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**OREGON
PUBLIC HEALTH MODERNIZATION**

**Modernization
Assessment
Report**





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Founded in 1988, we are an interdisciplinary strategy and analysis firm providing integrated, creative and analytically rigorous approaches to complex policy and planning decisions. Our team of strategic planners, policy and financial analysts, economists, cartographers, information designers and facilitators works together to bring new ideas, clarity, and robust frameworks to the development of analytically-based and action-oriented plans.

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INTRODUCTION

BACKGROUND

Since 2013, Oregon has been working to modernize its governmental public health system. The goals of a modern public health system include achieving sustainable and measurable improvements in population health; protecting individuals from injury and disease; and being fully prepared to respond to any public health threats that may occur.

In July 2015, the Oregon legislature passed House Bill 3100. This bill sets forth a clear path to

modernize Oregon’s governmental public health system so that it can proactively meet the needs of Oregonians. The new law identifies Foundational Capabilities and Programs for governmental public health as a framework for public health reform.

Foundational Capability

A knowledge, skill, or ability that is necessary to carry out a public health activity. They include:

- Assessment and Epidemiology
- Emergency Preparedness and Response

- Communications
- Policy and Planning
- Leadership and Organizational Competencies
- Health Equity and Cultural Responsiveness
- Community Partnership Development

Foundational Program

A public health program that is necessary to assess, protect, or improve the health of residents.

- Communicable Disease Control
- Environmental Public Health
- Prevention and Health Promotion
- Access to Clinical Preventative Services

Additional Programs

Public health programs and activities implemented in addition to Foundational programs to address specific identified community public health problems or needs. A more detailed description, including definitions and examples of each capability and program, can be found in the *Oregon Public Health Modernization Manual*.



Existing Governmental Public Health in Oregon

The Public Health Modernization framework differs significantly from Oregon State’s current public health framework. The new framework ensures that a common set of Foundational Capabilities and Programs are present at every governmental public health provider. These Foundational Capabilities and Programs support population-based health services such that they are provided uniformly across the state and present in all communities. With healthcare transformation in Oregon, the role of governmental public health as a provider of last resort for residents who don’t have access to healthcare in traditional settings is shrinking. Governmental public health can provide more efficient benefits by focusing on population-based health services and programs.

However, governmental public health in Oregon still plays a role in providing some localized public health services, or individualized interventions. These services are outside of the Foundational Capabilities and Programs, and are known as “Additional Programs.”

SERVICE DELIVERY

Oregon’s public health providers work as a system to deliver governmental public health services to all Oregonians.

Service Providers

Oregon’s governmental public health providers can be separated into two distinct groups by service area:

- **State Providers** provide services that are best delivered centrally for the entire state, for example development and maintenance of statewide data systems. Oregon currently has one statewide provider of governmental public health services, Oregon Health Authority’s (OHA’s) Public Health Division (PHD).
- **Local Providers** provide services that are best delivered locally. Oregon has 34 local governmental public health providers, known as Local Public Health Authorities (LPHAs). LPHA’s service areas each cover one county except for North Central Public Health District, which serves Gilliam, Sherman, and Wasco counties.

Cross Jurisdictional Services

Some LPHAs have existing services delivery relationships whereby they support each other in delivering public health services. Most often, these relationships are between proximate LPHA. Cross jurisdictional services are an efficient way to deliver public health services while still leveraging local knowledge.

Service Dependencies

The activities of state and local providers are interdependent. Many state provider support local activities, and some local activities feed back into the state provider’s work.

The transition to the Public Health Modernization framework provides an opportunity to review and revise the existing features of the governmental public health system in Oregon to maximize its efficiency and effectiveness.

To understand the potential programmatic and financial shift required to implement the Public Health Modernization framework in Oregon, House Bill 3100 also required that the Oregon Health Authority (OHA) adopt and update as necessary a Statewide Public Health Modernization Assessment.

PUBLIC HEALTH MODERNIZATION ASSESSMENT OVERVIEW

Public Health Division (PHD), a division of OHA, was tasked with developing and stewarding the first Statewide Public Health Modernization

Assessment. The Assessment would answer two key questions:

1. To what extent are the roles and responsibilities of Public Health Modernization being provided today? *(Qualitative and quantitative)*
2. What will it cost to fully implement the roles and responsibilities of Public Health Modernization? *(Quantitative)*

Programmatic Framework

Oregon’s Public Health Modernization framework is organized around seven Foundational Capabilities and four Foundational Programs. The *Public Health Modernization Manual* provides detailed definitions for each Foundational Capability and Program for governmental public health. It is primarily intended for administrators and staff of state and local public health authorities to guide the implementation of each Foundational Capability and Program. The manual defines each Foundational Capability and Program as they apply specifically to state and local public health authorities, who in turn work closely with community members and partners to implement them. Each Foundational capability and program definition includes:

- **Core system functions:** work that state and local public health must do together as a system;

Program	State		Local	
	Roles	Deliverables	Roles	Deliverables
Program				
P-CDC: Communicable Disease Control	26	24	19	16
P-EPH: Environmental Public Health	33	24	25	11
P-PHP: Prevention and Health Promotion	29	13	27	14
P-CPS: Clinical Preventative Services	29	6	24	7
Capability				
C-AEP: Assessment and Epidemiology	11	10	11	9
C-EPR: Emergency Preparedness and Response	26	12	10	11
C-COM: Communications	12	11	6	9
C-PAP: Policy and Planning	16	5	14	5
C-HEC: Health Equity and Cultural Responsiveness	59	7	44	6
C-CPD: Community Partnership Development	11	7	7	7
C-LOC: Leadership and Organizational Competencies	19	8	13	7
TOTAL	271	127	200	102

- **State provider role:** the unique responsibilities of the OHA Public Health Division;
- **Local provider role:** the unique responsibilities of local public health authorities;
- **Deliverables:** tangible work products produced by state and local public health authorities;
- **Critical tools and resources:** items necessary for state and local public health authorities to produce their deliverables.

BERK leveraged the December 2015 version of the manual to inform our programmatic

framework for the Public Health Modernization Assessment.

The detailed definitions provided in the *Modernization Manual* also presented challenges to the Assessment. For example, it is impractical to require any provider to generate resource estimates at the role or deliverable level considering that there are almost 400 state roles and deliverables and over 300 local roles and deliverables.

It was also difficult for local providers to generate estimates at the Foundational Capability and Program level.. To mitigate these challenges, we developed an intermediate level between Foundational Capabilities and Programs and roles and deliverables to be used to support local

providers in their assessments. The activities at this intermediate level were dubbed “functional areas” and describe how local providers might execute this work. There are 40 functional areas, defined in **Appendix B: Functional Area Definitions**.

302 local roles and deliverables were assigned to these functional areas through a one-to-one relationship. Definitions of the functional areas are provided in **Appendix A: Glossary and Acronyms**.

We did not develop complementary functional areas for state providers based on their activities.

Assessment Process

PHD engaged BERK Consulting, a public policy consultancy with experience and expertise related to public health modernization, to execute the Public Health Modernization Assessment. BERK knowledge of Public Health Modernization is from our work with the Washington State Department of Health (DOH), Washington State Association of Local Public Health Officials (WSALPHO), and the states 35 Local Health Jurisdictions (LHJs) in implementing public health modernization (known as Foundational Public Health Services there) in Washington.

Based on discussion with local providers through its Joint Leadership Team and the Coalition of

Local Health Officials (CLHO) the organization that represents LPHAs, PHD determined that an ideal Public Health Modernization Assessment would collect data from all 35 (state and local) governmental public health providers in Oregon. This presented several challenges:

- Collecting information based on a new framework of which there was a limited and inconsistent understanding
- Collecting information from two different kinds of governmental public health providers with two different sets of responsibilities as per the Public Health Modernization
- Collecting consistent responses from 34 LPHAs

To respond to these challenges, two information collection processes were used:

- An Assessment of all local providers completed by each LPHA
- An Assessment of the state provider completed by PHD

These processes were intended to collect responses from providers that would illuminate their unique activities. Each process is detailed further in the following sections.

LPHA ASSESSMENT PROCESS

Process Design

We developed an Assessment Tool which was vital to fostering consistency of responses from each of Oregon’s 34 LPHAs. The Assessment Tool enabled:

- Assessment of each LPHA’s current capacity for providing Foundational Capabilities and Programs; and
- Estimation the cost of what is needed to fully implement Foundational Capabilities and Programs.

Assessment Tool Development

The Assessment Tool’s development began in December 2015, and included several opportunities for LPHA feedback and usability review. This feedback helped improve the final Assessment Tool. The live Assessment Tool was distributed to LPHAs on January 19, 2016.

Tool Description

The Assessment Tool comprised of 28 tabs, including instruction and orientation tabs and two tabs (a Programmatic Self-Assessment and Resource tab) for each Foundational Capability and Program. Across these 28 tabs, over 2,000 data points were collected from each LPHA.

PROGRAMMATIC SELF-ASSESSMENT

The Programmatic Self-Assessment allowed LPHAs to 1) assess their current capacity and expertise to meet the requirements of the Public Health Modernization framework; 2) help LPHAs identify the degree to which they are already executing Public Health Modernization roles; and 3) understand the expertise with which they are providing those services as defined as part of Public Health Modernization. It includes two scales, capacity and expertise.

- **Capacity.** To what degree the organization currently has the staffing and resources necessary to provide the services/deliverables dictated.

- **Expertise.** To what degree the organization’s current capacity aligns with the appropriate knowledge necessary to implement the services/deliverables dictated.

The tool was a qualitative self-assessment of how closely LPHAs believe they are currently meeting the requirements of the new Public Health Modernization framework.

The Programmatic Self-Assessment had two levels:

- A **Detailed Assessment** of capacity and expertise for meeting local roles and providing deliverables outlined in the *Modernization Manual*; and

- A generalized **Rollup Assessment** for meeting the key functional areas as described in the cost estimation, and an overall assessment for this Foundational Capability or Program.

The detailed assessment used a five-point scale, while the rollup assessment used a ten-point scale, as shown below. It is important to remember that these scales are not linear (i.e., a three on the detailed assessment or a six on the rollup assessment don’t denote 60% implementation).

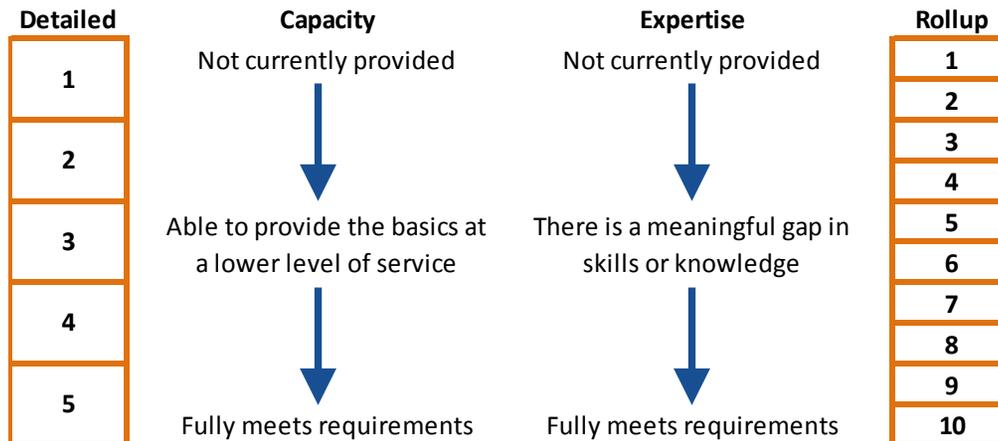
Rather, the scores map to a scoring rubric provided in the Assessment Tool, shown on this page.

These scores are used in conjunction with the cost estimations provided to help describe the resources needed to fully implement Public Health Modernization.

The Programmatic Self-Assessment results provide an overall indicator of the size, location, and nature of the programmatic gaps that currently exist in providing Foundational Capabilities and Programs in all communities across Oregon.

CURRENT SPENDING

To identify their current level of investment in each functional area, LPHA staff had to review all of their FY 2015 annual spending and allocate



those resources that supported each functional area.

We asked that LPHAs provide current spending for each functional area disaggregated by:

- **Full Time Equivalent (FTE):** Total staff directly supporting each program or capability.
- **Labor Costs:** Direct labor costs, the salaries and benefits of staff who are employed within or directly support each program or capability.
- **Non-Labor Costs:** The costs of supporting that program or capability’s function. Example costs include materials, supplies, small equipment (e.g., computers or lab equipment), professional services, or other contracted services.
- **Overhead Costs:** Facility-related costs such as rent, utilities, or maintenance.

As a general approach, we recommended that LPHAs:

- Begin with a FY 2015 budget and identify which FTE and line items are part of Public Health Modernization (Foundational).
- Allocate each Foundational FTE and line item to the appropriate Functional Area based on the Functional Area definitions provided in the Assessment Tool.

LPHA provided current spending estimates for each functional area in the resource tab for the appropriate Foundational Capability or Program and were asked to review the total on the Assessment Tool dashboard to prevent duplication and ensure all spending was captured.

FULL IMPLEMENTATION RESOURCE ESTIMATION

Within the Assessment Tool, LPHAs developed cost estimates for each Foundational Capability and Program. These cost estimates include values for:

- Full Time Equivalent (FTE)
- Labor Costs
- Non-Labor Costs
- Overhead Costs

Cost estimates for ten of the Foundational Capabilities and Programs, all excluding Leadership and Organizational Competencies, were generated using our Basic Cost Estimation Method. Cost estimates for Leadership and Organizational Competencies were generated using our Infrastructure Cost Estimation Method. Both cost estimation methods provide Initial Estimates and an Estimation Tool powered by an estimation calculator.

The estimation calculator relies on assumptions about:

- The percentage of costs that are fixed, i.e., expenses that do not change as a function of the activity of the Foundational Capability or Program;
- Demand drivers for public health services, factors that cause a change in the overall demand for a Foundational Capability or Program; and
- The influence each demand driver has in relation to one another. This variable is called “driver influence.”

These variables are used in conjunction with cost factors (units of cost directly proportional to the independent variables [in this case, demand drivers]) developed through prior research and cost factor weighting (a general variable that allows you to globally increase the magnitude of cost factors in any given area) to provide planning-level estimates for each functional area.

The Initial Estimates and Estimation Tool are provided as useful tools for developing final cost estimates, however use was optional.

The Cost Estimation Tabs identify the costs to fully implement and complete the local roles and associated deliverables, and to estimate the current level of investment in Foundational Capabilities and Programs. The cost estimates

collected in each cost estimation tab are planning-level estimates that provide an order of magnitude understanding of resource needs for full implementation of Public Health Modernization, not exact costs.

LPHA Assessment Completion

Great care was taken to ensure a smooth and high-quality data collection process that would secure good data to inform public health modernization implementation, conversations with key legislators, and likely a legislative budget request. At the time of data collection, many of the specifics on how a funding request might be made to the legislature for state general fund support for the 2017 legislative session were not yet confirmed. But it was clear that at a minimum, a lump sum total for all local health departments, and then the state health department, would need to be identified to make a request to the legislature.

This landscape made the tool collection and technical support phases of the work very important. The live tool was deployed to LPHAs on January 19, 2016. The collection process was structured in a wave system, so that half of the LPHA tools were due on March 1, 2016, and the other half were due on March 15, 2016. This phased system enabled a steady data validation process and high-touch technical assistance. Data validation occurred throughout the month of

March 2016 with members of the BERK team reviewing data in returned tools and, if data was questionable or unclear, contacting LPHA staff to clarify necessary points. Cost analysis was performed once all data was returned.

Throughout this timeline, robust technical assistance efforts were in place with live and personalized support available to each LPHA. All data collection as well as information sharing for the effort was hosted on a SharePoint site, allowing access to information at any time. Additionally, a comprehensive set of written materials were available to LPHA staff, a series of webinars were hosted throughout the process to address questions, and live phone assistance was provided upon request. A singular point of contact was provided through the orphmodernization@berkconsulting.com email inbox, where LPHA staff were able to send in a request and receive a response within one business day, although response times were often much quicker.

Technical Assistance was a cornerstone of the data collection process, and was carefully planned out to meet the needs of any LPHA staff, ranging from large, complex departments to small, resource-constrained departments. By the end of the data collection process, the technical assistance team had successfully responded to over **200** assistance requests.

CLHO TECHNICAL ASSISTANCE

To further support LPHA's in completing their Assessments, CLHO hired an outside consultant well known to CLHO members to provide additional technical assistance and advocate on behalf of LPHAs during the Assessment process. This consultant, Kelly McDonald, had existing relationships with LPHAs made her an invaluable part of technical assistance process, as LPHAs already had familiarity with and trust in her.

Kelly buttressed BERK's technical assistance, helping to build understanding around Public Health Modernization, answer questions, and provide strategies for approaching the work. She coordinated with all 34 LPHAs via email and spoke with 28 by phone, having three to four conversations with most of these LPHAs. She also visited with six counties in person to support them in completing their assessment tools.

Kelly also supported many conversations around cross jurisdictional sharing and facilitated discussions between four counties considering their current and potential future cross-jurisdictional relationship.

TECHNICAL ASSISTANCE PROGRAM AND COMPLETION RESOURCES

A robust technical assistance program was a key element of the Assessment Tool collection process from the launch of the Public Health Modernization Site through the completion and validation of all Assessment Tools. Beyond supporting LPHAs in completing their Assessments, it also helped to ensure high quality data was being collected. The program consisted of live technical assistance available by request within one business day from 8:00 am to 5:00 pm, live webinars, and over ten graphic-rich instructional and troubleshooting documents.

Live Technical Assistance

Live technical assistance was an important component of the data collection process, and a number of tools were used to connect LPHA staff with BERK resources. Technical assistance was provided via email and phone, with a unique inbox devoted to technical assistance and other requests as part of this work. This inbox was monitored during business hours, Monday – Friday from 8:00 am to 5:00 pm. Requests were responded to within one business day, and often more quickly than that.

Over **200** technical assistance requests were resolved from January through March 15. Of those, 86 were related to Modernization site access, 74 were related content questions

around completing the Assessment Tool, and 15 were related to tool deadlines. Other requests included questions about adding additional staff to the site, confidentiality, and what the data would be used for, among other things.

Many inquiries that were emailed to the inbox were resolved when they were received by simply calling the individual who requested assistance or scheduling a time to speak with them on the phone. During the months of January and February, BERK staff provided outreach via phone call 144 times and spent nearly 11 hours answering questions, troubleshooting, and providing guidance through tool completion over the phone with LPHA staff.

The technical assistance team received positive feedback from LPHA staff and many participants were appreciative of the level of personal assistance provided.

Some constructive feedback was provided over the course of this process, and the number and type of technical assistance requests provide some valuable lessons learned when considering the process:

- Many technical assistance requests related to gaining access to the SharePoint site, suggesting that greater outreach in relation to site access at the outset of the effort would be helpful in future efforts.

- Similarly, many of the site access issues related to end user email account set up and confusion around which email account should be associated with this work. Providing resources outlining the importance of using one consistent email account to gain site access would be helpful.
- Throughout the months that the data collection tool was available, many jurisdictions continuously requested that new staff be added to the site. In future efforts it may be useful to overview in initial webinars which staff may be needed to complete the tool and advise that jurisdictions select a core team to have site access, routing other input via email or another method to ensure clear coordination.
- Many tool-specific inquiries related to using the tool.

Webinars

To enhance the technical assistance process and familiarize participants with the assessment process and tool, BERK hosted ten live webinars.

In total, the live webinars reached over 100 people, and many more were able to watch the webinars after they occurred. Webinars were recorded and posted to the Modernization site after their completion to allow individuals who

were not able to join the live webinar to listen to the webinar at a later time. For each month during the data collection process there were two webinars provided.

Technical Assistance Instructions and Resources

Before the Assessment Tool launch, a series of technical assistance instructional documents were developed to prepare LPHA staff for the data collection process. Additional materials were developed as new requests were made.

PHD ASSESSMENT PROCESS

For the state OHA's Public Health Division, one agency with one budgeting and accounting system allowed a simpler approach but with the added challenge of a large organization with a large service area

Programmatic Self-Assessment

The Programmatic Self-Assessment allowed PHD to assess its current capacity and expertise to meet the requirements of the Public Health Modernization framework, and to help PHD identify the degree to which they are already executing Public Health Modernization roles and the expertise with which they are providing those services as defined as part of Public Health Modernization. This Programmatic Self-Assessment was extremely similar to that provided to the LPHAs in their Assessment Tools,

with the exception that it was based on state roles and deliverables, rather than local roles and deliverables. Like the LPHA Programmatic Self-Assessment, it included two scales, capacity, and expertise.

The tool was a qualitative self-assessment of how closely PHD believed they were currently meeting the requirements of the new Public Health Modernization framework.

Like the LPHA Programmatic Self-Assessment, PHDs Programmatic Self-Assessment had two levels: a detailed assessment and a rollup assessment.

The detailed assessment used a five-point scale, while the rollup assessment used a 10-point scale, as shown below. It is important to remember that these scales are not linear (i.e., a 3 on the detailed assessment or a six on the rollup assessment don't denote 60% implementation).

Rather, the scores should be interpreted based on the scoring rubric provided in the Assessment Tool, shown on the following page.

These scores are used in conjunction with the cost estimations provided to help describe the resources needed to fully implement Public Health Modernization.

The Programmatic Self-Assessment results provide an overall indicator of the size, location, and nature of the programmatic gaps that

currently exist in relation to providing state public health activities as defined by the newly defined Foundational Capabilities and Programs

Current Spending

To identify PHD's current level of investment in the Foundational Capabilities and Programs, PHD staff will have to review all of the FY 2015 annual spending and allocate those resources that support Foundational Capabilities and Programs.

We asked that PHD provide current spending for each Foundational Capability and Program disaggregated by:

- Full Time Equivalent (FTE)
- Labor Costs
- Non-Labor Costs
- Overhead Costs

To do this effectively, we suggested that PHD focus on allocating the resources from each of their Centers (Office of the State Public Health Director, Center for Health Protection, Center for Prevention and Health Promotion, and Center for Public Health Practice).As a general approach, we recommended:

- Beginning with a FY 2015 budget, identify which FTE and line items are part of Public Health Modernization (Foundational).

- Allocate each Foundational FTE and line item to the appropriate Foundational Capabilities and/or Programs based on the state roles and deliverables outlined in the *Public Health Modernization Manual*. This was somewhat subjective and certainly challenging.
- Include indirect costs in current spending. For those indirect costs that are determined on a percent basis of total or program budget, compare the individual Foundational Capabilities and Programs line item allocations to the total or program budget, and apply that proportion to the expected indirect costs.

PHD collected current spending estimates for individual programs and reviewed to prevent duplication and ensure all spending was captured, and provided a full set of spending for each Foundational Capability and Program to BERK.

Full Implementation Resource Estimation

To estimate the resources needed for PHD to fully implement Public Health Modernization, small groups of staff worked with Program Support Managers to generate estimations for each Foundational Capability and Program, disaggregated by:

- Full Time Equivalent (FTE)

- Labor Costs
- Non-Labor Costs
- Overhead Costs

Groups completed the resource estimations during two meetings, with additional work to be completed between meetings.

Once resource estimates for each Foundational Capability and Program were complete, estimates were reviewed by the Public Health Division Executive Team to identify and resolve any gaps or areas of overlap, and approve the estimates.

Limitations

As self-reported data, the information collected through the Assessment Process has certain inherent limitations. These include respondent biases, an uneven understanding of Public Health Modernization, and differing resource estimation expertise.

With all self-reported data, there is a question of respondent biases, especially if there are perceived benefits, such as possible future funding decisions. Additionally, attitudes about Public Health Modernization in general and the Assessment processes specifically are reflected in the data collected.

Respondents have differing levels of cost estimation backgrounds; the respondents of this

Assessment are generally experts in public health. While some LPHAs and PHD had staff with specialized expertise in cost estimation, the majority of LPHA respondents were public health professionals. Areas of Public Health Modernization are new activities for governmental public health, so some cost estimates had to be done without comparables.

Additionally, the Assessment Tool is a complicated form with over 2,000 data entry points, and completing the Tool was a challenge for some respondents. It was also a significant investment of resources for LPHAs that already feel resource constrained.

Completing the Assessment Tool was not only an unfamiliar exercise, but the Public Health Modernization framework was new for some respondents as well. This Assessment was first exposure to Public Health Modernization as implemented in the *Oregon Public Health Modernization Manual*, and a certain level of education was built into the process. We identified a number of inconsistencies originating in differing understandings

BERK was aware of these issues before releasing the tool and mitigated wherever possible. In addition to those efforts, there are a number of factors that diminish the data limitations' effects on the final estimate:

- Level of estimation. As a planning level estimate, expected accuracy is order of magnitude
- Limited standardization using the data set as a whole and external data sources to correct individual inconsistencies
- As all 34 LPHAs responded, these are population data, no sampling issues
- Research suggests that managers tend to underestimate the resources needed to perform new job tasks¹

Assessment Results

VALIDATION

Data were validated through a number of methods, some built into the Assessment Tool and some through post-collection analysis.

As suggested by Glen Mays in his recommended methodology for estimating the cost of Foundational Public Health Capabilities,² BERK incorporated anchoring questions. Using the work of Gary King and Jonathan Wand³ on using

anchoring vignettes to correct for issues of inter-rater reliability. By presenting hypothetical situations to respondents, general attitudes about resources needs can be approximated. Some respondents consistently assessed the anchoring questions higher or lower than their peers, which informed identifying and assessing outliers.

BERK has previous experience with this type of cost estimation, working with the Washington State Department of Health to estimate the cost of implementing Washington’s version of Public Health Modernization. This previous work, while not directly comparable because of differences in Public Health Modernization frameworks, was incorporated into initial estimates provided to LPHAs and used as a high-level estimate check.

Internal consistency. For example, if Programmatic Self-Assessment responses indicated full implementation of the activities included in Public Health Modernization but the respondent also reported a large funding need, this would indicate that further information is needed.

PHD collects LPHA revenue data annually. In an attempt to reduce reporting burden on LPHAs, PHD requested that BERK include this revenue data collection in the Assessment Tool. While not part of Public Health Modernization, these data allowed BERK to compare Public Health Modernization current spending totals with projected revenue. PHD provided multiple years of revenue data that allowed BERK to identify inconsistencies and work with LPHAs to correct estimates.

STANDARDIZATION

After working with respondents to validate data, BERK implemented standardization to correct for non-validated outliers. The order of magnitude level used for the total resource estimates largely negated any outliers and standardization provided only an additional check against respondent estimates.

¹ Whittington et al., “Strategic Methodologies in Public Health Cost Analyses” *Journal of Public Health Management Practice* (2016-02): 1-7.

² Glen Mays, “Estimating the Costs of Foundational Public Health Capabilities: A Recommended Methodology” The Robert Wood Johnson Foundation National Public Health Leadership Forum (2014).

³ King and Wand, “Comparing Incomparable Survey Responses: Evaluating and Selecting Anchoring Vignettes” *Political Analysis* 15, no. 1 (2007): 46-66.

ASSESSMENT RESULTS

PUBLIC HEALTH MODERNIZATION ASSESSMENT RESULTS

We present Assessment Results at several altitudes:

- For all Governmental Public Health providers
 - Overall Assessment Results
- For State providers
 - Foundational Program and Capability Level Results
- For Local providers
 - Foundational Program and Capability Level Results
 - Functional Area Level Results

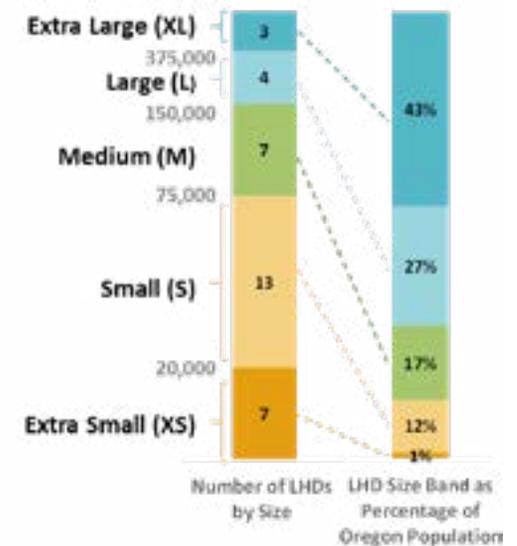
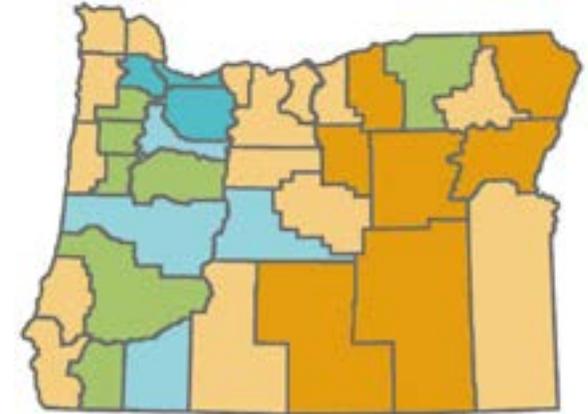
Following, we describe the individual analysis that provides the results at each of these altitudes.

Operational Size Construct

We developed an operational sizing construct for LPHAs to allow for a more detailed review of results. The sizing categories were created based on findings in the self-assessment results. We identified that LPHAs serving similar populations have similar levels of implementation and operational characteristics in common. This sizing construct is used as an additional

categorization to provide a higher level of detail to the Assessment Results. The sizes are broken down as follows and can also be seen in the image to the right.

- Extra Small – Population below 20,000
- Small – Population between 20,000 and 75,000
- Medium – Population between 75,000 and 150,000
- Large – Population between 150,000 and 375,000
- Extra Large – Population over 375,000



Reviewing Assessment Results

We present Assessment Results at several altitudes:

- For all Governmental Public Health providers
 - Overall Assessment Results
- For state providers
 - Foundational Program and Capability Level Results
- For Local providers
 - Foundational Program and Capability Level Results
 - Functional Area level results

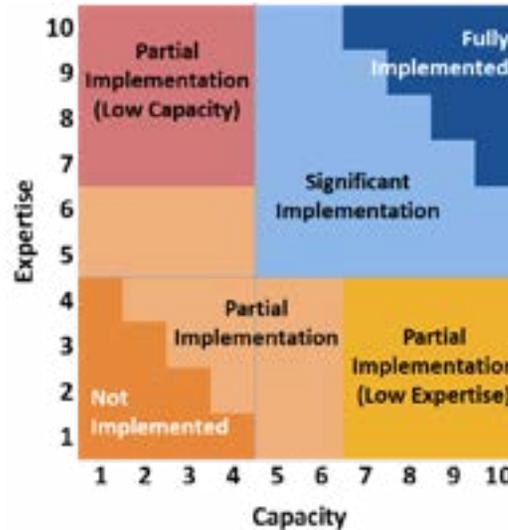
Following, we describe the individual analysis that provides the results at each of these altitudes.

DEGREE OF IMPLEMENTATION

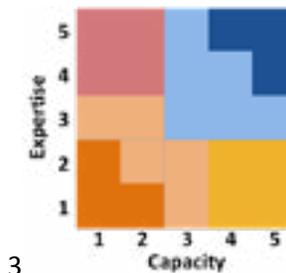
The degree of implementation of Foundational Capabilities and Programs, Functional Areas, and Roles and Deliverables is illustrated throughout the Assessment Results with both color-coding and charts. The image below illustrates level of implementation with Expertise on the y-axis and Capacity on the x-axis. On each chart you will find an accounting of how providers scored themselves for capacity and expertise for each Foundational Capability or Program. These scores identified providers' current capacity (x-axis) and

current expertise (y-axis). The chart is color coded to illustrate where these roles fall:

Degree of Implementation for Foundational Capabilities and Programs, and Functional Areas



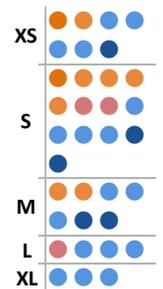
Degree of Implementation for Individual Roles and Deliverables



3

- **Dark Blue:** Services are mostly or fully implemented.
- **Light Blue:** Services are significantly implemented however, some meaningful gaps remain.
- **Yellow:** Services are partially implemented and, while the provider has significant capacity there are substantial gaps related to a lack of necessary expertise.
- **Red:** Services are partially implemented and, while the provider has significant expertise there are substantial gaps related to a lack of necessary capacity.
- **Light Orange:** Services are partially implemented and there are significant gaps in capacity and expertise.
- **Orange:** Services are mostly not or not at all implemented.

For LPHAs, we also show provider degree of implementation by organization size, as per our operational sizing construct. This graphic shows each LPHA as a dot by color (which identifies the LPHAs level of implementation).



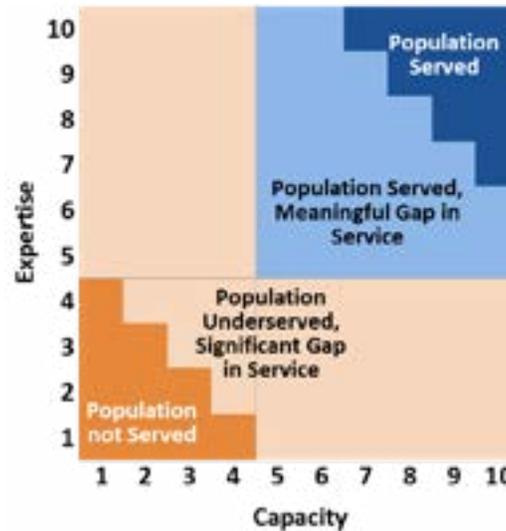
POPULATION BY LEVEL OF SERVICE

The Population by Level of Service exhibits describe how the Degree of Implementation of Foundational Capabilities and Programs and Functional Areas translate to population service and service equity.

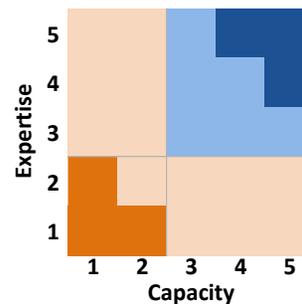
Both concepts use the Degree of Implementation results to demonstrate how implementation translates to population service for both the general population and the population living at or below the Federal poverty level. The latter is used as a screen to determine whether current implementation levels across the system involve service equity gaps (identifiable when the two percentage differ significantly). The exhibit to the right illustrates how implementation scores translate to Population by Level of Service. The chart is color coded to describe what scores mean for population service.

- **Blue:** The population is mostly or fully served.
- **Light Blue:** The population is mostly or fully served, but there are meaningful gaps in level of service.
- **Light Orange:** The population is underserved, but there are significant gaps in service.
- **Orange:** The population is mostly not or not at all served.

Degree of Implementation for Foundational Capabilities and Programs, and Functional Areas



Degree of Implementation for Individual Roles and Deliverables



RESOURCES

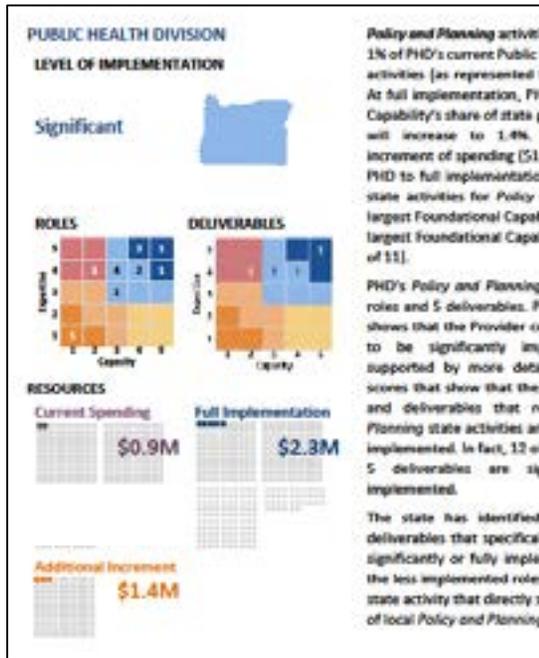
Resources appear repeatedly throughout the assessment results as well and also follow a specific color scheme.

- **Full Implementation.** The amount of resources needed to support full implementation of Public Health Modernization activities. ■ ■
- **Current Spending.** The amount of resources supporting existing Public Health Modernization Activities. ■ ■
- **Cost of Additional Increment of Service.** The cost of the additional resources needed to move to the degree of implementation supported by current spending to full implementation. ■ ■

The shading of the boxes indicates the level of activity for which a cost is displayed.

- **Light gray.** Total costs across programs, capabilities, and functional areas for modern health modernization activities.
- **Dark color.** The estimated total cost of a program or capability.
- **Light color.** The estimated total cost of a functional area. (Available only for LPHAs.)

INTERPRETING PHD RESULTS



Level of Implementation

This section explains the level to which PHD has determined that it has implemented this specific Public Health Modernization activity. The rating can range from partial (if PHD has only partially implemented this capability or program) to significant (if PHD has significantly implemented this capability or program). The level of implementation is indicated both with text and

with the shade of the Oregon shape, which follows the implementation color scheme.

Roles and Deliverables

There are two charts in this section, one for the Roles for the specific activity and one for the Deliverables. These follow the implementation color scheme and chart layout described in the Reviewing Assessment Results section.

Resources

The Resources section of the results illustrate the current spending by PHD on this capability or program, the estimated cost of full implementation, and the additional increment in spending needed to get PHD to full implementation.

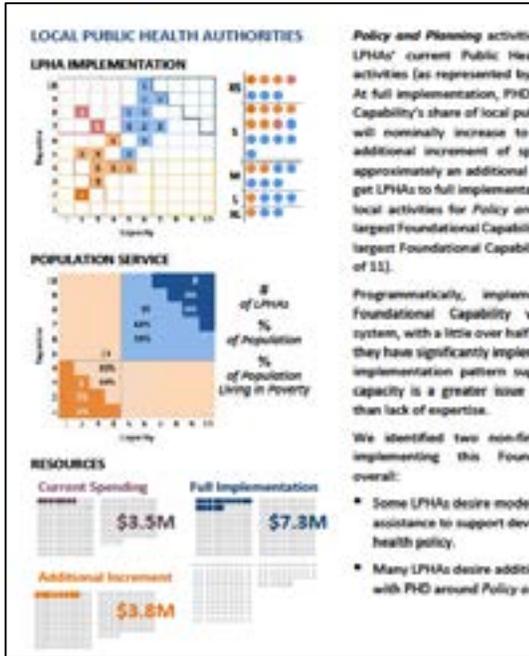
Narrative

The narrative to the right of the charts in each section walks the reader through the results summarized by the charts to the left of the page. More detail is given as to where the capability or program falls within PHD's total Public Health Modernization activities, including what percentage the capability or program comprises of PHD's current Public Health Modernization activities, what that percentage is expected to be upon full implementation, the additional increment of spending needed to reach full implementation, and where the capability or

program falls in terms of size of capability or program in relation to the others.

Additionally, the narrative gives more information about the roles and deliverables contained within the capability or program and any stand out information that is interesting or important to note from this capability or program's results.

INTERPRETING LPHA RESULTS



This page is repeated once for each

LPHA Implementation

This section illustrates where the 34 LPHAs have scored themselves in terms of degree of implementation for the Foundational Capability or Program. The numbers in each colored box shows the number that fall into each color category (described in the Degree of Implementation section).

To the right of the implementation chart is a table that illustrates the LPHAs, color coded per their

rating from the table at left, by their size. In the example to the left you can see that one extra-large LPHA has rated itself as partially implemented and two extra-large LPHAs have rated themselves as significantly implemented.

Population Service

The Population by Level of Service describe how the Degree of Implementation of Foundational Capabilities and Programs and Functional Areas translate to population service and service equity. This information is important for understanding the number of LPHAs in each service delivery bucket and, the percent of the state population served by the LPHAs in that category, and the percent of the population living in poverty in each of those categories. This chart also helps identify when an LPHA may represent a larger or smaller percent of the total population.

Resources

The Resources section of the results illustrate the current spending by LPHAs on this capability, program, or functional area, as well as the estimated cost of full implementation and the additional increment in spending needed to get LPHAs to full implementation.

Narrative

The narrative to the right of the charts in each section walks the reader through the results summarized by the charts to the left of the page. More detail is given as to where the capability or program falls within the LPHAs' total Public Health Modernization activities (in terms of what percentage the capability or program comprises of current Public Health Modernization activities), the additional increment of spending needed to reach full implementation, and where it falls in terms of size of capability or program in relation to the others.

Additionally, the narrative provides high level findings and themes from the LPHA results, presenting important take-aways from the analysis.

ASSESSMENT

Overall

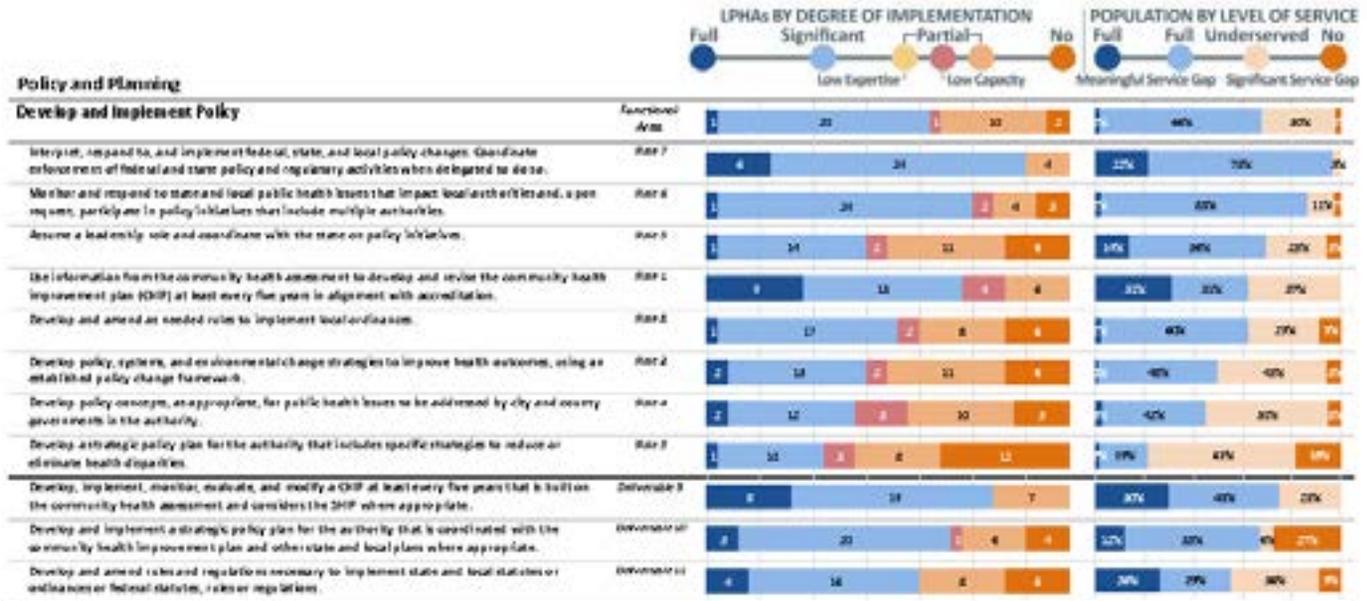
Functional Area Roles and Deliverables

Each Functional Area section of the report is accompanied by an additional chart, as illustrated to the right, which shows the Roles and Deliverables of the Functional Area in relation to the LPHAs' Degree of Implementation and Population by Level of Service.

