Public Health Modernization: Funding Report to Legislative Fiscal Office

In fulfillment of ORS 431.139 and ORS 431.380

September 2020

Oregon Health Authority
PUBLIC HEALTH DIVISION

Contents

Acknowledgements

The Oregon Health Authority Public Health Division acknowledges the work of the Public Health Advisory Board (PHAB) and, specifically, members of the Incentives and Funding Subcommittee. PHAB's forward-thinking strategies for modernizing the public health system to achieve equity are presented throughout this report.

For questions or comments about this report, or to request this publication in another format or language, please contact the Oregon Health Authority, Office of the State Public Health Director at 971-673-1222 or PublicHealth.Policy@state.or.us.

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Executive summary

Oregon's public health system is fundamentally shifting its practices to ensure public health protections for every person in Oregon. A modern public health system:

- Prevents disease and promotes health
- Is prepared to address emerging threats, and
- Works hand-in-hand with communities to eliminate health inequities.

Oregon has made progress with legislative investments in 2017 and 2019. However, the COVID-19 pandemic has exacerbated widespread existing health inequities and shown significant gaps in Oregon's ability to respond. As a result, it is essential that Oregon continue to focus on strengthening the public health system.

2019–21 accomplishments

- **For the first time, the public health modernization funding formula was used to allocate funds to local public health authorities (LPHAs).**

  ORS 431.380 requires this funding formula. It provides a minimal amount of base funding to all LPHAs and directs most funds to areas of the state with the greatest need to address health inequities.

- **Funds reached all areas of Oregon's governmental public health system.**

  This strengthens public health infrastructure and builds capacity in all areas of the system.

- **Ongoing investments in regional partnerships are showing results.**

  Each LPHA regional partnership has implemented regional strategies to address communicable disease priorities for their communities, while focusing on eliminating health disparities.

- **Public health modernization investments have supported Oregon's response to the COVID-19 pandemic.**

  LPHAs have leveraged local and regional public health skills and resources gained through public health modernization for the COVID-19 response. The Oregon Health Authority has used the public health modernization funding formula to allocate multiple streams of COVID-19 funding to LPHAs.

2021–23 investments

Based on recommendations provided by Oregon's Public Health Advisory Board, investments in 2021–23 will:

1. Continue and expand work within the foundational public health areas of communicable disease control, health equity and cultural responsiveness, and assessment and epidemiology. This includes continued work to apply skills and resources gained through public health modernization to support the ongoing COVID-19 response, and
2. Expand the focus to foundational public health areas of environmental health, leadership and organizational competencies, and emergency preparedness and response.

OHA estimates that an additional $68.9 million in state General Fund is necessary in 2021–23 to implement these priorities, while moving Oregon closer to eliminating health inequities that exist because of systemic racism and oppression and have been even further exacerbated by COVID-19.

Funding will build critical public health capacity across state, local and tribal public health authorities and community-based organizations to:

- Co-create public health interventions that ensure **equitable distribution or redistribution of resources and power** and recognize, reconcile and rectify historical and contemporary injustices
- Establish **coordinated systems for preventing and responding to communicable disease and environmental health threats** among disproportionately affected communities
- Protect communities from acute and communicable diseases through **prevention initiatives that directly address health inequities**
- **Reduce unhealthy environmental exposures** through policy and implementation of environmental health regulatory requirements
- Build healthy and resilient communities by promoting **natural resource, land use and built environment policies and programs** that support health
- **Mitigate impacts of climate change** on public health with a focus on the health inequities intensified by climate change, and
- Implement a statewide system for **environmental emergency preparedness**.

Introduction

The path toward a modern public health system

Since 2013, Oregon has been fundamentally shifting its practice to ensure essential public health protections for all people in Oregon through equitable, outcomes-driven and accountable services.

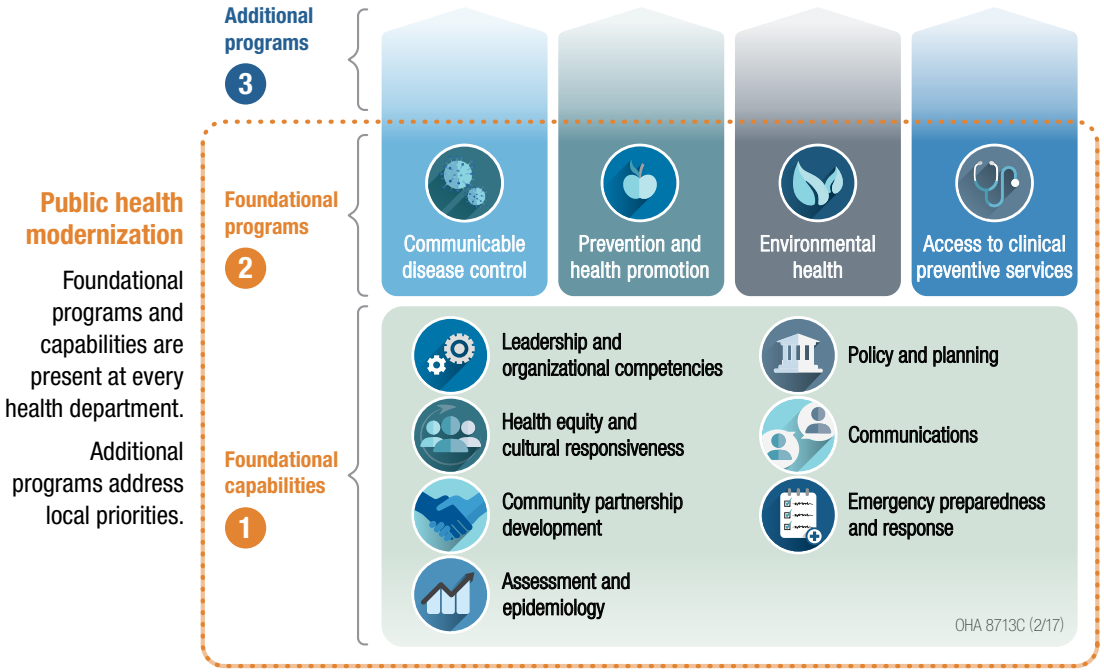
Oregon established a modernized framework for Oregon's governmental public health system in 2015 when the Legislature passed House Bill 3100. Public health modernization focuses on improving population health within four foundational program areas:

- Communicable disease control
- Environmental health
- Prevention and health promotion, and
- Access to clinical preventive services.

As shown in Figure 1, the public health system employs a set of capabilities to accomplish foundational program goals. These capabilities reflect the knowledge, skills and resources of the public health workforce.

Figure 1

MODERNIZED FRAMEWORK FOR GOVERNMENT PUBLIC HEALTH SERVICES



Oregon's public health system has directed initial funding toward communicable disease control, focusing on working directly with partners and communities to improve outcomes for those at highest risk, or for those who have been systemically underserved by the health system. Significant improvements have been made. However, the COVID-19 pandemic has shed light on major gaps in the public health system for responding to emerging events and eliminating health inequities. These inequities result in poorer health outcomes for systemically marginalized and other vulnerable groups.

Milestones

Improvements to date within the public health system have relied on continued support from Oregon's Legislature and the ongoing commitment of the Public Health Advisory Board and public health leaders.

Notable key milestones include:

- **2015:** Governor Brown appointed the Oregon Public Health Advisory Board (PHAB) as a committee of the Oregon Health Policy Board, responsible for providing policy direction on population health priorities. In 2017 PHAB membership expanded to include representation from Oregon's federally recognized Tribes.
- **2015 and 2016:** Public health leaders developed the Public Health Modernization Manual and completed a comprehensive system-wide assessment. The manual and corresponding assessment continue to be foundational resources for defining core system functions and identifying system-wide strategies for improvement.
- **2017 and 2019:** Oregon's Legislature demonstrated its commitment to strengthening the public health system through public health modernization investments. In both biennia, most funds went directly to communities through allocations to local public health authorities. In 2019, tribal public health authorities and other tribal organizations also received funds.
- **2017:** PHAB adopted accountability metrics for state and local public health authorities. Oregon is leading the nation in developing and reporting on accountability metrics for the public health system. Oregon Health Authority releases annual public health accountability metrics reports.

See Appendix A for a complete milestone timeline.

Legislative investments

In 2017, the Oregon Legislature made an initial $5 million investment to modernize Oregon's public health system. As advised by PHAB, this investment strengthened how Oregon prevents and responds to communicable diseases. Specifically, these funds helped build regional infrastructure for the public health system's core functions of health equity and cultural responsiveness, and assessment and epidemiology.

These functions are essential for communicable disease control and prevention. Funds supported eight regional partnerships spanning 33 of 36 counties. Regional partnerships developed innovative approaches to address local communicable disease priorities and began targeted approaches to eliminating related health inequities. Regional partnerships completed a health equity assessment and began work on health equity strategies that emphasized both internal workforce development and external community engagement and culturally and linguistically responsive public health interventions. A summary of 2017–19 achievements is available at https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/Public-Health-Modernization-Report-2017-2019.pdf.

The following pages include information about the 2019–21 investment.

This report fulfills OHA's requirements as described by ORS 431.139 and ORS 431.380. This report provides information on:

- The use of the 2019–21 legislative investment, and
- How to implement a 2021–23 investment to further Oregon's public health system modernization.

2019–21 legislative investment in public health modernization

Amount of funds received and description of how funds were allocated

In 2019, the Oregon Legislature allocated an additional $10 million in funding, bringing the total to $15.6 million to advance public health modernization. The Public Health Advisory Board (PHAB) provided recommendations to OHA to continue and build on the progress from the 2017–19 investment through ongoing support for regional partnerships, while also allocating funds directly to individual local public health authorities, Tribes and the Urban Indian Health Program, NARA.

2019–21 funds were allocated as follows:

Funding to local public health authorities (LPHAs) = $10.3 million:

- All 33 LPHAs are receiving a total of $7 million in funding through the Public Health Advisory Board's local public health authority funding formula. Funding supports LPHAs to:
  - » Build leadership and governance to plan for full implementation of public health modernization over subsequent biennia
  - » Implement workforce development and community strategies that improve health equity, and
  - » Implement strategies that improve local infrastructure to control communicable disease and reduce health disparities.

  The public health modernization funding formula for local public health authorities shows allocations for each LPHA (see Appendix B).
- Seven LPHAs are receiving an additional $3.3 million to continue to expand innovative regional communicable disease prevention and control initiatives that began during the 2017–19 biennium. These regional partnerships use the funds to support infrastructure put in place during the previous biennium. They use this regional infrastructure to implement and expand regional strategies to prevent and control communicable diseases and eliminate health inequities. See Appendix C for each regional partnership's allocations and description.
- The investment in local and regional LPHA public health modernization work plans has helped Oregon address the COVID-19 pandemic. For example:
  - » Local and regional health equity initiatives have been at the center of the COVID-19

response. This is due to COVID-19's disproportionate effect on communities of color because of long-standing inequities stemming from systemic racism and oppression.

  - » Regional public health modernization initiatives that began in the 2017–19 biennium created relationships with long-term care facilities to improve influenza vaccination and infection prevention. These connections have been essential for preventing the spread of COVID-19 in vulnerable congregate care settings.
  - » Regional public health modernization work has yielded working relationships and surge capacity agreements across county lines. LPHAs have stepped in to help each other when there has been an increase in cases in one county over another. Much of this work can be done remotely.

- To that end, LPHAs have used public health modernization funds to support their staff deployed to the COVID-19 response.

Funding to Tribes, NARA and the Northwest Portland Area Indian Health Board = $1.1 million (additional $100,000 included from other federal funds):

- Seven federally recognized Tribes and NARA (Urban Indian Health Program) are receiving funds to assess, plan and implement work related to public health modernization.
- The Northwest Portland Area Indian Health Board is receiving funds to provide technical assistance to Tribes and to evaluate the tribal public health modernization investment.

Oregon Health Authority Public Health Division = $4.2 million:

- Staffing
  - » Maintains 2.10 FTE in existing staff from the 2017–19 biennium and adds 4.0 FTE in new staff to support the legislative investment at the state and local levels: Staff include a health equity coordinator, surge epidemiologist, emerging environmental health risks lead and an information specialist from the Office of Information Services to support public health data system upgrades.
  - » These staff have been supporting the OHA response to COVID-19, including:
    - ♦ Providing daily support and technical assistance for local and tribal public health administrators and staff
    - ♦ Leading epidemiology surge support and epidemiology functions in Wallowa County, for which OHA is the local public health authority
    - ♦ Supporting health equity training and technical assistance in alignment with public health modernization objectives, and
    - ♦ Developing reopening and enforcement guidance.

- Technology, hardware and software maintenance and upgrades
  - » Includes functions for laboratory interface with electronic medical records; ALERT Immunization Information System and whole genome sequencing technology.
- Data collection, evaluation and reporting
  - » Collection of Student Health and Behavioral Risk Factor Surveillance System surveys
  - » Community-based participatory data collection and research briefs with four communities of color in partnership with researchers and the Coalition of Communities of Color
  - » Culturally responsive survey of Asian/Pacific Islander adults
  - » Literature review and plan for transition to other survey data collection methods beyond random digit dial telephone surveys for adults
  - » Annual data collection and reporting of public health accountability metrics
  - » Evaluation of the public health modernization investment within one local public health regional partnership.
- Technical assistance
  - » Initial development of the public health modernization learning collaborative, which is on hold for the remainder of the biennium due to COVID-19's impact on the public health workforce. Instead, state and local public health leaders will focus on health equity learning opportunities.

