CLHO In-Person Retreat | September 16, 2025

The table on page 2 includes opportunities to improve on Modernization identified during breakout group conversations.

These opportunities will be included in the “implementation plan” deliverable of the Modernization Vision Refresh process.

OHA and CLHO can review these opportunities and jointly determine priorities, resources/ capacity, and timeline to build out a shared workplan.

<u>Opportunities takeaways:</u>

- Reconsider using the term “Modernization”
- Update Modernization Manual
- Develop strategic communications brand/campaign
- Explore alternative funding models for CBOs
- Clarify decision-making venues and processes
- Convene larger group of public health system partners to discuss roles and opportunities for coordination and alignment
- Develop better onboarding materials for new LPHA administrators and staff

Category	Opportunity	Other Notes
Communications	Reconsider the use of the term “modernization” to describe foundational public health services.	Recommendation to use “foundational public health services” which more simply communicates the primary goals of modernization (i.e., provision of core public health services). Also, consider whether we need to move completely away from Modernization or use in combination with “FPHS” or “essential public health services”. Explore/learn from other states’ approaches, including what they call FPHS and how they communicate/frame the work. Need to be careful to avoid the perception that modernization has failed and needed to rebrand. Consider focus group with legislators/other decision-makers to discuss preferences for naming convention and key messages.
Communications	Reaffirm how we describe modernization: • Recenter role of governmental public health in modernization given statutory requirements to provide and/or ensure access to public health services and accountability to funding. • Describe modernization as both a dedicated funding stream and a systems change	Describe partners as critical to expanding governmental public health capacity for specific foundational programs and capabilities (e.g., CBOs support capacity for health equity and cultural responsiveness capability). Highlight the various funding streams that contribute to modernization and the importance

	initiative that pulls from multiple funding streams to implement. • Clarify whether "modernization" is providing core/foundational public health services or doing something extra or new. • Distinguish general public health practice and public health modernization.	of flexible, state general fund modernization dollars. Flexible funds support adaption/ resilience to external funding changes to maintain core public health services. Use the OHA program element table as a resource to better describe how the various funding streams from OHA contribute to modernization program priorities.
Communications	Develop a strategic communications plan and campaign (potentially based on a new name).	Conduct message testing and formal evaluation of a communications campaign/brand for modernization/FPHS. Consider how the OHA modernization website could be improved as part of strategic communications plan.
Partner engagement	Convene a larger group of public health system partners (e.g., education, health care, etc.) to discuss their role in the public health system, partnership with government public health, and support of modernization.	Hire third-party, neutral contractor to facilitate convening and discussion to identify opportunities for coordination and alignment.
Tools/Supports	Update the modernization manual to: • Reduce jargon/use plain language • Specify "must haves" from "nice to haves" • Ensure roles reflect current practice	"Must haves" could be defined in statute and/or clear community priorities from local leaders and decision makers. Consider the modernization manual as a living document with opportunity for more frequent updates to reflect current practice and language.

	• Make more “nebulous” sections as concrete as possible (e.g., environmental health) • Include explicit language that modernization will evolve over time and look differently in each community based on local priorities • Explicitly state that not every LPHA will meet every role in the modernization manual • Specify the roles of partners (or include in complementary documents if there is a desire to maintain the manual’s current focus on governmental public health)	
Tools/Supports	Develop more accessible guidance on: reporting requirements; workplan development; and incentive metrics and deliverables.	Will need to clarify what “accessible” means for these guidance documents. Consider how PE 51 and other Modernization guidance could more clearly tie back to the manual. Consider how OHA materials/guidance can better highlight best practices (e.g., public health practice standards such as recommended #EH specialists per X population).
Funding	Allow small proportion of LPHA modernization budget (10% to 15%) as flexible for use on direct service provision, if a community need.	LPHAs do not have to use this for direct services but it is allowable.
Funding	Explore alternative funding models for CBOs (referencing OHA Public Health Equity Grant):	Consider this new funding model in the 27-29 biennium which would give us time for a “soft