The color codes for this exactly match those used in the previous matrices. We have repeated them below.

LPHAs by Degree of Implementation

- **Dark Blue:** Services are mostly or fully implemented.
- **Light Blue:** Services are significantly implemented however some meaningful gaps remain.
- **Yellow:** Services are partially implemented and, while the provider has significant capacity there are substantial gaps related to a lack of necessary expertise.
- **Red.** Services are partially implemented and, while the provider has significant expertise there are substantial gaps related to a lack of necessary capacity.

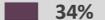


- **Light Orange:** Services are partially implemented and there are significant gaps in capacity and expertise.
- **Orange:** Services are mostly not or not at all implemented.

Population by Level of Service

- **Blue:** The population is mostly or fully served.
- **Light Blue:** The population is mostly or fully served, but there are meaningful gaps in level of service.
- **Light Orange:** The population is underserved, but there are significant gaps in service.
- **Orange:** The population is mostly not or not at all served.

PUBLIC HEALTH MODERNIZATION ASSESSMENT RESULTS

	Total Estimated Cost of Full Implementation	Current Spending	Cost of Additional Increment of Service
Foundational Programs	\$ 206,399,000  62%	\$ 152,448,000  66%	\$ 53,952,000  51%
Communicable Disease Control	\$ 60,007,000  18%	\$ 47,089,000  21%	\$ 12,918,000  12%
Environmental Public Health	\$ 59,647,000  18%	\$ 45,754,000  20%	\$ 13,893,000  13%
Prevention and Health Promotion	\$ 58,351,000  17%	\$ 41,441,000  18%	\$ 16,911,000  16%
Clinical Preventive Services	\$ 28,394,000  8%	\$ 18,164,000  8%	\$ 10,230,000  10%
Foundational Capabilities	\$ 129,068,000  38%	\$ 76,938,000  34%	\$ 52,129,000  49%
Leadership and Organizational Competencies	\$ 47,860,000  14%	\$ 32,455,000  14%	\$ 15,405,000  15%
Assessment and Epidemiology	\$ 31,984,000  10%	\$ 17,405,000  8%	\$ 14,578,000  14%
Emergency Preparedness and Response	\$ 12,214,000  4%	\$ 8,922,000  4%	\$ 3,292,000  3%
Community Partnership Development	\$ 9,941,000  3%	\$ 5,971,000  3%	\$ 3,970,000  4%
Policy and Planning	\$ 9,617,000  3%	\$ 4,400,000  2%	\$ 5,217,000  5%
Health Equity and Cultural Responsiveness	\$ 9,396,000  3%	\$ 4,412,000  2%	\$ 4,984,000  5%
Communications	\$ 8,056,000  2%	\$ 3,373,000  1%	\$ 4,683,000  4%
TOTAL	\$ 335,467,000	\$ 229,386,000	\$ 106,081,000

The Public Health Modernization Assessment resource estimates are presented in the table above.

The \$106M estimated additional cost increment represents the first step in an evolving process – it is a product of a particular time and place and likely doesn’t represent the final funding request needed to implement Public Health Modernization.

Both current spending and full implementation estimate that Foundational Programs represent approximately two-thirds of total costs.

However, full implementation rebalances some of these costs into Foundational Capability, with a 70% increase in Foundational Capabilities versus a 35% increase in Foundational Programs.

To reach full implementation, three Capabilities will require doubling current spending – Communications, Health Equity and Cultural Responsiveness, and Policy and Planning.

At the time of the assessment, cross-jurisdictional sharing conversations had just begun. Additionally, this estimate incorporates the current understanding of governmental public health, but true Public Health

Modernization will involve all providers opening a dialog about alternative service delivery options and funding.



COMMUNICABLE DISEASE CONTROL

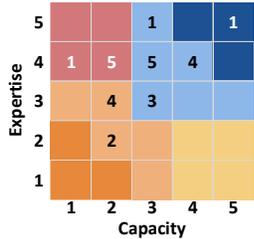
Ensure everyone in Oregon is protected from communicable disease threats.

PUBLIC HEALTH DIVISION
LEVEL OF IMPLEMENTATION

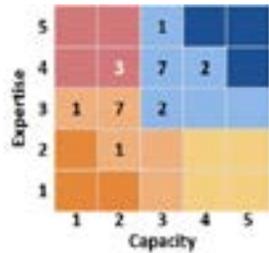
Significant



ROLES



DELIVERABLES

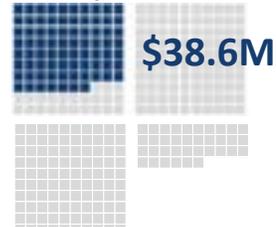


RESOURCES

Current Spending



Full Implementation



Additional Increment



Communicable Disease Control activities represent 25.7% of PHD’s current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Program’s share of state public health activities will decrease to 23.0%. A small additional increment of spending (\$2M) is needed to get PHD to full implementation. This will make the state activities for *Communicable Disease Control* the largest Foundational Program (out of 4) and largest Foundational Capability or Program (out of 11).

PHD’s *Communicable Disease Control* activities include 26 roles and 24 deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be only partially implemented. PHD also notes that only half of the roles and deliverables that represent *Communicable Disease Control* state activities are significantly or fully implemented. In fact, only 14 of the 26 roles and 12 of 24 deliverables are significantly or fully implemented.

A few of the less implemented roles and deliverables are state activities that directly support the provision of local *Communicable Disease Control* activities; these include:

- Provide disease-specific and technical expertise regarding epidemiologic and clinical characteristics to local public health authorities, health care professionals and others. Advise health care practitioners about evidence-based practices for communicable disease diagnosis, control, and prevention.
- Support local health departments as they investigate and control reportable diseases and outbreaks by providing technical assistance and surge capacity.
- Work with local public health to ensure adherence to Oregon Immunization Law, and collect and maintain records for reporting of school and children's facility immunization rates and vaccine exemptions.

In addition to these roles and deliverables that are directly applicable to the local health departments, there are a number of other deliverables that when fully implemented would benefit the LPHAs.

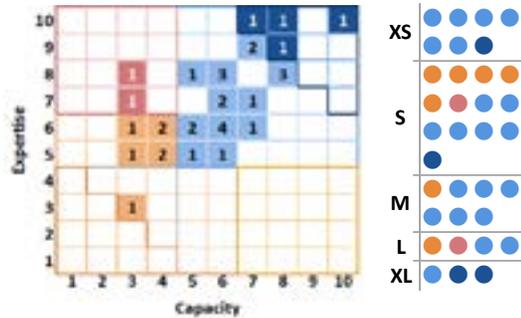
- Support staff working in local authorities to implement statewide disease control initiatives.

ASSESSMENT

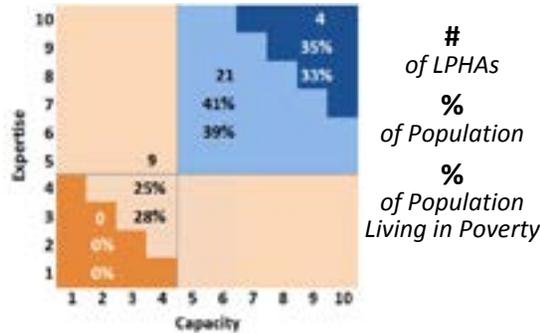
Communicable Disease Control

LOCAL PUBLIC HEALTH AUTHORITIES

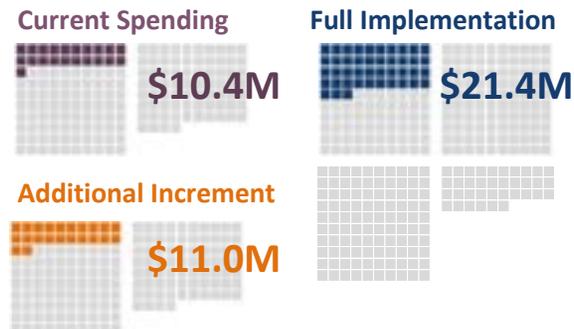
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



Communicable Disease Control activities represent 12% of LPHAs' current Public Health Modernization activities (as represented by current spending). At full implementation, the locals estimate that the Program's share of local public health activities will increase to 13%. An additional increment of spending (\$11M or approximately 105%) is needed to get LPHAs to full implementation. This will make the local activities for *Communicable Disease Control* the 3rd largest Foundational Program (out of 4) and 4th largest Foundational Capability or Program (out of 11).

Programmatically, this Foundational Program is relatively well-implemented, with 25 (out of 34) LPHAs documenting significant or full implementation.

Taken together with the programmatic findings, the large amount of additional spending (105%) needed to reach full implementation suggests a higher marginal cost associated with fully implementing than reaching significant implementation.

We identified two non-financial barriers to implementing this Foundational Program overall:

- Many LPHAs communicated that necessary data is inaccessible or outdated.
- In some counties, the pay scale is a barrier to recruiting the appropriate expertise.

Local *Communicable Disease Control* activities are broken down into four functional areas:

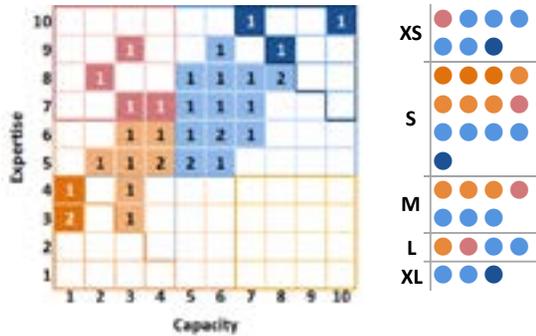
- 1. Communicable Disease Surveillance.** This functional area represents 20% of current local *Communicable Disease Control* activities; its share of local *Communicable Disease Control* activities would decrease to 17% at full implementation.
- 2. Communicable Disease Investigation.** This functional area represents 30% of current local *Communicable Disease Control* activities; at full implementation its share of local *Communicable Disease Control* activities remain unchanged (30%).
- 3. Communicable Disease Intervention and Control.** The most fully implemented functional area, it represents 40% of current local *Communicable Disease Control* activities. This share is expected to increase to 43% at full implementation with spending increasing 125%.
- 4. Communicable Disease Response Evaluation.** This is the least fully implemented functional area. It represents 11% of current local *Communicable Disease Control* activities and will remain relatively unchanged at full implementation (11%).

Following, we've provided profiles like this page for each of these four functional areas.

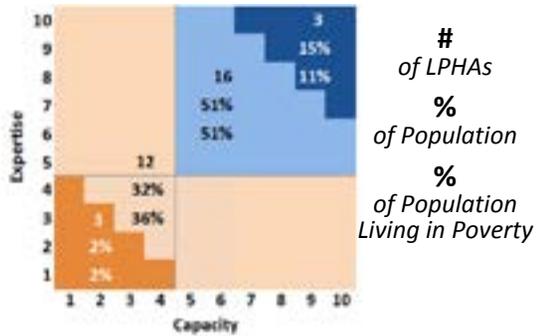
ASSESSMENT

Communicable Disease Control
Surveillance

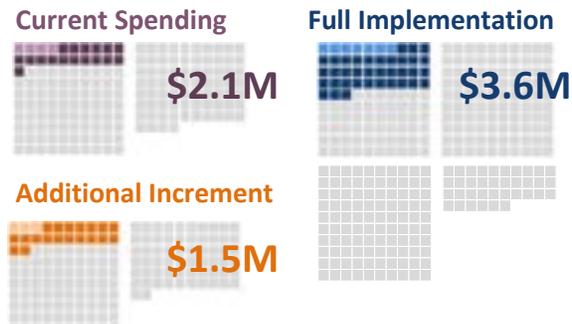
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 1:

Communicable Disease Surveillance

This is one of four functional areas that describe how local *Communicable Disease Control* activities are operationalized. This functional area represents 20% of current local *Communicable Disease Control* activities; its share of local *Communicable Disease Control* activities would decrease to 17% with the addition of 70% more funding (\$1.5M) to reach full implementation.

The degree of implementation of this functional area varies across the system. There is no clear pattern as to which LPHAs are at each level of implementation. A little more than one-half of providers have significantly or fully implemented these activities.

Implementation is similar from both a system and population service perspective. Approximately three-quarters of LPHAs have significantly or fully implemented and approximately three-quarters of residents are being served by an LPHA that is significantly or fully implemented.

The activities in the *Communicable Disease Surveillance* functional area include 2 roles and 2 deliverables. The degree of implementation of these roles and deliverables across local

providers and population by level of service are provided on the following page.

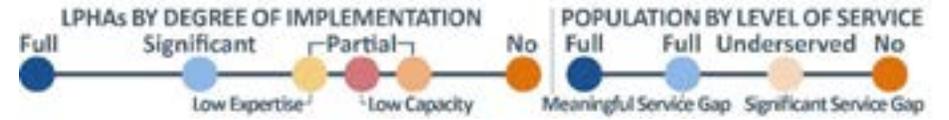
Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area's activities:

- (Functional Area) In some counties, the pay scale is causing difficulties in recruiting staff with appropriate expertise. This is causing vacancies and requiring more new-staff training and oversight.
- (Role 1) In some counties, LPHAs have local providers that do not report or receive reports from labs.
- (Role 2) LPHAs in some counties have no effective system for reviewing reports in a timely manner with existing part-time staff.

ASSESSMENT

Communicable Disease Control
Surveillance



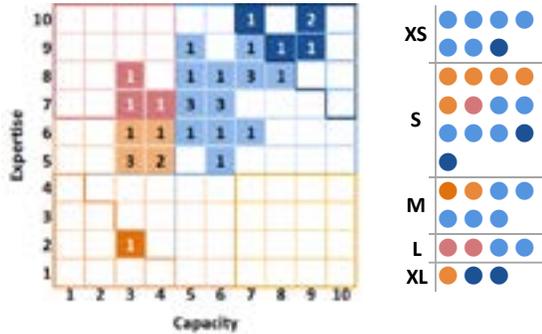
Communicable Disease Control

Communicable Disease Surveillance	Functional Area	Full	Significant	Partial	Low Expertise	Low Capacity	No	Full	Meaningful Service Gap	Underserved	Significant Service Gap
Ensure timely and accurate reporting of reportable diseases and educate local providers on reportable disease requirements.	Role 1	3	16	4	8	3	1	15%	51%	32%	1%
Monitor occurrence and distinguishing characteristics of infectious diseases and outbreaks.	Role 2	8	24	1	9			37%	54%	9%	
Produce timely reports of notifiable diseases.	Deliverable 3	8	16	1				37%	46%	17%	
Maintain portfolio of strategic partnerships with hospitals, health systems, providers, schools and other partners.	Deliverable 4	12	16	2	3	1		48%	46%	5%	
	Deliverable 4	7	20	1	5	1		26%	61%	12%	

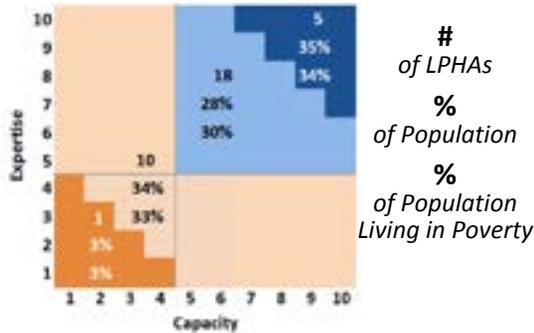
ASSESSMENT

Communicable Disease Control
Investigation

LPHA IMPLEMENTATION



POPULATION SERVICE



of LPHAs
% of Population
% of Population Living in Poverty

RESOURCES

Current Spending



Full Implementation



Additional Increment



COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 2:

Communicable Disease Investigation

This functional area represents 30% of current local *Communicable Disease Control* activities. This share is expected to remain relatively unchanged at full implementation (30%) with spending in this area increasing 105% (\$3.2M).

The degree to which this functional area is implemented varies across the system with no clear pattern as to which LPHAs are at each level of implementation. Approximately two-thirds of all LPHAs are at least significantly implemented. Almost half of small and large LPHAs are not fully implemented.

The population is serviced similarly, though to a decreased degree – 63% of Oregon residents live in a service area where these activities are present, while 68% of LPHAs are at least significantly implemented.

The activities included in the *Communicable Disease Investigation* functional area includes 5 roles and 5 deliverables. The degree of implementation of each of these roles and deliverables is fairly consistent across local providers, as shown on the following page.

Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area's activities:

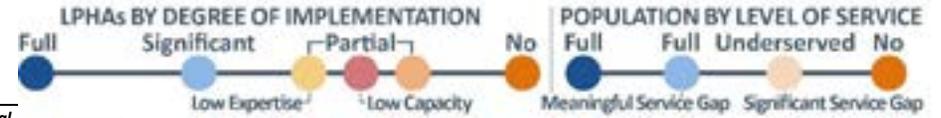
- (Functional Area) Data needed to perform these roles and provide the deliverables are often inaccessible or outdated.
- (Role 10). Some LPHAs communicated that there is confusion between state and locals about what information can and cannot be released.

ASSESSMENT

Communicable Disease Control
Investigation

Communicable Disease Control

Communicable Disease Investigation

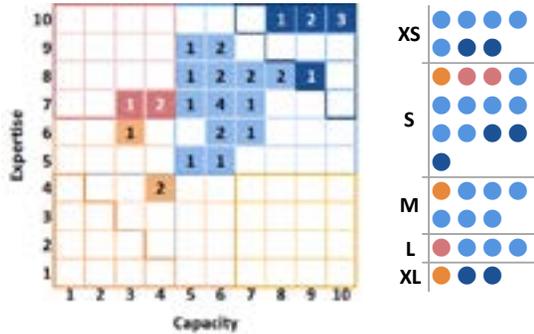


	Functional Area	Full	Significant	Partial	No	Full	Full Underserved	No		
		5	18	3	7	1	35%	28%	34%	3%
Maintain protocols and systems to ensure confidentiality throughout investigation, reporting and maintenance of data.	Role 3	16	18				65%	35%		
Investigate and control disease outbreaks within the authority, in collaboration with partners.	Role 1	7	21	3	2	1	37%	51%	11%	1%
Communicate clearly with members of the public in the authority about identified health risks.	Role 2	5	25	3	1		34%	53%	12%	
Summarize and share data to determine opportunities for intervention and to guide policy and program decisions.	Role 4	4	16	1	11	2	38%	33%	28%	1%
Collaborate with the state in a culturally responsive way on disease prevention and control initiatives and statewide and local health policies.	Role 5	6	17	2	9		36%	32%	32%	
Provide individual communicable disease case and outbreak data, consistent with Oregon statute, rule and program standards.	Deliverable 8	12	21		1		60%	39%	1%	
Secure personally identifiable data collected through audits, review, update and verification.	Deliverable 7	17	15		1	1	77%	21%	1%	
Document implementation of investigative guidelines appropriately.	Deliverable 6	14	17	1	2		65%	32%	2%	
Maintain protocols for proper preparation, packaging and shipment of samples of public health importance (e.g., animals and animal products).	Deliverable 9	8	22		4		16%	79%	5%	
Provide communications with the public about outbreak investigations.	Deliverable 10	6	22	2	3	1	35%	49%	15%	

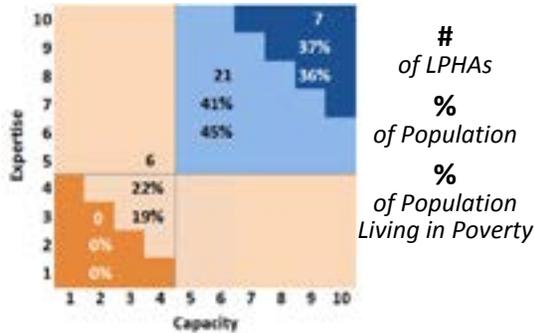
ASSESSMENT

Communicable Disease Control
Intervention and Control

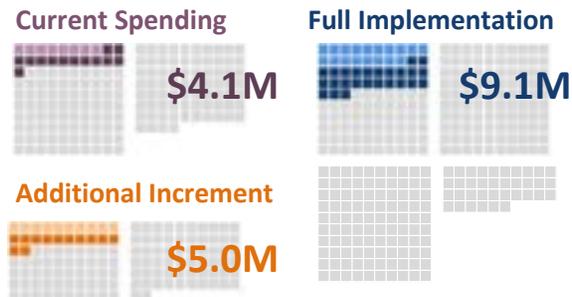
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 3:

Communicable Disease Intervention and Control

Communicable Disease Intervention and Control is the most implemented functional area, representing just 40% of current local *Communicable Disease Control* activities. This share is expected to increase to 43% at full implementation with the spending in this area increasing 125%.

Currently, this functional area has a high degree of implementation (82%) with only 18% of LPHAs at partial or no implementation. There is no clear pattern as to which LPHAs are at each level of implementation, with the size of those only partially implemented varying from small to extra-large.

This degree of implementation is consistent from a population service perspective – more than three-quarters (78%) of Oregon residents live in a service area where these activities are present, and over three-quarters of LPHAs (80%) have significantly or fully implemented this functional area.

The activities included in the *Communicable Disease Intervention and Control* functional area include 11 roles and 6 deliverables. The degree of implementation of each of these roles and deliverables across local providers and

population by level of service are provided on the following page.

Non-Financial Barriers

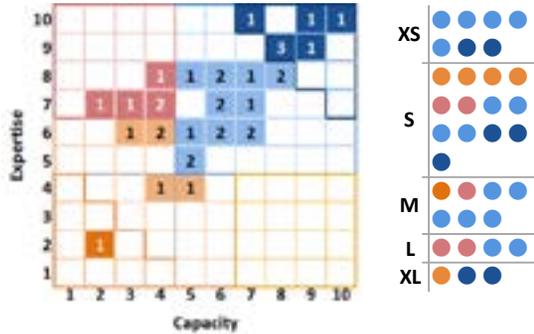
LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area’s activities:

- (Functional Area) In some counties, LPHAs are unable to hire appropriate expertise at the current pay scale.
- (Role 1) In some communities, although vaccines are accessible and LPHAs provide education around vaccines, some families choose not to immunize.
- (Role 8) Some counties communicated a lack of knowledge around culturally responsive strategies and a desire for more training.

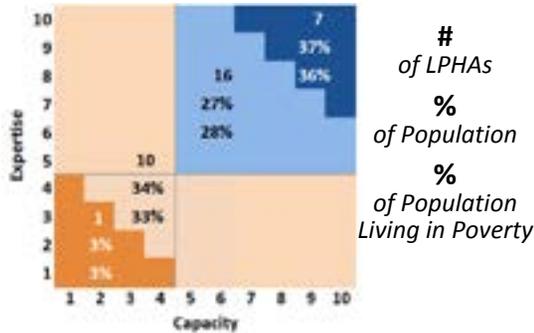
ASSESSMENT

Communicable Disease Control
Intervention and Control

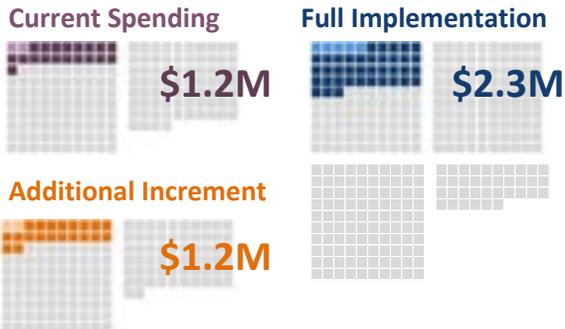
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 4:

Communicable Disease Response Evaluation

Communicable Disease Response Evaluation is the least implemented functional area, representing just 11% of current local *Communicable Disease Control* activities. LPHAs indicated it would cost them an additional \$1.2M (a 99% increase) to reach full implementation, at which point this program would represent a relatively unchanged share (11%) of local *Communicable Disease Control* activities.

Currently, the degree of implementation of this functional area varies across the system. The majority of extra-small, medium, large and extra-large providers have significantly or fully implemented this functional area, while the majority of partially or not implemented LPHAs are all small.

This degree of implementation is consistent from a population service perspective – two-thirds of the system is significantly or fully implemented and approximately two-thirds (64%) of Oregon residents live in a service area where these activities are present.

The activities included in the **Communicable Disease Response Evaluation** functional area include 1 role and 3 deliverables. The degree of implementation of each of these roles and

deliverables across local providers and population by level of service are provided on the following page.

Non-Financial Barriers

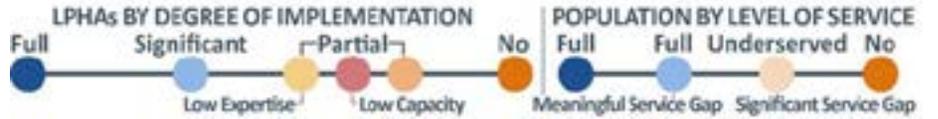
LPHAs identified one barrier to implementing the roles and deliverables that make up this functional area's activities:

- (Deliverable 4) Some LPHAs identified that there is no process for systematic evaluation of presentations and publications.

ASSESSMENT

Communicable Disease Control

Response Evaluation



Communicable Disease Control

Communicable Disease Response Evaluation

		Full	Significant	Partial	No	Full	Full Underserved	No		
Functional Area 4		7	16	5	5	1	37%	27%	34%	3%
Work with the OHA Public Health Division to evaluate disease control investigations and interventions. Use findings to improve these efforts.	<i>Role 1</i>	7	19	1	6	1	37%	51%	11%	1%
Document assessments of outbreak investigation and response efforts, both conducted by state and by local public health.	<i>Deliverable 3</i>	5	21	2	4	2	35%	56%	8%	1%
Document results of quality and process improvement initiatives.	<i>Deliverable 2</i>	2	17	1	12	2	14%	63%	34%	1%
Evaluate presentations and publications.	<i>Deliverable 4</i>	2	15	3	11	3	14%	47%	36%	4%



ENVIRONMENTAL PUBLIC HEALTH

Environmental health works to prevent disease and injury, eliminate disparate impact of environmental health risks and threats on population subgroups, and create health-supportive environments in which everyone in Oregon can thrive.

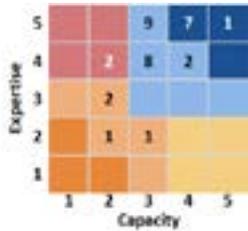
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

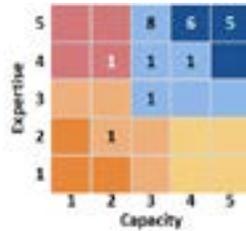
**Partial,
Low Capacity**



ROLES

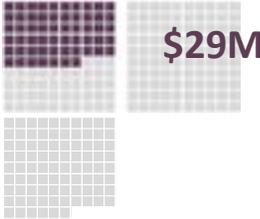


DELIVERABLES

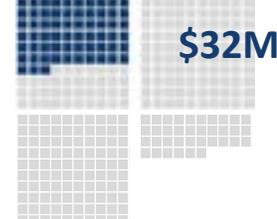


RESOURCES

Current Spending



Full Implementation



Additional Increment



Environmental Public Health activities represent 20% of PHD’s current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Program’s share of state public health activities will decrease to a little less than 19%. A small additional increment of spending (\$3M) is needed to get PHD to full implementation. This will make the state activities for *Environmental Public Health* the 2nd largest Foundational Program (out of 4) and 4th largest Foundational Capability or Program (out of 11).

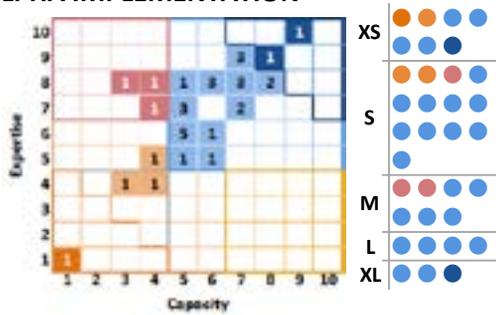
PHD’s *Environmental Public Health* activities include 33 roles and 24 deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be only partially implemented, with low capacity. However, PHD also notes that the majority of the roles and deliverables that represent *Environmental Public Health* state activities are significantly or fully implemented. In fact, 27 of the 33 roles and 22 of 24 deliverables are significantly or fully implemented.

A few of the less implemented roles and deliverables are state activities that directly support the provision of local *Environmental Public Health* activities; these include:

- Support capacity-building efforts at the local and regional level to assess and address emerging environmental public health issues.
- Conduct health analyses for organizations and recommend approaches to ensure healthy and sustainable built and natural environments.
- Serve as a liaison and convener between local public health and state/federal natural resource agencies on environmental health issues.
- Maintain information systems to provide current and accurate information to support environmental health functions at the state and local level.

LOCAL PUBLIC HEALTH AUTHORITIES

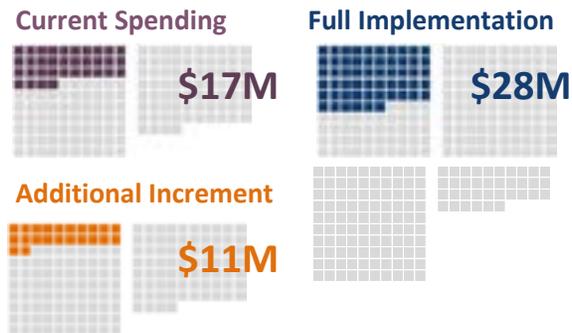
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



Environmental Public Health activities represent 20% of LPHAs' current Public Health Modernization activities (as represented by current spending). At full implementation, LPHAs estimate that the Program's share of local public health activities will decrease to a little less than 17%. A significant additional increment of spending (\$11M or approximately 65%) is needed to get LPHA to full implementation. This will make local activities for *Environmental Public Health* the 3rd largest Foundational Program (out of 4) and 4th largest Foundational Capability or Program (out of 11).

Programmatically, this Foundational Program is relatively well-implemented, with 27 (out of 34) LPHAs documenting significant or full implementation.

Taken together with the programmatic findings, the large amount (65%) of additional spending needed to reach full implementation suggests that the increase from significantly implemented to fully implemented has higher marginal costs than the initial activities needed to reach significant implementation.

We identified one non-financial barrier to implementing this Foundational Program overall:

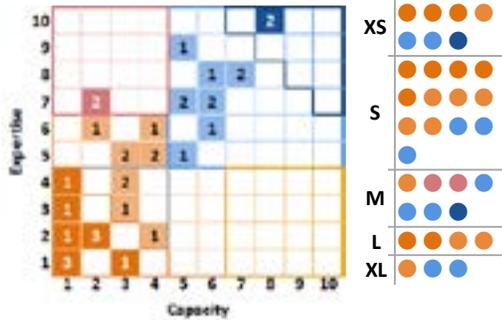
- In some counties, LPHAs are unable to hire appropriate expertise at the current pay scale.

Local *Environmental Public Health* activities are broken down into three functional areas:

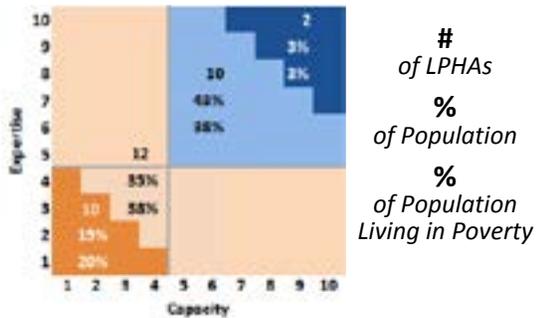
- 1. Identify and Prevent Environmental Health Hazards.** This functional area represents 24% of current local *Environmental Public Health* Activities; its share of local *Environmental Public Health* activities would decrease to 22% at full implementation.
- 2. Conduct Mandated Inspections.** This represents the majority (72%) of current local *Environmental Public Health* activities and will remain the largest (66%) share of local activities in this Foundational Program at full implementation. This functional area also appears to be the most implemented (with all but two LPHAs citing that they have significantly implemented it).
- 3. Promote Land Use Planning.** This is the least implemented functional area. It currently represents 4% of current local *Environmental Public Health* activities. This share is expected to increase to 12% at full implementation with the spending in this area increasing 345%.

Following, we've provided profiles like this page for each of these three functional areas.

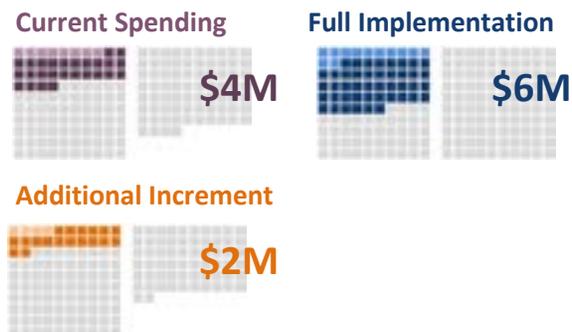
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



ENVIRONMENTAL PUBLIC HEALTH FUNCTIONAL AREA 1:

Identify and Prevent Environmental Health Hazards

This is one of three functional areas that describe how local *Environmental Public Health* activities are operationalized. This functional area represents 24% of current local *Environmental Public Health* activities; its share of local *Environmental Public Health* activities would decrease to 22% with the addition of 50% more funding (\$2M) to reach full implementation.

The degree of implementation of this functional area varies across the system. There is no clear pattern as to which LPHAs are at each level of implementation. A little more than one-third of providers have significantly or fully implemented these activities.

This is more balanced from a population service perspective: 56% of Oregon residents live in a service area where they are underserved or unserved, while 46% live in a service area where these activities are present (however, there is a meaningful gap in service for a large percentage of those services).

The activities in the *Identify and Prevent Environmental Health Hazards* functional area include 15 roles and 2 deliverables. The degree of implementation of these roles and

deliverables across local providers and population by level of service are provided on the following page.

Non-Financial Barriers

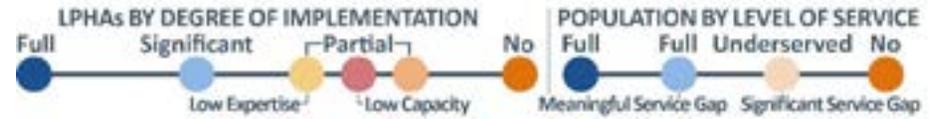
LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area’s activities:

- (Functional Area) In some counties, LPHAs are unable to hire appropriate expertise at the current pay scale.
- (Functional Area) State and local regulations are insufficient to ensure timely enforcement of hazards regulations.
- (Role 3) Capacity is dedicated to fee-for-service environmental inspection programs.
- (Role 10) Vector control programs in some counties are under the jurisdiction of each city/town and are not countywide. Therefore, public health is not involved in vector control programs locally.
- (Role 12) In some counties, there is limited regulatory authority to enforce regulations in institutional settings.

ASSESSMENT

Environmental Public Health

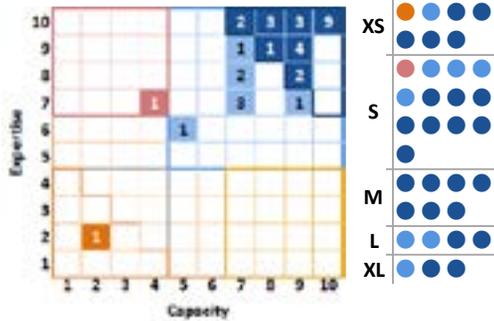
Identify and Prevent Environmental Health Hazards



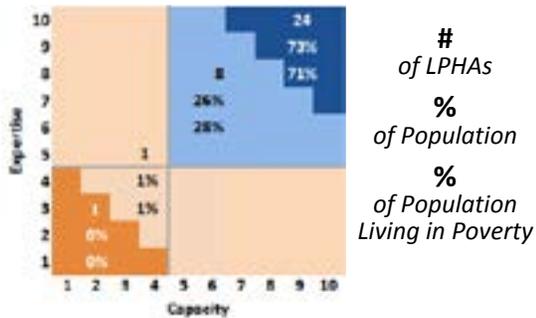
Environmental Public Health

Identify and Prevent Environmental Health Hazards	Functional Area	Full	Significant	Partial	No	Full (Meaningful Service Gap)	Full (Significant Service Gap)	Underserved	No
Identify and Prevent Environmental Health Hazards	Functional Area	2	10	2	10	10	10	10	10
Ensure consistent application of health regulations and policies.	Role 2	14	18	1	1	57%	41%	1%	1%
Implement state-mandated programs where appropriate (i.e., small drinking water systems, septic oversight).	Role 3	9	20	1	4	35%	62%	1%	1%
Develop, implement and enforce environmental health regulations.	Role 1	5	22	1	5	17%	76%	7%	1%
Maintain expertise in relevant environmental health topics.	Role 9	5	19	1	1	8	5%	84%	10%
Use environmental health expertise to address accident and disease prevention in institutional environments (longer-term care, assisted living, child care, etc.)	Role 12	2	11	5	13	3	3%	71%	25%
Deliver effective and timely outreach on environmental health hazards and protection recommendations to regulated facilities, the public and stakeholder organizations.	Role 14	6	12	7	6	3	25%	48%	26%
Ensure that environmental health is included in the community health assessment every five years.	Role 5	4	15	2	5	8	44%	25%	12%
Assure the development and maintenance of the ambulance service area plan.	Role 7	3	9	3	6	13	17%	43%	12%
Inform decision makers of the impacts to environmental public health based on program, project and policy decisions.	Role 11	5	10	2	10	7	25%	35%	27%
Monitor, investigate, and control infectious and noninfectious vector nuisances and diseases.	Role 8	3	11	3	15	2	20%	28%	50%
Measure the impact of environmental hazards on the health outcomes of priority/focal populations. Analyze and communicate environmental justice concerns and disparities.	Role 6	1	6	2	9	16	20%	27%	22%
Provide evidence based assessment of the health impacts of environmental hazards or conditions.	Role 4	10	2	12	10	44%	32%	24%	
Provide consultation and technical assistance including establishing best practices related to vector control.	Role 10	2	11	4	12	5	20%	24%	36%
Ensure meaningful participation of communities experiencing environmental health threats and inequities in programs and policies designed to serve them.	Role 15	2	8	2	15	7	20%	16%	42%
Use environmental health expertise to reduce hazardous exposures from air, land, water, and other exposure pathways.	Role 13	2	7	6	14	5	27%	56%	16%
Document communications on environmental health hazards and protection recommendations to regulated facilities, the public and stakeholder organizations.	Deliverable 17	5	20	1	5	3	37%	54%	8%
Produce policy briefs and other communications on the impacts to environmental public health.	Deliverable 16	3	5	5	10	11	34%	15%	30%

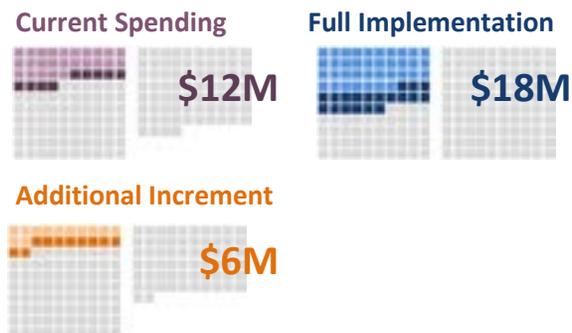
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



ENVIRONMENTAL PUBLIC HEALTH FUNCTIONAL AREA 2:

Conduct Mandated Inspections

This functional area represents the majority (72%) of current local *Environmental Public Health* activities. While this functional area also appears to be the most implemented, with all but two LPHAs citing that they have significantly implemented it, LPHAs noted that they need a large additional increment of funding (50%) to reach full implementation.

This functional area is highly implemented across the system. Only two LPHAs—one extra small and one small—are not at least significantly implemented. These LPHAs are outliers, and because inspections are mandated it is likely that another provider or agency is supporting these activities in that service area.

Taken together with this programmatic finding, the large amount (50%) of additional spending needed to reach full implementation suggests that the increase from significantly implemented to fully implemented has higher marginal costs than the initial activities needed to reach significant implementation.

This is consistent from a population service perspective – 99% of Oregon residents live in a service area where these activities are present. However, about a one-quarter (26%) of those

services are delivered such that there is a meaningful gap in service.

The activities included in the **Conduct Mandated Inspections** functional area includes 5 roles and 4 deliverables. The degree of implementation of each of these roles and deliverables across local providers and population by level of service are provided on the following page. Only one of these activities is far from full implementation, this role (role 5) is to “Conduct ongoing environmental and occupational health surveillance.”

Non-Financial Barriers

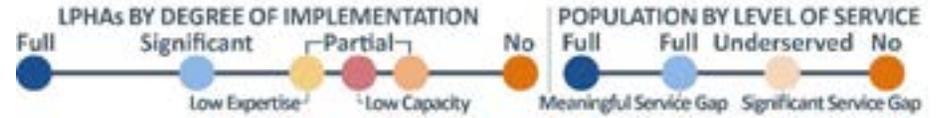
LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area’s activities:

- (Role 1) Providing licensing of recreational facilities and tourist accommodations were cited as weaker areas where LPHAs could benefit from additional state training and guidance.
- (Role 4) Some LPHAs have a limited ability to hire adequately to support surge during outbreak investigations.
- (Role 5) Capacity is dedicated to fee-for-service environmental inspection programs.

ASSESSMENT

Environmental Public Health

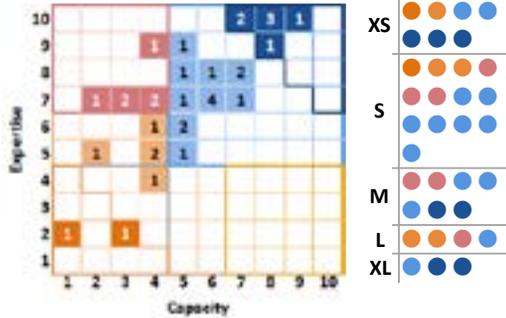
Conduct Mandated Inspections



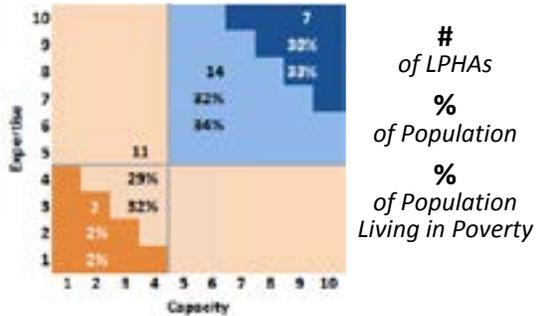
Environmental Public Health

Conduct Mandated Inspections	functional area	Full	Significant	Partial	No	Full	Full Underserved	No	
		24	8	1	1	73%	26%	1%	
Provide licensing and certification of recreational facilities, food service facilities and tourist accommodations.	Role 1	19	15			47%	53%		
Conduct timely inspection and review of regulated entities and facilities.	Role 2	19	15			44%	56%		
Perform and assist with outbreak investigations that have an environmental component.	Role 4	4	28	1	1	35%	64%	1%	
Enforce regulations.	Role 3	9	22	2	1	41%	55%	4%	
Conduct ongoing environmental and occupational health surveillance.	Role 5	2	10	3	12	7	46%	42%	11%
Document provision of licensing and certification of recreational facilities, food service facilities and tourist accommodations .	Deliverable 6	22	11	1			79%	20%	
Document reports of inspection and review of regulated entities and facilities.	Deliverable 7	21	12	1			69%	30%	
Document enforcement of regulations.	Deliverable 8	19	13	1	1		65%	33%	3%
Consult for the food service industry and the general public.	Deliverable 9	14	15	2	3		61%	24%	14%

LPHA IMPLEMENTATION

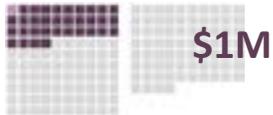


POPULATION SERVICE



RESOURCES

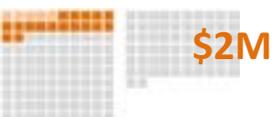
Current Spending



Full Implementation



Additional Increment



ENVIRONMENTAL PUBLIC HEALTH FUNCTIONAL AREA 3:

Promote Land Use planning

Promote Land Use Planning is the least implemented functional area, representing just 4% of current local Environmental Public Health activities. This share is expected to increase to 12% at full implementation with the spending in this area increasing 345%.

