendments. It has been referred to the Ways and Means Committee for further consideration.
- Accountability metrics subcommittee met in March, webinar was held on April 13th, launching a public survey, and will be presenting at the metrics and scoring committee in July.

Racial and Ethnic Approaches to Community Health (REACH)
-Rachael Banks Multnomah County Public Health

Rachel Banks presented on the Multnomah County Racial and Ethnic Approaches to Community Health (REACH) project. This project engages local communities to address health disparities. Non-traditional partners were involved including faith-based programs, child care centers, retail environments, and transportation partners to decrease health disparities among African Americans in a culturally specific way. The County used CDC grants and funding through the City of Gresham. The REACH project has increased ability to develop innovative approaches to reaching diverse community members; the City collaborated across departments on outreach efforts; stronger community relationships have been built; and equity impacts have been considered and reflected in policy development. The project leveraged over $10 million additional funds, increased capacity of culturally specific organizations, impacted 75% of the African American population, and contributed to the knowledge base of evidence-based practice.

Health equity policy
-Jeff Luck, PHAB Chair

Jeff reviewed the changes made to the health equity policy by a small group in between the March and April PHAB meetings. The definition of health equity included in the document was shortened and aligns with the definition of health equity that the Public Health Division is using. The Board decided to change the word "racism" to "race" in the definition. This policy will be applied as a lens to presentations and projects. This policy will be tested in the May Board meeting.

Motion: The Board voted to adopt the definition and policy.

All members in favor.

State Health Improvement Plan

-Aaron Dunn, Alison Dent, Sean Schafer, and Paul Cieslak Oregon Health Authority

Alison Dent and Aaron Dunn presented on the Immunization State Health Improvement Plan priority area. The plan's target measures the rate of two year olds who are fully vaccinated, HPV vaccination series rates among 13-17 year olds, and seasonal flu vaccination rates for the year 2020. The Oregon Immunization program has built a strong partnership with American Cancer Society and developed the Oregon Human Papillomavirus (HPV) Roundtable with a HPV Strategic Plan coming soon. A CCO Incentive Measure has been approved for 2-year old rates. School Based Health Centers added optional key performance measures for adolescent immunizations. The program has created the evidence-based strategies for improving childhood immunization rates guide for CCOs.

Some challenges for the immunizations priority area are key local partnerships, flu, outbreaks, and vaccine hesitancy. The program has partnered with BOOST Oregon to develop a Parent's Guide to Children's Vaccines. The Immunization program inquired where the Board recommends that the state-run Immunize Oregon coalition should be based in the future.

Board Recommendations:

- Immunization rates should be included in local health improvement plans.
- Connect with the REACH project team.
- Develop local immunization coalitions.
- Work with the Early Learning Hubs.
- Work with the Oregon Primary Care Association.

Paul Cieslak and Sean Schafer presented the Communicable Disease SHIP priority area. Some successes for the priority area are End HIV Oregon campaign launched to eliminate new HIV infections; 'SyphAware' campaign on public transit; 15% reduction in reported *E. coli* O157 infection; creation of hepatitis C action plan; and the containment of carbapenemase-producing organisms, a threatening health care acquired infection.

Some challenges faced are of culture-independent diagnostic tests, reducing barriers to Hepatitis C treatment, reducing barriers to PrEP, encouraging universal HIV screening, and promoting judicious antimicrobial use.

Public Comment Period

No public testimony was provided in person or on the phone.

Closing

The meeting was adjourned.

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

May 18, 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

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics subcommittee meeting minutes

April 26, 2017
10:00 – 11:00am

PHAB Subcommittee members in attendance: Muriel DeLaVergne-Brown, Teri Thalhofer, Eli Schwarz, and Jennifer Vines

OHA staff: Sara Beaudrault and Cara Biddlecom

Members of the public: Brittney Cannon, Jody Daniels, Ken House, Kelly McDonald, Danielle Sobel

Welcome and introductions

The February 14, 2017 and March 22, 2017 meeting minutes were approved.

Subcommittee updates

- OHA/PHD staff is working closely with Sara Kleinschmit who staffs the Metrics and Scoring committee. A public health accountability metrics presentation is scheduled for the June 16th meeting.
- The stakeholder survey will be released the first week of May.

Health outcome metrics

Public Health Division section managers selected the initial set of proposed accountability metrics. Health officers and local public health administrators provided feedback during a webinar and through written comments following the webinar. This subcommittee will review all feedback on the proposed accountability metrics and findings from the stakeholder survey at the May meeting, and will make recommendations on 1-2 accountability metrics per foundational program to take to the June PHAB meeting.

Sara provided an overview on feedback received from local administrators and health officers on the initial set of accountability metrics.

Muriel and Teri commented that the Oregon Healthy Teens survey data does not reflect the entire adolescent population in Oregon since school districts can refuse to participate in the survey.

The subcommittee agreed that tobacco and obesity should be highlighted in the prevention and promotion foundational program area. There was discussion regarding cigarette smoking prevalence versus e-cigarettes.

The subcommittee discussed whether public health has a clear role that will lead to improved two-year old vaccination rates, but felt there is value in providing some type of immunization measure.

The subcommittee noted that the access to clinical preventive services metrics are process measures, whereas other foundational programs include health outcome measures.

Muriel, Teri and Jenn recommend keeping the climate resilience strategies measure on the list, although many local administrators recommended removing it. The measure language could be changed to environmental resilience or changes in communicable disease and vector-borne disease resulting from weather change.

PHD is looking into an active transportation measure for environmental health. An asthma measure was also recommended.

Eli recommended that OHA report back to Public Health Advisory Board (PHAB) on a regular basis on metrics to inform if a measure needs to be changed or updated. Cara suggests that if reliable data is not available at the local level, measures that are important for the entire population could be reported at a statewide level.

The subcommittee recommends removing the blood lead testing for children under the age of 6 measure.

Stakeholder survey

The subcommittee reviewed a final draft of the survey. No changes were proposed.

