

OREGON STATE

**Public Health
Modernization
Assessment
Report**

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

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. As part of this path, Oregon's governmental public health authorities were asked to assess their current implementation of the public health modernization framework, and the full cost of implementation.

The assessment results are presented in detail in the following report. It is important to remember that these data represent a starting place for public health modernization implementation, however, using these data, we are able to generate significant findings that will be useful for the planning and executing of implementation.

Key Findings

Overall

- For many local public health authorities, this was the first detailed exposure to the public health modernization framework. The process helped to build a foundational shared understanding of the framework. This understanding will continue to evolve.
- Governmental public health authorities are already significantly executing the public health modernization framework, with \$209 million being spent on these activities. This is approximately two-thirds of the cost of full implementation of the framework.
- The estimated additional cost needed for full implementation is approximately \$105 million. This cost estimate provides a point-in-time, high-level estimates that provide only order of magnitude precision (which provide accuracy in terms of scale).
- The greatest additional increment of costs are concentrated in the four programs t and the Leadership and Organizational Competencies capability. Unlike the LPHAs, PHD has the highest additional increment of costs in the Assessment and Epidemiology capability, which also houses the Oregon State Public Health Laboratory.
- While the additional increment of costs are generally concentrated in the four programs and Leadership and Organizational Competencies capability, there is no foundational program or capability that does not have additional costs for at least one public health authority.
- Areas with a higher level of implementation do not necessarily need fewer resources than those areas with lower implementation. On the other hand, limited implementation does not always indicate that a substantial amount of funding is needed to support full implementation.
- There are significant existing shared resources among LPHAs today. These existing sharing arrangements provide examples for future sharing relationships.
- The current governmental public health service delivery model is divided into state activities, provided by PHD, which are provided centrally, and local activities, provided by LPHAs, which are provided locally. This service delivery model could be expanded to allow for cross jurisdictional service delivery options.

Programmatic

- There are meaningful gaps across the system in all governmental public health authorities. These gaps are not uniform, nor do they appear in the same places in every organization. As such, current implementation of public health modernization can be described as a “patchwork quilt.” Because of this, many global implementation decisions could have unintentional service delivery and coverage ramifications.
- Every foundational capability and program within the public health modernization framework includes roles and deliverables with varying levels of implementation.
 - There are some functional areas that include roles and deliverables that are well-established as governmental public health activities.
 - There are other functional areas that are dominated by roles and deliverables that may represent new governmental public health activities.
- There are no foundational programs or capabilities that are substantially implemented universally across all public health authorities.

Implementation

- Implementation of public health modernization will be a significant undertaking that should be phased to allow governmental public health authorities adequate time to plan intentional implementation strategies.
- LPHAs have a high degree of local expertise related to their service areas which should be leveraged to improve the efficiency and effectiveness of implementation. Implementation strategies should allow for flexibility and local decision making, which could be governed by local implementation plans.
- Implementing by wave of LPHAs could be challenging for several reasons, including but not limited to:
 - Risk of creating a two-tiered system (with some LPHAs operating under the Modernization framework, and others not).
 - Significance of potential impacts to health equity (with those served by modernized local public health authorities receiving a higher level of service than those being served by non-modernized local public health authorities).
- Implementing by foundational capability or program could also be challenging because current implementation is uneven across local public health authorities.
- There are significant service dependencies between state and local public health activities. Some of the state roles and deliverables that support local activities are not fully implemented; implementing the local activities without first implementing the state activities will hinder success.
- Many of the foundational capabilities and programs support one another. That is, in order to accomplish the goals of one foundational capability or program most effectively and efficiently, it is necessary to have access to the resources available through implementation of another. This is most intuitive when thinking of the foundational capabilities, for example, Educational Communications plays a significant role in producing information related to Healthy Eating Active Living and other programmatic initiatives.

Policy Implications

- There is still a need to strengthen the shared understanding around public health modernization definitions, core services, roles, and deliverables.
- The assessment process, though thorough, was not exhaustive. There is a need to continue exploring particular features of the existing system in order to identify opportunities for increased efficiency and effectiveness. These features may include:
 - Service delivery, including cross jurisdictional sharing
 - Non-governmental public health assets, resources, and partnerships that contribute to the accomplishment of public health modernization roles and deliverables.
 - Barriers to implementation
 - Short-term or one-time additional costs related to implementation itself

PHASING CONSIDERATIONS

Implementation can be phased in many ways, some of which may be influenced by statewide and local priorities. However, public health modernization is complex with many service dependencies among foundational capabilities and programs and state and local activities. There

are also inconsistencies in the existing implementation. Therefore, global strategies for all governmental public health authorities or relating to full implementation are likely to be difficult and inefficient to implement.

To minimize these risks and establish the most efficient, effective implementation process possible, a flexible implementation strategy that is responsive to specific governmental public health authority contexts is needed. We have identified preliminary criteria for this decision-making strategy, including:

- **Population Health Impacts:** The degree to which a specific activity will improve population health. This is challenging to measure, as all foundational capabilities and programs are foundational and therefore necessary to support population health. Another approach is comparing the relative severity of the population-wide consequences of inaction on each foundational capability and program, which do vary. Additionally, it is important to remember that many of the cross-cutting capabilities will likely increase the effectiveness of the foundational programs, so their population health impact should be identified accordingly.

- **Service Dependencies:** The activities of state and local governmental public health authorities are interdependent. Many of PHD's roles and deliverables support local activities, and some local activities feed back into the PHD's work. It is necessary to understand service dependencies as part of overall implementation process.
- **Coverage Maximization:** This assessment found that some roles and deliverables are not widely implemented by LPHAs, but are available to significant portions of the population because a few LPHAs with large populations have existing services that meet the modernization requirements.
- **Service Equity:** How services are implemented could greatly affect service equity. For example, implementation by wave could benefit higher resourced agencies, likely in areas with low poverty rates, while hurting those with limited resources, likely in areas with higher poverty rates.

There are tensions between these considerations; for example, maximizing coverage by population could be accomplished without increasing the level of implementation of some smaller LPHAs. It will be important to leverage governmental public health authorities' expertise to find balance while using this decision-making framework.

The flexibility of this decision-making framework will also allow the tracking of implementation results, allowing for continuous improvement, including course correction, within the implementation process.

This decision-making framework and the process by which it is applied should be refined through a collaborative process that would include all existing and potential governmental public health authorities (if others are identified as part of service delivery conversations).

2017-19 Biennium

Implementation of public health modernization will be a significant undertaking that should be phased to allow governmental public health authorities adequate time to plan intentional implementation strategies. This phasing will likely occur over more than one biennium.

To make meaningful and substantial progress on the implementation of public health modernization, some decisions about implementation priorities for the 2017-19 biennium will need to be made. Initial priorities, based on our high-level implementation considerations and the decision-making framework include:

1. Support additional planning and work related to public health modernization implementation for all governmental public health authorities, recognizing that executing implementation will require non-trivial resources as it is phased in.
2. Create a flexible funding structure to support LPHAs fund their "patchwork quilt" gaps based on locally-identified priorities.
3. Reduce gaps in state activities related to service dependencies to remove barriers to local implementation.

4. Invest in high priority public health initiatives with potential for the highest population health impacts.

Decisions about how much funding is allocated to each of these priorities should be made based on the availability of funding, in conjunction with an understanding of those decisions' ramifications on implementation of the public health modernization framework across the state.

Future Biennia

A flexible decision-making framework that is responsive to specific governmental public health authority contexts should be used to make future implementation decisions based on the success of the first phase (considered to be the 2017-19 biennium). This decision-making framework should support decisions that align to state and local implementation plans, such that those plans accurately reflect implementation.

ASSESSMENT PROCESS

BACKGROUND

Right now, Oregon’s communities are not equally equipped to support the health of Oregonians where they live, work, learn, and play. Since 2013, Oregon has been working to modernize its governmental public health system so that a common set of core public health capabilities and programs are present in all communities in the state. 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 seven foundational capabilities and four foundational programs that should be present at each public health authority in Oregon.

Foundational Capabilities

Foundational capabilities are the knowledge, skills, or abilities necessary to carry out a public health activity or program. 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

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

Additional Programs

Additional programs are public health activities and programs implemented in addition to foundational programs to address specific community public health problems or needs.

Public Health Modernization: New Framework for Health in Every Community

The public health modernization framework differs significantly from Oregon’s existing public health structure. The new framework supports the provision of population-based health services uniformly across the state. With health system transformation in Oregon, the role of governmental public health as a provider of last resort for residents who do not have access to health care 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 additional programs to meet local needs.

Foundational Programs

Foundational programs are those services that are necessary to assess, protect, or improve public health.



SERVICE DELIVERY

Oregon's governmental public health authorities work as a system to deliver governmental public health services to all Oregonians.

Governmental Public Health Authorities

Governmental public health authorities can be separated into two distinct groups by service area:

- **State Public Health Authorities** provide services that are best delivered centrally for the entire state, for example development and maintenance of statewide data systems. In Oregon, there is one state public health authority, PHD.
- **Local Public Health Authorities** provide services that are best delivered locally. Oregon has 34 local governmental public health authorities, known as LPHAs. LPHA's service areas each cover one county except for North Central Public Health District, which serves Gilliam, Sherman, and Wasco counties.

It is important to recognize that this governmental public health authority split is how the system is currently structured, but not the only way to structure it. While currently there is one state public health authority providing centralized state public health services, those services could be delivered through

decentralized state public health authorities located across the state. Similarly, although local public health services are delivered in a decentralized manner at the county-level (with the exception of North Central Public Health District), there are opportunities to provide some services in a more centralized manner to allow LPHA's to leverage types of expertise that might not be available system wide.

Cross Jurisdictional Sharing

Some LPHAs have existing service delivery relationships whereby they support each other in delivering public health services. Most often, these relationships are between proximate LPHAs. Cross jurisdictional sharing is an efficient way to deliver public health services while still leveraging local knowledge. Although there are significant sharing relationships within the current service delivery system, we have not reported on those relationships because of a desire to maintain anonymity of the assessment results.

PUBLIC HEALTH MODERNIZATION ASSESSMENT OVERVIEW

PHD was tasked with developing and stewarding the first statewide public health modernization assessment. The assessment seeks to 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.

The manual defines each foundational capability and program as it applies 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;
- **State roles:** the unique responsibilities of the OHA Public Health Division;
- **Local roles:** the unique responsibilities of the local public health authorities;

- **Deliverables:** tangible work products created by state and local public health authorities; and
- **Critical tools and resources:** items necessary for state and local public health authorities to fulfill their roles and produce their deliverables.

By defining what is included in public health modernization, the *Public Health Modernization Manual* also defines what activities are not included in the framework. For example, direct services and individualized interventions, like Women, Infants, and Children (WIC), are not included in the framework. Rather these programs are considered additional programs, to be delivered based on local priorities and outside of the public health modernization services.

To support our work, 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 *Public Health Modernization Manual*¹ 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 as there are almost 400 state roles and deliverables and over 300 local roles and deliverables. It is also numbered in such a way as to make specific cross-referencing with this assessment difficult.

It was also difficult for governmental public health authorities to generate estimates at the foundational capability and program level because of the range of roles and deliverables in each. To mitigate these challenges, we developed an intermediate level between foundational capabilities and programs and roles and deliverables to support local authorities in their assessments. To do this, the legislative definitions of each foundational program and capability were synthesized with the 302 local roles and deliverables which were assigned to the emerging functional areas on a one-to-one basis. 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**.

We did not develop complementary functional areas for state activities, because the single

governmental public health authority (PHD) allowed for less granularity in resource estimate generation.

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’s knowledge of public health modernization is from work with the Washington State Department of Health, Washington State Association of Local Public Health Officials, and the state’s 35 local health jurisdictions in implementing public health modernization (known as Foundational Public Health Services in Washington).

Based on discussion with LPHAs through the Coalition of Local Health Officials (CLHO), the organization that represents LPHAs, and the CLHO-PHD Joint Leadership Team, PHD determined that an ideal public health modernization assessment would collect data from all 35 (state and local) governmental public

¹ The latest copy of the *Public Health Modernization Manual* is available at: healthoregon.org/modernization

health authorities 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 authorities with two different sets of responsibilities as per the *Public Health Modernization Manual*
- Collecting consistent responses from 34 LPHAs

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

- A self-assessment completed by each LPHA
- A self-assessment completed by PHD

Each process is detailed further in the following sections.

LPHA ASSESSMENT PROCESS

Process Design

The LPHA assessment tool was created to:

- Assess each LPHA's current capacity for providing foundational capabilities and programs; and
- Estimate the cost to fully implement foundational capabilities and programs.

Use of such a tool allowed for LPHAs to complete the tool at their own pace while assuring a certain level of consistency across respondents.

Assessment Tool Development

The development of the assessment tool 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.

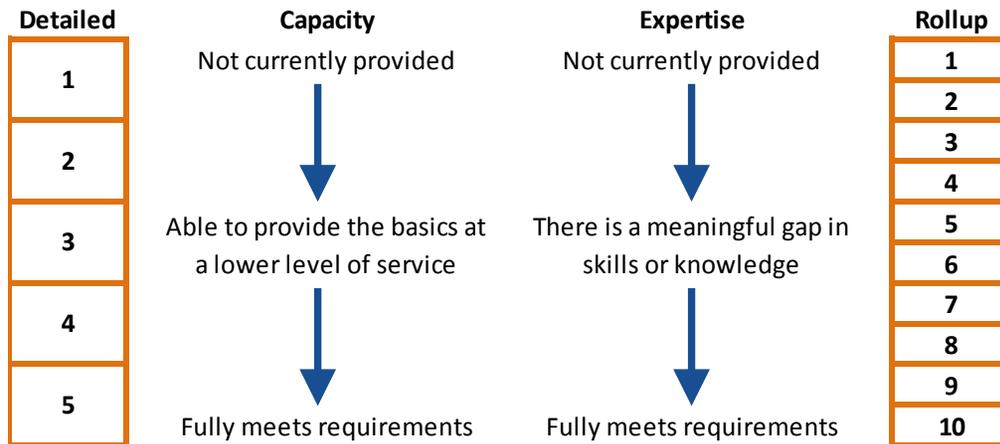
PROGRAMMATIC SELF-ASSESSMENT

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. That is, “do I have enough staff to provide the activity for all?”
- **Expertise.** To what degree the organization's current capacity aligns with the appropriate

knowledge necessary to implement the services/deliverables dictated. That is, “do I have enough expertise to provide the activity well?”

This section of 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.



allocated those resources that supported each functional area.

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 modernization-related spending was captured.

FULL IMPLEMENTATION RESOURCE ESTIMATION

Within the assessment tool, LPHAs developed annual cost estimates for each foundational capability and program.

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 programmatic self-assessment had two levels:

- A **detailed assessment** of capacity and expertise for meeting local roles and providing deliverables outlined in the *Public Health 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. 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 do not 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 by the authorities 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 annual level of investment in each functional area, LPHA staff reviewed their FY 2015 annual spending and

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.

These variables are used in conjunction with cost factors (units of cost directly proportional to the independent variables; in this case, demand drivers). Cost factors were 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 high-level, order of magnitude estimates (estimates that are at the right scale) for each functional area.

The initial estimates and estimation tool were provided to aid in the development of final cost estimates; however, use of the tools was optional.

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 in 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 the state health department, would need to be identified to make a request to the legislature.

This context 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 were questionable or unclear, contacting LPHA staff to clarify necessary points. Cost analysis was performed once all data were 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

CLHO TECHNICAL ASSISTANCE

To further support LPHAs in completing their assessments CLHO hired an outside consultant, Kelly McDonald, who was already well known to many CLHO members. The existing relationships with LPHAs that this consultant had made her an invaluable part of the 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.

webinars were hosted throughout the process to address questions, and live phone assistance was provided upon request. LPHA staff were able to send questions and requests via email, and received responses to those inquiries within one business day, although response times were often much quicker.

By the end of the data collection process, the technical assistance team had successfully responded to over 200 assistance requests. Technical assistance included:

PHD ASSESSMENT PROCESS

For PHD, 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, PHD's programmatic self-assessment had two levels: a detailed assessment and a rollout assessment. This assessment used the same levels of detail and scales as the LPHAs' assessment.

Current Spending

To identify PHD's current level of investment in the foundational capabilities and programs, PHD staff reviewed all of the FY 2015 annual spending and allocated resources that support foundational capabilities and programs.

To do this effectively, we suggested that PHD focus on allocating the resources from each of their four centers (Office of the State Public Health Director, Center for Health Protection, Center for Prevention and Health Promotion, and the Center for Public Health Practice).

PHD collected current spending estimates for individual programs and reviewed them to prevent duplication and ensure all spending was

captured. This allowed PHD to provide 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.

Once resource estimates for each foundational capability and program were complete, estimates were reviewed by the Public Health Division Executive Leadership 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 favorable 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. This was a particular challenge given the short six to eight week timeline for completion which constrained the time available for staff to learn and understand these complex topics.

