**Public Health Division**

Public Health Modernization

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# Public Health Modernization Funding Report to Legislative Fiscal Office

## In fulfillment of ORS 431.139 and ORS 431.380

**April 2025**

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# Report Contents

In compliance with ORS 431.139 and ORS 431.380 the Oregon Health Authority-Public Health Division (OHA-PHD) has prepared the following report to the Legislative Fiscal Office.

- Appendix D. Detailed description and methodology for floor and indicator funding formula components
- Appendix E. Funding formula health and demographic indicators
- Appendix F. County data for health and demographic indicators, May 2024
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# Executive Summary

Oregon established a framework for achieving a modern public health system in 2015, called public health modernization (PH modernization). PH Modernization ensures core governmental functions for improving population health within the following four foundational program areas:

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

Since 2017, Oregon has made progress with PH modernization legislative investments, including early investments in communicable disease control that provided crucial infrastructure for Oregon's response to the COVID-19 pandemic. With 2023-25 biennium funding, Oregon's Public Health Advisory Board (PHAB) recommended that OHA continue to invest in implementing statutory requirements for two of the four foundational programs, communicable disease control and environmental health.

## *2023-2025 accomplishments*

In 2023, the Oregon Legislature allocated an additional $50 million in funding, increasing the total investment in PH modernization for 2023-25 to $112.2 million. The majority of these funds reach Oregon communities through allocations to local public health authorities (LPHAs), Tribes and the Urban Indian Health Program (UIHP), and community-based organizations (CBOs).

- All 33 LPHAs received funds for PH modernization, which support more than 300 LPHA staff to implement PH modernization foundational capabilities and programs, including:
  - Local interventions to improve immunization rates;
  - Development and implementation of climate resilience plans, all hazards preparedness plans, and local health equity plans; and
  - Partnerships with community organizations to ensure public health programs are created with and for communities who are most affected by health inequities.
- Eight federally recognized Tribes and the UIHP chose to receive PH modernization funding, which was used to develop and implement action plans containing strategies to build and sustain public health infrastructure; enhance population-level data collection and improve Tribal access to data; and increase Tribal health and community member readiness for public health and other climate-related emergencies.

- OHA awarded PH modernization grant funding to 137 culturally specific CBOs across the state. Funded CBOs served all 36 Oregon counties and 70% of CBOs worked in a language other than English to ensure culturally responsive programming. Through investments:
    - CBOs held 774 local events throughout the state, including 298 for climate and health, 272 for emergency preparedness, and 261 for communicable disease control.
    - Most (87%) CBOs partnered with at least one other organization on their modernization-funded work; 27% of reported partnerships were new and developed as a result of work funded through PH modernization.
- OHA received a portion of the PH modernization investment, which provided capacity for the communicable disease control and environmental health foundational programs, including funding an epidemiologist position that prepares analyses of climate change and water-borne health impacts; a senior toxicologist who assesses risks to people from hazardous exposures; and four regional epidemiologist positions that respond to outbreaks of communicable diseases and provide surge capacity to Local and Tribal public health entities. OHA also implemented an updated system for accountability metrics, ensuring that investments result in improved health outcomes over time and support OHA's goal to eliminate health inequities by 2030.

### *2025-2027 investments*

OHA's 2025 PH modernization Policy Option Package provides an increase in funding of $2 million to make incremental progress on immunization rates for children and older adults. An additional investment of $2 million above current PH modernization funding levels would be allocated to LPHAs, federally recognized Tribes, the UIHP, and CBOs for the following activities:

- LPHAs will increase access to influenza vaccination for residents of long-term care facilities; and increase the percent of Vaccines for Children providers that participate in quality improvement to increase childhood vaccination rates.
- Tribes and the UIHP will further develop tribal health data, assessment, and epidemiology infrastructure; and implement tribal environmental public health programs.
- CBOs will increase educational materials provided in multiple languages and formats, especially those connecting community members to vaccinations.

## *Capacity and costs to implement public health modernization*

Oregon conducted its second Public Health Modernization Capacity and Cost Assessment (CCA) in 2024 to better understand governmental public health spending and capacity for PH modernization and determine needed investments to fully implement Oregon's foundational programs and capabilities. Thirty of Oregon's 33 LPHAs and OHA-PHD completed the assessment and found the highest capacity and expertise in the foundational program areas and capabilities that have received long-term investments from the Oregon Legislature. The foundational programs of communicable disease control, access to clinical preventive services, and environmental health had the highest self-reported expertise and capacity, while prevention and health promotion had the lowest of the foundational programs.

Assessment data indicate that LPHAs and OHA-PHD spent $602.2 million on PH Modernization foundational programs and capabilities in Fiscal Year 2023.[1] Oregon's gap in needed resources to implement foundational programs and capabilities is $262.0 million annually. In total, the governmental public health system requires $864.2 million annually to fully implement Oregon's statutorily outlined foundational capabilities and programs. Costing estimates show that foundational programs with the highest need for resources are those that have not been funded through State General Fund investments in PH Modernization. The prevention and health promotion foundational program had the largest estimated resource gap at $63.3 million annually.

## *Conclusion*

While PH modernization investments have allowed governmental public health and its partners to advance critical work in the areas of communicable disease control and environmental health, we know that Oregon's public health system continues to be underfunded. The gap in resources identified through the Capacity and Cost Assessment can be addressed over time through increases in federal, state, and local investment in public health modernization.

[1] Using Fiscal Year (FY) 2023 for OHA-PHD staffing costs significantly underestimates current spending given numerous position vacancies during the COVID pandemic response. Instead, FY 24 budgeted amounts for OHA-PHD staffing were used to more accurately reflect the staffing costs if all positions for which the agency has position authority were filled.

# Public Health Modernization – Brief Background

A strong public health system is critical for all 4.2 million people in Oregon to achieve optimal health. Since 2013, Oregon has been rebuilding its governmental public health system to ensure essential public health protections for all people in Oregon through equitable, community-centered, and accountable services.

**Public health modernization provides a strong foundation for OHA's strategic goal to eliminate health inequities by 2030.**

Oregon established the framework for achieving a modern public health system in 2015 with the passage of House Bill 3100. Public health modernization ensures core governmental functions for improving population health within four foundational program areas as described in ORS 431.141:

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

Building on a 2016 public health system assessment,[2] Oregon's Public Health Advisory Board (PHAB) developed a phased plan to modernize Oregon's public health system over three to five biennia, alongside increases in public health system investments by the Oregon Legislature. (**Figure 1** shows PHAB's recommended phased approach to public health modernization implementation).

Since 2017, Oregon has made progress with public health modernization (PH modernization) legislative investments, and early investments in communicable disease control provided crucial infrastructure for Oregon's response to the COVID-19 pandemic. However, the COVID-19 pandemic also showed significant gaps in Oregon's ability to respond to public health emergencies and emerging health threats. With continued funding, a modern public health system will close these gaps and make meaningful progress toward eliminating health inequities in Oregon by 2030.

With 2023-25 biennium funding, PHAB recommended that OHA continue investments in Phase 1, increasing capacity to implement statutory requirements for two of the four foundational programs – communicable disease control and environmental health – as well as the health equity and cultural responsiveness and emergency preparedness and response foundational capabilities.

[2] Oregon Health Authority (2016) Public Health Modernization Assessment Report. Available at: https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/PHModernizationFullDetailedReport.pdf.

Based on PHAB's recommendations, funds were allocated to the following areas:

- Strengthening and expanding communicable disease and environmental health emergency preparedness.
- Protecting communities from acute and communicable diseases through prevention initiatives that address health inequities.
- Protecting communities from environmental health threats through public health interventions that support equitable climate adaptation.
- Co-creating public health interventions that ensure equitable distribution or redistribution of resources and power to communities that experience historical and contemporary injustices.

A list of key PH modernization milestones since 2017 is available in **Appendix A**.

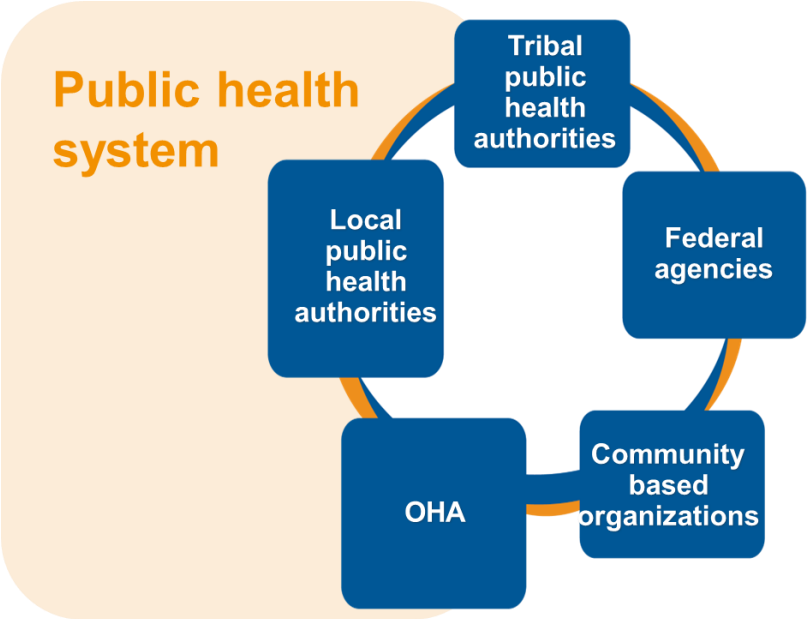
**Figure 1.** PHAB's proposed phases for foundational programs

# ORS 431.139. Reporting on foundational capabilities.

*Amount of state General Funds received by OHA in the 2023-25 biennium for the purpose of funding foundational capabilities established under ORS 431.131 and foundational programs established under ORS 431.141*

*Description of how funds were distributed to Local Public Health Authorities (LPHA), federally recognized Tribes, the Urban Indian Health Program (UIHP) and community-based organizations (CBOs)*

Oregon's governmental public health system is a network of state and local public health authorities, and government-to-government relationships with federally recognized Tribes. Oregon has a decentralized public health system, which means that many local public health functions are determined by local governing bodies. In Oregon, local and Tribal governments have authority over most public health functions to ensure the health and well-being of every person in their jurisdictions. State, local and Tribal public health authorities all have distinct yet mutually supportive functions.




The governmental public health system works with partners, including community-based organizations, to ensure that public health is delivering culturally and linguistically responsive interventions that reach those who experience a disproportionate burden of death and disease.

In 2023, the Oregon Legislature allocated an additional $50 million in funding, a notable investment in Oregon's public health system. The total investment in PH modernization for 2023-25 was $112.2 million. The majority of funds reach Oregon communities through allocations to LPHAs, Tribes and the Urban Indian Health Program (UIHP) and CBOs.

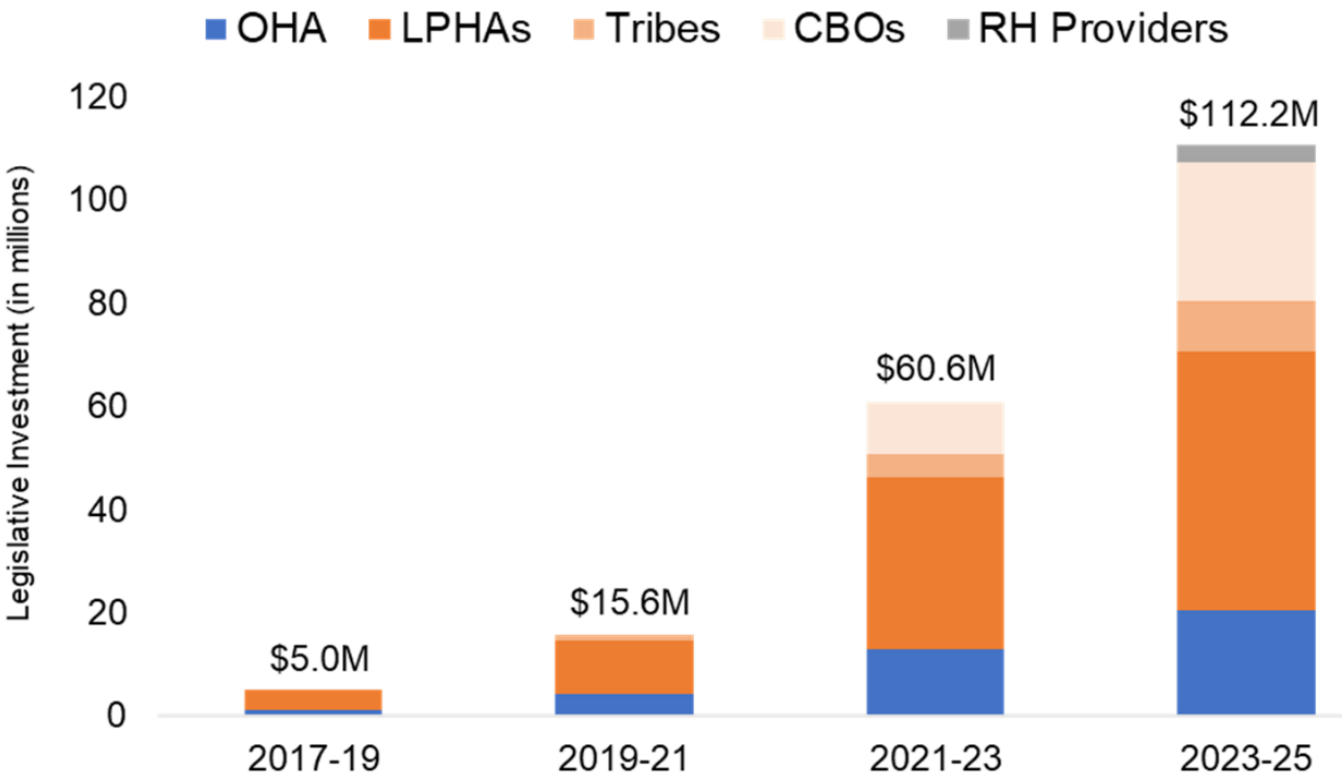
**Table 1.** Legislative investment in PH modernization by partner type, 2017-2025

| | 2017-19 | 2019-21 | 2021-23 | 2023-25 |
|---|---|---|---|---|
| **Local public health authorities** | $3.9 | $10.3 | $33.4 | $50.35 |
| **Federally recognized Tribes and UIHP**** | - | $1.1 | $4.4 | $9.7 |
| **Community-based organizations** | - | - | $10.0 | $26.95 |
| **OHA** | $1.1 | $4.2 | $12.8 | $20.3 |
| **Total** | **$5.0 million** | **$15.6 million** | **$60.6 million** | **$112.2* million** |

* Total funding amount in 2023-25 reflects $1.5 million in inflation.

** Also includes funding to the Northwest Portland Area Indian Health Board for Tribal-specific technical assistance and training.