Subcommittee Business

The next PHAB Accountability Metrics subcommittee agreed to extend its May meeting in order to have enough time to review all accountability metrics feedback and make recommendations on which measures to take to PHAB. Muriel will provide the subcommittee update at the May 18th PHAB meeting.

Public Comment: No public testimony.

Adjournment

The meeting was adjourned.

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes DRAFT
May 9, 2017
1:00-2:00 pm

Welcome and roll call

Meeting Chair: Jeff Luck

PHAB members present: Diane Hoover, Jeff Luck, Akiko Saito

Oregon Health Authority (OHA) staff: Sara Beaudrault, Chris Curtis, Angela Rowland

Members of the public: Channa Lindsay, Darren Yesser, Maria Tafolla, Kelly McDonald

February meeting minutes

The February 14th meeting minutes were not approved since a quorum was not present.

Proposal for role of Incentives and funding subcommittee

Meeting Goal: Review funding formula to confirm that funding formula principles remain intact at different funding levels.

HB 2310 passed out of the House and is now in the Ways and Means Committee. OHA Public Health Division (PHD) is developing a framework for how to align the scope of work for state and local public health departments with different funding levels. PHD is doing this planning work now so we are prepared for any funding outcome from the legislative session. More information will be provided at the May 18 Coalition of Local Health Officials (CLHO) and PHAB meetings, with additional work at the June meetings.

The subcommittee is being asked to finalize the funding formula, specifically to make recommendations on the floor funding component of the funding formula and to set a threshold for distributing funds to all local public health authorities (LPHAs) through the funding formula. This funding formula only addresses funding to LPHAs. It is understood that if the legislature provides funds to OHA for

public health modernization, the majority of funds will be allocated to LPHAs and a portion of funds will remain with OHA.

Funding Formula Floor

The subcommittee discussed the current funding formula at different funding levels as well as the set floor amount. The model developed by the subcommittee includes five floor tiers, one for each county size band. At the $10 million funding level, tiers range from $30,000 to $90,000. In this model, floor payments total $1.8 million.

Akiko noted that floor payments ensure stable funding. She commented that the CLHO Public Health Emergency Preparedness committee avoids reducing the floor when there are budget cuts in order to maintain staffing and stability. At funding levels above $10 million, floor payments could be proportionally increased.

The subcommittee discussed whether the floor tier amounts are sufficient for extra small and small counties. Diane noted that in her experience working at smaller agencies, change can be implemented with fewer resources as agency leaders have more direct control over the agency. Jeff would like to hear feedback from additional PHAB members who represent small and extra small counties.

Minimum funding level for using the funding formula

Initial recommendation, to be discussed at May 18 PHAB meeting:

- If less than $5M per year for LPHAs, direct all funds to pilot projects. Subcommittee members recommend considering that pilots from each size band are selected. Funds would not be distributed through the funding formula.
- If $5M-$10M per year, include floor payments at the levels set in the $10M model (ranging from $30,000-$90,000, totaling $1.8 million). All remaining funds would be used for pilots. Funds would not be distributed through the funding formula.
- If funds are equal to or above $10M per year, funds would be distributed to all LPHAs through the funding formula.
- For annual LPHA funding above $10M, floor payments would be proportionally increased.

Action Item: PHD will provide funding formula examples at different funding levels: $5M, $10M, and $15M increasing floor payment proportionally. These will be reviewed at the May 18 PHAB meeting.

Subcommittee Business

Jeff will provide the subcommittee update at the next PHAB meeting on May 18, 2017.

Public Comment

No public testimony.

Local public health funding formula model example - $5million annual funding for LPHAs

PHAB Incentives and Funding Subcommittee

Local public health funding formula model: This model includes a floor payment for each county. Awards for each indicator (burden of disease, health status, racial and ethnic diversity, poverty, income inequality, and limited English proficiency) are tied to each county's ranking on the indicator and the county population. **This funding formula assumes an annual allocation to LPHAs of $5 million. This is an example only.**