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 some LPHAs 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:

- As a high-level, order of magnitude estimate, accuracy at a budget or line-item level is not expected
- We performed some limited standardization using the data set as a whole and external data sources to correct individual inconsistencies
- As all 34 LPHAs responded, we have data for the whole population of LPHAs, which means we do not have to correct for sampling issues

- Research suggests that managers tend to underestimate the resources needed to perform new job tasks²

Additionally, the completed assessments were thorough, but not exhaustive. LPHAs expressed that there is a need to represent the additional capacity supported by partnerships and other shared assets. This should be considered in future assessment efforts.

Findings represent a snapshot in time based on current knowledge of public health needs, capacity and resources, which continue to evolve in real time as new public health issues arise. Public health and its role in protecting the community is highly dynamic; there are likely to be additional foundational roles and deliverables that public health will need to be involved in over time, such as mitigation of environmental health risks and new communicable diseases. As such, it is expected that the public health modernization framework will continue to evolve, at which point additional assessment efforts should be undertaken.

² Whittington et al., "Strategic Methodologies in Public Health Cost Analyses" *Journal of Public Health Management Practice* (2016-02): 1-7.

OVERALL ASSESSMENT RESULTS

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,³ BERK incorporated anchoring questions. Using the work of Gary King and Jonathan Wand⁴ 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 projected revenue data from LPHAs 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.

³ Glen Mays, "Estimating the Costs of Foundational Public Health Capabilities: A Recommended

Methodology" The Robert Wood Johnson Foundation National Public Health Leadership Forum (2014).

⁴ King and Wand, "Comparing Incomparable Survey Responses: Evaluating and Selecting Anchoring Vignettes" *Political Analysis* 15, no. 1 (2007): 46-66.

PUBLIC HEALTH MODERNIZATION ASSESSMENT OVERALL RESULTS

In the Overall Assessment Results section, we present assessment results at several different levels of detail:

- For all governmental public health authorities
 - Overall Assessment Results
- For PHD
 - Foundational Program and Capability Level Results
- For LPHAs
 - Foundational Program and Capability Level Results
 - Functional Area Level Results

For the purposes of this high-level overview, we have extracted data and exhibits that provide information to support our high-level findings from the assessment. Following, we describe features of the analysis that provides the results at each of these altitudes.

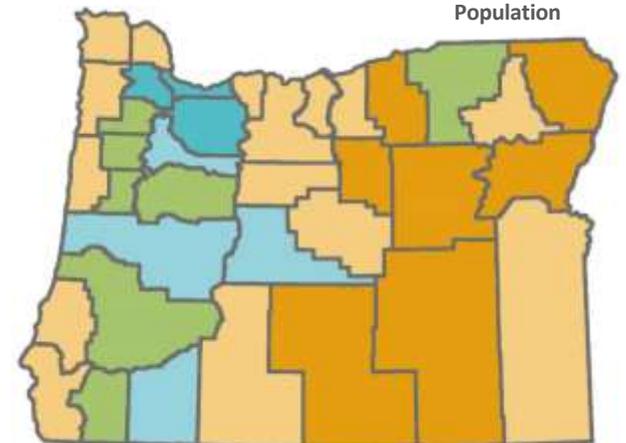
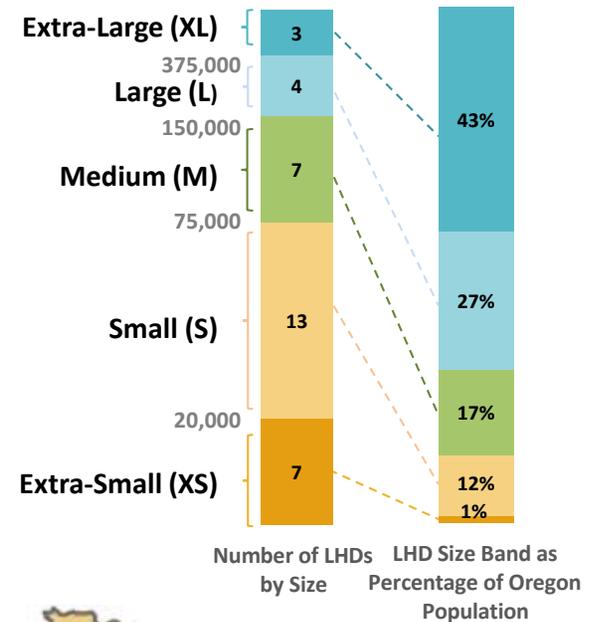
Interpreting Results

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 analysis of the self-assessment results. We identified that LPHAs serving similar populations, both in size and demographics, also have similar levels of implementation and common operational characteristics; these trends became the operational size grouping.

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

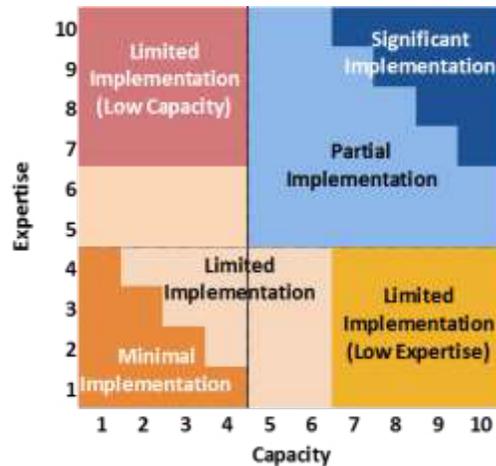


OVERALL ASSESSMENT RESULTS

LEVEL OF IMPLEMENTATION

The level of implementation of foundational capabilities and programs and functional areas, is illustrated throughout the Overall Assessment Results section with both color-coding and charts. The image below illustrates how programmatic self-assessment results are interpreted to provide insight on governmental public health authorities' level of implementation with capacity on the x-axis and expertise on the y-axis.

Level of Implementation for Foundational Capabilities and Programs and Functional Areas



- **Significant Implementation (Dark Blue):** Services are mostly or fully implemented. Likely, the majority of the activity.

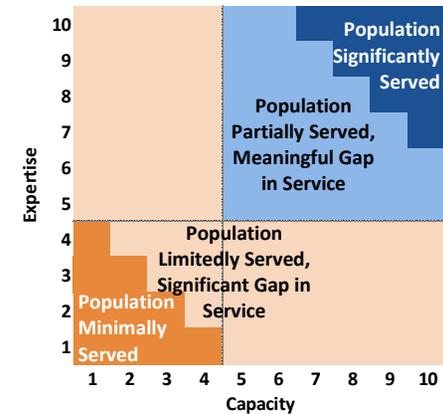
- **Partial Implementation (Light Blue):** Services are partially implemented however, some meaningful gaps remain.
- **Limited Implementation, Low Expertise (Yellow):** Services are limitedly implemented and, while the governmental public health authority has significant capacity there are substantial gaps related to a lack of necessary expertise.
- **Limited Implementation, Low Capacity (Red):** Services are limitedly implemented and, while the governmental public health authority has significant expertise there are substantial gaps related to a lack of necessary capacity.
- **Limited Implementation (Light Orange):** Services are limitedly implemented and there are significant gaps in capacity and expertise.
- **Minimal Implementation (Orange):** Services are mostly not or not at all implemented.

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 the level of service the population receives.

The image below illustrates how programmatic self-assessment results are interpreted to

provide insight on governmental public health authorities' population service with capacity on the x-axis and expertise on the y-axis.



- **Population Significantly Served (Blue):** The population is mostly or fully served.
- **Population Partially Served (Light Blue):** The population is partially served, and there are meaningful gaps in service.
- **Population Limitedly Served (Light Orange):** The population is underserved, and there are significant gaps in service.
- **Population Minimally Served (Orange):** The population is mostly not or not at all served.

SERVICE DEPENDENCIES

- The activities of state and local authorities are interdependent. The state supports many local activities, and some local activities feed back in to PHD's work. We identified clear



OVERALL ASSESSMENT RESULTS

service dependencies, particularly where state activities are needed to support implementation at the local level. These service dependencies should be considered in implementation to prevent them from becoming barriers to and inefficiencies in implementation.

OVERALL ASSESSMENT RESULTS

Cost of Full Implementation

The public health modernization assessment resource estimates are presented in the table above.

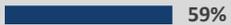
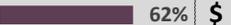
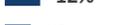
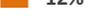
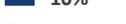
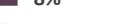
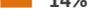
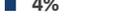
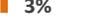
The \$105M estimated additional increment of cost represents the first step in an evolving process – it is a product of a particular time and place and likely doesn't represent the final funding request needed to fully implement public

health modernization. The current public health system in Oregon has existing efficiencies; implementation of public health modernization provides an opportunity to leverage and expand upon those efficiencies.

For both current spending and full implementation estimates, foundational programs represent approximately two-thirds of total costs. However, full implementation

rebalances some of these costs into foundational capabilities, 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.

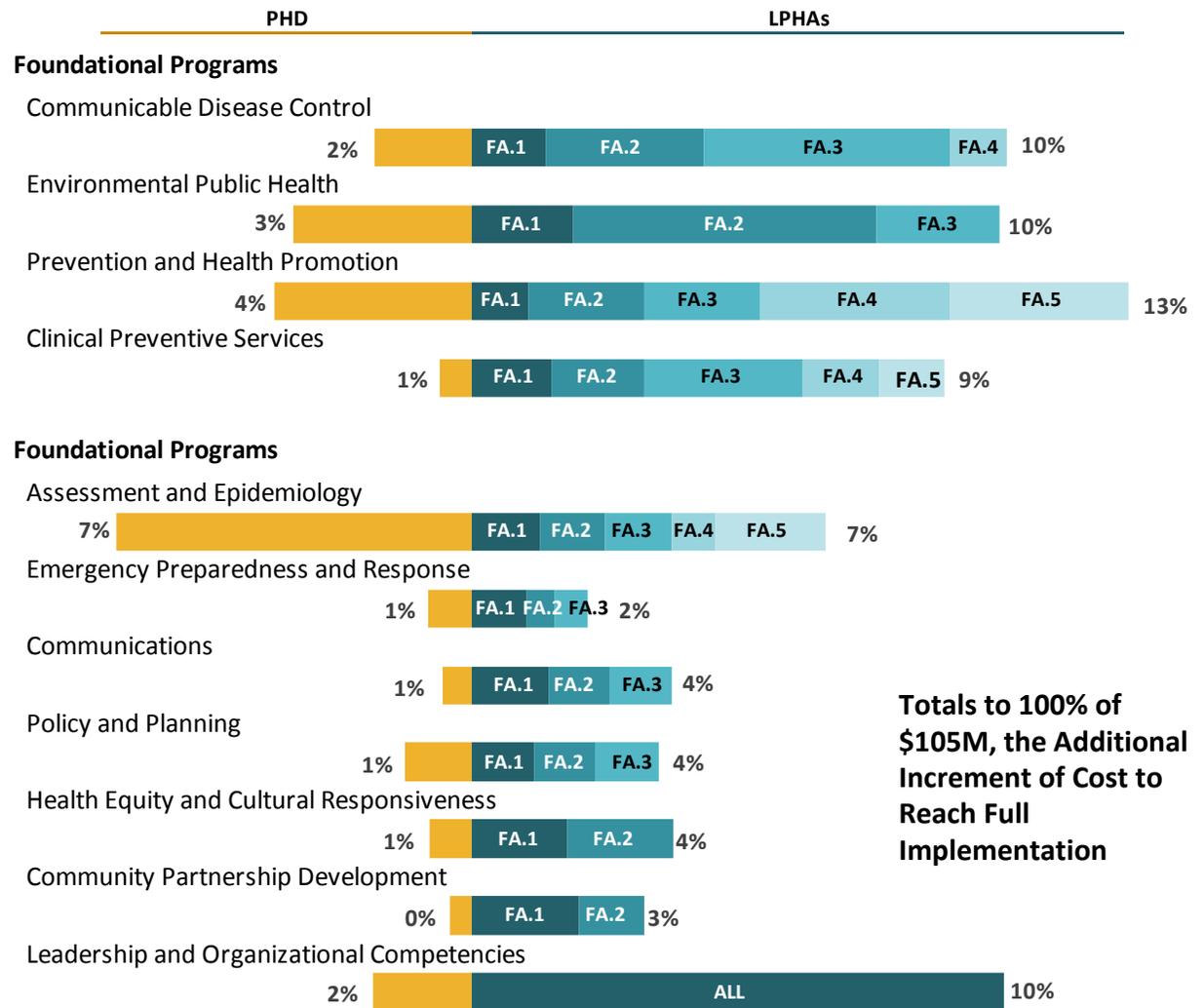
	Total Estimated Cost of Full Implementation	Current Spending	Additional Increment of Cost
Foundational Programs	\$ 184,714,000  59%	\$ 129,616,000  62%	\$ 55,098,000  53%
Environmental Public Health	\$ 59,647,000  19%	\$ 45,214,000  22%	\$ 14,433,000  14%
Prevention and Health Promotion	\$ 58,351,000  19%	\$ 40,908,000  20%	\$ 17,443,000  17%
Communicable Disease Control	\$ 38,322,000  12%	\$ 25,404,000  12%	\$ 12,918,000  12%
Clinical Preventive Services	\$ 28,394,000  9%	\$ 18,090,000  9%	\$ 10,304,000  10%
Foundational Capabilities	\$ 129,068,000  41%	\$ 79,602,000  38%	\$ 49,464,000  47%
Leadership and Organizational Competencies	\$ 47,860,000  15%	\$ 34,959,000  17%	\$ 12,901,000  12%
Assessment and Epidemiology	\$ 31,984,000  10%	\$ 17,504,000  8%	\$ 14,479,000  14%
Emergency Preparedness and Response	\$ 12,214,000  4%	\$ 8,966,000  4%	\$ 3,247,000  3%
Community Partnership Development	\$ 9,941,000  3%	\$ 5,974,000  3%	\$ 3,967,000  4%
Policy and Planning	\$ 9,617,000  3%	\$ 4,415,000  2%	\$ 5,202,000  5%
Health Equity and Cultural Responsiveness	\$ 9,396,000  3%	\$ 4,411,000  2%	\$ 4,985,000  5%
Communications	\$ 8,056,000  3%	\$ 3,373,000  2%	\$ 4,683,000  4%
TOTAL	\$ 313,782,000	\$ 209,218,000	\$ 104,562,000

OVERALL ASSESSMENT RESULTS

Distribution of Additional Increment of Service

The distribution of the \$105M in additional increment of costs needed to support full implementation of public health modernization is presented in the graph to the right. The additional increment of cost is split between PHD (yellow, left) and the LPHAs (teal, right). The LPHA cost estimates also include a breakdown for the individual functional areas within each foundational program and capability; each shade of teal represents one functional area. The percentages are that foundational program or capability's share of the additional increment of cost for either PHD or the LPHAs.

It is important to note that state and local public health authorities often have very different but mutually-supportive roles in the *Public Health Modernization Manual*, and resource needs vary widely across the state based on current capacity. Public health modernization aims to support the entire governmental public health system in achieving effective and efficient service delivery for everyone in Oregon.