Accomplishments to date for 2019–21

- **For the first time, the Oregon Health Authority used the public health modernization funding formula to allocate funds to LPHAs.**

  This formula, developed by PHAB, is designed to ensure that all local public health authorities have a minimal level of funding to make progress toward modernization. Most funds are allocated based on a set of demographic, health and socioeconomic indicators. This ensures that a higher proportion of funding goes to areas of the state with the greatest need to address health inequities.

2019–21 funding highlights

- For the first time, the public health modernization funding formula was used to allocate funds to local public health authorities (LPHAs).
- Funds reached all areas of Oregon's governmental public health system.
- Ongoing investments in regional partnerships are showing results.
- Investments in public health modernization have better prepared the public health system for responding to COVID-19.

- **Funds reached all areas of Oregon's governmental public health system.**

  Funds were allocated to local and tribal public health authorities, LPHA regional partnerships and the OHA Public Health Division. This funding strategy strengthens infrastructure and builds capacity in all areas of the public health system.

- **Ongoing investments in regional partnerships are showing results.**

  For example, since creating the Central Oregon Tri-County Outbreak Prevention, Surveillance and Response Team in 2017, these counties are demonstrating:

  - » Improved responsiveness, as seen in improved time to initiating case interviews and more rapid completion of case investigations
  - » Improved quality of services, as seen in regular tri-county flu surveillance and communicable disease reports and new tri-county websites for health system partners and the community at large, and
  - » Expanded reach within the Central Oregon community, as seen in regular infection prevention trainings for organizations that serve vulnerable populations, and expanded collaborations with Warm Springs Health and Wellness Center.

- **Investments in public health modernization have supported Oregon's response to the COVID-19 pandemic.**

  - » The public health modernization funding formula has been used to allocate multiple streams of COVID-19 funding, including State General Fund, CDC Public Health Emergency Preparedness, CARES Act, and Epidemiology and Laboratory Capacity funding to local public health authorities.
  - » Many LPHAs are leveraging local and regional public health resources to respond to the COVID-19 pandemic. The skills and resources gained through public health modernization have better prepared LPHAs for responding to COVID-19. Examples include:
    - ♦ Using the regional epidemiologist to conduct a deep dive analysis of COVID-19 data to understand groups most at risk
    - ♦ Developing, vetting and validating a regional public-facing Tableau dashboard within weeks of the first case in the region, and
    - ♦ Leveraging a partnership with a community-based organization to conduct an outreach campaign on safe sex practices to limit the spread of COVID, HIV and other sexually transmitted infections.

Progress toward accountability metrics

Public health accountability metrics show where Oregon is making progress toward population health priorities. Reporting data on and highlighting causes of health disparities are ways the public health system begins to address injustices that undermine health.

In 2017, PHAB adopted the first set of accountability metrics for Oregon's public health system. The framework for public health accountability metrics includes:

- Health outcome measures that reflect Oregon's population health priorities, and
- Process measures that articulate the specific work of local public health authorities to achieve changes in health outcomes.

OHA publishes an annual report showing progress toward accountability metrics. The 2020 report includes the following metrics:

Figure 2

ACCOUNTABILITY METRICS

Communicable disease control

Outcome measure: percent of 2-year-olds who received recommended vaccines
- **Process measure:** percent of Vaccines for Children clinics that participate in the Immunization Quality Improvement for Providers (IQIP) program

Outcome measure: gonorrhea incidence rate per 100,000 population
- **Process measure:** percent of gonorrhea cases that had at least one contact that received treatment
- **Process measure:** percent of gonorrhea case reports with completed data priority fields

Prevention & health promotion

Outcome measure: percent of adults who smoke cigarettes
- **Process measure:** percent of population reached by tobacco-free county properties policies
- **Process measure:** percent of population reached by tobacco retail licensure policies

Outcome measure: opioid mortality rate per 100,000 population
- **Process measure:** none

Environmental health

Outcome measure: percent of commuters who walk, bike, or use public transportation to get to work
- **Process measure:** local public health authority participation in leadership or planning initiatives related to active transportation, parks and recreation, or land use

Outcome measure: percent of community water systems meeting health-based standards
- **Process measure:** percent of water systems surveys completed
- **Process measure:** percent of water quality alert responses
- **Process measure:** percent of priority non-compliers resolved

Access to clinical preventive services

Outcome measure: percent of women at risk of unintended pregnancy who use effective methods of contraception
- **Process measure:** annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use

Developmental measure: percent of children age 0–5 with any dental visit
- **Process measure:** none

Notable findings from the 2020 Public Health Accountability Metrics Report include:

- **Immunization rates continue to improve statewide.**

  The childhood immunization rate has increased steadily from 66% in 2016 to 71% in 2019. This reflects the ongoing, coordinated efforts of public health and health care systems to remove barriers to immunization and address other root causes of lower immunization rates. Since 2017, some local public health partnerships have used modernization funding to improve childhood immunization rates, resulting in 25 of 33 LPHAs meeting the statewide benchmark for engaging health care clinics in immunization quality improvement.

- **Gonorrhea rates continue to rise. There are disparities by race and ethnicity.**

  Rates of gonorrhea continue to increase, from 107 per 100,000 in 2016 to 145 per 100,000 in 2019. Oregon, like much of the nation, continues to experience an alarming increase in gonorrhea cases. A sufficiently resourced public health system, working with the health care system, has the tools to control and prevent the spread of gonorrhea. State and local public health authorities identify where cases are occurring and make sure both the infected individuals and their partners receive proper treatment.

- **COVID-19 pandemic is having major health effects.**

  The COVID-19 pandemic reaches into all aspects of a person's health including access to preventive services, environmental risks, and mental health and well-being. This pandemic has exacerbated widespread existing health inequities borne by systemic racism and oppression, with communities of color and other vulnerable groups experiencing a disproportionate burden of COVID-19 infections. The effects of COVID-19 are not reflected in this report's 2019 outcomes. However, in future years Oregon will likely see poorer outcomes across the priority health indicators as a result of the COVID-19 pandemic.

The full report is available at https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/2020-Accountability-Metrics-Report-FINAL.pdf and in Appendix D.

2021–23 proposed legislative investment

Public Health Advisory Board recommendations for funding priorities and the funding formula

In 2016, PHAB originally recommended to OHA a phased approach to implementing public health modernization across the system over time. PHAB recommended that OHA scale up foundational programs in phases based on available funding. PHAB also recommended simultaneously building capacity and infrastructure for the foundational capabilities of governmental public health. PHAB has targeted investments to Phase 1 implementation in both the 2017–19 and 2019–21 biennia.

Figure 3

PROPROSED PHASES FOR FOUNDATIONAL PROGRAMS

In January 2020, the Public Health Advisory Board recommended funding priorities to OHA for the 2021–23 biennium. PHAB recommended:

- The public health system continues to focus on communicable disease control, health equity and cultural responsiveness, and assessment and epidemiology, and
- With additional funding, expand focus to include environmental health, leadership and organizational competencies, and emergency preparedness and response.

In July 2020, PHAB reviewed the 2019–21 public health modernization funding formula and recommended no changes for 2021–23. PHAB recommended that OHA:

- Continue to allocate funds at equal or increased funding levels to local public health authorities through the funding formula used during the current biennium. This funding formula provides a base amount of funds to each LPHA based on the county population. Distribution of most funds is based on burden of disease and other socioeconomic and demographic factors that direct funding to areas of the state with the greatest need to address health inequities.
- Continue to allocate a portion of funds to LPHA regional partnerships at equal or increased funding levels to build regional infrastructure for the governmental public health system.

The complete funding formula methodology is available in Appendix E.

Funding principles for maximizing benefits of public health funding

In 2018 PHAB developed a set of funding principles to use for all state and federal public health funding streams. Their goal was to maximize use of funds to eliminate health disparities and achieve improved health outcomes. These funding principles:

- Ensure all available resources go toward achieving improved outcomes
- Support system-wide approaches to providing foundational public health programs, and
- Increase transparency and understanding about state and local public health authority roles and funding.

In 2020 PHAB reviewed the funding principles and clarified PHAB's expectation of basing funding decisions on these principles when state or federal funds are allocated to local public health authorities. The funding principles are available in Appendix F.

Estimate of the amount of state General Fund needed for public health modernization

The "2016 Public Health Modernization Assessment Report" found a $105 million annual, or $210 million biennial, gap in public health spending needed to fully implement all four foundational programs and seven foundational capabilities included in Oregon's public health modernization statutes.

OHA estimates an additional $68.9 million in state General Fund is necessary in 2021–23 to:

- Co-create public health interventions that ensure **equitable distribution or redistribution of resources and power** and recognize, reconcile and rectify historical and contemporary injustices

- Establish **coordinated systems for preventing and responding to communicable disease and environmental health threats** among communities that are disproportionately affected
- Protect communities from acute and communicable diseases through **prevention initiatives that directly address health inequities**
- **Reduce unhealthy environmental exposures** through policy and implementation of environmental health regulatory requirements
- Build healthy and resilient communities by promoting **natural resource, land use and built environment policies and programs** that support health
- **Mitigate impacts of climate change** on public health with a focus on the health inequities intensified by climate change, and
- Implement a statewide system for **environmental emergency preparedness**.

An investment of $68.9 million for 2021–23 would support the following:

- **OHA-PHD:**
  - » Provide leadership for a community-based and equity-centered approach to public health in Oregon
  - » Manage local and tribal public health authority contracts and grants to community-based organizations
  - » Provide technical assistance to local, tribal and community-based organization grantees to support program implementation
  - » Maintain and annually report on public health accountability measures
  - » Enhance public health and health care data exchange
  - » Collect and report population health data for the public health system and its partners
  - » Convene partners to develop and implement a framework for using data to identify leading environmental risks to human health and corresponding plans to mitigate risks
  - » Implement a statewide plan to manage threats to the environment and human health resulting from changes to Oregon's climate, and
  - » Coordinate acute and communicable disease outbreak investigations, including communicable disease testing, at the Oregon State Public Health Laboratory.
- **Local public health authorities:**
  - » Monitor and regulate environmental health risks within communities

- » Convene local stakeholders to develop, exercise and implement emergency preparedness plans
- » Co-create health-related interventions with the community
- » Train clinic staff in culturally and linguistically responsive and evidence-based quality improvement activities
- » Track cases of acute and communicable diseases to ensure individuals and their partners receive treatment to curb the spread of disease, and
- » Implement performance management systems to ensure continuous improvement of the local public health authority's drive toward population health outcomes.

- **Tribal public health authorities:**
  - » Convene local stakeholders to develop, exercise and implement emergency preparedness plans
  - » Co-create health-related interventions with the community
  - » Track cases of acute and communicable diseases to ensure individuals and their partners receive treatment to curb the spread of disease
  - » Convene local stakeholders to develop, exercise and implement emergency preparedness plans, and
  - » Involve communities in the development and execution of health-related interventions.
- **Community-based organizations:**
  - » Co-create culturally and linguistically responsive public health interventions to ensure alignment with goals to eliminate health inequities and support community resilience and recovery.

The following list shows how each foundational capability of the public health system contributes to achieving the communicable disease and environmental health goals listed above and make progress toward an equitable Oregon:

- **Health equity and cultural responsiveness:** Ensure public health programs co-created by communities and public health programs are culturally and linguistically competent.
- **Assessment and epidemiology:** Analyze data to understand emerging trends for communicable disease and environmental health threats; make data readily available to communities and partners who rely on the information and use data to implement culturally and linguistically responsive interventions.
- **Community partnership development:** Leverage coordinated care organizations, government agencies and other partners to increase the impact of public health modernization work in communities.

- **Emergency preparedness and response:** Work with communities and partners to prepare for, respond to and recover from public health threats and emergencies; ensure that populations most at risk are at the center of planning efforts.
- **Leadership and organizational competencies:** Develop the public health workforce to be better equipped to nimbly respond to new public health threats; use performance management and quality improvement to ensure that public health interventions are resulting in improved outcomes; spread capacity from public health modernization across public health program areas.
- **Communications:** Ensure timely risk communications and proactive communications that are culturally and linguistically responsive.
- **Policy and planning:** Engage with partners, stakeholders and communities to develop and implement policy solutions that are responsive to community needs.