**Figure 2.** Legislative investment in PH modernization by partner type, 2017-2025 (in millions)



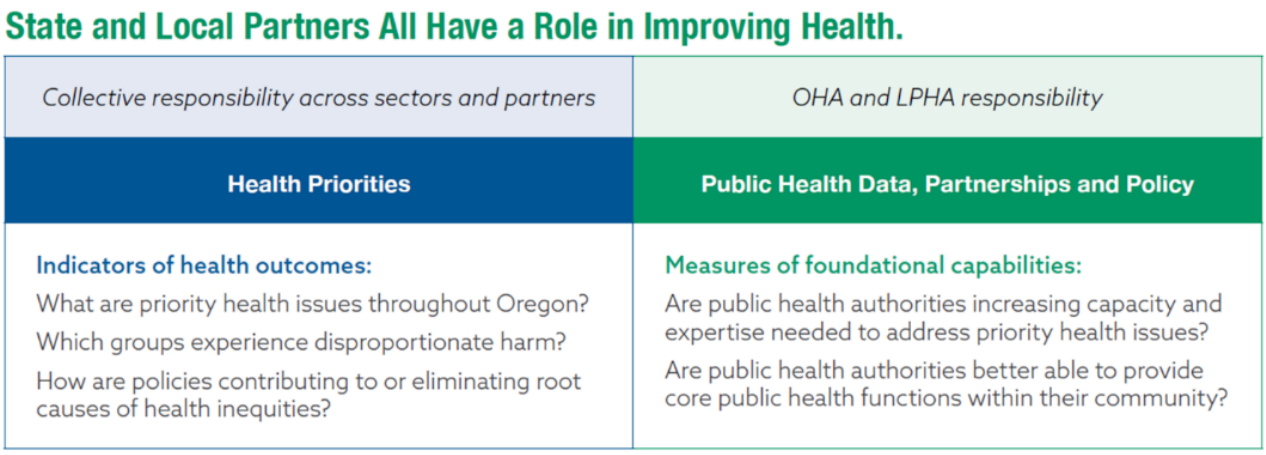

Note: The "RH Providers" category reflects PH modernization fund allocated in 2023-2025 to clinical agencies to ensure access to reproductive health care in Oregon.

## *Progress of LPHAs and OHA-PHD in meeting accountability metrics*

### Public Health Advisory Board (PHAB)

Oregon's PHAB is responsible for establishing, updating and tracking a set of accountability metrics to evaluate the progress of Oregon's public health system toward achieving statewide public health goals.[3] In 2023, PHAB updated Oregon's public health accountability metrics framework to center equity and emphasize that collaborations across sectors and partners are necessary to address root causes of poor health outcomes (see **Figure 3**). PHAB also established new metrics for the foundational programs currently funded through state investments in PH modernization, communicable disease control and environmental health.

**Figure 3.** PH modernization accountability metrics framework




The three metrics priority areas are:

- Reduce the spread of syphilis and prevent congenital syphilis.
- Protect people from preventable diseases through vaccination.
- Build community resilience for climate impacts on health (extreme heat and wildfire smoke).

Within each priority area, there are three interconnected levels of measures that, when reviewed as a whole, reflect the actions of governmental public health agencies and partners to improve health outcomes:

- **Health outcome indicators** reflect urgent health issues that are priorities for the public health system. Making improvements in health outcome indicators requires sufficient and sustainable funding, long-term focus and

[3] Oregon Revised Statutes 431.123. Available at: https://www.oregonlegislature.gov/bills_laws/ors/ors431.html.

must include other sectors and partners. Indicators are used to show progress toward 2030 goals to improve health outcomes.

- **LPHA process measures** bring attention to the core functions of LPHAs to improve health outcomes, including data and epidemiology, communications, partnerships and policy.

- **OHA process measures** bring attention to the unique functions of the state public health authority to support the public health system and serve all people in Oregon.

**Table 2.** Public health modernization accountability metrics health outcome indicators, 2023 baseline measures, and 2030 goals

| Priority area | Health outcome indicator | Indicator 2023 baseline | Indicator 2030 goal |
|---|---|---|---|
| Reduce the spread of syphilis and prevent congenital syphilis | Rate of congenital syphilis | 78.3/100k live births | 39.2/100k (50% decrease) |
| | Rate of syphilis (all stages) among people who can become pregnant | 72.2/100k | 65.0/100k (10% decrease) |
| | Rate of primary and secondary syphilis | 19.2/100k | 16.3/100k (15% decrease) |
| Protect people from preventable diseases by increasing vaccination rates | Two-year old vaccination rate (4:3:1:3:3:1:4 series*) | 68% | 80% (18% increase) |
| | Adult influenza vaccination rate, ages 65+ | 47% | 60% (28% increase) |
| Increase community resilience for climate impacts on health: extreme heat and wildfire smoke | Emergency department and urgent care visits due to heat | 1.79 heat-related illness visits (per 1M) per day ≥80°F Heat Index | 0.85 HRI visits (per 1M) per day ≥80°F Heat Index (50% decrease) |
| | Hospitalizations due to heat | 69 hospitalizations (per 4.2M) | 28 heat-related Hospitalizations (60% decrease) |
| | Heat deaths | 8 total statewide deaths | 2 total statewide deaths (70% decrease) |
| | Respiratory (non-infectious) emergency department and urgent care visits | 1.63 Non-infectious Respiratory Illness visits (per 10k) per day at or above Moderate air quality index | 1.30 visits (per 10k population) per day at or above Moderate air quality index (20% decrease) |

* The 4:3:1:3:3:1:4 series includes 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella and 4 PCV by 24 months of age.

In addition to tracking health outcome indicator data for the overall population, a 2024 Public Health Modernization Accountability Metrics Report will be published in early 2025 that will include indicator data for specific population demographics where possible, including county, race and ethnicity, sex, and age. Accountability metrics reports will be published annually, thereafter. OHA is also developing new health outcome indicators for drinking water security and the mental health effects of climate change to include in a future version of the metrics framework.

PHAB made the following recommendations for process measures that accompany each health outcome indicator, which were adopted by OHA:

1. LPHAs should select process measures from a menu of options so that each LPHA can best use resources to address the needs of their community. In the 2023-25 biennium, each LPHA is required to select two process measures for each priority area, for a total of six process measures.

2. Incentive payments to LPHAs required under ORS 431.380 should be awarded based on performance on process measures rather than health outcome indicators.

3. Although not required in statute, PHAB recommended that OHA also develop and track process measures to demonstrate improvements in state-level actions for each health outcome indicator.

The tables below detail the proportion of LPHAs that selected each focus area within the environmental health and communicable disease control foundational programs and selections for corresponding process measures. While process measures for the priority areas of immunizations, extreme heat, and wildfire smoke are tracked through LPHA reporting to OHA, process measures for the syphilis priority area are tracked through Orpheus, the state's integrated electronic disease surveillance systems.

LPHAs completed baseline reporting for process measures in July 2024 and will complete Year 1 reporting in spring 2025 to determine whether each LPHA has met their selected process measures. As required in ORS 431.380, beginning in 2025, incentive payments will be awarded to LPHAs that meet process measures. Year 1 process measure reporting will inform the allocation of incentive payments. The method for distributing incentive payments to LPHAs is described in the "ORS 431.380 Distribution of funds; rules" section of this report.

### *Environmental health*

The tables below show the proportion of LPHAs that selected to focus on the extreme heat, wildfire smoke, or both priority areas for their process measures

within the environmental health foundational program. Tables also show the "demonstrated actions" within each focus area to which they will be held accountability in annual process measures reporting to OHA.

**Table 3.** Environmental health accountability metrics priority areas (N = 33)

| Focus area | n (%) |
|---|---|
| Extreme heat | 14 (42.4%) |
| Wildfire smoke | 14 (42.4%) |
| Both priority areas | 5 (15.2%) |

**Table 4.** Extreme heat process measure selection (N = 19)

| Process measures | n (%) |
|---|---|
| Demonstrated actions in Communications to reduce the health impacts of extreme heat | 16 (84.2%) |
| Demonstrated use of data to identify populations of focus | 15 (78.9%) |
| Demonstrated actions in Community Partnerships to reduce the health impacts of extreme heat | 13 (68.4%) |
| Demonstrated actions in Policy to reduce the health impacts of extreme heat | 4 (21.1%) |

Note: LPHAs could select multiple process measures, so percentages may not equal 100%.

**Table 5.** Wildfire smoke process measure selection (N = 19)

| Process measures | n (%) |
|---|---|
| Demonstrated actions in Community Partnerships to reduce the health impacts of wildfire smoke | 18 (94.7%) |
| Demonstrated actions in Communications to reduce the health impacts of wildfire smoke | 14 (73.7%) |
| Demonstrated use of data to identify populations of focus | 14 (73.7%) |
| Demonstrated actions in Policy to reduce the health impacts of wildfire smoke | 6 (31.6%) |

Note: LPHAs could select multiple process measures, so percentages may not equal 100%.

### *Communicable disease control*

The tables below show the proportion of LPHAs that selected to focus on the 2-year-old vaccination rates, adult influenza vaccinations rates, or both for their process measures within the communicable disease control foundational program. Tables also show the "demonstrated actions" within each immunizations focus area. The proportion of LPHAs that selected to focus on the various process measures within the syphilis priority area are also shown below. "Demonstrated actions" for the syphilis priority area are not shown because process measures for the priority area are tracked through the state's integrated electronic disease surveillance systems rather than LPHA reporting to OHA.

**Table 6.** Immunizations accountability metrics priority areas (N = 33)

| Focus area | n (%) |
|---|---|
| 2-year-old vaccination rates | 17 (51.5%) |
| Adult influenza vaccination rates | 14 (42.4%) |
| Both priority areas | 2 (6.1%) |

**Table 7.** 2-year-old vaccination rate process measures selection (N = 19)

| Process measures | n (%) |
|---|---|
| Demonstrated outreach and educational activities conducted with community partners to increase vaccine access or demand | 17 (89.5%) |
| Demonstrated use of data to identify populations of focus | 17 (89.5%) |
| Demonstrated actions with health care provides to improve access to vaccination | 10 (52.6%) |
| Increased percent of health care providers participating in the Immunization Quality Improvement for Providers (IQIP) Program | 1 (5.3%) |

Note: LPHAs could select multiple process measures, so percentages may not equal 100%.

**Table 8.** Adult influenza vaccination rate process measure selection (N = 16)

| Process measures | n (%) |
|---|---|
| Demonstrated actions to improve access to vaccination for residents of long-term care facilities (LTCFs) | 14 (87.5%) |
| Demonstrated outreach and educational activities conducted with community partners to increase vaccine access or demand | 14 (87.5%) |
| Demonstrated actions with health care provides to improve access to vaccination | 13 (81.2%) |
| Demonstrated use of data to identify populations of focus | 13 (81.2%) |

Note: LPHAs could select multiple process measures, so percentages may not equal 100%.

**Table 9.** Congenital/all stages syphilis rates process measure selection (N = 33)

| Process measures | n (%) |
|---|---|
| Percent of congenital syphilis cases averted | 3 (9.1%) |
| Percent of syphilis cases interviewed | 27 (81.8% |
| Percent of completion of CDC core variables | 12 (36.4%) |
| Percent of early cases treated with appropriate regimen within 14 days | 24 (72.7%) |

Note: LPHAs could select multiple process measures, so percentages may not equal 100%.

*Funding allocations advance accountability metrics priorities*

State general fund investments in PH modernization significantly contribute to improvements in accountability metrics. LPHAs are required to use the funds they receive for PH modernization to address the accountability metrics priority

areas. OHA distributes other state and federal funding for programs addressing some, but not all, health priorities being addressed through accountability metrics. Locally, some LPHAs receive county general funds or other funds that can be used to support core work to address these health priorities. In some cases, state investments for PH modernization are the only source of funding to conduct activities necessary to meet process measures.

### *Future development of accountability metrics framework*

PHAB will continue its work on accountability metrics in 2025. In addition to tracking current metrics, PHAB will develop 2030 equity benchmarks for health outcomes indicators that currently reflect population-level indicator goals. PHAB will continue to develop a measurement strategy to reflect the role of policy and systems change in achieving progress on the outcome indicators. In addition, PHAB will discuss developing outcome indicators and process measures for the other foundational programs in the PH modernization framework not currently prioritized in Phase 1 implementation (i.e., prevention and health promotion and access to clinical preventive services), as well as develop a process to ensure LPHA and OHA process measures remain rigorous over time to incentivize continuous quality improvement. Lastly, PHAB will connect with the Oregon Health Policy Board's Metrics and Scoring Committee to discuss opportunities to align public health and coordinated care organization metrics.

## *Description of the level of work carried out by LPHAs, Tribes, the UIHP, CBOs and OHA during the 2023-2025 biennium*

### Investments in local public health authorities ($50.35 million)

All 33 LPHAs received funds through the PH modernization funding formula. As required in statute, LPHAs are required to spend funds in compliance with Program Element 51.[4]

Eight LPHAs are funded as Fiscal Agents for regional projects, reaching 26 of 36 counties. As recommended by PHAB, continued investments in regional projects expand public health capacity through alternate staffing and service delivery models. Examples include regional epidemiologists and regional climate resilience planning. See **Appendix B** for a summary of funding allocations to LPHAs and **Appendix C** for a map of LPHA regional partnerships.

LPHA investments support the following actions for achieving statutory requirements for communicable disease control and environmental health foundational programs:

[4] LPHA 2023-25 Program Elements. Available at: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/LOCALHEALTHDEPARTMENTRESOURCES/Pages/program-elements.aspx.

- Funding supports more than 100 positions at LPHAs to directly work within communicable disease control and environmental health programs, and more than 300 staff total to support implementation of PH modernization across foundational capabilities and programs.
- Development and implementation of climate resilience plans that support local actions for climate adaptation.
- Local interventions to improve immunization rates.
- All hazards preparedness plans, developed with community partners, to equip communities for wildfires, extreme heat and other emergencies and center communities most at risk.
- Implementation of local or regional health equity plans.
- Improvements to local public health data collection, analysis and reporting to allow better quality information to inform the plans listed above.
- New and expanded partnerships with community organizations that ensure public health programs are created with and for communities who are most affected by health inequities.
- Sustained partnerships for infection prevention and control in congregate settings such as in long-term care facilities, jails, shelters or childcare facilities, to prevent disease transmission in these settings.

