**Welcome, Introductions (as needed) and roll call**

Muriel DeLaVergne-Brown Kim La Croix (facilitator)
Hillary Saraceno Heather Kaisner
Michael Baker Morgan Cowling
Brian Johnson Sara Beaudrault
Florence Pourtal-Stevens
Judy Bankman
Dawn Emerick
Amanda Garcia Snell

**Review of minutes**Review and approval of minutes tabled until August 20th S/I Committee Call

**Agenda review and icebreaker**Agenda approved as presented

**Funding formula 101**

**PHAB funding principle walk through**

1. Morgan provided a historical perspective on CLHO and CLHO Committee discussions concerning funding.
	1. Other committees have discussed the funding principles, but this has usually been around reductions in funding and not overall principles (i.e. TPEP and PHEP).
	2. Key areas of funding discussions have concentrated on the following themes:.
		1. Base/tiered base
		2. Multiple versus single county
		3. How to incentivize cross jurisdictional sharing
		4. A new formula will most likely be required.
2. CLHO Board
	* 1. Wanted a new vision for funding.
		2. Check with other state funding practices for public health
		3. Review the Modernization funding requirements
		4. Review the recent work by the Reproductive Health and consider adjustments
		5. Review PHAB funding principles and consider how to make them actionable
3. Morgan reviewed the history outlined in the memo from the CLHO Board to the System and Innovations Committee (April 10, 2018).
4. Discussion at CLHO Board meeting on Thursday, July 19th
	1. CLHO Board wanted some kind of “tool” at the end of the S/I Committee work.
	2. Most appropriate tool was probably a checklist
	3. Consider other tools to help in the decision making process
	4. A tool that could be used in each committee when discussing new funding
	5. Previous funding committee
		1. Small group reviewed each new funding issue
		2. Required an additional step in funding discussions
		3. Slowed time sensitive discussions
5. The group discussed the working relationship with CLHO and the Oregon Health Authority/ Public Health Division.
6. The group discussed the need for clarification and consistency in funding allocations.
7. The group discussed the need for transparency when discussing funding issues.
8. The group discussed trust and relationships when dealing with OHA/PHD and highlighted the success of the PHEP program and their Liaison staff members (e.g. clear and easy to understand excel spreadsheet).
9. Muriel discussed the history of the CLHO Funding Committee.
	1. Previous to 2008, the committee seemed to have a good working relationship with OHA
	2. Things began to change in 2008 with the cuts to the PHEP program.
	3. Discussion on the need for funding in rural communities regardless of population size since an estimated 80% of FEMA declarations are in rural areas.
	4. Funding committee would typically discuss issues in an ad-hoc fashion and usually with a very short turnaround time.
	5. Muriel discussed the “Information Sheet to CLHO Funding Formula Committee” sheet that was previously used to discuss funding issues.
	6. Funding issues would typically come to the funding committee directly through the committees.
	7. Approximately 4 years ago, the funding committee was absorbed into the Healthy Structures committee.
	8. Some funding issues that were supposed to go to Healthy Structures would bypass the committee due to turnaround times or other issues, resulting in confusion and lack of consistency
	9. The group discussed work plans and the county’s responsibilities for funding.
	10. The group discussed the successful work by Reproductive Health and how they were able to have input and successfully were able to have a new funding formula that essentially used the PHAB public health modernization funding formula but was tweaked to make sense for Reproductive Health.
10. Sara discussed the PHAB funding principles.
	1. See “[Public Health Advisory Board- Funding principles for state and local public health authorities](https://www.oregon.gov/oha/PH/ABOUT/Documents/phab/public-health-funding-principles.pdf)”.
	2. Overall 7 separate principles.
	3. Principles were divided into two key areas; System Approach to Foundational Programs and Transparency.
		1. System Approach to Foundational Programs- Ensure infrastructure is in place while also ensuring that funding is used to achieve improved outcomes.
		2. Transparency- Ensure that local and state public health work together to understand the full scope of how funding is used to support the public health system .
	4. Discussion on historical underfunding for public health services in Oregon at both the state as well as the local level.
	5. Discussion on the funding requirements for Modernization (in statute) and the need to differentiate between Modernization funds (which applies to NEW funding) and funding for foundational public health programs in general.
	6. Discussion on financial assistance agreement (FAA) with OHA and how funds distributed through the FAA are not designed to fully fund local programs and local counties should be providing additional support (general fund).
		1. How to make this happen?
		2. What if it doesn’t happen?
		3. Enforcement behind statute?
11. See “PHAB Incentives and funding subcommittee-Local public health funding formula description and methodology”.
12. Public Health Modernization Formula.
	* 1. Base funds: allocated to LPHAs based on population and a set of demographic and health indicators
		2. Matching funds: Encourage local investment in local public health services and activities
		3. Incentive funds: Reward Innovation-accountability metrics
13. The group discussed the funding mechanism and spreadsheet found on page 10 of the document.
14. Discussion on public health accreditation and the potential for funding opportunities.
	* 1. Funding consideration for those currently accredited.
		2. Support for funding those that are working toward accreditation.