	• LPHAs eligible to receive funds for direct grantmaking to CBOs based on modernization funding formula • Grant-funded activities for CBOs align with LPHA workplans/CHIPs • For LPHAs that do not have grant-making infrastructure, could leverage OHA's infrastructure to do grant making in partnership with LPHA or LPHA can contract with a third-party intermediary (e.g., Oregon Public Health Institute, Seeds of Justice) to do the grant making and training/TA. • Regardless of the grant maker, OHA could still provide training and TA opportunities for all funded CBOs (e.g., technical expertise from OHA program staff, contract with Non-Profit Association of Oregon). • For LPHAs that do not have capacity for grant making and do not have identified CBOs in their communities, funding could be used to work with any community leader to advance modernization priorities.	landing" of the 25-27 state-directed funding and request for grant applications. This could respond to desire for shared accountability structure between CBOs and LPHAs. If alternative funding models are not possible, would need to determine a different way to develop shared accountability structures between LPHAs and CBOs.
Funding	Explore the following opportunities with CCOs: • CCOs pay public health for contributions to quality incentive metrics (public health needs to clearly show how it contributes). • Increase transparency of CCO contracts with LPHAs (allows us to elevate good	

	models; LPHAs can use successful strategies during negotiations) • Continue to prioritize local public health officials on CCO governing boards.	
Funding	Explore other funding opportunities, including: • Connecting with private entities to ask for non-monetary resources (expertise?) • "Hardwire" funding into the system/find opportunities for ongoing revenue streams (e.g., advocate that a portion of cannabis, tobacco, alcohol taxes go to public health).	
Decision-making	Clarify decision-making processes for modernization in the following ways: • Map governance spaces and whether they are "inform" or decision-making spaces and what types of decisions are made • Clearly name who has authority over each type of decision (reporting, workplans, funding allocations, language choice) • Create a decision-making matrix or map to clarify: type of decision; who is consulted; who decides; where change is possible; where it is not • Formally adopt models like "You said / We did" or IAP2 levels of engagement	

	• Develop conflict resolution processes so it is clear what to do when a final decision is made that not everyone agrees with • Build shared understanding of advocacy pathways vs. decision authority • Develop shared agreements that outline communication norms and engagement expectations.	
Workforce	Develop better onboarding materials for new LPHA administrators and identify resources for better succession planning.	Existing resources for succession planning may be available through ASTHO. NACCHO has a community of practice that is sharing best practices for dealing with the current funding climate in public health. Onboarding materials should orient new public health administrator to modernization decision-making structures, funding processes, and where/how to "plug in."
Workforce	Develop buddy system or small groups for LPHAs to support each other.	
Workforce	Continue to explore service sharing and regionalization opportunities as resources constrict, where it makes sense. Alternatively, explore sub-contracting between counties rather than shared positions/work to help keep the power local.	Acknowledge fiscal challenge when "commissioners in my county are adamant that no money from our county go to another county."

	Explore change to PE language to allow flexibility for LPHAs to partner with each other or pass through funds.	
Metrics	Explore the following improvements to accountability metrics: • Better communicate the locus of control over some health outcome measures • Better connect funding to state goals/outcome measures in accountability metrics (e.g., false narrative that modernization support vaccination outcome measures since vaccinations are not modernization funded) • Better pair accountability metrics updates with stories of the work in local communities. • Align accountability metrics with CCO incentive metrics	
Reporting	Explore the following improvements to: • Less burdensome reporting timelines and structures • Opportunity for verbal reporting (more conversation between OHA and LPHAs about LPHA work would be desirable)	Align with administrative burden assessment?

Breakout Group Notes

Group 1: Shared understanding of the public health modernization framework and purpose

- Developing a shared understanding is difficult when we do not have the funds to fully implement and need to prioritize only 2 of the 4 foundational programs. This makes it difficult for staff working in those other programs to feel invested/connected. Attempts to de-silo and braid funding are limited by the phased implementation that focuses on communicable disease and environmental health.

- Recommend describing modernization as both a dedicated funding stream and a systems change initiative that pulls from multiple funding streams to implement. How do we better talk about the various funding streams that contribute to modernization and the importance of flexible, state general fund modernization dollars in responding to changes to the other funding source (which supports resilience and adaptation of the system to ensure provision of core public health services).