County Group	Population[1]	Floor	Burden of Disease[2]	Health Status[3]	Race/Ethnicity[4]	Poverty[4]	Education[4]	Limited English Proficiency[4]	Total Award	Award Percentage	% of Total Population	Award Per Capita	Avg Award Per Capita
County 33	1,445	$ 30,000	$ 220	$ -	$ 66	$ 124	$ 115	$ 26	**$ 30,551**	**0.6%**	**0.0%**	**$ 21.14**	
County 31	7,100	$ 30,000	$ 1,297	$ 413	$ 229	$ 463	$ 365	$ 91	**$ 32,858**	**0.7%**	**0.2%**	**$ 4.63**	
County 12	7,295	$ 30,000	$ 1,800	$ 1,711	$ 417	$ 724	$ 671	$ 104	**$ 35,427**	**0.7%**	**0.2%**	**$ 4.86**	
County 11	7,430	$ 30,000	$ 1,078	$ 641	$ 312	$ 539	$ 670	$ 111	**$ 33,351**	**0.7%**	**0.2%**	**$ 4.49**	
County 18	8,010	$ 30,000	$ 1,545	$ 789	$ 771	$ 670	$ 866	$ 399	**$ 35,041**	**0.7%**	**0.2%**	**$ 4.37**	
County 24	11,630	$ 30,000	$ 1,756	$ 2,957	$ 4,987	$ 1,056	$ 2,051	$ 3,981	**$ 46,788**	**0.9%**	**0.3%**	**$ 4.02**	
County 1	16,425	$ 30,000	$ 3,355	$ 2,481	$ 776	$ 1,416	$ 1,250	$ 401	**$ 39,680**	**0.8%**	**0.4%**	**$ 2.42**	**$ 4.28**
County 7	21,085	$ 45,000	$ 3,755	$ 3,046	$ 1,982	$ 2,061	$ 2,396	$ 1,049	**$ 59,290**	**1.2%**	**0.5%**	**$ 2.81**	
County 15	22,445	$ 45,000	$ 5,363	$ 4,358	$ 5,647	$ 2,201	$ 2,619	$ 3,707	**$ 68,896**	**1.4%**	**0.6%**	**$ 3.07**	
County 8	22,470	$ 45,000	$ 5,912	$ 5,333	$ 1,748	$ 1,624	$ 1,542	$ 600	**$ 61,759**	**1.2%**	**0.6%**	**$ 2.75**	
County 13	24,245	$ 45,000	$ 2,963	$ 3,275	$ 9,483	$ 1,785	$ 3,213	$ 10,558	**$ 76,276**	**1.5%**	**0.6%**	**$ 3.15**	
County 28	25,690	$ 45,000	$ 4,897	$ 4,386	$ 3,201	$ 2,130	$ 2,010	$ 2,186	**$ 63,811**	**1.3%**	**0.6%**	**$ 2.48**	
County 30	26,625	$ 45,000	$ 4,467	$ 4,171	$ 1,455	$ 2,354	$ 1,819	$ 1,521	**$ 60,786**	**1.2%**	**0.7%**	**$ 2.28**	
County 26	30,135	$ 105,000	$ 5,992	$ 6,219	$ 5,769	$ 2,327	$ 3,132	$ 5,748	**$ 134,187**	**2.7%**	**0.8%**	**$ 4.45**	
County 22	31,480	$ 45,000	$ 5,356	$ 7,826	$ 13,194	$ 4,202	$ 4,663	$ 8,202	**$ 88,443**	**1.8%**	**0.8%**	**$ 2.81**	
County 4	37,750	$ 45,000	$ 7,907	$ 6,162	$ 3,860	$ 2,799	$ 2,564	$ 2,868	**$ 71,159**	**1.4%**	**0.9%**	**$ 1.89**	
County 20	47,225	$ 45,000	$ 11,184	$ 8,461	$ 5,037	$ 3,799	$ 4,083	$ 3,672	**$ 81,237**	**1.6%**	**1.2%**	**$ 1.72**	
County 5	50,390	$ 45,000	$ 9,035	$ 9,927	$ 2,865	$ 3,115	$ 3,891	$ 1,425	**$ 75,258**	**1.5%**	**1.3%**	**$ 1.49**	
County 6	62,990	$ 45,000	$ 14,834	$ 10,636	$ 4,657	$ 5,332	$ 5,345	$ 2,095	**$ 87,900**	**1.8%**	**1.6%**	**$ 1.40**	
County 17	67,110	$ 45,000	$ 15,153	$ 14,731	$ 9,719	$ 5,866	$ 6,307	$ 5,912	**$ 102,688**	**2.1%**	**1.7%**	**$ 1.53**	**$ 2.20**
County 27	78,570	$ 60,000	$ 10,937	$ 11,277	$ 12,795	$ 6,293	$ 5,573	$ 8,898	**$ 115,773**	**2.3%**	**2.0%**	**$ 1.47**	
County 29	79,155	$ 60,000	$ 13,677	$ 16,262	$ 25,435	$ 6,358	$ 9,832	$ 16,038	**$ 147,602**	**3.0%**	**2.0%**	**$ 1.86**	
County 16	83,720	$ 60,000	$ 18,833	$ 13,665	$ 7,231	$ 7,746	$ 7,072	$ 2,463	**$ 117,010**	**2.3%**	**2.1%**	**$ 1.40**	
County 2	90,005	$ 60,000	$ 9,649	$ 12,665	$ 7,825	$ 9,590	$ 3,632	$ 7,516	**$ 110,877**	**2.2%**	**2.2%**	**$ 1.23**	
County 34	103,630	$ 60,000	$ 14,993	$ 14,193	$ 20,371	$ 8,140	$ 10,251	$ 17,091	**$ 145,039**	**2.9%**	**2.6%**	**$ 1.40**	
County 10	109,910	$ 60,000	$ 24,731	$ 25,054	$ 7,057	$ 10,166	$ 9,731	$ 2,787	**$ 139,526**	**2.8%**	**2.7%**	**$ 1.27**	
County 21	120,860	$ 60,000	$ 20,861	$ 21,201	$ 12,664	$ 11,077	$ 9,415	$ 7,613	**$ 142,831**	**2.9%**	**3.0%**	**$ 1.18**	**$ 1.38**
County 9	170,740	$ 75,000	$ 23,929	$ 15,696	$ 16,794	$ 12,053	$ 9,062	$ 11,360	**$ 163,894**	**3.3%**	**4.3%**	**$ 0.96**	
County 14	210,975	$ 75,000	$ 37,278	$ 37,207	$ 31,154	$ 17,654	$ 17,627	$ 19,458	**$ 235,379**	**4.7%**	**5.3%**	**$ 1.12**	
County 23	329,770	$ 75,000	$ 51,115	$ 65,892	$ 106,661	$ 29,568	$ 40,409	$ 92,085	**$ 460,730**	**9.2%**	**8.2%**	**$ 1.40**	
County 19	362,150	$ 75,000	$ 59,483	$ 56,055	$ 36,778	$ 34,683	$ 24,102	$ 27,679	**$ 313,778**	**6.3%**	**9.0%**	**$ 0.87**	**$ 1.09**
County 3	397,385	$ 90,000	$ 53,352	$ 54,053	$ 41,294	$ 18,215	$ 21,235	$ 44,950	**$ 323,099**	**6.5%**	**9.9%**	**$ 0.81**	
County 32	570,510	$ 90,000	$ 62,388	$ 70,644	$ 118,040	$ 31,719	$ 40,156	$ 138,166	**$ 551,113**	**11.0%**	**14.2%**	**$ 0.97**	
County 25	777,490	$ 90,000	$ 121,904	$ 119,613	$ 110,726	$ 67,649	$ 57,830	$ 180,241	**$ 747,963**	**15.0%**	**19.4%**	**$ 0.96**	**$ 0.93**
Total	**4,013,845**	**$ 1,845,000**	**$ 631,000**	**$ 631,000**	**$ 631,000**	**$ 315,500**	**$ 315,500**	**$ 631,000**	**$ 5,000,000**	**100.0%**	**100.0%**	**$ 1.25**	**$ 1.25**

county size bands
extra small
small
medium
large
extra large

[1] Source: Portland State University Certified Population estimate July 1, 2015

[2] Source: Oregon State Health Profile. Premature death, 2010-14. Oregon death certificate data

