Conference of Local Health Officials

November 17th, 2022
Meeting of the Conference of Local Health Officials
Meeting Began: 9:43 AM

Executive Members: Present: Naomi Adeline, CLHO Chair, Polk; Jocelyn Warren, Past CLHO Chair, Lane; Carrie Brogoitti, Vice-Chair, Center for Human Development Union; Philip Mason-Joyner, Secretary/Treasurer, Clackamas; Dr. Pat Luedtke, Health Officer's Rep; Jackson Baures, Large County Representative, Jackson; Shane Sanderson, Medium County Representative, Linn; Katie Plumb, Small County Representative, Crook; Joseph Fiumara, Coalition of Local Environmental Health Specialists, Umatilla; Lindsey Manfrin, Public Health Administrators of Oregon, Yamhill; Marie Boman-Davis, CLHO Legislative Committee Representative, Washington
Absent: None

Members Present (x if present):

X	Baker – Meghan Chancey	X	Hood River - Trish Elliot	X	Multnomah – Adele Adams
X	Benton – April Holland	X	Jackson - Jackson Baures	X	North Central PHD - Shellie Campbell
X	Clackamas – Philip Mason-Joyner		Jefferson - Mike Baker	X	Polk – Naomi Adeline
	Clatsop – Jiancheng Huang	X	Josephine – Mike Weber	X	Tillamook - Marlene Putnam
X	Columbia – Jaime Aanensen	X	Klamath - Jennifer Little	X	Umatilla - Joseph Fiumara
X	Coos - Anthony Arton		Lake - Judy Clarke	X	Union - Carrie Brogoitti
X	Crook – Katie Plumb	X	Lane - Jocelyn Warren	X	Washington – Marie Boman-Davis
X	Deschutes – Tom Kuhn	X	Lincoln - Florence Pourtal	X	Wheeler - Shelby Thompson
	Douglas - Bob Dannenhoffer	X	Linn – Shane Sanderson	X	Yamhill - Lindsey Manfrin
	Gilliam – Hollie Winslow	X	Malheur - Sarah Poe	X	HO Caucus - Pat Luedtke
	Grant – Kimberly Lindsay	X	Marion – Wendy Zieker	X	CLEHS Caucus - Joseph Fiumara
	Harney – Sarah Laosia		Morrow – Robin Canaday	X	PHAO - Lindsey Manfrin

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OHA Public Health Division: Danna Drum, Andre Ourso, Andrew Epstein, Jamie Coleman-Wright, Courtney Fultineer, Tim Noe, Sara Beaudrault, Cara Biddlecom, Rachael Banks, Annick Benson, Heather Kaisner, Allison Goldstein, Emily Wegener, Alicia Knapp

CLHO Committee Chairs: Kathleen Rees (CD Co-Chair), Kathleen Johnson (EH Co-Chair), Selene Jaramillo (EPR Co-Chair), Jessica Dale (S&I Co-Chair)

Coalition of Local Health Officials: Sarah Lochner, Executive Director; Laura Daily, Program Manager

Guests: Sarah Dobra (OHA Ombudsmen Program), Libbie Rascon (OHA Ombudsmen Program), Rachel Burdon (OHA Transformation Center), Katie Howard (OHA Quality Metrics, Surveys and Evaluations), Lisa Krois (1115 Waiver Renewal Project Director), and Rebecca Donell (1115 Waiver Renewal Deputy Project Director)

Motion: Jackson Baures moved to approve the October 2022 minutes. Jocelyn Warren seconded the motion. Unanimous vote, motion passed.

Agenda Items

Appointments: Naomi Adeline made the follow appointments to the Emergency Preparedness and Response:
Gene Biggs (Yamhill), Carissa Heinige (Deschutes), Melinda Todd (Harney), Ed Colson (Tillamook), Rockie Philips (Tillamook)

PE 73 – HIV Early Intervention Services and Outreach (EISO): Alicia Knapp and Annick Benson (OHA) reviewed that OHA provided an overview of the PE 73 HIV Early Intervention Services and Outreach (EISO) to the CD Committee earlier in November. At this meeting, the tri-county area had some additional comments, and those have since been incorporated. Naomi asked if there was a specific motion they were bringing to the Board. Kathleen Rees (CD Co-Chair) added that the committee reviewed the narrative and PE changes and agreed to move it forward once the tri-county comments were considered. OHA staff revised the PE based on the tri-county comments – they incorporated most of them and provided reasons where they could not make changes. Kathleen sent this out to the whole CD Committee for additional comments – no other comments were sent in. Kathleen stated that the CD Committee did not vote and is not bringing a formal motion but that the committee has reviewed it and does not have changes.