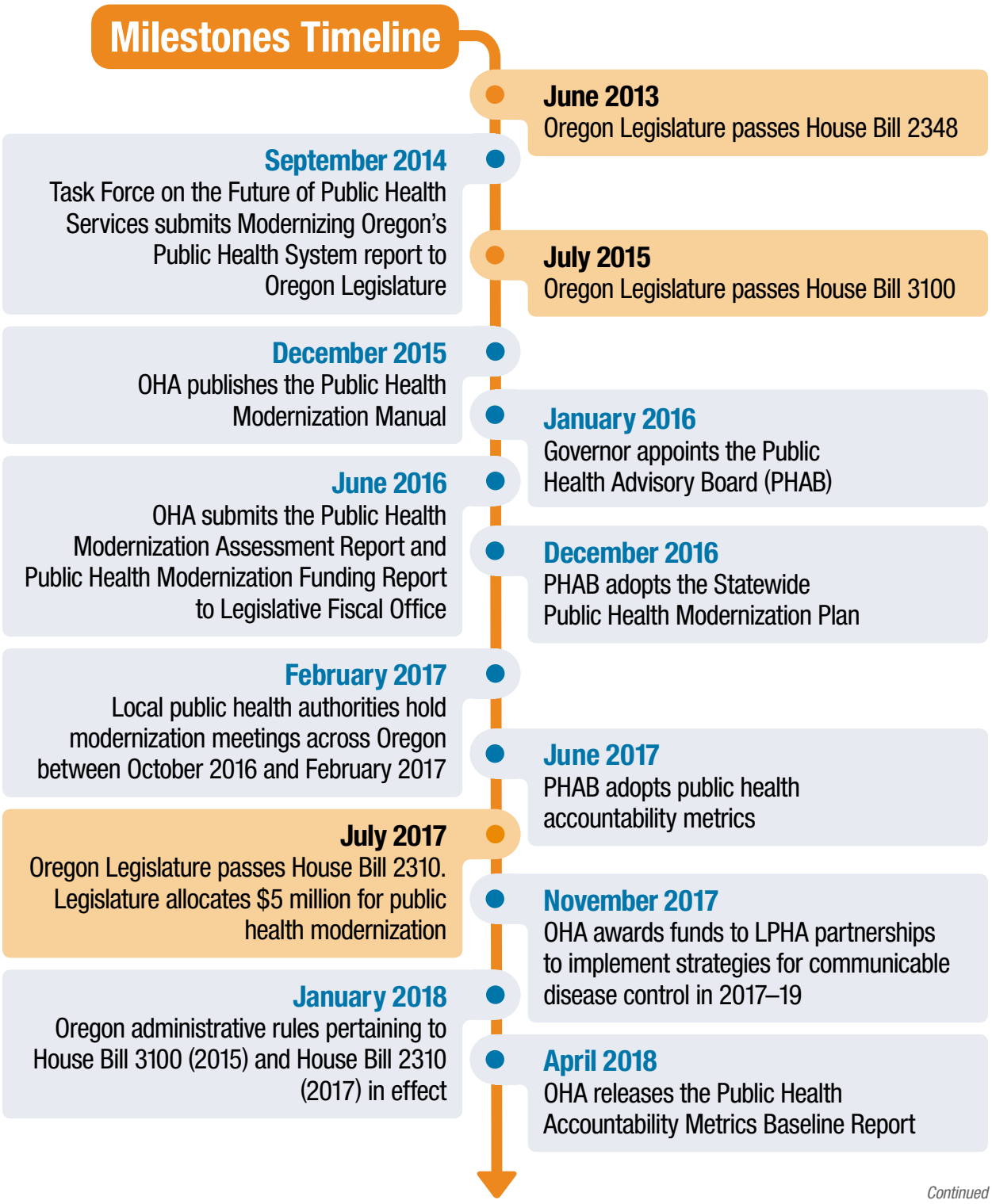
References

Oregon Health Authority. (2017). Public health modernization manual: foundational capabilities and programs for public health in Oregon. [cited 2020 Sept 13]. Available at: https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf.

Berk Consulting. (2016). State of Oregon public health modernization assessment report. [cited 2018 June 6]. Available at http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/PHModernizationFullDetailedReport.pdf.

Appendices

Appendix A: Public health modernization milestones



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Milestones Timeline *Continued*

June 2018
OHA submits Public Health Modernization Report to Legislative Fiscal Office

September 2018
OHA publishes Public Health Modernization Interim Evaluation Report

March 2019
OHA publishes the 2019 Public Health Accountability Metrics Report

June 2019
Oregon Legislature allocates an additional $10 million for public health modernization

October and December 2019
OHA awards $11.5 million to local and tribal public health authorities and the Urban Indian Health Program

February 2020
Public health modernization infrastructure and resources support Oregon's response to COVID-19

September 2020
OHA publishes the 2020 Public Health Accountability Metrics Report

LOCAL PUBLIC HEALTH FUNDING FORMULA MODEL — $7 MILLION EXAMPLE

Total biennial funds available to LPHAs: $7 million

		Base component									Matching and incentive fund components		Total county allocation				
County group	Population[1]	Floor	Burden of disease[2]	Health status[3]	Race/ tthnicity[4]	Poverty 150% FPL[4]	Rurality[5]	Education[4]	Limited English Proficiency[4]		Matching funds	Incentives	Total award	Award percentage	% of total population	Award per capita	Avg award per capita
Wheeler	1,450	$ 30,000	$ 292	$ 543	$ 138	$ 202	$ 1,588	$ 107	$ 5		$ -	$ -	$ 32,876	0.5%	0.0%	$ 22.67	
Wallowa	7,175	$ 30,000	$ 1,751	$ 1,076	$ 411	$ 725	$ 7,858	$ 530	$ 223		$ -	$ -	$ 42,576	0.6%	0.2%	$ 5.93	
Harney	7,380	$ 30,000	$ 2,492	$ 2,394	$ 846	$ 947	$ 3,581	$ 791	$ 511		$ -	$ -	$ 41,561	0.6%	0.2%	$ 5.63	
Grant	7,400	$ 30,000	$ 1,527	$ 1,661	$ 527	$ 797	$ 8,105	$ 786	$ 282		$ -	$ -	$ 43,684	0.6%	0.2%	$ 5.90	
Lake	8,115	$ 30,000	$ 2,172	$ 1,316	$ 1,043	$ 1,228	$ 5,626	$ 1,292	$ 505		$ -	$ -	$ 43,183	0.6%	0.2%	$ 5.32	
Morrow	11,885	$ 30,000	$ 2,449	$ 3,609	$ 4,055	$ 1,370	$ 5,975	$ 3,055	$ 6,496		$ -	$ -	$ 57,010	0.8%	0.3%	$ 4.80	
Baker	16,765	$ 30,000	$ 4,308	$ 2,719	$ 1,295	$ 1,905	$ 7,528	$ 1,727	$ 754		$ -	$ -	$ 50,237	0.7%	0.4%	$ 3.00	$ 5.17
Crook	22,710	$ 45,000	$ 5,711	$ 6,592	$ 2,287	$ 2,857	$ 11,939	$ 2,860	$ 943		$ -	$ -	$ 78,189	1.1%	0.5%	$ 3.44	
Curry	22,915	$ 45,000	$ 7,925	$ 6,624	$ 2,626	$ 2,642	$ 9,713	$ 2,409	$ 1,110		$ -	$ -	$ 78,048	1.1%	0.5%	$ 3.41	
Jefferson	23,560	$ 45,000	$ 6,835	$ 5,431	$ 8,140	$ 3,201	$ 16,282	$ 3,507	$ 4,157		$ -	$ -	$ 92,552	1.3%	0.6%	$ 3.93	
Hood River	25,310	$ 45,000	$ 4,092	$ 6,112	$ 7,866	$ 2,547	$ 14,470	$ 5,374	$ 13,834		$ -	$ -	$ 99,295	1.4%	0.6%	$ 3.92	
Tillamook	26,395	$ 45,000	$ 6,762	$ 6,245	$ 3,506	$ 2,855	$ 20,121	$ 2,775	$ 2,648		$ -	$ -	$ 89,912	1.3%	0.6%	$ 3.41	
Union	26,885	$ 45,000	$ 6,215	$ 4,722	$ 2,497	$ 3,619	$ 12,397	$ 2,043	$ 1,581		$ -	$ -	$ 78,073	1.1%	0.6%	$ 2.90	
Gilliam, Sherman, Wasco	30,970	$ 105,000	$ 8,070	$ 5,930	$ 6,184	$ 3,151	$ 14,077	$ 4,250	$ 6,106		$ -	$ -	$ 152,768	2.2%	0.7%	$ 4.93	
Malheur	31,925	$ 45,000	$ 7,354	$ 11,175	$ 10,615	$ 5,113	$ 16,923	$ 6,280	$ 9,277		$ -	$ -	$ 111,737	1.6%	0.8%	$ 3.50	
Clatsop	39,200	$ 45,000	$ 10,524	$ 7,410	$ 4,764	$ 4,027	$ 16,744	$ 3,468	$ 3,661		$ -	$ -	$ 95,600	1.4%	0.9%	$ 2.44	
Lincoln	48,210	$ 45,000	$ 15,049	$ 12,112	$ 7,157	$ 6,125	$ 19,853	$ 5,319	$ 4,169		$ -	$ -	$ 114,785	1.6%	1.1%	$ 2.38	
Columbia	51,900	$ 45,000	$ 11,869	$ 12,217	$ 4,911	$ 4,809	$ 24,784	$ 5,132	$ 2,514		$ -	$ -	$ 111,235	1.6%	1.2%	$ 2.14	
Coos	63,275	$ 45,000	$ 19,268	$ 16,978	$ 7,910	$ 8,278	$ 26,612	$ 6,915	$ 3,283		$ -	$ -	$ 134,243	1.9%	1.5%	$ 2.12	
Klamath	67,960	$ 45,000	$ 19,971	$ 17,820	$ 12,567	$ 9,346	$ 27,987	$ 8,913	$ 7,523		$ -	$ -	$ 149,126	2.1%	1.6%	$ 2.19	$ 2.88
Umatilla	80,765	$ 60,000	$ 17,350	$ 21,671	$ 23,138	$ 10,058	$ 25,741	$ 15,131	$ 29,336		$ -	$ -	$ 202,425	2.9%	1.9%	$ 2.51	
Polk	82,100	$ 60,000	$ 15,355	$ 14,519	$ 15,039	$ 8,262	$ 17,894	$ 7,947	$ 14,484		$ -	$ -	$ 153,500	2.2%	2.0%	$ 1.87	
Josephine	86,395	$ 60,000	$ 26,611	$ 20,126	$ 9,450	$ 12,498	$ 42,580	$ 9,801	$ 3,885		$ -	$ -	$ 184,952	2.6%	2.1%	$ 2.14	
Benton	93,590	$ 60,000	$ 12,962	$ 16,209	$ 15,194	$ 11,498	$ 19,271	$ 4,481	$ 13,598		$ -	$ -	$ 153,211	2.2%	2.2%	$ 1.64	
Yamhill	107,415	$ 60,000	$ 20,129	$ 25,022	$ 20,888	$ 9,954	$ 26,588	$ 13,081	$ 20,065		$ -	$ -	$ 195,727	2.8%	2.6%	$ 1.82	
Douglas	111,735	$ 60,000	$ 34,639	$ 31,888	$ 11,252	$ 12,931	$ 50,419	$ 12,327	$ 4,638		$ -	$ -	$ 218,095	3.1%	2.7%	$ 1.95	
Linn	125,575	$ 60,000	$ 28,856	$ 28,946	$ 15,589	$ 14,374	$ 43,461	$ 12,809	$ 9,122		$ -	$ -	$ 213,158	3.0%	3.0%	$ 1.70	$ 1.84
Deschutes	188,980	$ 75,000	$ 33,149	$ 26,275	$ 20,180	$ 16,006	$ 57,126	$ 12,785	$ 13,728		$ -	$ -	$ 254,249	3.6%	4.5%	$ 1.35	
Jackson	219,200	$ 75,000	$ 52,080	$ 49,191	$ 34,824	$ 25,275	$ 48,255	$ 24,412	$ 25,023		$ -	$ -	$ 334,061	4.8%	5.2%	$ 1.52	
Marion	344,035	$ 75,000	$ 68,536	$ 82,241	$ 100,653	$ 40,535	$ 49,361	$ 54,070	$ 128,532		$ -	$ -	$ 598,927	8.6%	8.2%	$ 1.74	
Lane	375,120	$ 90,000	$ 80,869	$ 73,659	$ 56,665	$ 45,770	$ 71,898	$ 33,187	$ 33,739		$ -	$ -	$ 485,786	6.9%	8.9%	$ 1.30	$ 1.48
Clackamas	419,425	$ 90,000	$ 74,842	$ 75,197	$ 62,993	$ 26,028	$ 83,146	$ 29,685	$ 60,938		$ -	$ -	$ 502,829	7.2%	10.0%	$ 1.20	
Washington	606,280	$ 90,000	$ 83,945	$ 98,345	$ 173,166	$ 44,487	$ 37,185	$ 54,900	$ 190,854		$ -	$ -	$ 772,881	11.0%	14.5%	$ 1.27	
Multnomah	813,300	$ 90,000	$ 162,706	$ 160,691	$ 208,288	$ 84,912	$ 11,580	$ 76,185	$ 239,142		$ -	$ -	$ 1,033,506	14.8%	19.4%	$ 1.27	$ 1.26
Total	**4,195,300**	**$ 1,860,000**	**$ 856,667**	**$ 856,667**	**$ 856,667**	**$ 428,333**	**$ 856,667**	**$ 428,333**	**$ 856,667**		$ -	$ -	**$ 7,000,000**	**100.0%**	**100.0%**	**$ 1.67**	**$ 1.67**

Estimate July 1, 2018

County Size Bands

Extra small	Small	Medium	Large	Extra large
Up to 20,000	20,000–75,000	75,000–150,000	150,000–375,000	above 375,000

[1] Source: Portland State University Certified Population estimate July 1, 2018

[2] Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon death certificate data, 2012–2016

[3] Source: Quality of life: Good or excellent health, 2012–2015

[4] Source: American Community Survey population 5-year estimate, 2013–2017

[5] Source: U.S. Census Bureau, Population estimates, 2010

Appendix C: 2019-21 allocations to local public health authority regional partnerships and descriptions of regional partnership goals and activities

Local public health authorities (LPHAs) are using $10.3 million provided by Oregon's Legislature to improve local systems for preventing and responding to communicable diseases. Every LPHA is receiving funds to address priorities in its community. And seven partnerships, covering 32 of 36 counties, are using public health modernization funding to build upon the successful regional interventions for communicable disease control established in 2017. Each regional partnership is described below.