    - Recommend maintaining flexibility of modernization funding to maintain core work when other funds go away, i.e., all funding sources contribute to modernization, but modernization-specific funds from the legislature help maintain core services/infrastructure when other funds go away (e.g., PHEP)

    - OHA program element table could be a resource to better describe how the various funding streams from OHA contribute to modernization program priorities

- Funding (modernization or otherwise) for disease-specific work is not sufficient for requirements. Question: not sufficient for PE requirements or mod manual roles?

- Lack of clear communication to health systems about what public health does/does not do. Also, lack of clear communication to health system partners about modernization specifically but may need to educate on public health generally before conversations about modernization.

- People outside public health do not understand public health or modernization. Revisit some of the simple, original language from 2015 that was used to describe modernization simply as "all Oregonians have access to core public health services no matter where they live" and that these services will also be unique to each community and center community solutions to jointly-defined public health problems.

- Question whether we should continue to use the term "modernization" to describe the systems change initiative as the word "trips people up." Other states refer to the work as "foundational public health services" and wonder if this would be more plain language and easily communicate what we are trying to achieve, i.e., does modernization imply ensuring core services or better than core services? Concern that the term "modernization" will not be evergreen.

    - Counterpoint: Nervous that rebranding away from "modernization" could be perceived by the legislature and other decision-makers as having "failed" to modernize. Should we change the word or clarify the meaning (we have an opportunity to reclaim the word!)?

- Re-affirm the central role of governmental public health in modernization given state and local governments are ultimately accountable to the funding (opportunity to clarify the dollars and related responsibilities of governmental public health). Suggestion to clarify that modernization is a governmental public health systems change effort with many critical partners that help achieve the goals, some of which are funded to support/provide additional capacity for certain foundational programs/capabilities (e.g., CBOs for health equity and cultural responsiveness). This will provide an opportunity to clarify partner roles, which we are starting through the visioning process.

    - The CBO supplement document could support the conversation on complementary CBO roles in modernization.

    - Reaffirming the role of governmental public health also allows us to recenter LPHA expertise/knowledge and existing community partnerships at the local level. This implies a critical look at the funding mechanism to CBOs (i.e., OHA Public Health Equity Grant where the state is directly funding CBOs). Explore LPHAs having option to receive the funding and do direct grantmaking with OHA to do grantmaking for LPHAs without capacity/infrastructure and providing training and technical assistance. Concern this is OHA "sacred cow" and LPHAs do not have influence over this structure; if there is not potential for change, do not start this conversation.

- Opportunity to update the modernization manual:

    - Modernization framework does not reflect actual practice in LPHAs. Clarify must haves (e.g., statutory requirements) or "core work" from nice to haves and understand that these can differ by local governing bodies.

    - Be more explicit in modernization manual that "we will never look the same" and not every LPHA needs to do everything outlined in the manual, i.e., it will be tailored to local communities. Clarify the manual is "aspirational."

    - Include a more explicit quality improvement orientation, so it is clearer that while the manual details governmental public health roles, the definition/scope of modernization may change as we continue to learn and iterate/conduct QI (QI orientation also feels more action oriented).

    - Opportunity for the manual to be a living document, regardless of the "how" which could change; try to connect roles to the shared end goal.

- Given LPHA administrator transitions/turnover, what could more robust onboarding of new administrators look like and who is responsible for this (CLHO? OHA? Both?). What can we do to ensure the workforce is more resilience to staff and leadership turnover? Are there existing resources that can support this?

- Lack of public health practice education or experience with new workforce hires requires more robust onboarding and succession planning to preserve institutional memory/practice. There may be succession planning resource from ASTHO. Opportunities for shared services and regionalization could address fewer qualified candidates being available for positions that require certain expertise (e.g., epidemiology).