Danna Drum added that these were specific EISO funds coming to an end after 5 years as part of the End HIV Oregon program. There was an initial round of funding, and there is now a second round of funding. The changes proposed here are based on administrators' request to simplify the funding, so these funds are being moved into the PH IGA for the counties that are currently receiving this funding. Annick added that the changes to this PE are identical to the feedback they've received from the counties.

> **Motion**: Florence Pourtal made motion to approve the changes to the PE 73. Jackson Baures seconded. Unanimous vote, motion passed.

PE 62 – Fentanyl Campaign Funds: Courtney Fultineer (OHA) reviewed that there is $140,000 available to assist counties with fentanyl campaigns. OHA has been working with an ad hoc committee of the Health Promotion and Prevention Committee to determine how to distribute this funding. The funds must be used by August 31st, 2023. Lane County and Klamath County have offered to provide their existing campaign materials, so while the funds can be used to create materials, it can also be used to adapt existing materials.

There are 11 counties with contracts through PE 62 and PE 70, so the proposal discussed by the HPP Committee is to distribute these supplementary funds to these counties through these two PEs, and these lead counties will partner with surrounding LPHAs and distribute the funds through existing contracts, MOUs, and other agreements. Courtney showed a list of 26 counties in total that will receive funds through this model (using the Public Health Modernization formula with a base of $5,000). For example, Clackamas County is receiving PE 62 funds but also offered to also take on the funds for Washington County, and then those two counties will work together to determine the best strategy for using these funds on fentanyl campaigns. Courtney added that the proposal is also to allow these funds to be used before the deadline and to allow OHA the flexibility to revise LPHA funding sources if this method has hiccups rather than coming back to the CLHO Board for full approval.

Danna Drum stated that this type of item should be brought by the HPP Committee and asked for Jennifer Little (co-chair of HPP) to provide the perspective of the committee. Jennifer stated that this is something the committee approved to expedite the process and to provide that flexibility for counties to partner and OHA to help with contracting. Naomi asked if the committee voted on this plan, and Jennifer confirmed that the HPP Committee did vote to approve and is bringing this motion to the Board. Naomi asked for questions before proceeding.

Sarah Poe stated in the chat: “Unfortunate that the funding would be going only to counties with Overdose Prevention Coordinators. Counties without those PEs need the funding more. And funding needs to go to counties to help track overdose deaths. The number for Malheur is grossly undercounted.” Danna asked Courtney to clarify why a county might not see their name on this list. Courtney stated that, to expedite this and spend the funding by August 2023, the solution was to go through the 11 counties that do receive these funds and ask them to identify which other counties they would be able to support. Jennifer stated that, as an example, Klamath will be supporting Malheur County, who is not on this list and does not receive these PE funds. Courtney added that another example of this is Crook County working with Baker County.

Danna received a question in the chat asking how counties were originally chosen for PE 62 funds. Courtney stated that it was before her time at OHA but that it was done through a grant with the CDC and was determined by overdose death rates.

Anthony asked in the chat who would make the purchases for Coos so he knows who his prevention specialist should be coordinating with. Jennifer stated that he would just look for whichever county that is the closest to Coos and receiving the funds, or they could connect him with the HPP Committee.

Florence Pourtal stated that there was an opportunity to say no to these funds as a county receiving PE 62 funds. Her prevention coordinator was consulted but she was not, and so Lincoln County is not on this list. Danna stated that this was something that needed to be shored up in the process because administrators needed to be consulted on funding.

> **Motion:** The HPP Committee has brought a motion to approve this method of distributing fentanyl campaign funds through PE 62 counties. Jocelyn Warren seconded. Unanimous vote, motion passed.