[3] Source: Oregon State Health Profile. Good or excellent health, 2010-13. BRFSS

[4] Source: American Community Survey population 5-year estimate, 2012

Local public health funding formula model example - $10 million annual funding for LPHAs

PHAB Incentives and Funding Subcommittee

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County Group	Population[1]	Floor	Burden of Disease[2]	Health Status[3]	Race/Ethnicity[4]	Poverty[4]	Education[4]	Limited English Proficiency[4]	Total Award	Award Percentage	% of Total Population	Award Per Capita	Avg Award Per Capita
County 33	1,445	$ 30,000	$ 568	$ -	$ 171	$ 321	$ 297	$ 67	**$ 31,425**	**0.3%**	**0.0%**	**$ 21.75**	
County 31	7,100	$ 30,000	$ 3,353	$ 1,067	$ 592	$ 1,197	$ 945	$ 235	**$ 37,388**	**0.4%**	**0.2%**	**$ 5.27**	
County 12	7,295	$ 30,000	$ 4,652	$ 4,422	$ 1,078	$ 1,872	$ 1,735	$ 270	**$ 44,029**	**0.4%**	**0.2%**	**$ 6.04**	
County 11	7,430	$ 30,000	$ 2,787	$ 1,657	$ 806	$ 1,394	$ 1,731	$ 286	**$ 38,661**	**0.4%**	**0.2%**	**$ 5.20**	
County 18	8,010	$ 30,000	$ 3,992	$ 2,039	$ 1,993	$ 1,733	$ 2,240	$ 1,033	**$ 43,030**	**0.4%**	**0.2%**	**$ 5.37**	
County 24	11,630	$ 30,000	$ 4,539	$ 7,642	$ 12,890	$ 2,729	$ 5,302	$ 10,291	**$ 73,393**	**0.7%**	**0.3%**	**$ 6.31**	
County 1	16,425	$ 30,000	$ 8,673	$ 6,412	$ 2,007	$ 3,659	$ 3,232	$ 1,038	**$ 55,020**	**0.6%**	**0.4%**	**$ 3.35**	**$ 5.44**
County 7	21,085	$ 45,000	$ 9,707	$ 7,873	$ 5,124	$ 5,328	$ 6,193	$ 2,713	**$ 81,937**	**0.8%**	**0.5%**	**$ 3.89**	
County 15	22,445	$ 45,000	$ 13,862	$ 11,266	$ 14,596	$ 5,689	$ 6,769	$ 9,583	**$ 106,765**	**1.1%**	**0.6%**	**$ 4.76**	
County 8	22,470	$ 45,000	$ 15,280	$ 13,784	$ 4,519	$ 4,197	$ 3,986	$ 1,551	**$ 88,318**	**0.9%**	**0.6%**	**$ 3.93**	
County 13	24,245	$ 45,000	$ 7,658	$ 8,465	$ 24,510	$ 4,615	$ 8,304	$ 27,291	**$ 125,843**	**1.3%**	**0.6%**	**$ 5.19**	
County 28	25,690	$ 45,000	$ 12,659	$ 11,337	$ 8,275	$ 5,504	$ 5,196	$ 5,651	**$ 93,622**	**0.9%**	**0.6%**	**$ 3.64**	
County 30	26,625	$ 45,000	$ 11,545	$ 10,781	$ 3,760	$ 6,085	$ 4,702	$ 3,931	**$ 85,804**	**0.9%**	**0.7%**	**$ 3.22**	
County 26	30,135	$ 105,000	$ 15,489	$ 16,075	$ 14,911	$ 6,014	$ 8,096	$ 14,857	**$ 180,441**	**1.8%**	**0.8%**	**$ 5.99**	
County 22	31,480	$ 45,000	$ 13,844	$ 20,228	$ 34,104	$ 10,862	$ 12,053	$ 21,200	**$ 157,291**	**1.6%**	**0.8%**	**$ 5.00**	
County 4	37,750	$ 45,000	$ 20,438	$ 15,927	$ 9,976	$ 7,236	$ 6,627	$ 7,412	**$ 112,616**	**1.1%**	**0.9%**	**$ 2.98**	
County 20	47,225	$ 45,000	$ 28,909	$ 21,871	$ 13,019	$ 9,820	$ 10,554	$ 9,491	**$ 138,665**	**1.4%**	**1.2%**	**$ 2.94**	
County 5	50,390	$ 45,000	$ 23,353	$ 25,658	$ 7,405	$ 8,053	$ 10,058	$ 3,682	**$ 123,209**	**1.2%**	**1.3%**	**$ 2.45**	
County 6	62,990	$ 45,000	$ 38,344	$ 27,492	$ 12,038	$ 13,782	$ 13,814	$ 5,416	**$ 155,886**	**1.6%**	**1.6%**	**$ 2.47**	
County 17	67,110	$ 45,000	$ 39,167	$ 38,077	$ 25,122	$ 15,161	$ 16,302	$ 15,280	**$ 194,110**	**1.9%**	**1.7%**	**$ 2.89**	**$ 3.50**
County 27	78,570	$ 60,000	$ 28,270	$ 29,148	$ 33,073	$ 16,267	$ 14,405	$ 22,998	**$ 204,162**	**2.0%**	**2.0%**	**$ 2.60**	
County 29	79,155	$ 60,000	$ 35,353	$ 42,033	$ 65,744	$ 16,434	$ 25,414	$ 41,455	**$ 286,432**	**2.9%**	**2.0%**	**$ 3.62**	
County 16	83,720	$ 60,000	$ 48,681	$ 35,322	$ 18,691	$ 20,021	$ 18,279	$ 6,366	**$ 207,360**	**2.1%**	**2.1%**	**$ 2.48**	
County 2	90,005	$ 60,000	$ 24,940	$ 32,736	$ 20,226	$ 24,789	$ 9,388	$ 19,428	**$ 191,507**	**1.9%**	**2.2%**	**$ 2.13**	
County 34	103,630	$ 60,000	$ 38,754	$ 36,686	$ 52,654	$ 21,040	$ 26,496	$ 44,178	**$ 279,807**	**2.8%**	**2.6%**	**$ 2.70**	
County 10	109,910	$ 60,000	$ 63,924	$ 64,760	$ 18,241	$ 26,278	$ 25,153	$ 7,203	**$ 265,558**	**2.7%**	**2.7%**	**$ 2.42**	
County 21	120,860	$ 60,000	$ 53,922	$ 54,801	$ 32,735	$ 28,631	$ 24,335	$ 19,677	**$ 274,101**	**2.7%**	**3.0%**	**$ 2.27**	**$ 2.57**
County 9	170,740	$ 75,000	$ 61,851	$ 40,572	$ 43,408	$ 31,155	$ 23,424	$ 29,362	**$ 304,771**	**3.0%**	**4.3%**	**$ 1.79**	
County 14	210,975	$ 75,000	$ 96,357	$ 96,173	$ 80,527	$ 45,631	$ 45,562	$ 50,295	**$ 489,544**	**4.9%**	**5.3%**	**$ 2.32**	
County 23	329,770	$ 75,000	$ 132,122	$ 170,316	$ 275,697	$ 76,427	$ 104,449	$ 238,020	**$ 1,072,031**	**10.7%**	**8.2%**	**$ 3.25**	
County 19	362,150	$ 75,000	$ 153,750	$ 144,889	$ 95,062	$ 89,647	$ 62,298	$ 71,544	**$ 692,191**	**6.9%**	**9.0%**	**$ 1.91**	**$ 2.38**
County 3	397,385	$ 90,000	$ 137,903	$ 139,715	$ 106,736	$ 47,083	$ 54,889	$ 116,185	**$ 692,510**	**6.9%**	**9.9%**	**$ 1.74**	
County 32	570,510	$ 90,000	$ 161,260	$ 182,600	$ 305,107	$ 81,987	$ 103,795	$ 357,130	**$ 1,281,878**	**12.8%**	**14.2%**	**$ 2.25**	
County 25	777,490	$ 90,000	$ 315,095	$ 309,174	$ 286,202	$ 174,859	$ 149,478	$ 465,885	**$ 1,790,693**	**17.9%**	**19.4%**	**$ 2.30**	**$ 2.16**
Total	**4,013,845**	**$ 1,845,000**	**$ 1,631,000**	**$ 1,631,000**	**$ 1,631,000**	**$ 815,500**	**$ 815,500**	**$ 1,631,000**	**$ 10,000,000**	**100.0%**	**100.0%**	**$ 2.49**	**$ 2.49**

