**In attendance**: Nancy State, Baker; Charlie Fautin, Benton; Dawn Emerick, Clackamas; Sherrie Ford, Columbia; Florence Pourtal-Stevens, Coos; Muriel DeLaVergne Brown, Crook; Ben Cannon, Curry; Bob Dannenhoffer, Douglas; Teri Thalhofer, North Central; Ellen Larsen, Hood River; Jackson Baures, Jackson; Mike Baker, Jefferson; Mike Weber, Josephine; Courtney VanBragt, Klamath; Jocelyn Warren, Lane; Rebecca Austen, Lincoln; Glenna Hughes, Linn; Pam Hutchinson, Marion; Sherrie, Morrow; Rachel Banks, Multnomah; Jim Setzer, Umatilla; Carrie Brogoitti, Union; Tricia Mortell, Washington; Lindsey Manfrin, Yamhill; Eric Mone, CLEHS; Pat Luedtke, Health Officer

**Public Health Division:** Cara Biddlecom, Danna Drum, Lillian Shirley, Tim Noe, Collette Young, Melissa Powell, Ruth Helsely, Karen Slothower, Amanda Timmons, Mai Quach

**CLHO:** Morgan Cowling; Caitlin Hill

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| Item | How | Discussion |
| Convene & Introduce |  |  |
| Agenda | Review |  |
| Minutes | **APPROVE** | Bob Dannenhoffer motioned to approve, Rebecca Austen seconded.CLHO Board approved. |
| Appointments | Appoint | Some people were confused and there were some miscommunications about the Committee appointments and transitions. Apologies to all who were impacted.New appointments:Preparedness* Teresa Mutchler (Douglas)
* Ann Parrot (Columbia County)
* Jenny Demaris (Lincoln)

Systems and Innovation* Dawn Emerick (Clackamas)
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| CLHO Communicable Disease: PE 01 – State Support for Public Health | Discuss & **APPROVE** | Revisions to PE01 include:* Removed standards for communicable disease control to line up with statute.
* Added investigative guidelines for all the diseases.
* Added reference in procedural requirements for training.
* Added in 24/7 assistance from PHD.

There was discussion about the language that said the Local Public Health Administrator is responsible to ensure reports. The Administrator is often not the person who completes the report. The PE reflects the language written in statute.CLHO Board approved.  |
| CLHO Communicable Disease: PE 03 – Tuberculosis | Discuss & **APPROVE** | Revisions to PE03 include:* Adapting to format for public health modernization.
* Changed county to LPHA.
* Includes language that allows the LPHA to distribute medications in compliance with the vendors with language to OHA in writing.

There was a discussion about the importance of TB and concern about counties with no general fund to support TB work. Also identified the need to enhance training about TB investigation and reporting.CLHO Board approved. |
| CLHO Communicable Disease: PE 08 – Ryan White | Discuss & **APPROVE** | PE08 originally went to Access to Clinical Services and CLHO CD made edits.Muriel DeLavergne Brown motioned to move PE08 to CLHO CD, Rachel Banks seconded. Board approved.Ryan White program has shifted to switch to a regional model as LPHAs have shifted away from local Ryan White funding. This PE impacts Polk, Tillamook, Hood, and the Tri-County region of Deschutes, Jefferson, and Crook.Discussion:Expectations look identical for contractors that are not LPHAs.Counties don’t get feedback around the relationship with the contractor and it would be helpful for them to know and get more specific information about the program and contractor.Jonathan will look into putting language into contract to reflect that reporting will be given to LPHAs so they know what is happening with contractor.Typo: warp vs wrapCLHO Board approved with typo change. |
| CLHO Communicable Disease: PE 10 – STD  | Discuss & **APPROVE** | Revisions to PE 10:Formatting* Added measures related to gonorrhea that are part of modernization.
* Performance measures mirror gonorrhea measure.
* Altered some language, restructured STD program and no longer have disease intervention specialist state staff, removed that language and changed it to STD/HIV prevention staff and added outbreak response.

Discussion:For 340b counties, LPHA can directly order the medication and then OHA reimburses. 340b counties get most affordable rate.For other counties, OHA makes purchases through MCAP and distributes the same way they always have, LHDs make order and OHA fills in and sends outCLHO Board approved. |
| CLHO Communicable Disease PE 43 – Immunizations  | Discuss & **APPROVE** | Revisions to PE 43 include:* PE was updated significantly a year ago, changes were to line it up with Modernization.
* Added new performance measure.

Discussion:* Counties have no control over who is in AFIX program.
* Smaller counties might have limitations around amount of VFC providers.
* Right now there is no data about number of VFC providers by county.
* General ongoing issues that Local Health Departments being held responsible for things out of their control.
* Many clinics will refer patients to get their vaccines at LPHAs.