### Investments in federally recognized Tribes and the Urban Indian Health Program ($9.7 million)

In the 2023-25 biennium eight federally recognized Tribes and the UIHP chose to receive funding. Participating Tribes and the UIHP developed and implemented action plans that include strategies to:

- Build and sustain public health infrastructure, including through strategies to develop and enhance partnerships among Tribal communities and with the broader community and LPHAs. For example,
    - Mobile vaccination events hosted in partnership with LPHAs, CCOs, and other local organizations to increase immunization rates.
    - Partnerships with OHA and the Northwest Portland Area Indian Health Board to increase sexually transmitted infection prevention, screening and treatment.
    - Enhancing existing prevention and health promotion programs, as well as establishing new programs (e.g. injury prevention, cancer screening).

- Enhance population-level data collection and improve Tribal access to data to support health improvement planning, emergency response and planning, and climate resilience planning.
    - Tribal health assessment data collection to support development of Tribal health improvement plan.
    - Regional partnerships to support community health needs assessment and community health improvement planning.
    - Enhanced usage of population level data systems to better understand chronic disease prevention and intervention needs within Tribal communities.
- Increased Tribal health and community member readiness for public health and other climate-related emergencies.
    - Emergency operations plans developed or updated.
    - Emergency preparedness educational materials and supplies distributed to Tribal members.
    - Tribal health staff training to support public health emergency response functions.
- Build Tribal public health capacities and provide quality public health services, including establishing a public health department or seeking national public health accreditation, if desired.
    - Developed infrastructure to support domestic well testing and safety.
    - Environmental health needs assessments and intentional efforts to gather Tribal ecological knowledge.

The Northwest Portland Area Indian Health Board is also funded to provide Tribal-specific technical assistance and training to support implementation of PH modernization funded Tribal efforts.

### Investments in community-based organizations ($26.95 million)

In 2024, OHA awarded Public Health Equity grant funding to 194 culturally-specific CBOs across the state, 137 of which were funded through state General Fund investments for PH modernization.[5] Funded CBOs contribute to progress

[5] OHA Public Health Equity Grantees for 2023-25. Available at: https://www.oregon.gov/oha/PH/ABOUT/MODCET%20CBO%20Documents/PH%20Equity%20Grant%20AY25%20Grantee%20List%20Website.pdf.

on PH modernization priorities, including the accountability metrics, by providing health education and communications to community members; identifying and assessing community priorities; supporting prevention and health promotion activities; and developing policy priorities that reflect community values. PH modernization funding has supported 99 new positions and 385 existing positions in CBOs that focus on climate impacts on health and communicable disease prevention and control.

Based on 2024 progress reporting to OHA, modernization-funded CBOs accomplished the following:

- Funded CBOs served all 36 Oregon counties.
- Among funded CBOs, 46% served people living in rural communities; 44% served people with disabilities; 41% served Black, African American, or African communities; 32% served houseless communities, and 32% served people with behavioral health conditions.
- 70% of CBOs worked in a language other than English to ensure culturally-responsive programming.
- CBOs held 774 local events, including 298 for climate and health, 272 for emergency preparedness, and 261 for communicable disease control.
- Of these community-specific events, 336 (43.4%) provided community-specific public health programs, services, resources, and supports; 243 (31.4%) provided health education and communication; 23 (3.0%) mobilized communities to participate in and inform health policy priorities; and 58 (7.5%) identified and assessed community priorities.
- Most (87%) CBOs partnered with at least one other organization on their modernization-funded work; 27% of reported partnerships were new and developed as a result of work funded through modernization.
- Of the 1,053 partnerships reported by CBOs, 469 (45%) were other CBOs, 134 (11%) were local public health departments, 90 (9%) were health care systems, and 79 (8%) were schools or school districts.
- Among the 111 CBOs that responded to a question about funding sustainability, 81 (73%) reported that having public health equity grant funding helped them obtain other sources of funding.

### OHA Public Health Division ($20.3 million)

OHA uses funds to provide system-wide supports and coordination for local and Tribal public health authorities and CBOs, and to carry out core functions of the

state public health authority and fulfill the foundational capabilities. These include:

- Technology infrastructure and data interoperability: Supports needed maintenance and upgrades to software and hardware for data systems, laboratory electronic data exchange, data visualization and data interoperability.
- Data collection, evaluation and reporting: Supports data collection through the Behavioral Risk Factor Surveillance System (BRFSS) and Oregon Student Health Survey (SHS); improvements toward community-centered data systems; annual reporting on public health accountability metrics; and evaluation of PH modernization investments.
- Survey representativeness: Supports the Youth Data Council to ensure the SHS better reflects lived experiences of youth; collaboration with the Northwest Portland Area Indian Health Board to develop Social Determinants of Health questions that are culturally-inclusive and relevant to Tribal communities; and training and guidance from the Coalition of Communities of Color to develop a process for coding qualitative data with an equity focus.
- Health equity and community engagement: Supports a Health Equity Office within OHA-PHD that strengthens community connections and provides grant management and technical assistance for community-based organizations funded through the Public Health Equity grant.
- Public health system change: Supports business innovations, workforce development, health equity capacity building and partnerships across OHA, LPHAs, Tribes, the UIHP, and CBOs.
- Public Health Advisory Board (PHAB): Supports the PHAB to complete two new deliverables this biennium. The Public Health System Workforce Plan provides recommendations and strategies to address current and future gaps in the public health workforce. The Public Health Equity Framework describes the roles of community partners to support governmental public health in fulfilling statutory requirements for foundational programs.

The OHA investment also provides capacity for the communicable disease control and environmental health foundational programs to meet statutory requirements, including:

- Environmental health: Funds an epidemiologist position that prepares analyses of climate change and water-borne health impacts to Oregonians, a senior toxicologist who assesses risks to people from hazardous exposures and three positions to advance health-in-all-policies work related

to climate and health, healthy homes and schools, and emerging environmental threats through interagency and external partner collaborations.
- Communicable disease control: Funds four regional epidemiologist positions that respond to outbreaks of communicable diseases; provide subject matter expertise on assigned diseases; and provide surge capacity to Local and Tribal public health entities when staffing or capacity constraints occur and when emerging threats or disease events occur that exceed the scope of routine public health work.

The 2023-2025 PH modernization investment also included funds to support access to reproductive health care. OHA-PHD's Reproductive Health Program has funded 36 clinical agencies to support infrastructure needs that are critical to maintaining access to reproductive health services. Specific examples include:

- Upgrading clinic space to be more accessible – ADA chairs, wheelchair access to building, adjustable exam tables and scales to accommodate various abilities.
- Adding a provider or clinical days to the schedule.
- Expanding technology to support accessibility and linguistic needs.
- Covering the costs of sexually transmitted infections screening and labs not covered by our program.
- Purchasing a vending machine for various sexual health supplies including emergency contraceptives.
- Expanding the use of pain management via nitrous sedation for patients undergoing various procedures.
- Expanding abortion services by expanding gestational age from 15 weeks 6 days to 17 weeks 6 days.

The Reproductive Health Program plans to work with OHA's Office of Actuarial and Financial Analytics over the next year to assess the Oregon Health Plan and the Reproductive Health Access Fund's current reimbursement methodologies and rates, study alternate payment methodology models, engage external partners, and develop recommendations for the adoption of aligned payment methodologies and increased reimbursement rates for a broad range of reproductive health services.

*Public Health Advisory Board recommendations for implementing foundational capabilities and foundational programs based on state funds received for the 2025-27 biennium; and*

*Brief description of the work planned by these entities expected during the 2025-27 biennium.*

OHA's Policy Option Package 410 provides an incremental increase in public health modernization funding of $2 million to address system-wide gaps that prevent Oregon from making progress toward eliminating health inequities in immunization rates for children and older adults. This funding will also help offset significant decreases in federal COVID-19 response funding to OHA and LPHAs and ensuing loss of local workforce capacity.

An additional investment of $2 million above current PH modernization funding levels would be allocated through special payments to LPHAs, federally recognized Tribes, the UIHP and CBOs for the following activities:

**LPHAs**

- Implement strategies from health equity plans developed during the 2023-25 biennium.
- Increase access to influenza vaccination for residents of long-term care facilities.
- Increase the percent of Vaccines for Children providers that participate in quality improvement to increase childhood vaccination rates.

**Tribes and the UIHP**

- Further develop tribal health data, assessment, and epidemiology infrastructure for tribal health assessments, tribal health improvement plans and other decision-making to improve community health.
- Continue implementation of new or expanded prevention and health promotion programs and activities.
- Implement tribal environmental public health programs.
- Continue to provide Tribal-specific technical assistance and training through the Northwest Portland Area Indian Health Board.

**CBOs**

- Increase educational materials provided in multiple languages and formats, especially those connecting community members to vaccinations.

In addition to directing new investments for vaccine equity, the 2025-27 biennium provides a unique opportunity for OHA and partners to discuss PH modernization

implementation nearly a decade into the initiative and identify opportunities for improvement. At an October 2024 PHAB planning retreat, members expressed interest in leading a process to refresh the state's vision and program priorities for PH modernization, reflecting on several new sources of information including the PH modernization capacity and cost assessment, 2023-25 Public Health Modernization Evaluation, 2024 Public Health Accountability Metrics Report, Public Health System Workforce Plan, and progress reports from PH modernization-funded LPHAs and CBOs.

# ORS 431.380. Distribution of funds; rules.

## *Updated LPHA funding formula used to allocate state General Funds for foundational capabilities and programs; and*

Under ORS 431.123, PHAB is responsible for making recommendations to OHA and the Oregon Health Policy Board for developing and modifying the PH modernization funding formula for LPHAs.

A PHAB subcommittee met between April and June 2024 to review and recommend updates to the funding formula for the 2025-27 biennium. The subcommittee considered feedback provided by LPHA administrators and through PHAB discussions to recommend the changes listed below.

PHAB voted on June 13, 2024, to approve the following components of the funding formula for the 2025-27 biennium (each component is described in further detail below and in related appendices):

1. No change to base component of the funding formula, including maintaining the floor funding of $400,000 to each county and using the same set of health and demographic indicators for allocations;
2. Implement matching component of funding formula in 2025 if total funds available to LPHAs through the funding formula increase by five percent (method for allocating matching funds is detailed below); and
3. Activate incentive payments to LPHAs in 2025 based on 2024 performance on PH modernization accountability metric process measures with incentive payment pool at 1% of total available funds to LPHAs.

### ***Base funding details***

*Floor funding*

In 2022 PHAB increased the floor funding to $400,000 per county when at least $40 million is allocated to LPHAs through the funding formula. This change was

made to ensure that extra small and small counties were able to hire or contract for new essential positions needed to fulfill PH modernization requirements, and all extra small and small counties received a significant increase in funding as a result.

Maintaining the current base component is based on feedback that OHA and PHAB received from a survey to LPHA administrators. Twenty-three (23) administrators responded to the survey, including those representing extra small to extra-large county size bands. In the survey, 9 of 13 respondents from extra small or small counties reported being better able to fulfill the requirements of PH modernization due to the 2023-2025 increase in floor funding. These same respondents also reported being able to hire new or retain existing staff to support PH modernization requirements that would not have been possible without the increased floor funding.

*Health and demographic indicators*

Health and demographic indicators are used to allocate funds based on community conditions that may indicate a greater need for the community to access public health services or additional complexities in eliminating health inequities. Indicators include health status, burden of disease, racial and ethnic diversity, poverty, educational attainment, population density, limited English proficiency and rurality. (See **Appendix D** for a detailed description and methodology for floor and indicator funding formula components.) While population-level indicators of community health status and burden of disease are required components of the funding formula under statute, PHAB recommended the inclusion of other sociodemographic indicators, such as rurality and percent of the population living below the federal poverty line. The indicators added by PHAB ensure investments reach communities and specific populations that face systemic barriers to good health and well-being and thus require a more concerted investment of resources.

See **Appendix E** for a detailed description of the health and demographic indicators, including indicator data sources and calculations. See **Appendix F** for county data for health and demographic indicators. See **Appendix G** for the calculation of county funding for each indicator separately.

### *Matching funds details*

OHA is required under statute to make payments using a method for awarding matching funds to a LPHA that invests in local public health activities and services above the base amount distributed.

PHAB approved the following approach to matching funds:

- Implement matching component of funding formula in 2025 if total funds available to local public health authorities through the funding formula increase by five percent (increase of about $2.35 million).

- When funding available to local public health authorities increases by 5%, counties will qualify to receive matching funds if they maintain county general fund investment over a two-year period.

- A buffer of 3% will be applied to the calculation of whether a county maintained general fund investment to account for standard budget fluctuations over time.

- Qualifying counties receive matching funds proportional to their county population among all counties that qualified to receive matching funds (i.e., qualifying county population / population of all qualifying counties).

Basing implementation of the matching component on a 5% increase in available funds responds to concerns from local public health administrators that reductions in base funding – that would result from 5% of current funds being reserved for matching – would be particularly detrimental to local public health's capacity to fulfill PH modernization contractual requirements given budget environments with overall reduced funding. Counties that would not qualify for matching funds due to lack of county investments would be most negatively affected by a reduction of base funding which will further exacerbate disparities in local investments.

### *Incentive funds details*

OHA is required under statute to make payments using a method for incentives based on performance on public health accountability metrics.

PHAB approved the following approach to incentive funds:

- Maintain at 1% of total available funds to local public health authorities through the funding formula, with funds to be awarded in 2025 based on performance in the 2023-25 biennium ($460,346 at current funding level).

- The proportion of total incentive funds available to each county is based on the county's population size (for example, Baker County has a population of 16,927 people, which is 0.39% of the total population of Oregon and results in $1,816 in available incentive funds (see **Appendix H** for each county's available incentive funds).

- The allocation of available incentive funds to each county is proportional to the number of incentive metrics met (for example, if Baker County meets 4 of 6 process measures, they receive 2/3 of their available incentive funding or $1,210.66).

- Incentive funding that is “left on the table” from counties not meeting all 6 process measures is redistributed (for example, Baker County would leave $605.33 on the table by meeting 4 of 6 process measures).

- To redistribute funds that are “left on the table”, OHA will calculate the average number of process measures met across all counties.

- Counties that are above this average qualify to receive a portion of incentive funds that were “left on the table.”

- The “left on the table” funds are allocated to qualifying counties based on the proportion of the county population among qualifying counties (qualifying county population / population of all qualifying counties).

Keeping the incentive funding at 1% is based on previous recommendations from PHAB to start with a smaller amount of incentive funding as a proof of concept given limited to no evidence base for pay-for-performance within the governmental public health sector. Tying incentive payments to the number of accountability metrics met (a proportional approach) was favored over “all-or-nothing” approaches so that counties receive at least some funding for making progress on any one of their selected metrics.

### *An estimate of the costs needed to implement foundational capabilities and foundational programs.*

In 2024, Oregon conducted its second Public Health Modernization Capacity and Cost Assessment (CCA) to better understand its current spending and workforce capacity for PH Modernization and needed investments to fully implement Oregon’s statutorily outlined foundational capabilities (ORS 431.131) and programs (ORS 431.141). Oregon published its first Public Health Modernization Assessment Report in 2016, a first of its kind in the nation. Like the 2024 assessment, the 2016 Public Health Modernization Assessment gathered detailed information about all foundational programs and capabilities from Oregon’s county and state government public health agencies.