Group 2: Shared Decision-Making Structures

Key Themes

Clarity in Decision-Making

- Who makes decisions at various levels (CBOs, LPHAs, OHA, PHAB, elected officials, legislature)?
- What decisions are shared, which are top-down, and which are truly collaborative?
- What is the process/pathway for how decisions are made and how they flow through the system?
- Can we clearly name who has authority over each type of decision (reporting requirements, workplans, funding allocations, language choices like modernization)?
- Is it possible to create a decision-making matrix or map to clarify:
    - Type of decision
    - Who is consulted
    - Who decides
    - Where change is possible
    - Where it is not

Previously, decision-making was more collaborative (CLHO/state joint teams), but now it feels more top-down, with little transparency.

Advocacy vs. Decision Authority

- Groups like AOC are seen as influential advocates, but decision-making power is unclear
- Confusion over what roles various groups play in the allocation of funding and policy decisions

Feedback Loops

- When stakeholders give feedback, how is it used?
- Is there a system for reporting back decisions and showing how input was integrated (or why it wasn't)?
- Could we adopt models like "You said / We did" or IAP2 levels of engagement (Inform, Consult, Involve, Collaborate, Empower)?
- Could we develop a shared language or classification system to clarify the intent of each engagement (for information, for consultation, for shared decision")?

- How does the modernization budget get decided? Who decides who gets a piece of the pie? What % to each recipient?

- Even when I don't have a say, I appreciate being told clearly , that in itself feels respectful.

Transparency: How do we share power while maintaining accountability?

- Many perceive CBOs as having power without the same level of accountability as governmental public health.

- CBOs often report to OHA, not counties, which creates disconnects in local alignment and implementation. *[overlap with recommendation to explore alternative ways to fund CBOs from Breakout Group #1]*

- Questions raised:

    - Who is holding whom accountable?
    - Do LPHAs have influence over CBO deliverables?
    - Is there a shared accountability structure between CBOs and LPHAs?

- Some smaller or rural counties lack CBOs altogether. How are they supported?

- Somebody has more power, somebody has less. The county feels like it lost control. How do we mend that?

Framing of Modernization

- Should we continue calling it modernization? *[same theme as Breakout Group #1]*

- Is the term confusing? Should we instead align with terms like foundational public health services (as used in other states)?

- Who decides the framing/language used?

- Many feel that modernization lacks a shared definition.

- The complexity of the work is compounded by confusion about what modernization is and isn't.

Washington just calls it foundational public health. They don't try to educate people about a model, they just advocate for flexible state funding. We can learn from other state's approaches.

Need for Orientation and Support for New Leaders

- Newer local leaders and administrators feel under-informed and overwhelmed.

- Suggestions:

    - Build a new administrator orientation around decision-making structures, funding processes, and where to plug in. [overlap with workforce themes from Group #1]

    - Include clear points of contact and explanations for how and when to escalate concerns.

How do we navigate disagreement and keep moving forward together?

- What do we do when a final decision is made that not everyone agrees with? We need a way to keep working together even when decisions don't go our way [more explicit conflict resolution processes]
- How do we remain in partnership, even when priorities diverge? How do we move forward in partnership when a final decision is made that we don't all agree with?
- This is about resilience, trust, and accountability:
    - Trusting leadership to name when decisions are final and why.
    - Having shared language to say, This part won't change, but we still want to move forward with you.
    - Not pretending consensus when there isn't one, but still finding shared ground

Tools & Supports Requested

- A decision-making matrix or table
- Build shared understanding of advocacy pathways vs. decision authority.
- Clarifying documents about:
    - Who makes which decisions
    - How feedback is used
    - How to engage at different levels (legislation, OHA policy, local implementation)
- More accessible guidance on:
    - Reporting requirements
    - Workplan development
    - Incentive metrics and deliverables
- Space to talk about what can't change and how to work with/around it.
- Shared agreements that outline communication norms and engagement expectations.
- Clarification around modernization funding allocation: how it changed over time and who decides now.
- Updated orientation materials for new staff and administrators

We want to know what we can change, where we can influence, and where we simply need to understand and adapt.