Totals to 100% of \$105M, the Additional Increment of Cost to Reach Full Implementation

Functional Area Code Key

Communicable Disease Control

FA.1: Communicable Disease Control Surveillance

FA.2: Communicable Disease Investigation

FA.3: Communicable Disease Intervention and Control

FA.4: Communicable Disease Response Evaluation

Environmental Public Health

FA.1: Identify and Prevent Environmental Health Hazards

FA.2: Conduct Mandated Inspections

FA.3: Promote Land Use Planning

Prevention and Health Promotion

FA.1: Prevention of Tobacco Use

FA.2: Improving Nutrition and Increase Physical Activity

FA.3: Improving Oral Health

FA.4: Improving Maternal and Child Health

FA.5: Reducing Unintentional and Intentional Injuries

Clinical Preventive Services

FA.1: Ensure Access to Effective Vaccination Programs

FA.2: Ensure Access to Effective Preventable Disease Screening Programs

FA.3: Ensure Access to Effective STD Screening Programs

FA.4: Ensure Access to Effective TB Treatment Programs

FA.5: Ensure Access to Cost Effective Clinical Care

Emergency Preparedness and Response

FA.1: Prepare for Emergencies

FA.2: Respond to Emergencies

FA.3: Communicate and Coordinate Before and During an Emergency

Functional Area Code Key, Continued

Assessment and Epidemiology

FA.1: Data Collection and Electronic Information Systems

FA.2: Data Access, Analysis, and Use

FA.3: Respond to Data Requests and Translate Data for Intended Audience

FA.4: Conduct and Use Basic Community and Statewide Health Assessments

FA.5: Infectious Disease-Related Assessment

Communications

FA.1: Regular Communications

FA.2: Emergency Communications

FA.3: Educational Communications

Policy and Planning

FA.1: Develop and Implement Policy

FA.2: Improve Policy with Evidence-Based Practice

FA.3: Understand Policy Results

Health Equity and Cultural Responsiveness

FA.1: Foster Health Equity

FA.2: Communicate and Engage Inclusively

Community Partnership Development

FA.1: Identify and Develop Partnerships

FA.2: Engage Partners in Policy

Leadership and Organizational Competencies

FA.1: Leadership and Governance

FA.2: Performance Management, Quality Improvement, and Accountability

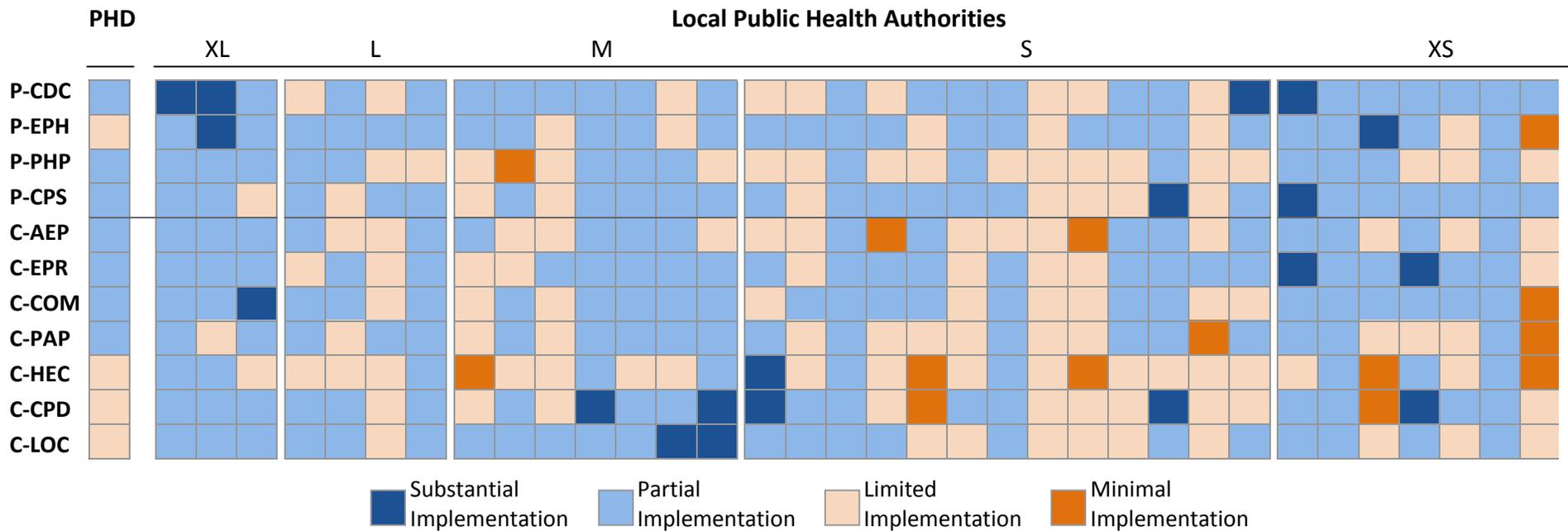
FA.3: Human Resources

FA.4: Information Technology

FA.5: Financial Management, Contracts and Procurement Services, Facility Operations

OVERALL ASSESSMENT RESULTS

Current Implementation of Foundational Programs and Capabilities



Above are the Foundational Program and Capability implementation levels for PHD and a randomized ordering of the LPHAs.

Each vertical set of boxes represent one public health authority. There are no Foundational Programs or Capabilities that are substantially implemented universally across all public health authorities. There are some areas with a higher concentration of limited and minimal implementation, such as the Health Equity and Cultural Responsiveness Capability and the Prevention and Health Promotion Program.

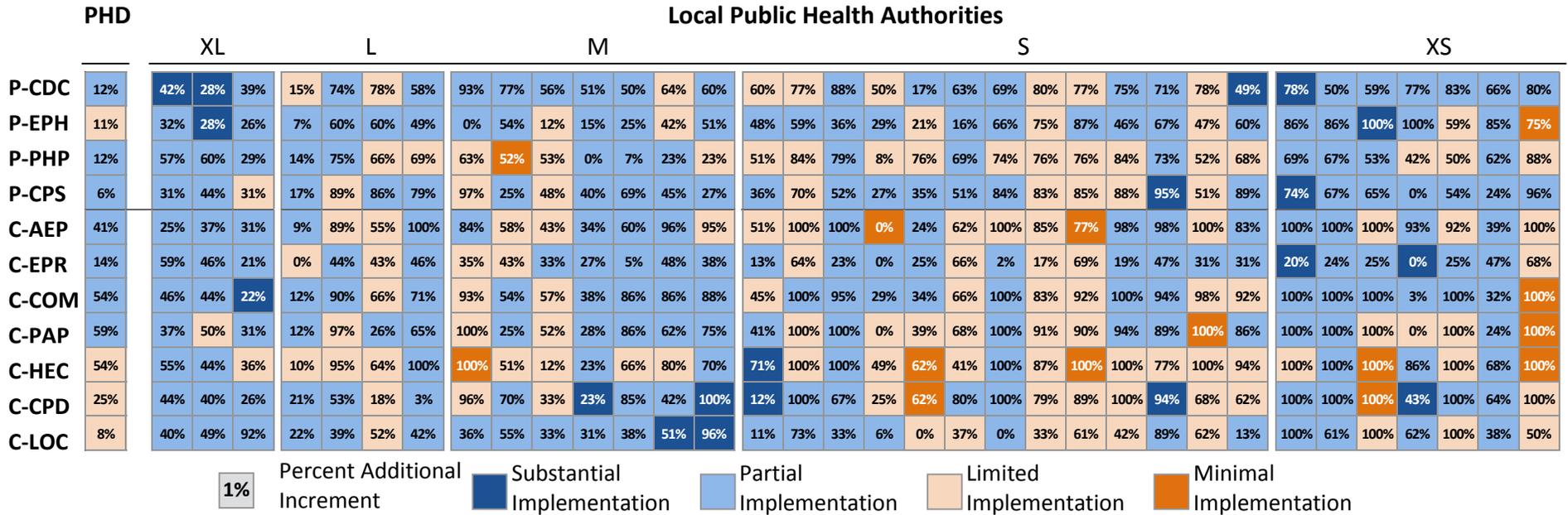
Additionally, you can see that some governmental public health authorities have larger programmatic gaps than others. However, there are gaps across the system in every size category.

Foundational Programs and Capabilities Code Key

- P-CDC:** Communicable Disease Control
- P-EPH:** Environmental Public Health
- P-PHP:** Prevention and Health Promotion
- P-CPS:** Clinical Preventive Services
- C-AEP:** Assessment and Epidemiology
- C-EPR:** Emergency Preparedness and Response
- C-COM:** Communications
- C-PAP:** Policy and Planning
- C-HEC:** Health Equity and Cultural Responsiveness
- C-CPD:** Community Partnership Development
- C-LOC:** Leadership and Organizational Competencies

OVERALL ASSESSMENT RESULTS

Current Implementation of Foundational Programs and Capabilities and Percent Increase in Cost to Reach Full Implementation



Above are the Foundational Program and Capability implementation levels and percent of full implementation additional increment of cost for PHD and a randomized ordering of the LPHAs.

Each vertical set of boxes represent on public health authority. The percentage within each box is the estimated additional increment of cost as a percentage of the full implementation cost for that Foundational Program or Capability. For example, in the upper left corner, PHD estimated that an additional 12% is needed for full implementation of Communicable Disease Control. There are 54 boxes that contain

100% of current spending; current spending was reported to be \$0 in 53 out of these 54 cases.

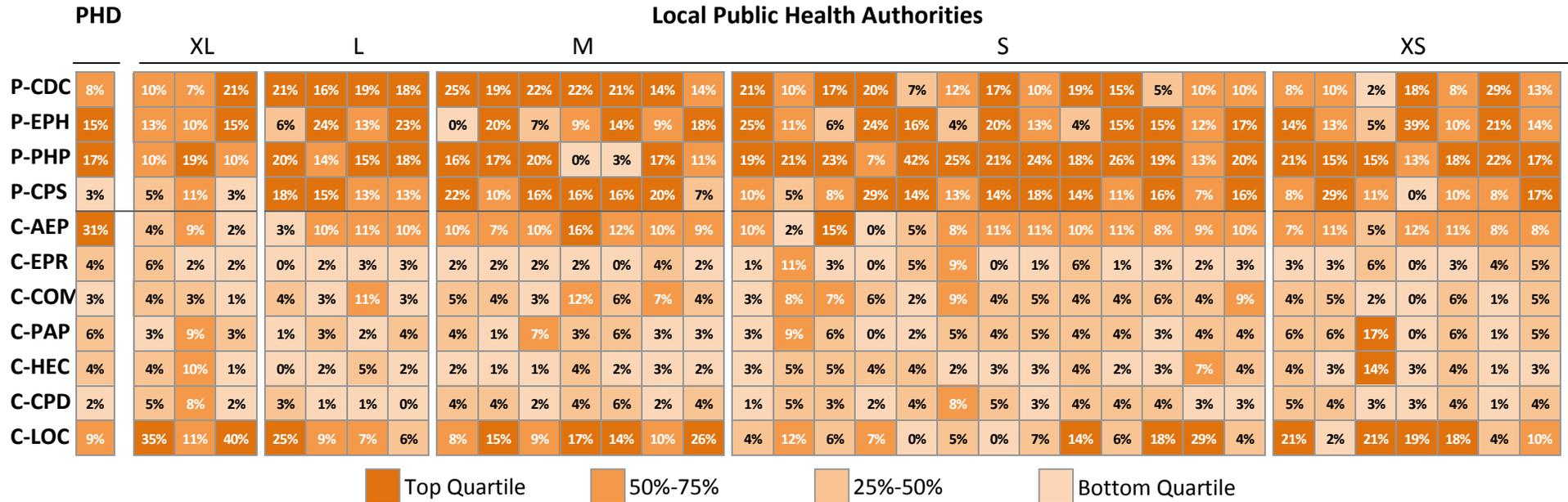
The chart demonstrates that areas with a higher level of implementation do not necessarily need fewer resources than those areas with lower implementation. On the other hand, limited implementation does not always indicate that a substantial amount of funding is needed.

Foundational Programs and Capabilities Code Key

- P-CDC:** Communicable Disease Control
- P-EPH:** Environmental Public Health
- P-PHP:** Prevention and Health Promotion
- P-CPS:** Clinical Preventive Services
- C-AEP:** Assessment and Epidemiology
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- C-PAP:** Policy and Planning
- C-HEC:** Health Equity and Cultural Responsiveness
- C-CPD:** Community Partnership Development
- C-LOC:** Leadership and Organizational Competencies

OVERALL ASSESSMENT RESULTS

Foundational Programs and Capabilities as a Percent of Each Authority's Additional Increment of Cost



Above are the percentages for each public health authority's additional increment of cost that the individual foundational programs and capabilities represent for PHD and each size band of LPHAs (randomly ordered within each size band).

For example, in the upper left corner, PHD estimated that of its total additional increment of cost, Communicable Disease Control constituted 8%. Each column represents one public health authority, and sums to 100% (although rounding may lead to a slight differences). The boxes have been color-coded by quartile to show patterns in the reported data. This chart shows that the greatest additional increment of costs are

concentrated in the programs (the four top rows) and the Leadership and Organizational Competencies capability (the bottom row). Unlike the LPHAs, PHD has the highest additional increment of costs in the Assessment and Epidemiology capability, which also houses the State Public Health Laboratory.

While the additional increment of costs are generally concentrated in the four programs and Leadership and Organizational Competencies capability, there is no foundational program or capability that does not have increased additional increment of costs for at least one public health authority.

Results by Foundational Capability and Program

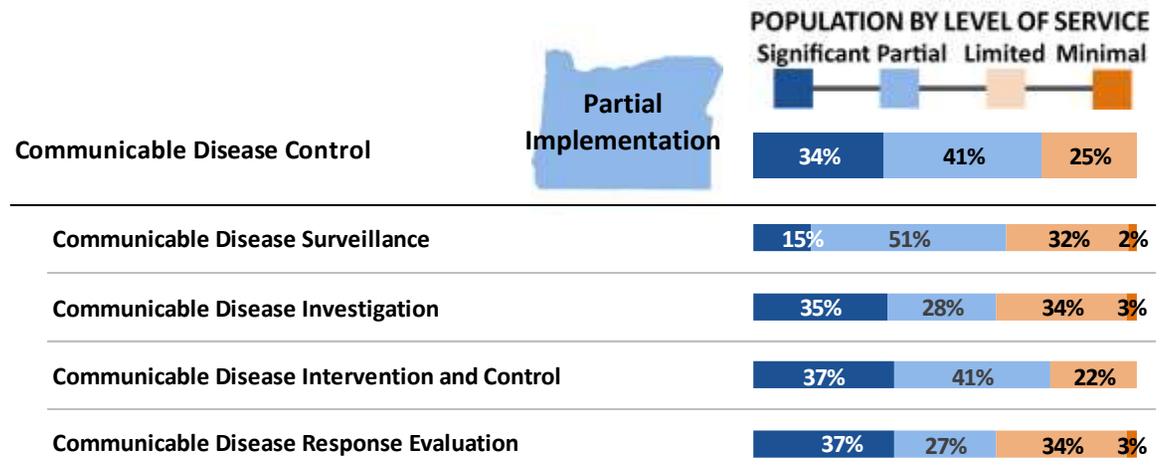
The following pages provide a high-level overview of assessment results by program and capability. Detailed assessment results, which are significantly more granular and reflect additional nuance are available in the “Detailed Assessment Results” section of the full report.

COMMUNICABLE DISEASE CONTROL

Communicable Disease Control represents 20.5% of current statewide public health modernization activities. At full implementation, these activities’ share will decrease to 17.9%.

This program has several service dependencies where state activities directly support provision of local activities, such as providing technical assistance and surge capacity for LPHAs investigating and controlling reportable diseases and outbreaks.

Implementation is mixed across all LPHAs, although know LPHA is less than limitedly implemented. Each of the four functional areas has a similar distribution of level of implementation.



OVERALL ASSESSMENT RESULTS

Environmental Public Health

Environmental Public Health represents 19.9% of current statewide public health modernization activities and is expected to decrease to 17.8% at full implementation.

This program has a few service dependencies between state and local activities, including the state’s maintenance of information systems.

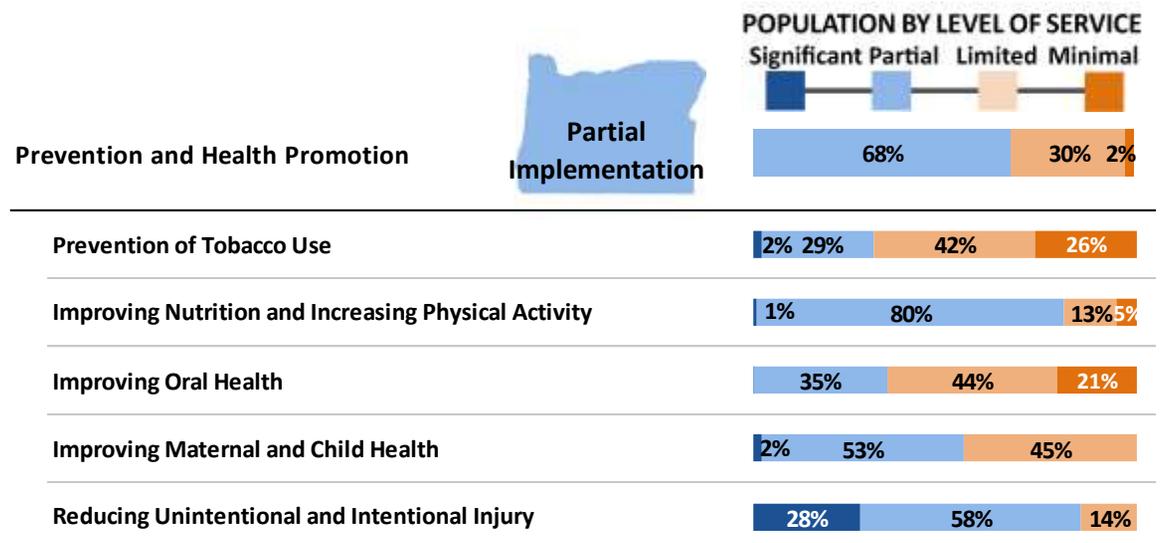
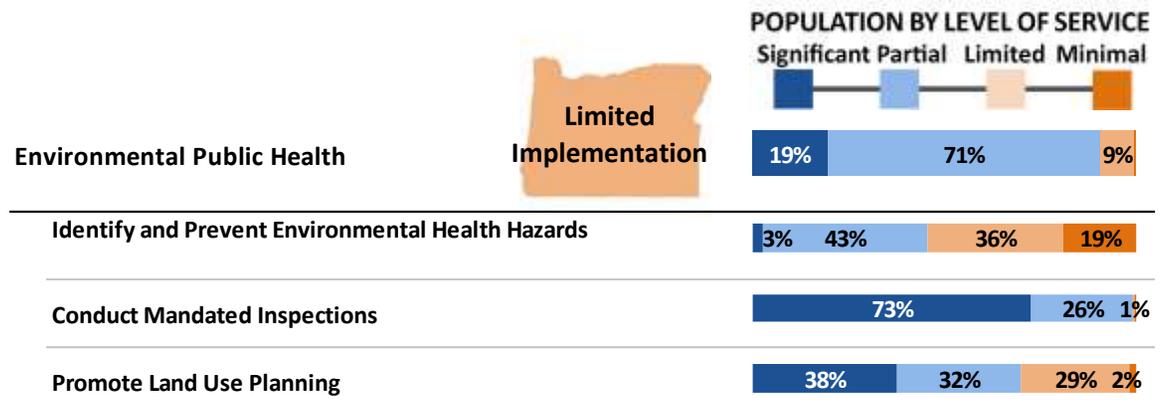
Implementation is fairly high across all LPHAs, with most LPHAs reporting partial or significant implementation. Additionally, Identify and Prevent Environmental Health Hazards is significantly less implemented than the other two functional areas.