Currently, the degree of implementation of this functional area varies across the system. There is no clear pattern as to which LPHAs are at each level of implementation. A little more than two-thirds of providers have significantly or fully implemented these activities.

This degree of implementation is consistent from a population service perspective – approximately two-thirds (67%) of Oregon residents live in a service area where these activities are present (however, about half of those services are delivered such that there is a meaningful gap in service).

The activities included in the *Promote Land Use Planning* functional area include 5 roles and 5 deliverables. The degree of implementation of each of these roles and deliverables across local providers and population by level of service are provided on the following page.

Non-Financial Barriers

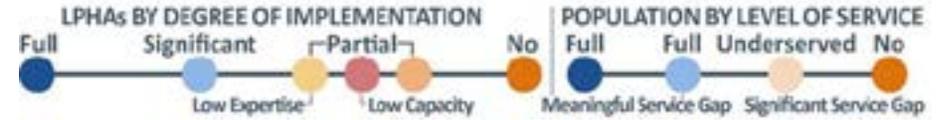
LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area’s activities:

- (Functional Area) In some counties, LPHAs are unable to hire appropriate expertise at the current pay scale.
- (Functional Area) State and local regulations are insufficient to ensure timely enforcement of hazards regulations.
- (Role 3) Capacity is dedicated to fee-for-service environmental inspection programs.
- (Role 10) Vector control programs in some counties are under the jurisdiction of each city/town and are not countywide. Therefore, public health is not involved in vector control programs locally.
- (Role 12) In some counties, there is limited regulatory authority to enforce regulations in institutional settings.

ASSESSMENT

Environmental Public Health

Promote Land Use Planning



Environmental Public Health

		Full	Significant	Partial	No	Full	Full Underserved	No		
Promote Land Use Planning	<i>functional area</i>	7	14	6	5	2	38%	32%	29%	2%
Provide consultation and technical assistance to the food service industry and the general public.	<i>Role 4</i>	15	18	1			48%	52%		
Maintain relationships with partners in local economic development, transportation, parks, and land use agencies.	<i>Role 3</i>	3	13	4	11	3	22%	38%	32%	9%
Provide technical assistance to integrate standard environmental public health practices into facilities that present high risk for harmful environmental exposures or	<i>Role 5</i>	6	12	4	7	5	25%	35%	28%	12%
Understand and participate in local land use and transportation planning processes.	<i>Role 2</i>	8	5	10	11		49%	31%	19%	
Conduct health analyses for other organizations and recommend approaches to ensure healthy and sustainable built and natural environments.	<i>Role 1</i>	8	4	9	13		49%	25%	26%	
Document integration of standard environmental public health practices into facilities that present high risk for harmful environmental exposures or disease transmission.	<i>Deliverable 10</i>	6	13	1	9	5	40%	39%	18%	3%
Produce community health assessments that includes environmental health produced at least every five years.	<i>Deliverable 6</i>	4	11	3	11	5	35%	26%	31%	8%
Write best practices related to vector control.	<i>Deliverable 9</i>	2	8	4	8	12	20%	30%	24%	26%
Prepare health analyses for other organizations and recommend approaches to ensure healthy and sustainable built and natural environments.	<i>Deliverable 7</i>	3	6	2	9	14	34%	14%	31%	21%
Communicate environmental justice concerns and disparities.	<i>Deliverable 8</i>	2	4	4	8	16	20%	17%	17%	46%



PREVENTION AND HEALTH PROMOTION

The public health system prevents and reduces harms from chronic diseases and injuries through policy change, enhanced community systems and practices, and improved health equity that support the health and development of Oregonians across the lifespan.

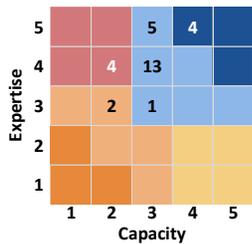
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

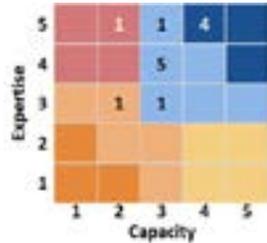
Significant



ROLES

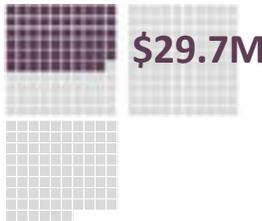


DELIVERABLES

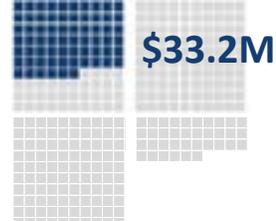


RESOURCES

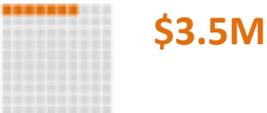
Current Spending



Full Implementation



Additional Increment



Prevention and Health Promotion activities represent 21% of PHD’s current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Program’s share of state public health activities will stay relatively flat. A small additional increment of spending (\$3.5M) is needed to get PHD to full implementation. This will make the state activities for *Prevention and Health Promotion* the second largest Foundational Program (out of four) and second largest Foundational Capability or Program (out of 11).

PHD’s *Prevention and Health Promotion* activities include 29 roles and 13 deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be significantly implemented. PHD reported that the majority of the roles and deliverables that represent *Prevention and Health Promotion* state activities are significantly or fully implemented. In fact, 23 of the 29 roles and 11 of 13 deliverables are significantly or fully implemented.

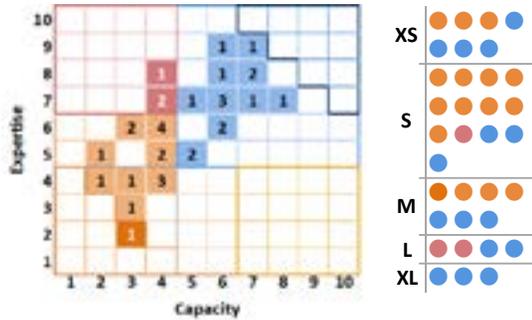
A few of the less implemented roles and deliverables are state activities that directly support the provision of local *Prevention and Health Promotion* activities, including:

postnatal care, and childhood and maternal health, physical activity, and intentional and unintentional injuries. Make data available at the local level.

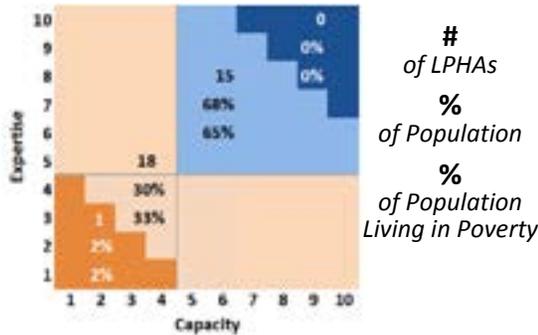
- Develop multi-faceted strategies designed to address social determinants of health.

LOCAL PUBLIC HEALTH AUTHORITIES

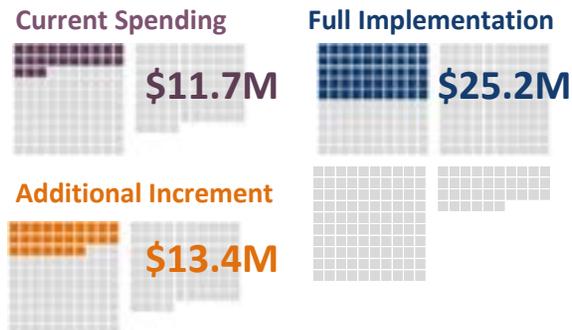
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



Prevention and Health Promotion activities represent 14% of the LPHAs' current Public Health Modernization spending. At full implementation, the LPHAs estimate that the Program's share of local public health activities will increase to 15%. The LPHAs estimated an additional \$13.4M is needed for full implementation of Public Health Modernization at the local level. This is a significant additional increment from the current spending of \$11.7M. At full implementation, the local activities in *Prevention and Health Promotion* are the second largest Foundational Capability or Program.

LPHAs rated this Foundational Program as not fully implemented, with only 15 out of 34 LPHAs documenting significant implementation and no LPHAs reporting full implementation.

No non-financial barriers to implementing this Foundational Program overall were identified. However, LPHAs identified barriers for individual roles and deliverables, which are included on the next page.

Local *Prevention and Health Promotion* activities are broken down into five functional areas:

- 1. Prevention of Tobacco Use.** This functional area represents 33% of current local *Prevention and Health Promotion* activities; its share would decrease to 20% at full implementation. The activities included in *Prevention of Tobacco Use* are the least implemented of the five functional areas.
- 2. Improving Nutrition and Increasing Physical Activity.** This represents 15% of current local *Prevention and Health Promotion* activities and will maintain that share at full implementation.
- 3. Improving Oral Health.** The smallest portion of this Program, these activities represent 5% of current local *Prevention and Health Promotion* spending and would be 12% at full implementation.
- 4. Improving Maternal and Child Health.** Representing 37% of current local Public Health Modernization, this functional area is the largest within this Program and will remain the largest at full implementation.
- 5. Reducing Accident Rates.** This functional area is the second smallest spending area, at 10%. The LPHAs estimate that spending at full implementation would be 19%, an increase of over 300%.

Non-Financial Barriers

LPHAs identified non-financial barriers specific to the ***Prevention of Tobacco Use*** functional area, although many of the barriers identified for *Prevention and Health Promotion* would be applicable:

- (Roles 1, 2, 3, 4, and 5) LPHAs identified data access and availability as a consistent barrier. For some areas, data are not currently collected.
- (Roles 10 and 11) Competition between health and social service providers hinders cooperation.
- (Roles 7, 9, 10, 12, 22) LPHAs requested greater access to tools on engaging community partners and targeted advocacy.
- (Role 7) One LPHA reported that the state Tobacco Prevention and Education Program does permit consumer education.
- (Role 25) Local political barriers restrict some LPHAs from enacting policies.

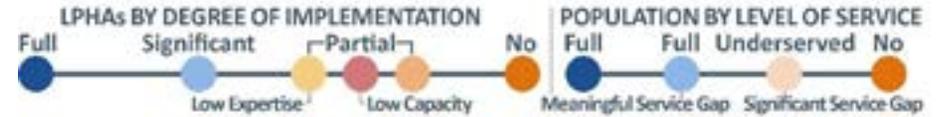
Unlike the other Foundational Programs and Capabilities, the roles and deliverables within *Prevention and Health Promotion* were not assigned to functional areas. The Public Health Modernization activities required for *Prevention and Health Promotion* are located across functional areas and are not tied to specific prevention and health areas.

The degree of implementation of all 27 roles and 14 deliverables across local providers and population by level of service are provided on the following four pages.

Following the implementation levels for roles and deliverables are profiles for each of the five functional areas.

ASSESSMENT

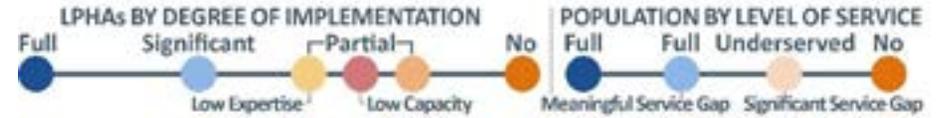
Prevention and Health Promotion



Prevention and Health Promotion	Foundational Program	1	7	2	9	15	29%	42%	26%
Provide input and guidance to the OHA Public Health Division on statewide planning.	Role 20	5	13	2	12	2	28%	56%	14%
Adhere to local, state and federal guidance, standards, and laws (e.g. guidance from CDC's Office on Smoking and Health, or state guidelines for healthy eating and active living).	Role 24	7	21	1	2	3	28%	67%	5%
Develop strategic, cross-sector partnerships and collaborations, across systems and settings, related to the functional areas with Prevention and Health Promotion, plus programs identified in the CHIP and behavioral health issues pertinent to health outcomes in this program.	Role 9	6	17	3	7	1	27%	59%	13%
Develop and implement community health improvement plan (CHIP) priorities for prevention and health promotion, revised at least every 5 years with annual updates.	Role 17	6	20		8		27%	63%	10%
Use community health assessment data and other relevant data sources to inform or identify priorities and develop planning documents.	Role 5	6	18		9	1	27%	66%	7%
Collaborate with the OHA Public Health Division to maintain subject matter expertise in policy, systems, and environmental change; best practices; social determinants of health; and, prevention and health promotion areas.	Role 15	5	16	4	6	3	27%	37%	35%
Include policies, programs, and strategies related to the functional areas with Prevention and Health Promotion, plus programs identified in the CHIP and behavioral health issues pertinent to health outcomes in this program.	Role 16	3	16	4	9	2	25%	52%	22%
Educate consumers about health impacts of unhealthy products like tobacco or sugary drinks, or health-protective products like car seats.	Role 7	5	12	5	9	3	24%	55%	18%
Build relationships with community partners who work with priority/focal populations.	Role 11	8	22	2	2		19%	75%	5%
Work with partners, stakeholders, and community members to identify community assets and understand community needs and priorities.	Role 12	6	21	3	2	2	19%	74%	6%
Align prevention and health promotion priorities across the CHIP, the LPHA's strategic plan, and other relevant internal and community planning documents.	Role 19	5	18	1	9	1	18%	71%	10%
Communicate information about the functional areas with Prevention and Health Promotion, plus programs identified in the CHIP and behavioral health issues pertinent to health outcomes in this program.	Role 6	4	17	2	10	1	17%	61%	22%

ASSESSMENT

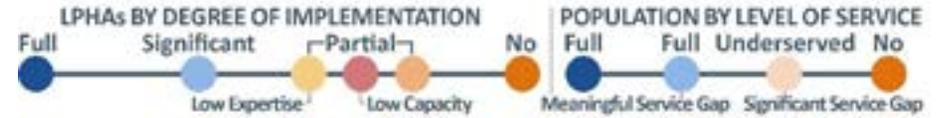
Prevention and Health Promotion



Role	Full	Significant	Partial	No	Full	Full Underserved	No		
Develop multi-faceted strategies designed to address social determinants of health.	3	10	3	11	7	17%	34%	34%	15%
Measure differences and trends in risk factors and burden of disease among diverse populations, or use information provided by PHD to monitor differences and trends.	2	13	1	2	13	3	15%	45%	39%
Demonstrate to communities, partners, policy makers, and others the connection between early prevention and educational achievement other outcomes.	3	14	3	12	2	11%	69%	18%	
Work with partners and stakeholders to develop and advance a common set of priorities, strategies and outcome measures, employing coalition building, community organizing, capacity building, and providing technical assistance to partners.	4	19	1	2	7	1	75%	19%	
Collaborate with partners and engage community leaders to identify and seek funding for prevention and health promotion programs and interventions.	3	22	1	6	2	78%	18%		
Develop and implement strategies in the CHIP intended to reduce the burden of health disparities. Include equity indicators to monitor the impact of interventions designed to improve health equity.	2	14	2	12	4	68%	26%		
Work with communities to build community capacity, community empowerment and community organizing. Support community action to assure policies that promote health and protection from unhealthy influences.	3	14	2	12	3	57%	38%		
Use surveillance data collected by the OHA Public Health Division and use assessment and epidemiology methods for the functional areas with Prevention and Health Promotion, plus programs identified in the CHIP and behavioral health issues pertinent to health outcomes in this program.	2	19	1	11	1	71%	25%		
Provide program funding to community partners to implement identified work.	2	3	7	8	14	15%	62%	20%	
Develop policy, systems, and environmental change strategies to improve health outcomes using problem identification, policy analysis, strategy and policy development, enactment, implementation, and evaluation.	1	12	1	16	4	67%	30%		

ASSESSMENT

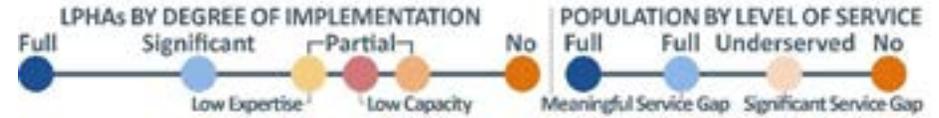
Prevention and Health Promotion



Activity	Role/Deliverable	Full	Significant	Partial	No	Full	Full Underserved	No	
Assess health status across the lifespan.	Role 2	1	17	3	9	4	61%	35%	
Monitor knowledge, attitudes, behaviors and health outcomes related to tobacco, nutrition, oral health, prenatal, natal and postnatal care, and childhood and maternal health, physical activity, and intentional and unintentional injuries by using data provided by the OHA Public Health Division or by conducting surveillance locally.	Role 3	1	11	3	16	3	55%	42%	
Implement programs and interventions for the functional areas with Prevention and Health Promotion, plus programs identified in the CHIP and behavioral health issues pertinent to health outcomes in this program.	Role 22	1	17	4	9	3	62%	35%	
Develop, use, and disseminate innovative, emerging, and evidence-based best practices.	Role 27	1	12	6	8	7	49%	40%	11%
With stakeholders, develop and implement an evaluation plan for the functional areas with Prevention and Health Promotion, plus programs identified in the CHIP and behavioral health issues pertinent to health outcomes in this program.	Role 26	8	5	13	8	29%	61%	10%	
Document participation or leadership in local coalitions.	Deliverable 33	9	17	3	5	30%	59%	10%	
Document shared priorities and strategies with partners and stakeholders.	Deliverable 32	7	15	3	8	1	30%	47%	20%
Document trainings and other learning opportunities made available to partners, stakeholders and community members.	Deliverable 35	5	19	3	4	3	26%	63%	8%
CHIP includes strategies intended to reduce the burden of health disparities.	Deliverable 38	3	23	1	6	1	25%	50%	24%
Maintain portfolio of partners and stakeholders, including local organizations that work with priority/focal populations.	Deliverable 31	5	15	4	7	3	20%	51%	24%
Document implementation and coordination of policies, programs, and strategies for the functional areas with Prevention and Health Promotion, plus programs identified in	Deliverable 39	2	17	4	8	3	16%	67%	15%

ASSESSMENT

Prevention and Health Promotion

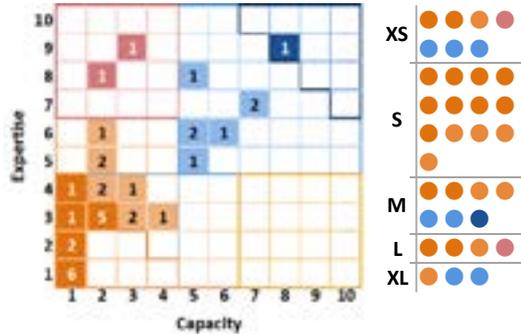


Deliverable Description	Deliverable ID	Full	Significant	Partial	No	Full	Full Underserved	No		
Document strategies employed to share data, summaries and reports with communities, partners, policy makers and others.	Deliverable 29	3	13	3	13	2	16%	31%	52%	
Document work with community to build capacity and support community organizing efforts.	Deliverable 34	6	17	2	4	5	13%	66%	7%	13%
Evaluate plans developed and implemented, and share results.	Deliverable 41	2	10	5	14	3	55%	38%		
Implement, monitor and revise the community health improvement plan at least every five years with updates annually.	Deliverable 37	2	21	3	8		63%	34%		
Secure local funds for prevention and health promotion programs and interventions.	Deliverable 40	1	12	7	13	1	47%	50%		
Prepare local summaries, reports, and information for the functional areas with Prevention and Health Promotion, plus programs identified in the CHIP and behavioral health issues pertinent to health outcomes in this program.	Deliverable 28	1	18	1	11	3	76%	14%	10%	
Document strategies employed to educate consumers about the impact on health of marketing strategies.	Deliverable 30	1	8	4	14	7	36%	49%	15%	
Publish local prioritized plan.	Deliverable 36	1	18	7	5	3	56%	40%		
Evaluate plans developed and implemented, and share results.	Deliverable 41	2	10	5	14	3	55%	38%		
Implement, monitor and revise the community health improvement plan at least every five years with updates annually.	Deliverable 37	2	21	3	8		63%	34%		
Secure local funds for prevention and health promotion programs and interventions.	Deliverable 40	1	12	7	13	1	47%	50%		
Prepare local summaries, reports, and information for the functional areas with Prevention and Health Promotion, plus programs identified in the CHIP and behavioral health issues pertinent to health outcomes in this program.	Deliverable 28	1	18	1	11	3	76%	14%	10%	
Document strategies employed to educate consumers about the impact on health of marketing strategies.	Deliverable 30	1	8	4	14	7	36%	49%	15%	

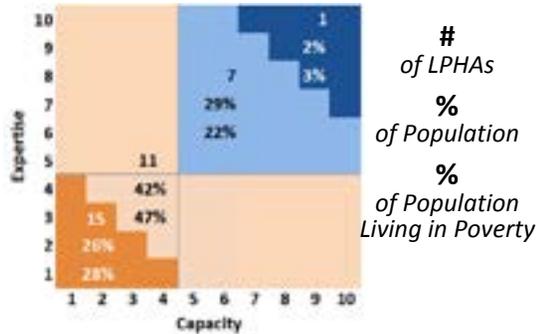
ASSESSMENT

Prevention and Health Promotion
Prevention of Tobacco Use

LPHA IMPLEMENTATION



POPULATION SERVICE



of LPHAs
% of Population
% of Population Living in Poverty

PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 1:

Prevention of Tobacco Use

This functional area represents 33% of current local *Prevention and Health Promotion* spending. At full implementation, its share of local *Prevention and Health Promotion* spending would decrease to 20% with the addition of 30% more funding (\$1.2M).

While *Prevention of Tobacco Use* is the second highest spending area for local *Prevention and Health Promotion* spending, it is the functional area rated least implemented by LPHAs. A little less than a quarter of providers have significantly or fully implemented these activities. Almost 45% of LPHAs reported little to no implementation of the Public Health Modernization activities for tobacco use prevention.

Non-Financial Barriers

No non-financial barriers specific to the prevention of tobacco use were identified, although many of the barrier identified for *Prevention and Health Promotion* would be applicable.

RESOURCES

Current Spending



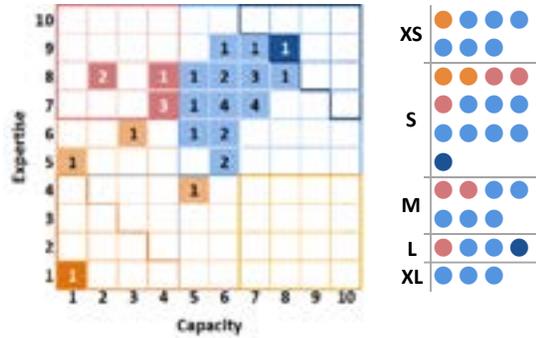
Full Implementation



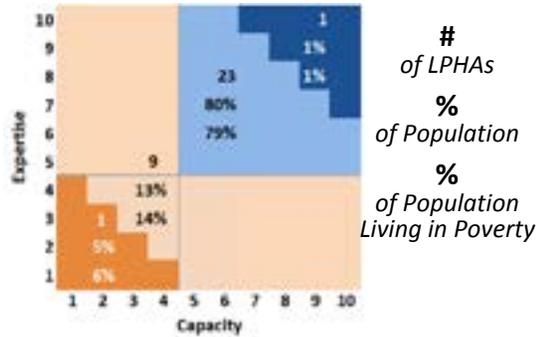
Additional Increment



LPHA IMPLEMENTATION



POPULATION SERVICE



PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 2:

Improving Nutrition and Increasing Physical Activity

This functional area represents 15% of current local *Prevention and Health Promotion* spending. LPHAs estimated that they need an additional funding increment equal to 135% of current spending to reach full implementation.

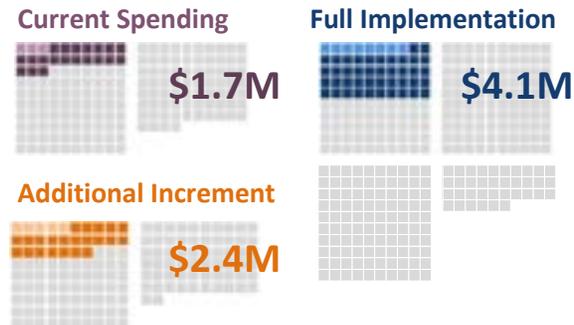
A majority of LPHAs reported significant implementation of *Prevention and Health Promotion* activities relating to *Improving Nutrition and Increasing Physical Activity*. Relatively few LPHAs rated themselves at low or full implementation.

Six LPHAs indicated a high expertise but low capacity, and another two LPHAs indicated mid-level expertise and low capacity, the highest number in these categories in the *Prevention and Health Promotion* Program.

Non-Financial Barriers

No non-financial barriers specific to *Improving Nutrition and Increasing Physical Activity* were identified, although many of the barriers identified for *Prevention and Health Promotion* would be applicable.

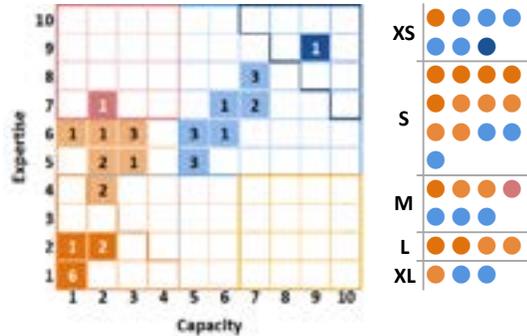
RESOURCES



ASSESSMENT

Prevention and Health Promotion
Improving Oral Health

LPHA IMPLEMENTATION



PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 3:

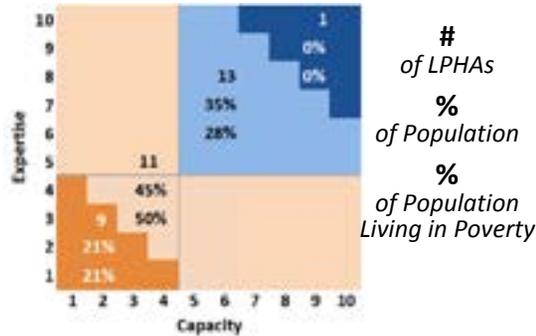
Improving Oral Health

With almost \$0.6M in current spending, the activities that constitute **Improving Oral Health** in Public Health Modernization represent the smallest share of *Prevention and Health Promotion*. Partially because current spending is relatively modest, full implementation will increase spending in this area by 400%, bringing this functional area’s share to 12%.

Non-Financial Barriers

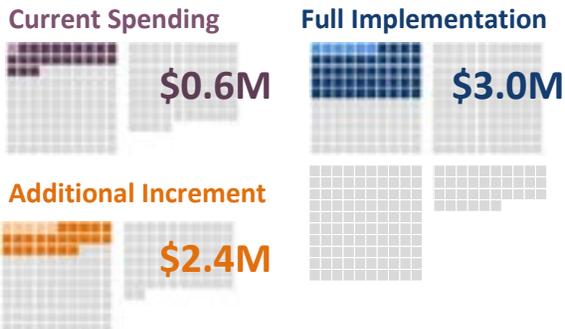
No non-financial barriers specific to **Improving Oral Health** were identified, although many of the barrier identified for *Prevention and Health Promotion* would be applicable.

POPULATION SERVICE

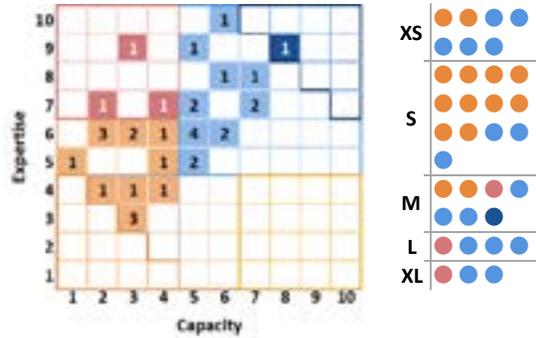


LPHAs reported a lower level of implementation for the new Public Health Modernization requirements in this functional area. There is no clear pattern as to which LPHAs are at each level of implementation, although jurisdictions with less than 20,000 residents rated themselves higher than any other size category. Approximately 40% of providers have significantly or fully implemented these activities.

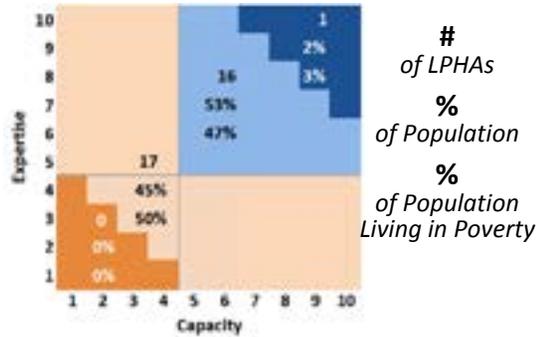
RESOURCES



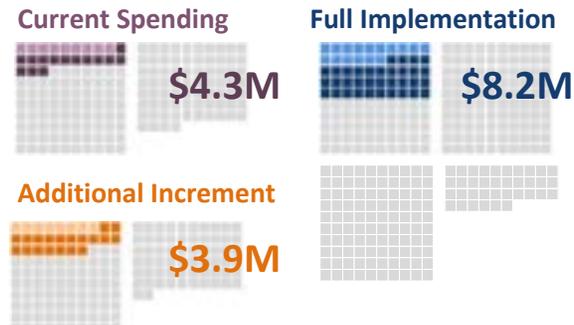
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 4:

Improving Maternal and Child Health

Improving Maternal and Child Health is the single largest spending category in the *Prevention and Health Promotion* Foundational Program. Of the spending aligned with Public Health Modernization in the five functional areas, 37% goes to *Improving Maternal and Child Health*. LPHAs estimated that a 90% increase in spending is required to meet full implementation.

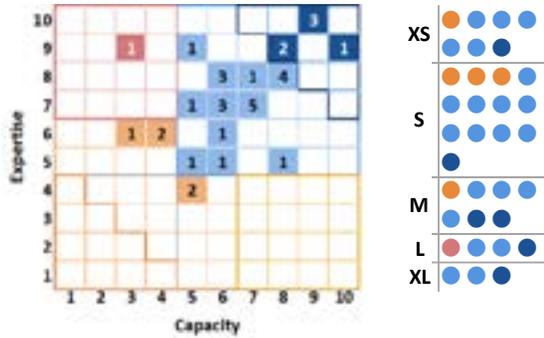
Half of LPHAs rated themselves as at partial implementation, although all LPHAs have implemented some activities.

Currently, the degree of implementation of this functional area is lowest among LPHAs serving smaller and mid-sized populations. LPHAs generally rated themselves higher in expertise than capacity for this functional area.

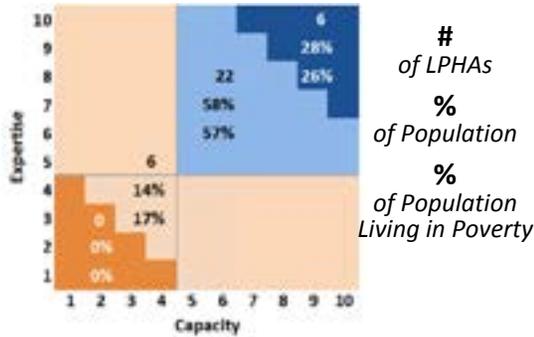
Non-Financial Barriers

No non-financial barriers specific to *Improving Maternal and Child Health* were identified, although many of the barriers identified for *Prevention and Health Promotion* would be applicable.

LPHA IMPLEMENTATION



POPULATION SERVICE



PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 5:

Reducing Accident Rates

Within *Prevention and Health Promotion*, **Reducing Accident Rates** is the fourth smallest spending area. However, it is also the most implemented *Prevention and Health Promotion* functional area. Over 80% of LPHAs identified that they had significant or full implementation of the activities required in this functional area.

This degree of implementation is consistent from a population service perspective – 86% of Oregon residents live in a service area where these activities are present.

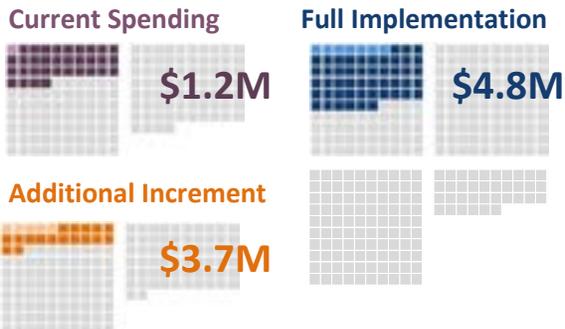
The 300% increase in costs to get to full from partial implementation suggests the activities associated with reducing accident rates have higher marginal costs.

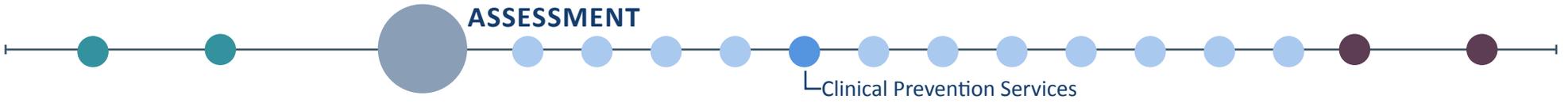
Non-Financial Barriers

LPHAs identified two barriers related to this functional area:

- (Functional Area) A high rate of staff turnover.
- (Functional Area) Lack of institutional knowledge around policy, systems, and processes.

RESOURCES





ACCESS TO CLINICAL PREVENTATIVE SERVICES

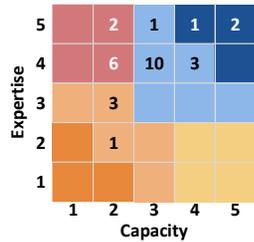
Assure Oregonians receive recommended, cost-effective, clinical preventive services.

**PUBLIC HEALTH DIVISION
LEVEL OF IMPLEMENTATION**

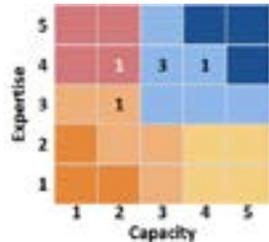
Significant



ROLES

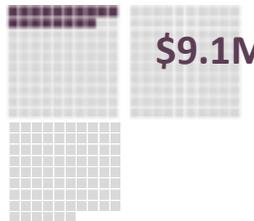


DELIVERABLES

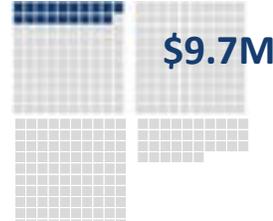


RESOURCES

Current Spending



Full Implementation



Additional Increment



Clinical Preventive Services activities represent 6.4% of PHD’s current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Program’s share of state public health activities will decrease to 5.8%. A small additional increment of spending (\$0.6M) is needed to get PHD to full implementation. This will make the state activities for *Clinical Preventive Services* the 4th largest Foundational Program (out of 4) and 6th largest Foundational Capability or Program (out of 11).

PHD’s *Clinical Preventive Services* activities include 29 roles and 6 deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be only partially implemented, with low capacity. However, PHD also notes that the majority of the roles and deliverables that represent *Clinical Preventive Services* state activities are significantly or fully implemented. In fact, 17 of the 29 roles and 4 of 6 deliverables are significantly or fully implemented.

A few of the less implemented roles and deliverables are state activities that directly support the provision of local *Clinical Preventive Services* activities; these include:

- Collect, analyze, and report on data on access to clinical preventive services.
- Analyze data to identify regional differences

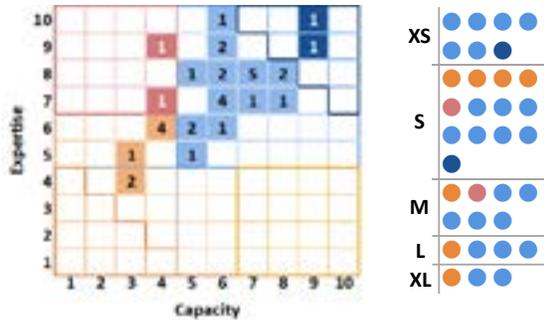
in access to clinical preventive services. Make data available at the local level.

- Partner with local public health authorities to identify access barriers and potential solutions.

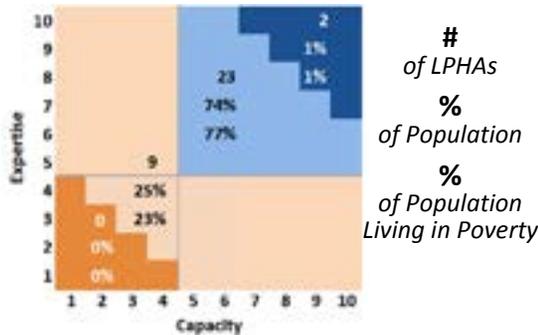
In addition to these *Clinical Preventive Services* activities that directly relate to LPHAs, there are a number of other activities that aren’t fully implemented and could be leveraged by the LPHAs, such as making policies and data created for other stakeholders available to LPHAs where appropriate.

LOCAL PUBLIC HEALTH AUTHORITIES

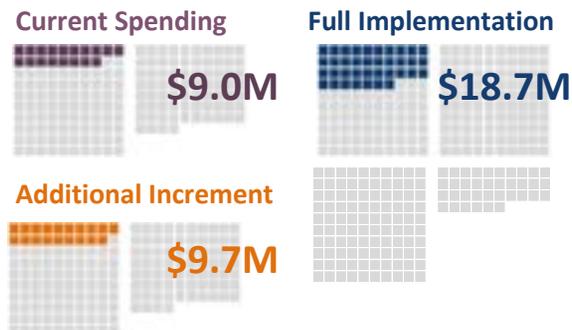
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



Clinical Preventive Services activities represent 10% of LPHAs' current Public Health Modernization activities (as a share of current spending). At full implementation, the LPHAs estimate that the Program would be 11% of local public health activities. Additional spending required to fully implement this program at the LPHAs is estimated to cost \$9.7M, an increase of approximately 107%. This will make the local activities for *Clinical Preventive Services* the 4th largest Foundational Program (out of 4) and 5th largest Foundational Capability or Program (out of 11).

Programmatically, this Foundational Program is relatively well-implemented, with 25 (out of 34) LPHAs documenting significant or full implementation.

Local *Clinical Preventive Services* activities are broken down into five functional areas:

1. Ensure Access to Effective Vaccination Programs. This functional area represents 28% of current local *Clinical Preventive Services* activities; its share of local *Clinical Preventive Services* activities would decrease to 22% at full implementation.

2. Ensure Access to Effective Preventable Disease Screening Programs. This is one of two least implemented functional areas. It represents 10% of current local *Clinical Preventive Services* activities. This share is expected to increase to 15% at full implementation, with the spending in this area increasing 217%.

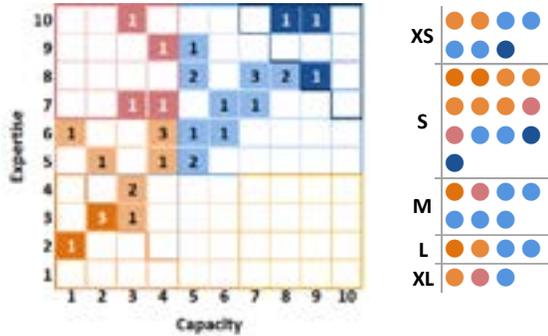
3. Ensure Access to Effective STD Screening Programs. This is the most implemented area and represents 30% of current local *Clinical Preventive Services* activities. This share is expected to increase to 32% at full implementation, with spending in this area increasing by \$3.2M.

4. Ensure Access to Effective TB Treatment Programs. This functional area represents 22% of current local *Clinical Preventive Services* activities; its share of local *Clinical Preventive Services* activities would decrease to 19% at full implementation

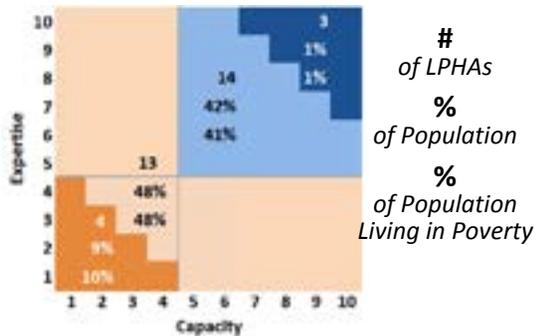
5. Ensure Access to Cost Effective Clinical Care. This is one of two least implemented functional areas. It represents 10% of current local *Clinical Preventive Services* activities. This share is expected to increase to 12% at full implementation, with the spending in this area increasing 157%.

Following, we've provided profiles like this page for each of these five functional areas.

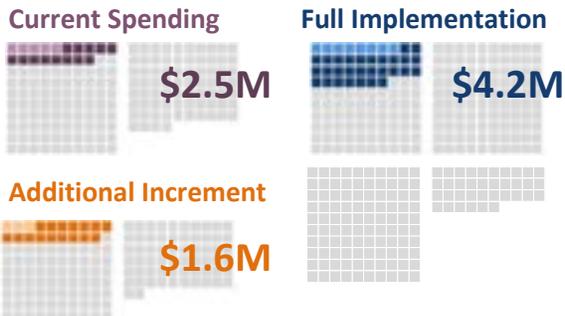
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 1:

Ensure Access to Effective Vaccination Programs

This is one of three functional areas that describe how local *Clinical Preventive Services* activities are operationalized. This functional area represents 28% of current local *Clinical Preventive Services* activities; its share of local *Clinical Preventive Services* activities would decrease to 22% with the addition of 64% more funding (\$1.6M) to reach full implementation.

System-wide, only half of LPHAs have significant or full implementation of this functional area. There is no clear pattern as to which LPHAs are at each level of implementation, though the pattern suggests that lack of capacity is a greater issue than lack of expertise.

There is a similar lack of service from a population service perspective: 57% of Oregon residents live in a service area where they are underserved or unserved, while 43% live in a service area where these activities are present (however, there is a meaningful gap in service for a large percentage of those services).

The activities in the *Ensure Access to Effective Vaccination Programs* functional area include 5 roles. The degree of implementation of these roles and deliverables across local providers and

population by level of service are provided on the following page.