Since 2016, many other states have conducted similar assessments. In March 2023, the National Public Health Accreditation Board published a Foundational Public Health Services Assessment instrument for use by local public health agencies. The National Public Health Accreditation Board's (national PHAB) Center for Innovation, in collaboration with the University of Minnesota Center for

Public Health Systems, developed the Foundational Public Health Services Capacity and Cost Assessment tool to support health departments and public health systems in understanding their capacity and resources (existing and needed).

OHA-PHD hired an external contractor to support the 2024 assessment process. The contractor worked with a technical workgroup, comprised of five LPHA representatives, a representative from the Coalition of Local Health Officials, a representative from the national Public Health Accreditation Board, and OHA staff, to adapt the national assessment tool to align with Oregon's Public Health Modernization Manual. Oregon's assessment tool consisted of an Excel workbook with detailed questions about four categories: current spending, cross-jurisdictional sharing, current workforce capacity and expertise in each foundational capability and program role, and estimated needed resources to fully implement each foundational capability and program. Thirty of Oregon's 33 LPHAs and OHA-PHD completed the 2024 assessment.

**Figure 4** illustrates implementation levels for each foundational program and capability ordered from the highest to lowest level of implementation.

CCA results show highest capacity and expertise in the foundational program areas and capabilities that have received long-term investments from the Oregon Legislature; communicable disease control, access to clinical preventive services, and environmental health had the highest self-reported expertise and capacity, while prevention and health promotion had the lowest of the foundational programs. Communicable disease control and environmental health were the foundational programs prioritized for Phase 1 funding by Oregon's Public Health Advisory Board, and a focus on access to clinical preventive services became important during the COVID-19 emergency response.

The emergency preparedness, assessment and epidemiology, and community partnerships workforce capabilities had the highest self-assessed expertise and capacity ratings and were similarly a focus of the legislative investment in PH modernization, as well as essential capabilities for the COVID-19 response. Other workforce capabilities like policy and planning, health equity, and organizational competencies (e.g., Human Resource and Information Technology systems) had lower expertise and capacity ratings. Of note, the OHA-PHD assessment team for the health equity capability explained their lower rating was due to a more nuanced understanding of what is required to meaningfully advance health equity in Oregon than in 2016.

**Figure 4.** Implementation levels for each foundational program and capability

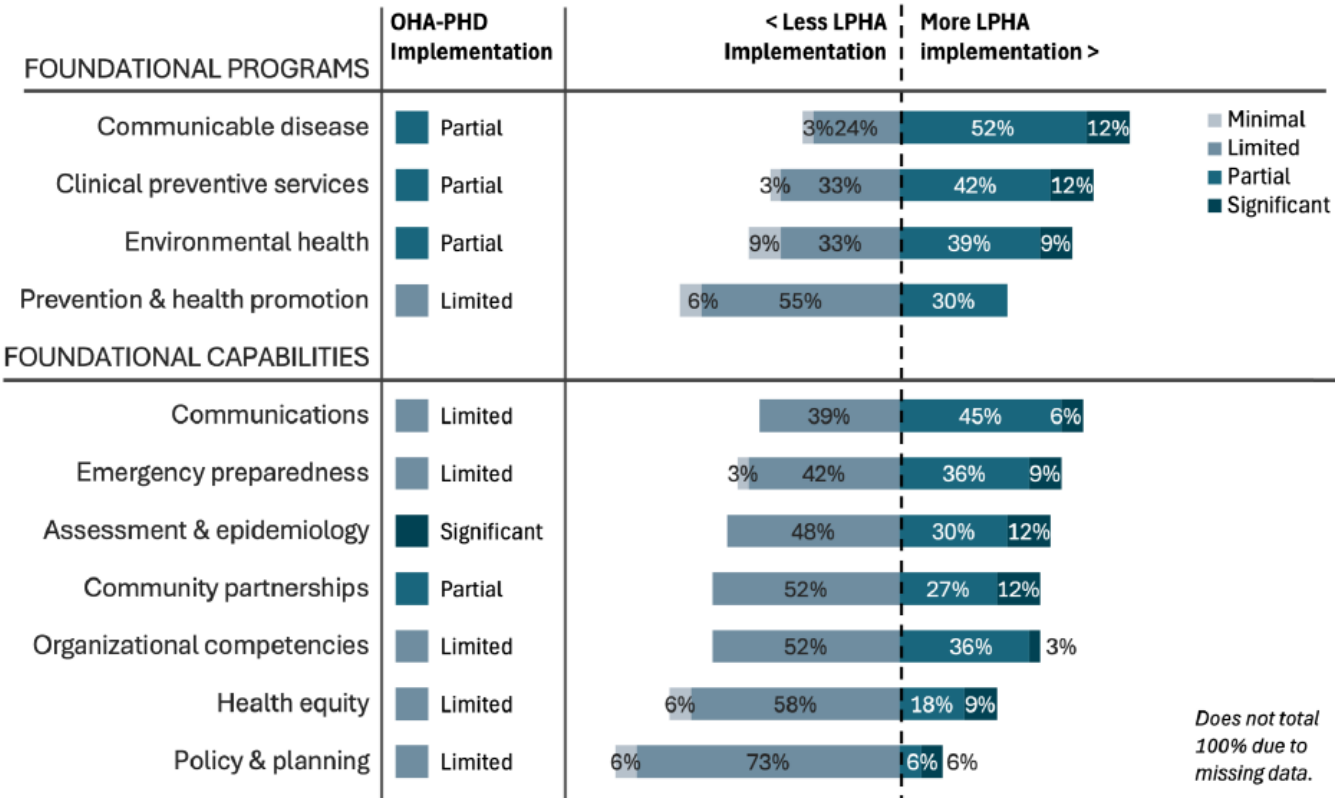



**Figure 5** shows current spending, the gap in needed resources, and the full implementation costs for foundational programs and capabilities and additional important programs for OHA-PHD and LPHAs combined. Assessment data indicate that LPHAs and OHA-PHD spent $602.2 million on PH Modernization foundational programs and capabilities in Fiscal Year 2023.[6] Oregon's gap in needed resources to implement foundational programs and capabilities is $262.0 million annually, or $524.0 million per biennium. In total, the governmental public health system requires $864.2 million annually to fully implement Oregon's statutorily outlined foundational capabilities and programs.

In addition:

- The estimated annual costs to fulfill statutory requirements should be comprised of federal, state and local funding sources.
- Full funding maintains progress on communicable disease control and building climate-resilient communities, as well as new investments in the

[6] Using Fiscal Year (FY) 2023 for OHA-PHD staffing costs significantly underestimates current spending given numerous position vacancies during the COVID pandemic response. Instead, FY 24 budgeted amounts for OHA-PHD staffing were used to more accurately reflect the staffing costs if all positions for which the agency has position authority were filled.

prevention and health promotion and access to clinical preventive services foundational programs.

- The estimate includes grant funds for CBOs, which are administered by OHA-PHD.
- The estimate does not include funding for the nine Federally Recognized Tribes and Urban Indian Program, which was outside the scope of the assessment; however, OHA-PHD will continue to work with Tribes and Urban Indian Program each biennium to determine their allocation of PH Modernization investments.

The assessment also collected data on current spending and the resource gap for "additional important programs." While foundational programs are a common set of essential services that must be available to everyone in the state wherever they live, LPHAs may have certain programs that they also prioritize based on local needs and available resources. Additional important programs, for example, could include direct service programs provided by LPHAs or statewide programs administered by OHA that are outside of programs included in ORS 431.141. LPHAs and OHA-PHD spent $233.5 million on additional important programs in FY 23 and estimated needing an additional $42.7 million annually to fully cover these context-specific programs.

**Figure 5.** Estimated annual spending, gap in needed resources, and full implementation costs for PH Modernization foundational programs and capabilities and additional important programs

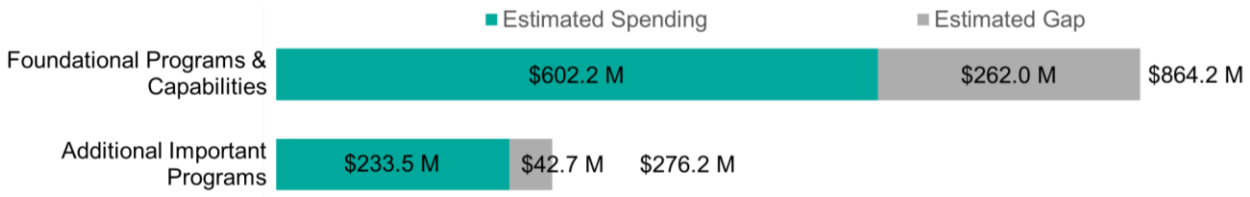



**Figure 6** shows current spending, the gap in needed resources, and the full implementation costs for each foundational program. Assessment data indicate that the prevention and health promotion foundational program has the largest estimated resource gap at $63.3 million annually, followed by environmental health ($47.4 million), access to clinical preventive services ($18.2 million), and communicable disease control ($9.7 million).

Costing estimates show that foundational programs with the highest need for resources are those that have not been funded through State General Fund investments in PH Modernization. Communicable disease control and environmental health were the foundational programs prioritized for Phase 1 funding by Oregon's Public Health Advisory Board, and a focus on and

investment in access to clinical preventive services became important during the COVID-19 pandemic emergency response. However, the one-time federal funding for COVID-19 response will end eventually, which may increase the resource gap for access to clinical preventive services. Prevention and health promotion, on the other hand, has received less attention and funding as a foundational program to be implemented in Phase 2 of PH Modernization and only activated with additional funding.

**Figure 6.** Estimated annual spending, gap in needed resources, and full implementation costs for foundational programs (ordered from largest to smallest estimated gap in needed resources)

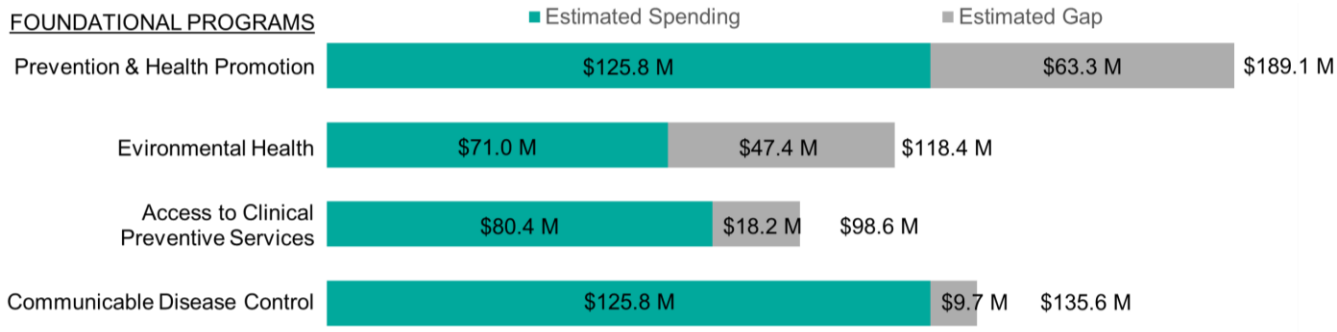



**Figure 7** shows current spending, the gap in needed resources, and the full implementation costs for each foundational capability. Assessment data indicate that the leadership and organizational competencies foundational capability has the largest estimated resource gap at $31.9 million annually, followed by assessment and epidemiology ($23.3 million), health equity and cultural responsiveness ($18.2 million), community partnership development ($17.4 million), emergency preparedness and response (14.6 million), communications ($11.3 million), and policy and planning ($6.7 million).

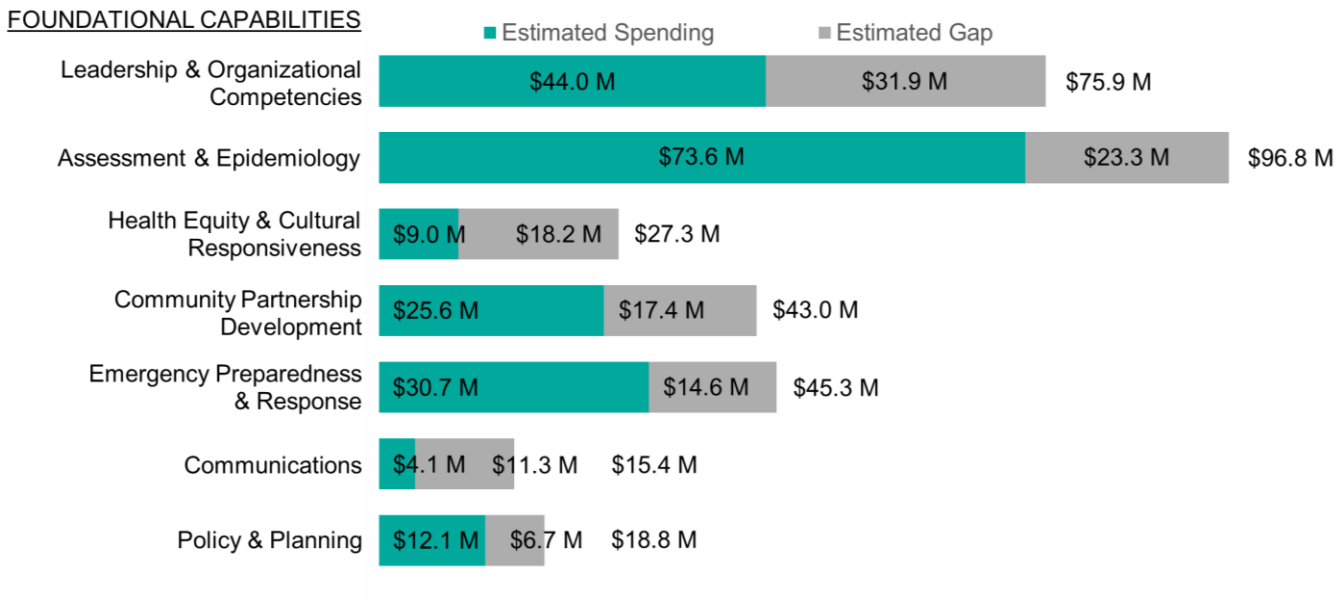
The gap estimate for the leadership and organizational competencies capability reflects needed investments in human resources, information technology, performance management systems, and financial management to ensure efficient, effective, and transparent agency operations.

The assessment and epidemiology capability had the highest current spending across all capabilities, which likely reflects investments in this capability during the COVID-19 pandemic response that were needed to fulfill public health's core role of monitoring population health and investigating health hazards. Despite having the highest current spending, the assessment and epidemiology capability had the second highest estimate of needed resources; likely a response to gaps in critical public health data systems (e.g., information technology infrastructure) and specialized staff roles identified during the COVID-19 pandemic response.