Central Oregon Public Health Partnership: **$466,637**

Deschutes, Crook and Jefferson counties; Central Oregon Health Council

- Utilize Central Oregon's communicable disease prevention, surveillance and response team to promptly respond to communicable disease outbreaks and prevent further spread of disease;
- Provide technical assistance and training on infection prevention and control to long-term care facilities and other facilities that serve vulnerable populations in Central Oregon;
- Expand regional partnerships to prevent and control communicable diseases and promote health equity;
- Conduct regional surveillance on communicable diseases and emerging public health threats, and share timely information with health care providers, partner agencies and the public so they can better protect themselves and their patients.

Coast-to-Valley Modernization Partnership: **$444,137**

Lane, Benton, Lincoln and Linn counties; Linn-Benton Health Equity Alliance

- Provide training and technical assistance to health care to increase childhood and adolescent immunization rates;
- Provide training and technical assistance to health care to address high and increasing sexually transmitted infection rates;
- Engage and collaborate with community organizations and communities impacted by disparities to prevent and control communicable disease and address related health disparities.

Eastern Oregon Modernization Collaborative: **$490,637**

North Central Public Health District, Baker, Grant, Harney, Hood River, Lake, Malheur, Morrow, Umatilla, Union and Wheeler counties; Eastern Oregon CCO

- Build capacity and improve performance for communicable disease control across eastern Oregon through regional infrastructure;
- Improve communicable disease reporting and outbreak control measures with health care providers through sharing of evidence-based and emerging best practices;
- Increase capacity for LPHAs to use data and reports to reduce disparities in health outcomes;
- Use a regional approach for identifying and addressing barriers to achieving health equity across eastern Oregon.

Marion and Polk Regional Partnership: **$354,137**

Marion and Polk counties; Willamette Health Council

- Continue to expand the role of the Marion and Polk Communicable Disease Task Force;
- Provide targeted outreach and communications to communities most affected by HIV and STDs, and to the general public;
- Work with the health care system to implement new methods for STD testing and treatment.

Multnomah, Clackamas, Washington and Yamhill: **$435,137**

Multnomah, Clackamas, Washington and Yamhill counties; and Oregon Health Equity Alliance

- Modernize data analytics infrastructure to improve infectious disease data access, analysis and critical real-time data-sharing;
- Strengthen regional data governance and create a platform for secure exchange of health data across sectors;
- Engage community partners and collaborate regionally to examine health data, set goals, and develop plans that specifically address health inequities and social determinants of health.

Oregon Coast Partnership: **$376,637**

Clatsop, Columbia and Tillamook counties; Columbia Pacific CCO

- Implement regional strategies to prevent and control the spread of sexually transmitted infections.

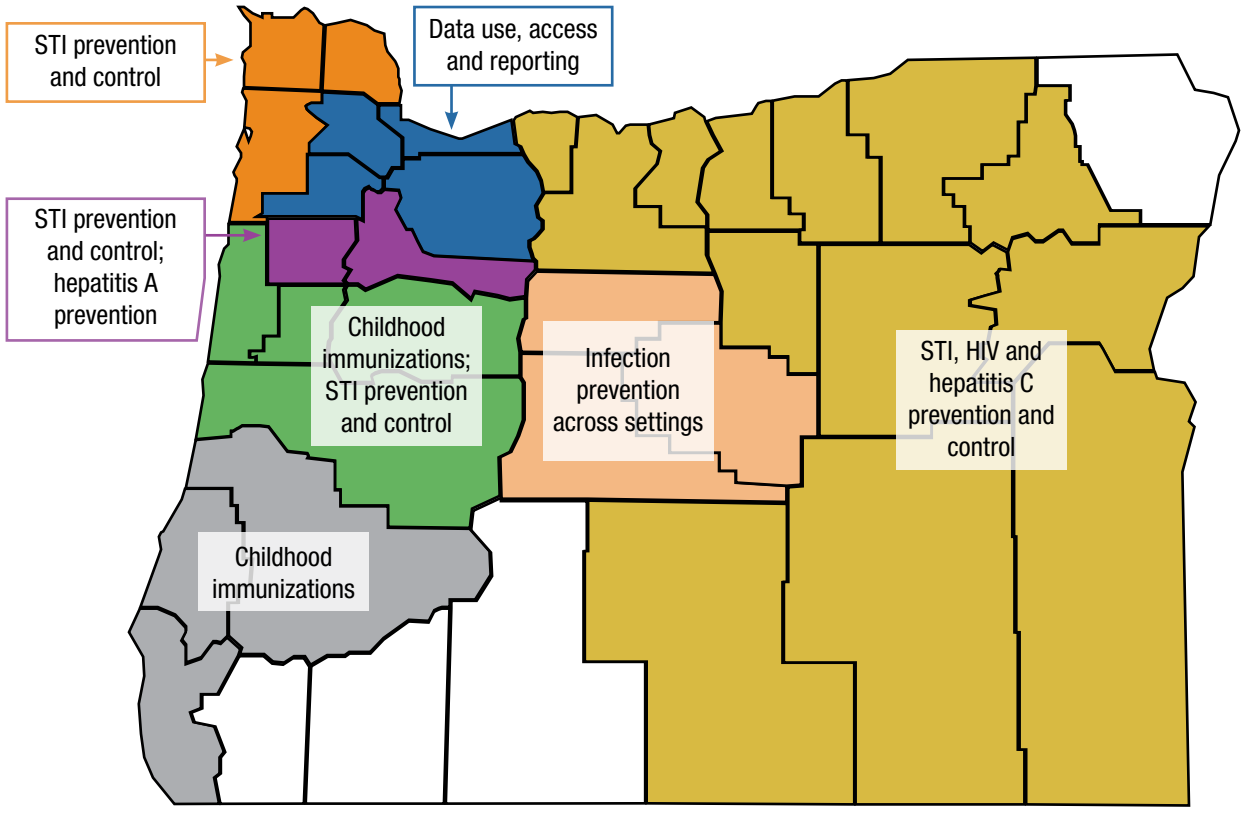
- Develop a regional communicable disease report to update providers about threats and encourage best practices for management
- Evaluate health equity in the region and plan how to mitigate disparities.

Southwest Regional Partnership: **$399,137**

Douglas, Coos and Curry counties; Advanced Health CCO, Umpqua Health Alliance CCO, Coquille Indian Tribe, Cow Creek Band of the Umpqua Tribe of Indians

- Enhance partnerships with local organizations to develop meaningful relationships with populations experiencing a disproportionate burden of communicable disease and poor health outcomes. Promote health equity;
- Create a regional epidemiology network to standardize work and mutually support county epi efforts in order to solve lack of coverage and work flow process issues;
- Work with health care partners to improve communicable disease reporting and control;
- Improve two-year-old and adolescent immunization rates.

2019-21 public health modernization regional partnerships



For more information, visit healthoregon.org/modernization

Public Health Accountability Metrics

Annual Report
June 2020






Oregon Health Authority

About this Report

General

This report fulfills statutory requirements under ORS 431.139 for reporting on public health accountability metrics.

Questions

For questions or comments about this report, or to request this publication in another format or language, please contact the Oregon Health Authority, Office of the State Public Health Director at: (971) 673-1222 or PublicHealth.Policy@state.or.us

Acknowledgements

We acknowledge the Public Health Advisory Board (PHAB) and the PHAB Accountability Metrics Subcommittee

Table of Contents

Accountability metrics show progress

Immunization rates continue to improve statewide.

The childhood immunization rate has increased steadily from 66% in 2016 to 71% in 2019. This reflects the ongoing, coordinated efforts of public health and health care systems to remove barriers to immunization and address other root causes of lower immunization rates. Since 2017, some local public health partnerships have used modernization funding to improve childhood immunization rates, resulting in 25 of 33 LPHAs meeting the statewide benchmark for engaging health care clinics in immunization quality improvement.

Gonorrhea rates continue to rise. There are disparities by race/ethnicity.

Rates of gonorrhea continue to increase, from 107 per 100,000 in 2016 to 145 per 100,000 in 2019. Oregon, like much of the nation, continues to experience an alarming increase in gonorrhea cases. A sufficiently-resourced public health system, working with the health care system, has the tools to control and prevent the spread of gonorrhea. State and local public health authorities identify where cases are occurring and make sure both the infected individuals and their partners are properly treated.

Public health modernization funding

In 2017 and 2019, funding allocated by the Oregon Legislature for public health modernization has been used to implement strategies for communicable disease control and eliminate related health disparities. These funds have partially filled the gap in funding for communicable disease control that were identified in a 2016 public health system assessment. These investments have strengthened the public health system's ability to respond to ongoing and new communicable disease threats, and to work with communities to eliminate health disparities.

Impact of COVID-19

The COVID-19 pandemic reaches into all aspects of a person's health including access to preventive services, environmental risks, and mental health and well-being. This pandemic has exacerbated widespread existing health inequities borne by systemic racism and oppression, with communities of color and other vulnerable groups experiencing a disproportionate burden of COVID-19 infections. While the effects of COVID-19 are not reflected in the 2019 outcomes shown in this report, in future years Oregon will likely see poorer outcomes across the priority health indicators included in this report as a result of the COVID-19 pandemic.

Communicable disease control, health equity are focus of modernization funding.

Framework, funding, health equity

Public health modernization framework

Oregon's public health system is changing how it prevents diseases and protects and promotes health. A modern public health system ensures critical public health protections are in place for every person in Oregon, that the public health system is prepared to address emerging threats, and that all parts of the public health system work hand-in-hand with communities to eliminate health disparities. Oregon has made progress since efforts to modernize the public health system began in 2013, and ongoing focus is essential as the COVID-19 pandemic has highlighted continued systemic gaps in protections for communities of color and other vulnerable populations.

Public health modernization in Oregon is focused on population health priorities in four foundational program areas: Communicable Disease Control, Prevention and Health Promotion, Environmental Health, and Access to Clinical Preventive Services.

To accomplish the population health priorities, the public health system employs a set of seven foundational capabilities in the following areas:

- Leadership and organizational competencies
- Health equity and cultural responsiveness
- Community partnership development
- Policy and planning
- Communications
- Emergency preparedness and response
- Assessment and epidemiology

Public health accountability metrics are one way that Oregon's public health system demonstrates that it is improving health and effectively using public dollars through a modern public health system. Established by the Public Health Advisory Board in 2017, public health accountability metrics provide an annual review of the population health priorities for all Oregonians and highlight the work of local public health authorities (LPHAs) to achieve population health goals. Annual reports also show where the public health system is not making progress, and where new approaches and resources must be focused.

The 2020 Public Health Accountability Metrics Annual Report provides an in-depth look at how Oregon's public health system is doing on key health issues like childhood immunization, tobacco use, opioid mortality, access to clean drinking water, and effective contraceptive use. Starting with data from 2016, the third edition of this report shows annual progress of LPHAs in achieving health outcomes, as well as identifies gaps and areas where additional resources are needed. The effects of the COVID-19 pandemic are not reflected in the 2019 outcomes shown in this report.

Funding

Efforts to modernize the governmental public health system were set in motion by Oregon's legislature in 2013 and in subsequent legislative sessions, through the passage of bills that redesigned the framework for governmental public health. These changes included enacting laws to use public health accountability metrics to track the progress of state and local public health authorities to meet population health goals to measure the effective and equitable provision of public health services (Oregon Revised Statute 431.115).

In 2019, the Oregon Legislature made a $15.6 million investment in the modernization of the governmental public health system. The Oregon Health Authority (OHA) distributed $10.3 million to LPHAs to address local and regional priorities for communicable disease control with an emphasis on eliminating health disparities. To support local investments, OHA has used funding to improve communicable disease data systems that are used across the state and to improve how population health data are collected, reported, and made available to communities and partners who rely on them.

2019-21 modernization funds for OHA and LPHAs directly support the communicable disease metrics in this report. OHA distributes state and federal funding for programs addressing some, but not all, other accountability metrics reported for other foundational programs. The remainder of funds come through county general funds or other sources.

Modernization funding uniquely requires each local or tribal public health authority to identify and address the most significant communicable disease risks for vulnerable populations in each community, rather than all funds being directed to a single disease or priority population. In this way, modernization funding supports local decision-making based on each community's unique priorities.

Health Equity

Society as a whole has a responsibility to address the social conditions and correct historical and contemporary injustices that undermine health. One way the public health system begins to do this is by collecting and reporting data that show where health disparities exist and highlighting the underlying causes for why certain racial and ethnic groups experience poor health.

The reasons that disparities in health outcomes exist across racial and ethnic groups **are complex** and occur because of generations-long social, economic and environmental injustices. These injustices have a greater influence on health outcomes than biological or genetic factors **and cannot be attributed to an individual's choices.**

Where possible, data are reported by race/ethnicity in this report. **This report shows that some groups, including communities of color and those living with fewer financial resources, continue to bear a greater burden of illness and disease. This report does not provide detailed information about existing disparities. The summary information provided in this report should be used to guide ongoing discussions and actions to toward achieving health equity.**

Organization of this report

This report is organized by Public Health Modernization Foundational Program areas: Communicable Disease Control, Prevention and Health Promotion, Environmental Health, Access to Clinical Preventive Services.