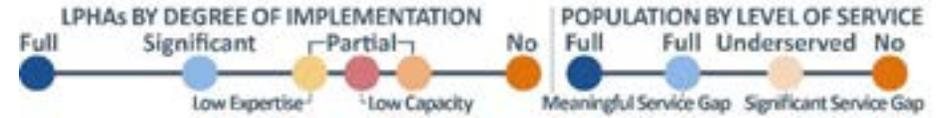
Non-Financial Barriers

LPHAs did not identify any barriers to implementing the roles and deliverables that make up this functional area's activities.

ASSESSMENT

Clinical Prevention Services

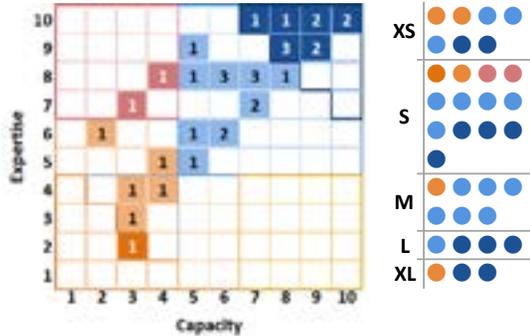
Ensure Access to Effective Vaccination Programs



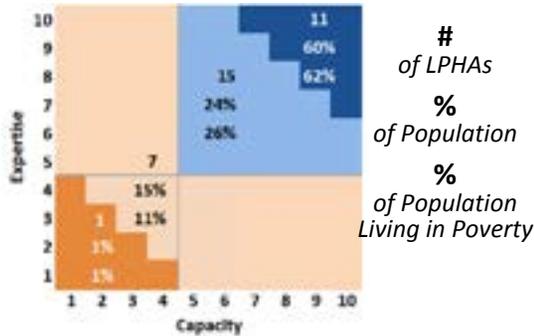
Clinical Preventive Services

Functional Area	Full	Significant	Partial	No	Full	Full Underserved	No		
Ensure Access to Effective Vaccination Programs	3	14	4	9	4	42%	48%		
Ensure access to all vaccines required by Oregon law for school attendance, including ensuring no child is denied due to inability to pay.	15	16	2	1	30%	65%	4%		
Quality standard or recommendation: CDC Advisory Committee on Immunization Practices (ACIP) recommended adult and childhood vaccines.	17	13	3	1	48%	47%	5%		
Ensure access to all immunization-related services necessary to protect the public and prevent the spread of preventable disease.	8	21	2	3	45%	48%	6%		
Work with local providers and public health delegate agencies to ensure access to immunization services.	9	16	2	6	1	18%	62%	18%	
Ensure access to vaccines as appropriate during public health emergencies.	5	11	3	10	5	6%	33%	52%	8%

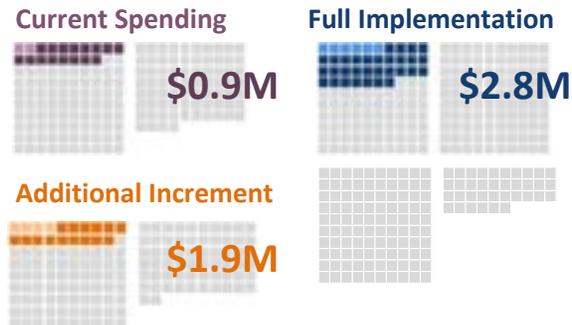
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 2:

Ensure Access to Effective Preventable Disease Screening Programs

This functional area represents only 10% of current local *Clinical Preventive Services* activities. While this functional area does not have a large share of current activities, it is significantly or fully implemented in many LPHAs (77%). The larger the LPHA, the more likely it is that they have implemented this functional area in a more than significant way. LPHAs reported needing an additional increment of \$1.9M to fully implement this functional area, a 217% increase over current spending.

This functional area is highly implemented across the system. Only two medium, large, or extra-large LPHAs aren't at least significantly implemented. Similarly, only 30% of extra-small and small LPHAs aren't at least significantly implemented.

Taken together with this programmatic finding, the large amount of additional spending (217%) needed to reach full implementation suggests that the increase from significantly implemented to fully implemented has higher marginal costs than the initial activities needed to reach significant implementation.

This is consistent from a population service perspective – 84% of Oregon residents live in a

service area where these activities are present. However, over half (58%) of those services are delivered such that there is a meaningful gap in service.

The activities included in the **Ensure Access to Effective Preventable Disease Screening Programs** functional area include 3 roles. The degree of implementation of each of these roles and deliverables across local providers and population by level of service are provided on the following page. Only one of these activities is far from full implementation; this role (role 3) is to “Support provision of evidence-based programs and treatments that reduce the impact and costs associated with the leading causes of disease and disability in Oregon.”

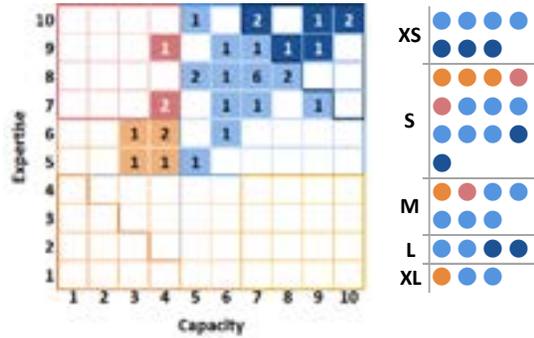
Non-Financial Barriers

LPHAs did not identify any barriers to implementing the roles and deliverables that make up this functional area's activities.

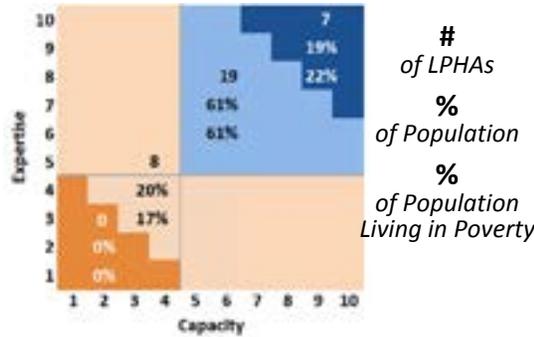


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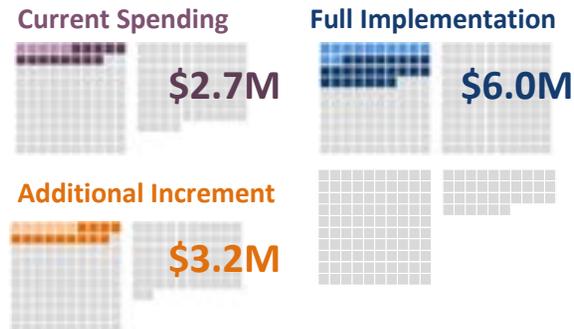
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 3:

Ensure Access to Effective STD Screening Programs

Ensure Access to Effective STD Screening Programs is the most implemented functional area, representing 30% of current local *Clinical Preventive Services* activities. This share is expected to increase to 32% at full implementation, with the spending in this area increasing 118%.

Currently, the degree of implementation of this functional area varies across the system. There is no clear pattern as to which LPHAs are at each level of implementation. A little more than three-quarters of providers have significantly or fully implemented these activities, while those that have partially implemented exist across size bands.

This degree of implementation is consistent from a population service perspective – a little over three-quarters (80%) of Oregon residents live in a service area where these activities are present. However, a significant proportion of those services (over 70%) are delivered with a meaningful gap in service.

The activities in the *Ensure Access to Effective STD Screening Programs* functional area include 2 roles that are well implemented. The degree of implementation of each of these roles

and deliverables across local providers and population by level of service are provided on the following page.

Non-Financial Barriers

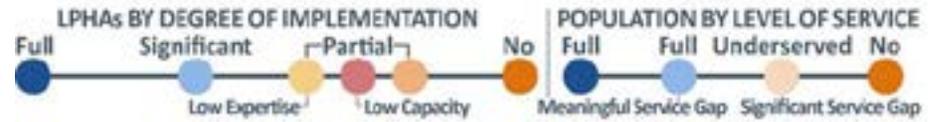
LPHAs identified one barrier to implementing the roles and deliverables that make up this functional area's activities:

- (Role 2) Filling PHN vacancies to treat sexually transmitted infections is noted as a difficulty for some LPHAs.

ASSESSMENT

Clinical Prevention Services

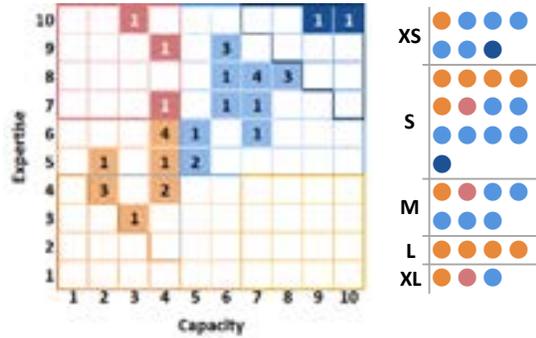
Ensure Access to Effective STD Screening Programs



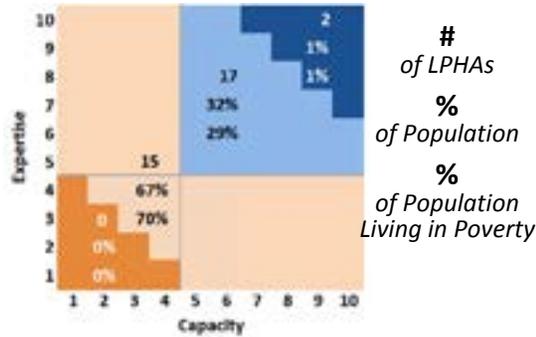
Clinical Preventive Services

		Full	Significant	Partial	No	Full	Full Underserved	No
Ensure Access to Effective STD Screening Programs	<i>functional area</i>	7	19	3	5	19%	61%	20%
"2015 CDC Sexually Transmitted Disease Treatment Guidelines" for HIV, syphilis, gonorrhea, chlamydia and hepatitis B and C.	<i>Role 1</i>	9	19	3	3	21%	46%	34%
Assure access to treatment for sexually transmitted infections either as a component of primary care or as specialty care.	<i>Role 2</i>	10	15	4	5	39%	23%	37%

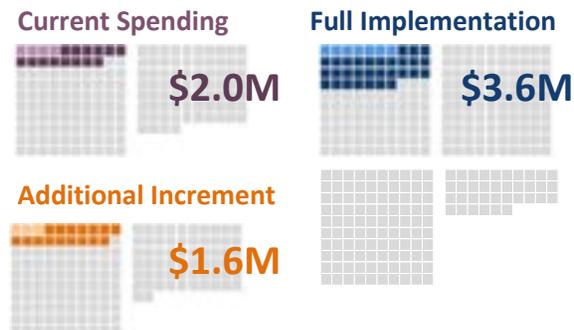
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 4:

Ensure Access to Effective TB Treatment Programs

Ensure Access to Effective TB Treatment Programs represents 22% of current local *Clinical Preventive Services* activities. This share is expected to decrease slightly to 19% at full implementation, with spending in this area increasing by \$1.5M (77%).

Currently, the degree of implementation of this functional area varies across the system. There is no clear pattern to determine which LPHAs are more or less successful in implementation. Over half of the providers have either significantly or fully implemented these activities, while a little less than half have not. A concentration of partial implementation exists in the larger LPHAs.

As expected due to the lower implementation in the larger LPHAs, there is a slightly lower implementation from a population service perspective. Approximately one-third (33%) of Oregon residents live in a service area where these activities are present, however, almost 90% of those services are delivered with a meaningful gap in service.

The activities in the *Ensure Access to Effective TB Treatment Programs* functional area include 4 roles. The degree of implementation of each

of these roles and deliverables across local providers and population by level of service are provided on the following page.

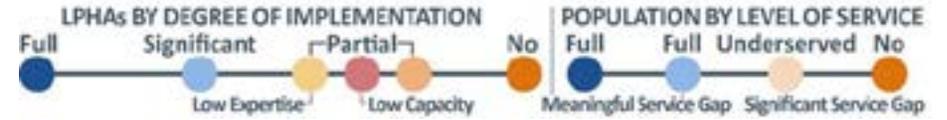
Non-Financial Barriers

LPHAs did not identify any barriers to implementing the roles and deliverables that make up this functional area’s activities.

ASSESSMENT

Clinical Preventive Services

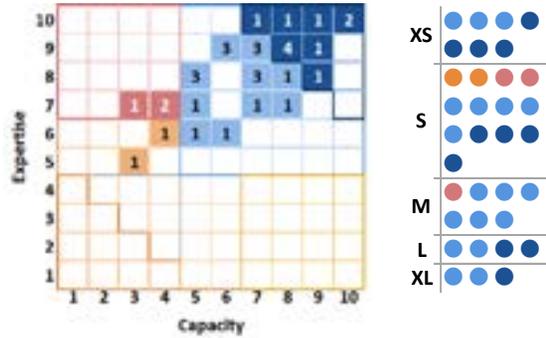
Ensure Access to Effective TB Treatment Programs



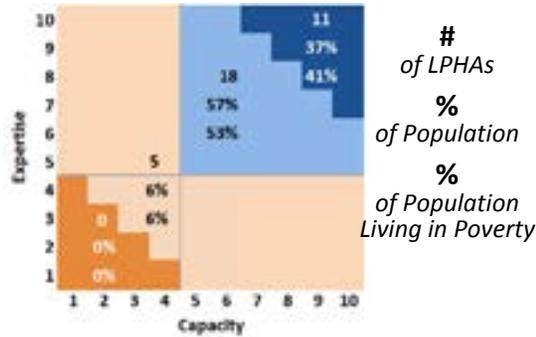
Clinical Preventive Services

Functional Area	Full	Significant	Partial	No	Full	Full Underserved	No		
Ensure Access to Effective TB Treatment Programs	2	17	3	12	32%	67%			
Investigate contacts, including testing and treatment.	11	17	2	3	32%	34%	33%		
Ensure diagnosis and treatment of those with latent TB infection (including contacts of people with TB, new immigrants, other high-risk populations).	8	19	2	5	26%	38%	36%		
Ensure that TB cases are diagnosed and treated using directly observed therapy.	8	18	2	6	26%	29%	45%		
Submit data on TB cases, contacts and new immigrants ("B waiver").	5	16	1	3	7	2	14%	32%	52%

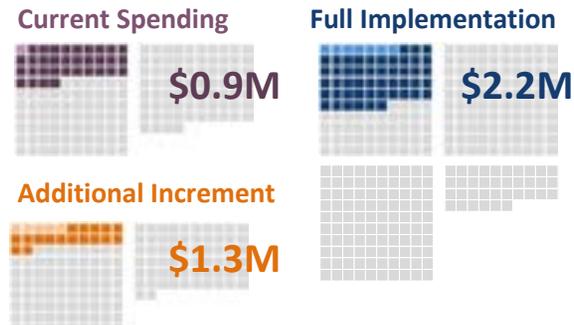
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 5:

Ensure Access to Cost Effective Clinical Care

Ensure Access to Cost Effective Clinical Care is one of two least implemented functional areas, representing just 10% of current local *Clinical Preventive Services* activities. This share is expected to increase to 12% at full implementation, with spending in this area increasing 157%.

Currently, the degree of implementation of this functional area is fairly high, with only five LPHAs reporting less than significant implementation. The majority (80%) of the LPHAs reporting partial implementation are small LPHAs. Approximately 38% of LPHAs have fully implemented this functional area. Despite the high implementation, there is still an anticipated increase in costs of over 157% for full implementation, indicating a higher marginal cost of fully implementing.

This degree of implementation is consistent from a population service perspective – approximately 94% of Oregon residents live in a service area where these activities are present (however, 62% of those services are delivered such that there is a meaningful gap in service).

The activities included in the *Ensure Access to Effective STD Screening Programs* functional

area include 9 roles and 7 deliverables. The degree of implementation of each of these roles and deliverables across local providers and population by level of service are provided on the following page.

Non-Financial Barriers

LPHAs identified one barrier to implementing the roles and deliverables that make up this functional area’s activities:

- (Role 1) In some counties, LPHAs are facing hiring competition, with better wages and benefits.

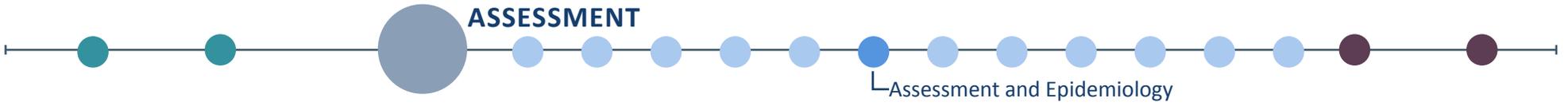
ASSESSMENT

Clinical Prevention Services

Ensure Access to Cost Effective Clinical Care

Clinical Preventive Services

Ensure Access to Cost Effective Clinical Care	Functional Area	11	18	3	2	37%	57%	6%		
Partner with the OHA Public Health Division on assessments of access to clinical preventive services.	Role 1	2	20	3	6	3	61%	30%	8%	
Share data and information about access to clinical preventive services with the community, the health care system, policy makers, and other stakeholders.	Role 2	5	12	6	9	2	24%	29%	44%	3%
Provide information to the health care delivery system about the leading causes of death and disability and evidence-based clinical interventions to address them.	Role 3	4	15	3	8	4	15%	45%	34%	5%
Collaborate with OHA to identify regional barriers and potential solutions to clinical preventive services.	Role 4	2	12	4	14	2	52%	45%	3%	
Engage with regional stakeholders to identify and address barriers to access to clinical preventive care.	Role 5	2	20	2	8	2	62%	35%	2%	
Evaluate the impact of local policies, activities and programs on access to clinical preventive services.	Role 6	1	13	3	13	4	38%	58%	3%	
Create and support local policies that increase access to evidence-based, high quality and effective clinical health services.	Role 7	2	14	5	8	5	46%	35%	18%	
Support policy solutions that increase access to culturally competent clinical preventive services.	Role 8	4	13	4	10	3	39%	51%	8%	
Provide guidance and best practices to local organizations, including those that serve community members with lower access to care.	Role 9	2	17	4	8	3	51%	41%	7%	
Produce jurisdictional reports on access to clinical preventive services.	Deliverable 10	2	4	5	15	8	9%	5%	77%	9%
Provide resources for clinical and community partners on evidence-based guidelines for the delivery of clinical preventive services.	Deliverable 11	3	10	5	11	5	33%	57%	8%	
Document meetings with partners to recommend strategies for improving access to clinical preventive services.	Deliverable 12	6	11	5	10	2	25%	29%	46%	1%
Plan for improved access to clinical preventive services, particularly for vulnerable populations.	Deliverable 13	5	12	3	10	4	25%	33%	38%	4%
Document implementation of these plans.	Deliverable 14	5	7	4	13	5	17%	30%	48%	5%
Produce evaluations of policies implemented to improve access to clinical preventive services.	Deliverable 15	3	7	3	10	11	16%	16%	51%	17%
Document compliance with state and federal laws.	Deliverable 16	9	20	1	2	2	32%	42%	25%	1%



ASSESSMENT AND EPIDEMIOLOGY

Apply the principles and skilled practice of epidemiology, laboratory investigation and program evaluation to support planning, policy, and decision making across the foundational program areas in Oregon's governmental public health system.

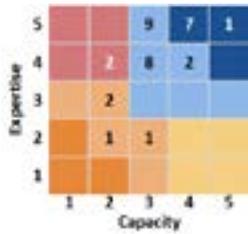
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

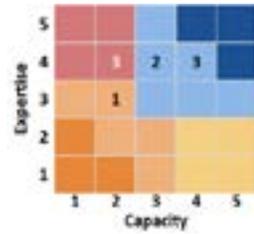
Significant



ROLES



DELIVERABLES

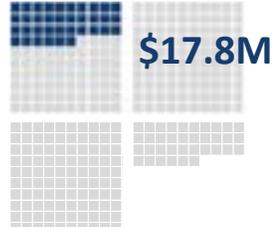


RESOURCES

Current Spending



Full Implementation



Additional Increment



Assessment and Epidemiology activities include both activities that complement the LPHA assessment and epidemiology activities in addition to the State Public Health Laboratory, which has activities that complement other Foundational Program and Capabilities such as *Environmental Public Health and Policy and Planning*.

Together, *Assessment and Epidemiology* and the State Public Health Laboratory represent 7% of PHD’s current Public Health Modernization spending. At full implementation, PHD estimates that the Program’s share of state public health activities will increase to 11%. An additional increment of \$7.3M is needed to get PHD to full implementation, or 70% of current spending. This will make the state activities for *Assessment and Epidemiology* the second largest Foundational Capability (out of 7) and fifth largest Foundational Capability or Program (out of 11).

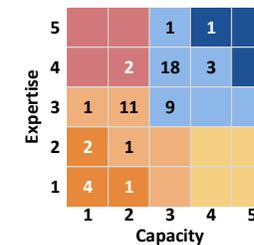
Considering the *Assessment and Epidemiology* and State Public Laboratory activities separately, PHD’s *Assessment and Epidemiology* activities include 12 roles and 10 deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be fully implemented. However, PHD also identified that 45% of the roles and deliverables that represent *Assessment and Epidemiology* state activities are partially implemented.

A few of the less implemented roles and deliverables are state activities that directly support the provision of local *Assessment and Epidemiology* activities; these include:

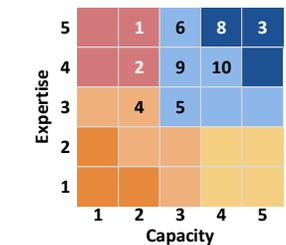
- Maintain information systems.
- Provide state-level public health informatics capability.

PHD’s **State Public Health Laboratory** activities include 54 roles and 48 deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be significantly implemented. However, PHD also reported that 40% of the core functions are not or partially implemented.

CORE FUNCTIONS

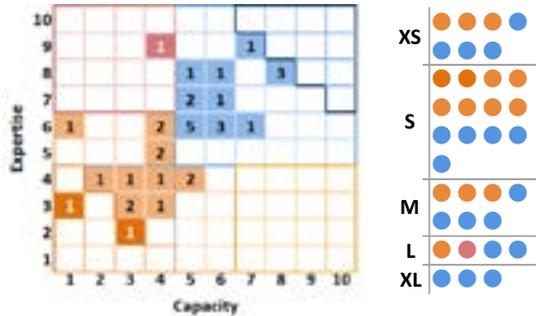


DELIVERABLES

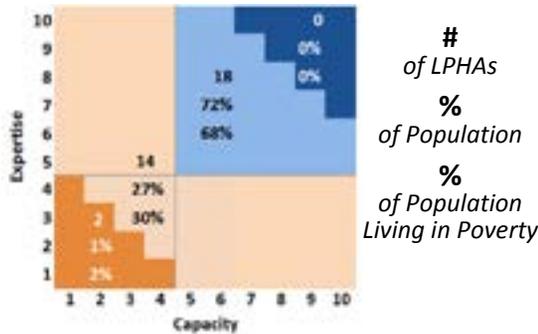


LOCAL PUBLIC HEALTH AUTHORITIES

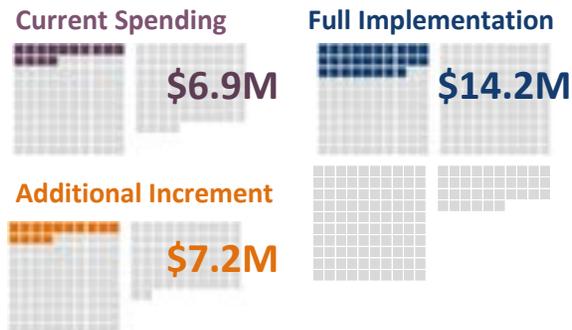
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



Assessment and Epidemiology activities represent 8% of LPHAs’ current Public Health Modernization spending. At full implementation, the LPHAs estimate that the Capability’s share of local public health activities will increase marginally. A significant additional increment of spending (\$7.2M or approximately double current spending) is needed to get to full implementation. This will make the state activities for *Assessment and Epidemiology* the second largest Foundational Capability (out of 7) and sixth largest Foundational Capability or Program (out of 11).

Overall, this Foundational Capability is relatively less-implemented, with a little over half of LPHAs reporting significant implementation and no LPHAs reporting full implementation. This Capability is particularly data-intensive, and data availability and access issues were themes that emerged from LPHA self-assessment comments.

There were not any non-financial barriers to overall implementation of this Foundational Program identified, although all functional areas included data availability barriers.

Local *Assessment and Epidemiology* activities are broken down into five functional areas:

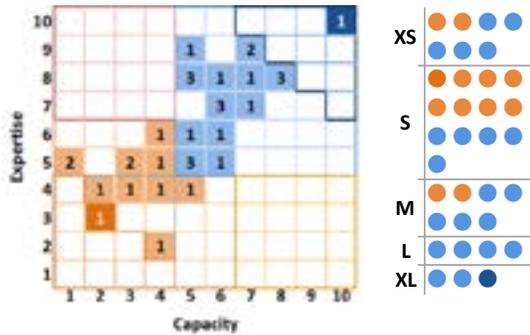
- 1. Data Collection and Electronic Information Systems.** This functional area represents 40% of current local *Assessment and Epidemiology* spending; under full

implementation, spending would increase over 50%, but resource allocation would rebalance the functional areas and it would decrease in share of total spending to 30%.

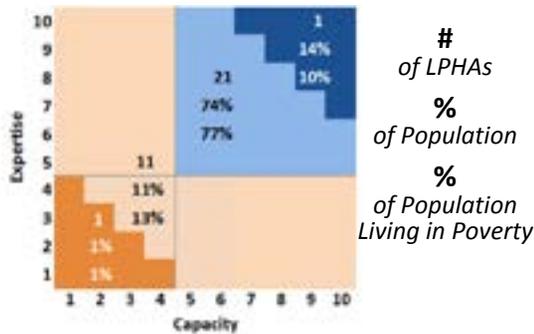
- 2. Data Access, Analysis, and Use.** This area represents 19% of current local *Assessment and Epidemiology* spending and will need an additional 100% of current spending to reach full implementation.
- 3. Respond to Data Requests and Translate Data for Intended Audiences.** This area represents 11% of current local *Assessment and Epidemiology* spending. LPHAs estimate full implementation would require a spending increase of 117%.
- 4. Conduct and Use Basic Community and Statewide Health Assessments.** The smallest spending area under full implementation, this functional area is also the least available to Oregon residents within *Assessment and Epidemiology*.
- 5. Infectious Disease-Related Assessment.** This is the least resourced functional area within *Assessment and Epidemiology*, representing less than 10% of current spending, but increasing to 21% in full implementation, with an additional 350% of current spending.

Profiles of each of these five functional areas follow.

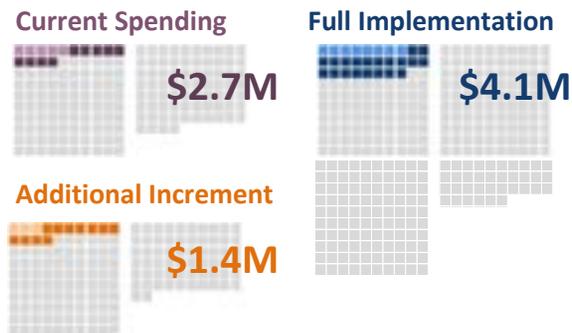
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 1:

Data Collection and Electronic Information Systems

Within the *Assessment and Epidemiology* Capability, the activities within **Data Collection and Electronic Information Systems** represent the greatest concentration of current Public Health Modernization spending for LPHAs. Almost 40% of current *Assessment and Epidemiology* Public Health Modernization spending is in this area. As a percentage of current spending, an increment of 53% is needed to reach full implementation, although this functional area will remain the largest area of spending.

Reflecting the relatively small increase in resources needed for full implementation, the LPHAs rated this functional area as the most implemented within *Assessment and Epidemiology*, both from the count of providers and the percent of population living in areas with significant or full implementation.

The activities in the **Data Collection and Electronic Information Systems** functional area include four roles and no deliverables. The degree of implementation of these roles across LPHAs and population by level of service is on the following page.

Non-Financial Barriers

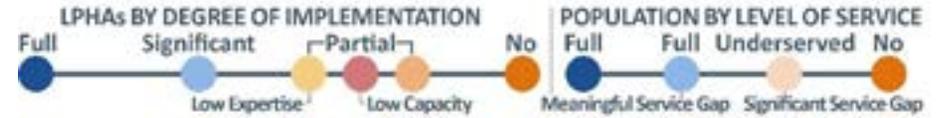
LPHAs identified two barriers to implementing the roles that make up this functional area’s activities:

- (Role 2) Information technology is an ongoing challenge for LPHAs, especially the differences in local systems and difficulty in locating state data.
- (Role 4) At least one LPHA reported a need for tools to evaluate efficacy.

ASSESSMENT

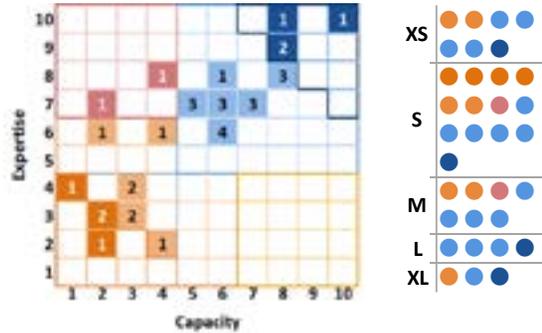
Assessment and Epidemiology

Data Collection and Electronic Information Systems

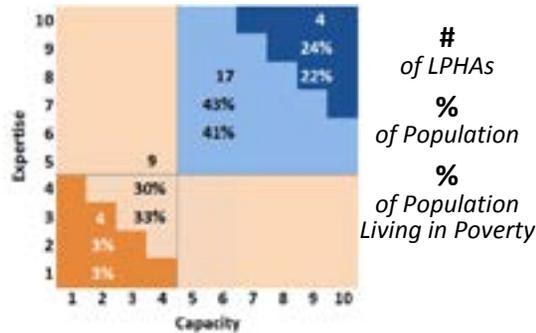


Data Collection and Electronic Information Systems	Functional Area	Full	Significant	Partial	No	Full	Full Underserved	No
	1	21	11	1	14%	74%	11%	
Access statewide information and surveillance systems and report into these systems in a timely manner.	Role 1	9	21	1	3	31%	48%	21%
Use applied research and evaluation techniques to assure that interventions meet the needs of the community to be served.	Role 3	4	12	14	4	17%	47%	30%
Evaluate the efficacy of public health policies, strategies and interventions.	Role 4	1	9	3	11	10	50%	34%
Provide local public health informatics capability, or access statewide capability.	Role 2	3	13	3	9	6	45%	31%

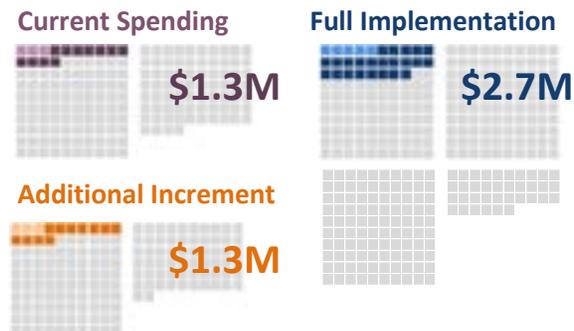
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 2:

Data Access, Analysis, and Use

This functional area represents 19% of LPHA Public Health Modernization spending in the *Assessment and Epidemiology* Capability. LPHAs reported that doubling current spending would be needed for full implementation.

Over 60% of LPHAs rated themselves as having significant or full implementation of the two activities required in this functional area.

There are no clear patterns in the implementation levels across population size categories, nor is implementation strongly connected to the percentage of population living at or below the Federal poverty level.

This functional area has one role and one deliverable. The degree of implementation of each across LPHAs and population by level of service is on the following page.

Non-Financial Barriers

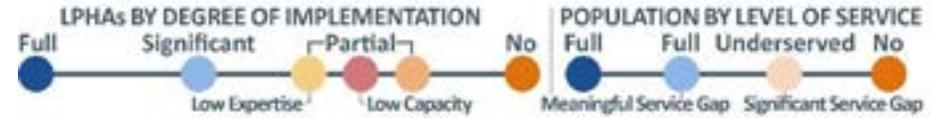
LPHAs identified a barrier to implementation for the role and the deliverable that make up this functional area's activities:

- (Role 1) Current data systems are not adequate to collection, process, and analyze data to assess population health trends and needs.
- (Role 2) One LPHA identified that vital record data are not available in a timely manner.

ASSESSMENT

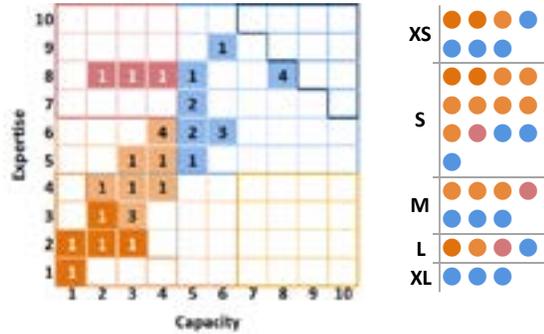
Assessment and Epidemiology

Data Access, Analysis, and Use

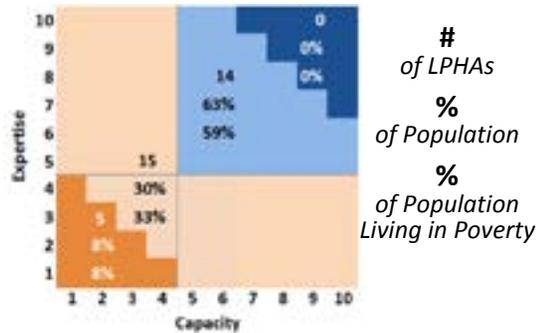


Functional Area	Role	Full	Significant	Partial	No	Full	Full Underserved	No	
Data Access, Analysis, and Use	functional area	4	17	2	7	4	24%	43%	30%
Collect, maintain, analyze and report on vital records.	Deliverable 2	6	15	1	9	3	35%	46%	18%
Collect, process and analyze data to assess population health priorities, patterns and needs in the local authority.	Role 1	3	14	4	10	3	26%	24%	48%

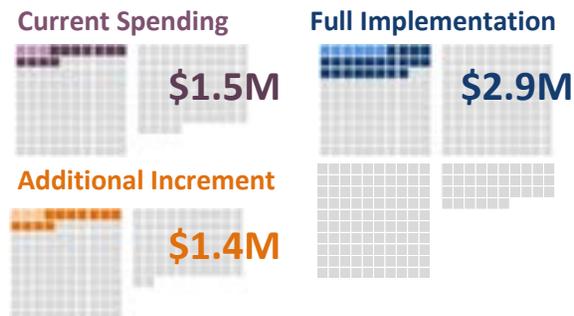
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 3:

Respond to Data Requests and Translate Data for Intended Audiences

Respond to Data Requests and Translate Data for Intended Audiences is the second largest spending area, representing 22% of current local *Assessment and Epidemiology*. LPHAs estimated that an increment of \$1.4M would be needed for full implementation, or 88% of current spending.

Currently, the degree of implementation of this functional area is varied across all size bands, except for the three most populous jurisdictions, which all reported significant implementation.

Two-thirds of LPHAs reported a high level of implementation for producing local summaries of disease occurrence, outbreaks, and epidemics, but the four summaries were less implemented, with 50% or less of LPHAs reporting significant or full implementation.

The activities in the *Respond to Data Requests and Translate Data for Intended Audiences* functional area include one role and five deliverables. The degree of implementation of each of these roles and deliverables across local providers and population by level of service can be found on the following page.

Non-Financial Barriers

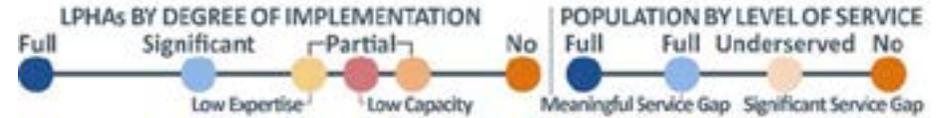
LPHAs identified two barriers to implementation for this functional area, both relating to access to information:

- (Functional Area) Some LPHAs reported difficulty obtaining information about assessments.
- (Roles 5 and 6) LPHAs experience difficulties finding data that is both timely and available down to the appropriate geographic scale.

ASSESSMENT

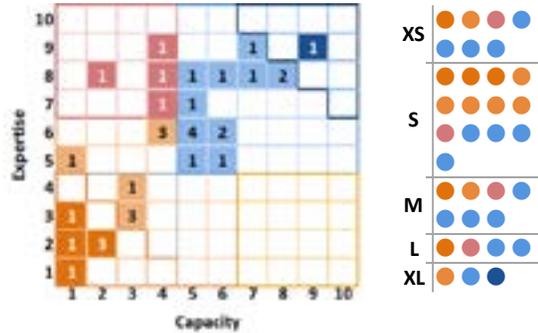
Assessment and Epidemiology

Respond to Data Requests and Translate Data for Intended Audiences

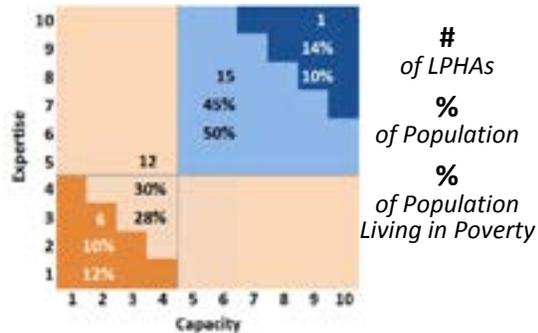


Functional Area / Deliverable / Role	Full	Significant	Partial	No	Full	Underserved	No		
Respond to Data Requests and Translate Data for Intended Audiences	14	3	12	5	63%	30%	8%		
Produce local summaries of disease occurrence, outbreaks and epidemics.	5	18	2	6	3	44%	43%	11%	
Produce local summaries on key indicators of community health, which include information about upstream or root causes of health.	4	13	13	4	26%	43%	29%		
Produce local summaries on leading causes of disease, injury, disability and death, which include information about health disparities.	3	13	2	11	5	16%	51%	28%	
Produce local summaries with analyses of statewide surveys on health attitudes, beliefs, behaviors and practices.	3	9	1	14	7	34%	18%	41%	7%
Produce local summaries describing the impact of public health policies, programs and strategies on health outcomes, including economic analyses when appropriate.	1	11	3	11	8	35%	44%	21%	
Support the appropriate use and timely communication of the data to support community health and resiliency.	1	13	4	11	5	14%	20%	61%	5%

LPHA IMPLEMENTATION

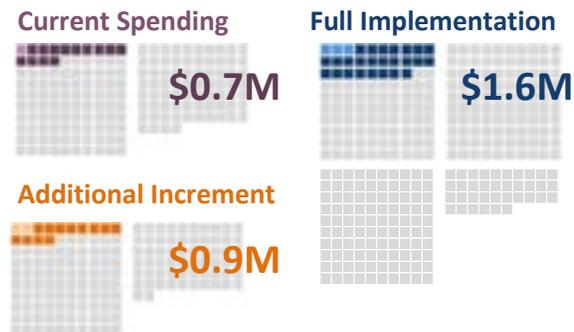


POPULATION SERVICE



of LPHAs
% of Population
% of Population Living in Poverty

RESOURCES



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 4:

Conduct and Use Basic Community and Statewide Health Assessments

The smallest spending area under full implementation, this functional area is also the least available to the residents of Oregon within *Assessment and Epidemiology*. **Conduct and Use Basic Community and Statewide Health Assessments** represents less than 10% of current local *Assessment and Epidemiology* spending. LPHAs estimate that an additional 117% of current spending will be required to meet full implementation of the activities in this functional area.

Almost 60% of Oregon’s population live in a jurisdiction that has significant or full implementation. However, 10% of Oregonians live in areas that have little to no implementation of these services, which is the highest in the *Assessment and Epidemiology* Capability.

The activities in the **Conduct and Use Basic Community and Statewide Health Assessments** functional area include two roles and two deliverables. The degree of implementation of these roles and deliverables across local providers and population by level of service is on the facing page.

Non-Financial Barriers

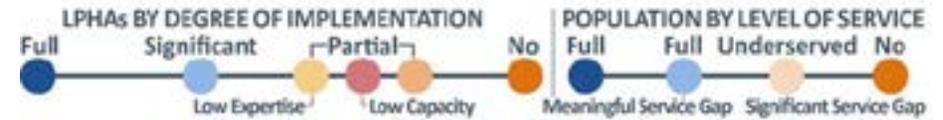
LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area’s activities:

- (Functional Area) Some LPHAs reported a lack of knowledge of data sources needed to fulfill the roles and deliverables.
- (Role 1) Without a doctor or epidemiologist available, some LPHAs face a barrier conducting assessments.
- (Role 4) There are not local-level data from state and Federal sources in a format that is usable.

ASSESSMENT

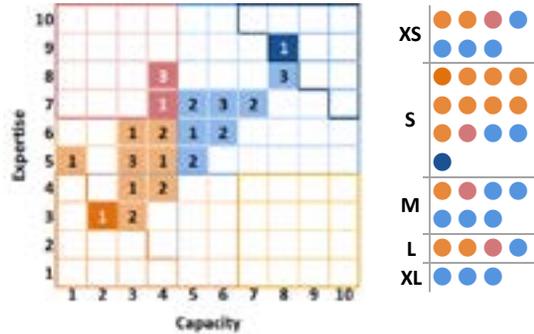
Assessment and Epidemiology

Conduct and Use Basic Community and Statewide Health Assessments

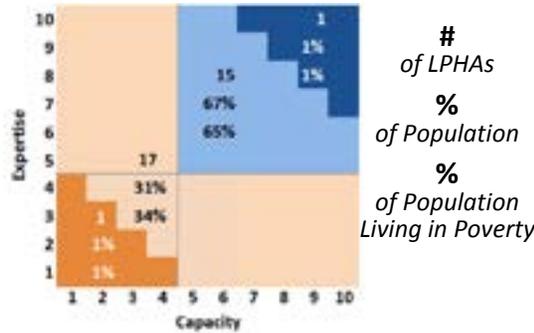


Objective	Functional Area	Full	Significant	Partial	No	Full	Full	Underserved	No	
Conduct and Use Basic Community and Statewide Health Assessments	functional area	1	15	4	8	6	14%	45%	30%	10%
Community health assessment conducted at least every five years.	Deliverable 3	9	21	1	3	38%	57%	5%		
Local data used to inform annual updates on community health improvement plan.	Deliverable 4	8	15	3	8	28%	38%	34%		
Conduct a community health assessment and identify priorities arising from that assessment.	Role 2	6	17	10	1	27%	49%	22%		
Ensure collaboration between state and local public health authorities when conducting assessment and epidemiological efforts.	Role 1	4	21	2	7	21%	60%	19%		

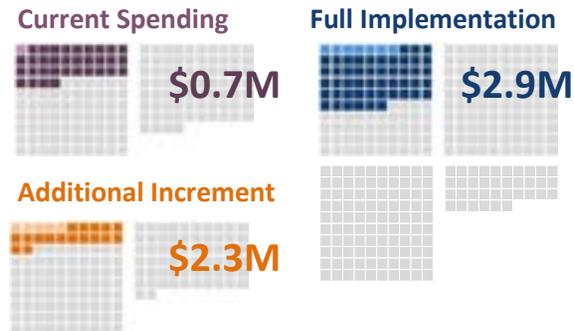
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 5:

Infectious Disease-Related Assessment

Infectious Disease-Related Assessment represents 10% of current LPHA spending in Public Health Modernization *Assessment and Epidemiology* activities. It is the functional area with the greatest resource increase within this Capability, with an estimated 347% increase from current spending.