county size bands
extra small
small
medium
large
extra large

[1] Source: Portland State University Certified Population estimate July 1, 2015

[2] Source: Oregon State Health Profile. Premature death, 2010-14. Oregon death certificate data

[3] Source: Oregon State Health Profile. Good or excellent health, 2010-13. BRFSS

[4] Source: American Community Survey population 5-year estimate, 2012

Local public health funding formula model example - $15million annual funding for LPHAs

PHAB Incentives and Funding Subcommittee

Local public health funding formula model: This model includes a floor payment for each county. Awards for each indicator (burden of disease, health status, racial and ethnic diversity, poverty, income inequality, and limited English proficiency) are tied to each county's ranking on the indicator and the county population. **This funding formula assumes an annual allocation to LPHAs of $15 million. This is an example only.**

County Group	Population[1]	Floor	Burden of Disease[2]	Health Status[3]	Race/Ethnicity[4]	Poverty[4]	Education[4]	Limited English Proficiency[4]	Total Award	Award Percentage	% of Total Population	Award Per Capita	Avg Award Per Capita
County 33	1,445	$ 45,000	$ 853	$ -	$ 256	$ 482	$ 446	$ 101	$ 47,138	0.3%	0.0%	$ 32.62	
County 31	7,100	$ 45,000	$ 5,029	$ 1,601	$ 888	$ 1,795	$ 1,417	$ 353	$ 56,082	0.4%	0.2%	$ 7.90	
County 12	7,295	$ 45,000	$ 6,978	$ 6,633	$ 1,618	$ 2,808	$ 2,602	$ 405	$ 66,043	0.4%	0.2%	$ 9.05	
County 11	7,430	$ 45,000	$ 4,180	$ 2,486	$ 1,210	$ 2,091	$ 2,596	$ 429	$ 57,991	0.4%	0.2%	$ 7.80	
County 18	8,010	$ 45,000	$ 5,989	$ 3,059	$ 2,989	$ 2,599	$ 3,360	$ 1,549	$ 64,545	0.4%	0.2%	$ 8.06	
County 24	11,630	$ 45,000	$ 6,809	$ 11,463	$ 19,335	$ 4,094	$ 7,953	$ 15,436	$ 110,090	0.7%	0.3%	$ 9.47	
County 1	16,425	$ 45,000	$ 13,009	$ 9,618	$ 3,010	$ 5,489	$ 4,848	$ 1,556	$ 82,530	0.6%	0.4%	$ 5.02	$ 8.16
County 7	21,085	$ 67,500	$ 14,560	$ 11,810	$ 7,685	$ 7,992	$ 9,289	$ 4,069	$ 122,906	0.8%	0.5%	$ 5.83	
County 15	22,445	$ 67,500	$ 20,794	$ 16,898	$ 21,894	$ 8,533	$ 10,154	$ 14,374	$ 160,147	1.1%	0.6%	$ 7.14	
County 8	22,470	$ 67,500	$ 22,921	$ 20,677	$ 6,778	$ 6,296	$ 5,979	$ 2,327	$ 132,477	0.9%	0.6%	$ 5.90	
County 13	24,245	$ 67,500	$ 11,487	$ 12,698	$ 36,765	$ 6,922	$ 12,455	$ 40,936	$ 188,765	1.3%	0.6%	$ 7.79	
County 28	25,690	$ 67,500	$ 18,988	$ 17,006	$ 12,412	$ 8,257	$ 7,794	$ 8,476	$ 140,432	0.9%	0.6%	$ 5.47	
County 30	26,625	$ 67,500	$ 17,318	$ 16,172	$ 5,640	$ 9,128	$ 7,053	$ 5,896	$ 128,706	0.9%	0.7%	$ 4.83	
County 26	30,135	$ 157,500	$ 23,233	$ 24,113	$ 22,366	$ 9,021	$ 12,144	$ 22,285	$ 270,662	1.8%	0.8%	$ 8.98	
County 22	31,480	$ 67,500	$ 20,766	$ 30,341	$ 51,156	$ 16,293	$ 18,080	$ 31,800	$ 235,936	1.6%	0.8%	$ 7.49	