Topic 3: Consistent use of tools and guidance

Modernization Manual *[aligns with same theme from Group 1]*

- Opportunities/Observations:
    - Manual is very jargon-y. Needs more plain language.
    - Any entity included in Modernization needs to be integrated into the model, guidance, manual, etc.
        - If CBOs are part of modernization, they need a manual
        - Need clarity on who is included. Manual needs to reflect this
    - "Manual" is a little deceiving as a term → implies a how-to, which the Modernization Manual is not. A little confusing for new folks.
    - CD portion of the manual feels more concrete, EH more nebulous. Revision of manual should try to move nebulous sections toward being more concrete.
- Questions:
    - Should the manual evolve into more of a playbook or stay broad?
    - Is the manual required or is it guidance?
- Ideas:
    - Show how different program elements fit within the Modernization Manual and how funding streams are connected. Include in manual update – integrate throughout? Own section? Separate document? *[same theme as Group 1]*
    - Build terminology flexibility into manual update to help with adapting to current environment. *[aligns with theme to see manual as living document that can be updated as language and practice change]*

PE-51 Reporting & Deliverables

- Opportunities/Observations:
    - Reporting timelines, structures are burdensome *[align with administrative burden assessment?]*
    - Coordinating reporting takes too much time
    - SmartSheet is very difficult to use
    - Huge learning curve for those new to public health to get use to PH reporting
    - Lacking in opportunity to make plans feel meaningful right now, especially when needing to create so many in a short period of time. Feeling like trying to check things off a checklist and LPHAs want it to feel more meaningful than that.

    - PE 51 and other Modernization guidance doesn't clearly tie back to the manual. Need to more clearly communication the linkages

- Ideas and possibilities:
    - Reporting should be set up to better capture the stories of Modernization
    - Title V reporting happens through meeting/conversation that OHA staff capture. This works really well.
    - Give more verbal feedback on reporting, deliverables

Guidance and Technical Assistance

- Opportunities/Observations:
    - Program staff that have subject expertise for deliverables aren't well-versed in Modernization → muddies guidance
    - Modernization "chats" don't feel relevant to LPHAs
    - More TA, training from OHA needed *[in what areas?]*
    - Online resources could be improved. Going to CLHO website more than OHA for resources related to Modernization
    - All the plans feel siloed, not like they fit together or build toward something larger
- Ideas and possibilities:
    - Buddy system or small groups for LPHAs to support each other
    - Accreditation workgroup was very helpful during initial PHAB accreditation → set up something like that for Modernization
    - Because Modernization represents a system change, need some change management tools
    - How do we create a space to help elevate and support strategic thinking related to Modernization? *[PHAB?]*
    - Would like to see best practices highlighted more in OHA materials and guidance:
        - Ex. Public health practice standards such as recommended #EH specialists per X population
        - Both general academic/national public health best practices and locally developed practices
        - Ex. Recommended metrics for assessing different things, such as access to care and how to use these metrics to improve things locally.

- Wisconsin had a standardized "scorecard" that was given to LPHAs annually → would help guide EH work using data/metrics *[balance of standardization and flexibility?]*

- Ensure tools and guidance for Modernization are part of the orientation for new administrators

- Deliverables/plans from manual: Create an outline of all the plans that visualizes how the plans fit together.

Communication/Messaging

- Need clarity on who all within the public health system is included.

- Not clear to folks who are new that the manual is aspirational and that it is not the expectation that we be doing it all right now. Aspirational nature of the manual needs to be better communicated. *[same theme as Group 1]*

- Need better support/tools/training for communicating difference between Modernization as a whole vs. PE 51

- Stop calling it Modernization – term is too vague, conjures certain implications such as a finish line *[same theme as Groups 1 & 2]*

- Need to close communication loops directly with LPHAs re: accountability metrics before publishing information about them

- More verbal reporting and feedback, more discussion/conversation between OHA and LPHAs about LPHA work would be desirable

- In current environment, need clear communication about what is required and what can be let go.

Modernization as a model/system change vs. PE 51. Alignment between manual and PE 51

- There is tension between Modernization being a culture change, improvement, and a program element.