Most LPHAs rated themselves at a partial or significant level of implementation of the required activities, with only one reporting no implementation and one reporting full implementation. Over two-thirds of Oregon residents live in a service area where these activities are present.

The activities included in the *Infectious Disease-Related Assessment* functional area include three roles and one deliverable. The degree of implementation of each of these roles and deliverable across local providers and population by level of service are on the following page.

Non-Financial Barriers

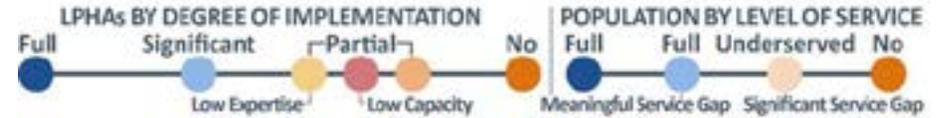
LPHAs identified two barriers to implementing this functional area:

- (Functional Area) Electronic information systems are not presently adequate to complete the roles and deliverable of this functional area.
- (Role 1) LPHAs report that lack of flexibility in their county Information Technology systems, compounded by the multiple data systems in use across counties.

ASSESSMENT

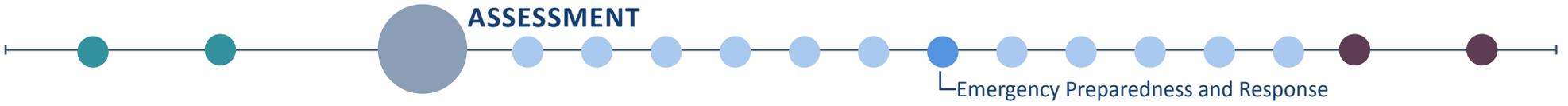
Assessment and Epidemiology

Infectious Disease-Related Assessment



Infectious Disease-Related Assessment

functional area	Full	Significant	Partial	Low Expertise	Low Capacity	No	Full	Meaningful Service Gap	Underserved	Significant Service Gap
Infectious Disease-Related Assessment	1	15	4		13	1	67%		31%	
Promptly identify and lead outbreak investigations that initiate or primarily occur in the local authority. Actively participate in outbreak investigations that cross multiple	7	22			4	1	55%	41%		4%
Maintain the capacity and staff to provide laboratory services including diagnostic and screening tests, and follow protocols established by the OHA Public Health Division.	4	22			8		25%	66%		9%
Ensure local public health capacity to respond to emerging threats to health by maintaining flexibility related to staffing and information systems.	4	15	6		8	1	11%	69%		18%
Capacity to interact with the State Public Health Lab on a 24/7 basis.	13	15	4		2		57%	19%		24%



EMERGENCY PREPAREDNESS AND RESPONSE

A healthy community is a resilient community, which is prepared and able to respond to and recover from public health threats and emergencies.

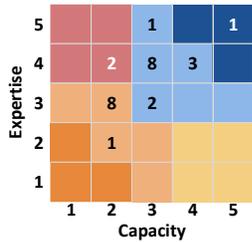
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

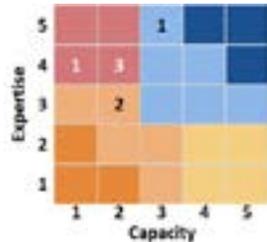
Significant



ROLES



DELIVERABLES



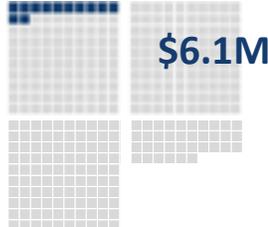
RESOURCES

Current Spending



\$5.2M

Full Implementation



\$6.1M

Additional Increment



\$0.9M

Emergency Preparedness and Response

activities represent 4% of PHD’s current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Capability’s share of state public health activities will stay the same. A small additional increment of spending (\$0.9M), representing a 17% increase, is needed to get PHD to full implementation. This will make the state activities for *Emergency Preparedness and Response* the 4th largest Foundational Capability (out of 7) and 7th largest Foundational Capability or Program (out of 11).

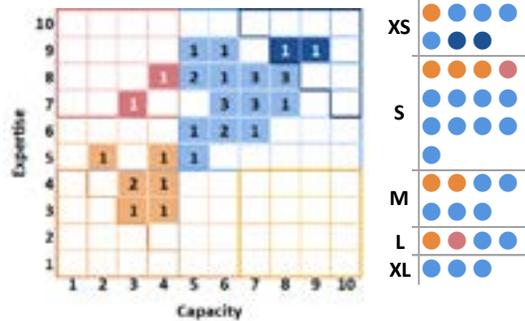
PHD’s *Emergency Preparedness and Response* activities include 26 roles and 7 deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be significantly implemented. However, PHD also notes that the majority of the roles and deliverables that represent *Emergency Preparedness and Response* state activities are only partially implemented. In fact, 11 of the 26 roles and 6 of 7 deliverables are only partially implemented.

A few of the less implemented roles and deliverables are state activities that indirectly (for instance preparing the community or developing partnership networks that can be leveraged by LPHAs) support the provision of local *Emergency Preparedness and Response* activities; these include:

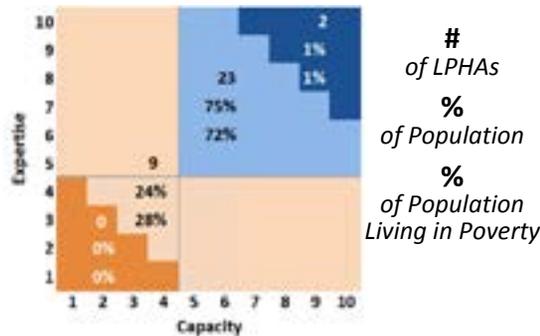
- Establish and promote basic, ongoing community readiness, resilience, and preparedness by communicating and enabling the public to take necessary action before, during, or after an emergency.
- Promote community preparedness by communicating with the public in advance of an emergency, engaging vulnerable populations proactively, and including steps that can be taken before, during, or after an emergency.
- Maintain public health preparedness plans in accordance with the 15 core capabilities.
- Maintain a public health preparedness training and exercise plan, including but not limited to the coordination of training public health /medical surge events and community engagement in preparedness efforts.
- Develop public health short-term and long-term goals for recovery operations.
- Build community partnerships to support health preparedness and recovery efforts, including partnerships with organizations serving priority/focal populations.
- Engage with community organizations to foster public health, medical, and mental/behavioral health social networks.

LOCAL PUBLIC HEALTH AUTHORITIES

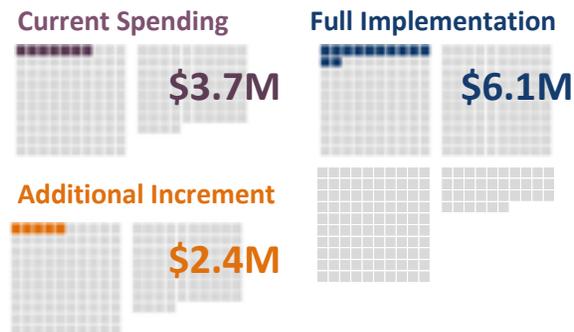
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



Emergency Preparedness and Response activities represent 20% of LPHAs’ current Public Health Modernization activities (as represented by current spending). At full implementation, LPHAs estimate that the Capability’s share of local public health activities will decrease to 17%. A significant additional increment of spending (\$2.4M or approximately 65%) is needed to get LPHAs to full implementation. This will make the local activities for *Emergency Preparedness and Response* the 7th largest Foundational Capability (out of 7) and 11th largest Foundational Capability or Program (out of 11).

Programmatically, this Foundational Program is relatively well-implemented, with 25 (out of 34) LPHAs documenting significant or full implementation.

We identified two non-financial barriers to implementing this Foundational Program overall:

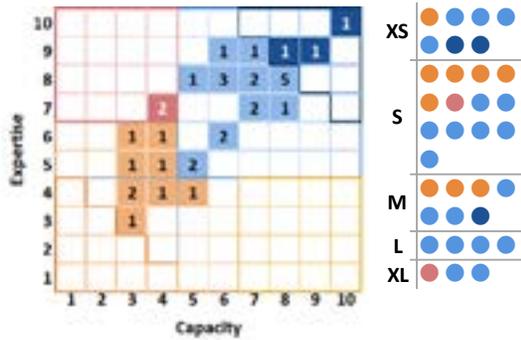
- LPHAs would like to have consistent statewide standards for some of their emergency response efforts.
- Surge capacity is limited, making it difficult to reallocate staff from programs to respond to emergencies, affecting their ability to execute their primary work.

Local *Emergency Preparedness and Response* activities are broken down into three functional areas:

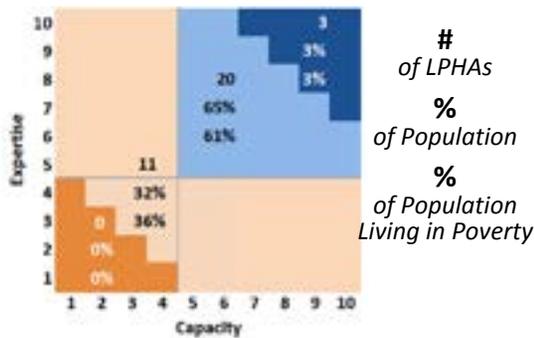
- 1. Prepare for Emergencies.** This functional area represents 56% of current local *Emergency Preparedness and Response* activities; its share of local *Emergency Preparedness and Response* activities would decrease to 53% at full implementation.
- 2. Respond to Emergencies.** This functional area represents 20% of current local *Emergency Preparedness and Response* activities; its share of local *Emergency Preparedness and Response* activities would increase nominally to 21% at full implementation.
- 3. Coordinate and Communicate Before and During an Emergency.** This is the least implemented functional area. It represents 24% of current local *Emergency Preparedness and Response* activities. This share is expected to increase to 26% at full implementation.

Following, we’ve provided profiles like this page for each of these three functional areas.

LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES

Current Spending

\$2.1M

Full Implementation

\$3.2M

Additional Increment

\$1.1M

EMERGENCY PREPAREDNESS AND RESPONSE FUNCTIONAL AREA 1:

Prepare for Emergencies

This is one of three functional areas that describe how local *Emergency Preparedness and Response* activities are operationalized. This functional area represents 56% of current local *Emergency Preparedness and Response* activities; its share of local *Emergency Preparedness and Response* activities would decrease to 53% with the addition of 55% more funding (\$1.1M) to reach full implementation.

The degree of implementation of this functional area varies across the system. There is no clear pattern as to which LPHAs are at each level of implementation. Twenty-three of 34 providers (68%) have significantly or fully implemented these activities.

This is balanced from a population service perspective: 68% of Oregon residents live in a service area where these activities are present (however, there is a meaningful gap in service for a large percentage of those services).

The activities in the *Prepare for Emergencies* functional area include 8 roles and 5 deliverables. The degree of implementation of these roles and deliverables across local providers and population by level of service are provided on the following page.

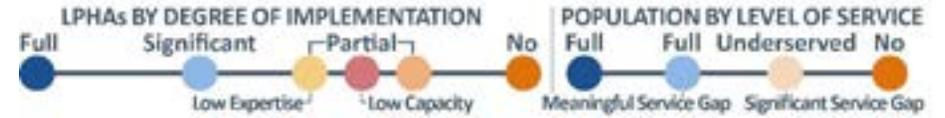
Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area's activities:

- (Functional Area) Coordination between Oregon Health Authority and Office of Emergency Management is lacking and affects the applicability and productivity of exercises for LPHAs.
- (Role 8) LPHAs suggested that it would be helpful to have statewide standards for fatality management in an emergency.
- (Deliverable 13) LPHAs suggested that it would be helpful to have statewide standards for emergency pharmaceutical distribution.

ASSESSMENT

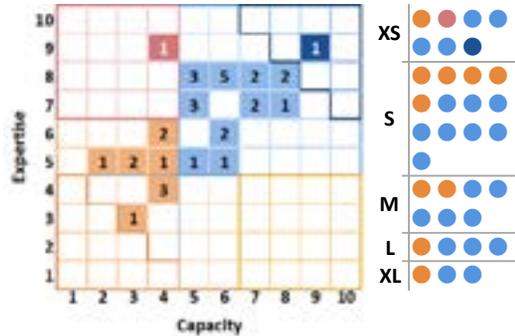
Emergency Preparedness and Response
Prepare for Emergencies



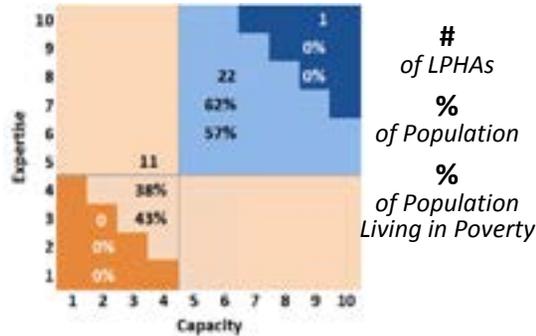
Emergency Preparedness and Response

Prepare for Emergencies	Functional Area	Full	Significant	Partial	No	Full	Full Underserved	No
Prepare for Emergencies	Functional Area	3	20	2	9	3%	65%	32%
Conduct jurisdictional assessment of risk, resources, and priority of public health preparedness capabilities.	Role 1	5	23	5	1	5%	87%	6%
Maintain continuity of operations plan for the authority.	Role 2	3	25	5	1	3%	85%	13%
Maintain a public health preparedness training and exercise plan.	Role 5	4	22	1	7	3%	82%	15%
Maintain public health preparedness plans in accordance with the 15 core public health capabilities.	Role 4	3	23	7	1	3%	81%	14%
Build community partnerships to support health preparedness, recovery and resilience efforts.	Role 7	4	23	7	7	15%	53%	32%
Maintain surveillance and response plans inclusive of disaster epidemiology and an active epidemiological surveillance plan.	Role 3	2	18	1	10	3%	59%	33%
Develop public health short term and long term goals for recovery operations.	Role 6	1	19	1	7	6	45%	49%
Maintain pharmaceutical access.	Role 8	1	13	2	11	7	44%	47%
Prepare public health emergency preparedness plans in accordance with established guidelines.	Deliverable 12	7	23	1	3	21%	75%	4%
Document emergency preparedness exercises.	Deliverable 11	11	19	1	3	35%	61%	5%
Produce continuity of operations plan for the local health authority.	Deliverable 9	4	24	1	5	5%	88%	6%
Plan emergency preparedness exercise.	Deliverable 10	7	21	6	6	7%	81%	12%
Plan for the distribution of pharmaceuticals in the event of an emergency.	Deliverable 13	3	19	2	7	3	72%	23%

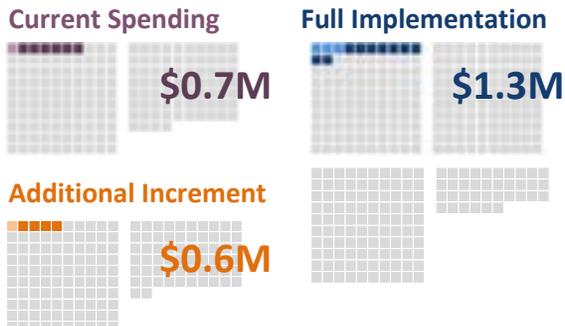
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



EMERGENCY PREPAREDNESS AND RESPONSE FUNCTIONAL AREA 2:

Respond To EMergencies

This functional area represents (20%) of current local *Emergency Preparedness and Response* activities. At full implementation, this share will increase nominally to 21%. LPHAs noted that they need a large additional increment of funding (77%) to reach full implementation.

The degree to which this functional area is implemented varies across the system. There is not a clear pattern by LPHA size. Approximately two-thirds of LPHAs are significantly or fully implemented.

Population service is a bit lower, with only 62% of residents living in a service area where these activities are present. However, almost all of those services are delivered such that there is a meaningful gap in service.

This is one area with a bit of a difference between degree of population service for the overall population and the population of those living in poverty. Five percent more of the population is currently served by an LPHA that is significantly or fully implemented, compared to 57% of those living in poverty.

The activities included in the *Respond to Emergencies* functional area include 1 role and 4 deliverables. The degree of implementation of each of these roles and deliverables across local

providers and population by level of service are provided on the following page.

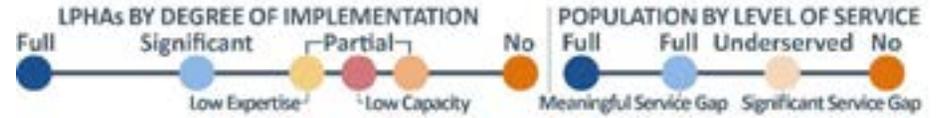
Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area’s activities:

- (Functional Area) Surge capacity is limited, making it difficult to reallocate staff from programs to respond to emergencies, affecting their ability to execute their primary work.
- (Role 4) LPHA coordination efforts are challenged by competing priorities from other agencies during emergencies.
- (Role 4) Some LPHAs have a limited ability to hire adequately to support surge during outbreak investigations.
- (Deliverable 5) LPHAs need more experience in responding to emergencies, which could be attained through additional exercises.

ASSESSMENT

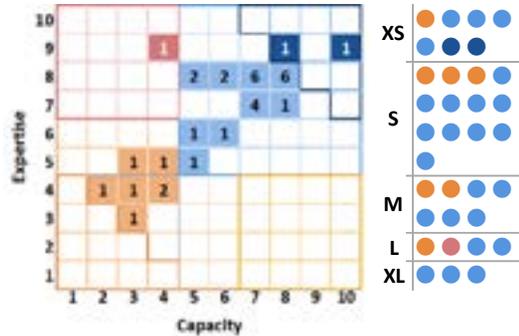
Emergency Preparedness and Response
Emergency Communications



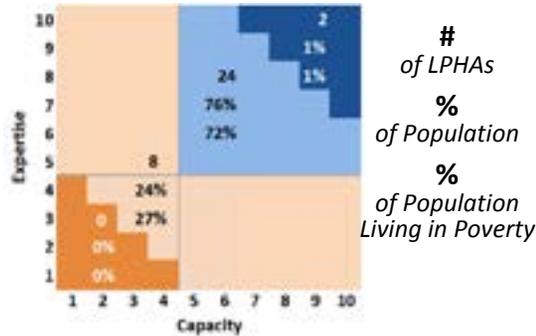
Emergency Preparedness and Response

functional area	Full	Significant	Partial	No	Full	Full Underserved	No
Respond to Emergencies	1	22	1	10	62%	38%	
Provide efficient and appropriate situation assessment, determine objectives to address the health needs of those affected, allocating resources to address those	3	20	1	9	1	77%	19%
Document participation in emergency response efforts.	9	21	1	3	19%	76%	5%
Document enforcement of emergency public health orders.	5	21	1	4	3	15%	76%
Develop situational assessments and resulting operational plans, including objectives, resources needed and how to resume routine operations.	6	15	1	9	3	14%	50%
Produce disaster epidemiology reports.	11	2	11	10	44%	43%	13%

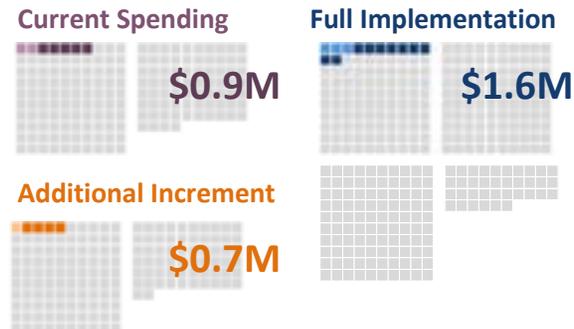
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



EMERGENCY PREPAREDNESS AND RESPONSE FUNCTIONAL AREA 3:

Coordinate And Communicate Before and During an Emergency

This functional area represents 24% of current local *Emergency Preparedness and Response* activities. This share is expected to increase to 26% at full implementation, with the spending in this area increasing 76%.

Currently, three-quarters of providers have significantly or fully implemented these activities. There is no clear pattern as to which LPHAs are at each level of implementation. In fact, the two LPHAs who said they have fully implemented this functional area are both extra small. It is likely that they are able to consider this area fully implemented because, since they are so small, they would have access to sufficient additional resources from other providers if they had a public health emergency.

This degree of implementation is consistent from a population service perspective – a little over three-quarters (77%) of Oregon residents live in a service area where these activities are present (however, about half of those services are delivered such that there is a meaningful gap in service).

The activities included in the **Coordinate and Communicate Before and During an Emergency** functional area include 1 role and 2

deliverables. These roles and deliverables are all implemented to a similar degree as the functional area overall.

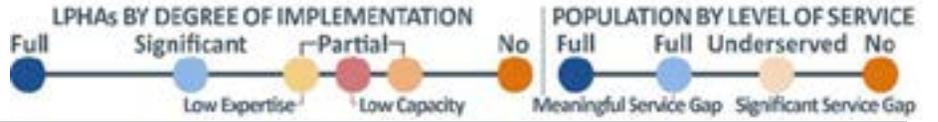
Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area’s activities:

- (Role 2) In some counties, the community doesn’t have a strong presence or involvement in emergency preparedness efforts.
- (Deliverable 3) Need a more streamlined method for communication between PHD and LPHAs during an emergency so that LPHAs can more effectively and quickly communicate with residents through their traditional and social media channels.

ASSESSMENT

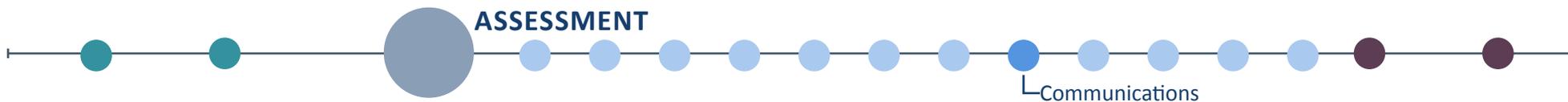
Emergency Preparedness and Response
 Coordinate and Communicate Before and During an Emergency



Emergency Preparedness and Response

Coordinate and Communicate Before and During an Emergency

	<i>functional area</i>	Full	Significant	Partial	No	Full	Full Underserved	No
		2	24	1	7	76%		24%
Act as the jurisdictional administrator of notification systems Oregon's logistical ordering system and syndromic surveillance system.	<i>Role 1</i>	3	22	6	3	79%	10%	9%
Deliver health alerts and preparedness communications to partners and the general public.	<i>Deliverable 3</i>	11	17	1	4	24%	62%	13%
Maintain a portfolio of community partnerships to support preparedness and recovery efforts.	<i>Deliverable 2</i>	8	17	1	7	25%	60%	14%



COMMUNICATIONS

Governmental public health is a trusted source of clear, consistent, accurate and timely health information. Governmental public health consistently uses health communication strategies, interventions and tools to eliminate health disparities and achieve equity.

PUBLIC HEALTH DIVISION

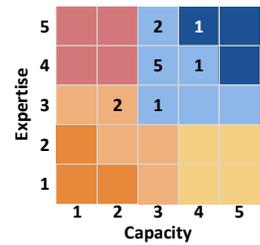
LEVEL OF IMPLEMENTATION

Significantly

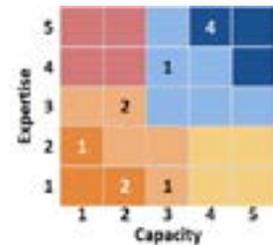


Communications activities represent 0.4% of PHD’s current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Capability’s share of state public health activities will increase to 0.7%. A small additional increment of spending (\$0.6M) is needed to get PHD to full implementation. This will make the state activities for *Communications* the 7th largest Foundational Capability (out of 7) and 11th largest Foundational Capability or Program (out of 11).

ROLES



DELIVERABLES



PHD’s *Communications* activities include 12 roles and 11 deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be significantly implemented. However, PHD also notes that over half of its deliverables in this area are significantly or fully implemented.

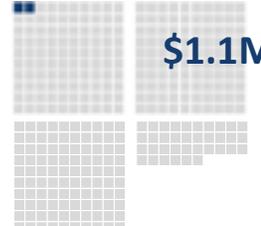
RESOURCES

Current Spending



\$0.5M

Full Implementation



\$1.1M

The focus of PHD’s less implemented roles and deliverables are around developing, implementing, and generating content in alignment with a strategic communications plan. Based on the scores it appears that PHD does not have a strong plan of this type at this time. This is likely an impediment to its other activities.

Additional Increment

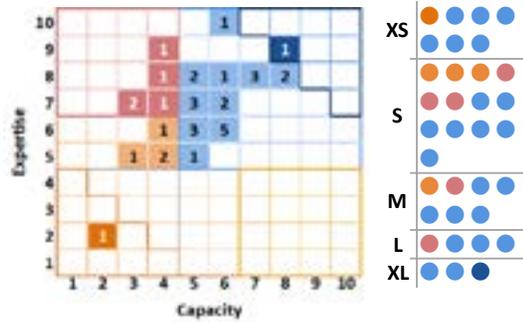


\$0.6M

However it does not appear that the less implemented roles and deliverables are state activities that directly support the provision of local *Communications* activities.

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

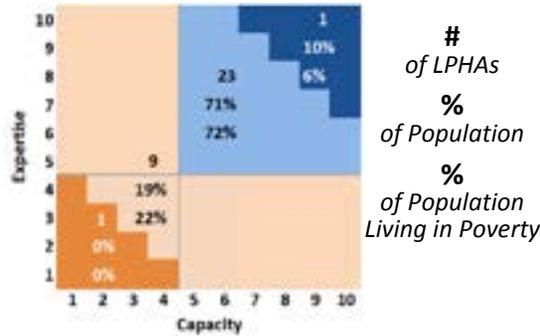


Communications activities represent 3% of LPHAs’ current Public Health Modernization activities (as represented by current spending). At full implementation, LPHAs estimate that the Capability’s share of local public health activities will increase to 4%. A significant additional increment of spending (\$4.1M or approximately an additional 143%) is needed to get LPHA to full implementation. This will make local activities for Communications the 6th largest Foundational Capability (out of 7) and 10th largest Foundational Capability or Program (out of 11).

Local Communications activities are broken down into three functional areas:

- 1. Regular Communications.** This functional area represents 44% of current local Communications activities; its share of local Communications activities would decrease to 41% at full implementation.
- 2. Emergency Communications.** This represents the majority (12%) of current local Communications activities and will remain the largest (23%) share of local activities in this Foundational Capability at full implementation. This functional area also appears to be the most implemented (with all but four LPHAs citing that they have significantly implemented it).
- 3. Educational Communications.** The degree of implementation of this functional area is extremely similar to the degree of implementation of the first. It represents 44% of current local Communications activities. This share is expected to increase to 36% at full implementation.

POPULATION SERVICE

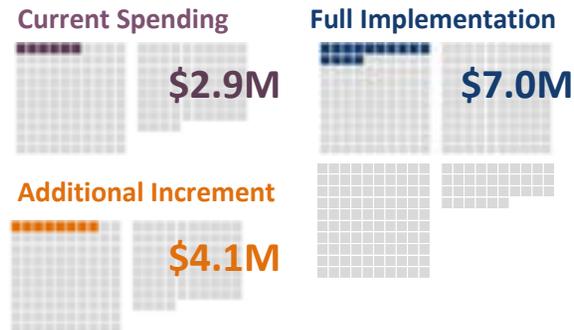


Programmatically, this Foundational Program is relatively well-implemented, with 24 (out of 34) LPHAs (serving 81% of the population overall) documenting significant or full implementation.

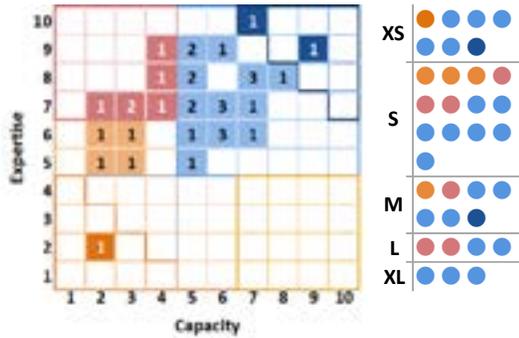
Taken together with the programmatic findings, the large amount (143%) of additional spending needed to reach full implementation suggests that the increase from significantly implemented to fully implemented has higher marginal costs than the initial activities needed to reach significant implementation.

Following, we’ve provided profiles like this page for each of these three functional areas.

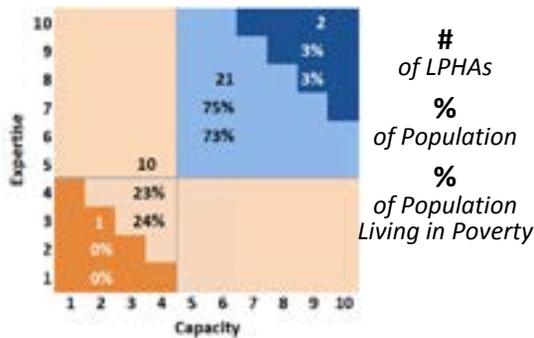
RESOURCES



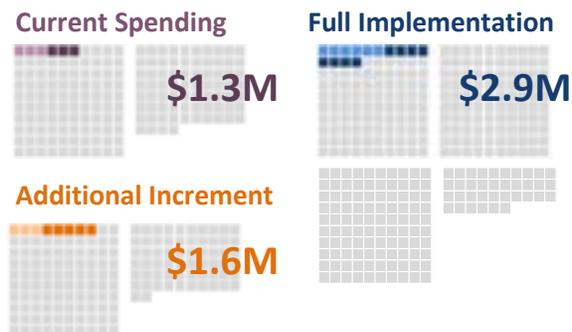
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



COMMUNICATIONS FUNCTIONAL AREA 1:

Regular Communications

This functional area represents 44% of current local Environmental Public Health Activities; its share of local *Communications* activities would decrease to 41% with the addition of 124% more funding (\$1.6M) to reach full implementation.

The degree of implementation of this functional area seems to be concentrated in the partially implemented, low capacity, and significantly implemented sections of the scoring matrix. There is no clear pattern as to what size LPHA is most likely to be more or less implemented. It does appear that lack of capacity is a greater issue than lack of expertise, however.

The system implementation and population service perspectives are relatively balanced in this functional area.

The activities in the *Regular Communications* functional area include 5 roles and 9 deliverables. The degree of implementation of these roles and deliverables across local providers and population by level of service are provided on the following page.

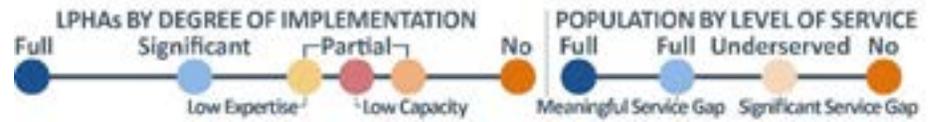
Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area’s activities:

- (Role 3) A few LPHAs identified that having a single communications channel through a public information officer was a challenge in that it delays the time it takes to get the information out to the public.
- (Role 3) Some LPHAs identified developing two-way communication with limited English-speaking residents as a challenge related to the lack of countywide policy or significant political support for it.

ASSESSMENT

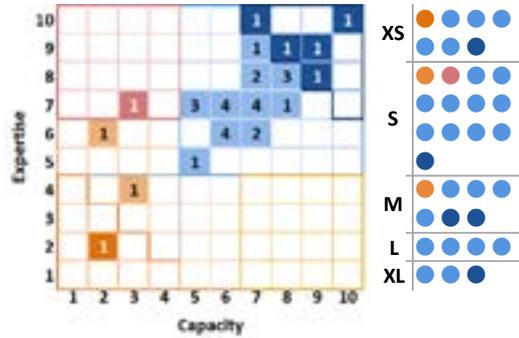
Communications
Regular



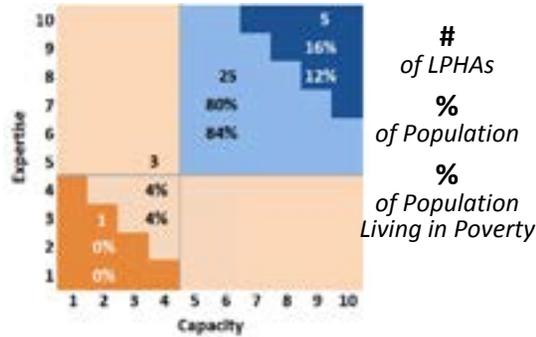
Communications

Regular Communications	Functional Area	Full	Significant	Partial	No	Full	Full Underserved	No		
Regular Communications		2	21	6	4	1	28%	75%	23%	
Local public health authorities shall maintain a public-facing website with updates made to content no less than annually.	Role 4	6	19	1	8		28%	44%	28%	
Local public health authorities shall be a reputable source of health information.	Role 3	4	21	3	5	1	4%	56%	38%	
Local public health authorities shall regularly evaluate the effectiveness of communications efforts.	Role 5		11	7	8	8		38%	45%	16%
Local public health authorities shall develop and implement a strategic communication plan.	Role 1	1	16	10	6	1	10%	27%	62%	
Local public health authorities shall develop and disseminate print and media materials in accordance with the strategic communications plan and risk communication needs.	Role 2	1	18	5	8	2	10%	19%	70%	
News releases and public meeting notices.	Deliverable 8	7	24	2	1		20%	76%	4%	
Evidence of two-way communications with the public.	Deliverable 11	6	18	8	2		21%	60%	16%	
Public-facing website with updates made to content regularly.	Deliverable 10	7	17	2	6	2	40%	32%	25%	
Document communications support for any staff beyond the public information officer who communicate with the public about public health issues.	Deliverable 13	3	17	1	6	7	23%	48%	24%	
Policy briefs and other policy-related communications.	Deliverable 9	2	14	3	11	4	3%	64%	31%	
Strategic communication plan that articulates the local public health authority's mission, value, role, and responsibilities in its community.	Deliverable 6	2	17	5	8	2	2%	57%	39%	
Print and media materials in accordance with the strategic communications plan and risk communication needs.	Deliverable 7	3	15	3	11	2	11%	43%	45%	
Document two-way communications with the OHA Public Health Division. Evaluation Communications evaluation plan that is structured around health equity and literacy.	Deliverable 14	1	13	1	10	9		23%	50%	27%
Evaluation reports documenting the effectiveness of communications efforts using tools such as web analytics, surveys, panel surveys and polls.	Deliverable 12	1	8	2	10	13		21%	52%	27%

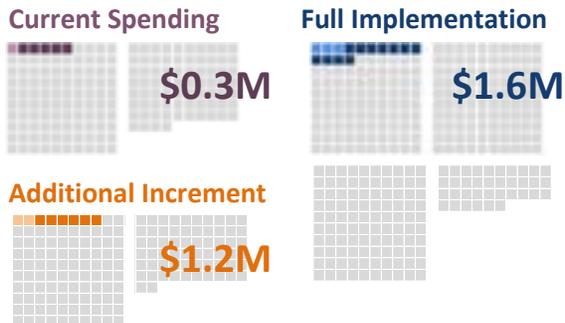
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



COMMUNICATIONS FUNCTIONAL AREA 2:

Emergency Communications

This functional area represents 12% of current local communications activities. While this functional area also appears to be the most implemented, with all but 4 LPHAs citing that they have significantly or fully implemented it, LPHAs noted that they need a large additional increment of funding relative to their current spending (367%) to reach full implementation.

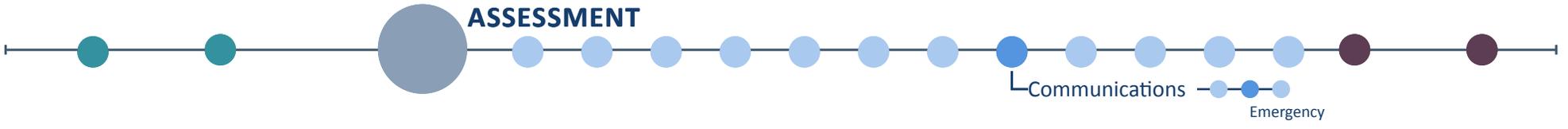
This functional area is highly implemented across the system. Only four LPHAs—one extra small, two small, and one medium—aren’t at least significantly implemented.

Taken together with this programmatic finding, the large amount of additional spending (367% of current) needed to reach full implementation suggests that the increase from significantly implemented to fully implemented has higher marginal costs than the initial activities needed to reach significant implementation. It is likely that this has to do with allocation of additional resources to support surge capacity.

Only one role is included in the **Emergency Communication** functional area. The degree of implementation of this role and across local providers and population by level of service are provided on the following page.

Non-Financial Barriers

LPHAs did not identify any barriers to implementing this functional area’s activities.



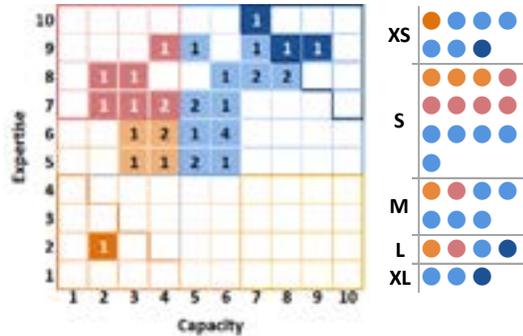
Communications

Emergency Communications

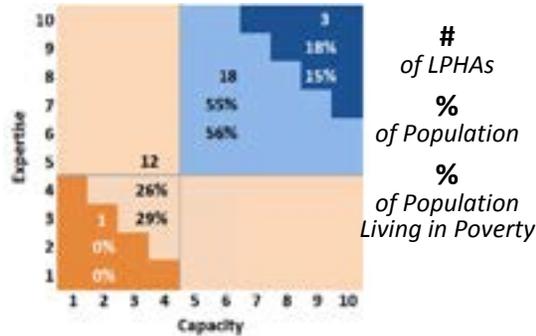
Local public health authorities shall engage with the OHA Public Health Division when an outbreak or significant public health risk is identified to determine the scope of the

<i>functional area</i>	5	25	1	2	1	16%	80%	4%
<i>Role 1</i>	11	21	2			53%	45%	2%

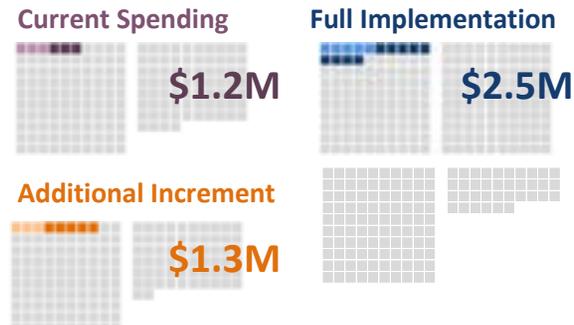
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



COMMUNICATIONS FUNCTIONAL AREA 3:

Educational Communications

The degree of implementation of *Educational Communications* is similar to the degree of implementation of the Regular Communications functional area. This functional area represents 44% of current local Communications activities. This share is expected to decrease to 36% at full implementation, with the spending in this area increasing 100%.

The degree of implementation of this functional area seems to be concentrated in the partially implemented, low capacity, and significantly implemented sections of the scoring matrix. There is no clear pattern as to what size LPHA is most likely to be more or less implemented. It does appear that lack of capacity is a greater issue than lack of expertise, however.

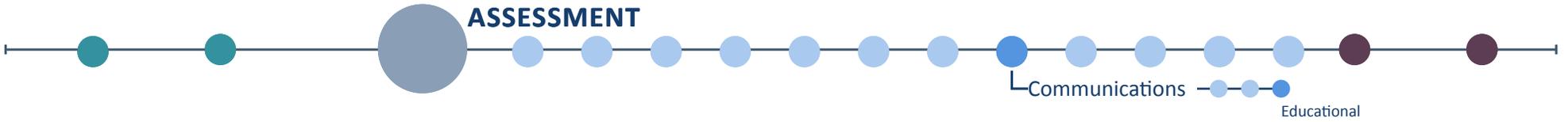
The percentage of the population in a service area for an LPHA that is significantly or fully implemented is a bit higher than the number of LPHAs at that degree of implementation. This is not surprising, considering that all three extra-large agencies cited themselves as significantly or fully implemented.

No specific roles and deliverables are included in this functional area, however, as a cross-cutting capability it is likely that this functional

area supports educational communications for many of the Foundational Programs.

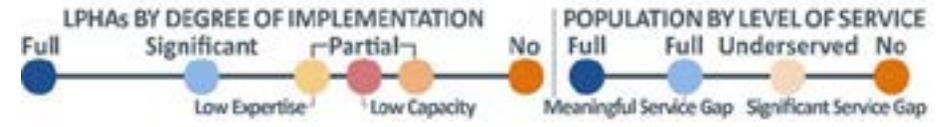
Non-Financial Barriers

LPHAs did not identify any barriers to implementing this functional area's activities.

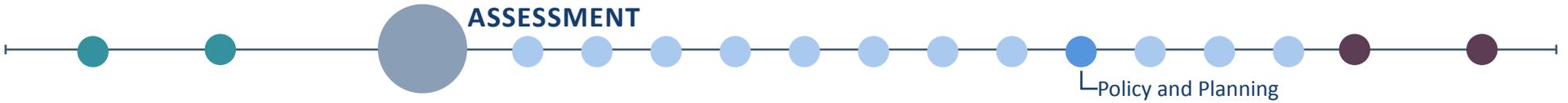


Communications

Educational Communications



<i>functional area</i>	3	18	7	5	1	18%	55%	26%
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POLICY AND PLANNING

The public health system will implement policies, systems and environmental changes that meet the community's changing needs and align with state and federal policies that aim to eliminate health disparities, reduce leading causes of death and disability and improve health outcomes for all people in Oregon.

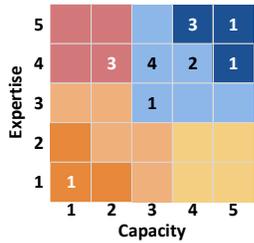
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

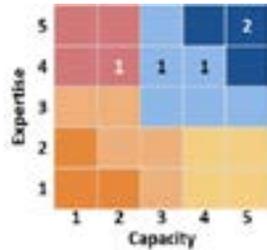
Significant



ROLES

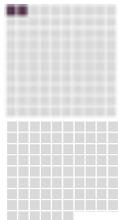


DELIVERABLES



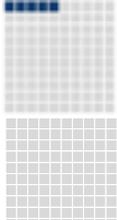
RESOURCES

Current Spending



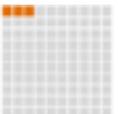
\$0.9M

Full Implementation



\$2.3M

Additional Increment



\$1.4M

Policy and Planning activities represent less than 1% of PHD’s current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Capability’s share of state public health activities will increase to 1.4%. A small additional increment of spending (\$1.4M) is needed to get PHD to full implementation. This will make the state activities for *Policy and Planning* the 4th largest Foundational Capability (out of 7) and 8th largest Foundational Capability or Program (out of 11).