Prevention and Health Promotion

Prevention and Health Promotion represents 18.1% of current statewide public health modernization activities. At full implementation, these activities’ share is expected to decrease to 17.4%.

This program only has a couple of service dependencies between state and local health authorities that are not yet fully implemented.

Implementation is lower than other foundational capabilities and programs, with Prevention of Tobacco Use and Improving Oral health being the lowest.



OVERALL ASSESSMENT RESULTS

CLINICAL PREVENTIVE SERVICES

Clinical Preventive Services represent 7.9% of current statewide public health modernization activities. At full implementation, these activities' share is expected to increase to 8.5%.

This Program only has a couple of service dependencies between state and local health authorities that are not yet fully implemented.

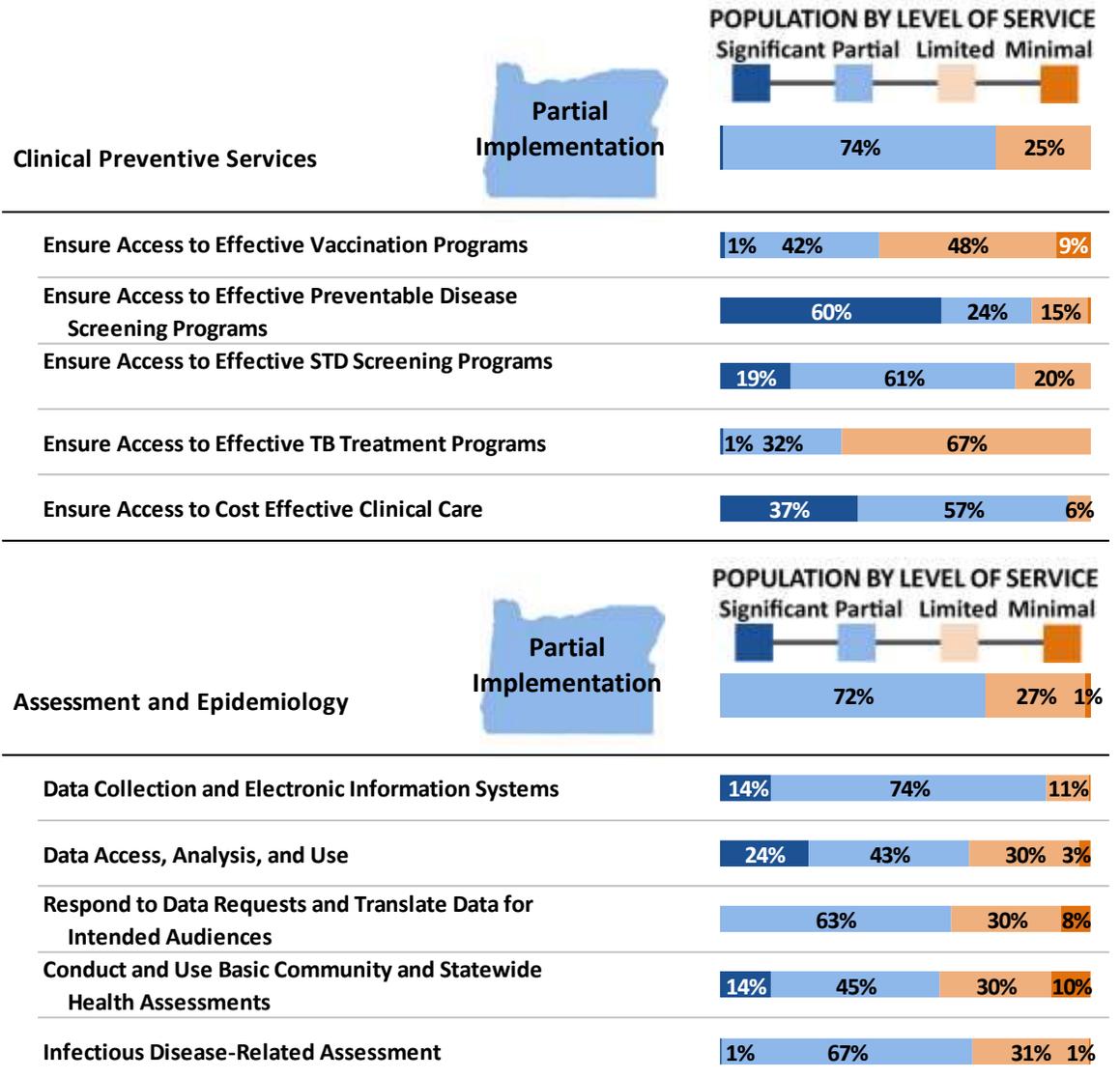
Level of implementation of the program is consistent with many others, however a few of the functional areas are relatively less implemented, including Ensure Access to Vaccines and Ensure Access to TB Treatment.

ASSESSMENT AND EPIDEMIOLOGY

Assessment and Epidemiology makes up 7.6% of current statewide public health modernization activities. At full implementation, these activities' share is expected to increase to 9.5%. State Assessment and Epidemiology activities also include the state public health laboratory.

This program only has a couple service dependencies between state and local health authorities that aren't yet fully implemented.

Level of implementation of the program and functional areas are all somewhat similar.



OVERALL ASSESSMENT RESULTS

EMERGENCY PREPAREDNESS AND RESPONSE

Emergency Preparedness and Response makes up 3.9% of current statewide public health modernization activities. At full implementation, these activities' share is expected to decrease slightly to 3.6%.

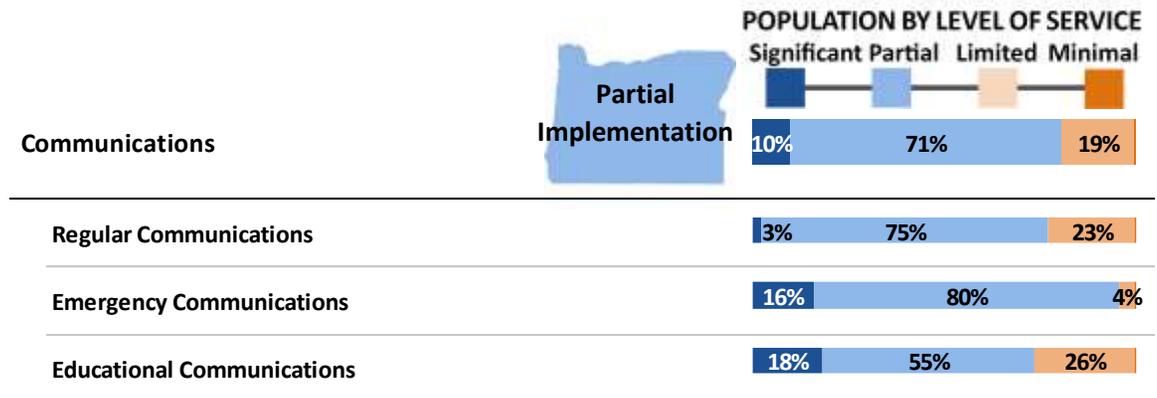
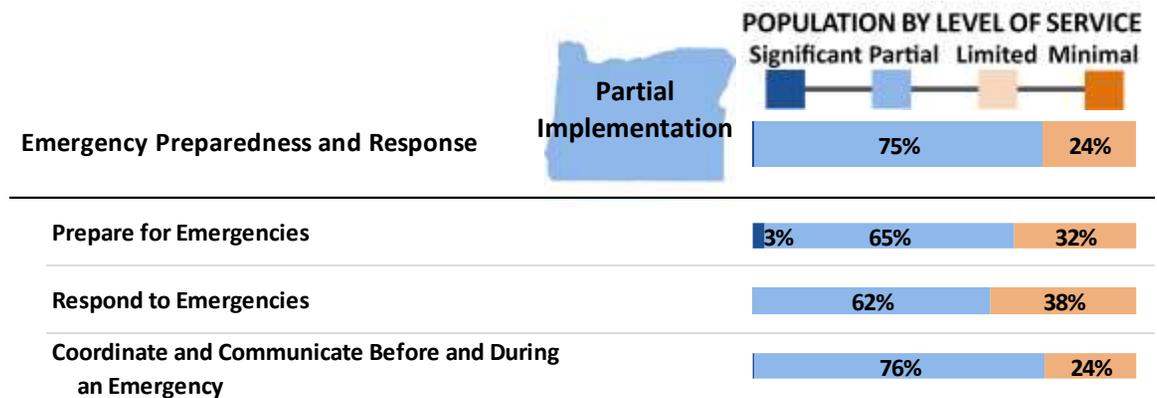
This capability has many service dependencies between the state and local authorities.

Level of implementation of the program and functional areas are all somewhat similar, with somewhere around two-thirds of the population being partially served.

COMMUNICATIONS

Communications represents 1.5% of current statewide public health modernization activities. At full implementation, this activity's share is expected to increase to 2.4%.

Level of implementation of the program and functional areas are all somewhat similar, except for Emergency Communications where almost 100% of Oregonians are being at least partially served.



OVERALL ASSESSMENT RESULTS

POLICY AND PLANNING

Policy and Planning represents 1.9% of current statewide public health modernization activities. At full implementation, these activities' share is expected to increase to 2.8%

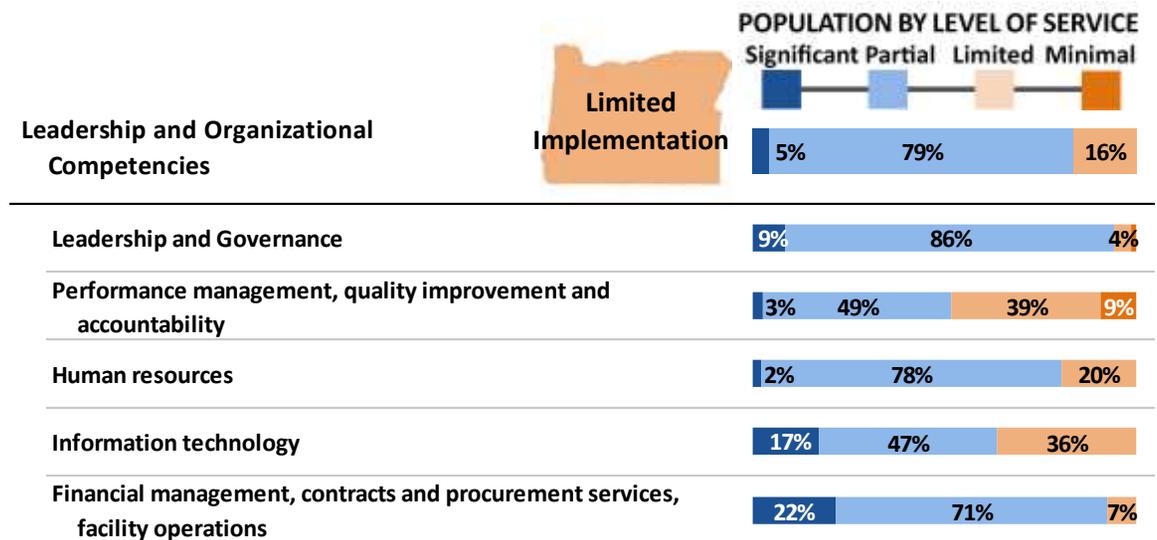
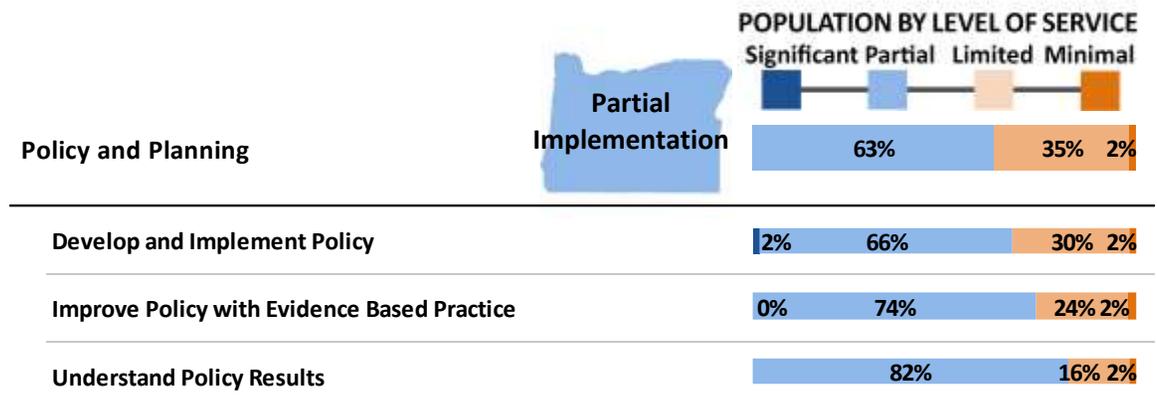
Level of implementation is a bit lower than for other programs, however the functional areas are all at least partially implemented for over two-thirds of Oregonians.

LEADERSHIP AND ORGANIZATIONAL COMPETENCIES

Leadership and Organizational Competencies represent 14.1% of current statewide public health modernization activities. At full implementation, the share for these activities is expected to increase slightly to 14.3%.

This capability has several service dependencies that are not yet fully implemented, where state roles and deliverables support local activities.

Although this foundational program is well-implemented, a significant additional increment of resources will be needed to provide infrastructure to support the additional work being done as part of full implementation of public health modernization overall. .



OVERALL ASSESSMENT RESULTS

HEALTH EQUITY AND CULTURAL RESPONSIVENESS

Health Equity and Cultural Responsiveness represent 1.9% of current statewide public health modernization Activities. At full implementation, these activities' share is expected to increase slightly to 2.9%.

This capability has a few service dependencies between the state and local authorities.

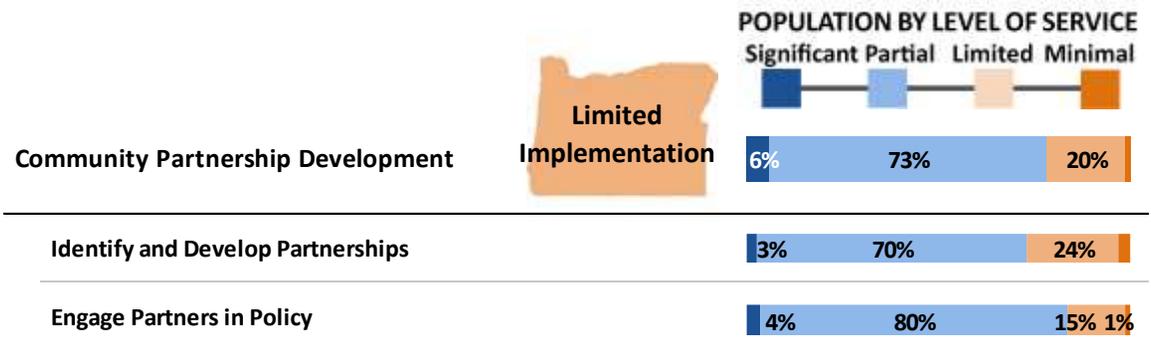
This is one of the least implemented programs.

COMMUNITY PARTNERSHIP DEVELOPMENT

Community Partnership Development represents 2.6% of current statewide public health modernization activities. At full implementation, **these activities'** share is expected to increase slightly to 3.0%.

While there aren't specific service dependences between state and local authorities, there are indirect ones such that state activities can augment and support local activities.

This is one of the best implemented local programs, with almost three-quarters of Oregonians being at least partially served by the foundation capability and both functional areas.



Summary Findings

This report presents an initial assessment of PHD and LPHAs' current execution of public health modernization; capacity and expertise needs to fully implement; and the costs associated with full implementation. It is important to remember that these data represent a starting place for public health modernization implementation; however, using these data, we are able to generate findings that will be useful for the planning and executing of implementation.. These findings are provided following:

Overall

- For many local public health authorities, this was the first detailed exposure to the public health modernization framework. The process helped to build a foundational shared understanding of the framework. This understanding will continue to evolve.
- The assessment process was designed to be highly detailed and required the participation of all LPHAs. However, many LPHAs found supplying this high level of detail burdensome and the response schedule challenging to manage over six to eight weeks with their existing workloads.
- Implementation of public health modernization is intended to be a transformative process that will reform

public health based on the post-Affordable Care Act health context and align funding to a core set of public health services available universally and uniformly statewide.

Breaking out of current paradigms to allow for imaginative solutions to improve the efficiency and effectiveness of the governmental public health system will be an ongoing process.

- The assessment process, though thorough, was not exhaustive. There is a need to continue exploring particular features of the existing system, to identify opportunities to increase efficiency and effectiveness. These features may include:
 - Service delivery, including cross-jurisdictional sharing
 - Non-governmental public health assets, resources, and partnerships that contribute to the accomplishment of public health modernization roles and deliverables.
 - Barriers to implementation
 - Short-term or one-time additional costs related to implementation itself
- The “functional areas” defined as part of this process seem to accurately define how the foundational capabilities and programs, as defined through core services, roles, and

deliverables in the *Modernization Manual*, will be operationalized by local public health authorities.