PHEP Funding Formula: Selene Jaramillio (EPR Chair) reviewed that this funding is carry-over from previous PE 12 PHEP BP3 funding (total of $309,730). The EPR Committee explored a population-based funding distribution first but opted to have a $3,000 base with additional funds allocated based on population so that every county has at least some funding for travel (for example, to the Emergency Preparedness Conference in Atlanta) though it does not have to be used for travel. The EPR Committee voted unanimously to approve this.

> **Motion**: The Emergence Preparedness and Response has made a motion to approve this funding distribution of the carry-over PE 12 funds. Jennifer Little seconded. Unanimous vote, motion passed.

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PE 51-05 – CDC Infrastructure Funds: Danna Drum reviewed that there is an additional section added to PE 51 (05) to define and distribute the funding from the CDC Infrastructure Funds (exact amount unknown – notice of award may come as late as December 1st). It is one-time funding to be used over five years. The additions to the PE made by JLT+ are left very broad to allow as much flexibility as possible for each LPHA. Danna reviewed the changes to the PE (Section 4):

Requirements that apply to Section 4: Public Health Infrastructure

a. Implement at least one of the following activities:

1) Implement strategies and activities to recruit, hire and retain a diverse public health workforce that reflects the communities served by the LPHA.
2) Recruit and hire and/or retain new public health staff to increase workforce capacity in foundational capabilities and programs, including but not limited to epidemiology, communicable disease, community partnership and development, policy and planning, communications, and basic infrastructure (fiscal, human resources, contracts, etc.). LPHA will determined its specific staffing needs.
3) Support and retain public health staff through systems development and improvements.
4) Support and retain public health staff through workforce training and development.
5) Transition COVID-19 staffing positions to broader public health infrastructure positions.
6) Recruit and hire new public health staff, with a focus on seeking applicants from communities and populations served to provide additional capacity and expertise in the foundational capabilities and programs identified by the LPHA as critical workforce needs.

b. LPHA may request in writing prior approval for other related activities. No such activities may be implemented without written approval of OHA.

OHA has set aside $14 million for LPHAs – however, the amount Oregon receives may be smaller. Danna added the building and vehicle purchases will be very challenging to get approved as would funds for staff retreats and such (different from travel for training).

Section 6 clarifies that OHA will collect data and information required by the CDC for reporting and evaluation but will not collect more than that. Philip Mason-Joyner stated that he liked the changes to the PE but he is concerned that the reporting requirements are so broad that it may create additional administrative burden for LPHAs. Danna stated that OHA doesn't have much information about what the CDC will require. However, the reporting requirements in Section 6 discussing a

workplan does not apply to PE 51-05 funds. Sara Beaudrault clarified that they would collect budgets for PE 51-05 funds but not workplans.

Danna reviewed the funding formula (Public Health Modernization funding formula) and county allocations. The amount shown on the spreadsheet will be the one-time amount the LPHA receives for the entire 5 years. Sarah Poe asked if these funds would carry over – Danna clarified that yes, these would carry over, and LPHAs can decide if they use it all in the first year (or any year) or spread out over the years.

Danna suggested that the Board vote on the proposed PE 51-05 language and funding formula before moving onto the disbursement schedule. If there is a significant change in the amount, OHA will bring it back to CLHO.

> **Motion**: Florence Pourtal made a motion to approve the PE and funding formula. Lindsey Manfrin seconded. Unanimous vote, motion passed.

Danna then reviewed the potential disbursement schedule. JLT+ discussed whether this should be disbursed in an upfront lump sum to LPHAs. After conversations with OHA's fiscal staff, Danna stated that OHA would prefer to not disburse the entire amount in a lump sum at the beginning of the 5 years. OHA learned during COVID that lump sum payments leave LPHAs with a lot of cash-on-hand which makes reconciling challenging. Since some counties will want the funds immediately upon approval and others may want to wait until later (until year 3 or 4, for example), OHA proposes windows of time where LPHAs can opt into receiving their award. For example, in April of each year, LPHAs can let OHA know if they want it in the upcoming fiscal year, and OHA will add the full award to the LPHA's IGA in the new fiscal year in July. LPHAs could receive it through 1/12th payments like other funds (in which case, OHA and LPHAs would do the normal reconciliation process). Another option would be for OHA to provide funds in 3-month payments. LPHAs would then submit R&E reports, and if they spent over the amount provided for that 3-month time, they would be reimbursed. This method would provide LPHAs with the initial cash flow and then move towards reimbursement to avoid the constant reconciliation. These funds do carry-over, so even though an LPHA opts to receive the funds in year one and is awarded the full amount in year one by OHA, they can still use the funds in subsequent years if they have planned it out that way.