County 4	37,750	$ 67,500	$ 30,657	$ 23,890	$ 14,964	$ 10,854	$ 9,941	$ 11,118	$ 168,924	1.1%	0.9%	$ 4.47	
County 20	47,225	$ 67,500	$ 43,364	$ 32,807	$ 19,529	$ 14,730	$ 15,831	$ 14,237	$ 207,997	1.4%	1.2%	$ 4.40	
County 5	50,390	$ 67,500	$ 35,030	$ 38,487	$ 11,107	$ 12,079	$ 15,087	$ 5,523	$ 184,814	1.2%	1.3%	$ 3.67	
County 6	62,990	$ 67,500	$ 57,515	$ 41,238	$ 18,057	$ 20,673	$ 20,722	$ 8,125	$ 233,830	1.6%	1.6%	$ 3.71	
County 17	67,110	$ 67,500	$ 58,750	$ 57,116	$ 37,684	$ 22,742	$ 24,453	$ 22,920	$ 291,165	1.9%	1.7%	$ 4.34	$ 5.25
County 27	78,570	$ 90,000	$ 42,406	$ 43,722	$ 49,610	$ 24,401	$ 21,607	$ 34,497	$ 306,244	2.0%	2.0%	$ 3.90	
County 29	79,155	$ 90,000	$ 53,029	$ 63,049	$ 98,616	$ 24,651	$ 38,121	$ 62,182	$ 429,648	2.9%	2.0%	$ 5.43	
County 16	83,720	$ 90,000	$ 73,021	$ 52,983	$ 28,037	$ 30,032	$ 27,418	$ 9,549	$ 311,040	2.1%	2.1%	$ 3.72	
County 2	90,005	$ 90,000	$ 37,410	$ 49,104	$ 30,339	$ 37,184	$ 14,082	$ 29,141	$ 287,260	1.9%	2.2%	$ 3.19	
County 34	103,630	$ 90,000	$ 58,131	$ 55,029	$ 78,980	$ 31,560	$ 39,744	$ 66,267	$ 419,711	2.8%	2.6%	$ 4.05	
County 10	109,910	$ 90,000	$ 95,885	$ 97,140	$ 27,361	$ 39,417	$ 37,729	$ 10,805	$ 398,337	2.7%	2.7%	$ 3.62	
County 21	120,860	$ 90,000	$ 80,884	$ 82,201	$ 49,102	$ 42,947	$ 36,502	$ 29,515	$ 411,151	2.7%	3.0%	$ 3.40	$ 3.85
County 9	170,740	$ 112,500	$ 92,776	$ 60,858	$ 65,112	$ 46,732	$ 35,136	$ 44,043	$ 457,157	3.0%	4.3%	$ 2.68	
County 14	210,975	$ 112,500	$ 144,535	$ 144,259	$ 120,790	$ 68,447	$ 68,343	$ 75,442	$ 734,317	4.9%	5.3%	$ 3.48	
County 23	329,770	$ 112,500	$ 198,184	$ 255,474	$ 413,546	$ 114,640	$ 156,673	$ 357,030	$ 1,608,046	10.7%	8.2%	$ 4.88	
County 19	362,150	$ 112,500	$ 230,625	$ 217,334	$ 142,594	$ 134,471	$ 93,447	$ 107,316	$ 1,038,286	6.9%	9.0%	$ 2.87	$ 3.57
County 3	397,385	$ 135,000	$ 206,854	$ 209,573	$ 160,104	$ 70,624	$ 82,333	$ 174,277	$ 1,038,766	6.9%	9.9%	$ 2.61	
County 32	570,510	$ 135,000	$ 241,890	$ 273,900	$ 457,661	$ 122,980	$ 155,692	$ 535,695	$ 1,922,818	12.8%	14.2%	$ 3.37	
County 25	777,490	$ 135,000	$ 472,643	$ 463,761	$ 429,303	$ 262,289	$ 224,217	$ 698,827	$ 2,686,039	17.9%	19.4%	$ 3.45	$ 3.24
Total	**4,013,845**	**$ 2,767,500**	**$ 2,446,500**	**$ 2,446,500**	**$ 2,446,500**	**$ 1,223,250**	**$ 1,223,250**	**$ 2,446,500**	**$ 15,000,000**	**100.0%**	**100.0%**	**$ 3.74**	**$ 3.74**

county size bands
- extra small
- small
- medium
- large
- extra large

[1] Source: Portland State University Certified Population estimate July 1, 2015

[2] Source: Oregon State Health Profile. Premature death, 2010-14. Oregon death certificate data

[3] Source: Oregon State Health Profile. Good or excellent health, 2010-13. BRFSS