**Brainstorm concrete actions and standard approaches to operationalize the PHAB funding principles.**

**Principle 1-** Ensure that public health services are available to every person in Oregon, whether they are provided by an individual local public health authority, through cross-jurisdictional sharing arrangements, and/or by the Oregon Health Authority.

* 1. Requirement to review previous local public health modernization assessments. Identify specifically what is meant by services
		1. Identified in statute?
		2. Program elements?
		3. Modernization manual?
		4. Essential services?
1. Services not identified in modernization manual should be agreed upon before finalizing.
2. Consider available partners to support work.
3. Consider local capacity to complete work.
4. What is the best delivery model for this service? Consider cross-jurisdictional sharing, state-based services, fee for service, etc.
5. Local health must review work at a program by program level to identify services needed.
6. The group recommended reordering the funding principles so that discussion about this funding principle – determining the best model for providing a public health service – occurs after discussions about burden of disease, health disparities, etc.
7. **Principle 2-**Align funding with burden of disease, risk, and state and community health assessment and plan priorities, while minimizing the impact to public health infrastructure when resources are redirected.
	1. Do not eliminate funding for successful programs based on burden of disease. Funding needs to remain for successful prevention strategies as well as funding to address immediate area of concern (e.g. STD).
	2. Consider directing funding to high burden areas similar to the Prescription Drug Overdose Program (PDOP) and Early Intervention and Support (EIS).
	3. Eliminate the need for new funding for new work and incorporate funding into services already being done.
	4. The group stressed the need for funding to support current workloads and “routine” work.
	5. A true integration of prevention onto other health services and not a focus on individual programs (e.g. health promotion, behavioral health). Acknowledge the combination of multiple funding streams to make a F.T.E.
8. **Principle 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.
	1. The group could not identify a single funding source that considered health equity as a priority for funding.
	2. Focus should be placed in this area.
		1. Equity
		2. Isolation
		3. Persons of color
		4. Poverty
	3. Better and consistent use of data. Consider proxies for areas that lack data due to small numbers.
	4. Equity conversation must include race as this is an indicator for many other issues.
	5. Early Learning has a set of questions that considers issues with am “Equity Lens”.
	6. There is need for clear criteria.
	7. Some of these issues are built into the modernization funding formula.
	8. Group stressed the need to be consistent and follow these considerations
	9. Race should be considered as a leading indicator and should weighheavier on the decision making process.
9. **Principle 4-** Use funding to incentivize changes to the public health system intended to increase efficiency and improve health outcomes, which may include cross-jurisdictional sharing.
	1. Additional consideration for those agencies that are accredited or working towards it.
	2. Ability to choose what is incentivized and what is not.
	3. Local public health understands the needs of its communities greater than state or other partners
	4. Base funding can dis-incentivize shared services. Consider how to incentivize cross-jurisdictional sharing.
	5. Do not penalize those areas that do serve as a region.
	6. Important to remember the political landscape of each county will be different, even in regional approaches.
	7. Regional work is not less expensive or “easier” as the distance and other issues can greatly impact the ability to provide the service. Regional work may build technical expertise, and may work best when a group of counties works with the same partners (i.e. a health system that covers multiple counties). Regional approaches can also help addresses workforce issues.
	8. Local public health must evaluate each program to ensure efficiencies (i.e. workforce efficiencies). Cross jurisdictional sharing may work better in some programs than others.
	9. Funding decisions should include outcomes and behaviors
	10. Funding considerations should not just be at the local level, but the state was well.
	11. Look at other state’s funding models.
	12. Consider integrated funding across programs. The state should braid and blend funding and look for opportunities to work outside of silos.
10. **Principle 5-** Align public health work and funding to coordinate resources with health care, education and other sectors to achieve health outcomes.
	1. The group discussed the different ways in which CCOs operate.
	2. The group discussed the difficulties some counties have in working with their CCOs (and in some cases multiple CCOs).
	3. The group discussed the role of Public Health within the new CCO 2.0.
	4. The group stressed that CCOs deal with a very specific population whereas Public Health serves all.
	5. Stress the importance of Public health work and how it impacts the bottom line of other partners and services. Be explicit about shared goals and how public health benefits other sectors.