CLHO CD agreed to have a more in depth conversation about the PE revisions and bring back to CLHO. State staff will provide data so they can make an informed decision. |
| Public Health Funding Principles -  | Discuss & Feedback | In the next several months the PHAB has to update the fiscal formula and need to draft funding principles.PHAB is looking at overarching principles and CLHO is going to help inform the funding principles.PHAB Incentives and Funding principles:Public health system approach to foundational programs1. Ensure services are available everywhere across Oregon, but not necessarily county by county.
2. Align funding with burden of disease and risk, while considering the impact to public health infrastructure.
3. Use funding to advance health equity in Oregon, which may include directing funds to areas of the state experiencing a disproportionate burden of disease or where health disparities exist

Discussion:Glad to see the burden of disease and reference to health equity which can mean we are addressing disproportionate need. Large counties have a disadvantage if all counties are treated the same.1. Use funding to incentivize changes to the public health system intended to increase efficiency and improve health outcomes, which may include regional approaches to service provision.

Discussion: This is not about 8 regional health departments but innovative ways to share public health services. Suggestion to change the word regionalization to innovation.Another alternative in the language could be Cross Jurisdictional Sharing. Maybe it’s a separate principle to engage cross jurisdictionally with healthcare and early learning. The word regionalization is distracting. 1. Recognize the individual roles of state and local public health authorities to achieve outcomes.

Discussion:Need a principle about the public health system, not just state and local.1. Improve transparency about funded work and state and local roles.

CLHO Funding Principles Document Document is a compilation of all of the conversations. Not in high level form like the PHAB funding principles.Discussion:* Can be used to operationalize the next piece. Not in any priority, more as a listing over time. Probably don’t want funding reductions as overall principles but more general.
* Tying funding to the work. Don’t always have the funding to do the work that is needed to be done
* There isn’t a discussion about the work being tied to funding at PHAB.
* Until we are fully modernized the burden of work has to be reflected in the funding.
* Good conversation for PHAO to have if PHAB doesn’t adopt it.
* Strategies for implementation – priorities on the document and look more at how to implement these principles in the committee.
* Will revisit during February meeting.
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| Cost Allocation Update & Timeline | Update | Karen Slothower presented on background of cost allocation. OHA uses cost allocation process for pulling in and distributing administrative overhead and charges which makes it really hard to budget appropriately for cost allocation charges.In 2015 started planning for an indirect cost rate. Set percentage against each of the grants to cover administrative overhead. Helps smooth out cost allocation over time. In 2016 another visit back to the group when they put the planning on hold for OHA’s org structure that could have impacted any rate that they set.Needed to finalize the analysis to make sure they had time to approve the rates.In 2017 picked up planning again. Finalized many design dependencies. Cost allocation methodology is still going to be applied to public health division. Proposes indirect cost rate and planned to implement in July for estimates of rates.OHA is moving Medicaid eligibility program to DHS. Sure it will have an impact on cost allocation assessment. Moving it to July 2019. There is a 12 month lag in reviewing cost allocation proposals. Establish implementation at July 1 2019 but want to move forward as soon as possible so there are no further delays.When would there be an opportunity for the group to see the indirect rate being proposed? In the next quarter will do another review of the rate calculations and as they develop proposal they would come back to CLHO. Will LPHAs need to negotiate their own rates with HHS? Need to look into the impact on LHDs |
| Financial Assistance Agreement Boilerplate | Review & **APPROVE** | Group looking at and approving boilerplate language. There were some outstanding boilerplate issues. Agreed to move the contract through but would come back and look at these issues.The issues they are in conversation about:* Language related to the security of OHA computer systems to which LPHAs have access

• Language related to requirements regarding alternative formats andlanguage access. OHA has federal requirements related to it. Feds require that to be provided. Nothing legally that they can do to change the financial agreement.• Language regarding unannounced site reviews by OHA.Wanted to review this language and change it to 24 hour notice• Force Majeure language that states either party may terminate the FAA upon written notice to the other partyStill working on this language. Will be able to provide either party language but still in discussion.If a CLHO rep wants to attend the FAA workgroup, let Morgan know.Changes that need to be made to FAA because of the changes in the OAR that impact public health:* Language regarding administrative costs (direct or indirect charges) and OHA ability to request information about administrative costs of LPHA, its subcontracts and/or subrecipients applied to funds received through the LPHA FAA. So funds would go to the program or service. Can request information but can’t say anything about the percentage.
* Align boilerplate language with new OAR regarding subcontracting of public health services – OHA can request to see contracts but cannot actually approve contracts
* Behavioral Health Collaborative Language boilerplate addition

Work is moving forward. If there is a significant change they will bring back to CLHO. There is an OHA steering committee for that group. Concern that there could be a BHC meeting that administrators could miss. Danna will make sure to send out information.* Update OAR references as needed to reflect newly adopted rules

• Remove reference to different expenditure report for family planning• Change reference to OHA Assistant Administrator. There is no position. OHA will designate who would fill this role.OHA Statutory Authority – if county isn’t performing, OHA has ability to step in. It’s a last resort but the contract needs to not supersede that statutory piece.An amendment for the EH IGA with LPHAs is also being processed in the next couple of months to:• Align subcontracting approval language with OARs. It says approval of OHA but it is actually a notification |
| Systems & Innovation Update – Expenditure Reporting Update | Update | Mai Quach, Program Support Manager at PHD, presented on expenditure reporting.* Revising report because they want to get revenues by quarter.
* Will help with reporting and reimbursing LPHAs. Indirect cost was incorporating into quarterly reporting.
* Created revised report.
* All expenditures should be categorized so they are detailed. Other category should be used sparingly.
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| Adjourn – Stretch Break! |  |  |