Danna paused and asked for questions. Joe Fiumara stated that he believes he was following but that this process meant to simplify the disbursement seems more complicated.

Trish Elliot added that it would make budgeting at the local level a challenge since they budget in January. Danna clarified that LPHAs would know the amounts and what is coming, so they should still be able to plan for it in their budgeting.

Shane Sanderson added that, while he would need to look at the award amounts and strategize with his supervisor team, he would like to see an option to receive it in 1/5ths payments each year over the five years. When Linn County received the first lump sum COVID payments, the commissioners viewed that money as covering all of public health and didn't think they needed to continue their tax levy for certain programs. Shane explained that these funds were restricted and semi-restricted, and this was poorly understood. If he were to receive this award in a lump sum, he would be lucky to make it last a year. Danna clarified that LPHAs would not receive the lump sum as a single check – it would just show in the LPHA award. 1/5th payments each year would be possible but challenging for OHA. It would be important to look at the dollar amount since this grant is dedicated to recruiting/retaining or building up infrastructure to support the workforce, and spreading it thin across 5 years might not achieve that.

Philip Mason-Joyner asked if OHA would not disburse the funds until July 2023. Danna clarified that LPHAs would state when they want to receive the funds. Assuming an award date of January 1, LPHAs could receive it for the remainder of FY 22 or could delay until FY 23 or 25, and so on. Philip stated Clackamas would want some of the funding this year because, like many counties, they cannot get approval to hire unless there is money in the bank account.

Florence stated that she agreed with Philip and asked if a portion could be an amendment in the current biennium and the rest awarded in the next biennium. She also asked if the approach could be simpler, such as 50% now and 50% in the next biennium. She stated, to Philip's point, the counties need some funds now to be able to start the hiring process.

Danna stated that OHA can send out a survey to ask LPHAs how much of the funds they want for FY 22, and OHA will send out another survey in March to ask LPHAs how much they want in FY 23. She clarified that, like with any PE, the LPHA won't receive a lump sum. Naomi stated that this seemed like a good solution for now since we won't be able to reach a conclusion today.

SDOH CCO Metric: Naomi amended the schedule slightly to accommodate presenters with time constraints and moved to the Coordinated Care Organization Metrics presentation. Rachel Burdon and Katie Howard began presenting.

The CCO Quality Improvement Program conducted an equity impact assessment and incorporated these recommendations into the new 1115 Medicaid Waiver. In past waivers, there was one set of metrics with the Health Plan Quality Metrics Committee (HPQMC) selecting the menu and the Metrics and Scoring Committee (M&SC) picking the metrics and benchmarks, and CCOs earned bonuses by meeting benchmarks or a target percentage of all the measures. In the new process, there are sets of both upstream and downstream metrics, and there is a greater focus on specific metrics that are incentivized to work on root causes of inequities and maintaining basic quality, and there will be a greater role for communities in the committees for setting priorities for metrics.

The upstream measures are a smaller set and likely home-grown measures:

- Focused on strategic goal to eliminate health inequities by 2030
- For example, home-grown measures such as social determinants of health, meaningful language access, and health aspects of kindergarten readiness

The downstream metrics are selected from CMS Medicaid Core sets:

- OHA will be required to report to CMS on about 35 Core measures
- Not all will be selected as incentive metrics
- For use in Oregon, OHA will stratify where possible using Race, Ethnicity, Language and Disability (REALD) data

The upstream metrics already in place include:

- Health assessments for children in ODHS custody
- Kindergarten readiness: CCO system-level social-emotional health
- Meaningful language access to culturally responsive health care services
- Social determinants of health: Social needs screening & referral **(focus of today's presentation)**

The measure development process was guided by three principles: equity, feasibility, and alignment. OHA engaged with many partners to ensure the metrics met these principles. While equity was part of these guiding principles, the real opportunity to advance equity lies with partnering with community to implement strategies to meet the metrics.