- Need more clear alignment between manual and PE 51 – more clearly identify in PE, etc what parts of the manual are being addressed

- Need better support/tools/training for communicating difference between Modernization as a whole vs. PE 51

- Think about renaming PE 51 so it doesn't imply that Modernization is fully encompassed by this program element.

- Think about calling model/system change Foundational Public Health model instead of modernization

Metrics/Demonstrating success

- OHA is best positioned to know what legislature wants to see re: accountability metrics
- Would like to see more measures of success within foundational programs/capabilities vs. accountability metrics *[what does this mean?]*
- Idea: pick some winnable battles to work on together so we can report on wins and show concrete success. Ex. Childhood lead poisoning

Misc

- Title V is great at balancing flexibility and concrete guidelines → good model
- Would like to see more PE 51 flexibility in current times → would be good to be able to use some % on clinical staff

Group 4: Alignment and coordination between and within public health system partners

CCOs

- Lots of good local wins (PMPM, positions funded in PH, CCO provides billing functions for LPHA, % of incentive payments allocated to LPHAs, etc.).
    - Also funding through grants, which is less of a win but still a source of funding.
    - These funds that LPHAs currently receive usually feel at risk, like they could be taken away at any point.
    - There is a need to look at opportunities at a statewide level to formalize anything that is working, know what the levers are, put pressure on.
- Quality Incentive Metrics (QIM): CCOs should be paying PH for contributions to QIMs.
    - Shared savings
    - PH needs to be able to show contributions
    - Some LPHAs receive a portion of QIM payments for certain metrics like imm. As high as 15%.
    - OHA shared that CCOs are required to report on how they use their QIM dollars and which providers they are shared with. CCOs also have to publish a plan that let's others know how they can be eligible to receive QIM dollars.
- CCO contract negotiations and transparency: people need clarification on what the laws/rules are for CCOs

    - Some CCOs say they are legally not allowed to negotiate with more than one LPHA at a time, whereas others definitely do negotiate with multiple LPHAs at the same table.
    - As a result, LPHAs working with the same CCO have very different contracts.
    - There is no transparency on the contracts CCOs have in place with LPHAs. More transparency would mean more chance to elevate good models, allow LPHAs to use similar successful strategies during negotiations, etc

- Having a local public health official on the CCO governing board continues to be a priority.
    - Does this have to happen through statute or could it be through contract?
    - Two bills in last session, neither passed
- CCO contract should require that CCOs come to PH on issues that affect the community and this shared work should be funded.

CBOs

- Interest in knowing how to more effectively work with CBOs being funded through OHA. The scope is broader than only the PH Equity grant program
- Opportunities to improve collaboration
    - Shared work plans (Erin Jolly from Washington County wants to work on this)
    - Requirement to engage with public health earlier; give LPHA a chance to talk about what the priorities in the community are that could be addressed with funding
- More directly tie funding to CBOs to gaps identified by LPHA. When CBOs are funded for entirely different bodies of work, it can add work for LPHAs.
- Increase LPHA role in making decisions on which CBOs are funded
- Give LPHAs a role in determining how funds are used. Buying giveaways does not feel like a good use of PHM dollars. *[aligns with Group 1 theme to explore alternative funding models for CBOs]*
- Need clarity on roles within PH system for PHM (role of OHA, role of LPHAs, role of CBOs)

Public health and behavioral health

- Many different relationships and configurations in how funding is shared and work is aligned across agencies. Areas that overlap include ADPEP, problem-gambling, opioids, suicide prevention.

- Opportunity to learn about the different configurations and learn from one another

Service sharing between LPHAs

- Informal to formal relationships, many outside of what OHA funds
- People who are newer want to learn from others about who's doing it, what's being shared, what works, what doesn't
- How could some LPHAs share if they are interested in service sharing and connect with other LPHAs that might also be interested
- Want to know where the opportunities are

CHAs and CHIPs

- CCO funding programs, like SHARE and CBIR
- Differences in how the shared work is funded, how partnerships are organized, who serves as backbone org
- At least one LPHAs was surprised to learn that the CCO should be contributing to the CHA. It's basically been handed to PH.