PHD’s *Policy and Planning* activities include 16 roles and 5 deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be significantly implemented. This is supported by more detailed Self-Assessment scores that show that the majority of the roles and deliverables that represent *Policy and Planning* state activities are significantly or fully implemented. In fact, 12 of the 16 roles and 4 of 5 deliverables are significantly or fully implemented.

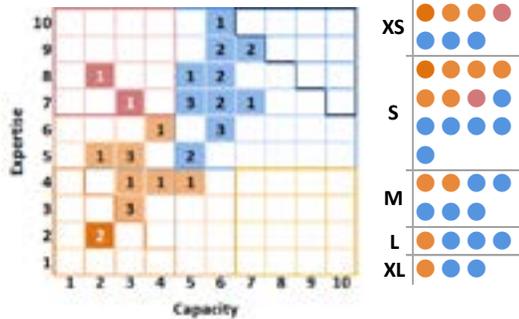
The state has identified that its roles and deliverables that specifically support LPHAs are significantly or fully implemented. Only one of the less implemented roles and deliverables is a state activity that directly supports the provision of local *Policy and Planning* activities:

- Make information and state health data readily available to community members.

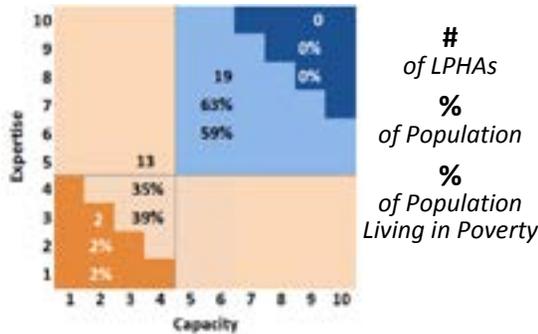
While this roles doesn’t directly identify LPHAs as its beneficiary, LPHAs are more likely to interface with residents seeking this data, which means LPHAs are likely shouldering some of this burden for PHD at this time.

LOCAL PUBLIC HEALTH AUTHORITIES

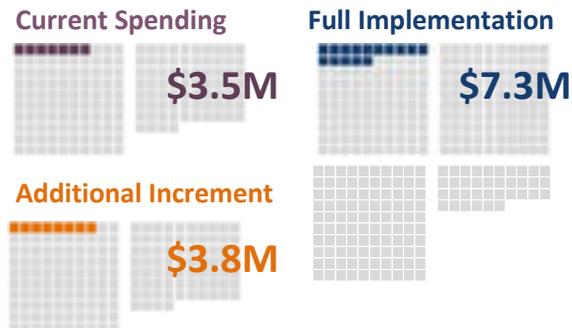
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



Policy and Planning activities represent 4% of LPHAs' current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Capability's share of local public health activities will nominally increase to 5%. A significant additional increment of spending (\$3.8M or approximately an additional 109%) is needed to get LPHAs to full implementation. This will make local activities for *Policy and Planning* the 4th largest Foundational Capability (out of 7) and 8th largest Foundational Capability or Program (out of 11).

Programmatically, implementation of this Foundational Capability varies across the system, with a little over half of LPHAs citing that they have significantly implemented it. The LPHA implementation pattern suggests that lack of capacity is a greater issue to implementation than lack of expertise.

We identified two non-financial barriers to implementing this Foundational Program overall:

- Some LPHAs desire models and technical assistance to support developing local public health policy.
- Many LPHAs desire additional coordination with PHD around *Policy and Planning* efforts.

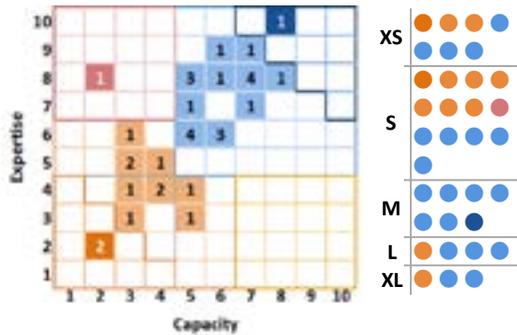
Local *Policy and Planning* activities are broken down into three approximately evenly-sized (both currently and at full implementation) functional areas:

- Develop and Implement Policy.** Represents 36% of current local *Policy and Planning* activities; its share of local *Policy and Planning* activities would decrease to 34% at full implementation.
- Improve Policy with Evidence Based Practice.** Represents 31% of current local *Policy and Planning* activities, and would increase nominally to 32% at full implementation.
- Understand Policy Results.** Represents 33% of current local *Policy and Planning* activities. This share is expected to nominally increase to 34% at full implementation.

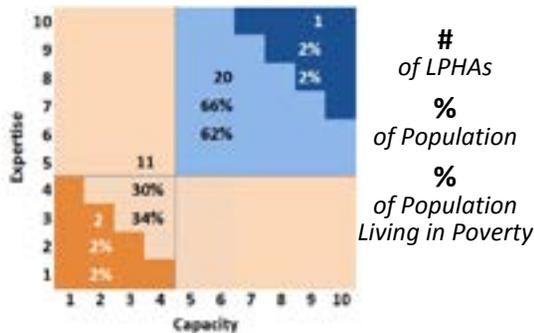
Each of these functional areas has varied levels of implementation across the system, and seems to be more implemented in larger LPHAs. Along with the non-financial barrier that many LPHAs would like models and technical assistance in these efforts, each functional area may present opportunities for cross jurisdictional delivery.

Following, we've provided profiles like this page for each of these three functional areas.

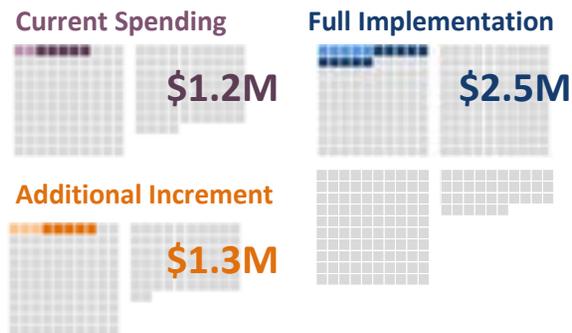
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



POLICY AND PLANNING FUNCTIONAL AREA 1:

Develop and Implement Policy

Develop and Implement Policy is one of three functional areas that together describe local *Policy and Planning* activities. This functional area represents 36% of current local *Policy and Planning* activities; its share of local *Policy and Planning* activities would decrease to 34% with the addition of 104% more funding (\$1.3M) to reach full implementation.

While the degree of implementation of this functional area varies across the system, there is a clear pattern as to which LPHAs are at each level of implementation. The majority of medium, large, and extra large providers have significantly or fully implemented this functional area, while the majority of partially or not implemented LPHAs are smalls or extra small.

Implementation is similar from both a system and population service perspective. Approximately two-thirds of LPHAs have significantly or full implemented, and approximately two-thirds of residents are being served by an LPHA that is significantly or fully implemented.

The activities in the *Develop and Implement Policy* functional area include 8 roles and 3 deliverables. The degree of implementation of these roles and deliverables across local

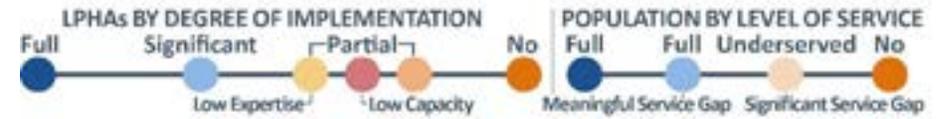
providers and population by level of service are provided on the following page.

Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area’s activities:

- (Role 1) Community Health Improvement Plans need to be developed such that there is more ownership by those community institutions and members who will participate in its implementation.
- (Role 1) LPHAs have limited access to relevant data for inclusion in Community Health Improvement Plans.
- (Role 1) There are limited opportunities to collaborate and coordinate with OHA on local implementation strategies related to the State Health Improvement Plan.
- (Role 3 and 4) Some LPHAs desire models and technical assistance from the state to support developing local public health policy.
- (Deliverable 9) The State Health Improvement Plan isn’t well publicized and seems to be oriented toward urban public health.

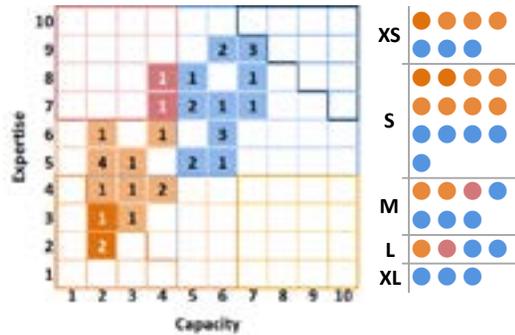
ASSESSMENT



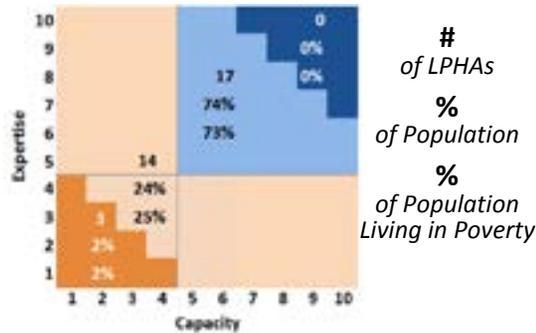
Policy and Planning

Functional Area	Full	Significant	Partial	No	Full	Full Underserved	No			
Develop and Implement Policy	1	20	1	10	2	2%	66%	30%	2%	
Interpret, respond to, and implement federal, state, and local policy changes. Coordinate enforcement of federal and state policy and regulatory activities when delegated to do so.	Role 7	6	24	4	22%	75%	3%			
Monitor and respond to state and local public health issues that impact local authorities and, upon request, participate in policy initiatives that include multiple authorities.	Role 6	1	24	2	4	3	2%	85%	11%	2%
Assume a leadership role and coordinate with the state on policy initiatives.	Role 5	1	14	2	11	6	14%	56%	25%	5%
Use information from the community health assessment to develop and revise the community health improvement plan (CHIP) at least every five years in alignment with accreditation.	Role 1	9	15	4	6	31%	31%	37%		
Develop and amend as needed rules to implement local ordinances.	Role 8	1	17	2	8	6	2%	60%	29%	9%
Develop policy, systems, and environmental change strategies to improve health outcomes, using an established policy change framework.	Role 2	2	13	2	11	6	1%	48%	45%	5%
Develop policy concepts, as appropriate, for public health issues to be addressed by city and county governments in the authority.	Role 4	2	12	5	10	5	3%	42%	50%	5%
Develop a strategic policy plan for the authority that includes specific strategies to reduce or eliminate health disparities.	Role 3	1	10	3	8	12	2%	19%	61%	18%
Develop, implement, monitor, evaluate, and modify a CHIP at least every five years that is built on the community health assessment and considers the SHIP where appropriate.	Deliverable 9	8	19	7	30%	45%	25%			
Develop and implement a strategic policy plan for the authority that is coordinated with the community health improvement plan and other state and local plans where appropriate.	Deliverable 10	3	20	1	6	4	12%	55%	6%	27%
Develop and amend rules and regulations necessary to implement state and local statutes or ordinances or federal statutes, rules or regulations.	Deliverable 11	4	16	8	6	26%	29%	36%	9%	

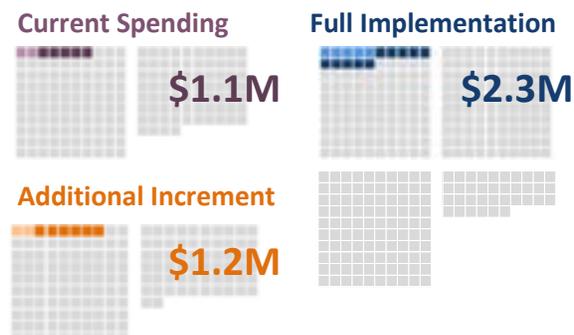
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



POLICY AND PLANNING FUNCTIONAL AREA 2:

Improve Policy With Evidence Based Practice

This functional area represents the majority (31%) of current local *Policy and Planning* activities. LPHAs indicated that it would cost them an additional \$1.2M (a 114% increase) to reach full implementation, at which point this program would represent a similar share (32%) of local *Policy and Planning* activities.

This functional area is not highly implemented across the system. Approximately half of providers are significantly implemented, while the other half are only partially or not at all implemented. It is notable that no LPHA identified that they had fully implemented this functional area. LPHAs likely aren't able to devote the needed resources to this more proactive functional area because of lack of capacity across their LPHA for more reactive functions.

While half of providers are significantly implemented, three-quarters of residents live in a service area where these activities are present. This skew is likely because all three extra large providers scored themselves as significantly implemented.

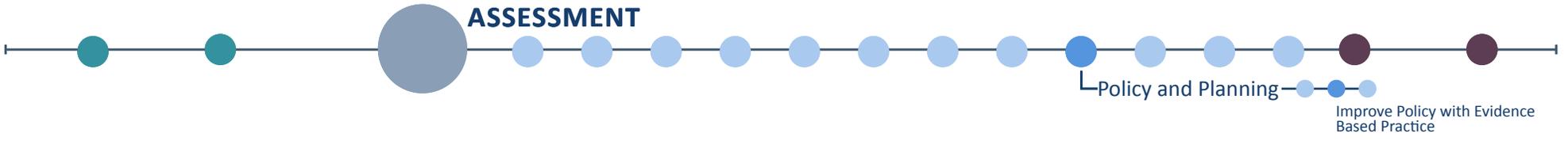
The activities included in the **Improve Policy With Evidence Based Practice** functional area

includes only one role, however cross-cutting capabilities support the Foundational Programs, so it is likely that many LPHAs are improving other policies based on evidence based practice.

Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area's activities:

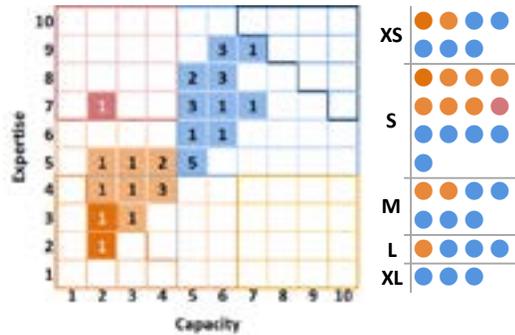
- (Role 1) Some LPHAs identified that they need model tools and technical assistance/training on public health economic assessments.
- (Role 1) Some LPHAs perceive that PHD is not inclusive on who it develops economic analyses with.



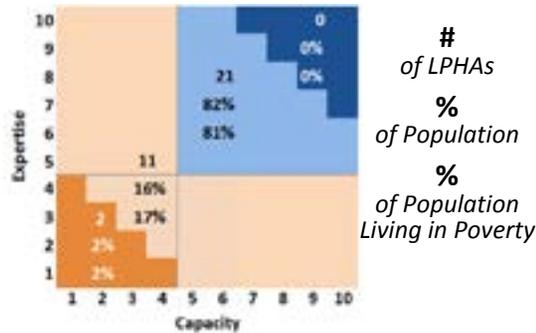
Policy and Planning

Improve Policy with Evidence Based Practice	<i>functional area</i>	17	2	12	3	74%	24%	2%
Coordinate with the state on development of economic analyses (e.g. analysis of cost/risk of non-investment return on investment) for proposed policy changes.	<i>Role 1</i>	7	9	18		10%	17%	73%

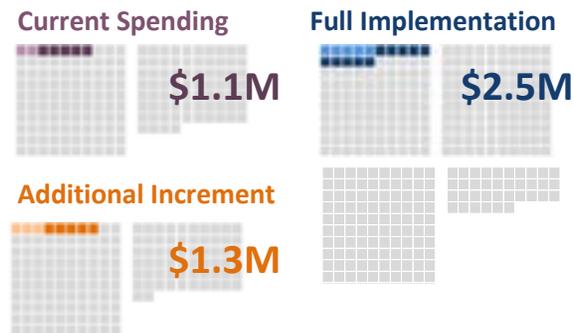
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



POLICY AND PLANNING FUNCTIONAL AREA 3:

Understand Policy Results

Understand Policy Results represents 33% of current local *Policy and Planning* activities. This share is expected to increase nominally to 34% at full implementation with the spending in this area increasing 116% (\$1.3M).

Currently, while the degree of implementation of this functional area varies across the system, it seems that medium, large, and extra-large providers are more likely to be significantly implemented. Again, it is notable that no LPHA identified that they had fully implemented this functional area. LPHAs likely aren't able to devote the needed resources to this more proactive functional area because of lack of capacity across their LPHA for more reactive functions.

We do see similar skew (a lower percentage of providers at significant implementation relative to residents living in service areas where this functional area is significantly implemented) to the previous functional area. While it is less pronounced in this example, it is again likely because all three extra-large providers scored themselves as significantly implemented.

The activities included in the *Understand Policy Results* functional area include 5 roles and 2 deliverables. The degree of implementation of

each of these roles and deliverables is fairly consistent across local providers, as shown on the following page.

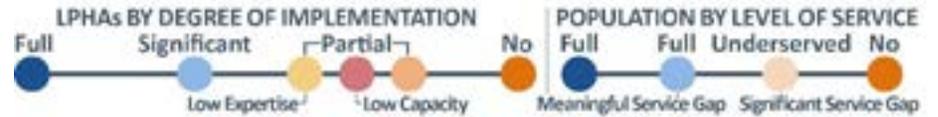
Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area's activities:

- (Role 1) There are significant political considerations in each community related to how LPHA's communicate how policy changes impact health.
- (Role 5) Many LPHAs do not tie their existing priority/focal population outreach efforts to specific policy initiatives.

ASSESSMENT

Policy and Planning
Understand Policy Results



Policy and Planning

Functional Area	Full	Significant	Partial	Low Expertise	Low Capacity	No	Full	Meaningful Service Gap	Underserved	Significant Service Gap
Understand Policy Results		21	1	10	2		82%	16%	2%	
Make information and community health data readily available to community members.	6	19	2	5	2		9%	81%	10%	
Identify and convene strategic partners, as needed.	9	20	1	4			21%	68%	12%	
Engage traditional and nontraditional partners in conversations about efforts to improve health outcomes.	5	20	6	3			17%	56%	25%	2%
Assume a leadership role for communicating with the community about how policy changes may impact health.	3	17	1	11	2		7%	49%	42%	3%
Make intentional efforts to engage priority/focal populations and their partner organizations.	5	17	3	9			8%	42%	49%	
Make information about the community health improvement plan available to the public at least annually.	7	20	3	4			31%	60%	9%	
Share information with the governing body to whom the local health authority is accountable about progress on the CHIP at least twice a year.	4	21	3	5	1		17%	66%	14%	3%



LEADERSHIP AND ORGANIZATIONAL COMPETENCIES

Provide team-based leadership within public health departments at the state and local level that defines strategic direction necessary to achieve public health goals including health equity and lead stakeholders in achieving those goals.

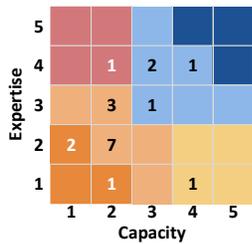
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

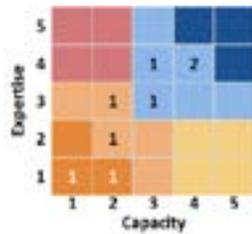
Partial



ROLES

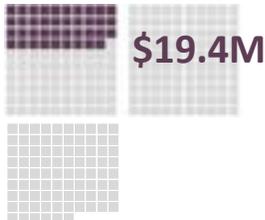


DELIVERABLES



RESOURCES

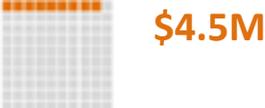
Current Spending



Full Implementation



Additional Increment



Leadership and Organizational Competencies activities represent 14% of PHD’s current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Capability’s share of state public health activities will increase modestly, but still represent 14% of activities. A small additional increment of spending (\$4.5M) is needed to get PHD to full implementation. This will make the state activities for *Leadership and Organizational Competencies* the largest Foundational Capability (out of seven) and 4th largest Foundational Capability or Program (out of 11).

PHD’s *Leadership and Organizational Competencies* activities include 19 roles and eight deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be only partially implemented. PHD reported generally high levels of implementation in Leadership and Governance and lower implementation concentrated in the Public Health Modernization activities of Human Resources and Information Technology.

Some of the less implemented state roles and deliverables directly support local *Leadership and Organizational Competencies* activities, especially in workforce development and technology systems, such as:

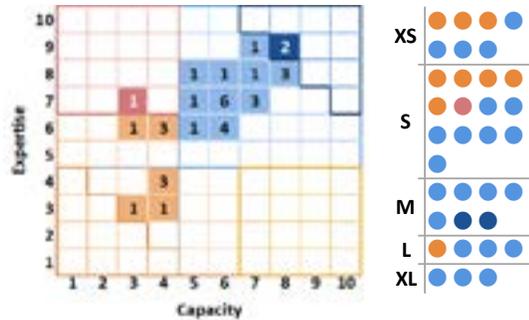
- Coordinate, or perform when necessary, assessments to capture the skills, knowledge, and abilities of the Oregon public health workforce (state, tribal and LPHAs), and develop workforce strategies to address gaps.
- Promote workforce development and capacity building, including provision of workforce development planning resources to LPHAs and tribal authorities, and build relationships with public health programs in higher education for future public health workforce needs.
- Develop, operate, and maintain interoperable technology that meets current and future public health practice needs.
- Assess public health information assets and needs; develop and implement a strategic plan with LPHAs, health system, and other partners to address information needs.

ASSESSMENT

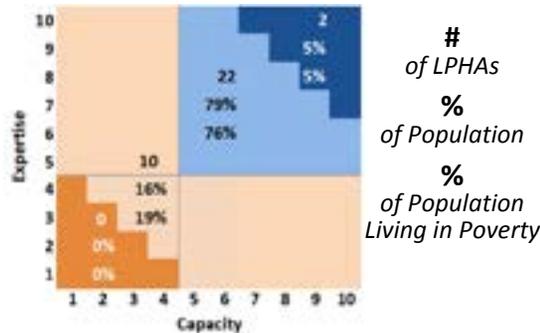
Leadership and Organizational Competencies

LOCAL PUBLIC HEALTH AUTHORITIES

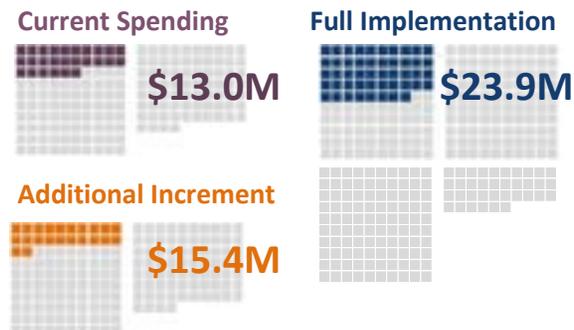
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



Leadership and Organizational Competencies

activities represent 15% of the LPHAs' current Public Health Modernization activities (as represented by current spending). At full implementation, the LPHAs estimate that the Capability's share of local public health activities will decrease to 14%. A significant additional increment of spending (\$11M, or 84% of current spending) is needed to get the LPHAs to full implementation. As a spending category, *Leadership and Organizational Competencies* will represent the largest Foundational Capability (out of seven) and the third largest Foundational Capability or Program (out of 11).

This Foundational Capability is relatively well-implemented, with 24 out of 34 LPHAs documenting significant or full implementation.

Taken together with the programmatic findings, the large amount (84%) of additional spending needed to reach full implementation suggests that the increase from significantly implemented to fully implemented has higher marginal costs than the initial activities needed to reach significant implementation.

There were no non-financial barriers identified for the capability overall, although barriers were reported within individual functional areas.

Local *Leadership and Organizational Competencies* activities are broken down into five functional areas:

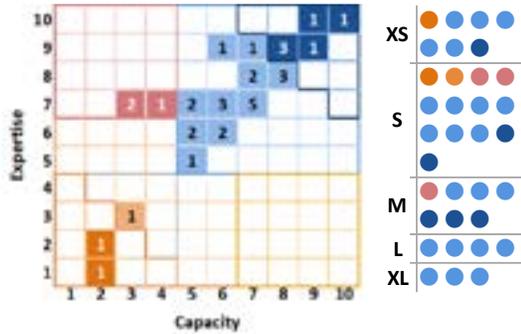
1. Leadership and Governance
2. Performance Management, Quality Improvement, and Accountability
3. Human Resources
4. Information Technology
5. Financial Management, Contracts and Procurement Services, and Facility Operations

Following are profiles for each of these five functional areas. However, LPHAs were not asked to estimate resource needs for each functional area.

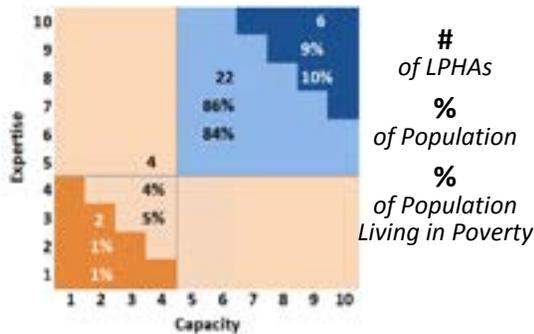
ASSESSMENT

Leadership and Organizational Competencies
 Leadership and Governance

LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES

LPHAs estimated the Leadership and Organizational Competencies Foundational Capability as a whole. LPHAs were not required to estimate resource needs for each functional area.

LEADERSHIP AND ORGANIZATIONAL COMPETENCIES FUNCTIONAL AREA 1:

Leadership and Governance

This functional area is well implemented with more than 80% of LPHAs reporting significant or full implementation covering 96% of the residents of Oregon.

The activities in the *Leadership and Governance* functional area include three roles and two deliverables. The degree of implementation of the deliverables across local providers and population by level of service are on the following page. Due to an oversight, the three roles were not included in the self-assessment survey.

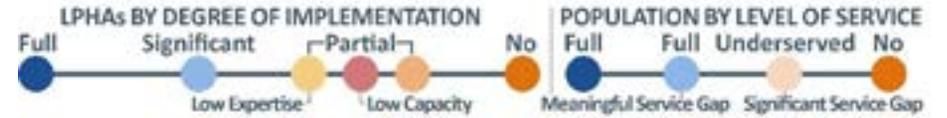
Non-Financial Barriers

LPHAs identified two barriers to implementing the activities in this functional area:

- (Deliverable 4) State programs have differing approaches as to when LPHAs are engaged.
- (Deliverable 4) Some LPHAs reported that they did not have a strategic plan for public health initiatives.

ASSESSMENT

Leadership and Organizational Competencies
 Leadership and Governance

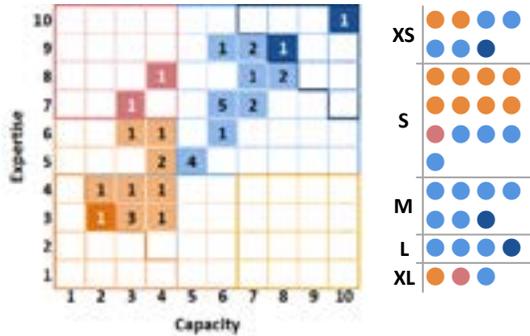


Leadership and Governance	Functional Area	Full	Significant	Partial	Low Expertise	Low Capacity	No	Full	Meaningful Service Gap	Underserved	Significant Service Gap
		6	22	3	1	2		9%	86%		4%
Evidence of engagement in health policy development, discussion and adoption with the OHA Public Health Division to define a strategic plan for public health initiatives.	Deliverable 4	4	15	3	8	4		21%	53%	15%	10%
Evidence of engagement with appropriate governing entity about public health's legal authorities and what new legislative concepts, laws, and policies may be needed.	Deliverable 5	3	23	1	3	4		19%	74%		4%

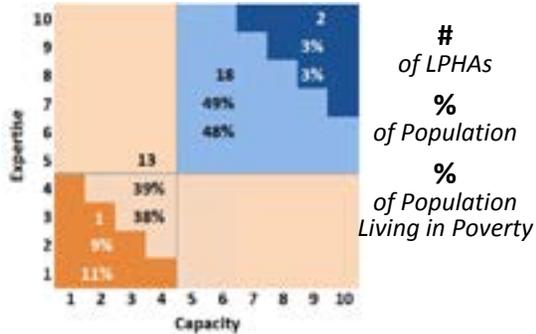
ASSESSMENT

Leadership and Organizational Competencies
Performance Management, Quality Improvement and Accountability

LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES

LPHAs estimated the Leadership and Organizational Competencies Foundational Capability as a whole. LPHAs were not required to estimate resource needs for each functional area.

LEADERSHIP AND ORGANIZATIONAL COMPETENCIES FUNCTIONAL AREA 2:

Performance Management, Quality Improvement, and Accountability

This functional area includes activities that are generally implemented, as reported by LPHAs, but as a whole this area has service gaps, with only two LPHAs reporting full implementation.

Significant and full implementation was reported by all LPHAs with populations between 50,000 and 150,000, with greater service gaps in small and extra-large jurisdictions.

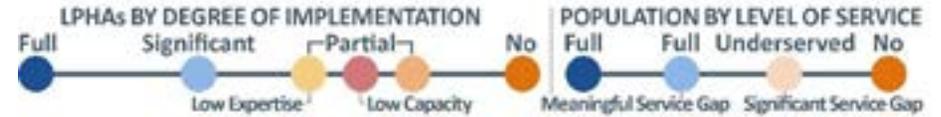
There are four activities in this functional area, three roles and one deliverable. The degree of implementation of each of these roles and deliverables across local providers and population by level of service are provided on the following page.

Non-Financial Barriers

LPHAs did not report non-financial barriers specific to the activities in this functional area.

ASSESSMENT

Leadership and Organizational Competencies
Performance Management, Quality Improvement and Accountability

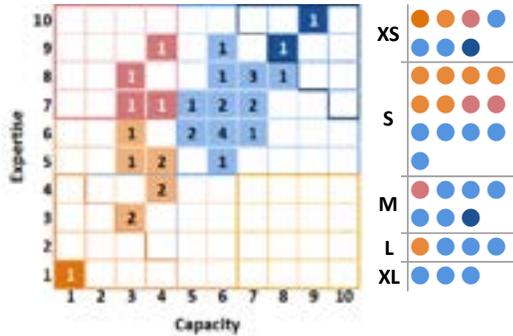


		Full	Significant	Partial	No	Full	Full Underserved	No		
Performance Management, Quality Improvement, and Accountability	<i>functional area</i>	2	18	2	11	1	49%	39%	9%	
Implementation of a performance management system to monitor achievement of public health objectives using nationally recognized framework and quality improvement tools and methods.	<i>Deliverable 4</i>	3	16	1	5	9	23%	38%	6%	33%
Use principles of public health law, agency rules, and constitutional guarantee of due process to plan, implement and enforce public health orders.	<i>Role 2</i>	6	20	1	6	1	22%	70%	7%	
Ensure the management of organizational change (e.g., refocusing a program or an entire organization, etc.)	<i>Role 1</i>	5	23	1	2	3	20%	57%	23%	
Use performance management, quality improvement tools and coaching to promote and monitor organizational objectives and sustain a cultural of quality.	<i>Role 3</i>	3	21	4	4	2	17%	65%	18%	

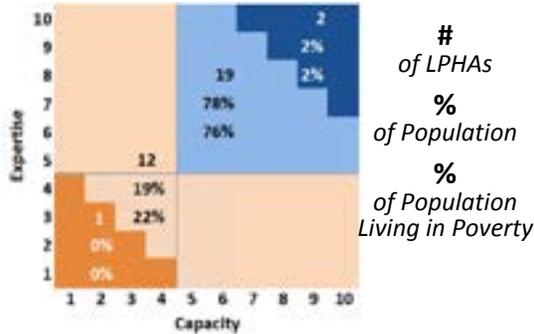
ASSESSMENT

Leadership and Organizational Competencies
Human Resources

LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES

LPHAs estimated the Leadership and Organizational Competencies Foundational Capability as a whole. LPHAs were not required to estimate resource needs for each functional area.

LEADERSHIP AND ORGANIZATIONAL COMPETENCIES FUNCTIONAL AREA 3:

Human Resources

Approximately two-thirds of LPHAs report implementing the activities that make up the **Human Resources** functional area.

Currently, the degree of implementation of this functional area varies across the system, with a slight concentration in jurisdictions with smaller populations. As a primarily internal set of activities, the relatively high percentage of population living within areas with significant and full implementation (80%) is less meaningful in this context.

There are four roles and one deliverable included in the **Human Resources** functional area. The degree of implementation of each of these roles and deliverables across local providers and population by level of service are provided on the following page.

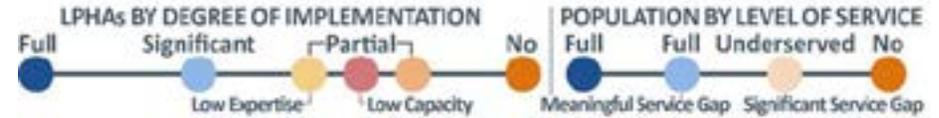
Non-Financial Barriers

LPHAs identified two barriers to implementing the roles and deliverables that make up this functional area's activities:

- (Functional Area) In some counties, LPHAs are unable to hire appropriate expertise at the current pay scale.
- (Functional Area) Some LPHAs are hindered in ensuring nimble human resources support by the larger government entities they are housed within.

ASSESSMENT

Human Resources Leadership and Organizational Competencies

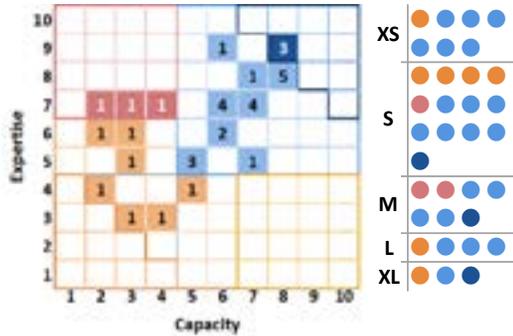


Human Resources	functional area	Full	Significant	Partial	No	Full	Full Underserved	No	
		2	19	4	8	1	78%	19%	
Assessment of staff competencies; the provision of individual training and professional development and the provision of a supportive work environment.	Deliverable 6	4	20	2	6	2	23%	37%	38%
Ensure a high quality public health workforce by promoting workforce development and capacity building and assure a future public health workforce by building relationships with public health programs in higher education.	Role 3	3	20	4	6	1	19%	34%	46%
Coordinate, or convene when necessary, efforts to assess leadership and organizational capabilities within their local authority to understand capacity and to identify gaps.	Role 2	3	23	4	4		15%	51%	30%
Ensure nimble human resources support for public health work, including composition and maintenance of up-to-date job classifications suitable for the above listed roles and activities, use of temporary staffing and other methods to expand and contract staff to meet immediate public health demands.	Role 5	2	15	6	8	3	62%	34%	
Collaborate and share workforce development planning resources with the state, tribal and other local authorities.	Role 1	1	16	2	10	5	43%	33%	23%

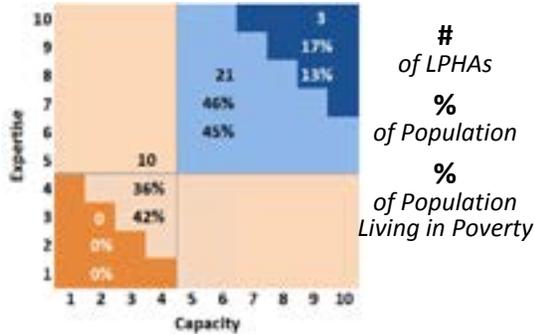
ASSESSMENT

Leadership and Organizational Competencies
Information Technology

LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES

LPHAs estimated the Leadership and Organizational Competencies Foundational Capability as a whole. LPHAs were not required to estimate resource needs for each functional area.

LEADERSHIP AND ORGANIZATIONAL COMPETENCIES FUNCTIONAL AREA 4:

Information Technology

LPHAs assess their overall implementation level as relatively high, with 70% reporting significant or full implementation. The functional area **Information Technology** has the least implemented roles and deliverables within the *Leadership and Organizational Competencies*. Implementation does not have a clear connection with size, although this functional area does seem to be less implemented in areas with a higher percentage of the population living below the Federal poverty level.

The activities included in the **Information Technology** functional area include three roles and two deliverables. With the exception of ensuring the privacy of health information, which all LPHAs reported as being significantly or fully implemented, more than half of Oregon’s population live in service areas with significant service gaps. The degree of implementation of each of these roles and deliverables across local providers and population by level of service are provided on the following page.

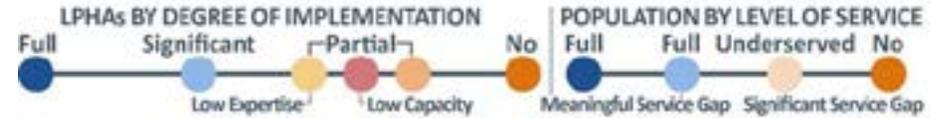
Non-Financial Barriers

LPHAs identified barriers to implementing the deliverables that make up this functional area’s activities:

- (Deliverable 4) County Information Technology can be unresponsive to the needs of Public Health.
- (Deliverable 5) Expertise for training local public health technology users does not exist in all locations.

ASSESSMENT

Leadership and Organizational Competencies
Information Technology

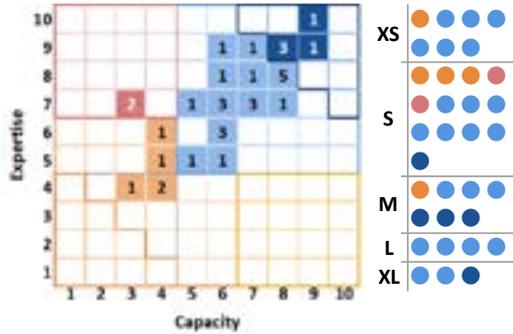


Information Technology	functional area	Full	Significant	Partial	No	Full	Full Underserved	No	
		3	21	3	7	17%	46%	36%	
Ensure privacy and protection of personally identifiable and/or confidential health information in data systems and information technology.	Role 2	15	19			43%	57%		
In collaboration with health systems and other partners, use the information assets/needs assessment to develop and implement a vision and strategic plan. The plan should include a funding strategy and appropriate governance processes to address information management and supportive information systems.	Role 3	3	12	3	8	8	30%	44%	24%
Develop and maintain local public health technology and resources to support current and emerging public health practice needs. Document that information technology supports public health and administrative functions of the department.	Role 1	1	18	4	7	4	39%	57%	
Implementation of a technical support plan that provides users of local public health technology systems and technology resources with appropriate training.	Deliverable 5	1	17	2	7	7	34%	39%	27%
Implementation of a current, interoperable technology that meets current and future public health practice needs and maintenance of those resources. Assurance that technology systems and technology resources are sufficient to support current and future local public health practice needs and ability to maintain those systems.	Deliverable 4		19	1	7	7	44%	41%	15%

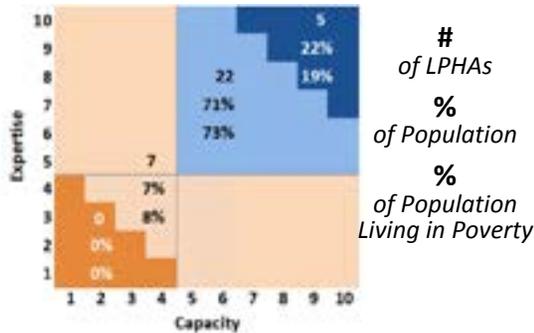
ASSESSMENT

Leadership and Organizational Competencies
 Financial Management, Contracts and Procurement Services, Facility Operations

LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES

LPHAs estimated the Leadership and Organizational Competencies Foundational Capability as a whole. LPHAs were not required to estimate resource needs for each functional area.

LEADERSHIP AND ORGANIZATIONAL COMPETENCIES FUNCTIONAL AREA 5:

Financial Management, Contracts and Procurement Services, and Facility Operations

This functional area is well implemented across the system – almost 80% of LPHAs report significant or full implementation of the activities required.

Of the six LPHAs that reported partial implementation, all but one are jurisdictions with less than 40,000 residents.

More than 90% of Oregon’s population is living in jurisdictions that have implemented most or all activities within this functional area.

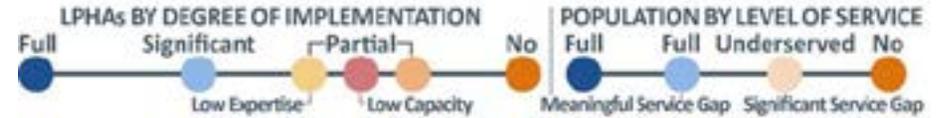
The **Financial Management, Contracts and Procurement Services, and Facility Operations** functional area has two roles and one deliverable. The degree of implementation of each of these roles and deliverable across local providers and population by level of service are provided on the following page.

Non-Financial Barriers

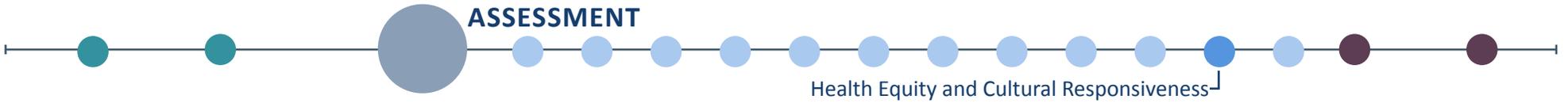
LPHAs did not identify barriers specific to implementing the roles and deliverables that make up this functional area’s activities.

ASSESSMENT

Leadership and Organizational Competencies
 Financial Management, Contracts and Procurement Services, Facility Operations



Functional Area	Full	Significant	Partial	No	Full	Full Underserved	No	
Financial Management, Contracts and Procurement Services, and Facility Operations	5	22	2	5	22%	71%	7%	
Policies and procedures that protect personally identifiable and/or confidential health information.	17	16	1		73%	26%	1%	
Work with partners to seek and sustain funding for additional public health priority work.	5	16	3	6	4	39%	32%	26%
Ensure use of financial analysis methods to make decisions about policies, programs and services and ensure that all are managed within current and projected budgets.	6	19	1	5	3	28%	47%	20%



HEALTH EQUITY AND CULTURAL RESPONSIVENESS

Ensure the equal opportunity to achieve the highest attainable level of health for all populations through implementation of policies, programs, and strategies that respond to the factors within culture that impact health and seek to correct historic injustices borne by certain populations. Make development of strong cultural responsiveness a priority for public health organizations.