While the governmental public health system has invested heavily in the health equity and cultural responsiveness and community partnership development capabilities – including allocating a portion of PH Modernization funding to community-based organizations – these capabilities had the third and fourth highest estimated resource needs, respectively. These higher estimates of needed resources may reflect a more nuanced understanding of what is required to advance health equity and partner with community organizations and members to address unfair barriers to health and well-being, compared to when the first Capacity and Cost Assessment was completed in 2016.

There is some degree of overlap in resources for foundational programs and capabilities, because successful program implementation depends on these capabilities being present in the workforce. Consequently, lower estimated gaps in resources for the communications and policy and planning foundational capabilities may be driven by staffing and other expenditures that contribute to these capabilities being captured in the assessment as foundational programs.

**Figure 7.** Estimated annual spending, gap in needed resources, and full implementation costs for foundational capabilities (ordered from largest to smallest estimated gap in needed resources)




This report provides a high-level summary of capacity and costing results for the PH Modernization Capacity and Cost Assessment. A standalone Capacity and Cost Assessment report with detailed results will be published in April 2025.

OHA anticipates several uses for Capacity and Cost Assessment results in 2025:

- PHAB will use results for future planning and priority setting. For example, PHAB may discuss directing future new investments to foundational

programs with lower implementation that are not currently receiving PH modernization investments, like prevention and health promotion.

- LPHAs will use results to develop their PH modernization plans that are a statutorily required deliverable to OHA by the end of 2025.
- OHA-PHD will use results with programs and sections to address gaps in staffing and workforce development to implement foundational programs.

Since 2013, Oregon has been on a path to fundamentally transform the public health system to ensure essential protections for every person in Oregon. While public health modernization investments to date have allowed governmental public health and its partners to advance critical work in the areas of communicable disease control and environmental health, we know that Oregon's public health system continues to be underfunded. In addition to results from the 2024 Capacity and Cost Assessment, an analysis of public health funding investments from the United Health Foundation ranked Oregon among the bottom half of states, at 28 out of 50.[7] For comparison, California ranked #10, Washington ranked #16, and Idaho ranked #18. Oregon's public health system is also facing stagnant and reducing federal investment in the programs that people in Oregon rely on the most – sexually transmitted infection prevention services, access to immunizations and communicable disease investigation and prevention. The gap in resources identified through the Capacity and Cost Assessment and highlighted in the United Health Foundation's analysis can be addressed over time through increases in federal, state, and local investment in public health modernization. In addition, Oregon's Public Health Advisory Board can use Assessment results to prioritize investments of future funding across foundational programs and capabilities.

[7] America's Health Rankings (2023). 2023 Annual Report. Available at: https://www.americashealthrankings.org/explore/measures/PH_funding.

# Appendices

## **Appendix A.** Public health modernization milestones

Improvements within the public health system have relied on increased investments from the Oregon Legislature, the vision and direction provided by the Public Health Advisory Board, and collaboration with public health and community leaders.

Notable key milestones include:

- **2015:** Oregon's Legislature passed House Bill 3100, which adopted recommendations from the Task Force on the Future of Public Health Services to achieve a modern public health system. House Bill 3100 codified the foundational public health services framework through ORS 431.131 – 431.145.
- **2015:** Governor Kate Brown appointed the Oregon Public Health Advisory Board[8] (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. In **2023**, membership expanded to include community-based organizations, health equity expertise and an education representative.
- **2015 and 2016:** State and local public health leaders developed the Public Health Modernization Manual[9] and completed a comprehensive system-wide assessment.[10] The manual, adopted in Oregon Administrative Rules, continues to be a foundational resource for defining governmental public health work and identifying strategies for improvement. The 2016 assessment guided priorities and use of funding through 2024.
- **2017:** PHAB adopted accountability metrics[11] for state and local public health authorities as required in ORS 431.123. OHA released annual reports from 2018-2020. Also in 2017, PHAB adopted a public health modernization funding formula[12] that allocates funds to local public health authorities based on county population and health and demographic factors of the community served.

[8] PHAB membership is listed in ORS 431.122.
[9] Oregon Health Authority (2017). Public Health Modernization Manual. Available at: https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf.
[10] As required in ORS 431.115.
[11] As required in Oregon Revised Statutes 431.123.
[12] As required in Oregon Revised Statutes 431.380.

- **2017:** Three federally recognized Tribes and the Northwest Portland Area Indian Health Board complete a pilot Tribal public health modernization assessment. All federally recognized Tribes and the UIHP completed an assessment by 2021.
- **2017:** PHAB developed a Health Equity Policy and Procedure to ensure that Board discussions, decisions and deliverables intentionally advance health equity. The Policy and Procedure was updated in **2020** and **2023**.
- **2017, 2019, 2021 and 2023**: Oregon's legislature demonstrated its commitment to strengthening the public health system through public health modernization investments. In each biennium, most funds went directly to communities through allocations to local public health authorities (beginning in 2017), federally recognized Tribes and the Urban Indian Health Program (beginning in 2019) and community-based organizations (beginning in 2021).
- **2023**: PHAB established a new set of public health accountability metrics, which will remain in place through 2030. These metrics recognize that improving health outcomes is a collective responsibility across sectors and that governmental public health has a role to convene partners around shared goals. Metrics also recognize the core, daily work of governmental public health agencies to implement programs and strategies to improve health outcomes. Incentive payments will be awarded to LPHAs in 2025 based on performance on accountability metrics.
- **2024**: OHA and LPHAs completed an updated public health modernization Capacity and Cost assessment to identify changes in system capacity since the 2016 assessment and resources needed to fulfill statutory requirements for public health modernization.
- **2025**: Every LPHA will submit to OHA a local modernization plan that describes how the LPHA will fulfill statutory requirements for public health modernization by December 31, 2025.[13]

[13] As required in ORS 431.115.

# Appendix B. Funding formula allocations to Oregon counties, updated May 2024

**Public Health Modernization LPHA Funding Formula**
**Updated May, 2024**
**Total biennial funds available to LPHAs through the funding formula = $46,034,623**

| | | Base component | | | | | | | | Matching and Incentive fund components | | Total county allocation | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| County Group | Population[1] | Floor | Burden of Disease[2] | Health Status[3] | Race/ Ethnicity[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 | 1,533 | $ 400,000 | $ 407 | $ 587 | $ 1,038 | $ 2,522 | $ 9,958 | $ 1,972 | $ 664 | $ - | $ 164 | **$ 417,311** | **0.9%** | **0.0%** | **$ 272.22** | |
| Gilliam | 2,062 | $ 400,000 | $ 904 | $ 758 | $ 1,777 | $ 3,142 | $ 13,394 | $ 3,223 | $ 1,635 | $ - | $ 156 | **$ 424,989** | **0.9%** | **0.0%** | **$ 206.11** | |
| Wallowa | 7,631 | $ 400,000 | $ 2,847 | $ 1,575 | $ 4,529 | $ 8,247 | $ 49,569 | $ 7,854 | $ 2,697 | $ - | $ 819 | **$ 478,137** | **1.0%** | **0.2%** | **$ 62.66** | |
| Harney | 7,600 | $ 400,000 | $ 3,785 | $ 2,058 | $ 5,461 | $ 14,147 | $ 21,908 | $ 10,253 | $ 2,052 | $ - | $ 815 | **$ 460,479** | **1.0%** | **0.2%** | **$ 60.59** | |
| Grant | 7,418 | $ 400,000 | $ 3,044 | $ 2,472 | $ 4,582 | $ 11,785 | $ 48,185 | $ 12,416 | $ 2,199 | $ - | $ 796 | **$ 485,479** | **1.1%** | **0.2%** | **$ 65.45** | |
| Lake | 8,562 | $ 400,000 | $ 4,498 | $ 2,687 | $ 6,625 | $ 16,288 | $ 55,617 | $ 17,069 | $ 7,287 | $ - | **$ 919** | **$ 510,988** | **1.1%** | **0.2%** | **$ 59.68** | |
| Morrow | 13,010 | $ 400,000 | $ 5,257 | $ 6,236 | $ 24,038 | $ 26,118 | $ 84,510 | $ 46,476 | $ 49,436 | $ - | $ 1,396 | **$ 643,467** | **1.4%** | **0.3%** | **$ 49.46** | |
| Baker | 16,927 | $ 400,000 | $ 8,702 | $ 5,458 | $ 9,451 | $ 26,922 | $ 45,517 | $ 22,453 | $ 2,928 | $ - | $ 1,816 | **$ 523,247** | **1.1%** | **0.4%** | **$ 30.91** | **$ 60.92** |
| Crook | 26,583 | $ 400,000 | $ 11,173 | $ 9,828 | $ 16,243 | $ 26,560 | $ 86,073 | $ 39,890 | $ 5,337 | $ - | $ 2,852 | **$ 597,956** | **1.3%** | **0.6%** | **$ 22.49** | |
| Curry | 24,439 | $ 400,000 | $ 14,245 | $ 8,773 | $ 18,383 | $ 33,769 | $ 82,279 | $ 33,529 | $ 14,922 | $ - | $ 2,622 | **$ 608,522** | **1.3%** | **0.6%** | **$ 24.90** | |
| Jefferson | 25,878 | $ 400,000 | $ 14,450 | $ 14,296 | $ 55,436 | $ 39,095 | $ 112,616 | $ 48,304 | $ 31,117 | $ - | $ 2,776 | **$ 718,088** | **1.6%** | **0.6%** | **$ 27.75** | |
| Hood River | 24,406 | $ 400,000 | $ 6,198 | $ 8,604 | $ 30,878 | $ 23,883 | $ 82,114 | $ 59,549 | $ 77,702 | $ - | $ 2,618 | **$ 691,545** | **1.5%** | **0.6%** | **$ 28.34** | |
| Tillamook | 28,000 | $ 400,000 | $ 14,594 | $ 11,736 | $ 20,909 | $ 38,406 | $ 110,324 | $ 40,078 | $ 28,901 | $ - | $ 3,004 | **$ 667,952** | **1.5%** | **0.7%** | **$ 23.86** | |
| Union | 26,335 | $ 400,000 | $ 11,884 | $ 11,095 | $ 15,924 | $ 44,028 | $ 73,413 | $ 29,254 | $ 7,279 | $ - | $ 2,825 | **$ 595,702** | **1.3%** | **0.6%** | **$ 22.62** | |
| Sherman, Wasco | 28,969 | $ 800,000 | $ 13,543 | $ 10,648 | $ 31,507 | $ 46,288 | $ 188,175 | $ 59,934 | $ 38,764 | $ - | $ 3,108 | **$ 1,191,968** | **2.6%** | **0.7%** | **$ 41.15** | |
| Malheur | 32,981 | $ 400,000 | $ 13,269 | $ 13,612 | $ 46,972 | $ 76,049 | $ 126,122 | $ 94,182 | $ 63,206 | $ - | $ 3,538 | **$ 836,950** | **1.8%** | **0.8%** | **$ 25.38** | |
| Clatsop | 42,095 | $ 400,000 | $ 19,044 | $ 17,011 | $ 34,442 | $ 52,001 | $ 106,947 | $ 50,272 | $ 24,982 | $ - | $ 4,516 | **$ 709,216** | **1.5%** | **1.0%** | **$ 16.85** | |
| Lincoln | 51,930 | $ 400,000 | $ 27,182 | $ 19,423 | $ 51,328 | $ 81,747 | $ 128,182 | $ 57,196 | $ 41,601 | $ - | $ 5,571 | **$ 812,231** | **1.8%** | **1.2%** | **$ 15.64** | |
| Columbia | 53,143 | $ 400,000 | $ 22,096 | $ 21,933 | $ 38,737 | $ 56,429 | $ 142,305 | $ 77,293 | $ 11,792 | $ - | $ 5,701 | **$ 776,285** | **1.7%** | **1.2%** | **$ 14.61** | |
| Coos | 66,945 | $ 400,000 | $ 35,638 | $ 29,356 | $ 54,856 | $ 115,431 | $ 165,855 | $ 102,793 | $ 31,880 | $ - | $ 7,182 | **$ 942,992** | **2.0%** | **1.6%** | **$ 14.09** | |
| Klamath | 71,919 | $ 400,000 | $ 41,357 | $ 24,116 | $ 84,001 | $ 131,368 | $ 176,366 | $ 118,337 | $ 47,310 | $ - | $ 7,716 | **$ 1,030,572** | **2.2%** | **1.7%** | **$ 14.33** | **$ 20.21** |
| Umatilla | 81,842 | $ 400,000 | $ 33,961 | $ 31,314 | $ 119,164 | $ 119,103 | $ 168,726 | $ 195,460 | $ 152,612 | $ - | $ 8,780 | **$ 1,229,120** | **2.7%** | **1.9%** | **$ 15.02** | |
| Polk | 90,553 | $ 400,000 | $ 28,301 | $ 33,674 | $ 105,244 | $ 118,048 | $ 120,026 | $ 114,546 | $ 82,451 | $ - | $ 9,715 | **$ 1,012,006** | **2.2%** | **2.1%** | **$ 11.18** | |
| Josephine | 88,814 | $ 400,000 | $ 49,524 | $ 32,073 | $ 61,981 | $ 172,345 | $ 248,893 | $ 122,977 | $ 35,176 | $ - | $ 9,528 | **$ 1,132,498** | **2.5%** | **2.1%** | **$ 12.75** | |
| Benton | 99,355 | $ 400,000 | $ 19,383 | $ 21,997 | $ 111,430 | $ 166,756 | $ 125,241 | $ 61,461 | $ 104,270 | $ - | $ 10,659 | **$ 1,021,197** | **2.2%** | **2.3%** | **$ 10.28** | |
| Yamhill | 109,743 | $ 400,000 | $ 36,154 | $ 46,236 | $ 129,720 | $ 133,111 | $ 188,827 | $ 170,547 | $ 143,788 | $ - | $ 11,774 | **$ 1,260,156** | **2.7%** | **2.6%** | **$ 11.48** | |
| Douglas | 113,748 | $ 400,000 | $ 64,596 | $ 43,522 | $ 78,868 | $ 182,791 | $ 298,353 | $ 152,899 | $ 31,746 | $ - | $ 12,203 | **$ 1,264,978** | **2.7%** | **2.7%** | **$ 11.12** | |
| Linn | 131,984 | $ 400,000 | $ 56,805 | $ 52,769 | $ 113,946 | $ 184,581 | $ 293,598 | $ 186,165 | $ 94,839 | $ - | $ 14,160 | **$ 1,396,863** | **3.0%** | **3.1%** | **$ 10.58** | **$ 11.62** |
| Deschutes | 212,141 | $ 400,000 | $ 59,549 | $ 63,841 | $ 133,189 | $ 227,764 | $ 402,951 | $ 187,228 | $ 112,836 | $ - | $ 22,759 | **$ 1,610,117** | **3.5%** | **4.9%** | **$ 7.59** | |
| Jackson | 222,762 | $ 400,000 | $ 90,927 | $ 71,825 | $ 202,852 | $ 337,769 | $ 298,016 | $ 308,124 | $ 148,136 | $ - | $ 23,899 | **$ 1,881,548** | **4.1%** | **5.2%** | **$ 8.45** | |
| Marion | 352,249 | $ 400,000 | $ 124,028 | $ 157,492 | $ 615,819 | $ 529,266 | $ 351,301 | $ 772,822 | $ 895,032 | $ - | $ 37,791 | **$ 3,883,550** | **8.4%** | **8.2%** | **$ 11.03** | **$ 9.37** |
| Lane | 384,374 | $ 400,000 | $ 152,882 | $ 134,675 | $ 390,952 | $ 638,126 | $ 450,194 | $ 423,475 | $ 217,656 | $ - | $ 41,237 | **$ 2,849,197** | **6.2%** | **9.0%** | **$ 7.41** | |
| Clackamas | 424,043 | $ 400,000 | $ 127,220 | $ 129,433 | $ 459,263 | $ 352,370 | $ 471,280 | $ 368,351 | $ 409,891 | $ - | $ 45,493 | **$ 2,763,300** | **6.0%** | **9.9%** | **$ 6.52** | |
| Washington | 610,245 | $ 400,000 | $ 144,409 | $ 255,790 | $ 1,172,899 | $ 539,124 | $ 217,825 | $ 670,105 | $ 1,223,148 | $ - | $ 65,469 | **$ 4,688,772** | **10.2%** | **14.2%** | **$ 7.68** | |
| Multnomah | 801,306 | $ 400,000 | $ 296,860 | $ 261,811 | $ 1,358,925 | $ 1,035,993 | $ 66,711 | $ 944,881 | $ 1,466,098 | $ - | $ 85,967 | **$ 5,917,247** | **12.9%** | **18.7%** | **$ 7.38** | **$ 7.31** |
| **Total** | **4,291,525** | **$ 14,400,000** | **$ 1,558,714** | **$ 1,558,714** | **$ 5,611,370** | **$ 5,611,370** | **$ 5,611,370** | **$ 5,611,370** | **$ 5,611,370** | **$ -** | **$ 460,346** | **$ 46,034,623** | **100.0%** | **100.0%** | **$ 10.73** | **$ 10.73** |