ESF8

- Hospitals are partners in mass medical care, do they have responsibilities under ESF8?
- Lane Co bringing together ESF8 and ESF6, to include HHS, housing
- Death industry partners. Mass fatality responsibility and management is a shared responsibility
- Mortality review boards, PH has an opportunity to bring in prevention

Benton County Health and Safety Levee

- Levee pays for police, fire, some positions in PH
- PH pieces are very tangible and easily understood and supported by the community
- Other LPHAs are interested in replicating

Group 5: Communicating the value of investing in modern public health

Hard to define and explain public health modernization

- PHM funding increase to other partners, and expanded definition of who's included in PHM, resulted in confusion .

- Definition of funded modernization partners changed and can't now answer community partner questions about "what is modernization now?"
- Don't have dictionary definition/elevator speech.
- Focus on equity and leading with race made it hard to explain in rural areas.
- Hard to explain to commissioners without public health background.
- Other gov't groups using term "modernization". People think it's about data systems/health care focused

Accountability metrics

- Hate accountability metrics. Multi-factorial things PH can't control.
- Hard to translate theoretical of acc. metrics to staff.
- Issues with vaccination metrics. Vaccination not PHM-funded; false narrative.
- Align PH metrics with CCO metrics
- Legislators need stories, not accountability metrics.
- Difficult to convey complexity and would like metrics to reflect our work

Lack of tools/resources

- Lack tools and skills to self-promote
- Limited staff capacity and resources
- "Fax is not modern"

Other

- Privacy/legal issues around medical records/Orpheus. Value: being respected as source of expertise.

Communication tools/resources needed

- Modernization definition
- Succinct and compelling stories.
- Statewide marketing campaign
- Focus groups and message testing
- Simple language, such as "Same core protections for public health no matter where you live, work or play.

- Communicate services offered
- Deschutes County/CLHO resources: “Day in the Life” (to communicate what PH does)
- Tell the story of quality assurance
- “Modernized public health = doing core PH services but better”
- Need Medicaid navigators (CCO-funded) – invest in infrastructure outside the box.
- Modernizing data systems in coordination with partners would help communicate our value.
- We all need to be talking about the same thing. Common message. Customize for different audience. Marketing plan
- Emphasize value of local flexibility. $ to meet local needs. Local innovation
- Update to old CLHO communication tools.
- County college for new commissioners
- Put a price on it. Dollars saved – need to know the costs.
- Talk about programs within PHM that people care about.
- Importance/controversial alignment. Be louder about items that aren’t controversial. Careful messaging.
- Describe local and state in the story. Can’t have one without the other. (Bob’s norovirus outbreak/response example)
- Better address “What am I buying” question from legislature → link to accountability metrics

Champions/Partnerships

- Need hardwired sources funding (e.g., tobacco tax)
- Many logical partners and opportunities. Need infrastructure and mechanism
- Need other entities (e.g. hospital, fire) to talk about PH
- Build network of groups who can advocate for funding
- Need a legislative champion
- How do we get our partners to talk about our work (example: Deschutes support for fire camps)
- How PH work supports work of partners, e.g. public safety, hospital systems

Group 6: Long-term sustainability within boom-and-bust funding cycles

Assets

- We have each other to learn from!
- Professional organizations like NACCHO – they have a community of practice that is sharing best practices for dealing with the current funding climate in public health https://www.naccho.org/programs/public-health-infrastructure/public-health-finance
- Relationships we have with partners
    - Example of NCPHD and the work they did during a recent wildfire resulted in them building a relationship with the sherif and others in emergency management.

Opportunities

Take money from the rich!

- CCOs – they have money! Alignment of CHA/CHIP with CCOs in service area. Show CCOs are value and negotiate PMPMs (per member/per month) or incentives for quality metrics (vaccines for example).
- Behavioral Health – they have money coming in right now and we want some of that money for prevention.
- Opioid settlement
- Think about up and coming rich – be on the look out to try to get in at the beginning for new potential revenue streams.

Find other people with resources (doesn't have to be money) and have them invest in public health.