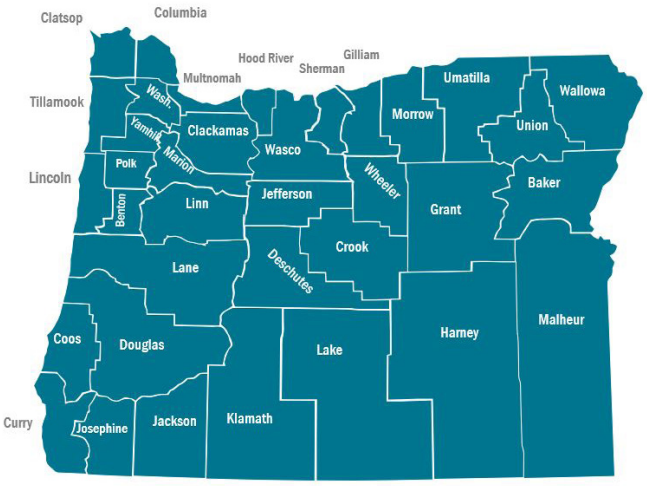
The collection of health outcome and local public health process measures, defined below, are collectively referred to as public health accountability metrics. Measures are shown in Table 1.

Health outcome measures reflect population health priorities for the public health system. Making improvements on the health outcome measures requires long-term focus and must include other sectors.

Local public health process measures reflect the core functions of a local public health authority to make improvements in each health outcome measure. Local public health process measures capture the work that each local public health authority must do in order to move the needle on the health outcome measures.

Developmental measures reflect population health priorities but for which comprehensive public health strategies are yet to be determined. These health outcome measures will be tracked and reported without a corresponding local public health process measure.

A complete description of data sources, methods, and public health program information for this report can be found in the Technical Supplement at www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/2020-Technical-supplement.pdf



Oregon County Map

Accountability metrics

Communicable disease control

Outcome measure: percent of two-year olds who received recommended vaccines

- **Process measure:** percent of Vaccines for Children clinics that participate in the Immunization Quality Improvement for Providers (IQIP) program

Outcome measure: gonorrhea incidence rate per 100,000 population

- **Process measure:** percent of gonorrhea cases that had at least one contact that received treatment
- **Process measure:** percent of gonorrhea case reports with completed data priority fields

Prevention & health promotion

Outcome measure: percent of adults who smoke cigarettes

- **Process measure:** percent of population reached by tobacco-free county properties policies
- **Process measure:** percent of population reached by tobacco retail licensure policies

Outcome measure: opioid mortality rate per 100,000 population

- **Process measure:** none

Environmental health

Outcome measure: percent of commuters who walk, bike or use public transportation to get to work

- **Process measure:** local public health authority participation in leadership or planning initiatives related to active transportation, parks and recreation, or land use

Outcome measure: percent of community water systems meeting health-based standards

- **Process measure:** percent of water systems surveys completed
- **Process measure:** percent of water quality alert responses
- **Process measure:** percent of priority non-compliers resolved

Access to clinical preventive services

Outcome measure: percent of women at risk of unintended pregnancy who use effective methods of contraception

- **Process measure:** annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use

Developmental measure: percent of children age 0–5 with any dental visit

- **Process measure:** none

Childhood Immunization

HEALTH OUTCOME MEASURE

Percent of two-year olds who received recommended vaccines, Oregon 2019

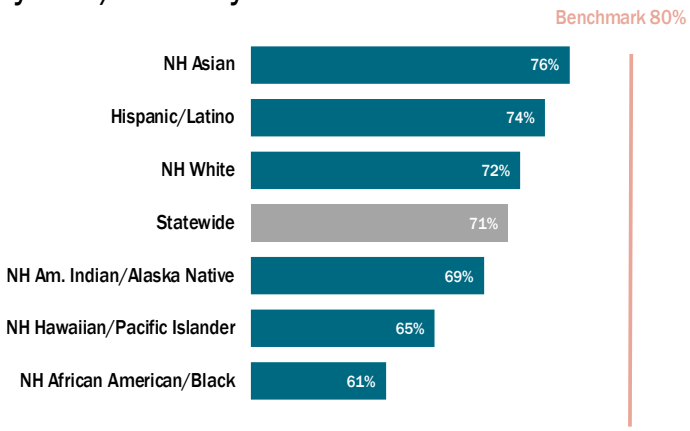
Routine vaccination for young children protects against 14 serious and potentially life-threatening illnesses

The Oregon legislature prioritized communicable disease control as part of modernization funding

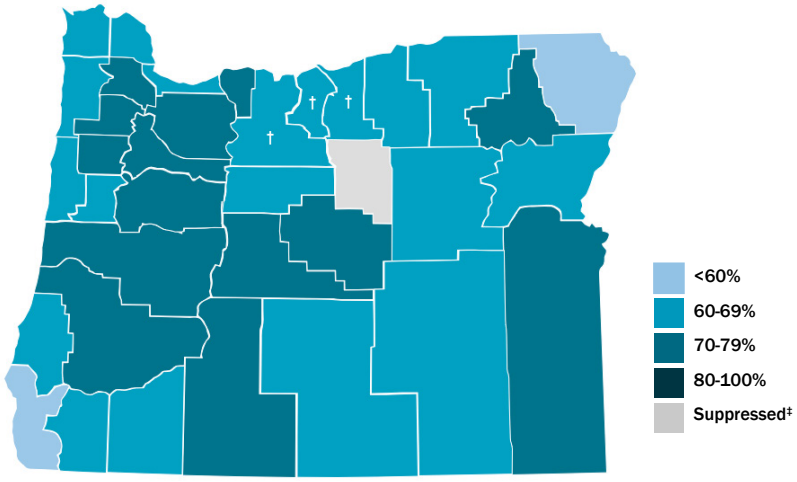
Statewide, rates have increased steadily, from 66% in 2016 to 71% in 2019

Additional information about childhood immunizations is available at healthoregon.org/imm

There are large disparities in vaccination rates by race/ethnicity*



No counties in Oregon met or exceeded the 80% benchmark in 2019



*NH refers to non-Hispanic. † One immunization rate is shown for each county that comprises the North Central Public Health District (Gilliam, Sherman, Wasco).
‡ Rates are not displayed for populations of fewer than 50 people.*

Childhood Immunization

LOCAL PUBLIC HEALTH PROCESS MEASURE

Percent of Vaccines for Children clinics participating in IQIP*

Foundational capabilities used by LPHAs to achieve this measure:

- Leadership and organizational competencies
- ✓ Health equity and cultural responsiveness
- ✓ Community partnership development
- ✓ Policy and planning
- Communications
- Emergency preparedness
- ✓ Assessment and epidemiology

OHA supports for this measure include:

- ALERT Immunization Information System
- Vaccines for Children Program
- IQIP technical assistance for LPHAs
- Funding to all LPHAs to provide immunization services

Twenty Oregon counties had 25% or more of their VFC clinics participating in IQIP in 2019

Benchmark 25% clinic participation

	2017	2018	2019
Statewide	14%	28%	26%
Baker	33%	33%	67%
Benton	18%	36%	38%
Clackamas	21%	33%	0%
Clatsop	14%	57%	57%
Columbia	0%	50%	22%
Coos	18%	70%	18%
Crook	0%	25%	100%
Curry	0%	100%	71%
Deschutes	13%	48%	24%
Douglas	39%	79%	20%
Grant	0%	0%	67%
Harney	67%	33%	33%
Hood River	33%	20%	20%
Jackson	2%	8%	20%
Jefferson	0%	50%	50%
Josephine	0%	54%	29%
Klamath	0%	8%	77%
Lake	33%	33%	33%
Lane	11%	29%	42%
Lincoln	0%	67%	67%
Linn	5%	6%	20%
Malheur	43%	0%	17%
Marion	34%	24%	17%
Morrow	50%	0%	100%
Multnomah	6%	12%	19%
North Central PH District†	29%	29%	29%
Polk	33%	20%	50%
Tillamook	0%	0%	50%
Umatilla	45%	27%	33%
Union	0%	0%	44%
Wallowa‡	0%		
Washington	10%	21%	12%
Wheeler	0%	0%	100%
Yamhill	17%	8%	0%

** Immunization Quality Improvement for Providers (IQIP) program. † North Central Public Health District is comprised of Gilliam, Sherman, and Wasco counties. ‡ Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.*

Gonorrhea Rate

HEALTH OUTCOME MEASURE

Gonorrhea incidence rate per 100,000 population, Oregon 2019

Significant disparities exist in gonorrhea rates for Black/African Americans. The reasons for these disparities are complex and result from generations-long systemic inequities. The disparities in gonorrhea rates cannot be attributed to an individual's behavior choices alone.

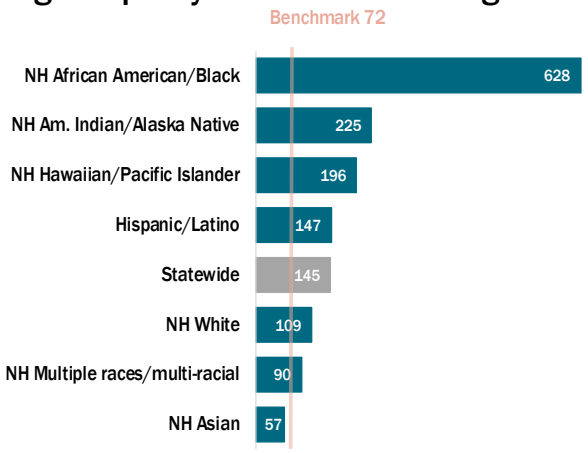
The Oregon legislature prioritized communicable disease control as part of modernization funding

The statewide incidence of gonorrhea increased from 107 per 100,000 in 2016 to 145 per 100,000 in 2019

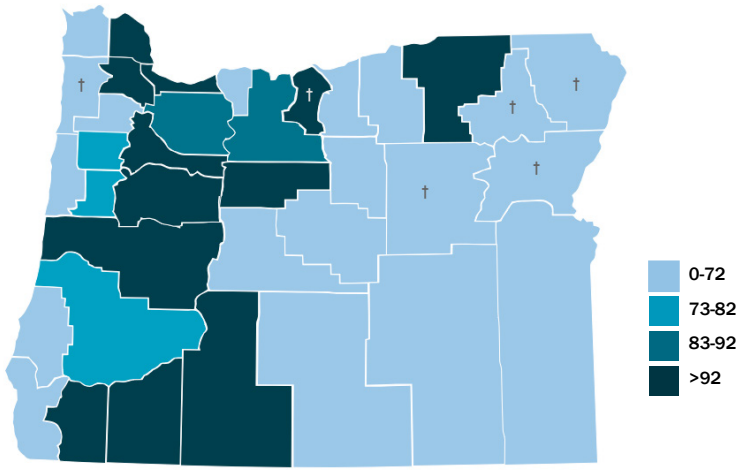
Thirty-two counties in Oregon had gonorrhea cases in 2019

Additional information about gonorrhea is available at healthoregon.org/std

African American/Black Oregonians experience a very large disparity in the rate of new gonorrhea cases*



Twenty counties in Oregon were at or below (lower is better) the benchmark of 72 in 2019



NH refers to non-Hispanic. † Rates based on 1-5 events are considered unreliable.

Gonorrhea Rate

LOCAL PUBLIC HEALTH PROCESS MEASURE

Percent of gonorrhea cases that had at least one contact that received treatment

Foundational capabilities used by LPHAs to achieve this measure:

- Leadership and organizational competencies
- ✓ Health equity and cultural responsiveness
- Community partnership development
- Policy and planning
- Communications
- Emergency preparedness
- ✓ Assessment and epidemiology

OHA supports for this measure include:

- Orpheus statewide communicable disease database
- Providing technical assistance to LPHAs and medical providers to identify and treat people with STDs and their contacts
- Subsidizing lab testing programs and STD medications and condoms
- Funding all LPHAs for communicable disease investigations

Just 3 LPHAs exceeded the 35% benchmark in 2019

Benchmark 35%

	2016	2017	2018	2019
Statewide	13%	15%	11%	9%
Baker	0%	0%	14%	0%
Benton	4%	13%	8%	17%
Clackamas	9%	8%	7%	5%
Clatsop	14%	36%	19%	33%
Columbia	14%	11%	7%	8%
Coos	24%	48%	29%	8%
Crook	33%	64%	50%	40%
Curry	18%	0%	13%	29%
Deschutes	49%	37%	52%	33%
Douglas	19%	21%	20%	41%
Gilliam*	0%	0%		
Grant*	0%		0%	0%
Harney*	20%	67%		
Hood River	0%	22%	17%	7%
Jackson	5%	12%	11%	8%
Jefferson	19%	19%	26%	17%
Josephine	0%	1%	2%	2%
Klamath	18%	17%	18%	34%
Lake*	14%	40%		
Lane	19%	14%	12%	8%
Lincoln	29%	22%	21%	26%
Linn	20%	23%	21%	9%
Malheur	21%	28%	37%	26%
Marion	35%	38%	29%	22%
Morrow	32%	0%	67%	0%
Multnomah	5%	8%	4%	4%
Polk	8%	6%	11%	12%
Sherman*				100%
Tillamook	0%	7%	7%	0%
Umatilla	58%	22%	26%	21%
Union	18%	75%	33%	20%
Wallowa* †				
Wasco	33%	7%	19%	17%
Washington	14%	13%	11%	8%
Wheeler*	0%			
Yamhill	23%	25%	15%	9%