Full Implementation Cost

- Governmental public health authorities are already significantly executing the public health modernization framework, with \$209 million being spent on these activities. This is approximately two-thirds of the cost of full implementation of the framework.
- The estimated additional cost needed for full implementation is approximately \$105 million. This is the other one-third of the cost of full implementation of the framework. This cost estimate provides a point-in-time, high-level estimates that provide only order of magnitude precision, but will necessarily evolve as the Modernization framework, implementation strategies, and other policies evolve.
- To reach full implementation, three Capabilities will require doubling current spending – Communications, Health Equity and Cultural Responsiveness, and Policy and Planning.
- There were 54 instances where a LPHA reported that full implementation costs would be 100% of current spending current

spending was reported to be \$0 in 53 out of these 54 cases.

- The greatest additional increment of costs are concentrated in the four programs (the four top rows) and the Leadership and Organizational Competencies capabilities (the bottom row). Unlike the LPHAs, PHD has the highest additional increment of costs in the Assessment and Epidemiology capability, which also houses the state public health laboratory.
- While the additional increment of costs are generally concentrated in the four programs and Leadership and Organizational Competencies capability, there is no foundational program or capability that does not have increased additional increment of costs for at least one public health authority.
- Areas with a higher level of implementation do not necessarily need fewer resources than those areas with lower implementation. On the other hand, limited implementation does not always indicate that a substantial amount of funding is needed to support full implemented.
- There are significant existing shared resources among LPHAs today. These existing sharing arrangements provide examples for future sharing relationships.

- The current governmental public health service delivery model is divided into state activities, provided by PHD, which are provided wholly centrally, and local activities, provided by LPHAs, which are provided wholly locally. This is service delivery model which could be expanded to allow for cross-jurisdictional service delivery options.

Programmatic

- There are meaningful gaps across the system in all foundational capabilities and programs.
- Every Foundational Capability and Program within the public health modernization framework includes roles and deliverables with varying levels of implementation.
 - There are some functional areas that include roles and deliverables that are well established as governmental public health activities. For some of these activities, local health departments generally rated themselves highly in expertise, although potentially low in capacity.
 - There are other functional areas that are dominated by roles and deliverables that may represent new governmental public health activities. In these areas, local public health authorities were

more likely to provide scores that identified that they are not currently providing the activities.

- There are meaningful gaps across the system in all governmental public health authorities. These gaps are not uniform, nor do they appear in the same places in every organization. As such, current implementation of public health modernization can be described as a “patchwork quilt.” Because of this, many global implementation decisions could have unintentional service delivery and coverage ramifications.
- There are no Foundational Programs or Capabilities that are substantially implemented universally across all public health authorities. There are some areas with a higher concentration of limited and minimal implementation, such as the Health Equity and Cultural Responsiveness Capability and the Prevention and Health Promotion Program. Additionally, you can see that some governmental public health authorities have larger programmatic gaps than others. However, there are gaps across the system in every size category.
- PHD has partially implemented or limitedly implemented all of its foundational capabilities and programs. The least implemented (limitedly implemented)

capabilities and programs are Environmental Public Health, Health Equity and Cultural Responsiveness, Community Partnership Development, and Leadership and Organizational Competencies.

- Overall over 50% of the population is receiving services from a LPHA that has at least partially implemented the Foundational Capability or Program.
 - The most implemented Foundational Capabilities, across the system, are Environmental Public Health and Leadership and Organizational Competencies. The least implemented are Health Equity and Cultural Responsiveness and Policy and Planning.
 - The most implemented functional areas are Conduct Mandated Inspections and Ensure Access to Cost Effective Clinical Care.
 - The least implemented functional areas are ensure access to effective tuberculosis treatment programs and prevention of tobacco use. Prevention of Tobacco Use should be considered carefully however, as many LPHAs communicated that they low scored themselves in this area because prevention of tobacco use is an ongoing challenge that will take significant

resources, perhaps beyond those this assessment identifies, to solve.

Implementation

- Implementation of public health Modernization will be a significant undertaking that should be phased to allow governmental public health authorities adequate time to plan intentional implementation strategies.
- LPHAs have a high degree of local expertise related to their service areas which should be leveraged to improve the efficiency and effectiveness of implementation. Implementation strategies should allow for some flexibility and local decision making, which could be governed by local implementation plans.
- Implementing by wave of LPHAs could be challenging for several reasons, including but not limited to:
 - Risk of creating a two-tiered system (with some LPHAs operating under the Modernization framework, and others not).
 - Significance of potential impacts to health equity (with those served by modernized local public health authorities receiving a higher level of service than those being served by non-

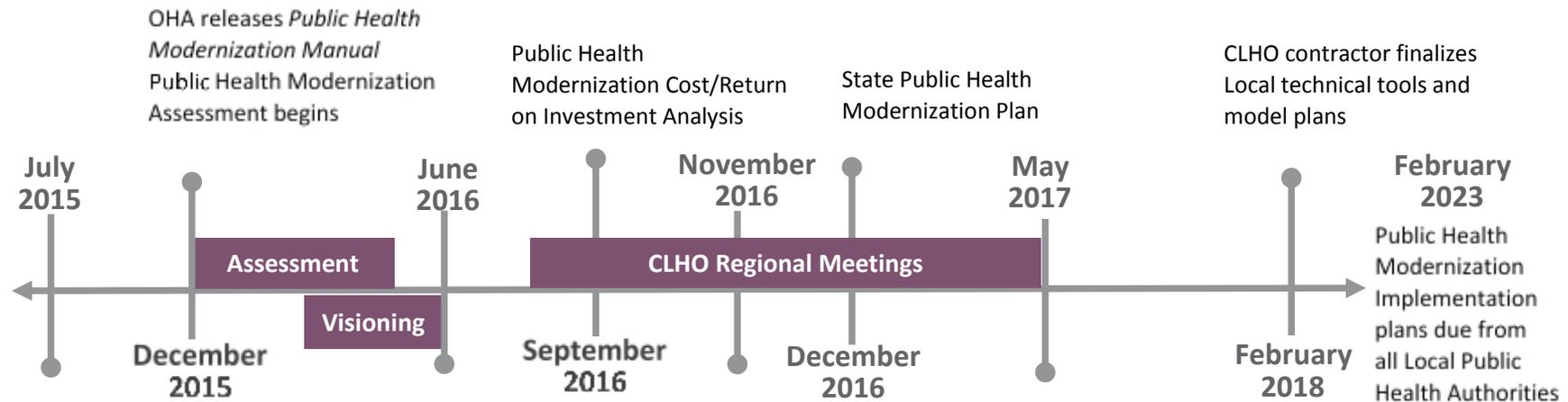
modernized local public health authorities).

- Implementing by Foundational Capability or Foundational Program could also be challenging because current implementation is uneven across local public health authorities.
- There are significant interdependencies between state and local public health activities. Some of the state roles and deliverables that support local activities are not fully implemented.
- Many of the foundational capabilities and programs support one another. That is, in order to accomplish the goals of one Foundational Capability or Program most effectively and efficiently, one might have to have access to the resources available through implementation of another. This is most intuitive when thinking of the Foundational Capabilities, for example, educational communications plays a significant in role producing information related to healthy eating active living and other programmatic initiatives.

POLICY IMPLICATIONS

POLICY IMPLICATIONS

Development of these public health modernization 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

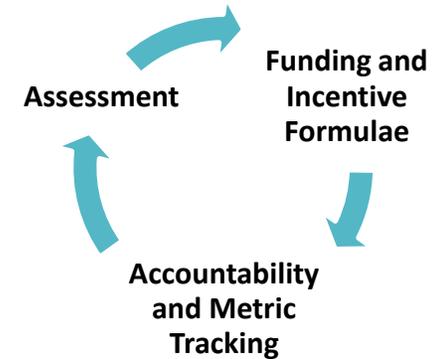
The assessment results will provide data to support many of these other activities, including:

- **Public Health Modernization Funding Allocations and Incentive Formulae.** A major need for implementation of public health modernization is new funding sources to support additional services. As part of this, PHD in collaboration with the PHAB are developing new funding allocation and local funding incentive formulae for any new funds received to support public health modernization.
- **Public Health Modernization Cost/Return of Investment Analysis.** This analysis is being undertaken by PHD’s Program Design 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 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 to be complete by December 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 Plans.** Like the state public health provider, LPHAs will develop their own Public Health Modernization Plans. Required by House Bill 3100, these Plans are due no later than December 2023. However, House Bill 3100 also allows that PHD may establish a schedule by which LPHAs will submit their local plans for implementation; this schedule could be more ambitious to allow for use of local Plans as a tool for implementation if all LPHAs begin implementation on the same schedule.

Additionally, House Bill 3100 requires that assessment results be updated as necessary. The assessment, or a scaled and simplified version, has the potential to be a critical implementation tracking and accountability tool. This will be invaluable to implementation as it will allow of tracking of implementation results, and continuous improvement, and as necessary course correction, of implementation processes. The cycle in which updated assessment results

might help to support implementation tracking and accountability is shown and described following.



- **Assessment.** Updated assessment results will help to identify current level of implementation at future points in time, which will allow for longitudinal review of the impacts of implementation strategies and the remaining gaps in implementation.
- **Funding and Incentive Formulae.** Initial public health modernization dollars are expected to be distributed through public health modernization-specific funding and incentive formula; updated assessment results will allow for midstream allocation decisions to align funding with implementation strategies. It is important to remember that this formulae are designed to allocate an additional increment of funds, not the full flexible funding available for

LPHAs, so alignment between these formulae and implementation strategies will be critical. As these strategies will likely change as implementation progresses, realignment will likely be necessary.

- **Accountability and Metric Tracking.** PHD has undertaken work that will identify the economic and health outcomes of implementation of public health modernization, which will help to identify metrics for tracking implementation and its effects on population health. This will help to tie assessment results to population health outcomes to ensure that implementation is creating meaningful change, and also to help inform funding decisions to support implementation strategies. PHD's metric and accountability work will also present an opportunity to ensure that service dependencies are adequately identified and that there is accountability among governmental public health authorities to ensure that those service dependencies do not become barriers to implementation.

Implications for Implementation

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 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 *Public Health Modernization Manual*. It is important to recognize that that framework is not static because of the evolving nature of public health work which will need to be reflected in it. This illustrates why these numbers will necessarily change.

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.

OVERALL

- There is still a need to strengthen the shared understanding around public health modernization definitions, core services, roles, and deliverables.
 - The *Public Health Modernization Manual* was significant help in explaining the modernization framework; however, it should continue to be refined as implementation proceeds to respond both to changes in the needs of the State and to programmatic learning.
- Assessment participants from both PHD and local public health authorities expressed a

lack of clarity as to who will provide the critical tools and resources (those items necessary for state and local public health authorities to produce their deliverables) outlined in the *Public Health Modernization Manual*. Although many of these resources are provided online (and their web addresses provided in the *Public Health Modernization Manual*) many participants asked who would provide those tools and resources. This presents an easy opportunity to improve clarity around public health modernization implementation.

- Many LPHA authorities communicated that further clarity is needed as to what constitutes additional programs (public health programs and activities implemented in addition to foundational programs to address specific identified community public health problems or needs), how additional programs are different from foundational capabilities and programs, and who is responsible for additional programs. Participants expressed some concerns about their particular local priorities, not being included in the public health modernization framework and were unclear as to how that might change support or funding for those services in the future.
- The assessment process, though thorough, was not exhaustive. There is a need to

continue exploring particular features of the existing system in order to identify opportunities for increased efficiency and effectiveness. These features may include:

- Service delivery, including cross jurisdictional sharing
- Non-governmental public health assets, resources, and partnerships that contribute to the accomplishment of public health modernization roles and deliverables
- Barriers to implementation
- Short-term or one-time additional costs related to implementation itself

As this assessment was the first step in an evolving process, we expect to see ongoing implementation work that refines the programmatic understanding and cost estimates presented in this report.

EFFICIENCY AND EFFECTIVENESS

Service Delivery

One of the primary ways in which these estimates is through identification of additional efficiencies, especially those relate to service delivery. Two opportunities for efficiencies include:

- Cross jurisdictional sharing
- Cross jurisdictional delivery

At the time of the assessment, conversations about additional cross-jurisdictional sharing had just begun in some regions of the state.

This estimate reflects the current understanding of governmental public health, but true public health modernization will involve all stakeholders engaging in a dialogue about alternative service delivery options and funding.

Cross Jurisdictional Sharing

Many LPHAs reported significantly sharing resources, both with each other and with nonprofits and other local agencies. The public health modernization assessment process catalyzed some conversations between LPHAs around how they might develop future cross jurisdictional relationships.

There is need for additional time and resources to support further conversations. While LPHAs should have autonomy in developing new cross jurisdictional sharing relationships, PHD and CLHO should explore how to facilitate those discussions.

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

In addition to cross jurisdictional sharing, PHD and LPHAs might find additional efficiencies through cross jurisdictional delivery, which allows for more flexibility for both state and local public health authorities in the level of centralization of services of the activities they are charged with completing. Currently, public health activities can be separated into two distinct groups by service area and level of centralization of services:

- **State Public Health Activities** are provided centrally to the whole state by a state public health authority, PHD.
- **Local Public Health Activities** are provided on a county basis by a decentralized network of LPHAs.

The cross jurisdictional delivery concept recognizes that there are other options for service delivery, and that the current split is merely one way to structure the system. For example, while currently there is one state public health authority providing centralized state public health services, those services could be delivered through decentralized state public health authorities located across the state. Similarly, although local public health services are

delivered in a decentralized manner at the county-level (with the exception of North Central Public Health District), there are opportunities to provide some services in a more centralized manner to allow LPHA's to leverage types of expertise that might not be available system wide.

PHD and LPHAs should review their current activities to determine whether there are roles and deliverables that may be appropriate for cross jurisdictional delivery.

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

PHASING CONSIDERATIONS

PHASING CONSIDERATIONS

Implementation can be phased in many ways, some of which may be influenced by statewide and local priorities. However, public health modernization is complex with many service dependencies among foundational capabilities and programs and state and local activities. There are also inconsistencies in the existing implementation. Therefore, global strategies for all governmental public health authorities or relating to full implementation are likely to be difficult and inefficient to implement.

Implementation can be phased in many ways, some of which may be influenced by statewide and local priorities. However, public health modernization is complex with many service dependencies among foundational capabilities and programs and state and local activities. There are also inconsistencies in the existing implementation. Therefore, global strategies for all governmental public health authorities or relating to full implementation are likely to be difficult and inefficient to implement, and may lead to unintentional consequences like creating service inequities, establishing a bifurcated system, or creating implementation barriers.

To minimize these risks and establish the most efficient, effective implementation process possible, a flexible implementation strategy that is responsive to specific governmental public

health authority contexts is needed. The variation in the assessment results suggests that a decision-making framework should be developed to support making implementation decisions as implementation proceeds. We have identified preliminary criteria for this decision-making strategy, including:

- **Population Health Impacts:** The degree to which a specific activity will improve population health. This is challenging to measure, as all foundational capabilities and programs are foundational and therefore necessary to support population health. Another approach is comparing the relative severity of the population-wide consequences of inaction on each foundational capability and program, which do vary. Additionally, it is important to remember that many of the cross-cutting capabilities will likely increase the effectiveness of the foundational programs, so their population health impact should be identified accordingly.
- **Service Dependencies:** The activities of state and local governmental public health authorities are interdependent. Many of PHD's roles and deliverables support local activities, and some local activities feed back into the PHD's work. It is necessary to understand service dependencies as part of overall implementation process.

- **Coverage Maximization:** This assessment found that some roles and deliverables are not widely implemented by LPHAs, but are available to significant portions of the population because a few LPHAs with large populations have existing services that meet the modernization requirements.

- **Service Equity:** How services are implemented could greatly affect service equity. For example, implementation by wave could benefit higher resourced agencies, likely in areas with low poverty rates, while hurting those with limited resources, likely in areas with higher poverty rates.

There are tensions between these considerations; for example, maximizing coverage by population could be accomplished without increasing the level of implementation of some smaller LPHAs. It will be important to leverage governmental public health authorities' expertise to find balance while using this decision-making framework.

The flexibility of this decision-making framework will also allow the tracking of implementation results, which in turn will allow for continuous improvement, including course correction, within the implementation process. It will also incentivize continued evaluation of opportunities to increase efficiency and effectiveness, which

could be disincentivized or even penalized if strict implementation strategies were already in place.

This decision-making framework and the process by which it is applied should be refined through a collaborative process that would include all existing and potential governmental public health authorities (if others are identified as part of service delivery conversations). This process would also provide a venue to determine how this decision-making framework will be reconciled with State and Local Implementation Plans.

Implementation of public health modernization will be a significant undertaking that should be phased to allow governmental public health authorities adequate time to plan implementation strategies. This phasing will likely occur over more than one biennium.

Phasing of any transformative initiative across a complex system is always challenging, but that is especially true for public health because of the diversity of activities that the service dependencies. A phased implementation process should consider how:

- Implementation can build on the strengths of the existing system
- Current and future phases can be organized to build upon successes and incorporate learning

- Early phases can be accomplished to demonstrate the value in the initiative to stakeholders, and to create momentum for long term implementation
- Initial phasing decisions can support meaningful change
- Efficiency and effectiveness can be maximized

With an awareness of these factors, we can use our decision-making framework and the assessment results to develop strategies for deploying additional resources toward phasing implementation.