[1] Source: Portland State University Certified Population estimate July 1, 2023

[2] Source: Premature death: Leading causes of years of potential life lost before age 75. OHA, Center for Health Statistics, Oregon Death Certificate data, 2018-2022.

[3] Source: Quality of life: OHA, Oregon Behavioral Risk Factor Surveillance System (BRFSS), county file 2018-2021.

[4] Source: U.S. Census Bureau, American Community Survey (ACS), 5-year estimates, Table B02001, B15002, C16001, C17002, 2018-2022.

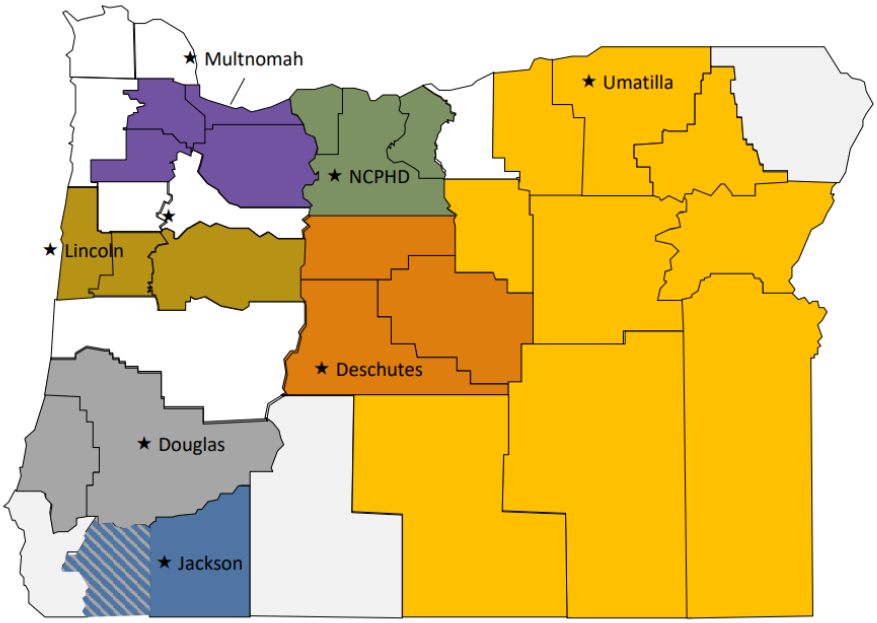
[5] Source: U.S. Census Bureau, Decennial Census, SF1 Table P2, 2020

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,( | above 375,000 |

## **Appendix C.** 2023-2025 Public health modernization regional partnerships

### Supporting communicable disease prevention and investigation, regional climate and health strategies, health equity assessment and community health improvement plans




★ Fiscal agent for regional partnership

## **Appendix D.** Detailed description and methodology for floor and indicator funding formula components

The base component of the public health modernization funding formula includes a “base floor” payment for each county and additional allocations through the health and demographic indicator pool.

### Floor funding

Floor funding is dependent on the total amount of funds allocated through the funding formula. These payments provide funding for a basic level of staffing and operations infrastructure needed to fulfill requirements. At all funding levels, remaining base component funding is distributed through the indicator pool. For funding at or above $40,000,000, the floor payment allocated to each county is $400,000.

### Indicator allocations

Health and demographic indicators are used to allocate funds based on community conditions that may indicate a greater need for the community to access public health services or additional complexities in serving communities.

- Health and demographic indicators funding levels are determined through an equation based on the county population and rank of a specific county on each indicator. Indicator ranks are updated annually to reflect the most current data for each indicator.
- Indicators include health status, burden of disease, racial and ethnic diversity, poverty, educational attainment, population density, limited English proficiency and rurality. Please see the table below for the measure description and data source for each indicator, as well as the proportion of total funding allocated to each indicator and related dollar amounts.
- An individual county payout is determined through an equation that multiplies the county population by its health or demographic indicator rank. The solution results in the health or demographic indicator per capita. After the indicator has been determined for all counties, it is then turned into a percentage per capita. The county payout is determined by multiplying the percent of health or demographic indicator per capita by the total indicator pool. The “indicator pool payment” is the total amount of funding allocated per health indicator.
- An example of indicator allocations can be found in Benton County and the indicator for burden of disease, assuming that a total of $40 million or more is allocated through the funding formula. According to the latest Portland State University census, Benton County’s population is 99,355. The most

up-to-date ranking of the county's burden of disease is 3.83% of the population. The equation multiplies the population by the county's burden rank (99,355 x 3.83% = 3,803) to determine the burden per capita, which is 3,803 people. After the burden has been determined for all counties (305,824 is Oregon's total of burdened people), it is then turned into a percentage per capita. Benton County's percent of burden per capita is 1.24%, (3,803/305,824 = 1.24%). The county payout is determined by multiplying the percent of burden per capita by the total indicator pool, (1.24% x $1,558,714 = $19,383). The "indicator pool" is the total amount of funding allocated per health indicator, in this case the total pool for burden of health is $1,558,714 for all counties, and $19,383 for Benton County.

## Appendix E. Funding formula health and demographic indicators

| | Measure | Indicator required by statute? | Data source | Percent allocation of indicator funding | Total allocation at $40 million funding level |
|---|---|---|---|---|---|
| **Burden of disease** | Premature death: Leading causes of years of potential life lost before age 75. | Yes | Oregon death certificate data | 5% | $1,558,714 |
| **Health status** | Quality of life: Good or excellent health. | Yes | Behavioral Risk Factor Surveillance System | 5% | $1,558,714 |
| **Racial and ethnic diversity** | Percent of population not categorized as “White alone”. | No | U.S. Census Bureau, American Community Survey population five-year estimate | 18% | $5,611,370 |
| **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 | 18% | $5,611,370 |
| **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 | 18% | $5,611,370 |
| **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 | 18% | $5,611,370 |
| **Rurality** | Percent of population living in a rural area | No | U.S. Census Bureau Population estimates | 18% | $5,611,370 |
| **Total** | | | | 100% | $31,174,277 |

## **Appendix F.** County data for health and demographic indicators, updated May 2024

**Total Pool:** **$46,034,623**

| County Group | County Population | Floor | Burden of Disease Rank | Health Status Rank | % Non-white Population | Population below 150% FPL | Rurality | High School Education | Limited English Proficiency |
|---|---|---|---|---|---|---|---|---|---|
| Category Weight | 0.00% | 31.28% | 3.39% | 3.39% | 12.19% | 12.19% | 12.19% | 12.19% | 12.19% |
| Category Dollars | $0 | $14,400,000 | $1,558,714 | $1,558,714 | $5,611,370 | $5,611,370 | $5,611,370 | $5,611,370 | $5,611,370 |
| Baker | 16,927 | Extra Small | 10.1% | 15.0% | 9.1% | 24.2% | 41.4% | 8.6% | 0.7% |
| Benton | 99,355 | Medium | 3.8% | 10.3% | 18.2% | 25.6% | 19.4% | 4.0% | 4.2% |
| Clackamas | 424,043 | Extra Large | 5.9% | 14.2% | 17.6% | 12.7% | 17.1% | 5.6% | 3.9% |
| Clatsop | 42,095 | Small | 8.9% | 18.8% | 13.3% | 18.8% | 39.1% | 7.8% | 2.4% |
| Columbia | 53,143 | Small | 8.2% | 19.2% | 11.9% | 16.2% | 41.2% | 9.4% | 0.9% |
| Coos | 66,945 | Small | 10.4% | 20.4% | 13.3% | 26.3% | 38.1% | 10.0% | 1.9% |
| Crook | 26,583 | Small | 8.2% | 17.2% | 9.9% | 15.2% | 49.8% | 9.7% | 0.8% |
| Curry | 24,439 | Small | 11.4% | 16.7% | 12.2% | 21.0% | 51.8% | 8.9% | 2.5% |
| Deschutes | 212,141 | Large | 5.5% | 14.0% | 10.2% | 16.4% | 29.2% | 5.7% | 2.1% |
| Douglas | 113,748 | Medium | 11.1% | 17.8% | 11.3% | 24.5% | 40.4% | 8.7% | 1.1% |
| Gilliam | 2,062 | Extra Small | 8.6% | 17.1% | 14.0% | 23.2% | 100% | 10.2% | 3.2% |
| Grant | 7,418 | Extra Small | 8.1% | 15.5% | 10.0% | 24.2% | 100% | 10.9% | 1.2% |
| Harney | 7,600 | Extra Small | 9.8% | 12.6% | 11.7% | 28.3% | 44.4% | 8.8% | 1.1% |
| Hood River | 24,406 | Small | 5.0% | 16.4% | 20.6% | 14.9% | 51.8% | 15.9% | 12.9% |
| Jackson | 222,762 | Large | 8.0% | 15.0% | 14.8% | 23.1% | 20.6% | 9.0% | 2.7% |
| Jefferson | 25,878 | Small | 11.0% | 25.7% | 34.8% | 23.0% | 67.0% | 12.1% | 4.9% |
| Josephine | 88,814 | Medium | 10.9% | 16.8% | 11.3% | 29.6% | 43.1% | 9.0% | 1.6% |
| Klamath | 71,919 | Small | 11.3% | 15.6% | 19.0% | 27.8% | 37.8% | 10.7% | 2.7% |
| Lake | 8,562 | Extra Small | 10.3% | 14.6% | 12.6% | 29.0% | 100.0% | 13.0% | 3.4% |
| Lane | 384,374 | Extra Large | 7.8% | 16.3% | 16.5% | 25.3% | 18.0% | 7.2% | 2.3% |
| Lincoln | 51,930 | Small | 10.3% | 17.4% | 16.1% | 24.0% | 38.0% | 7.2% | 3.2% |
| Linn | 131,984 | Medium | 8.4% | 18.6% | 14.0% | 21.3% | 34.2% | 9.2% | 2.9% |
| Malheur | 32,981 | Small | 7.9% | 19.2% | 23.2% | 35.1% | 58.9% | 18.6% | 7.7% |
| Marion | 352,249 | Large | 6.9% | 20.8% | 28.4% | 22.9% | 15.4% | 14.3% | 10.3% |
| Morrow | 13,010 | Extra Small | 7.9% | 22.3% | 30.0% | 30.6% | 100.0% | 23.2% | 15.4% |
| Multnomah | 801,306 | Extra Large | 7.3% | 15.2% | 27.6% | 19.7% | 1.3% | 7.7% | 7.4% |
| Sherman, Wasco | 28,969 | Small | 9.2% | 17.1% | 17.7% | 24.3% | 100.0% | 13.4% | 5.4% |
| Polk | 90,553 | Medium | 6.1% | 17.3% | 18.9% | 19.9% | 20.4% | 8.2% | 3.7% |
| Sherman | 1,917 | Extra Small | 8.9% | 17.1% | 12.1% | 24.9% | 100.0% | 11.8% | 0.6% |
| Tillamook | 28,000 | Small | 10.2% | 19.5% | 12.1% | 20.9% | 60.7% | 9.3% | 4.2% |
| Umatilla | 81,842 | Medium | 8.1% | 17.8% | 23.7% | 22.2% | 31.7% | 15.5% | 7.5% |
| Union | 26,335 | Small | 8.9% | 19.6% | 9.8% | 25.5% | 42.9% | 7.2% | 1.1% |
| Wallowa | 7,631 | Extra Small | 7.3% | 9.6% | 9.7% | 16.5% | 100.0% | 6.7% | 1.4% |
| Wasco | 27,052 | Small | 9.2% | 17.1% | 18.1% | 24.3% | 34.8% | 13.6% | 5.8% |
| Washington | 610,245 | Extra Large | 4.6% | 19.5% | 31.3% | 13.5% | 5.5% | 7.1% | 8.1% |
| Wheeler | 1,533 | Extra Small | 5.2% | 17.8% | 11.0% | 25.1% | 100.0% | 8.4% | 1.8% |
| Yamhill | 109,743 | Medium | 6.5% | 19.6% | 19.2% | 18.5% | 26.5% | 10.1% | 5.3% |
| **Population Total** | **4,291,525** | | | | | | | | |