** Indicates counties that had 0 gonorrhea cases in years where no data are shown. † Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.*

Gonorrhea Rate

LOCAL PUBLIC HEALTH PROCESS MEASURE

Percent of gonorrhea case reports with completed data priority fields

Foundational capabilities used by LPHAs to achieve this measure:

- Leadership and organizational competencies
- ✓ Health equity and cultural responsiveness
- Community partnership development
- Policy and planning
- Communications
- Emergency preparedness
- ✓ Assessment and epidemiology

OHA OHA supports for this measure include:

- Orpheus statewide communicable disease database
- Providing technical assistance to LPHAs and medical providers to identify and treat people with STDs and their contacts
- Subsidizing lab testing programs and STD medications and condoms
- Funding all LPHAs for communicable disease investigations

One LPHA exceeded the 70% benchmark in 2019

Benchmark 70%

	2016	2017	2018	2019
Statewide	19%	24%	29%	26%
Baker	100%	60%	14%	25%
Benton	13%	27%	32%	46%
Clackamas	13%	15%	33%	45%
Clatsop	14%	32%	38%	50%
Columbia	14%	11%	7%	14%
Coos	15%	13%	18%	16%
Crook	53%	7%	40%	20%
Curry	18%	0%	13%	14%
Deschutes	35%	35%	65%	46%
Douglas	25%	7%	20%	24%
Gilliam*	0%	100%		
Grant*	0%		0%	100%
Harney*	0%	33%		
Hood River	25%	56%	56%	27%
Jackson	6%	30%	33%	36%
Jefferson	0%	2%	3%	29%
Josephine	2%	2%	1%	9%
Klamath	16%	8%	7%	14%
Lake*	14%	0%		
Lane	21%	32%	41%	42%
Lincoln	8%	11%	21%	39%
Linn	13%	34%	31%	18%
Malheur	34%	23%	26%	22%
Marion	42%	49%	47%	41%
Morrow	5%	0%	42%	17%
Multnomah	17%	17%	23%	15%
Polk	8%	30%	46%	25%
Sherman*				33%
Tillamook	0%	0%	21%	0%
Umatilla	0%	4%	12%	24%
Union	36%	0%	17%	0%
Wallowa* †				
Wasco	17%	50%	63%	22%
Washington	26%	35%	40%	34%
Wheeler*	0%			
Yamhill	3%	31%	25%	24%

** Indicates counties that had 0 gonorrhea cases in years where no data are shown. † Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.*

Adult Smoking Prevalence

HEALTH OUTCOME MEASURE

Percent of adults who smoke cigarettes, Oregon 2018

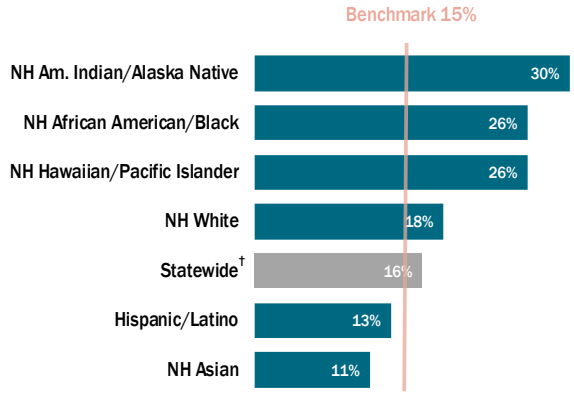
Oregon's adult smoking rate of 16% in 2018 was higher than the national rate of 14%

The adult smoking rate exceeds the 15% benchmark established by the State Health Improvement Plan 2020 target (lower is better)

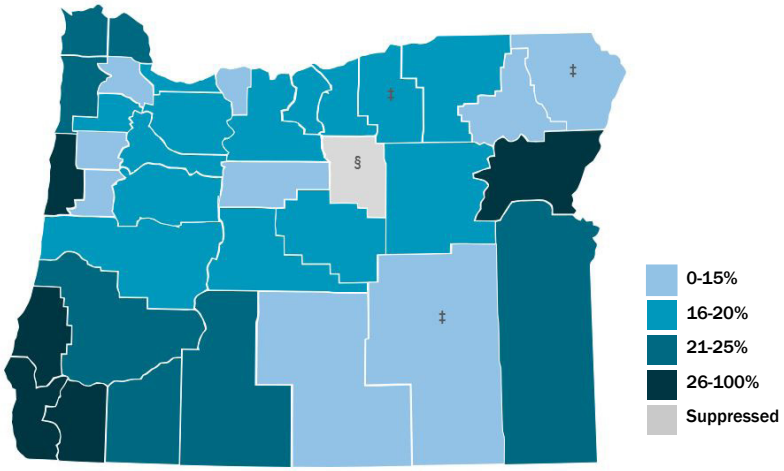
Rates declined slightly from 17% in 2016 to 16% in 2018

Additional information about tobacco prevention is available at healthoregon.org/tobacco

There was considerable variability in adult smoking rates by race/ethnicity in 2015-17*



Nine counties in Oregon were at or below the 15% benchmark in 2014-17



** NH refers to non-Hispanic. † Statewide rate is 2018. ‡ Indicates estimates that have relative standard error >= 30 and <50 and are considered unreliable. § Indicates estimates that are suppressed due to number of respondents <30.*

Adult Smoking Prevalence

LOCAL PUBLIC HEALTH PROCESS MEASURE

Percent of population reached by tobacco-free county properties policies

Foundational capabilities used by LPHAs to achieve this measure:

- ✓ Leadership and organizational competencies
- Health equity and cultural responsiveness
- Community partnership development
- ✓ Policy and planning
- Communications
- Emergency preparedness
- ✓ Assessment and epidemiology

OHA supports this measure by:

- Enforcing Oregon's tobacco and clean indoor air laws
- Ensuring the Tobacco Quit Line is available for all Oregonians with enhancements for populations suffering from tobacco disparities
- Funding all LPHAs for tobacco education and prevention, health system changes, policy advancement in tobacco retail environments, and to create tobacco free environments
- Providing technical assistance to LPHAs, Tribes and other partners
- Providing statewide mass media campaigns

Benchmark 100%

	2016	2017	2018	2019
Statewide	63%	70%	70%	73%
Baker	0%	0%	0%	0%
Benton	100%	100%	100%	100%
Clackamas	0%	0%	0%	0%
Clatsop	100%	100%	100%	100%
Columbia	100%	100%	100%	100%
Coos	100%	100%	100%	100%
Crook	100%	100%	100%	100%
Curry	0%	0%	0%	0%
Deschutes	100%	100%	100%	100%
Douglas	100%	100%	100%	100%
Gilliam	0%	0%	0%	0%
Grant	0%	100%	100%	100%
Harney	0%	100%	100%	100%
Hood River	100%	100%	100%	100%
Jackson	0%	100%	100%	100%
Jefferson	0%	100%	100%	100%
Josephine	100%	100%	100%	100%
Klamath	100%	100%	100%	100%
Lake	0%	0%	0%	0%
Lane	100%	100%	100%	100%
Lincoln	0%	100%	100%	100%
Linn	0%	0%	0%	100%
Malheur	100%	100%	100%	100%
Marion	100%	100%	100%	100%
Morrow	0%	0%	0%	0%
Multnomah	100%	100%	100%	100%
Polk	100%	100%	100%	100%
Sherman	0%	0%	0%	0%
Tillamook	100%	100%	100%	100%
Umatilla	100%	100%	100%	100%
Union	100%	100%	100%	100%
Wallowa*	100%	100%		
Wasco	0%	0%	0%	0%
Washington	0%	0%	0%	0%
Wheeler	0%	0%	0%	0%
Yamhill	100%	100%	100%	100%

** Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.*

Adult Smoking Prevalence

LOCAL PUBLIC HEALTH PROCESS MEASURE

Percent of population reached by tobacco retail licensure policies

Foundational capabilities used by LPHAs to achieve this measure:

- Leadership and organizational competencies
- ✓ Health equity and cultural responsiveness
- Community partnership development
- ✓ Policy and planning
- Communications
- Emergency preparedness
- Assessment and epidemiology

OHA supports this measure by:

- Enforcing Oregon's tobacco and clean indoor air laws
- Ensuring the Tobacco Quit Line is available for all Oregonians with enhancements for populations suffering from tobacco disparities
- Funding all LPHAs for tobacco education and prevention, health system changes, policy advancement in tobacco retail environments, and to create tobacco free environments
- Providing technical assistance to LPHAs, Tribes and other partners
- Providing statewide mass media campaigns

Benchmark 100%

	2016	2017	2018	2019
Statewide	23%	26%	26%	32%
Baker	0%	0%	0%	0%
Benton	29%	93%	97%	98%
Clackamas	0%	0%	0%	0%
Clatsop	0%	0%	0%	0%
Columbia	0%	0%	0%	0%
Coos	0%	0%	0%	0%
Crook	0%	0%	0%	0%
Curry	0%	0%	0%	0%
Deschutes	0%	0%	0%	0%
Douglas	0%	0%	0%	0%
Gilliam	0%	0%	0%	0%
Grant	0%	0%	0%	0%
Harney	0%	0%	0%	0%
Hood River	0%	0%	0%	0%
Jackson	0%	0%	0%	0%
Jefferson	0%	0%	0%	0%
Josephine	0%	0%	0%	0%
Klamath	0%	96%	96%	97%
Lake	0%	0%	0%	0%
Lane	31%	31%	32%	33%
Lincoln	0%	0%	0%	0%
Linn	0%	0%	0%	0%
Malheur	0%	0%	0%	0%
Marion	0%	0%	0%	0%
Morrow	0%	0%	0%	0%
Multnomah	100%	100%	100%	100%
Polk	0%	0%	0%	0%
Sherman	0%	0%	0%	0%
Tillamook	0%	0%	0%	0%
Umatilla	0%	0%	0%	0%
Union	0%	0%	0%	0%
Wallowa*	0%	0%		
Wasco	0%	0%	0%	0%
Washington	0%	0%	0%	0%
Wheeler	0%	0%	0%	0%
Yamhill	0%	0%	0%	0%

** Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.*

All Opioid Mortality

HEALTH OUTCOME MEASURE

All opioid mortality rate per 100,000 population, Oregon 2014-18

The statewide opioid mortality rate of 8 per 100,000 for 2014-18 exceeded the benchmark of <6 per 100,000 (lower is better)

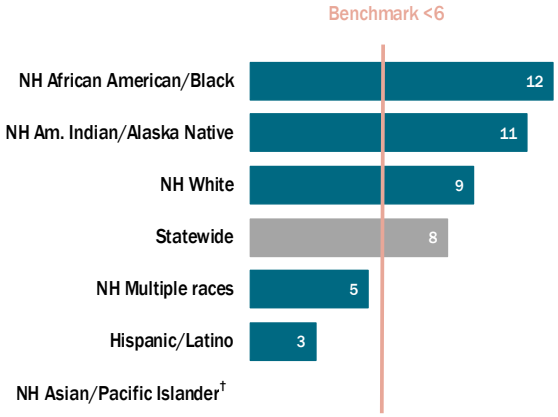
Opioid mortality rates have been declining steadily in Oregon in recent years

OHA provides capacity-building grants to nine LPHAs, which support 22 counties through regional work to bolster health equity by coordinating multi-sector overdose prevention initiatives, identifying and responding to the needs of impacted populations with culturally-responsive support, and developing stragwicw overdose prevention plans

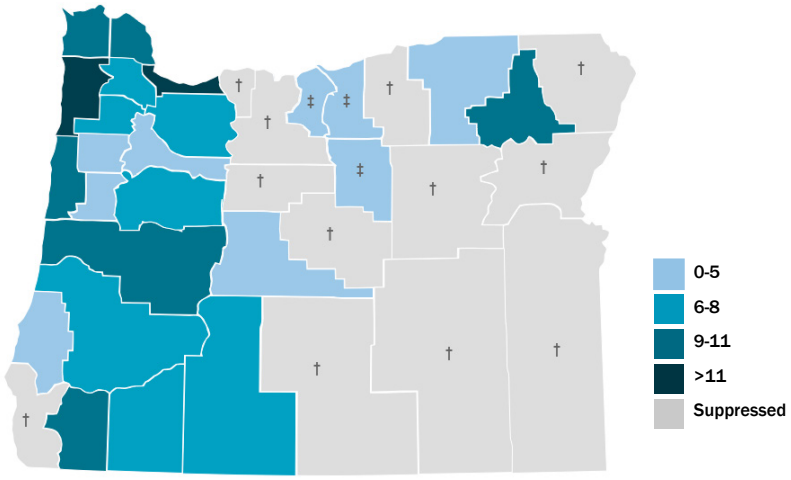
Three counties had no opioid-related deaths in 2014-18

Additional information about opioid mortality is available at healthoregon.org/ipv

American Indian/Alaska Native and African American/ Black Oregonians experience a notable disparity in the rate of opioid deaths*



Nine counties in Oregon were at or below (lower is better) the benchmark of <6 per 100,000 in 2014-18



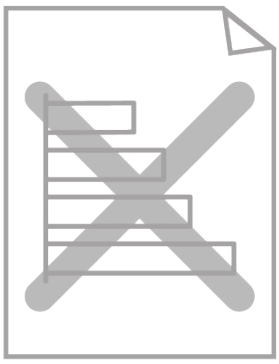
NH refers to non-Hispanic. † Rates not shown for 5 or fewer events or relative squared error >=30. ‡ Zero counts.