The SDOH metric focuses on three things: food insecurity, housing insecurity, and transportation needs. Component 1 (to be measured in the 2023-2025) assesses CCOs' plans for implementation of social needs screening and referral in an equitable, trauma-informed manner; and ensures groundwork is laid for data sharing and reporting. Component 2 - (to be measured in the 2024-2026) measures the percentage of CCOs' members screened and, as appropriate, referred to services.

For Component 1, CCOs have three domains in which they are measured: screening practices, referral practices and resources, and data collection and sharing. The full list of measures and what year the CCOs must pass them is in slides 9-10 in the meeting materials. CCOs will be collaborating with OHA and CBOs to implement these elements of work.

This SDOH metric was first proposed in 2015 by the Oregon Food Bank. From 2018-19, the M&SC and the HPQMC approved the boarder, plan-level social needs measure and request development. From 2019-2022, OHA conducted further engagement, measure development, testing, and piloting with Coordinated Care Organizations. It will be implemented from 2023-2025. The Transformation Center is planning support and technical assistance for the implementation of this metric. They will hold a variety of webinars and learning collaboratives and are partnering with Oregon Rural Practice-based Research Network (ORPRN). They have already provided two webinars (recording linked in the slides), one for clinical partners and one for CBO partners.

Katie and Rebecca opened it up for questions. Pat Luedtke stated that many health officers' and health departments have found it generally impossible to access claims-based data, and there are concerns that this SDOH data will also not be available. He asked if there was anything within these changes to compel that sharing. Katie responded that she will get back to Pat but that a key component of this measure is that CCOs share this data back out with partners in a meaningful way. Rebecca added that the Community Information Exchanges (CIEs) have been a major player in building this metric, so this sharing of data is on the Transformation Center's radar for technical assistance.

Sara Beaudrault stated that health administrators should be aware that CCOs are required (based on previous metric implementation) to produce a plan to show how they are distributing their incentive funds to health care providers, public health providers, and CBO partners. They will also be required to produce a report showing the distribution of these funds shortly and must be transparent about how community partners can access those funds.

Naomi asked that further questions be sent to Laura Daily to be answered after the meeting. Katie also provided an email to direct questions to: Metrics.Questions@odhsoha.oregon.gov

Questions asked and answered in the chat:
Marie Boman-Davis : Will this be integrated with https://oregon.uniteus.com/?

Rachel Burdon : Marie - we are very aware of and working to include community information exchange (CIE) as part of the systems-level work needed to support the implementation of this metric. unite us/connect Oregon is one CIE being used pretty widely across Oregon, but there are other CIE platforms/companies.
Florence Pourtal : Love the idea of CIE - we are seeing a big issue with implementation in community as this is "another" data system to be used. Is there anyway to help CCOs think about ways in which we could use existing systems or at least have CIEs that can "talk" to other systems?
Rachel Burdon : Yes, I understand, Florence - there are many different places where this social data lives or could live. Much to dig into at State level and also at the local/regional level around data platforms/systems and interoperability.
Marie Boman-Davis : Agree with Florence. Rachel are data sharing agreements in place? That would likely come before interoperability. Exports that can be imported and read by different systems (e.g., R, Tableau) is a way around interoperability.
Rachel Burdon : Florence and Marie - really good points and questions. I don't have answers now, but one thing I think could be helpful in a follow-up presentation for CLHO is from another team in OHA/Health Policy & Analytics and that is the OHIT (Oregon Health Information Technology). They are leading the work related to CIE and are much more knowledgeable.

1115 Medicaid Waiver Renewal: Rebecca Donell (Lisa Krois had to leave join another call) presented on the 1115 Medicaid Waiver approved for 2022-2027. This is the blueprint for Oregon's Medicaid Program and is negotiated with CMS. Every five years, there is a community process to determine what will be included in the new waiver, and then OHA enters negotiations (from February to September of 2022 for this waiver).

The overarching goal of this waiver is to Advance Health Equity. To achieve this, there are 4 sub-goals: ensuring people can maintain their coverage; improving health outcomes by addressing health-related social needs; ensuring smart, flexible spending for health-related social needs and health equity; and creating a more equitable, culturally-and-linguistically-responsive health care system.