- Schools – we don't want to take money from schools but we have aligned interests – in a climate of limited resources can we partner to reduce load on each of our respective teams?
- Public—Private partnerships: can we connect with private entities and ask them for something other than money (expertise?). Ask for non-monetary resources.
    - Example from Seattle-King County – they asked Starbucks for help with efficiency when setting up vaccine clinics. Starbucks can move people in and out of their stores quickly – what tips can we take when setting up mass vaccination clinics? In this example Starbucks then decided to sponsor the vaccine clinic, win-win!!
    - Are there other opportunities for sponsorships? Who might want to partner with public health?

“Hardwire” funding into the system – find opportunities for ongoing revenue streams.

- Taxes – cannabis tax, tobacco tax, alcohol tax – we could lobby/advocate to get a portion of these directed to PH.
- Sheriffs levies – lean into the protection piece of public health and advocate for a carve out of a sherif levy
    - Shared interests include suicide prevention and safe strong (?)
- Transportation funding? Is there a way to get a piece of transportation funding and make the case that its needed to fund PH work that improves access/changes to built environment that promote healthy behaviors.

Innovation ideas

- Could we use AI for contact tracing?
- In lieu of services – can we use this more? https://www.oregon.gov/oha/hsd/ohp/pages/ilos.aspx
- Rethink how tobacco funded positions expand into other areas such as nutrition

Data!

- How do we both get data from partners and share our own data with others?
- For example, we don’t necessarily have the capacity to work on social determinants of health but we can share the data we have with partners who may be able to help.
    - Example from Linn County of sharing their food dessert mapping with the local food bank to show them areas of need and help them see where they could have the greatest impact.
- Some states have chronic disease databases – that would be great to have.
- How do we partner with health care providers who have the data? We want them to own it, manage it – we don’t necessarily have the resources to take on new data but we could leverage data from other partners if they would provide it.
- CCOs should be required to share data with us – is this something OHA can help with?

How do we address together?

Replicate what is working

- “Regionalize” where we can – especially areas like environmental health/climate, communicable disease, and health officer sharing. The regional money from OHA helps, but there are challenges.

    - Need to ensure that we keep local expertise to inform any shared/regional personnel
    - This works when "we aren't viewed as taking it over – we are [seen as] helping."
    - There are fiscal challenges here – "Commissioners in my county are adamant that no money from our county go to another county."
    - Hard to work together when one county is the fiscal agent (gives them power)
    - Some counties have crafted MOUs
    - Needs to be a clear understanding that one county can't impose on another county (tell them what to do) when in a regional relationship.
    - Challenges when the regional person doesn't have on the ground knowledge in the specific area they are working on.
    - Need to front load on the relationship building to make this work!
- **Instead of shared positions/work, sub-contracting between counties can help keep the power local.**
    - How do we create a mechanism where we can share with other counties what we have to offer with support AND how can we ask other LPHAs for support?

State support for collaboration – both for LPHAs with each other and LPHAs with other partners

- Can the state set up funding to allow for collaboration? Within PE language for example – making it flexible where we can so LPHAs can partner with each other or pass through funds.
- Example of historical healthy communities funding – can we bring something like this back? This was when LPHAs have funding to bring in all their partners to help with relationship building and collaboration. It was braided funding.
- Data sharing – help with DUAs and specifically help with data sharing with CCOs

Develop a flexible funding/reprioritization mechanism

- Identify ways for us to work together to flex funding (within the scope of funding regulations) so we can me more agile in the future

Examples shared of LPHAs currently working together

This is not all inclusive – just what was shared

- During COVID, Umatilla offered contact tracing support to surrounding counties when needed.

- Environmental health –
    - Umatilla is supporting Gilliam and Morrow with inspections
    - Jefferson and Crook partnered
    - Wallowa, Grant, Wheeler sharing an inspector
- Jefferson and Coos worked together on nurse workforce project
- Umatilla and Morrow partner on Nurse Home Visiting
- Washington and Clackamas work on breastfeeding
- Funded regional partnerships: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/LOCALHEALTHDEPARTMENTRESOURCES/Documents/LPHA.Tribes/PH%20Modernization/PE51/PE51-02_RegionalPartnershipsMap.pdf