Active Transportation

HEALTH OUTCOME MEASURE

Percent of commuters who walk, bike, or use public transportation to get to work, Oregon 2018

Race/ethnicity data not available



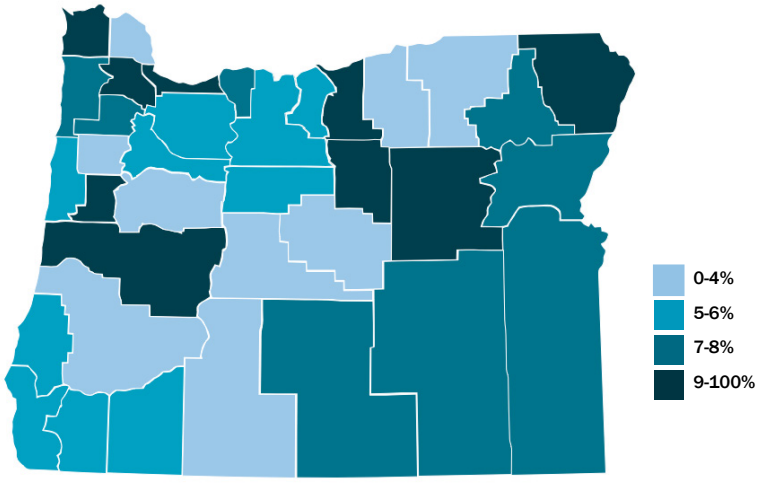
Statewide, 19% of Oregon adults reported getting no physical activity outside of work in the past month. Improving active transportation options can help people in Oregon be more active.

Statewide, Oregon has exceeded the 9% benchmark annually since 2016

The percent of Oregonians who use active transportation for work has remained constant since 2016

Additional information about active transportation is available at healthoregon.org/npa and healthoregon.org/epht

Nine counties in Oregon met or exceeded the benchmark of 9% in 2014-18



Active Transportation

LOCAL PUBLIC HEALTH PROCESS MEASURE

Local public health authority participation in leadership or planning initiatives related to active transportation, parks and recreation, or land use*

Foundational capabilities used by LPHAs to achieve this measure:

- ✓ Leadership and organizational competencies
- Health equity and cultural responsiveness
- ✓ Community partnership development
- ✓ Policy and planning
- Communications
- Emergency preparedness
- Assessment and epidemiology

OHA supports achievement of this process measure by:

- Partnering with ODOT to develop a statewide policy framework that prioritizes active transportation, health, and health equity
- Providing technical assistance for health impact assessments

OHA does not fund LPHAs for active transportation

Fifty-nine percent of LPHAs reported participating in leadership or planning initiatives for active transportation, parks and recreation or land use in 2018

	2018
Statewide	59%
Baker	no
Benton	yes
Clackamas	yes
Clatsop	no
Columbia	no
Coos	no
Crook	yes
Curry	no
Deschutes	yes
Douglas	yes
Grant	yes
Harney	yes
Hood River	no
Jackson	no
Jefferson	yes
Josephine†	
Klamath	yes
Lake	no
Lane	yes
Lincoln	yes
Linn‡	
Malheur‡	
Marion	yes
Morrow	no
Multnomah	yes
North Central PH District§	yes
Polk‡	
Tillamook	yes
Umatilla	no
Union	no
Wallowa‖	
Washington	yes
Wheeler	no
Yamhill	yes

**Survey was not conducted in 2019. † LPHA did not respond to survey. ‡ LPHA responded there were no planning initiatives or unsure to all. § North Central Public Health District is comprised of Gilliam, Sherman, and Wasco counties. ‖ Wallowa County transferred its public health authority to the Oregon Health Authority in 2018.*

Drinking Water

HEALTH OUTCOME MEASURE

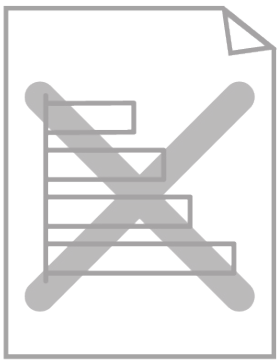
Percent of community waters systems meeting health-based standards, Oregon 2019*

Statewide, the percent of community water systems meeting standards has exceeded the 92% benchmark annually since 2017

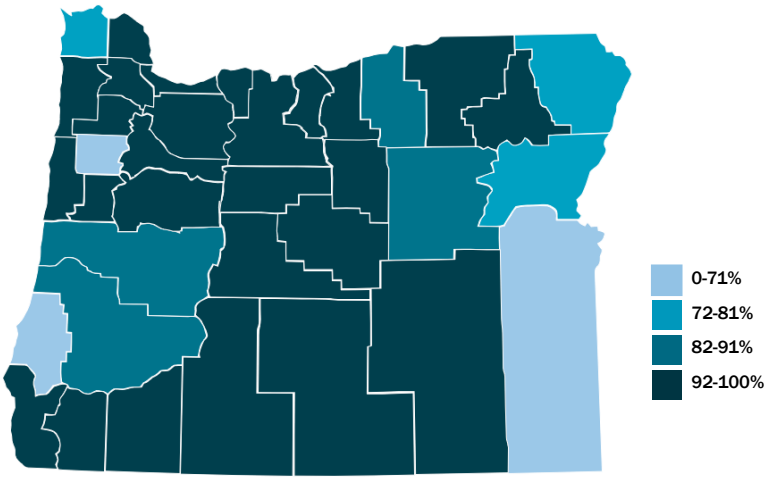
Ten counties did not have at least 92% of community water systems meeting standards in 2019

Additional information about drinking water is available at healthoregon.org/dws

Race/ethnicity not applicable



Statewide, 93% of community water systems met health-based standards in 2019



*Data are based on violations for the federal fiscal year, October-September.

Drinking Water

LOCAL PUBLIC HEALTH PROCESS MEASURE

Percent of water systems surveys completed

Foundational capabilities used by LPHAs to achieve this measure:

- Leadership and organizational competencies
- Health equity and cultural responsiveness
- Community partnership development
- Policy and planning
- Communications
- ✓ Emergency preparedness
- ✓ Assessment and epidemiology

OHA supports achievement of this measure by:

- Managing laboratory data submitted by public water systems and maintaining statewide database
- Enforcing water system compliance
- Providing technical and field assistance to water systems
- Funding safe drinking water programs in some counties

A majority of LPHAs completed water system surveys in 2019

Benchmark 100%

	2016	2017	2018	2019
Statewide	97%	99%	99%	97%
Baker*		100%		
Benton	100%	100%	100%	100%
Clackamas	100%	100%	98%	100%
Clatsop	100%	100%	100%	100%
Columbia	100%	100%	100%	100%
Coos	100%	100%	100%	100%
Crook	100%	100%	100%	100%
Curry	83%	88%	100%	100%
Deschutes	100%	100%	100%	100%
Douglas	100%	100%	93%	100%
Gilliam	100%	100%	100%	100%
Grant*				
Harney*				
Hood River	100%	100%	100%	75%
Jackson	100%	100%	100%	100%
Jefferson	100%	100%	100%	100%
Josephine	56%	100%	100%	67%
Klamath	100%	100%	100%	100%
Lake*				
Lane	98%	98%	98%	100%
Lincoln	100%	100%	100%	100%
Linn	100%	100%	100%	100%
Malheur	100%	100%	100%	100%
Marion	100%	100%	100%	100%
Morrow*				
Multnomah	100%	100%	100%	100%
Polk	100%	100%	100%	100%
Sherman	100%	100%	100%	25%
Tillamook	100%	100%	100%	100%
Umatilla*				
Union	100%	100%	100%	100%
Wallowa* †				
Wasco	89%	100%	100%	100%
Washington	100%	94%	100%	100%
Wheeler*				
Yamhill	100%	100%	100%	100%

**No water systems surveys in years where no data are shown. † Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.*

Drinking Water

LOCAL PUBLIC HEALTH PROCESS MEASURE

Percent of water quality alert responses

Foundational capabilities used by LPHAs to achieve this measure:

- Leadership and organizational competencies
- Health equity and cultural responsiveness
- Community partnership development
- Policy and planning
- Communications
- ✓ Emergency preparedness
- ✓ Assessment and epidemiology

OHA supports achievement of this measure by:

- Managing laboratory data submitted by public water systems and maintaining statewide database
- Enforcing water system compliance
- Providing technical and field assistance to water systems
- Funding safe drinking water programs in some counties

A majority of LPHAs responded to all water quality alerts in 2019

Benchmark 100%

	2016	2017	2018	2019
Statewide	87%	89%	91%	96%
Baker*†	0%			
Benton	86%	81%	36%	78%
Clackamas	97%	86%	86%	100%
Clatsop	93%	91%	100%	67%
Columbia	70%	100%	100%	80%
Coos	100%	100%	100%	100%
Crook	68%	94%	92%	100%
Curry	35%	68%	100%	100%
Deschutes	88%	94%	91%	100%
Douglas	94%	91%	94%	89%
Gilliam†	50%	100%		100%
Grant*				
Harney*				
Hood River	73%	57%	100%	89%
Jackson	85%	99%	92%	96%
Jefferson	100%	100%	100%	100%
Josephine	77%	100%	82%	77%
Klamath	85%	100%	100%	100%
Lake*				
Lane	97%	96%	100%	100%
Lincoln	100%	96%	94%	100%
Linn	94%	93%	100%	100%
Malheur	80%	57%	71%	69%
Marion	93%	98%	100%	100%
Morrow*				
Multnomah	100%	100%	100%	100%
Polk	75%	94%	100%	100%
Sherman	67%	43%	86%	100%
Tillamook	75%	85%	100%	92%
Umatilla*				
Union	57%	82%	100%	100%
Wallowa*‡				
Wasco	67%	45%	51%	91%
Washington	93%	73%	100%	100%
Wheeler*				
Yamhill	100%	61%	88%	100%

** Water quality alerts not applicable where no data are shown. † Zero water quality alerts for Baker County in 2018, 2019; for Gilliam County in 2018. ‡ Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.*

Gonorrhea Rate

LOCAL PUBLIC HEALTH PROCESS MEASURE

Percent of gonorrhea case reports with completed data priority fields

Foundational capabilities used by LPHAs to achieve this measure:

- Leadership and organizational competencies
- ✓ Health equity and cultural responsiveness
- Community partnership development
- Policy and planning
- Communications
- Emergency preparedness
- ✓ Assessment and epidemiology

OHA OHA supports for this measure include:

- Orpheus statewide communicable disease database
- Providing technical assistance to LPHAs and medical providers to identify and treat people with STDs and their contacts
- Subsidizing lab testing programs and STD medications and condoms
- Funding all LPHAs for communicable disease investigations

One LPHA exceeded the 70% benchmark in 2019

Benchmark 70%

	2016	2017	2018	2019
Statewide	19%	24%	29%	26%
Baker	100%	60%	14%	25%
Benton	13%	27%	32%	46%
Clackamas	13%	15%	33%	45%
Clatsop	14%	32%	38%	50%
Columbia	14%	11%	7%	14%
Coos	15%	13%	18%	16%
Crook	53%	7%	40%	20%
Curry	18%	0%	13%	14%
Deschutes	35%	35%	65%	46%
Douglas	25%	7%	20%	24%
Gilliam*	0%	100%		
Grant*	0%		0%	100%
Harney*	0%	33%		
Hood River	25%	56%	56%	27%
Jackson	6%	30%	33%	36%
Jefferson	0%	2%	3%	29%
Josephine	2%	2%	1%	9%
Klamath	16%	8%	7%	14%
Lake*	14%	0%		
Lane	21%	32%	41%	42%
Lincoln	8%	11%	21%	39%
Linn	13%	34%	31%	18%
Malheur	34%	23%	26%	22%
Marion	42%	49%	47%	41%
Morrow	5%	0%	42%	17%
Multnomah	17%	17%	23%	15%
Polk	8%	30%	46%	25%
Sherman*				33%
Tillamook	0%	0%	21%	0%
Umatilla	0%	4%	12%	24%
Union	36%	0%	17%	0%
Wallowa* †				
Wasco	17%	50%	63%	22%
Washington	26%	35%	40%	34%
Wheeler*	0%			
Yamhill	3%	31%	25%	24%

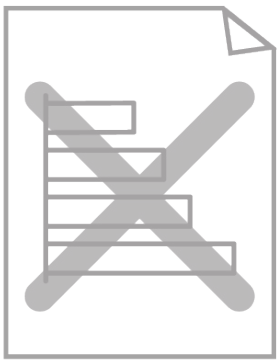
** Indicates counties that had 0 gonorrhea cases in years where no data are shown. † Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.*

Effective Contraceptive Use

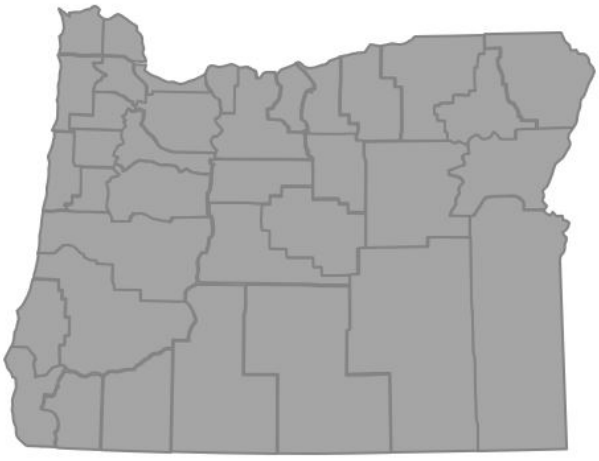
HEALTH OUTCOME MEASURE

Percent of women at risk of unintended pregnancy who use effective methods of contraception, Oregon 2018

Race/ethnicity data not available



68% percent statewide. County data not available.