Following, we present three implementation scenarios to show what potential impacts different implementation strategies could have during Phase I (2017-19 biennium) of implementation. These scenarios are:

1. **Implementation by Wave.** \$40M (\$20M annually) equally distributed by proportional need across one governmental public health authority of each size and PHD.

2. **Implementation by Foundational Programs and Capabilities.** \$40M (\$20M annually) equally distributed by proportional need to a few key foundational programs and capabilities of interest. For this purpose, we focused on Communicable Disease Control, Environmental Public Health, and Leadership and Organizational Competencies.

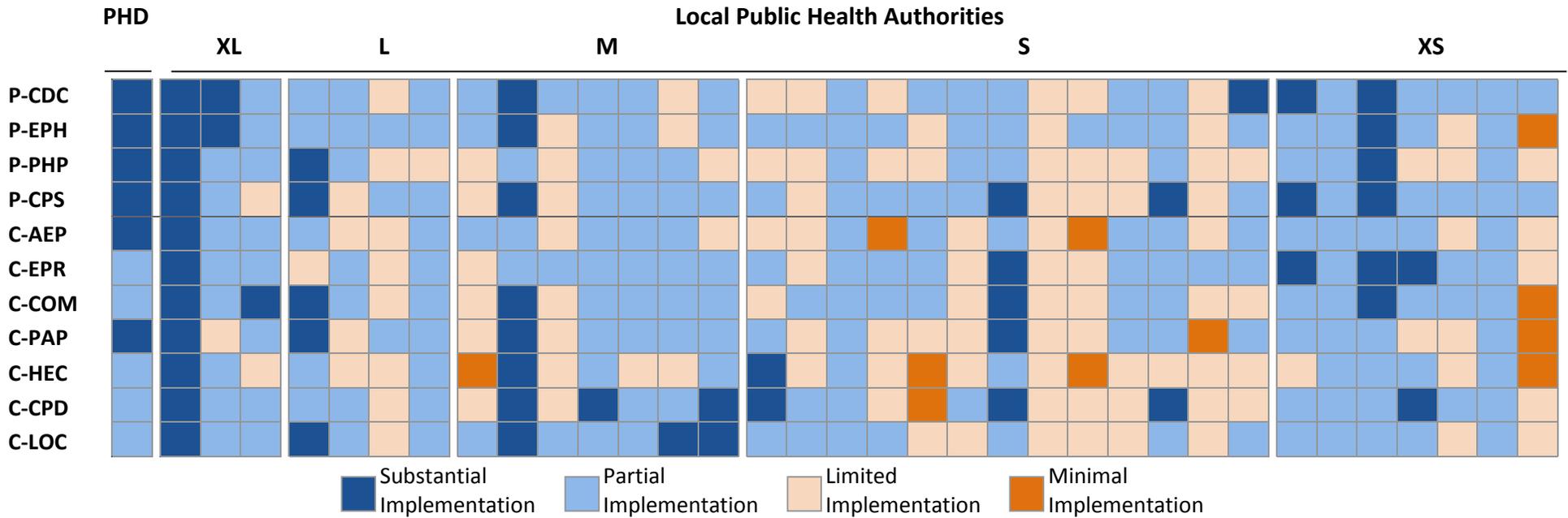
3. **Flexible Implementation Based on the “Patchwork Quilt.”** \$40M equally distributed by proportional need across all capabilities and programs with less than partial implementation according to this assessment.

These scenarios were created using a linear estimation process that incorporates the self-assessment data and the resources estimates to step-wise allocate increases in funding.

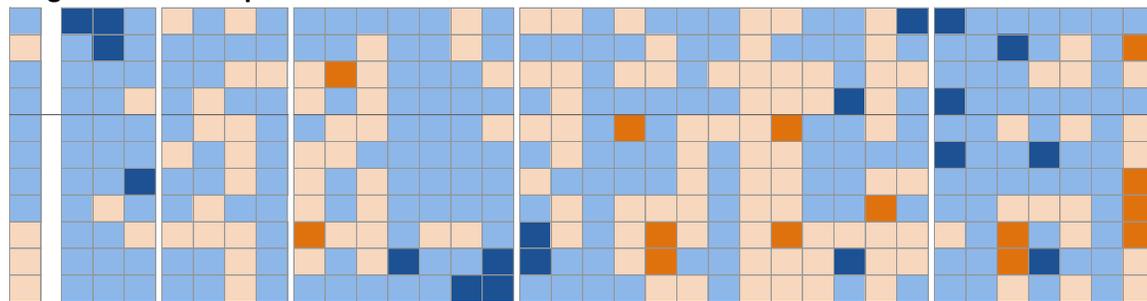
This provides a helpful illustration that only approximates what outcomes different phasing options might have. Reality is much more nuanced, but these illustrations are helpful in demonstrating why phasing needs to be flexible.

PHASING CONSIDERATIONS

Implementation by Wave



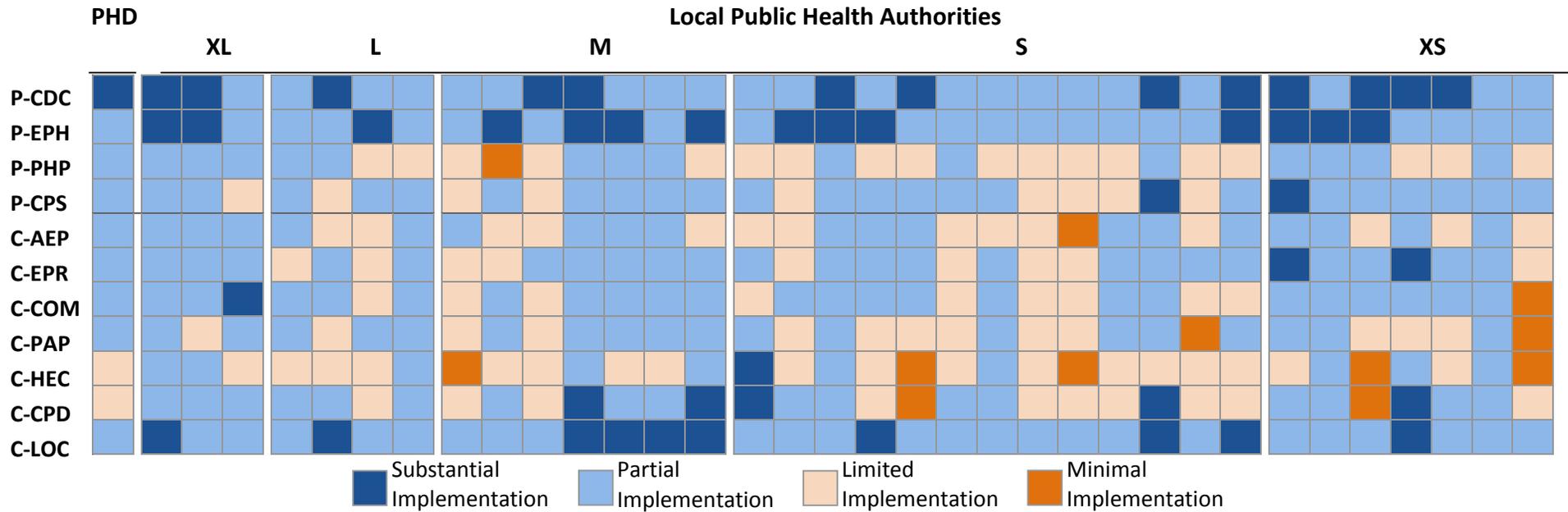
Original Level of Implementation



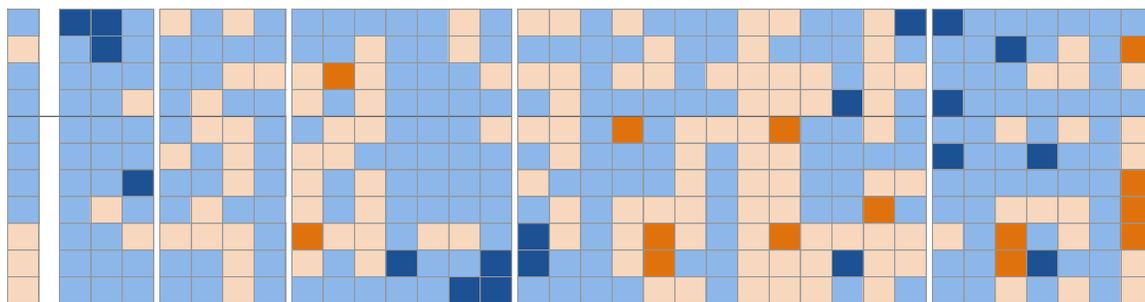
This scenario demonstrates the effect of focusing investment across one governmental public health authority of each size and PHD. This has appreciable effects, but focused in just those governmental public health authorities that funding was distributed to. Other LPHAs maintain their current level of implementation, which created service inequities across the system.

PHASING CONSIDERATIONS

Implementation by Foundational Programs and Capabilities



Original Level of Implementation



The scenario suggests the result of allocating investment by foundational program and capability. An investment of \$40M (\$20M annually) would increase the level of implementation in the selected foundational programs and capabilities; however, there are still significant gaps and a “patchwork quilt” level of implementation across public health modernization.

2017-19 Biennium

To make meaningful and substantial progress on the implementation of public health modernization, some decisions about implementation priorities for the 2017-19 biennium will need to be made. Initial priorities, based on our high-level implementation considerations and the decision-making framework include:

1. Support additional planning and work related to public health modernization implementation for all governmental public health authorities, recognizing that executing implementation will require non-trivial resources as it is phased in. This may include:
 - Funding resources to support implementation and ongoing assessment.
 - Funding one-time infrastructure and start-up costs related to hiring, scaling, and any new roles and deliverables being implemented.
 - Dedicated local public health administrator time to continue identification of methods for optimizing efficiency and effectiveness, including through refinement of service delivery models, such as sharing certain services with other local public health

authorities and organizations, based on community need.

- Incentivize development of local implementation plans
2. Create a flexible funding structure to support LPHAs fund their “patchwork quilt” gaps based on locally-identified priorities.
 - Where possible, these resources should support roles and deliverables that are least constrained by service dependencies.
 - PHAB may identify particular focus areas or goals to restrict these flexible funds to; however, we recommend maintaining some flexibility within foundational capability and program areas, knowing that gaps vary significantly across the system.
 - As the public health authorities will have to scale Leadership and Organizational Competencies capabilities to meet increased infrastructure demands from new implementation priorities, removing barriers should include flexibility to use a percentage of resources to invest in this foundational capability.
 3. Reduce gaps in state activities related to service dependencies to remove barriers to local implementation.

4. Invest in high priority public health initiatives with potential for the highest population health impacts.
 - To the degree there are high priority initiatives within public health modernization that need to be funded immediately, invest in those priorities, based on recognition of “patchwork quilt” in funding allocation.

Decisions about how much funding is allocated to each of these priorities should be made based on the availability of funding, in conjunction with an understanding of those decisions’ ramifications on implementation of the public health modernization framework across the state.

Future Biennia

As mentioned previously, a flexible decision-making framework that is responsive to specific governmental public health authority contexts should be used to make future implementation decisions based on the success of the first phase (considered to be the 2017-19 biennium). This decision-making framework should support decisions that align to state and local implementation plans, such that those plans accurately reflect implementation.

**DETAILED
ASSESSMENT
RESULTS**

INTERPRETING DETAILED ASSESSMENT RESULTS

Like our overall assessment results, we present our detailed 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

To present all of these altitudes together, in a cohesive narrative that helps the reader interpret and digest results, we have organized them into subsections by foundational capability.

Foundational Capability or Program Subsection Structure

The detailed assessment results are organized into 11 subsections, one for each foundational capability and program. To aid review, each section has a similar layout and structure, modified only where necessary because of

nuances in the data collected (for example, we provide an additional page of PHD results for the State Public Health Laboratory in the Assessment and Epidemiology subsection). This structure is as follows:

- **PHD foundational capability or program assessment results.** In most cases, a single page that describes the overall level of implementation of the program, provides a visual of the distribution of scores for the state roles and deliverables included in that program, shows the current spending, additional increment of cost, and full implementation cost, and narrative that describes the state activities, level of implementation, and any less implemented roles and deliverables for activities that represent service dependencies between the state and LPHAs.
- **LPHA foundational capability or program assessment results.** In most cases, a single page that describes the overall level of implementation of the program, provides a visual of the distribution of scores for all 34 LPHAs for the foundational capability or program, shows the current spending, additional increment of cost, and full implementation cost, and narrative that describes the local activities, level of implementation, and the functional areas

that make up the foundational capability or program.

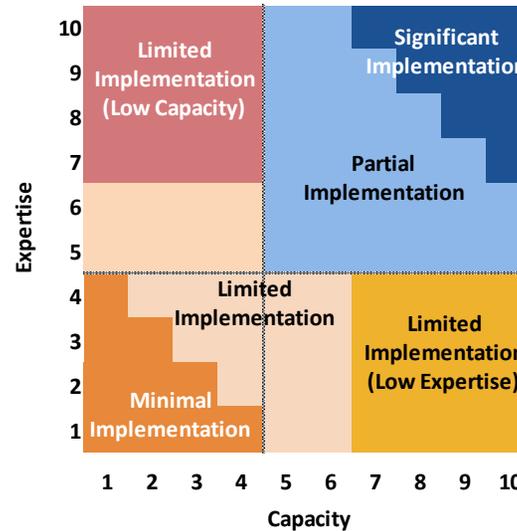
- **LPHA functional area assessment results (one for each functional area).** In most cases, a single page that is structured similarly to the LPHA foundational capability or program assessment results page and one or more pages that show the level of implementation and population by level of service for the roles and deliverables included in the functional area.

Following, we describe the charts, graphics, and narrative that together illustrate and describe the results of the assessment at each of these altitudes. However, first it is necessary to revisit how the programmatic self-assessment scores were interpreted to provide insight on governmental public health authorities' level of implementation and population by level of service.

LEVEL OF IMPLEMENTATION

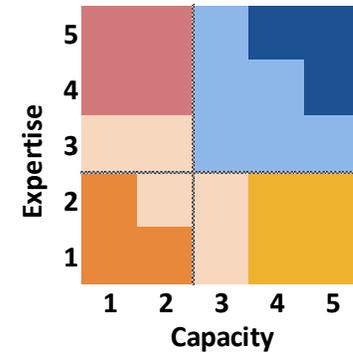
The level of implementation of Foundational Capabilities and Programs and Functional Areas is illustrated throughout the overall and detailed assessment results with both color-coding and charts. The image below illustrates how programmatic self-assessment results are interpreted to provide insight on governmental public health authorities' level of implementation with Expertise on the y-axis and Capacity on the x-axis.

Programmatic Self-Assessment Scoring Relationship to Level of Implementation for Foundational Capabilities and Programs, and Functional Areas



- **Significant Implementation (Dark Blue):** Services are mostly or fully implemented. Likely, the majority of the activity.
- **Partial Implementation (Light Blue):** Services are partially implemented however, some meaningful gaps remain.
- **Limited Implementation, Low Expertise (Yellow):** Services are limitedly implemented and, while the governmental public health authority has significant capacity, there are substantial gaps related to a lack of necessary expertise.

Programmatic Self-Assessment Scoring Relationship to Level of Implementation for Roles and Deliverables



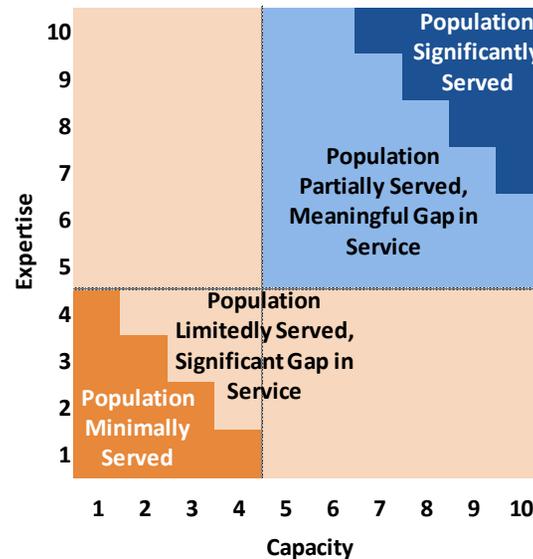
- **Limited Implementation, Low Capacity (Red):** Services are limitedly implemented and, while the governmental public health authority has significant expertise, there are substantial gaps related to a lack of necessary capacity.
- **Limited Implementation (Light Orange):** Services are limitedly implemented and there are significant gaps in capacity and expertise.
- **Minimal Implementation (Orange):** Services are mostly not or not at all implemented.

POPULATION BY LEVEL OF SERVICE

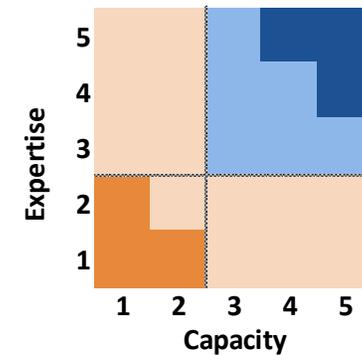
The population by level of service exhibits describe how the level of implementation of foundational capabilities and programs and functional areas translate to the level of service the population receives.