In the 2022-2027 Waiver, there were several new authorities approved:

- Continuous enrollment for children through age 6
- Two-years of continuous enrollment for people aged six and up
- Providing health-related social need (HRSN) benefits (housing and nutrition services) to OHP members going through life transitions (slide 6 of presentation for all included members)

- Providing HRSN benefits related to extreme weather events (such as air conditioners and air filters). Oregon is the first in the nation to offer this.
- OHP will include all Early Periodic Screening, Diagnosis, and Treatment (EPSDT) required services for children and youth to age 21.
- The Youth with Special Health Care Needs (YSHCN) eligibility criteria will allow these youth to have expanded benefits, including EPSDT, until age 26.
- HRSN benefits will be available for YSHCN, children and youth who are welfare involved, and youth involved in criminal justice and their families.

The full list of HRSNs available is on slide 8.

Rebecca clarified that the Health-Related Services (HRS) Flexible Services currently exist and are available to all CCO members (not available to fee-for-service recipients). The new HRSNs differ in that only populations going through select transitions are eligible, but they are open to those populations regardless of whether they are CCOs members or fee-for-service. Jennifer Little asked if access these HRSN services will require a doctor's note and if there is a cap on the benefits. Rebecca stated that the process for requesting HRSN benefits is still in development and that there is no cap.

Oregon and CMS agreed that the Prioritized List as it is currently used in Oregon's Medicaid program no longer requires waiver authority and that it is preferable to transition the Prioritized List to the State Plan. Given the nearly thirty-year history of the Prioritized List, the state will need to complete a detailed regulatory and operational review with the potential for meaningful changes in law, rules, or processes. Accordingly, the waiver of amount, scope and duration will terminate on January 1, 2027, to give the state sufficient time to make necessary changes.

The items that Oregon requested were not included in this waiver are:

- Rate-setting flexibilities for CCOs
- Pharmacy flexibilities
- Expediated Medicaid enrollment via the Supplemental Nutrition Assistance Program (SNAP) – this will likely be approved through a different avenue.
- Employment and transportation HRSN benefits – conversations are continuing around this.
- Covering peer-delivered behavioral health services outside a care plan – this will be added to Oregon's State Plan Amendment (SPA)

Oregon received authority for $268 million Designated State Health Programs (DSHP) federal buy out for the five years of the demonstration. The buy-out allows federal matching funds for a state-funded Designated State Health Program that "free up" state funding to support YSHCN coverage and HRSN services and related infrastructure investments. The "freed up" state funding will result in $1.2 billion across the demonstration, which includes a state contribution of $88 million during the last year of the demonstration. Therefore, the total in federal funds are $1.1 billion for the demonstration.

Due to time, Rebecca skipped over the proposed legislative concept. There are several items that are still in negotiation, including the Tribal related requests, OHP coverage before people leave custody (such as the jail or state hospital), and the Community Investment Collaboratives to fund local health equity efforts. EPSDT will go live in January 2023, and continuous enrollment will go into effect in spring of 2023. OHA will have a year to implement these other new authorities, and the HRSN benefits will go into effect in January 2024.

Due to time, Naomi requested that anyone with questions send them to Laura Daily for follow-up.

Modernization Implementation Plans: Florence Pourtal and Jessica Dale (S&I Co-Chairs) reviewed the S&I's Committee work thus far on the Modernization Implementation Plans and asked to establish a process for reporting progress to the Board to ensure the Committee's direction is correct. For background, Florence referred to the ORS: "Subject to the availability of funds paid pursuant to ORS 431.380 (Distribution of funds), each local public health authority shall […]:

- In consideration of the local public health modernization assessment, adopt, implement, monitor, evaluate and modify as necessary a local public health modernization plan that includes:
    - A plan for applying the foundational capabilities established under ORS 431.131 (…) and implementing the foundational programs established under ORS 431.141 (…) as required by ORS 431.417 (…); and
    - Any other local public health program or activity that the local public health authority considers necessary to protect the public health and safety […];

S&I's approach to this work thus far has been to ensure all the committee members are up to speed and to establish common language and principles to guide the work. The committee is also checking on the "vision" for a local modernized public health system by brainstorming within the committee and extracting data from the PE 51 Reporting that all LPHAs submitted/are submitting to OHA (specifically, the "elevator pitch" requested about each county's PHM work). The committee then plans to analyze the themes to establish that common vision and use this to develop a guiding document for LPHA's on

how to approach the PHM Implementation Plan. The Committee could also produce a template and potentially provide technical assistance workshops to LPHAs if these are needed. S&I is not rushing this process and is aiming for a due date of July 2024, which provides LPHAs with 18 months to develop their plans. Throughout this, S&I will be checking in with the CLHO Board and with PHAB to ensure the vision and direction is correct.