	6. Consider the development of a “Best Practice” or other model for other CLHO committees to utilize when having this discussion.
	7. The group stressed that this principle is a very “high level” discussion that requires a much larger picture of public health as a system and that will be difficult to summarize in small funding decisions.
	8. Consider aligning public health metrics with other sector metrics (e.g. transportation).
	9. Consider giving LPHAs first right of refusal when public health dollars become available for which CCOs can apply.
	10. Consider separating this from discussions about public health funding formulas.
11. **Principle 6-**Acknowledge how the public health system works to achieve outcomes, and direct funding to close the identified gaps across the system in all governmental public health authorities.
	1. A spreadsheet that shows how all funds are budgeted would be helpful.
	2. Difficult to have a discussion about transparency, funding, and local services when overall funding is unclear.
	3. Clear expectations on reporting and deliverables should be improved.
	4. Metrics and reporting are sometimes difficult.
		1. CCO vs. Public Health clients
		2. Outcomes are important
	5. Public Health System is a partnership between local and state agencies and therefore better cooperation and communication is essential to success.
	6. Important to remember that OHA is not exclusively “in charge” of funding.
		1. Consideration for federal requirements on grants to the state that are passed to locals.
		2. Clear communication on need for deliverables and/or changes in work plans based on federal requirements.
		3. PHEP program was applauded for their communication with local staff.
	7. The group discussed the importance of understanding measures and metrics when making funding decisions.
		1. Example of STD/STD rates… increase funding leads to increased rates. Funding can be seen as not making an impact. In reality, funding helps to identify and treat more cases showing a good return on investment and good public health services.
	8. Identify what funding is actually doing and/or buying.
	9. The group discussed the need to look closely at gaps in the public health system and not just individual programs.
		1. Modernization assessments from 3-4 years ago
		2. System-wide opportunities
12. **Principle 7-** Improve transparency about funded work across the public health system and scale work to available funding.
	1. The group discussed the need for complete awareness of information and the need for a tracking system or spreadsheet that shows how all funds are budgeted.
	2. A spreadsheet that shows how all funds are budgeted would be helpful. (HSPR provides this to the CLHO PHEP committee)
	3. Important to stress the work outcomes with less funding
		1. With less funding public health can no longer do this work.
		2. Dispel belief that with less funding public health will find a way to continue doing the work.
13. Understand the political resistance to some public health services
14. Include this information in the program elements.
15. Allow for flexibility of funding to work on local issues.
	* 1. MCH and Title V was a great example of how the “big picture” requirements of the funding were allowed to be implemented on a local level and the ability to scale work based on resources
		2. Consider using tiers where LPHAs that receive more funds are required to do additional work.
		3. MCH staff were commended on their working relationships with local public health staff.
16. Clearer explanation of how state funds are budgeted and how the funding requirements are translated to deliverable at the local level.
	* 1. The recent tobacco funding was discussed as an example of how this was not managed effectively.
17. The group discussed the way OHA/PHD are working at coordinating across divisions.
	* 1. Coordinate trainings based on content and geography
		2. Standardize PE and workplans
18. The group discussed the need for regular sharing and presenting of budget information. Consider a standard template for how money is spent from year to year and across funding types (e.g. CDC, TMSA, M44).
19. A need for more consistency across different funding types.
20. A need for clear expectations that funders have placed on OHA/PHD to clarify the expectations to OHA/PHD to local health.

**Next Steps**

1. Development of checklist or form to share with CLHO
2. Development of “How to use” instructions for the checklist or form (similar to the charter)
3. Re-organize the funding principles on the PHAB list to go to from bigger picture to specific program issues in the document that CLHO S&I produces.
4. Consider a “Best Practice” or recommendations to include with fiscal review (i.e. identify appropriate data sources to consider).
5. Group division of PHAB Principles for translation of each principle into actionable priority items for a checklist.
	1. Judy & Morgan
	2. Brian & Florence
	3. Michael & Amanda
	4. Hillary & Heather
	5. Sara & Muriel
	6. Kim & Morgan & Sara
	7. Amanda & Muriel
6. Review again on August 13th and submit a Draft to CLHO on August 16th.
7. Forward on for use in tobacco discussion. Re-evaluate after committee use and bring “final draft” to CLHO for the September retreat or October meeting.
8. The meeting reaffirmed that Systems and Innovations is by the far the most exciting committee.