[4] Source: American Community Survey population 5-year estimate, 2012

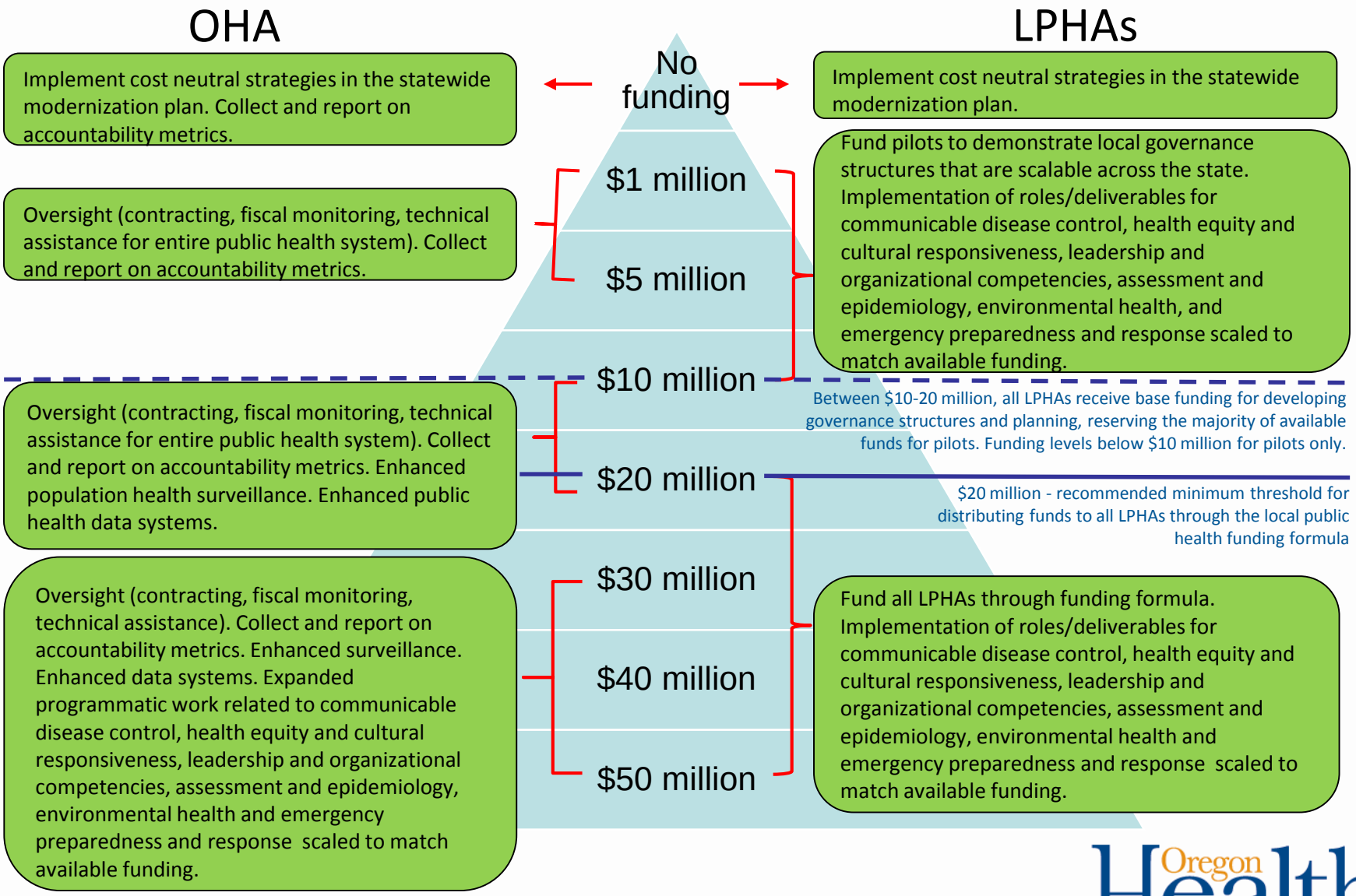
Inputs for aligning funding and scope of work

- Available funding
- Legislative guidance, to be determined
- Phase 1 priorities identified by the Public Health Advisory Board
- *Public Health Modernization Manual*
- Public health modernization assessment
- Public health accountability metrics
- Local public health funding formula
- *Health and Economic Benefits of Public Health Modernization* report

Principles (value questions) for aligning funding and scope of work

- What is the balance of funding areas that are ready versus areas of greatest need?
- How can we set this up in order to have quick wins, show progress in a short timeframe, and set the entire system up for success?
- How can we make sure we are building a public health infrastructure that is sustainable through future funding shifts?

Scope of work at a range of funding levels for 2017-19*



Oregon Health Authority

Timeline

Implementation timeline based on additional funding for the 2017-19 biennium.

Activities	Jun-17	Jul-17	Aug-17	Sep-17	Oct/Nov-17	Dec-17	Jan-18	Responsible group
Scope of work and funding								
Develop recommendations for scope of work	★	★	★					OHA, PHAB, CLHO
Finalize scope of work			★					OHA, PHAB, CLHO
Finalize funding formula			★					PHAB
RFP for pilots (If available funding is below threshold set by PHAB)								
Begin pilot selection criteria discussions	★	★						PHAB
Develop and issue RFP			★					OHA
Select pilots								OHA, PHAB
Contract amendment								
Develop program element and contract amendment			★					OHA
Reviews, revisions, signatures				★	★	★		OHA, LPHAs
Contracts go into effect							★	
Monitoring and oversight								
Develop structures and processes for OHA oversight, technical assistance and reporting for modernization activities and funding		★	★	★	★	★	★	OHA

Public Health Advisory Board Ad Hoc Committee
Second draft: Guiding principles for public health and health care collaboration

March 24, 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.

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; 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/improvement plans). (Public Health Modernization Manual)

Value statement: The expertise that the public health system 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 are represented on one another's governing and/or leadership boards. Leverage health care and public health funding to improve population health outcomes. (Public Health 3.0)
- Shared metrics and data: Implement common metrics that move health care and public health towards improvement in 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. (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 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. (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.

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

Public Health Advisory Board
Health equity review policy and procedure
April 2017

Background

The Public Health Advisory Board (PHAB), established by House Bill 3100 (2015), serves as the accountable body for governmental public health in Oregon. PHAB reports to the Oregon Health Policy Board (OHPB) and makes recommendations to OHPB on the development of statewide public health policies and goals. PHAB is committed to using best practices and an equity lens to inform its recommendations to OHPB on policies needed to address priority health issues in Oregon, including the social determinants of health.