Some of the guiding principles for the committee are:

- Guided by ORS
- Maximum flexibility and adaptability for LPHAs
- Plan is for full implementation of foundational programs and capabilities
- Focus on outcomes and goals, “the what” rather than the strategies or “the how”
- Local plan is forward-looking and forward-thinking (not a work plan of current work)
- S&I should provide something that allows every jurisdiction to be successful in meeting requirements in ORS
- Maximize usefulness and meaning for LPHAs
- Think about review criteria as they draft the guiding document

Florence reviewed the timeline for this work.

- In Fall of 2022, the Committee set up the regular meetings, presented primary themes for the vision, and developed an outline of the work.
- In Winter of 2023, S&I will present a draft shared vision to the CLHO Board (hopefully in time for Legislative Session so our messaging is unified), and establish regular check-ins with PHAB.
- In Spring of 2023, S&I will add the requirements to start working on a PHM Implementation Plan to PE 51 and will update PE 51 based on any new legislative investment (taking a pause from developing the actual plan)
- In Summer of 2023, S&I will finalize the guiding document.

This timeline is more condensed than what S&I is planning (due date of July 2024) to provide room for changes to schedule.

Florence and Jessica opened it up for questions. Jennifer Little asked if this is meant to replace the Public Health Modernization Manual. Florence clarified that this is separate – the ORS requires LPHAs to develop a local plan for the full implementation of PHM, and this guiding document is to help LPHAs develop those plans. Jessica added that this is building off the 2016 costing assessment Oregon did to identify gaps and needs within LPHAs for these foundational programs and capabilities.

Naomi asked Florence to provide clarification on the difference between this work and PE 51. Florence stated that PE 51 provides the program requirements and expectations for LPHAs based on the current funding level, and as the funding goes up, the expectation in PE 51 increase. At our current funding level, PE 51 is focused on two foundational programs (Communicable Disease and Environmental Health) and most of the foundation capabilities. Florence added that S&I thinks that some of the Public Health Modernization Manual will eventually need to be updated, but for now, that is not the focus. This PHM Implementation Plan is instead each LPHA's blueprint for how they fully implement all four programs and all the foundational capabilities when the full funding amount is provided.

Naomi asked the Board if they approve of this direction that S&I is proposing and what check-in schedule to establish. Jocelyn Warren offered that S&I have check-ins with the Board when they hit major milestones rather than regular check-ins. Philip stated that he appreciates the work Florence and Jessica have done on this important work, and because it's been a long meeting, he would like to dig into this more at a future meeting to ensure the CLHO Board has the background information necessary to direct the S&I Committee and is aligned around the vision or a modernized local public health system.

Public Health Modernization Policy Option Package Prioritization Process: Due to time, Naomi moved to Sara Beaudrault to discuss the Public Health Modernization policy option package (PHM POP) prioritization process. Sara stated that OHA has been requested to provide examples of work that can be achieved at funding levels lower than their budget request – this is a normal process that happens every budget cycle for all state agencies and is right on schedule. OHA began with PHAB earlier in the fall, but PHAB members asked that OHA convene a workgroup to have conversations about prioritization across LPHAs, CBOs, and PHAB (Tribes will use a separate, government-to-government process). This is a shift from what we normally do, and CLHO members who have previously participated in the JLT+ workgroup will see those meetings coming off their calendars, and Sara will be sending out a request for LPHA people to sit on this group (some LPHA representatives on PHAB have already volunteered).

Other agenda items: Due to time, the following agenda items will be addressed outside the meeting:

- 2023-2025 PH IGA Updates (Danna will send an email)
- CIC Certificate and Training (Heather Kaisner will send an email
- PHAB Accountability Metrics (this will return at the December meeting)

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Meeting Adjourned at 11:40 AM