## **Appendix G.** Funding formula allocations to Oregon counties for each indicator, updated May 2024

Burden of disease

| | |
|---|---|
| **Total Pool** | **$46,034,623** |
| **Burden Indicator Pool** | **$1,558,714** |

| County Group | County Population | Percent Burden Per Capita | Product Burden Per Capita | Average Burden Per Capita | County Payout | County Payout Per Capita |
|---|---|---|---|---|---|---|
| Baker | 16,927 | 10.09% | 1,707 | 0.56% | $8,702 | $0.51 |
| Benton | 99,355 | 3.83% | 3,803 | 1.24% | $19,383 | $0.20 |
| Clackamas | 424,043 | 5.89% | 24,961 | 8.16% | $127,220 | $0.30 |
| Clatsop | 42,095 | 8.88% | 3,737 | 1.22% | $19,044 | $0.45 |
| Columbia | 53,143 | 8.16% | 4,335 | 1.42% | $22,096 | $0.42 |
| Coos | 66,945 | 10.44% | 6,992 | 2.29% | $35,638 | $0.53 |
| Crook | 26,583 | 8.25% | 2,192 | 0.72% | $11,173 | $0.42 |
| Curry | 24,439 | 11.44% | 2,795 | 0.91% | $14,245 | $0.58 |
| Deschutes | 212,141 | 5.51% | 11,684 | 3.82% | $59,549 | $0.28 |
| Douglas | 113,748 | 11.14% | 12,674 | 4.14% | $64,596 | $0.57 |
| Gilliam | 2,062 | 8.60% | 177 | 0.06% | $904 | $0.44 |
| Grant | 7,418 | 8.05% | 597 | 0.20% | $3,044 | $0.41 |
| Harney | 7,600 | 9.77% | 743 | 0.24% | $3,785 | $0.50 |
| Hood River | 24,406 | 4.98% | 1,216 | 0.40% | $6,198 | $0.25 |
| Jackson | 222,762 | 8.01% | 17,840 | 5.83% | $90,927 | $0.41 |
| Jefferson | 25,878 | 10.96% | 2,835 | 0.93% | $14,450 | $0.56 |
| Josephine | 88,814 | 10.94% | 9,717 | 3.18% | $49,524 | $0.56 |
| Klamath | 71,919 | 11.28% | 8,114 | 2.65% | $41,357 | $0.58 |
| Lake | 8,562 | 10.31% | 883 | 0.29% | $4,498 | $0.53 |
| Lane | 384,374 | 7.80% | 29,996 | 9.81% | $152,882 | $0.40 |
| Lincoln | 51,930 | 10.27% | 5,333 | 1.74% | $27,182 | $0.52 |
| Linn | 131,984 | 8.44% | 11,145 | 3.64% | $56,805 | $0.43 |
| Malheur | 32,981 | 7.89% | 2,603 | 0.85% | $13,269 | $0.40 |
| Marion | 352,249 | 6.91% | 24,335 | 7.96% | $124,028 | $0.35 |
| Morrow | 13,010 | 7.93% | 1,031 | 0.34% | $5,257 | $0.40 |
| Multnomah | 801,306 | 7.27% | 58,245 | 19.05% | $296,860 | $0.37 |
| Polk | 90,553 | 6.13% | 5,553 | 1.82% | $28,301 | $0.31 |
| Sherman, Wasco | 28,969 | 9.17% | 2,657 | 0.87% | $13,543 | $0.47 |
| Tillamook | 28,000 | 10.23% | 2,863 | 0.94% | $14,594 | $0.52 |
| Umatilla | 81,842 | 8.14% | 6,663 | 2.18% | $33,961 | $0.41 |
| Union | 26,335 | 8.85% | 2,332 | 0.76% | $11,884 | $0.45 |
| Wallowa | 7,631 | 7.32% | 559 | 0.18% | $2,847 | $0.37 |
| Washington | 610,245 | 4.64% | 28,334 | 9.26% | $144,409 | $0.24 |
| Wheeler | 1,533 | 5.20% | 80 | 0.03% | $407 | $0.27 |
| Yamhill | 109,743 | 6.46% | 7,094 | 2.32% | $36,154 | $0.33 |
| **Total** | **4,291,525** | **3** | **305,824** | **1.00** | **$1,558,714** | **$0.36** |

**Premature Death: Years of Potential Life Lost Relative to Age 75 per 100,000 (YPLL75)**

Health status

**Total Pool** **$46,034,623**

**Health Status Indicator Pool** **$1,558,714**

| County Group | County Population | % Health Status Per Capita | Product Health Status Per Capita | Health Status Per Capita | County Payout | County Payout Per Capita |
|---|---|---|---|---|---|---|
| Baker | 16,927 | 15.0% | 2,539 | 0.35% | $5,458 | $0.32 |
| Benton | 99,355 | 10.3% | 10,234 | 1.41% | $21,997 | $0.22 |
| Clackamas | 424,043 | 14.2% | 60,214 | 8.30% | $129,433 | $0.31 |
| Clatsop | 42,095 | 18.8% | 7,914 | 1.09% | $17,011 | $0.40 |
| Columbia | 53,143 | 19.2% | 10,203 | 1.41% | $21,933 | $0.41 |
| Coos | 66,945 | 20.4% | 13,657 | 1.88% | $29,356 | $0.44 |
| Crook | 26,583 | 17.2% | 4,572 | 0.63% | $9,828 | $0.37 |
| Curry | 24,439 | 16.7% | 4,081 | 0.56% | $8,773 | $0.36 |
| Deschutes | 212,141 | 14.0% | 29,700 | 4.10% | $63,841 | $0.30 |
| Douglas | 113,748 | 17.8% | 20,247 | 2.79% | $43,522 | $0.38 |
| Gilliam | 2,062 | 17.1% | 353 | 0.05% | $758 | $0.37 |
| Grant | 7,418 | 15.5% | 1,150 | 0.16% | $2,472 | $0.33 |
| Harney | 7,600 | 12.6% | 958 | 0.13% | $2,058 | $0.27 |
| Hood River | 24,406 | 16.4% | 4,003 | 0.55% | $8,604 | $0.35 |
| Jackson | 222,762 | 15.0% | 33,414 | 4.61% | $71,825 | $0.32 |
| Jefferson | 25,878 | 25.7% | 6,651 | 0.92% | $14,296 | $0.55 |
| Josephine | 88,814 | 16.8% | 14,921 | 2.06% | $32,073 | $0.36 |
| Klamath | 71,919 | 15.6% | 11,219 | 1.55% | $24,116 | $0.34 |
| Lake | 8,562 | 14.6% | 1,250 | 0.17% | $2,687 | $0.31 |
| Lane | 384,374 | 16.3% | 62,653 | 8.64% | $134,675 | $0.35 |
| Lincoln | 51,930 | 17.4% | 9,036 | 1.25% | $19,423 | $0.37 |
| Linn | 131,984 | 18.6% | 24,549 | 3.39% | $52,769 | $0.40 |
| Malheur | 32,981 | 19.2% | 6,332 | 0.87% | $13,612 | $0.41 |
| Marion | 352,249 | 20.8% | 73,268 | 10.10% | $157,492 | $0.45 |
| Morrow | 13,010 | 22.3% | 2,901 | 0.40% | $6,236 | $0.48 |
| Multnomah | 801,306 | 15.2% | 121,799 | 16.80% | $261,811 | $0.33 |
| Polk | 90,553 | 17.3% | 15,666 | 2.16% | $33,674 | $0.37 |
| Sherman, Wasco | 28,969 | 17.1% | 4,954 | 0.68% | $10,648 | $0.37 |
| Tillamook | 28,000 | 19.5% | 5,460 | 0.75% | $11,736 | $0.42 |
| Umatilla | 81,842 | 17.8% | 14,568 | 2.01% | $31,314 | $0.38 |
| Union | 26,335 | 19.6% | 5,162 | 0.71% | $11,095 | $0.42 |
| Wallowa | 7,631 | 9.6% | 733 | 0.10% | $1,575 | $0.21 |
| Washington | 610,245 | 19.5% | 118,998 | 16.41% | $255,790 | $0.42 |
| Wheeler | 1,533 | 17.8% | 273 | 0.04% | $587 | $0.38 |
| Yamhill | 109,743 | 19.6% | 21,510 | 2.97% | $46,236 | $0.42 |
| **Total** | **4,291,525** | **6** | **725,138** | **1.00** | **$1,558,714** | **$0.36** |

**Adults (age 18+) Who Report "Poor or Fair" Health by County, 2018-2021**
**Oregon Behavioral Risk Factor Surveillance System (BRFSS)**

Race and ethnicity

**Total Pool** **$46,034,623**

**Ethnicity Indicator Pool** **$5,611,370**

| County Group | County Population | Percenty Ethnicity Per Capita | Product Ethnicity Per Capita | Average Ethnicity Per Capita | County Payout | County Payout Per Capita |
|---|---|---|---|---|---|---|
| Baker | 16,927 | 9.1% | 1,537 | 0.17% | $9,451 | $0.56 |
| Benton | 99,355 | 18.2% | 18,122 | 1.99% | $111,430 | $1.12 |
| Clackamas | 424,043 | 17.6% | 74,691 | 8.18% | $459,263 | $1.08 |
| Clatsop | 42,095 | 13.3% | 5,601 | 0.61% | $34,442 | $0.82 |
| Columbia | 53,143 | 11.9% | 6,300 | 0.69% | $38,737 | $0.73 |
| Coos | 66,945 | 13.3% | 8,921 | 0.98% | $54,856 | $0.82 |
| Crook | 26,583 | 9.9% | 2,642 | 0.29% | $16,243 | $0.61 |
| Curry | 24,439 | 12.2% | 2,990 | 0.33% | $18,383 | $0.75 |
| Deschutes | 212,141 | 10.2% | 21,661 | 2.37% | $133,189 | $0.63 |
| Douglas | 113,748 | 11.3% | 12,827 | 1.41% | $78,868 | $0.69 |
| Gilliam | 2,062 | 14.0% | 289 | 0.03% | $1,777 | $0.86 |
| Grant | 7,418 | 10.0% | 745 | 0.08% | $4,582 | $0.62 |
| Harney | 7,600 | 11.7% | 888 | 0.10% | $5,461 | $0.72 |
| Hood River | 24,406 | 20.6% | 5,022 | 0.55% | $30,878 | $1.27 |
| Jackson | 222,762 | 14.8% | 32,990 | 3.62% | $202,852 | $0.91 |
| Jefferson | 25,878 | 34.8% | 9,016 | 0.99% | $55,436 | $2.14 |
| Josephine | 88,814 | 11.3% | 10,080 | 1.10% | $61,981 | $0.70 |
| Klamath | 71,919 | 19.0% | 13,661 | 1.50% | $84,001 | $1.17 |
| Lake | 8,562 | 12.6% | 1,077 | 0.12% | $6,625 | $0.77 |
| Lane | 384,374 | 16.5% | 63,582 | 6.97% | $390,952 | $1.02 |
| Lincoln | 51,930 | 16.1% | 8,348 | 0.91% | $51,328 | $0.99 |
| Linn | 131,984 | 14.0% | 18,531 | 2.03% | $113,946 | $0.86 |
| Malheur | 32,981 | 23.2% | 7,639 | 0.84% | $46,972 | $1.42 |
| Marion | 352,249 | 28.4% | 100,152 | 10.97% | $615,819 | $1.75 |
| Morrow | 13,010 | 30.0% | 3,909 | 0.43% | $24,038 | $1.85 |
| Multnomah | 801,306 | 27.6% | 221,006 | 24.22% | $1,358,925 | $1.70 |
| Polk | 90,553 | 18.9% | 17,116 | 1.88% | $105,244 | $1.16 |
| Sherman, Wasco | 28,969 | 17.7% | 5,124 | 0.56% | $31,507 | $1.09 |
| Tillamook | 28,000 | 12.1% | 3,401 | 0.37% | $20,909 | $0.75 |
| Umatilla | 81,842 | 23.7% | 19,380 | 2.12% | $119,164 | $1.46 |
| Union | 26,335 | 9.8% | 2,590 | 0.28% | $15,924 | $0.60 |
| Wallowa | 7,631 | 9.7% | 737 | 0.08% | $4,529 | $0.59 |
| Washington | 610,245 | 31.3% | 190,752 | 20.90% | $1,172,899 | $1.92 |
| Wheeler | 1,533 | 11.0% | 169 | 0.02% | $1,038 | $0.68 |
| Yamhill | 109,743 | 19.2% | 21,097 | 2.31% | $129,720 | $1.18 |
| **Total** | **4,291,525** | | **912,593** | **1.00** | **$5,611,370** | **$1.31** |

RACE (Table B02001)
Universe: Total Population
Source: ACS, 5 year estimates, 2018-2022

Rurality

| | |
|---|---|
| **Total Pool** | **$46,034,623** |
| **Rurality Indicator Pool** | **$5,611,370** |

| County Group | County Population | Percent Rurality Per Capita | Product Rurality Per Capita | Average Rurality Per Capita | County Payout | County Payout Per Capita |
|---|---|---|---|---|---|---|
| Baker | 16,927 | 41.4% | 7,007 | 0.81% | $45,517 | $2.69 |
| Benton | 99,355 | 19.4% | 19,280 | 2.23% | $125,241 | $1.26 |
| Clackamas | 424,043 | 17.1% | 72,552 | 8.40% | $471,280 | $1.11 |
| Clatsop | 42,095 | 39.1% | 16,464 | 1.91% | $106,947 | $2.54 |
| Columbia | 53,143 | 41.2% | 21,907 | 2.54% | $142,305 | $2.68 |
| Coos | 66,945 | 38.1% | 25,533 | 2.96% | $165,855 | $2.48 |
| Crook | 26,583 | 49.8% | 13,251 | 1.53% | $86,073 | $3.24 |
| Curry | 24,439 | 51.8% | 12,667 | 1.47% | $82,279 | $3.37 |
| Deschutes | 212,141 | 29.2% | 62,033 | 7.18% | $402,951 | $1.90 |
| Douglas | 113,748 | 40.4% | 45,930 | 5.32% | $298,353 | $2.62 |
| Gilliam | 2,062 | 100.0% | 2,062 | 0.24% | $13,394 | $6.50 |
| Grant | 7,418 | 100.0% | 7,418 | 0.86% | $48,185 | $6.50 |
| Harney | 7,600 | 44.4% | 3,373 | 0.39% | $21,908 | $2.88 |
| Hood River | 24,406 | 51.8% | 12,641 | 1.46% | $82,114 | $3.36 |
| Jackson | 222,762 | 20.6% | 45,879 | 5.31% | $298,016 | $1.34 |
| Jefferson | 25,878 | 67.0% | 17,337 | 2.01% | $112,616 | $4.35 |
| Josephine | 88,814 | 43.1% | 38,316 | 4.44% | $248,893 | $2.80 |
| Klamath | 71,919 | 37.8% | 27,151 | 3.14% | $176,366 | $2.45 |
| Lake | 8,562 | 100.0% | 8,562 | 0.99% | $55,617 | $6.50 |
| Lane | 384,374 | 18.0% | 69,306 | 8.02% | $450,194 | $1.17 |
| Lincoln | 51,930 | 38.0% | 19,733 | 2.28% | $128,182 | $2.47 |
| Linn | 131,984 | 34.2% | 45,198 | 5.23% | $293,598 | $2.22 |
| Malheur | 32,981 | 58.9% | 19,416 | 2.25% | $126,122 | $3.82 |
| Marion | 352,249 | 15.4% | 54,082 | 6.26% | $351,301 | $1.00 |
| Morrow | 13,010 | 100.0% | 13,010 | 1.51% | $84,510 | $6.50 |
| Multnomah | 801,306 | 1.3% | 10,270 | 1.19% | $66,711 | $0.08 |
| Polk | 90,553 | 20.4% | 18,478 | 2.14% | $120,026 | $1.33 |
| Sherman, Wasco | 28,969 | 100.0% | 28,969 | 3.35% | $188,175 | $6.50 |
| Tillamook | 28,000 | 60.7% | 16,984 | 1.97% | $110,324 | $3.94 |
| Umatilla | 81,842 | 31.7% | 25,975 | 3.01% | $168,726 | $2.06 |
| Union | 26,335 | 42.9% | 11,302 | 1.31% | $73,413 | $2.79 |
| Wallowa | 7,631 | 100.0% | 7,631 | 0.88% | $49,569 | $6.50 |
| Washington | 610,245 | 5.5% | 33,534 | 3.88% | $217,825 | $0.36 |
| Wheeler | 1,533 | 100.0% | 1,533 | 0.18% | $9,958 | $6.50 |
| Yamhill | 109,743 | 26.5% | 29,069 | 3.37% | $188,827 | $1.72 |
| **Total** | **4,291,525** | **17** | **863,853** | **1.00** | **$5,611,370** | **$1.31** |