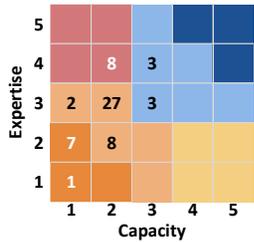
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

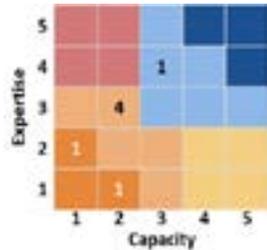
Partial



ROLES



DELIVERABLES



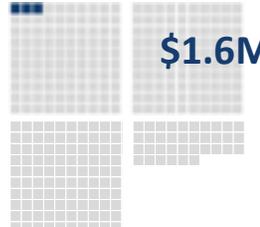
RESOURCES

Current Spending



\$0.7M

Full Implementation



\$1.6M

Additional Increment



\$0.9M

Health Equity and Cultural Responsiveness

activities represent 0.5% of PHD’s current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Capability’s share of state public health activities will increase to 0.9%. A small additional increment of spending (\$0.9M; proportionally large at 119% of current spending) is needed to get PHD to full implementation. This will make the state activities for *Health Equity and Cultural Responsiveness* the 6th largest Foundational Capability (out of 7) and 10th largest Foundational Capability or Program (out of 11).

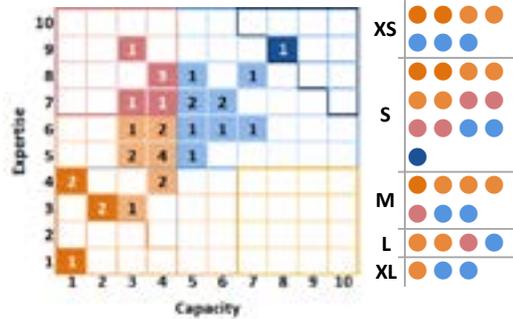
PHD’s *Health Equity and Cultural Responsiveness* activities include 59 roles and seven deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be only partially implemented. Additionally, PHD notes that the majority of the roles and deliverables that represent *Health Equity and Cultural Responsiveness* state activities are partially or not at all implemented. In fact, 53 of the 59 roles and six of seven deliverables are partially or not at all implemented.

A few of the less implemented roles and deliverables are state activities that directly support the provision of local *Health Equity and Cultural Responsiveness* activities; these include:

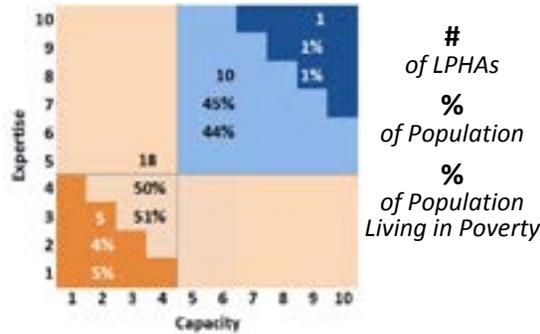
- Increase the value for cultural responsiveness in OHA Public Health Division and among local public health authorities.
- Promote community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government.
- Work collaboratively with local public health authorities on state and local policies, programs, and strategies intended to ensure health equity.
- Develop and implement assessment and training programs to improve staff knowledge and capabilities about health inequity. Make these tools available to local public health authorities.
- Develop and provide health equity and cultural responsiveness best practices, technical assistance, and tools to local public health authorities.

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

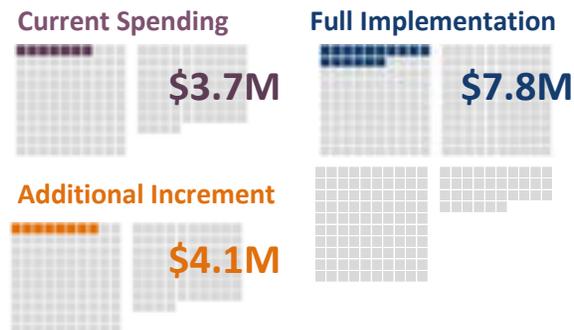


POPULATION SERVICE



of LPHAs
% of Population
% of Population Living in Poverty

RESOURCES



Health Equity and Cultural Responsiveness activities represent 4% of LPHAs’ current Public Health Modernization spending. At full implementation, LPHAs estimate that the Capability’s share of local public health activities will marginally increase to 5%. Compared to current spending, more than double is needed for full implementation – from \$3.7M to \$7.9M. This will make the state activities for *Health Equity and Cultural Responsiveness* the 4th largest Foundational Capability (out of 7) and 8th largest Foundational Capability or Program (out of 11).

Currently this Capability is not generally implemented across the state. Out of 34 LPHAs, 11 reported significant or full implementation. Five LPHAs reported that overall they have not implemented the activities outlined in *Health Equity and Cultural Responsiveness*.

There are no clear patterns in implementation by population size, and overall, 55% of the population live in areas with significant service gaps within this Foundational Capability.

Some LPHAs identified that county hiring processes limit their ability to increase workplace equity and community representativeness. Additionally, barriers related to individual functional area and roles and deliverables are included below.

Local *Health Equity and Cultural Responsiveness* activities are broken down into two functional areas:

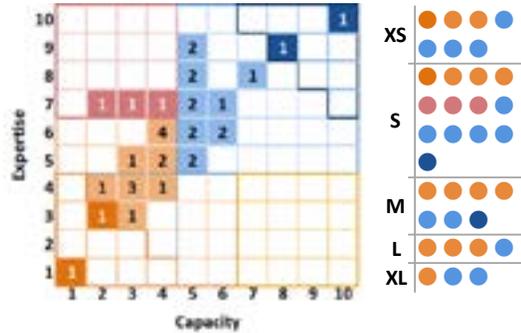
- Foster Health Equity.** This functional area represents 61% of current local *Health Equity and Cultural Responsiveness* spending; its share of local *Health Equity and Cultural Responsiveness* activities would decrease to 54% at full implementation.
- Communicate and Engage Inclusively.** The activities within this functional area represent 39% of current local *Health Equity and Cultural Responsiveness* spending. LPHAs identified a greater resource need in this functional area, increasing spending by almost 150%.

Profiles for each functional area can be found on the following pages.

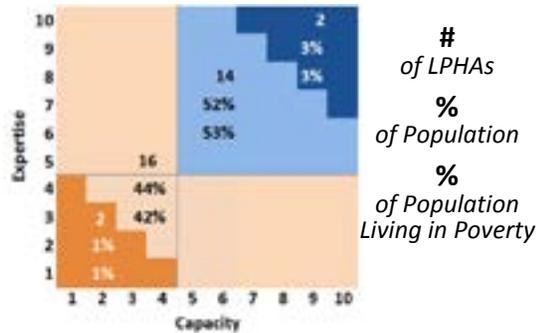
ASSESSMENT

● Health Equity and Cultural Responsiveness
 ○ Foster Health Equity

LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES

Current Spending



Full Implementation



Additional Increment



HEALTH EQUITY AND CULTURAL RESPONSIVENESS FUNCTIONAL AREA 1:

Foster Health Equity

This functional area represents 61% of current local Health Equity and Cultural Responsiveness Activities; its share of local *Health Equity and Cultural Responsiveness* activities would decrease to 54% with the addition of 88% more funding (\$2.0M) to reach full implementation.

In comparison to *Health Equity and Cultural Responsiveness* overall implementation and the other functional area, LPHAs' activities in the **Foster Health Equity** functional area are more implemented: 47% of LPHAs reported significant or full implementation, covering 55% of the Oregon population.

The activities in the **Foster Health Equity** functional area include 44 roles and six deliverables. The degree of implementation of these roles and deliverables across local providers and population by level of service are on the following two pages.

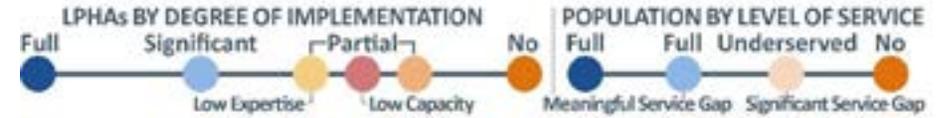
Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area's activities:

- (Role 1) There are data limitations, including limited information on health equity and population diversity in OHA Public Health Division data. Additionally, the small population size of some LPHAs makes confidentiality a concern.
- (Role 3) Capacity to identify groups with disparate health outcomes is limited by the data available and a lack of appropriate geographic scale.
- (Role 7) Some LPHAs reported a need for tools and talking points to make the economic case for health equity.
- (Deliverable 34) Immigration concerns make it difficult to collect accurate data for some LPHAs.

ASSESSMENT

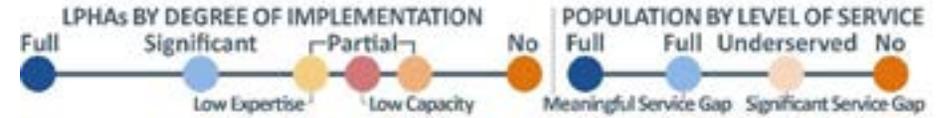
Health Equity and Cultural Responsiveness
Foster Health Equity



Foster Health Equity	Functional Area	Full	Significant	Partial	No	Full	Meaningful Service Gap	Underserved	Significant Service Gap	
		2	14	3	13	2	3%	52%	44%	13%
Provide services that are effective, equitable, understandable, respectful, and responsive to diverse cultural health practices.	Role 9	5	24	4	1	7%	80%	13%		
Collect and maintain data, or use data provided by the OHA Public Health Division, that reveal inequities in the distribution of disease.	Role 1	1	18	8	3	4	9%	80%	15%	4%
Ensure health equity and cultural responsiveness are fully integrated in local strategic priorities and plans.	Role 27	3	18	2	9	2	31%	48%	21%	
Develop and promote shared understanding of the determinants of health, health equity and lifelong health with local partners and the community.	Role 4	1	21	2	7	3	2%	76%	20%	2%
Compile local data on health resources and health threats.	Role 2	1	17	5	6	5	9%	75%	20%	4%
Identify local population subgroups or geographic areas characterized by an excess burden of adverse health or socioeconomic outcomes.	Role 3	1	15	5	8	5	9%	70%	24%	5%
Work collaboratively with the OHA Public Health Division on state and local policies, programs and strategies intended to assure health equity.	Role 12	2	19	4	5	4	3%	67%	20%	10%
Advocate for comprehensive policies that improve physical, environmental, social, and economic conditions in the community.	Role 15	1	19	3	6	5	2%	65%	25%	8%
Develop or use an existing assessment of and training to improve staff knowledge and capabilities about health inequity.	Role 22	2	19	1	9	3	16%	51%	32%	1%
Partner to enhance multi-disciplinary and multi-sector capacity to address health equity. Support health equity in all policies.	Role 11	4	14	4	9	3	3%	63%	23%	10%
Develop or use an existing anti-discrimination training as part of building a competent workforce.	Role 23	3	22	8	1	4%	59%	35%	1%	
Conduct an internal assessment of the local public health authority's overall capacity to act on the root causes of health inequities.	Role 28	12	2	12	8	55%	33%	13%		
Promote a common understanding of cultural responsiveness.	Role 5	2	17	2	10	3	3%	50%	46%	1%
Stay current with the literature on health equity, synthesize research, and disseminate findings as they are applicable to staff and community.	Role 30	14	5	11	4	50%	48%	2%		
Make available to people data and information on health status and conditions that influence health status.	Role 8	1	17	3	7	6	47%	40%	13%	
Play a leadership role in reducing or mitigating social and economic inequities and conditions that exist locally that lead to inequities.	Role 13	2	17	2	9	4	3%	44%	45%	8%
Increase awareness and practice of health equity among hiring managers and supervisors.	Role 26	1	20	2	4	7	9%	37%	39%	15%
Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improving workplace equity.	Role 24	2	14	2	12	4	9%	45%	52%	2%

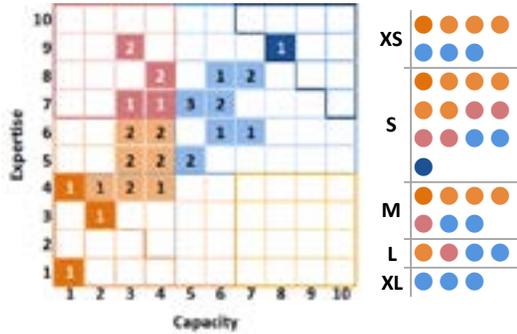
ASSESSMENT

Health Equity and Cultural Responsiveness
Foster Health Equity

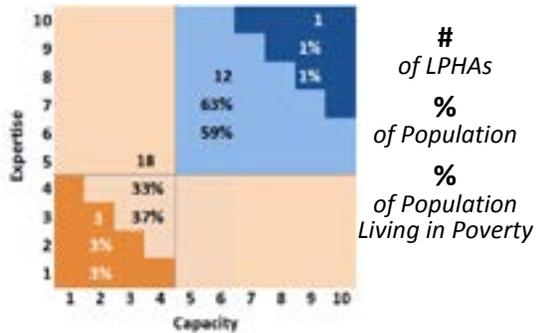


Item	Role	Full	Significant	Partial	No	Full	Full Underserved	No
Leverage health reform funding for health equity and to build cultural responsiveness into health care delivery.	Role 17	13	2	10	9	46%	39%	15%
Leverage health reform funding for health equity and to build cultural responsiveness into funding mechanisms.	Role 18	12	2	9	11	43%	36%	21%
Use existing evidence-based measures or develop public health measures of neighborhood conditions, institutional power, and social inequalities.	Role 14	1	11	3	7	42%	39%	19%
Ensure local programs integrate achieving health equity as a measureable outcome through cultural responsiveness of staff and programs.	Role 29	1	11	2	13	36%	53%	9%
Make the economic case for health equity, including the value of investment in cultural responsiveness.	Role 7	14	3	8	9	35%	29%	36%
Promote understanding of the extent and consequence of systems of oppression.	Role 6	2	9	1	13	28%	37%	32%
Promote public and private investments in community infrastructure to sustain and improve community health.	Role 16	2	14	3	10	26%	67%	4%
Support, implement, and evaluate strategies that tackle the root causes of health inequities, in strategic, lasting partnerships with public and private organizations and social movements.	Role 10	2	14	4	10	24%	64%	10%
Monitor funding allocations to ensure sustainable impact on health equity.	Role 19	11	11	12		18%	51%	31%
Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities.	Role 21	8	2	13	11	9%	66%	24%
Increase flexible categorical and non-categorical funding to address health equity.	Role 20	8	3	8	15	9%	35%	56%
Establish parity goals and create specific metrics with benchmarks to track progress.	Role 25	1	6	5	10	24%	62%	32%
Develop and implement annual training plan to increase local public health authority staff capacity to address the causes of health inequities.	Deliverable 33	18	2	12	2	55%	44%	1%
Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of public health policies, programs, and strategies.	Deliverable 34	1	12	1	14	14%	36%	45%
Conduct an internal assessment of the local public health authority's overall capacity to apply a health equity lens to programs and services.	Deliverable 31	15	4	9	6	30%	66%	4%
Develop an action plan resulting from the internal assessment to ensure an equity lens to policies, programs, and strategies.	Deliverable 32	9	5	10	10	25%	57%	18%
Develop and implement an annual training plan to increase local public health authority staff capacity.	Deliverable 35	1	5	14	10	15	2	12

LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



HEALTH EQUITY AND CULTURAL RESPONSIVENESS FUNCTIONAL AREA 2:

Communicate and Engage Inclusively

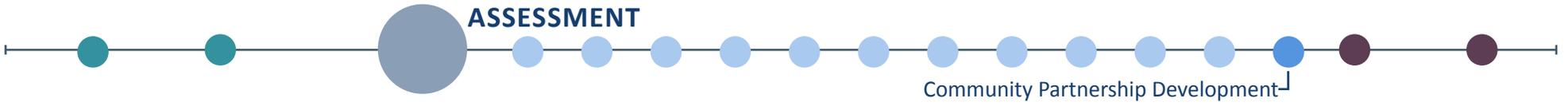
This functional area represents 40% of current local *Health Equity and Cultural Responsiveness* spending. Full implementation would increase share of spending to 46%. To reach full implementation, LPHAs reported that they need a comparatively large additional increment of funding (150% of current spending).

Implementation appears to be more likely in large jurisdictions, which explains the population service distribution – while 38% of LPHAs reported significant or full implementation, 64% of Oregon’s residents live in an area with significant to full implementation.

The *Communicate and Engage Inclusively* functional area includes 15 identified activities, 14 roles, and one deliverable. The degree of implementation of these roles and deliverable across local providers and population by level of service are on the following page.

Non-Financial Barriers

LPHAs did not identify specific barriers to implementing the roles and deliverables that make up this functional area’s activities, although multiple LPHAs noted that engaging marginalized and underrepresented communities require greater resources.



COMMUNITY PARTNERSHIP DEVELOPMENT

Relationships with diverse partners allow the governmental public health system to define and achieve collaborative public health goals.

PUBLIC HEALTH DIVISION

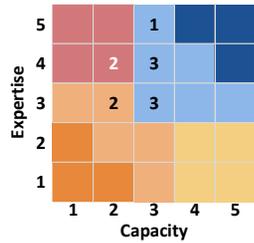
LEVEL OF IMPLEMENTATION

Partial

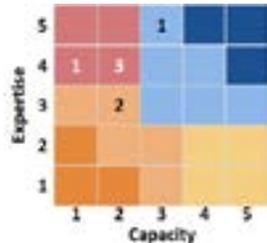


Community Partnership Development activities represent 0.9% of PHD’s current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Capability’s share of state public health activities will increase to 1.8%. A small additional increment of spending (34%) is needed to get PHD to full implementation. This will make state activities for *Community Partnership Development* the 5th largest Foundational Capability (out of 7) and 9th largest Foundational Capability or Program (out of 11).

ROLES



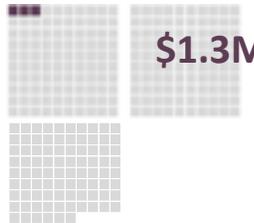
DELIVERABLES



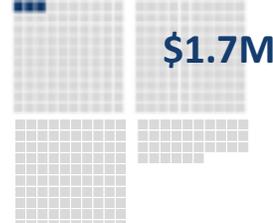
PHD’s *Community Partnership Development* activities include 11 roles and 7 deliverables. PHD’s Self-Assessment shows that the Provider considers this program to be only partially implemented.

RESOURCES

Current Spending



Full Implementation



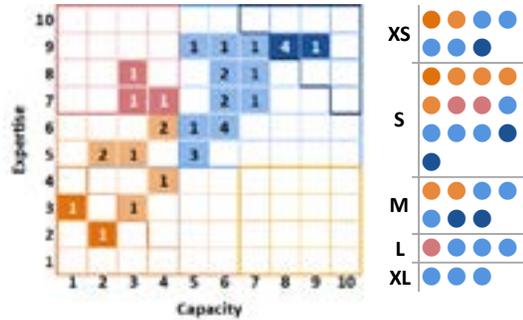
Additional Increment



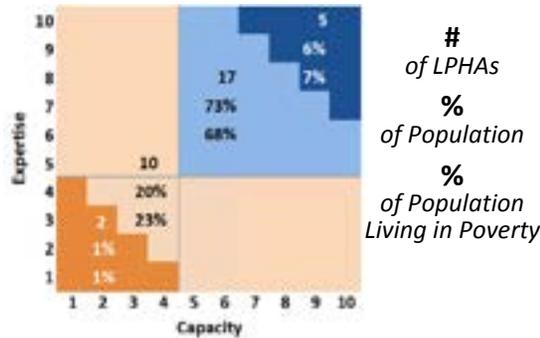
While none of the less implemented roles and deliverables are state activities that directly support the provision of local *Community Partnership Development* activities, it is likely that the state’s ability to complete its own activities related to partners are critical to the ability of LPHAs to attract and engage their partners. A strong state partner network is likely a critical component of a strong local partner network.

LOCAL PUBLIC HEALTH AUTHORITIES

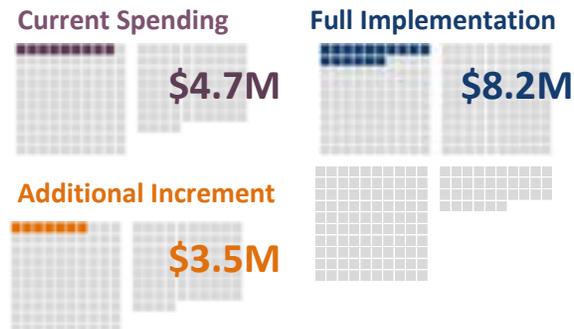
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



Community Partnership Development activities represent 5.4% of LPHAs' current Public Health Modernization activities (as represented by current spending). At full implementation, PHD estimates that the Capability's share of local public health activities will decrease to 4.9%. A significant additional increment of spending (\$3.5M or approximately 76%) is needed to get LPHAs to full implementation. This will make the local activities for *Community Partnership Development* the 4th largest Foundational Capability (out of 7) and 7th largest Foundational Capability or Program (out of 11).

Programmatically, this Foundational Program is relatively well implemented, with approximately two-thirds of LPHAs documenting significant or full implementation.

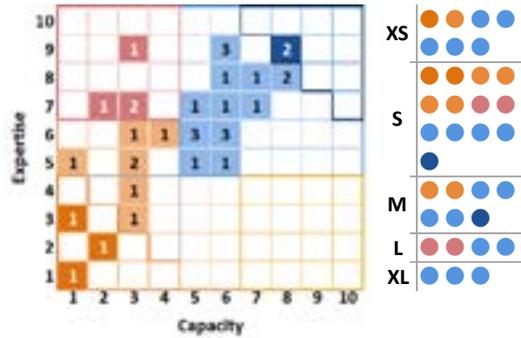
Local *Community Partnership Development* activities are broken down into two functional areas:

2. Engage Partners in Policy. This represents the other one-third (34%) of current local *Community Partnership Development* activities and will remain approximately the same (35%) share of local activities in this Foundational Program at full implementation.

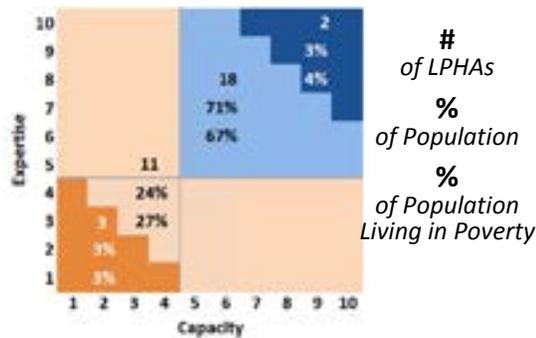
Following, we've provided profiles like this page for each of these two functional areas.

1. Identify and Develop Partnerships. This functional area represents 66% of current local *Community Partnership Development* activities; its share of local *Community Partnership Development* activities would decrease to 65% at full implementation.

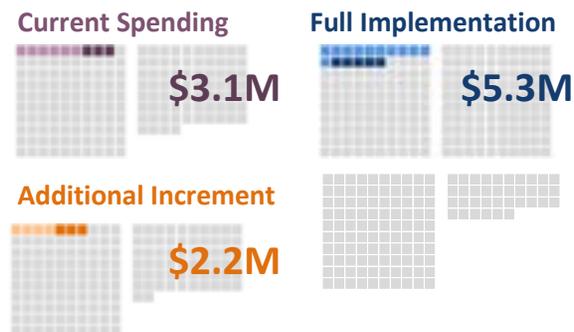
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



COMMUNITY PARTNERSHIP DEVELOPMENT FUNCTIONAL AREA 1:

Identify and Develop Partnerships

This is one of three functional areas that describe how local *Community Partnership Development* activities are operationalized. This functional area represents 66% of current local *Community Partnership Development* activities; its share of local *Community Partnership Development* activities would decrease to 65% with the addition of 72% more funding (\$2.2M) to reach full implementation.

The degree of implementation of this functional area varies across the system. There is no clear pattern as to which LPHAs are at each level of implementation. A little more than two-thirds of providers have significantly or fully implemented these activities.

The degree of implementation appears higher from a population service perspective: 74% of Oregonians live in a service area where these activities are present (however, there is a meaningful gap in service for a large percentage of those services).

The activities in the *Identify and Develop Partnerships* functional area include 3 roles and 6 deliverables. The degree of implementation of these roles and deliverables across local providers and population by level of service are provided on the following page.

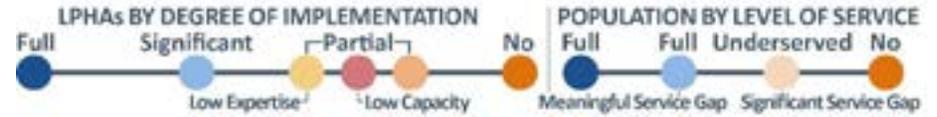
Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area's activities:

- (Role 3) At LPHAs there is a lack of understanding of evidence-based best practices for improving population health, and this prevents LPHAs from providing training and technical support on these matters to partners.
- (Deliverable 9) LPHAs would benefit from reproducible tools for reporting on the effectiveness of partnerships, and for evaluating those reports.

ASSESSMENT

Community Partnership Development
Identify and Develop Partnerships

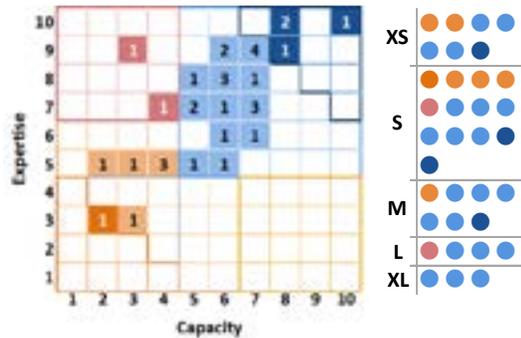


Community Partnership Development

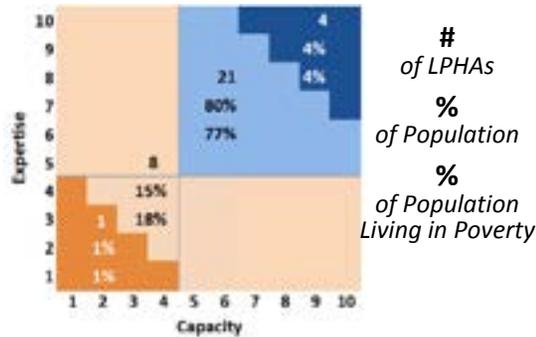
Identify and Develop Partnerships

	Functional Area	Full	Significant	Partial	No	Full	Full Underserved	No		
		2	18	4	7	3	71%	24%		
a Support and maintain cross-sector partnerships with health-related orgs; orgs representing priority/focal populations; private businesses; and local government agencies and non-elected officials.	Role 1	6	23	1	3	1	8%	87%	5%	
Coordinate programmatic activities with those of partner organizations to advance cross-cutting, strategic goals.	Role 2	4	22	2	6		3%	81%	16%	
Promote the use of evidence-based strategies to improve population health by providing training, technical assistance, and other forms of support to partners.	Role 3	1	18	3	9	3	7%	75%	23%	
List all community partners involved in local and regional health needs, health impact, and health hazard vulnerability assessments; include descriptions of partners involved, their roles, and	Deliverable 5	4	15	4	9	2	16%	54%	29%	
List all key regional health-related organizations with whom the health department has developed relationships with about public health issues of mutual interest.	Deliverable 6	4	16	4	8	2	16%	51%	33%	
The portfolio of cross-sector partnerships should include a description of partnering organizations and how the partnership supports population health.	Deliverable 4	3	15	5	9	2	15%	50%	34%	
List all local community groups or organizations representing priority/focal populations the local public health authority has developed relationships with so that public health goals are attainable	Deliverable 7	3	15	4	9	3	3%	52%	42%	
Document training, technical assistance, and other forms of support provided to partners, along with evaluation if the effectiveness of this support in promoting population health.	Deliverable 8	3	14	6	8	3	5%	42%	53%	
Evaluate reports on the effectiveness of partnerships.	Deliverable 9	1	10	6	10	7	1%	30%	59%	10%

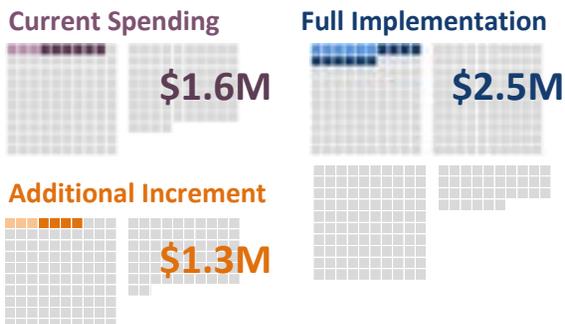
LPHA IMPLEMENTATION



POPULATION SERVICE



RESOURCES



COMMUNITY PARTNERSHIP DEVELOPMENT FUNCTIONAL AREA 2:

Engage Partners in Policy

This functional area represents about one-third (34%) of current local *Community Partnership Development* activities. This share will increase nominally to 35% of the Capability's activities with the addition of 83% more funding (\$1.3M).

This functional area is more implemented in larger LPHAs. Overall, 25 of 34 LPHAs consider themselves to have significantly or fully implemented this functional area.

The degree of implementation is a bit higher from a population service perspective: 84% of Oregonians live in a service area where these activities are present (however, there is a meaningful gap in service for a large percentage of those services).

The activities in the *Engage Partners in Policy* functional area include 4 roles and 1 deliverable. The degree of implementation of each of these roles and deliverables across local providers and population by level of service are provided on the following page.

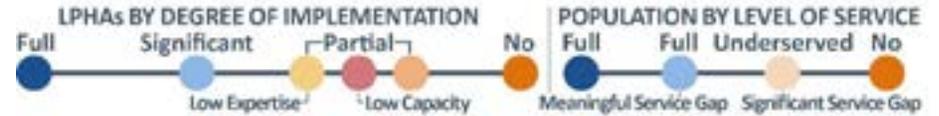
Non-Financial Barriers

LPHAs identified several barriers to implementing the roles and deliverables that make up this functional area's activities:

- (Role 1) Some communities and partners distrust organizations that provide state-mandated programs.
- (Role 1) Communities and partners located further from LPHA offices are harder to build strong relationships with, as coordination is more difficult and there are likely to be fewer informal opportunities for relationships to develop.
- (Role 4) LPHAs recognize that transportation and child care are barriers to engaging some participants.
- (Role 4) LPHAs have not identified good mechanisms for reaching some populations or organizations that might directly or indirectly support them.

ASSESSMENT

Community Partnership Development
Engage Partners in Policy



Community Partnership Development

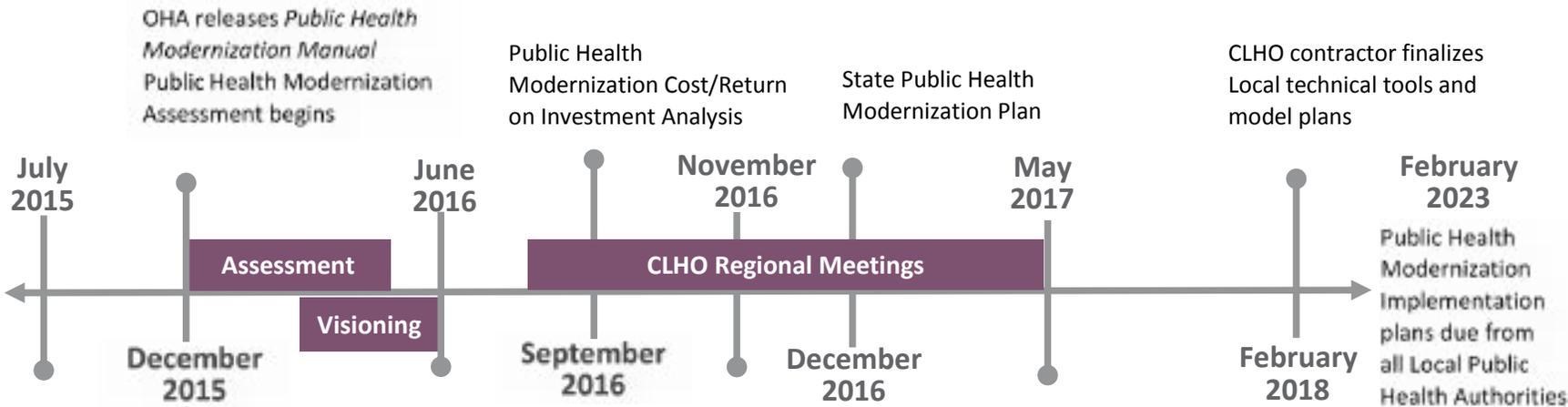
Engage Partners in Policy	functional area	Full	Significant	Partial	No	Full	Full Underserved	No
Engage Partners in Policy	functional area	4	21	2	6	1	81%	15%
Ensure that community partners can participate fully in local and state public health planning efforts.	Role 2	2	20	4	6	2	86%	10%
Join with partners in health assessments, using their input to develop a community health improvement plan to guide implementation work.	Role 3	7	21	1	4	1	16%	69%
Earn and maintain the trust of community residents by engaging them at the grassroots level.	Role 1	3	21	1	1	7	1	79%
Specifically engage priority/focal populations so they can actively participate in planning and funding opportunities to address their communities' needs.	Role 4	4	13	3	10	4	50%	43%
Document engagement through meetings, communications or other means with communities disproportionately affected by health issues.	Deliverable 5	3	15	3	9	4	57%	36%



POLICY IMPLICATIONS

POLICY IMPLICATIONS

Development of these Public Health Modernization Assessment results is one of many ongoing activities related to Public Health Modernization Implementation, as shown in the timeline below.



- Oregon Legislature passes HB 3100; included were:
- Implementation of the Task Force report
 - Wave structure implementation, allowing local public health authorities to implement separately
 - Requirement for Oregon Health Authority to assess current abilities and cost for full implementation

PHAB presents Public Health Modernization Narrative and findings to Legislative Fiscal Office

PHAB presents Funding Allocation and Incentives Structure to Legislative Fiscal Office

The Assessment Results will provide data to support many of these other activities, but are one piece of an evolving story

Public Health Modernization Narrative and Vision

This narrative is being developed to provide context on the purpose and Vision for Public Health Modernization in Oregon.

Public Health Funding Allocations and Incentives Formulae

A major need for implementation of Public Health Modernization is new funding sources to support additional services. As part of this, the Public Health Division in collaboration with the Public Health Advisory Board are developing new funding allocation and local funding incentive formulae.

Public Health Modernization Cost/Return of Investment Analysis

This analysis is being undertaken by the Program Development and Evaluation Services to quantify the financial benefit and the benefit to health outcomes of implementation of Public Health Modernization. The Assessment Results presented in this Assessment Report and the data collected as part of the Assessment process will support this effort.

State Public Health Modernization Plan

The State Public Health Modernization Plan will provide detailed strategies for the implementation of Public Health Modernization in Oregon. It is likely that the Assessment Results herein will be used to inform those strategies. Required by House Bill 3100, this Plan is due by December of 2016.

CLHO Regional Meetings

CLHO has received funds to host ten regional meetings with LPHAs to discuss and gather provider perspectives on Public Health Modernization implementation strategies.

Local Public Health Modernization Plan

Like the state public health provider, LPHA's will develop their own Public Health Modernization Plans. Required by House Bill 3100, these Plans are due by December of 2023.

Assessment Implications

This Public Health Assessment is the first step of an evolving process that will continue to be refined as implementation progresses. The Assessment Results presented in this Assessment Report represent point in time, planning-level estimates for the cost of full implementation of the Public Health Modernization framework, as outlined in the December 2015 *Modernization Manual*. It is important to recognize that that

framework, is not static and presents one reason for which these numbers will necessarily evolve. Additionally, there are opportunities to continue to refine these numbers by leveraging the strengths of the existing system identified during this Assessment. These opportunities are outlined below.

Service Delivery

One of the primary ways in which this number may evolve is through identification of additional efficiencies, which will likely relate to service delivery. Two opportunities for efficiencies include:

- Cross jurisdictional sharing
- Cross jurisdictional delivery

CROSS JURISDICTIONAL SHARING

Many LPHAs are already significantly sharing resources (with each other and with nonprofits and other local agencies). The Public Health Modernization Assessment process catalyzed conversations between LPHAs around how they might develop future cross jurisdictional

There is need for additional time and resources to support further conversations. LPHAs should have autonomy but still be supported in developing new cross jurisdictional sharing relationships.

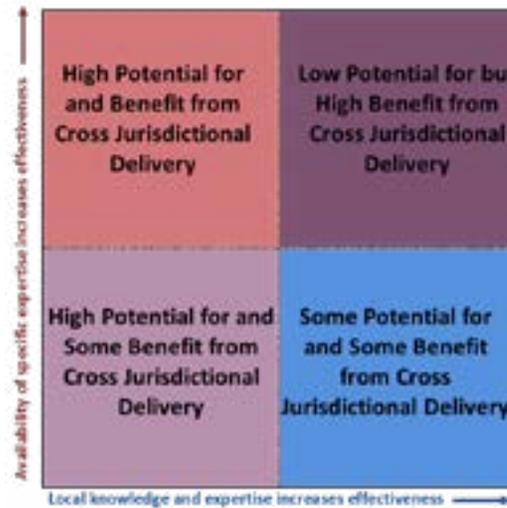
INITIAL POLICY IMPLICATIONS

This section provides initial policy implications. It is our expectation that these implications will continue to evolve based on the substantive feedback we receive on this draft. We felt it wise to leverage the collective expertise of Oregon’s governmental public health providers in identifying the most important findings before diving too deeply into what we think the Assessment Results mean.

Looking for a venue to document these conversations CLHO developed a survey to be distributed to LPHAs for them to discuss additional opportunities for Cross Jurisdictional Sharing. The results of this survey are forthcoming and will provide additional data to support the continued evolution of the Assessment results published in this report.

CROSS JURISDICTIONAL DELIVERY

Some roles and deliverables may be appropriate for cross jurisdictional delivery. According



Local providers should be involved in determining what roles and deliverables are delivered cross-jurisdictionally.

Phasing

The pace and order of phasing should be calibrated based on many considerations:

- **Available Funding and Funding Sustainability.** Full implementation of Public Health Modernization will necessarily require additional funding. Oregon’s ability to implement, and the speed with which it

implements will be determined by the availability of this funding.

- **Implementation Priorities.** Implementation can be phased in many ways, some of which may be influenced by statewide priorities.
- **Provider Readiness.** Public Health Modernization is a relatively new concept and not all providers may be ready to implement now. Providers should be given an opportunity to prepare for implementation.
- **Service Dependencies.** The activities of state and local governmental public health providers are interdependent. Many state provider support local activities, and some local activities feed back into the state provider’s work. It will be necessary to understand service dependencies as part of
- **Service Equity.** How services are implemented could greatly affect service equity. For example, implementation by wave could benefit highly resourced agencies, likely in areas with low poverty rates, while hurting those with limited resources, likely in areas with higher poverty rates.

IMPLEMENTATION

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wave could benefit highly resourced agencies, likely in areas with low poverty rates, while hurting those with limited resources, likely in areas with higher poverty rates.

APPENDICES

APPENDIX A: GLOSSARY AND ACRONYMS

Abbreviations/Acronyms

Term	Abbreviation/Acronym
Governmental Public Health Providers	Providers
State Governmental Public Health Providers	State Providers
Local Governmental Public Health Providers	Local Providers
Local Public Health Authorities	LPHA
Oregon Health Authority Public Health Division	PHD
Coalition of Local Health Officials	CLHO
Additional Increment of Spending to Reach Full Implementation	Additional Increment
Full Time Equivalents	FTE

Definitions

Term	Definition
Public Health System	All public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction. These systems are a network of entities with differing roles, relationships, and interactions that contribute to the health and well-being of the community or state.

Governmental Public Health System	State Governmental Public Health Providers
Current Spending	The amount of resources supporting existing Public Health Modernization Activities.
Full Implementation	The amount of resources needed to support full implementation of Public Health Modernization activities.
Capacity	To what degree the organization currently has the staffing and resources necessary to provide the services/deliverables dictated.
Expertise	To what degree the organization’s current capacity aligns with the appropriate knowledge necessary to implement the services/deliverables dictated.
Detailed Self-Assessment	Ask about capacity and expertise for meeting local roles and providing deliverables outlined in the <i>Modernization Manual</i> .
Rollup Self-Assessment	Ask about capacity and expertise for meeting Foundational Capabilities and Programs, and where applicable, Functional Areas.
Drivers	Demand factors that causes a change in the overall cost of a Foundational Capability or Program.
Cost Factors	Units of cost directly proportional to the independent variables (in this case, cost drivers).
Determinants of Health	Direct causes and risk factors which, based on scientific evidence or theory, are thought to influence directly the level of a specific health problem. These maybe defined as the “upstream” factors that affect the health status of populations and individuals. Roughly divided into the social environment (cultural, political, policy, economic systems, social capital, etc.), the physical environment (natural and built), and genetic endowment. The determinants of health affect both individual response (behavior and biology) and the prevalence of illness and disease.
Fixed Costs	Costs that that do not change as a function of the activity of the Foundational Capability or Program.
Variable Costs	Costs that change as a function of the activity of the Foundational Capability or Program.
Labor Costs	The salaries and benefits of staff that are employed within each program.
Non-Labor Costs	The costs of supporting the program’s functions. Examples include materials, supplies, small equipment such as computers or lab equipment, professional services, and other contracted services.
Overhead Costs	Facility costs such as rent, maintenance, or utilities and other overhead costs like fleet.

APPENDIX B: FUNCTIONAL AREA DEFINITIONS

Foundational Programs

Communicable Disease Control

Communicable Disease Surveillance

Produce timely reports of notifiable diseases.

- Ensure timely and accurate reporting of reportable diseases and educate local providers on reportable disease requirements.
- Monitor occurrence and distinguishing characteristics of infectious diseases and outbreaks.
- Develop, engage, and maintain local strategic partnerships with hospitals, health systems, schools, day care centers and others to prevent and control communicable diseases. Ensure engagement of priority/focal populations in efforts to prevent and control communicable diseases.

Communicable Disease Investigation

Develop and deploy a communicable disease investigative process.

- Document implementation of investigative guidelines appropriately.
- Provide individual communicable disease case and outbreak data, consistent with Oregon statute, rule and program standards.
- Maintain protocols for proper preparation, packaging and shipment of samples of public health importance (e.g., animals and animal products).

Communicate with the public about ongoing communicable disease outbreaks and investigation. Ensure confidentiality through communications.

- Provide communications with the public about outbreak investigations. Communicate clearly with members of the public in the authority about identified health risks.
- Maintain protocols and systems to ensure confidentiality throughout investigation, reporting and maintenance of data.
- Summarize and share data to determine opportunities for intervention and to guide policy and program decisions.
- Secure personally identifiable data collected through audits, review, update and verification.

Communicable Disease Intervention and Control

Provide timely, statewide, locally relevant and accurate information to the state and community on communicable diseases and their control. Promote immunization through education of the public and through collaboration with schools, health care providers and other community partners.