Definition of health equity

Health equity exists when all people can reach their full health potential and are not disadvantaged from attaining it because of their social and economic status, social class, race, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance.[1]

Health equity is also defined as the absence of unfair, avoidable, or remediable difference in health among social groups.[2]

How health equity is attained

Achieving health equity requires the equitable distribution of resources and power resulting in the elimination of gaps in health outcomes between within and different social groups.

Health equity also requires that public health professionals look for solutions outside of the health care system, such as in the transportation or housing sectors and through the distribution of power and resources, to improve health with communities.

Policy

PHAB demonstrates its commitment to advancing health equity by implementing an equity review process for all formally adopted work products, reports and deliverables. In addition, all presenters to the Board will be expected to specifically address how the topic being discussed is expected to affect health disparities or health equity. The purpose of this policy is to ensure all

[1] Winnipeg Regional Health Authority. (n.d.). Winnipeg Regional Health Authority's Position Statement on Health Equity. Available at http://www.wrha.mb.ca/about/healthequity/statement.php.
[2] World Health Organization, Commission on Social Determinants of Health, (2007). A Conceptual Framework for Action on the Social Determinants of Health.

Board guidance and decision-making will advance health equity and reduce the potential for unintended consequences that may perpetuate disparities.

Procedure

Board work products, reports and deliverables

The questions below are designed to ensure that decisions made by PHAB promote health equity. The questions below may not be able to be answered for every policy or decision brought before PHAB, but serve as a platform for further discussion prior to the adoption of any motion.

The answers to the following questions will be submitted to PHAB for review with the meeting materials prior any official Board action involving a vote to adopt a work product, report or and deliverable. The subcommittee or PHAB member responsible for bringing the work product, report or deliverable forward for a motion will begin by walking through the responses to these questions prior to introducing the work product, report or deliverable for a motion.

1. How is the work product, report or deliverable different from the current status?
2. What health disparities exist among which groups? Which health disparities does the work product, report or deliverable aim to eliminate?
3. How does the work product, report or deliverable support individuals in reaching their full health potential?
4. Which source of health inequity does the work product, report or deliverable address (social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?
5. How does the work product, report or deliverable ensure equitable distribution of resources and power?
6. How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?
7. How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?
8. How will data be used to monitor the impact on health equity resulting from this work product, report or deliverable?

Presentations to the Board

OHA staff will work with presenters prior to Board meetings to ensure that presenters specifically address the following, as applicable:

1. What health disparities exist among which groups? Which health disparities does the presentation topic aim to eliminate?
2. How does the presentation topic support individuals in reaching their full health potential?

3. Which source of health inequity does the presentation topic address (social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?
4. How does the presentation topic ensure equitable distribution of resources and power?
5. How was the community engaged in the presentation topic? How does the presentation topic content impact the community?
6. How does the presentation topic engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?
7. How will data be used to monitor the impact on health equity resulting from the presentation topic?

Policy and procedure review

The PHAB health equity review policy and procedure will be reviewed annually by the Board. Board members will discuss whether the policy and procedure has had the intended effect of reducing disparities or improving health equity to determine whether changes are needed to the policy and procedure.

Resources

The City of Portland, Parks and Recreation. Affirmation of Equity Statement.

Multnomah County Health Department (2012). Equity and Empowerment Lens.

Oregon Health Authority, Office of Equity and Inclusion. Health Equity and Inclusion Program Strategies.

Oregon Education Investment Board. Equity Lens.

Oregon Health Authority, Office of Equity and Inclusion. Health Equity Policy Committee Charter.

Jackson County Health Department and So Health-E. Equity planning documents and reports.

Health Equity Policy Review

For

Guiding Principles for Health Care and Public Health Collaboration

May 2017

PUBLIC HEALTH DIVISION
Office of the State Public Health Director

1. How is the work product, report or deliverable different from the current status?

- The guiding principles for health care and public health collaboration seek to reinforce broad, cross-sector collaboration between public health; CCOs, hospitals and other groups within the health care sector; early learning and education; and community-based organizations.
- More robust collaboration has the potential to lead to a greater focus across the health system on social determinants of health and health equity.

2. What health disparities exist among which groups? Which health disparities does the work product, report or deliverable aim to eliminate?

- This deliverable does not directly address health disparities or specific health disparities among identified groups.
- Greater collaboration with coordinated care organizations among public health may lead to additional opportunities to address health disparities that currently exist among Medicaid recipients. These include:
  - Higher rates of chronic diseases than the general adult population
  - Higher rates of overweight, obesity and morbid obesity than the general adult population
  - Greater use of cigarettes than the general adult population
  - Greater food insecurity and hunger than the general adult population

Source: 2014 Medicaid Behavioral Risk Factor Surveillance System Survey

3. How does the work product, report or deliverable support individuals in reaching their full health potential?

- This deliverable does not specifically support individuals in reaching their full health potential.
- However, greater collaboration between health care and public health may lead to additional opportunities to address health disparities.

4. Which source of health inequity does the work product, report or deliverable address (social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?

- This deliverable does not specifically address one source of health inequity.

5. How does the work product, report or deliverable ensure equitable distribution of resources and power?

- This deliverable encourages collaboration in governance between health care and public health.
- Specifically, the guiding principles encourage health care and public health to be represented on one another's governing and/or leadership boards, and encourages health care and public health to leverage funding to improve population health outcomes.

6. How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?

- The community has not been engaged in the deliverable. Stakeholders from affected organizations have been involved.
- The deliverable has the potential to positively impact the community through greater opportunity for community input and leadership on population health issues (e.g., community advisory councils as required of coordinated care organizations).

7. How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?

- The deliverable engages partners within the health care system.
- The deliverable could be used as a model for collaboration with other sectors.

8. How will data be used to monitor the impact on health equity resulting from this work product, report or deliverable?

- This deliverable does not include a specific monitoring plan.
- However, down the road it is possible to identify the impact of the deliverable through public health modernization. For example: partnerships formalized through contracts or memoranda of understanding; shared work plans; and/or governance structure changes.