2020 Decennial Census, Summary File 1, Table P2
Universe: Total Population

Poverty

| | |
|---|---|
| **Total Pool** | **$46,034,623** |
| **Poverty Indicator Pool** | **$5,611,370** |

| County Group | County Population | Percent Poverty Per Capita | Product Poverty Per Capita | Average Poverty Per Capita | County Payout | County Payout Per Capita |
|---|---|---|---|---|---|---|
| Baker | 16,927 | 24.2% | 4,100 | 0.48% | $26,922 | $1.59 |
| Benton | 99,355 | 25.6% | 25,397 | 2.97% | $166,756 | $1.68 |
| Clackamas | 424,043 | 12.7% | 53,666 | 6.28% | $352,370 | $0.83 |
| Clatsop | 42,095 | 18.8% | 7,920 | 0.93% | $52,001 | $1.24 |
| Columbia | 53,143 | 16.2% | 8,594 | 1.01% | $56,429 | $1.06 |
| Coos | 66,945 | 26.3% | 17,580 | 2.06% | $115,431 | $1.72 |
| Crook | 26,583 | 15.2% | 4,045 | 0.47% | $26,560 | $1.00 |
| Curry | 24,439 | 21.0% | 5,143 | 0.60% | $33,769 | $1.38 |
| Deschutes | 212,141 | 16.4% | 34,689 | 4.06% | $227,764 | $1.07 |
| Douglas | 113,748 | 24.5% | 27,839 | 3.26% | $182,791 | $1.61 |
| Gilliam | 2,062 | 23.2% | 479 | 0.06% | $3,142 | $1.52 |
| Grant | 7,418 | 24.2% | 1,795 | 0.21% | $11,785 | $1.59 |
| Harney | 7,600 | 28.3% | 2,155 | 0.25% | $14,147 | $1.86 |
| Hood River | 24,406 | 14.9% | 3,637 | 0.43% | $23,883 | $0.98 |
| Jackson | 222,762 | 23.1% | 51,443 | 6.02% | $337,769 | $1.52 |
| Jefferson | 25,878 | 23.0% | 5,954 | 0.70% | $39,095 | $1.51 |
| Josephine | 88,814 | 29.6% | 26,248 | 3.07% | $172,345 | $1.94 |
| Klamath | 71,919 | 27.8% | 20,008 | 2.34% | $131,368 | $1.83 |
| Lake | 8,562 | 29.0% | 2,481 | 0.29% | $16,288 | $1.90 |
| Lane | 384,374 | 25.3% | 97,187 | 11.37% | $638,126 | $1.66 |
| Lincoln | 51,930 | 24.0% | 12,450 | 1.46% | $81,747 | $1.57 |
| Linn | 131,984 | 21.3% | 28,112 | 3.29% | $184,581 | $1.40 |
| Malheur | 32,981 | 35.1% | 11,582 | 1.36% | $76,049 | $2.31 |
| Marion | 352,249 | 22.9% | 80,608 | 9.43% | $529,266 | $1.50 |
| Morrow | 13,010 | 30.6% | 3,978 | 0.47% | $26,118 | $2.01 |
| Multnomah | 801,306 | 19.7% | 157,783 | 18.46% | $1,035,993 | $1.29 |
| Polk | 90,553 | 19.9% | 17,979 | 2.10% | $118,048 | $1.30 |
| Sherman, Wasco | 28,969 | 24.3% | 7,050 | 0.82% | $46,288 | $1.60 |
| Tillamook | 28,000 | 20.9% | 5,849 | 0.68% | $38,406 | $1.37 |
| Umatilla | 81,842 | 22.2% | 18,139 | 2.12% | $119,103 | $1.46 |
| Union | 26,335 | 25.5% | 6,705 | 0.78% | $44,028 | $1.67 |
| Wallowa | 7,631 | 16.5% | 1,256 | 0.15% | $8,247 | $1.08 |
| Washington | 610,245 | 13.5% | 82,109 | 9.61% | $539,124 | $0.88 |
| Wheeler | 1,533 | 25.1% | 384 | 0.04% | $2,522 | $1.65 |
| Yamhill | 109,743 | 18.5% | 20,273 | 2.37% | $133,111 | $1.21 |
| **Total** | **4,291,525** | | **854,617** | **1.00** | **$5,611,370** | **$1.31** |

RATIO OF INCOME TO POVERTY LEVEL IN THE PAST 12 MONTHS (Table C17002)
Universe: Population For Whom Poverty Status Is Determined
Source: ACS, 5 year estimates, 2018-2022

## Education

| | |
|---|---|
| **Total Pool** | **$46,034,623** |
| **Education Indicator Pool** | **$5,611,370** |

| County Group | County Population | Percent Education Per Capita | Product Education Per Capita | Average Education Per Capita | County Payout | County Payout Per Capita |
|---|---|---|---|---|---|---|
| Baker | 16,927 | 8.6% | 1,459 | 0.40% | $22,453 | $1.33 |
| Benton | 99,355 | 4.0% | 3,993 | 1.10% | $61,461 | $0.62 |
| Clackamas | 424,043 | 5.6% | 23,933 | 6.56% | $368,351 | $0.87 |
| Clatsop | 42,095 | 7.8% | 3,266 | 0.90% | $50,272 | $1.19 |
| Columbia | 53,143 | 9.4% | 5,022 | 1.38% | $77,293 | $1.45 |
| Coos | 66,945 | 10.0% | 6,679 | 1.83% | $102,793 | $1.54 |
| Crook | 26,583 | 9.7% | 2,592 | 0.71% | $39,890 | $1.50 |
| Curry | 24,439 | 8.9% | 2,178 | 0.60% | $33,529 | $1.37 |
| Deschutes | 212,141 | 5.7% | 12,165 | 3.34% | $187,228 | $0.88 |
| Douglas | 113,748 | 8.7% | 9,934 | 2.72% | $152,899 | $1.34 |
| Gilliam | 2,062 | 10.2% | 209 | 0.06% | $3,223 | $1.56 |
| Grant | 7,418 | 10.9% | 807 | 0.22% | $12,416 | $1.67 |
| Harney | 7,600 | 8.8% | 666 | 0.18% | $10,253 | $1.35 |
| Hood River | 24,406 | 15.9% | 3,869 | 1.06% | $59,549 | $2.44 |
| Jackson | 222,762 | 9.0% | 20,020 | 5.49% | $308,124 | $1.38 |
| Jefferson | 25,878 | 12.1% | 3,138 | 0.86% | $48,304 | $1.87 |
| Josephine | 88,814 | 9.0% | 7,990 | 2.19% | $122,977 | $1.38 |
| Klamath | 71,919 | 10.7% | 7,689 | 2.11% | $118,337 | $1.65 |
| Lake | 8,562 | 13.0% | 1,109 | 0.30% | $17,069 | $1.99 |
| Lane | 384,374 | 7.2% | 27,514 | 7.55% | $423,475 | $1.10 |
| Lincoln | 51,930 | 7.2% | 3,716 | 1.02% | $57,196 | $1.10 |
| Linn | 131,984 | 9.2% | 12,096 | 3.32% | $186,165 | $1.41 |
| Malheur | 32,981 | 18.6% | 6,119 | 1.68% | $94,182 | $2.86 |
| Marion | 352,249 | 14.3% | 50,213 | 13.77% | $772,822 | $2.19 |
| Morrow | 13,010 | 23.2% | 3,020 | 0.83% | $46,476 | $3.57 |
| Multnomah | 801,306 | 7.7% | 61,392 | 16.84% | $944,881 | $1.18 |
| Polk | 90,553 | 8.2% | 7,442 | 2.04% | $114,546 | $1.26 |
| Sherman, Wasco | 28,969 | 13.4% | 3,894 | 1.07% | $59,934 | $2.07 |
| Tillamook | 28,000 | 9.3% | 2,604 | 0.71% | $40,078 | $1.43 |
| Umatilla | 81,842 | 15.5% | 12,700 | 3.48% | $195,460 | $2.39 |
| Union | 26,335 | 7.2% | 1,901 | 0.52% | $29,254 | $1.11 |
| Wallowa | 7,631 | 6.7% | 510 | 0.14% | $7,854 | $1.03 |
| Washington | 610,245 | 7.1% | 43,539 | 11.94% | $670,105 | $1.10 |
| Wheeler | 1,533 | 8.4% | 128 | 0.04% | $1,972 | $1.29 |
| Yamhill | 109,743 | 10.1% | 11,081 | 3.04% | $170,547 | $1.55 |
| **Total** | **4,291,525** | | **364,588** | **1.00** | **$5,611,370** | **$1.31** |

SEX BY EDUCATIONAL ATTAINMENT FOR THE POPULATION 25 YEARS AND OVER (Table B15002)
Universe: Population 25 Years And Over
Source: ACS, 5 year estimates, 2018-2022

## **Appendix H.** Available incentive funding to each county and payout example

| | |
|---|---|
| **Total Pool** | **$46,034,623** |
| **Incentives Indicator Pool** | **$460,346** |

| | | Incentive 1 | | |
|---|---|---|---|---|
| **County Group** | **County Population** | **Qualified Population** | **Population Payout** | **Payout Per Capita** |
| Baker | 16,927 | 16,927 | $ 1,816 | $ 0.11 |
| Benton | 99,355 | 99,355 | $ 10,659 | $ 0.11 |
| Clackamas | 424,043 | 424,043 | $ 45,493 | $ 0.11 |
| Clatsop | 42,095 | 42,095 | $ 4,516 | $ 0.11 |
| Columbia | 53,143 | 53,143 | $ 5,701 | $ 0.11 |
| Coos | 66,945 | 66,945 | $ 7,182 | $ 0.11 |
| Crook | 26,583 | 26,583 | $ 2,852 | $ 0.11 |
| Curry | 24,439 | 24,439 | $ 2,622 | $ 0.11 |
| Deschutes | 212,141 | 212,141 | $ 22,759 | $ 0.11 |
| Douglas | 113,748 | 113,748 | $ 12,203 | $ 0.11 |
| Gilliam | 2,062 | 1,456 | $ 156 | $ 0.08 |
| Grant | 7,418 | 7,418 | $ 796 | $ 0.11 |
| Harney | 7,600 | 7,600 | $ 815 | $ 0.11 |
| Hood River | 24,406 | 24,406 | $ 2,618 | $ 0.11 |
| Jackson | 222,762 | 222,762 | $ 23,899 | $ 0.11 |
| Jefferson | 25,878 | 25,878 | $ 2,776 | $ 0.11 |
| Josephine | 88,814 | 88,814 | $ 9,528 | $ 0.11 |
| Klamath | 71,919 | 71,919 | $ 7,716 | $ 0.11 |
| Lake | 8,562 | 8,562 | $ 919 | $ 0.11 |
| Lane | 384,374 | 384,374 | $ 41,237 | $ 0.11 |
| Lincoln | 51,930 | 51,930 | $ 5,571 | $ 0.11 |
| Linn | 131,984 | 131,984 | $ 14,160 | $ 0.11 |
| Malheur | 32,981 | 32,981 | $ 3,538 | $ 0.11 |
| Marion | 352,249 | 352,249 | $ 37,791 | $ 0.11 |
| Morrow | 13,010 | 13,010 | $ 1,396 | $ 0.11 |
| Multnomah | 801,306 | 801,306 | $ 85,967 | $ 0.11 |
| Polk | 90,553 | 90,553 | $ 9,715 | $ 0.11 |
| Sherman, Wasco | 28,969 | 28,969 | $ 3,108 | $ 0.11 |
| Tillamook | 28,000 | 28,000 | $ 3,004 | $ 0.11 |
| Umatilla | 81,842 | 81,842 | $ 8,780 | $ 0.11 |
| Union | 26,335 | 26,335 | $ 2,825 | $ 0.11 |
| Wallowa | 7,631 | 7,631 | $ 819 | $ 0.11 |
| Washington | 610,245 | 610,245 | $ 65,469 | $ 0.11 |
| Wheeler | 1,533 | 1,533 | $ 164 | $ 0.11 |
| Yamhill | 109,743 | 109,743 | $ 11,774 | $ 0.11 |
| **Total** | **4,291,525** | **4,290,919** | **$ 460,346** | **$ 0.11** |

**Baker County Example**

| Process Measures | Percent of PM | Payout | LOT Funds |
|---|---|---|---|
| 1/6 | 0.166666667 | $ 302.67 | $ (1,513.33) |
| 2/6 | 0.333333333 | $ 605.33 | $ (1,210.66) |
| 3/6 | 0.5 | $ 908.00 | $ (908.00) |
| 4/6 | 0.666666667 | $ 1,210.66 | $ (605.33) |
| 5/6 | 0.833333333 | $ 1,513.33 | $ (302.67) |
| 6/6 | 1 | $ 1,815.99 | $ - |

LOT = Left On Table