The statewide benchmark of 70% has not been met since 2016

Effectiveness is only one factor that influences contraceptive method choice

Client-centered approaches should always be used in contraceptive counseling to ensure that an individual's choices are respected

Additional information about effective contraceptive use is available at healthoregon.org/rh

Effective Contraceptive Use

LOCAL PUBLIC HEALTH PROCESS MEASURE

Annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use

Statewide Benchmark 70%

Foundational capabilities used by LPHAs to achieve this measure:

- Leadership and organizational competencies
- ✓ Health equity and cultural responsiveness
- ✓ Community partnership development
- ✓ Policy and planning
- Communications
- Emergency preparedness
- Assessment and epidemiology

OHA supports achievement of this measure by:

- Providing technical assistance to a network of reproductive health clinics
- Supporting linkages to community resources
- Resolving gaps in existing services OHA funds LPHAs to assure access to reproductive health services
- Funding LPHAs to assure access to reproductive health services

LPHAs work collaboratively to identify gaps and barriers in access to reproductive health services. Funding has been used by LPHAs for identifying partners, developing collaborative relationship, or conducting needs assessments, which represents important work toward developing a strategic plan.

	2018	2019
Statewide	0%	0%
Baker	no	no
Benton	no	no
Clackamas	no	no
Clatsop	no	no
Columbia	no	no
Coos	no	no
Crook	no	no
Curry	no	no
Deschutes	no	no
Douglas	no	no
Grant	no	no
Harney	no	no
Hood River	no	no
Jackson	no	no
Jefferson	no	no
Josephine	no	no
Klamath	no	no
Lake	no	no
Lane	no	no
Lincoln	no	no
Linn	no	no
Malheur	no	no
Marion	no	no
Morrow	no	no
Multnomah	no	no
Polk	no	no
Tillamook	no	no
Umatilla	no	no
Union	no	no
Wallowa*		
Washington	no	no
Wheeler	no	no
Yamhill	no	no

** Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.*

Dental Visits Children Aged 0-5

Developmental Measure

Percent of children age 0-5 with any dental visit, Oregon 2018*

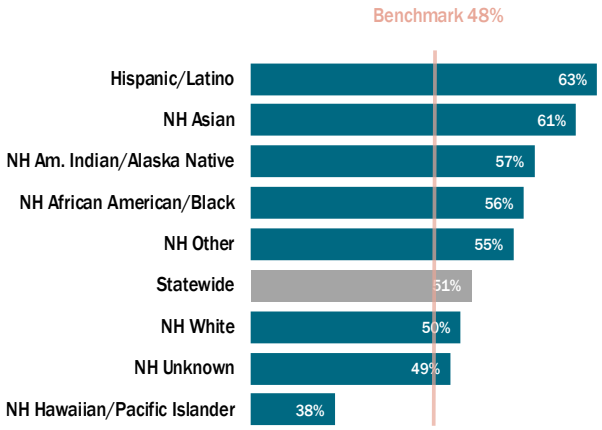
Statewide, the 48% benchmark has been met or exceeded since 2016 for Medicaid-enrolled children

Having a healthy mouth is an important part of overall health. If left untreated, cavities can negatively affect a child's development and school performance. The American Academy of Pediatric Dentistry recommends every child have a dental visit as soon as the first tooth appears or by age 1.

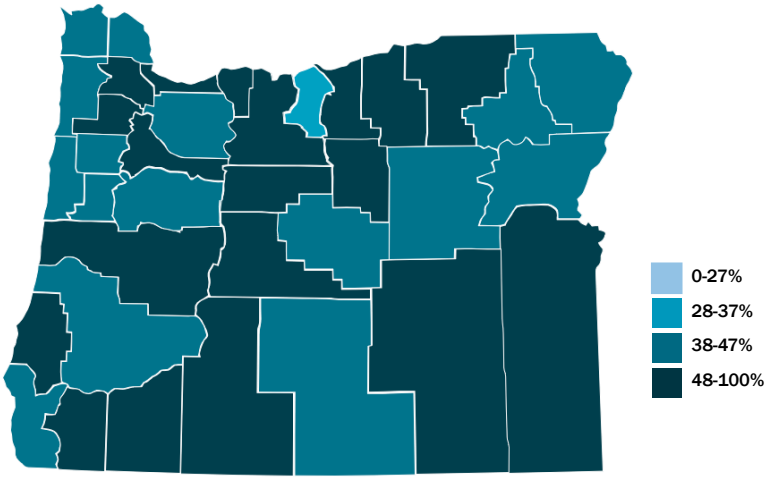
This measure is considered developmental and includes any service by a dentist or dental hygienist. It does not include dental services provided in a medical setting.

Additional information about oral health is available at healthoregon.org/oralhealth

Native Hawaiian/Pacific Islander children experienced a very large disparity in the rate of dental visits in 2018†



19 counties in Oregon met or exceeded the 48% benchmark in 2018



Medicaid-enrolled children. †NH refers to non-Hispanic.

Appendix E: Funding formula description and methodology

This appendix provides additional detail and describes the methodology for each of the funding formula components. An example showing how funds are allocated across each component of the funding formula is available at the end of this section.

The base component

- Includes a floor payment for each county and additional allocations through the indicator pool.

Floor payments

- Floor payments are based on five tiers of county size bands. At the $10 million level, floor payments range from $30,000 to $90,000 and total $1.845 million.
  - » Floor payments increase proportionally at funding levels above $10 million (remaining at 18.45% of total base component funds).
  - » Floor payments are intended to ensure stable funding for a basic level of public health staffing and operations.

Total funds	Range of floor payments*	Floor payment total	Indicator pool total
$10 million	$30,000–90,000	$1,845,000	$8,155,000
$15 million	$45,000–135,000	$2,767,500	$11,332,500
$20 million	$60,000–180,000	$3,690,000	$15,110,000

- All remaining base component funding is distributed through the indicator pool.

Indicator pool

Every county receives additional allocations through the indicator pool based on the county's ranking on a set of health and demographic indicators.† A description of each indicator, measure and data source follows. Each of the health and demographic indicators receives an equal percentage of available indicator pool dollars.

* In the future PHAB may consider whether to establish a cap for the maximum dollar amount going to base component floor payments.

† Indicators include health status, burden of disease, racial and ethnic diversity, poverty, educational attainment, population density, limited English proficiency and rurality.

Note: As designed, PHAB intended that the public health modernization funding formula would only be used for funding amounts of $10 million for LPHAs and above. However, in 2019 PHAB decided to use the funding formula for a funding amount of $7 million.

	Measure	Indicator required by statute?	Data source	Percent allocation
Burden of disease	Premature death: Leading causes of years of potential life lost before age 75.	Yes	Oregon death certificate data	16.67%%
Health status	Quality of life: Good or excellent health.	Yes	Behavioral Risk Factor Surveillance System	16.67%
Racial and ethnic diversity	Percent of population not categorized as "White alone".	No	U.S. Census Bureau, American Community Survey population five-year estimate	16.67%
Poverty*	Percent of population living below 150% of the federal poverty level in the past 12 months.	No	U.S. Census Bureau, American Community Survey population five-year estimate	8.33%
Education*	Percent of population age 25 years and over with less than a high school graduate education level.	No	U.S. Census Bureau, American Community Survey population five-year estimate	8.33%
Limited English proficiency	Percent of population age 5 years and over that speaks English less than "very well".	No	U.S. Census Bureau, American Community Survey population five-year estimate	16.67%
Rurality	Percent of population living in a rural area	No	U.S. Census Bureau Population estimates	16.67%
Total				100%

* PHAB recommended including two measures under one indicator for socioeconomic status.

Methodology

Base funding = floor payment + indicator pool payment

Floor payment = based on county size band

Indicator pool payment = all remaining base component funds

Indicator pool payment = (LPHA weight/sum of all LPHA weights) * Total indicator pool

LPHA weight = LPHA population * LPHA indicator percentage

The matching funds component

- Matching funds will be awarded for sustained or increased county general fund investments over time.
- Five percent of funds will be allocated to matching funds at or above the $15 million level. (At the $15 million level, $750,000 would be allocated to matching funds.
- Of the total funds allocated to matching funds, 50% will be awarded for sustained county general fund investments, and 50% will be awarded for increased county investment.
  - » Maintenance payment: Awarded to counties that demonstrate sustained county general fund investment. Available funds awarded equally to all qualifying counties.
  - » Additional allocation: Awarded to counties that demonstrate increased county general fund investment. Allocations for increased investment are determined based on the available pool, percent funding increase and county population.

Total funds	Total matching funds	Maintenance payments	Additional allocation
$10 million	$0	$0	$0
$15 million	$750,000	$375,000	$375,000
$20 million	$1,000,000	$500,000	$500,000

Methodology

Compares county general fund investment over two years.*

* If funding for matching funds is available in 2021–23, OHA may recommend an initial matching funds award based on one year of county general fund data.

Matching funds = maintenance payment for sustained investment + additional allocation for increased investment

Maintenance payment = All counties eligible to receive the same floor payment.

Additional allocation = Based on percent county funding increase, county population and total funds available to counties with funding increases

Additional allocation = (LPHA weight/sum of all LPHA weights) * total available pool for counties with funding increases

LPHA weight = LPHA population * percent county funding increase

The incentive funds component

Structure for public health accountability metrics

- Public health accountability metrics are comprised of the set of health outcomes measures and local public health process measures that have been adopted by PHAB.
- Public health accountability metrics will become incentivized when there is base funding going out to LPHAs through the funding formula for a foundational program. For example, if 2021–23 public health modernization funds are directed to communicable disease control, the public health accountability metrics for communicable disease control will be incentivized.
- Incentive funds will be awarded based on performance on the local public health process measures.
- Performance includes meeting a benchmark or improvement target.
- PHAB is responsible for establishing benchmarks and improvement targets.
- Public health accountability metrics will be collected and reported on annually.

Incentive funds

- Each county that achieves an accountability metric will receive an incentive fund floor payment and an additional allocation.
  - » All qualifying counties receive the same floor payment. Twenty percent of incentive funds will go to floor payments, with a minimum threshold of $1,000.
  - » Additional allocations are proportionally distributed to qualifying counties based on county population.
- One percent of funds will be allocated to incentive funds at or above the $15 million level. (At the $15 million, $150,000 would be allocated to incentive funds.)

» Available funds will be split across incentivized accountability metrics.

* PHAB recommended including two measures under one indicator for socioeconomic status.

Total funds	Total incentive funds	Floor payment (20%)	Additional Allocation (80%)
$10 million	$0	$0	$0
$15 million	$150,000	$30,000 (minimum payment to qualifying counties is $1,000)	$120,000
$20 million	$200,000	$40,000	$160,000

Methodology

Incentive funds = These are floor payment plus additional allocation based on county population.

Floor payment = All qualifying counties receive the same floor payment.

Additional allocation = All qualifying counties receive proportion of remaining incentive funds based on county population.

EXAMPLE OF HOW FUNDS WOULD BE DISTRIBUTED THROUGH FUNDING FORMULA COMPONENTS AT THE $15 MILLION BIENNIAL FUNDING LEVEL FOR LOCAL PUBLIC HEALTH AUTHORITIES IN 2019–21.

Total LPHA biennial funding level	**$15 million**					
Funding formula component	Base funds ($14.1 million, 94% of funds)		Matching funds ($750,000, 5% of funds)		Incentive funds ($150,000, 1% of funds)	
How funds are allocated	Floor payment **to all counties** based on county size band	Additional allocation **to all counties** based on funding formula indicators	Maintenance payment **to counties that sustain county investment**	Additional payment **to counties that increase county investment**	Floor payment **to counties that achieve an accountability metric**	Additional allocation **to counties that achieve an accountability metric**
Percent of funding	18.45% of base funds	81.55% of base funds	50% of matching funds	50% of matching funds	20% of incentive funds, minimum threshold = $1,000	80% of incentive funds
Funding amount	$2,767,500 (Size band range = $45,000–$135,000)	$11,323,500 (County award based on indicator ranking and population)	$375,000 divided evenly among qualifying counties	$375,000 divided among qualifying counties based on percent funding increase and population	$30,000, minimum of $1,000 to qualifying counties	$120,000 divided among qualifying counties based on population

Appendix F: Public Health Advisory Board funding principles for state and local public health authorities

July 2020

The Public Health Advisory Board recognizes that funding for foundational capabilities and programs is limited, but innovations can maximize the benefit of available resources. These funding principles are designed to apply to the public health system, which means state and local public health authorities in Oregon. These funding principles can be applied to increases or decreases in public health funding.

Public health system approach to foundational programs

1. Ensure that public health services are available to every person in Oregon, whether they are provided by an individual local public health authority, a tribal health authority, through cross-jurisdictional sharing arrangements, and/or by the Oregon Health Authority.
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.
3. Use funding to advance health equity in Oregon, which includes directing funds to areas of the state experiencing a disproportionate burden of disease or where health disparities exist.
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.
5. Align public health work and funding to leverage resources with health care, education and other sectors to achieve health outcomes.

Transparency across the public health system

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.
7. Improve transparency about funded work across the public health system and scale work to available funding.

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