The image below illustrates how programmatic self-assessment results are interpreted to provide insight into governmental public health authorities' population service with Expertise on the y-axis and Capacity on the x-axis.

Programmatic Self-Assessment Scoring Relationship to Level of Service for Foundational Capabilities and Programs, and Functional Areas



Programmatic Self-Assessment Scoring Relationship to Level of Service for Roles and Deliverables



- **Population Significantly Served (Blue):** The population is mostly or fully served.
- **Population Partially Served (Light Blue):** The population is partially served, and there are meaningful gaps in service.
- **Population Limitedly Served (Light Orange):** The population is underserved, and there are significant gaps in service.
- **Population Minimally Served (Orange):** The population is mostly not or not at all served.

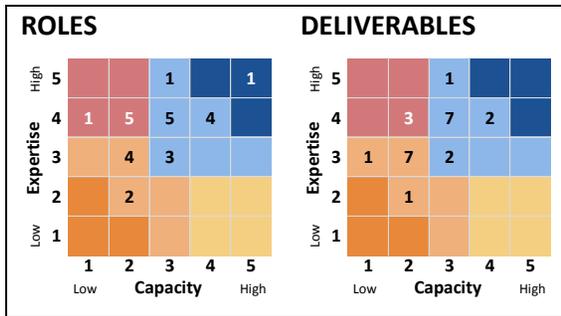
Interpreting PHD Results

LEVEL OF IMPLEMENTATION



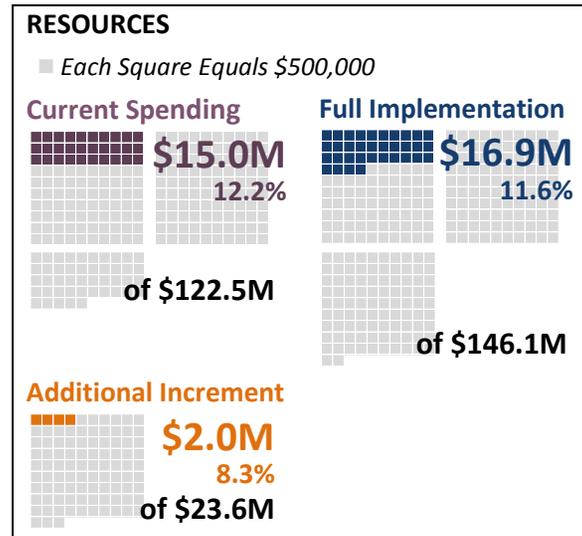
This graphic illustrates PHD’s level of implementation for the foundational capability or program.

ROLES AND DELIVERABLES



These charts provide a visual of the distribution of scores for the state roles and deliverables included in the program or capability.

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 of cost needed to get PHD to full implementation. These are represented by waffle charts that equal PHD’s total (for all foundational programs and capabilities) for each value (current spending, full implementation, and additional increment of cost). The total amount for the specific capability or program is then colored in.

NARRATIVE

The narrative to the right of the chart column describes the state activities considered part of the foundational capability or program, level of implementation, and any less implemented roles and deliverables for activities that represent service dependencies between the state and LPHAs.

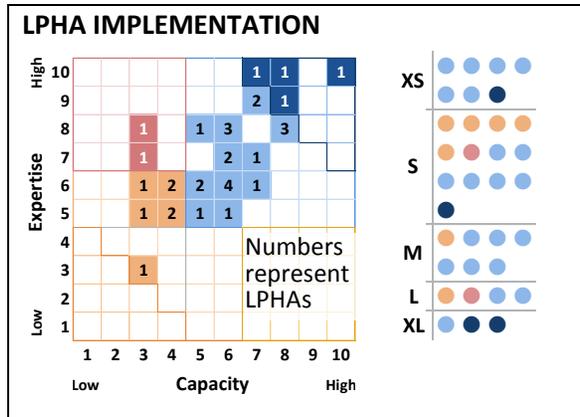
Service dependencies are activities of state and local public health authorities that are interdependent. The state supports many local activities and some local activities feed back in to PHD’s work. Where clear, we identified service dependencies where state activities are needed to support implementation at the local level in this narrative. This is because it is important to consider these service dependencies as part of implementation to prevent them from becoming barriers to and inefficiencies in implementation.

DETAILED ASSESSMENT RESULTS

Interpreting Results

INTERPRETING LPHA RESULTS

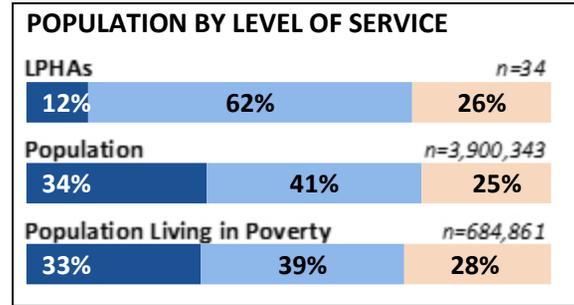
LPHA Implementation



These leftmost charts provide a visual of the distribution of overall scores for each foundational capability or program or functional area for all 34 LPHAs. Each filled in square illustrates the number of LPHAs that provided that score. The Cartesian plane is color-coded based on the relationship between the programmatic self-assessment scoring and level of implementation.

The rightmost chart shows the level of implementation reported by each LPHA based on their programmatic self-assessment score. These scores were categorized by LPHA size to allow for analysis of any patterns in level of implementation that might exist based on LPHA size.

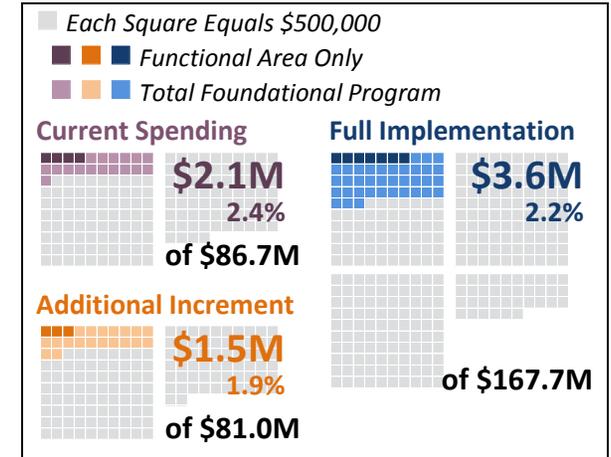
Population Service



This chart shows LPHAs' level of implementation in relationship to what it means for the overall population of Oregon being served. The first bar shows the level of service being provided by each LPHA. The second bar translates that level of service to population, based on the level of service for each LPHA's service area. This is important, because LPHAs serve different size populations, so one LPHA being minimally implemented would have different effects if it were an extra-large than if it were an extra-small.

The third bar translates the level of service to the population living in poverty, based on the level of service for each LPHA's service area. Comparison between the second and third bar is important because a difference in results (specifically, if the level of service is lower for the population living in poverty) might demonstrate a service inequity.

Resources



The resources section of the results illustrate the current spending by LPHAs on this capability or program, the estimated cost of full implementation, and the additional increment of cost needed to get all LPHAs to full implementation. These are represented by waffle charts that equal LPHAs' total (for all foundational programs and capabilities) for each value (current spending, full implementation, and additional increment of cost). The total amount for the specific capability or program is then colored in. Within the waffle chart, one square equals \$500,000.

DETAILED ASSESSMENT RESULTS

↳ Interpreting Results

NARRATIVE

LPHA results were provided at two different altitudes, by foundational capability or program and by functional area. The charts used to illustrate each are the same, however the narratives are somewhat different.

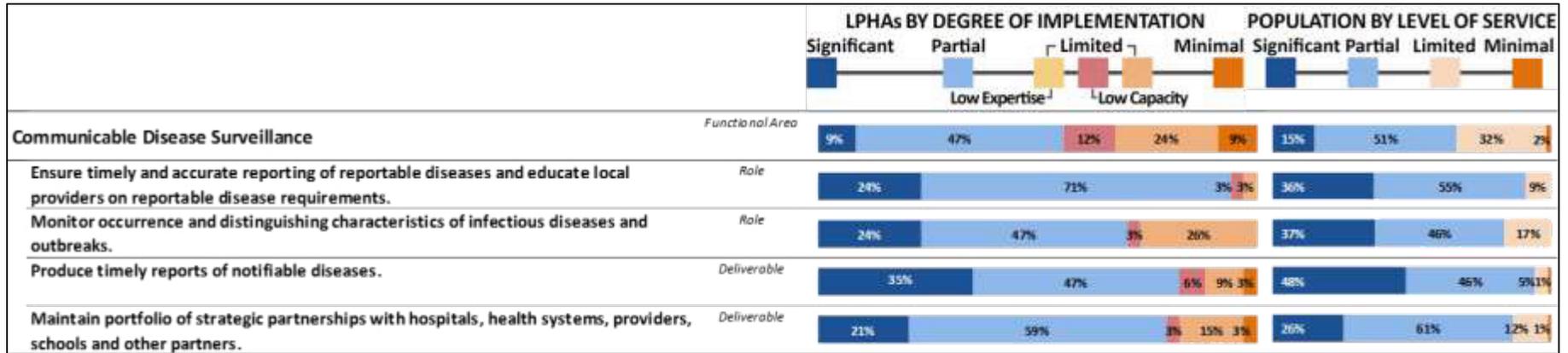
Foundational Capability or Program

The narrative to the right of the chart column describes the local activities considered part of the foundational capability or program, level of implementation, and the functional areas by share of the overall foundational capability or program.

Area Definitions), level of implementation, and introduces the roles and deliverables included in the functional area.

ROLES AND DELIVERABLES

Each functional area page is accompanied by an additional chart, as illustrated below, which shows the Roles and Deliverables of the Functional Area in relation to the LPHAs' level of implementation and how that translates to the general population-based on level of service.



Functional Area

The narrative to the right of the chart column describes the functional area based on its definition (available in *Appendix B: Functional*

COMMUNICABLE DISEASE CONTROL

*Ensure everyone in Oregon is protected from communicable
disease threats.*

DETAILED ASSESSMENT RESULTS

Communicable Disease Control

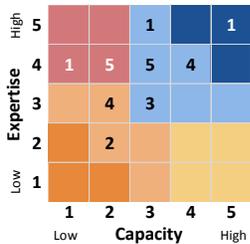
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

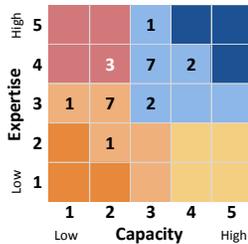
Partially Implemented



ROLES



DELIVERABLES



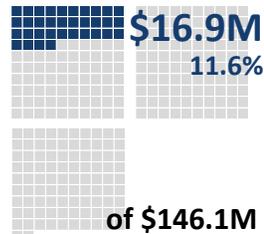
RESOURCES

Each Square Equals \$500,000

Current Spending



Full Implementation



Additional Increment



PHD's *Communicable Disease Control* activities include 26 roles and 24 deliverables. These activities include, but are not limited to, development of standards for investigation and response to disease and outbreak reports; monitoring occurrence of and trends in infectious diseases; collecting, analyzing, and sharing communicable disease data; lead disease prevention and control initiatives; and enforcing public health laws, including isolation and quarantine.

PHD's self-assessment shows that it considers this program to be only limitedly implemented. PHD also notes that only half of the roles and deliverables that represent state activities for *Communicable Disease Control* are partially or significantly implemented. In fact, only 14 of the 26 roles and 12 of 24 deliverables are partially or significantly 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:

- Support staff working in local authorities to implement statewide disease control initiatives. (Limitedly implemented, low capacity.)
- Provide disease-specific and technical expertise regarding epidemiologic and clinical characteristics to local public health

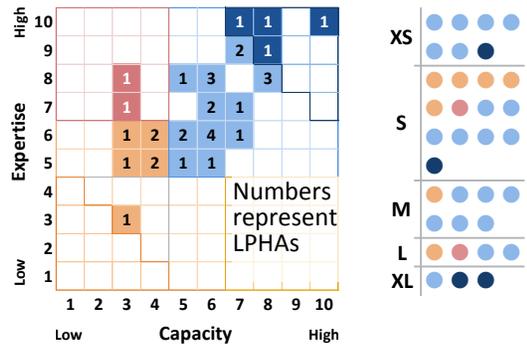
authorities, health care professionals, and others. Advise health care practitioners about evidence-based practices for communicable disease diagnosis, control, and prevention. (Partially implemented.)

- Support local health departments as they investigate and control reportable diseases and outbreaks by providing technical assistance and surge capacity. (Limitedly implemented, low 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. (Partially implemented.)

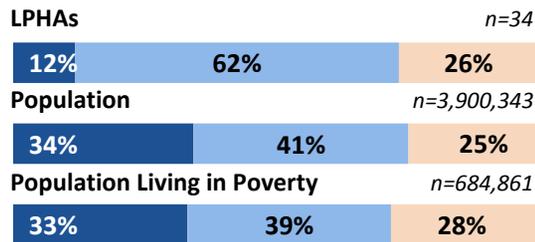
In addition to these roles and deliverables that are directly applicable to the LPHAs, there are a number of other deliverables that when significantly implemented might help better support LPHA activities. These include: investigative guidelines for state and local response; outbreak investigation tools; reports of acute and communicable disease gaps; mitigation of identified risks; standards; technical support for enforcement of public health laws; and outbreak summaries.

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

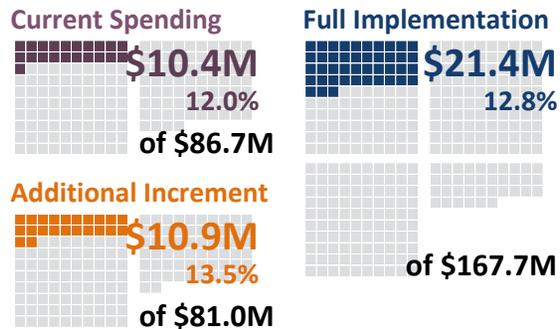


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000



LPHAs' *Communicable Disease Control* activities are very similar to the state's, but for their local jurisdiction.

These activities are relatively well-implemented, with 25 (out of 34) LPHAs documenting partial or significant implementation. A large amount of additional spending (105% or \$10.9M) is needed to reach full implementation, suggesting a higher marginal cost associated with significant implementation versus partial implementation.

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 significant implementation.
- 2. Communicable Disease Investigation.** This functional area represents 29% of current local *Communicable Disease Control* activities; at significant implementation its share of local *Communicable Disease Control* activities remain unchanged (29%).

3. Communicable Disease Intervention and Control. The most significantly implemented functional area, it represents 39% of current local *Communicable Disease Control* activities. This share is expected to increase to 43% at significant implementation, with spending increasing 125%.

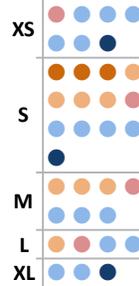
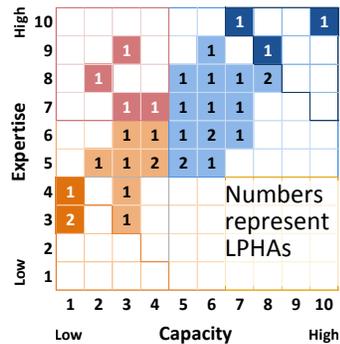
4. Communicable Disease Response Evaluation. This is the least significantly implemented functional area. It represents 11% of current local *Communicable Disease Control* activities and will remain relatively unchanged at significant implementation (11%).

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

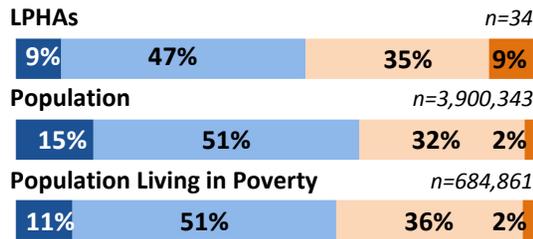
DETAILED ASSESSMENT RESULTS

Communicable Disease Control
Surveillance

LPHA IMPLEMENTATION

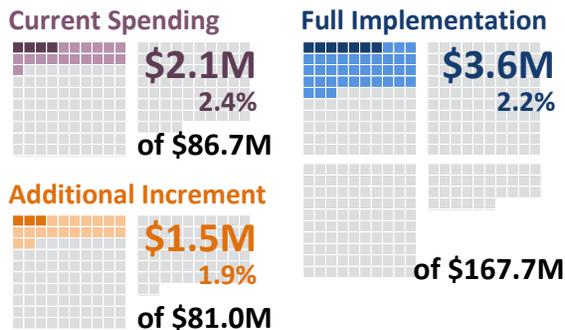


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Program



COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 1:

Communicable Disease Surveillance

Communicable Disease Surveillance is one of four functional areas that describes how local *Communicable Disease Control* activities are operationalized. These activities support awareness and timely and accurate reporting of notifiable diseases.

This functional area represents one-fifth of current local *Communicable Disease Control* activities, and the addition of 70% more funding or \$1.5M would allow LPHAs 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 partially or significantly implemented these activities.