- Provide health education resources for the general public, health care providers, long-term care facility staff, infection control specialists and others regarding vaccine-preventable diseases, healthcare associated infections, antibiotic resistance and other issues.
- Provide interventions with communities that are disproportionately non-immunized.
- Use information about immunization proportions to increase immunization overall for citizens in local jurisdictions.

- Ensure equitable access to immunizations among people of all ages. Implement culturally responsive strategies to improve access to immunizations. Identify statewide and local communicable disease control community assets, develop processes for information sharing between providers to reduce disease transmission, and maintain emergency/outbreak plans.
- Develop protocols or process maps for information sharing between providers to reduce disease transmission.
- Maintain plans for the allocation of scarce resources in the event of an emergency or outbreak.
- Produce reports about acute and communicable disease gaps and opportunities for mitigation of identified risks.
- Provide technical support for enforcement of public health laws (e.g., isolation and quarantine, school exclusion laws).
- Ensure timely and accurate reporting of reportable diseases and educate local providers on reportable disease requirements.
- Develop, engage, and maintain local strategic partnerships with hospitals, health systems, schools, day care centers and others to prevent and control communicable diseases. Ensure engagement of priority/focal populations in efforts to prevent and control communicable diseases.
- Provide subject matter expertise to inform program design, policies and communications that inform providers, the public and stakeholders about public health risks.
- Provide disease-specific and technical expertise regarding epidemiologic and clinical characteristics to health care professionals and others. Advise health care practitioners about evidence-based practices for communicable disease diagnosis, control and prevention.
- Work with partners to enforce public health laws, including isolation and quarantine.
- Work with the OHA Public Health Division to provide guidance for the control and prevention of rare diseases and conditions of public health importance. Assure the appropriate treatment of individuals who have active communicable diseases, including HIV, STD, and TB cases. Develop reporting and partner notification services for relevant diseases.
- Provide appropriate screening and treatment for HIV, STD, and TB cases, including pre- and post- exposure prophylaxis for HIV.
- Collaborate with the state in a culturally responsive way on disease prevention and control initiatives such as antibiotic resistance, sexually transmitted disease prevention messaging, infection control protocols, hand hygiene, field investigations of outbreaks and epidemics, and statewide and local health policies.
- Provide input into what diseases should be reportable to the state and subsequent disease investigation and control guidelines.
- Assure the availability of partner notification services for newly diagnosed cases of syphilis, gonorrhea, and HIV, as recommended by OHA.

Communicable Disease Response Evaluation

Evaluate and assess communicable disease outbreak response, and document distinguishing characteristics of outbreaks.

- Document assessments of outbreak investigation and response efforts, both conducted by state and by local public health.

Assess process improvement initiatives, including materials.

- Document results of quality and process improvement initiatives.
- Evaluate presentations and publications.
- Monitor occurrence and distinguishing characteristics of infectious diseases and outbreaks.
- Work with the OHA Public Health Division to evaluate disease control investigations and interventions. Use findings to improve these efforts.

Environmental Public Health

Identify and Prevent Environmental Health Hazards

Preventing and investigating environmental health hazards, including radioactive materials, animal bites and vector-borne diseases

- Develop, implement and enforce environmental health regulations.
- Ensure consistent application of health regulations and policies.
- Implement state-mandated programs where appropriate (i.e., small drinking water systems, septic oversight).

- Provide evidence based assessment of the health impacts of environmental hazards or conditions.
- Ensure that environmental health is included in the community health assessment every five years.
- Measure the impact of environmental hazards on the health outcomes of priority/focal populations. Analyze and communicate environmental justice concerns and disparities.
- Assure the development and maintenance of the ambulance service area plan.
- Monitor, investigate, and control infectious and noninfectious vector nuisances and diseases.
- Maintain expertise in relevant environmental health topics.
- Provide consultation and technical assistance including establishing best practices related to vector control.
- Inform decision makers of the impacts to environmental public health based on program, project and policy decisions.
- Use environmental health expertise to address accident and disease prevention in institutional environments (longer-term care, assisted living, child care, etc.)
- Use environmental health expertise to reduce hazardous exposures from air, land, water, and other exposure pathways.
- Deliver effective and timely outreach on environmental health hazards and protection recommendations to regulated facilities, the public and stakeholder organizations.
- Ensure meaningful participation of communities experiencing environmental health threats and inequities in programs and policies designed to serve them.

Conduct Mandated Inspections

Testing and analysis for purposes related to environmental health

Perform inspections and educate recipients of inspections including for:

- Restaurants and other food service establishments
- Recreation sites, lodges, and swimming pools
- Septic systems
- Portable water systems
- Radiological equipment
- Hospital and other health care facilities
 - Conduct timely inspection and review of regulated entities and facilities.
 - Enforce regulations.
 - Perform and assist with outbreak investigations that have an environmental component.
 - Conduct ongoing environmental and occupational health surveillance.
 - Document communications on environmental health hazards and protection recommendations to regulated facilities, the public and stakeholder organizations.
 - Consult for the food service industry and the general public.
 - Document provision of licensing and certification of recreational facilities, food service facilities and tourist accommodations.
 - Document reports of inspection and review of regulated entities and facilities.
 - Document enforcement of regulations.

Promote Land Use Planning

Promoting land use planning and sustainable development activities that create positive health outcomes

- Conduct health analyses for other organizations and recommend approaches to ensure healthy and sustainable built and natural environments.
- Understand and participate in local land use and transportation planning processes.
- Maintain relationships with partners in local economic development, transportation, parks, and land use agencies.
- Provide consultation and technical assistance to the food service industry and the general public.
- Provide technical assistance to integrate standard environmental public health practices into facilities that present high risk for harmful environmental exposures or disease transmission.

Produce community health assessments that includes environmental health produced at least every five years.

Prepare health analyses for other organizations and recommend approaches to ensure healthy and sustainable built and natural environments.

Communicate environmental justice concerns and disparities.

Write best practices related to vector control.

Document integration of standard environmental public health practices into facilities that present high risk for harmful environmental exposures or disease transmission.

Prevention and Health Promotion

Prevention of Tobacco Use

Prevention and control of tobacco use

- Use surveillance data collected by the OHA Public Health Division and use assessment and epidemiology methods to prevent and control tobacco use.
 - Include prevention and health promotion programs identified on the community health improvement plan or other local priorities;
 - Include surveillance of behavioral health issues that impact health outcomes for the areas listed above (e.g. trauma, chronic stress, addiction or violence).
- Monitor knowledge, attitudes, behaviors and health outcomes around tobacco use.
- Use community health assessment data and other relevant data sources to inform or identify priorities and develop planning documents around tobacco use.
- Educate consumers about health impacts of the health impacts of unhealthy products like tobacco products.
- Demonstrate to communities, partners, policy makers and others the connection between early prevention and educational achievement, health outcomes, intergenerational outcomes, and other outcomes (i.e. individuals who experience a disproportionate burden of death, injury and disease)
- Convene and engage communities and organizational partners, and cultivate leadership and vision for prevention and health promotion policies, programs and strategies.
- Develop strategic, cross-sector partnerships and collaborations, across systems and settings.
- Work with partners and stakeholders to develop and advance a common set of priorities, strategies and outcome measures, employing coalition building, community organizing, capacity building and providing technical assistance to partners.
- Build relationships with community partners who work with priority/focal populations.
- Work with partners, stakeholders, and community members to identify community assets and understand community needs and priorities.
- Work with communities to build community capacity, community empowerment and community organizing. Support community action to assure policies that promote health and protection from unhealthy influences.
- Provide program funding to community partners to implement identified work.
- Collaborate with the OHA Public Health Division to maintain subject matter expertise in:

- Policy, systems and environmental change;
- Evidence-based and emerging best practices;
- Social determinants of health and the health impact of prenatal/early childhood experiences;
- Prevention and health promotion areas.
- Develop multi-faceted strategies designed to address social determinants of health.
- Implement local policies, programs and strategies to improve social, emotional, and physical health and safety at the level supported by existing funding.
- Implement programs and interventions around this area, as part of this:
 - Develop prevention and health promotion programs identified on the community health improvement plan or other local priorities;
 - Integrate efforts to address population-level behavioral health issues that impact health outcomes for the areas listed above (e.g. trauma, chronic stress, addiction or violence).
- Collaborate with partners and engage community leaders to identify and seek funding for prevention and health promotion programs and interventions.
- Adhere to local, state and federal guidance, standards, and laws (e.g. guidance from CDC's Office on Smoking and Health, or state guidelines for healthy eating and active living).
- Develop policy, systems and environmental change strategies to improve health outcomes using problem identification, policy analysis, strategy and policy development, policy enactment, policy implementation and policy evaluation.
- With stakeholders, develop and implement an evaluation plan for this area.
- Develop, use, and disseminate innovative, emerging, and evidence-based best practices.

Improving Nutrition and Increasing Physical Activity

Improving nutrition and incentivizing increased physical activity

- Use surveillance data collected by the OHA Public Health Division and use assessment and epidemiology methods to improve nutrition and to increase physical activity.
 - Include prevention and health promotion programs identified on the community health improvement plan or other local priorities.
- Monitor knowledge, attitudes, behaviors and health outcomes around nutrition and physical activity.
- Use community health assessment data and other relevant data sources to inform or identify priorities and develop planning documents around nutrition and physical activity.
- Educate consumers about health impacts of the health impacts of unhealthy products like tobacco and sugary drinks.
- Demonstrate to communities, partners, policy makers and others the connection between early prevention and educational achievement, health outcomes, intergenerational outcomes, and other outcomes (i.e. individuals who experience a disproportionate burden of death, injury and disease)
- Convene and engage communities and organizational partners, and cultivate leadership and vision for prevention and health promotion policies, programs, and strategies.
- Develop strategic, cross-sector partnerships and collaborations, across systems and settings.
- Work with partners and stakeholders to develop and advance a common set of priorities, strategies and outcome measures, employing coalition building, community organizing, capacity building, and providing technical assistance to partners.
- Build relationships with community partners who work with priority/focal populations.
- Work with partners, stakeholders, and community members to identify community assets and understand community needs and priorities.

- Work with communities to build community capacity, community empowerment and community organizing. Support community action to assure policies that promote health and protection from unhealthy influences.
- Provide program funding to community partners to implement identified work.
- Collaborate with the OHA Public Health Division to maintain subject matter expertise in:
 - Policy, systems, and environmental change;
 - Evidence-based and emerging best practices;
 - Social determinants of health and the health impact of prenatal/early childhood experiences;
 - Prevention and health promotion areas.
- Develop multi-faceted strategies designed to address social determinants of health.
- Implement local policies, programs and strategies to improve social, emotional, and physical health and safety at the level supported by existing funding.
- Implement programs and interventions around these areas; as part of this:
 - Develop prevention and health promotion programs identified on the community health improvement plan or other local priorities;
 - Integrate efforts to address population-level behavioral health issues that impact health outcomes for the areas listed above (e.g. trauma, chronic stress, addiction or violence).
- Collaborate with partners and engage community leaders to identify and seek funding for prevention and health promotion programs and interventions.
- Adhere to local, state and federal guidance, standards, and laws (e.g. guidance from CDC's Office on Smoking and Health, or state guidelines for healthy eating and active living).
- Develop policy, systems and environmental change strategies to improve health outcomes using problem identification, policy analysis, strategy and policy development, policy enactment, policy implementation, and policy evaluation.
- With stakeholders, develop and implement an evaluation plan for these areas.
- Develop, use, and disseminate innovative, emerging, and evidence-based best practices.

Improving Oral Health

- Use surveillance data collected by the OHA Public Health Division and use assessment and epidemiology methods to improve oral health.
 - Include prevention and health promotion programs identified on the community health improvement plan or other local priorities.
- Monitor knowledge, attitudes, behaviors and health outcomes around oral health.
- Use community health assessment data and other relevant data sources to inform or identify priorities and develop planning documents around oral health.
- Educate consumers about health impacts of the health impacts of unhealthy products like tobacco and sugary drinks.
- Demonstrate to communities, partners, policy makers and others the connection between early prevention and educational achievement, health outcomes, intergenerational outcomes, and other outcomes (i.e. individuals who experience a disproportionate burden of death, injury and disease)
- Convene and engage communities and organizational partners, and cultivate leadership and vision for prevention and health promotion policies, programs, and strategies.
- Develop strategic, cross-sector partnerships and collaborations, across systems and settings.
- Work with partners and stakeholders to develop and advance a common set of priorities, strategies and outcome measures, employing coalition building, community organizing, capacity building, and providing technical assistance partners.
- Build relationships with community partners who work with priority/focal populations.
- Work with partners, stakeholders, and community members to identify community assets and understand community needs and priorities.

- Work with communities to build community capacity, community empowerment and community organizing. Support community action to assure policies that promote health and protection from unhealthy influences.
- Provide program funding to community partners to implement identified work.
- Collaborate with the OHA Public Health Division to maintain subject matter expertise in:
 - Policy, systems, and environmental change;
 - Evidence-based and emerging best practices;
 - Social determinants of health and the health impact of prenatal/early childhood experiences;
 - Prevention and health promotion areas.
- Develop multi-faceted strategies designed to address social determinants of health.
- Implement local policies, programs and strategies to improve social, emotional, and physical health and safety at the level supported by existing funding.
- Implement programs and interventions around this area, as part of this:
 - Develop prevention and health promotion programs identified on the community health improvement plan or other local priorities;
 - Integrate efforts to address population-level behavioral health issues that impact health outcomes for the areas listed above (e.g. trauma, chronic stress, addiction or violence).
- Collaborate with partners and engage community leaders to identify and seek funding for prevention and health promotion programs and interventions.
- Adhere to local, state and federal guidance, standards, and laws (e.g. guidance from CDC's Office on Smoking and Health, or state guidelines for healthy eating and active living).
- Develop policy, systems and environmental change strategies to improve health outcomes using problem identification, policy analysis, strategy and policy development, policy enactment, policy implementation and policy evaluation.
- With stakeholders, develop and implement an evaluation plan for this area.
- Develop, use, and disseminate innovative, emerging, and evidence-based best practices.

Improving Maternal and Child Health

Improving prenatal, natal and postnatal care, maternal health and the health of children

- Use surveillance data collected by the OHA Public Health Division and use assessment and epidemiology methods to improve prenatal, natal, and postnatal care, maternal health, and the health of children.
 - Include prevention and health promotion programs identified on the community health improvement plan or other local priorities.
- Monitor knowledge, attitudes, behaviors and health outcomes around maternal and child health.
- Use community health assessment data and other relevant data sources to inform or identify priorities and develop planning documents around maternal and child health.
- Educate consumers about health impacts of health-protective products for pregnant women and children and the health impacts of unhealthy products like tobacco and sugary drinks.
- Demonstrate to communities, partners, policy makers and others the connection between early prevention and educational achievement, health outcomes, intergenerational outcomes, and other outcomes (i.e. individuals who experience a disproportionate burden of death, injury and disease)
- Convene and engage communities and organizational partners, and cultivate leadership and vision for prevention and health promotion policies, programs, and strategies.
- Develop strategic, cross-sector partnerships and collaborations, across systems and settings.

- Work with partners and stakeholders to develop and advance a common set of priorities, strategies and outcome measures, employing coalition building, community organizing, capacity building, and providing technical assistance to partners.
- Build relationships with community partners who work with priority/focal populations.
- Work with partners, stakeholders, and community members to identify community assets and understand community needs and priorities.
- Work with communities to build community capacity, community empowerment and community organizing. Support community action to assure policies that promote health and protection from unhealthy influences.
- Provide program funding to community partners to implement identified work.
- Collaborate with the OHA Public Health Division to maintain subject matter expertise in:
 - Policy, systems, and environmental change;
 - Evidence-based and emerging best practices;
 - Social determinants of health and the health impact of prenatal/early childhood experiences;
 - Prevention and health promotion areas.
- Develop multi-faceted strategies designed to address social determinants of health.
- Implement local policies, programs and strategies to improve social, emotional, and physical health and safety at the level supported by existing funding.
- Implement programs and interventions around this area, as part of this:
 - Develop prevention and health promotion programs identified on the community health improvement plan or other local priorities;
 - Integrate efforts to address population-level behavioral health issues that impact health outcomes for the areas listed above (e.g. trauma, chronic stress, addiction or violence).
- Collaborate with partners and engage community leaders to identify and seek funding for prevention and health promotion programs and interventions.
- Adhere to local, state and federal guidance, standards, and laws (e.g. guidance from CDC's Office on Smoking and Health, or state guidelines for healthy eating and active living).
- Develop policy, systems and environmental change strategies to improve health outcomes using problem identification, policy analysis, strategy and policy development, policy enactment, policy implementation and policy evaluation.
- With stakeholders, develop and implement an evaluation plan for this area.
- Develop, use, and disseminate innovative, emerging, and evidence-based best practices

Reduce Unintentional And Intentional Injuries

- Decreasing the occurrence and impacts of both unintentional and intentional injuries, such as motor vehicle accidents and suicide
- Use surveillance data collected by the OHA Public Health Division and use assessment and epidemiology methods to decrease the occurrence and impacts of injuries.
 - Include prevention and health promotion programs identified on the community health improvement plan or other local priorities;
 - Include surveillance of behavioral health issues that impact health outcomes for reducing accident rates (e.g. trauma, chronic stress, addiction or violence).
- Monitor knowledge, attitudes, behaviors and health outcomes around injury prevention and suicide.
- Use community health assessment data and other relevant data sources to inform or identify priorities and develop planning documents around maternal and child health.
- Educate consumers about health impacts of health-protective products like car seats.

- Demonstrate to communities, partners, policy makers and others the connection between early prevention and educational achievement, health outcomes, intergenerational outcomes, and other outcomes (i.e. individuals who experience a disproportionate burden of death, injury and disease)
- Convene and engage communities and organizational partners, and cultivate leadership and vision for prevention and health promotion policies, programs, and strategies.
- Develop strategic, cross-sector partnerships and collaborations, across systems and settings.
- Work with partners and stakeholders to develop and advance a common set of priorities, strategies and outcome measures, employing coalition building, community organizing, capacity building, and providing technical assistance to partners.
- Build relationships with community partners who work with priority/focal populations.
- Work with partners, stakeholders, and community members to identify community assets and understand community needs and priorities.
- Work with communities to build community capacity, community empowerment and community organizing. Support community action to assure policies that promote health and protection from unhealthy influences.
- Provide program funding to community partners to implement identified work.
- Collaborate with the OHA Public Health Division to maintain subject matter expertise in:
 - Policy, systems, and environmental change;
 - Evidence-based and emerging best practices;
 - Social determinants of health and the health impact of prenatal/early childhood experiences;
 - Prevention and health promotion areas.
- Develop multi-faceted strategies designed to address social determinants of health.
- Implement local policies, programs and strategies to improve social, emotional, and physical health and safety at the level supported by existing funding.
- Implement programs and interventions around this area, as part of this:
 - Develop prevention and health promotion programs identified on the community health improvement plan or other local priorities;
 - Integrate efforts to address population-level behavioral health issues that impact health outcomes for the areas listed above (e.g. trauma, chronic stress, addiction or violence).
- Collaborate with partners and engage community leaders to identify and seek funding for prevention and health promotion programs and interventions.
- Adhere to local, state and federal guidance, standards, and laws (e.g. guidance from CDC's Office on Smoking and Health, or state guidelines for healthy eating and active living).
- Develop policy, systems and environmental change strategies to improve health outcomes using problem identification, policy analysis, strategy and policy development, policy enactment, policy implementation and policy evaluation.
- With stakeholders, develop and implement an evaluation plan for this area.
- Develop, use, and disseminate innovative, emerging, and evidence-based best practices.

Clinical Preventative Services

Ensure Access To Effective Vaccination Programs

- Immunizations
- Ensure access tall vaccines required by Oregon law for school attendance. This includes ensuring that vaccines are provided at convenient times and locations, and that no child is denied immunizations due to inability to pay. (ORS 433.269)

- Ensure access to all immunization-related services necessary to protect the public and prevent the spread of vaccine preventable disease.
- Work with local providers and public health delegate agencies to ensure access to immunization services.
- Ensure access to vaccines as appropriate during public health emergencies.
- Document meetings with partners to recommend strategies for improving access to clinical preventive services.
- Produce jurisdictional reports on access to clinical preventive services.
- Provide resources for clinical and community partners on evidence-based guidelines for the delivery of clinical preventive services.
- Plan for improved access to clinical preventive services, particularly for vulnerable populations.
- Document implementation of these plans.
- Produce evaluations of policies implemented to improve access to clinical preventive services.

Ensure Access To Effective Preventable Disease Screening Programs

- Screening for preventable cancers and other diseases
- Document meetings with partners to recommend strategies for improving access to clinical preventive services.
- Produce jurisdictional reports on access to clinical preventive services.
- Provide resources for clinical and community partners on evidence-based guidelines for the delivery of clinical preventive services.
- Plan for improved access to clinical preventive services, particularly for vulnerable populations.
- Document implementation of these plans.
- Produce evaluations of policies implemented to improve access to clinical preventive services.

Ensure Access To Effective STD Screening Programs

- Screening for sexually transmitted infections
- Assure access to treatment for sexually transmitted infections either as a component of primary care or as specialty care.
- Document meetings with partners to recommend strategies for improving access to clinical preventive services.
- Produce jurisdictional reports on access to clinical preventive services.
- Provide resources for clinical and community partners on evidence-based guidelines for the delivery of clinical preventive services.
- Plan for improved access to clinical preventive services, particularly for vulnerable populations.
- Document implementation of these plans.
- Produce evaluations of policies implemented to improve access to clinical preventive services.

Ensure Access To Effective Tb Treatment Programs

- Evaluation of and treatment for tuberculosis and latent tuberculosis infections
- Ensure that TB cases are diagnosed and treated using directly observed therapy.
- Ensure diagnosis and treatment of those with latent TB infection (including contacts of people with TB, new immigrants, other high-risk populations).
- Investigate contacts, including testing and treatment.
- Submit data on TB cases, contacts and new immigrants ("B waiver").
- Produce jurisdictional reports on access to clinical preventive services.
- Provide resources for clinical and community partners on evidence-based guidelines for the delivery of clinical preventive services.
- Plan for improved access to clinical preventive services, particularly for vulnerable populations.
- Document implementation of these plans.
- Produce evaluations of policies implemented to improve access to clinical preventive services.

Ensure Access To Cost Effective Clinical Care

- Work with health care providers to support provision of evidence-based programs and treatments that are proven to reduce the impact and costs associated with the leading causes of disease and disability in Oregon (e.g., tobacco Quit Line, chronic disease self-management programs, expedited partner therapy, non-opioid therapies for chronic non-cancer pain, appropriate prescribing guidelines).
- Document meetings with partners to recommend strategies for improving access to clinical preventive services.
- Produce jurisdictional reports on access to clinical preventive services.
- Provide resources for clinical and community partners on evidence-based guidelines for the delivery of clinical preventive services.
- Plan for improved access to clinical preventive services, particularly for vulnerable populations.
- Document implementation of these plans.
- Produce evaluations of policies implemented to improve access to clinical preventive services.

Foundational Capabilities

Assessment and Epidemiology

Data Collection And Electronic Information Systems

Ability to collect sufficient statewide data to develop and maintain electronic information systems to guide public health planning and decision making at the state and local level.

- Access statewide information and surveillance systems and report into these systems in a timely manner.
- Use applied research and evaluation techniques to assure that interventions meet the needs of the community to be served.

Use relevant data to implement, monitor, evaluate and modify state health improvement plans or community health improvement plans

- Evaluate the efficacy of public health policies, strategies and interventions.
 - Evaluate the effectiveness, accessibility, and quality of population-based health services.
 - Perform or access expertise needed to conduct economic analysis of public health strategies (e.g. economic analyses including the cost/risk of non-investment, return on investment).
 - Assist in the development of and evaluate public health interventions.
- Provide local public health informatics capability, or access statewide capability.

Data Access, Analysis, and Use

Process data from a variety of sources (e.g. including vital records, health records, hospital data, insurance data and indicators of community, environmental health) in a manner that is accurate, timely, statistically valid, actionable, usable and meaningful by the requester.

- Collect, process and analyze data to assess population health priorities, patterns and needs in the local authority.
- Collect, maintain and analyze vital records and statistics.
- Input local data in state data systems to support a statewide understanding of population health and coordination between health authorities.

Analyze key indicators of a community's health

- Use demographic information (e.g. census, vital records) to understand the population and the characteristics of that population.
- Conduct and assess surveys about health behaviors and practices.

Analyze data related to the causes and burdens of disease, injury, disability and death.

- Identify populations experiencing a disproportionate burden of death, injury and disease. Identify how disease, injury, disability and death disproportionately affect certain populations, including populations specific to sex, race, ethnicity and socioeconomic status.
- Using quantitative and qualitative data, identify how disease, injury, disability and death disproportionately affect specific populations (e.g. populations grouped by sex, sexual orientation, gender identity, race, ethnicity, urban/rural residence, immigration status and socioeconomic status).

Respond to Data Requests and Translate Data for Intended Audiences

Prioritize and respond to requests for data, information and reporting. Communicate the response in a manner that is accurate, statistically valid and usable by the requester.

- Support the appropriate use and timely communication of the data to support community health and resiliency.
- Produce summaries of local epidemiology of disease of public health importance.
- Make data, reports and information available to policy makers, stakeholders, community members, and other partners at least annually.
- Produce local summaries for four categories and include any relevant analyses of statewide surveys on health attitudes, beliefs, behaviors and practices:
 - Disease occurrence, outbreaks and epidemics.
 - Impact of public health policies, programs and strategies on health outcomes, including economic analyses when appropriate.
 - Key indicators of community health, which include information about upstream or root causes of health.
 - Leading causes of disease, injury, disability and death, which include information about health disparities.
- Review evidence-based literature and conduct research on innovative solutions to health problems to inform public health practice.

Conduct and Use Basic Community and Statewide Health Assessments

Ability to conduct a basic community and statewide health assessment and identify health priorities arising from that assessment, including analysis of health disparities

- Ensure collaboration between state and local public health authorities when conducting assessment and epidemiological efforts.
- Conduct a community health assessment and identify priorities arising from that assessment, at least every five years.
- Use relevant data to implement, monitor, evaluate, and modify community health improvement plans at least every five years. Update the community health improvement plan annually using local data.
- Conduct or inform health impact assessments.
- Ensure that meaningful and accurate metrics are used to evaluate community health improvement plan.

Infectious Disease-Related Assessment

Identify and respond to disease outbreaks and epidemics

- Ensure local public health capacity to respond to emerging threats to health by maintaining flexibility related to staffing and information systems.
- Promptly identify and lead outbreak investigations that initiate or primarily occur in the local authority and actively participate in outbreak investigations that cross multiple authorities. Incorporate standards and standard case definitions
 - Investigate and develop appropriate interventions to mitigate local/jurisdictional outbreaks and epidemics.

Analyze and respond to information related to disease outbreaks and epidemics

Maintain the capacity and staff to provide laboratory services including diagnostic and screening tests, and follow protocols established by the OHA Public Health Division.

Emergency and Response

Prepare for Emergencies

Develop, exercise, improve and maintain preparedness and response plans in the event that either a natural or man-made disaster or an emergency occurs

- Conduct jurisdictional assessment of risk, resources, and priority of public health preparedness capabilities.
- Maintain public health surveillance and response plans inclusive of disaster epidemiology and an active epidemiological surveillance plan.
- Plan for the distribution of pharmaceuticals in the event of an emergency.
- Prepare and maintain public health preparedness plans in accordance with the 15 core public health capabilities including but not limited to public health surveillance and disaster epidemiology, identifying and initiating medical countermeasures dispensing strategies, communications with public and partners, outlining public health's role in fatality management, and monitoring mass care/population health
- Maintain a public health preparedness training and exercise plan, including but not limited to the coordination of public health staff training to support the system in public health /medical surge events and community empowerment and engagement in preparedness efforts.
- Plan emergency preparedness exercises.
- Document emergency preparedness exercises.
- Develop public health short term and long term goals for recovery operations.

Maintain and execute a plan providing for continuity of operations during a disaster or emergency, including a plan for accessing resources necessary to recover from or respond to disaster or emergency

- Maintain continuity of operations plan for the authority.
- Produce continuity of operations plan for the local health authority.
- Maintain pharmaceutical access.

Address the needs of vulnerable populations during a disaster or emergency

Respond to Emergencies

Be notified of and respond to potential disasters and emergencies. Activate emergency response personnel during a disaster or emergency, and recognize if public health has a primary, secondary or ancillary role in response activities

- Provide efficient and appropriate situation assessment, determine objectives to address the health needs of those affected, allocating resources to address those needs, and return to routine operations.
- Develop situational assessments and resulting operational plans, including objectives, resources needed and how to resume routine operations.
- Document participation in emergency response efforts
- Produce disaster epidemiology reports.

Issue and enforce emergency health orders

- Document enforcement of emergency public health orders.

Coordinate and Communicate Before and During an Emergency

Communicate and coordinate with health care providers, emergency service providers and other agencies and organizations that respond to disasters and emergencies

- Build community partnerships to support health preparedness, recovery and resilience efforts, including training and exercising with community partners per federal guidelines, and the ongoing training and support provided by local public health authorities (e.g. schools, hospitals, emergency medical, community organizations, organizations serving priority/focal populations, etc.)
- Maintain a portfolio of community partnerships to support preparedness and recovery efforts.

Act as the jurisdictional administrator of public health notification systems (e.g. alert networks, hospital capacity programs, etc.), Oregon's logistical ordering system and syndromic surveillance system.

Use communications systems effectively and efficiently during a disaster or emergency

- Deliver health alerts and preparedness communications to partners and the general public.

Communications

Regular Communications

Local public health authorities shall develop and implement a strategic communication plan that articulates the local public health authority's mission, value, role, and responsibilities.

- Engage in two-way communications with the public through the use of a variety of accessible methods of communication channels:
 - Effectively use mass media and social media to transmit communications to and receive communications from the public
 - Local public health authorities shall maintain a public-facing website with updates made to content no less than annually.
 - News releases and public meeting notices.
 - Policy briefs and other policy-related communications.
- Content:
 - Local public health authorities shall develop and disseminate communications on emerging public health issues.
 - Local public health authorities shall develop and disseminate print and media materials in accordance with the strategic communications plan and risk communication needs.
 - Local public health authorities can also adopt or customize statewide print and media materials provided by the OHA Public Health Division. Materials shall be in compliance with ADA Section 508 and consider health literacy needs, and communications for the public shall consider the end user and use appropriate communication format(s) and language(s). Communications shall be tailored for specific audiences, such as policymakers, stakeholders, local public health authorities, health care providers, the public and specific population groups.
 - Local public health authorities shall be a reputable source of health information, through public health branding, by disseminating news releases and public meeting notices in a timely and transparent fashion. Local public health authorities shall support ongoing interaction with the public by offering and inviting two-way communications with the public; (e.g. contact information, surveys, comment boxes, etc.)
- Communicate with specific populations in a manner that is culturally and linguistically appropriate

Local public health authorities shall regularly evaluate the effectiveness of communications efforts using tools such as web analytics, surveys, panel surveys and polls. Local public health authorities shall use evaluation findings to adjust communications and communications strategies accordingly.

Communication training and capacity building

- Document communications support for any staff beyond the public information officer who communicate with the public about public health issues (e.g. media content reviewed by the public information officer).
- Document two-way communications with the OHA Public Health Division. Evaluation Communications evaluation plan that is structured around health equity and literacy.

Emergency Communications

During a disease outbreak or other disaster or emergency, provide accurate, timely and understandable information, recommendations and instructions to the public

- Local public health authorities shall engage with the OHA Public Health Division when an outbreak or significant public health risk is identified to determine the scope of the health risk and all potential populations impacted (i.e., neighborhood or county-level risk versus statewide risk). Based on this risk assessment, local public health authorities and the OHA Public Health Division will inform which agency shall take the lead role in coordinating communications to the public.

Educational Communications

Develop and implement educational programs and preventive strategies

Policy and Planning

Development and Implement Policy

Provide guidance and coordinate planning for the purpose of developing, adopting and implementing public health policies. Develop public health policy options necessary to protect and improve the health of the public and specific adversely impacted populations.

- Develop policy, systems, and environmental change strategies to improve health outcomes, using an established policy change framework that includes problem identification, policy analysis, strategy and policy development, policy enactment, policy implementation, and policy evaluation. Activities include:
 - Identify, analyze and develop statutory changes that are necessary to address an identified public health issue or are in response to a change in regional, state or federal statute, regulation or rule.
 - Identify, analyze and develop proposed systems or environmental changes that are necessary to address an identified public health issue or are in response to a change in federal statute, regulation or rule.
 - Evaluate the effectiveness of policy change, in coordination with staff with assessment and epidemiology skills and capacity.
- Develop a strategic policy plan for the authority that includes specific strategies to reduce or eliminate health disparities. A strategic policy plan is a document that identifies and guides the strategic policy priorities and policy goals for the authority and can align with other local public health plans (e.g. CHIP or strategic plan), but can also include policy goals not related to other plans, if appropriate.
 - This plan must be reviewed and updated at least once a year.
- Develop policy concepts, as appropriate, for public health issues to be addressed by city and county governments in the authority.
- Monitor and respond to state and local public health issues that impact local authorities and, upon request, participate in policy initiatives that include multiple authorities.
- Interpret, respond to, and implement federal, state, and local policy changes. Coordinate enforcement of federal and state policy and regulatory activities when delegated to do so.
- Develop and amend as needed rules to implement local ordinances.

Understand and use the principles of public health law to improve and protect the health of the public

Improve Policy with Evidence Based Practice

Enable the Oregon Health Authority and local public health authorities to serve as a primary and expert resource for using science and evidence-based best practices to inform the development and implementation of public health policies

- Coordinate with the state on development of economic analyses (e.g. analysis of cost/risk of non-investment return on investment) for proposed policy changes in the authority.
- Provide coordination among local agencies and other organizations on policies that impact health, including those that address health equity and the social determinants of health.
- Inform federal policy work through NACCHO or other organizations.
- Coordinate enforcement of federal, state, and local policy and regulate activities when delegated to do so.

- Coordinate local public health policy agendas with the state policy agenda and support the state public health position on legislation, when appropriate.
- Share information about implementation of public health best practices or innovative strategies that may be relevant to the OHA Public Health Division or other local public health authorities.
- Participate in state-led discussions to identify, analyze, and develop or revise systems or rules that are needed to address an identified public health issue (e.g. review of existing rules).
- Respond to policy initiatives that may impact health.

Understand Policy Results

Analyze and disseminate findings on the intended and unintended impacts of public health policies

- Assume a leadership role for communicating with the community about how policy changes may impact health.
- Engage traditional and nontraditional partners in conversations about efforts to improve health outcomes.

Implement, monitor, evaluate and modify state health improvement plans or community health improvement plans

- Ensure communication with the governing body (e.g. Board of Commissioners or sub designee) to whom the health authority is accountable for progress on the CHIP at least twice a year.
- Make information about the community health improvement plan available to the public.

Health Equity and Cultural Responsiveness

Foster Health Equity

Support public health policies that promote health equity

- Develop and promote shared understanding of the determinants of health, health equity and lifelong health with local partners and the community.
- Make the economic case for health equity, including the value of investment in cultural responsiveness.

Engage with the community to identify and eliminate health inequities.

Implement processes within public health programs that create health equity

- Promote a common understanding of cultural responsiveness.
- Promote understanding of the extent and consequence of systems of oppression.

Recognize and address health inequities that are specific to certain populations, including differences stemming from race, class, gender, disability, and/or national origin

- Collect and maintain data, or use data provided by the OHA Public Health Division, that reveal inequities in the distribution of disease. Focus on information that characterizes the social conditions (including strengths, assets, and protective factors) under which people live that influence health.
- Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic wellbeing, and environmental quality) with local partners, or use information collected and provided by the OHA Public Health Division.
- Identify local population subgroups or geographic areas characterized by (i) either an excess burden of adverse health or socioeconomic outcomes; (ii) an excess burden of environmental health threats;
- Foster shared understanding and will to achieve health equity and cultural responsiveness.
- Make available to people data and information on health status and conditions that influence health status by race, ethnicity, language, geography, disability, and income. Consider health literacy, preferred languages, cultural health beliefs and practices and other communication needs when issuing data and information.

Communicate and Engage Inclusively

Communicate with the public and stakeholders in a transparent and inclusive manner

- Make easily and quickly available clear and transparent communications with their constituents on issues related to the health of their authority, especially regarding policies and decisions relating to health equity priorities.
- Provide technical assistance to communities with respect to analyzing data, setting priorities, identifying levers of power, and developing policies, programs, and strategies.
- Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community

Engage the community, including diverse populations, in community health planning

- Engage with community members to learn about the values, needs, major concerns, and resources of the community in order to effectively prioritize resources and services to best address health inequities.
- Learn about the culture, values, needs, major concerns, and resources of the community. Respect local community knowledge and seek to understand and formally evaluate it.
- Promote the community's analysis of and advocacy for policies and activities that will lead to the elimination of health inequities. Share, discuss, and respond to feedback from people on civil rights implementation using tracked findings to report to people ways to decrease civil rights violations.
- Promote community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government.
- Routinely invite and involve community members and representatives from community-based organizations in public health authority planning, procedures, evaluation, and policies. Offer means of engagement that respond to unique cultures of community members.
- Increase racial and ethnic representation on councils and committees.

Community Partnership Development

Identify and Develop Partnerships

Convene and sustain relationships with traditional and nontraditional governmental partners and stakeholders and traditional and nontraditional nongovernmental partners and stakeholders

- Coordinate programmatic activities with those of partner organizations to advance cross-cutting, strategic goals.
- Promote the use of evidence-based strategies to improve population health by providing training, technical assistance, and other forms of support to partners.
- List all community partners involved in local and regional health needs, health impact, and health hazard vulnerability assessments; include descriptions of partners involved, their roles, and contributions to the effort.
- List all key regional health-related organizations with whom the health department has developed relationships with about public health issues of mutual interest. Document these efforts, resulting areas of collaboration, and benefits to the public's health resulting from the collaboration in relevant grant progress reports and other summaries of activities.
- Document training, technical assistance, and other forms of support provided to partners, along with evaluation if the effectiveness of this support in promoting population health.
- Evaluate reports on the effectiveness of partnerships.

Develop, strengthen and expand connections across disciplines, such as education and health care, and with members of the community who work in those disciplines.

- Support and maintain cross-sector partnerships with health-related organizations; organizations representing priority/focal populations; private businesses; and local government agencies and non-elected officials.

- The portfolio of cross-sector partnerships should include a description of partnering organizations and how the partnership supports population health. Specifically describe, if at all, how the partnership addresses health disparities.
- List all local community groups or organizations representing priority/focal populations, including private businesses, healthcare organizations; and relevant tribal, regional, and local government agencies the local public health authority has developed relationships with so that public health goals are effectively and efficiently attainable for all populations. As part of program evaluation efforts, address successes, lessons learned, recognized barriers to such collaboration, and strategies to overcome these barriers.

Engage Partners in Policy

Foster and support community involvement and partnerships in developing, adopting and implementing public health policies

- Earn and maintain the trust of community residents by engaging them at the grassroots level.
- Ensure that community partners can participate fully in local and state public health planning efforts.
- Join with partners in health assessments, using their input to develop a community health improvement plan to guide implementation work with partners and to coordinate activities and use of resources.
- Specifically engage priority/focal populations so they can actively participate in planning and funding opportunities to address their communities' needs.
- Document engagement through meetings, communications or other means with communities disproportionately affected by health issues so they can actively participate in planning and funding opportunities to address their communities' needs.

Engage members of the community in implementing, monitoring, evaluating and modifying state health improvement plans or community health improvement plans

Leadership and Organizational Competencies

Leadership and Governance

Define the strategic direction necessary to achieve public health goals and align and lead stakeholders in achieving goals:

- Develop and implement a strategic plan for local governmental public health.
- Work with the state and other local and tribal authorities to improve the health of the community.
- Collaborate with systems and organizations in developing a vision for a healthy community.
- Provide evidence of engagement in health policy development, discussion and adoption with the OHA Public Health Division to define a strategic plan for public health initiatives.
- Provide evidence of engagement with appropriate governing entity about public health's legal authorities and what new legislative concepts, laws, and policies may be needed.

Performance Management, Quality Improvement, and Accountability

Use the principles of public health law, including relevant agency rules and the constitutional guarantee of due process, in planning, implementing and enforcing public health initiatives

- Promote and monitor organizational objectives while sustaining a culture of quality of service
- Ensure the management of organizational change (e.g., refocusing a program or an entire organization, etc.)
- Use performance management, quality improvement tools and coaching to promote and monitor organizational objectives and sustain a cultural of quality.
- Implement a performance management system to monitor achievement of public health objectives using nationally recognized framework and quality improvement tools and methods.

Human Resources

Maintain a competent workforce necessary to ensure the effective and equitable provision of public health services

- Collaborate and share workforce development planning resources with the state, tribal and other local authorities.
- Coordinate, or convene when necessary, efforts to assess leadership and organizational capabilities within their local authority to understand capacity and to identify gaps.
- Develop and implement a workforce development plan that identifies needed technical and/or informatics skills, competencies and/or positions. The plan should include strategies for recruiting, hiring and/or developing existing staff to meet the needs.
- Assess staff competencies; provide individual training and professional development and the provision of a supportive work environment.
- Ensure a high quality public health workforce by promoting workforce development and capacity building.
- Provide continuing education and other training opportunities necessary to maintain a competent workforce.
- Ensure nimble human resources support for public health work, including composition and maintenance of up-to-date job classifications suitable for the above listed roles and activities, use of temporary staffing and other methods to expand and contract staff to meet immediate public health demands.
- Develop partnerships with institutions of higher education necessary to maintain a competent workforce.

To the extent practicable, ensure that local public health administrators, local health officers and individuals who work in the field of public health reflect the demographics of the community being served and the changing demographics of this state

Information Technology

Implement and maintain the technology needed to support public health operations while simultaneously protecting personally identifiable information and other confidential health information

- Develop and maintain local public health technology and resources to support current and emerging public health practice needs. Document that information technology supports public health and administrative functions of the department.
- Ensure privacy and protection of personally identifiable and/or confidential health information in data systems and information technology.
- In collaboration with health systems and other partners, use the information assets/needs assessment to develop and implement a vision and strategic plan. The plan should include a funding strategy and appropriate governance processes to address information management and supportive information systems.
- Implement current, interoperable technology that meets current and future public health practice needs and maintenance of those resources. Assurance that technology systems and technology resources are sufficient to support current and future local public health practice needs and ability to maintain those systems.
- Implement a technical support plan that provides users of local public health technology systems and technology resources with appropriate training.

Financial Management, Facility Operations, and Contracts and Procurement Services

Use accounting and business best practices in budgeting, tracking finances, billing, auditing, securing grants and other sources of funding and distributing moneys to governmental and nongovernmental partners.

- Ensure use of financial analysis methods to make decisions about policies, programs and services and ensure that all are managed within current and projected budgets.
- Work with partners to seek and sustain funding for additional public health priority work.