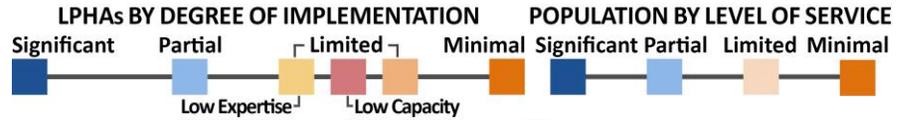
Implementation is similar from both a system and population service perspective. Approximately three-quarters of LPHAs have partially or significantly implemented and approximately three-quarters of residents are being served by an LPHA that is partially or significantly implemented.

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 LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Communicable Disease Control
Surveillance

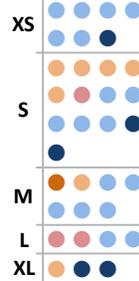
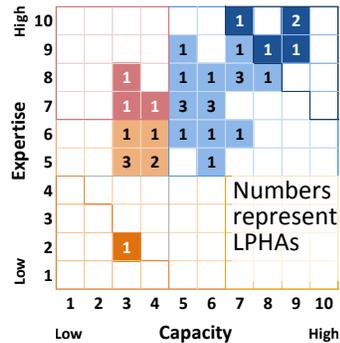


Functional Area	LPHAs BY DEGREE OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE				
	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Communicable Disease Surveillance	9%	47%	12%	24%	9%	15%	51%	32%	2%
Ensure timely and accurate reporting of reportable diseases and educate local providers on reportable disease requirements.	24%	71%	3%	3%	36%	55%	9%		
Monitor occurrence and distinguishing characteristics of infectious diseases and outbreaks.	24%	47%	3%	26%	37%	46%	17%		
Produce timely reports of notifiable diseases.	35%	47%	6%	9%	3%	48%	46%	5%	1%
Maintain portfolio of strategic partnerships with hospitals, health systems, providers, schools and other partners.	21%	59%	3%	15%	3%	26%	61%	12%	1%

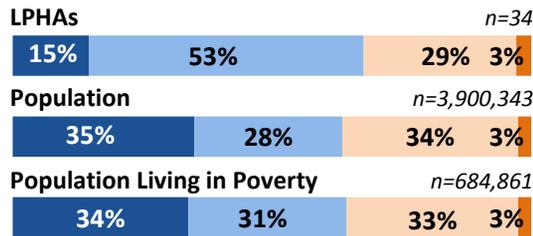
DETAILED ASSESSMENT RESULTS

Communicable Disease Control
Investigation

LPHA IMPLEMENTATION

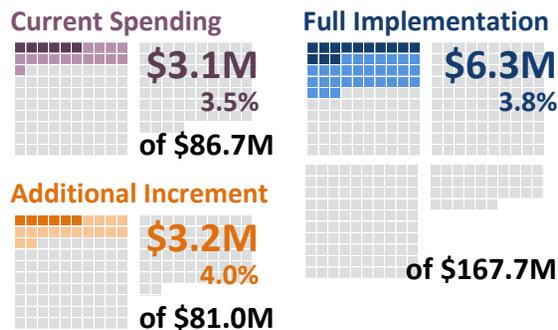


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Program



COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 2:

Communicable Disease Investigation

Communicable Disease Investigation is the second of four functional areas that describes how *Communicable Disease Control* activities are operationalized. These activities include the development and deploying of communicable disease investigative process and communicating with the public about ongoing communicable disease outbreaks and investigation, while ensuring confidentiality.

This functional area represents nearly one-third of current local *Communicable Disease Control* activities, and the addition of 105% more funding (\$3.2M) would allow LPHAs to reach significant implementation.

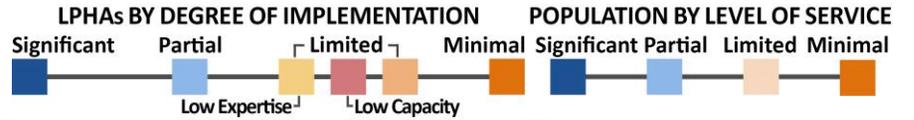
The degree to which this functional area is implemented varies across the system with no clear pattern as to which LPHAs are at each level of implementation. Approximately two-thirds of all LPHAs are at least partially implemented. Almost half of small and large LPHAs are not significantly implemented.

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

The activities included in the Communicable Disease Investigation functional area includes 5 roles and 5 deliverables. The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon’s population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Communicable Disease Control
Investigation



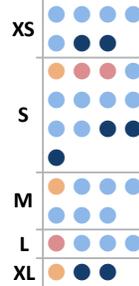
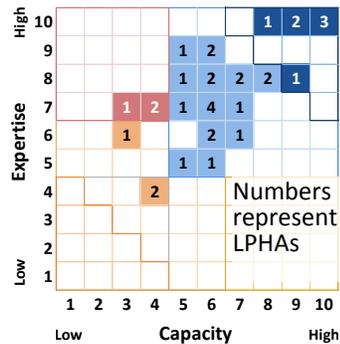
Functional Area	Role	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Communicable Disease Investigation		15%	53%	9%	21%	3%	35%	28%	34%	3%
Maintain protocols and systems to ensure confidentiality throughout investigation, reporting and maintenance of data.	Role	47%	53%				65%		35%	
Investigate and control disease outbreaks within the authority, in collaboration with partners.	Role	21%	62%	9%	6%	3%	37%	52%	11%	
Communicate clearly with members of the public in the authority about identified health risks.	Role	15%	74%	9%	3%		34%	53%	12%	
Summarize and share data to determine opportunities for intervention and to guide policy and program decisions.	Role	12%	47%	3%	32%	6%	38%	33%	29%	1%
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.	Role	18%	50%	6%	26%		36%	32%	32%	
Provide individual communicable disease case and outbreak data, consistent with Oregon statute, rule and program standards.	Deliverable	35%	62%			3%	60%	39%	1%	
Secure personally identifiable data collected through audits, review, update and verification.	Deliverable	50%	44%	3%	3%		77%	22%	1%	
Document implementation of investigative guidelines appropriately.	Deliverable	41%	50%	3%	6%		65%	32%	3%	
Maintain protocols for proper preparation, packaging and shipment of samples of public health importance (e.g., animals and animal products).	Deliverable	24%	65%		12%		16%	79%	5%	
Provide communications with the public about outbreak investigations.	Deliverable	18%	65%	6%	9%	3%	35%	50%	15%	

DETAILED ASSESSMENT RESULTS

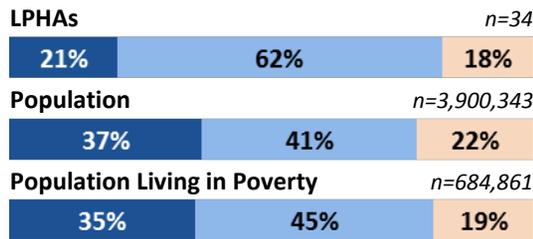
Communicable Disease Control

Intervention and Control

LPHA IMPLEMENTATION

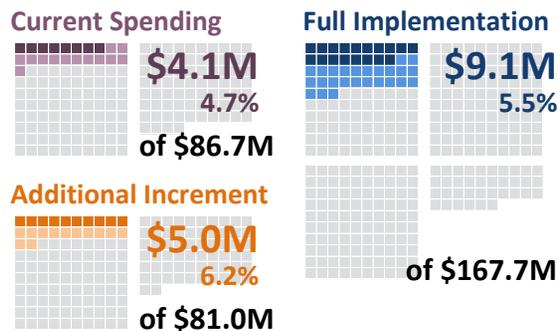


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Program



COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 3:

Communicable Disease Intervention and Control

Communicable Disease Intervention and Control is the third of four functional areas that describes how *Communicable Disease Control* activities are operationalized. This functional area covers several important things:

- Providing timely, statewide, and locally relevant and accurate information to the state and community on communicable disease and their control.
- Promoting immunization through education of the public and through collaboration with schools, health care providers, and other community partners.
- Identifying statewide and local communicable disease control community assets, developing processes for information sharing between providers to reduce disease transmission, and maintaining emergency/outbreak plans.

This functional area is the most implemented, representing 40% of current local *Communicable Disease Control* activities. An increase of 123% of spending, or \$5.0M would allow LPHAs to reach full implementation.

Currently, this functional area has a high degree of implementation (83%) with only 18% of LPHAs at limited or minimal implementation. There is no clear pattern as to which LPHAs are at each level of implementation, with the size of those only limitedly implemented varying from small to extra-large.

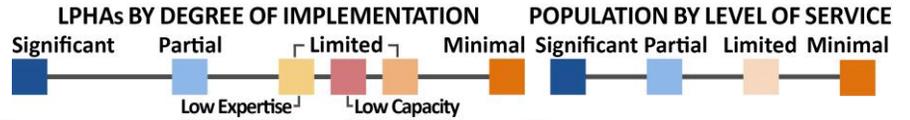
This degree of implementation is consistent from a population service perspective – more than three-quarters (78%) of Oregon residents live in a service area where these activities are present, and over three-quarters of LPHAs (80%) have partially or significantly implemented this functional area.

The activities included in the *Communicable Disease Intervention and Control* functional area include 11 roles and 6 deliverables. The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon’s population is provided on the following pages.

DETAILED ASSESSMENT RESULTS

Communicable Disease Control

Intervention and Control

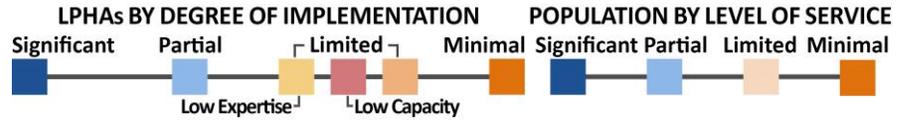


Functional Area	LPHAs BY DEGREE OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Communicable Disease Intervention and Control	21%	62%	9%	9%	37%	41%	22%	
Provide technical support for enforcement of public health laws (e.g., isolation and quarantine, school exclusion laws).	15%	65%	6%	15%	16%	71%	13%	
Maintain plans for the allocation of scarce resources in the event of an emergency or outbreak.	15%	50%	32%	3%	21%	50%	24%	5%
Provide appropriate screening and treatment for HIV, STD, and TB cases, including pre- and post- exposure prophylaxis for HIV.	12%	53%	12%	18%	6%	21%	46%	30%
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.	6%	59%	12%	24%	1%	52%	48%	
Develop protocols or process maps for information sharing between providers to reduce disease transmission.	12%	32%	9%	35%	12%	2%	50%	39%
Produce reports about acute and communicable disease gaps and opportunities for mitigation of identified risks.	12%	29%	12%	29%	18%	34%	7%	46%

DETAILED ASSESSMENT RESULTS

Communicable Disease Control

Intervention and Control



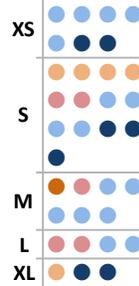
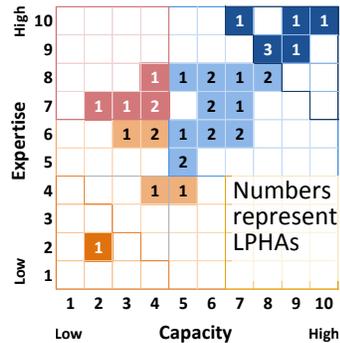
Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Communicable Disease Investigation	15%	53%	9%	21%	3%	35%	28%	34%	3%
Maintain protocols and systems to ensure confidentiality throughout investigation, reporting and maintenance of data.	Role	47%	53%			65%	35%	0%	
Investigate and control disease outbreaks within the authority, in collaboration with partners.	Role	21%	62%	9%	6%	3%	37%	52%	11%
Communicate clearly with members of the public in the authority about identified health risks.	Role	15%	74%	9%	3%	34%	53%	12%	0%
Summarize and share data to determine opportunities for intervention and to guide policy and program decisions.	Role	12%	47%	3%	32%	6%	38%	33%	29%
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.	Role	18%	50%	6%	26%	36%	32%	32%	0%
Provide individual communicable disease case and outbreak data, consistent with Oregon statute, rule and program standards.	Deliverable	35%	62%	3%	60%	39%	0%		
Secure personally identifiable data collected through audits, review, update and verification.	Deliverable	50%	44%	3%	77%	22%	1%		
Document implementation of investigative guidelines appropriately.	Deliverable	41%	50%	3%	65%	32%	3%		
Maintain protocols for proper preparation, packaging and shipment of samples of public health importance (e.g., animals and animal products).	Deliverable	24%	65%	12%	16%	79%	5%		
Provide communications with the public about outbreak investigations.	Deliverable	18%	65%	6%	9%	3%	35%	50%	15%

DETAILED ASSESSMENT RESULTS

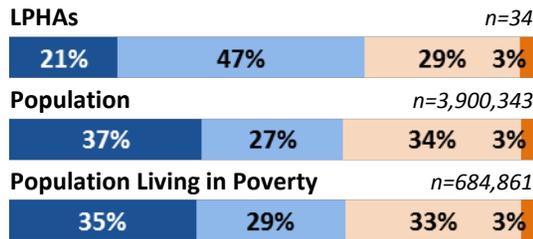
Communicable Disease Control

Response Evaluation

LPHA IMPLEMENTATION

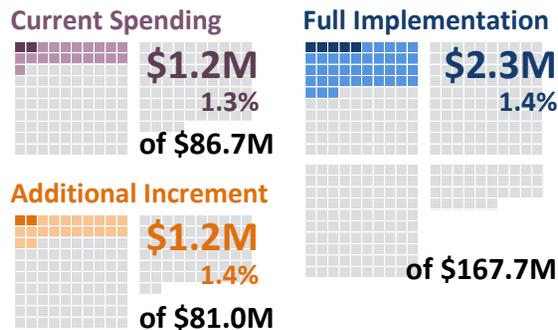


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Program



COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 4:

Communicable Disease Response Evaluation

Communicable Disease Response Evaluation is the final of four functional areas that describes how local *Communicable Disease Control* activities are operationalized. This functional area includes evaluation and assessment of communicable disease outbreak response and documentation of distinguishing characteristics, and assessment of process improvement initiative, including materials.

This functional area represents just 11% of current local *Communicable Disease Control* activities, and an increase in spending of 99% or \$1.2M would be required for LPHAs to reach full implementation

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 partially or significantly implemented this functional area, while the majority of limitedly or minimally implemented LPHAs are all small.

This degree of implementation is consistent from a population service perspective – two-thirds of the system is partially or significantly implemented and approximately two-thirds

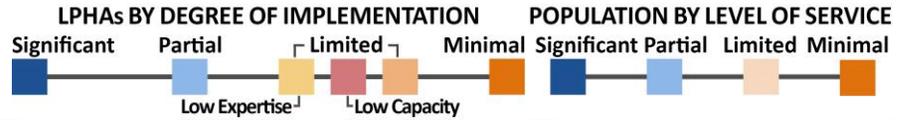
(64%) of Oregon residents live in a service area where these activities are present.

The activities included in the *Communicable Disease Response Evaluation* functional area include 1 role and 3 deliverables. The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon’s population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Communicable Disease Control

Response Evaluation



Communicable Disease Response Evaluation	Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
		21%	47%	15%	15%	3%	37%	27%	34%	3%
Work with the OHA Public Health Division to evaluate disease control investigations and interventions. Use findings to improve these efforts.	Role	21%	56%	3%	18%	3%	37%	51%	11%	
Document assessments of outbreak investigation and response efforts, both conducted by state and by local public health.	Deliverable	15%	62%	6%	12%	6%	35%	56%	8%	1%
Document results of quality and process improvement initiatives.	Deliverable	6%	50%	3%	35%	6%	1%	63%	34%	1%
Evaluate presentations and publications.	Deliverable	6%	44%	9%	32%	9%	14%	47%	36%	2%

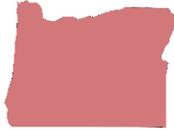
ENVIRONMENTAL PUBLIC HEALTH

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.

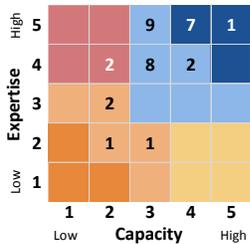
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

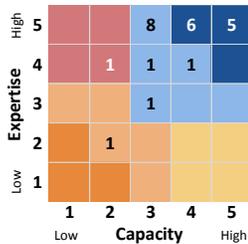
Limitedly Implemented, Low Capacity



ROLES



DELIVERABLES



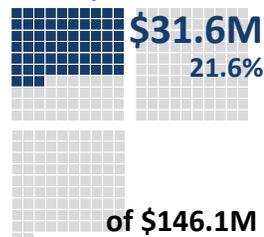
RESOURCES

Each Square Equals \$500,000

Current Spending



Full Implementation



Additional Increment



PHD's *Environmental Public Health* activities include 33 roles and 24 deliverables. These activities include acting as a liaison and convener between local public health and state/federal natural resources agencies; developing, adopting, and applying environmental health regulations; providing licensing and certification. These activities also include planning and assessment related to environmental public health; development of environmental public health policy and programs; health promotion and outreach around mitigating environmental health risks; and providing environmental consultations.

PHD's Self-Assessment shows that the governmental public health authority considers this program to be only limitedly implemented. However, PHD also notes that the majority of the roles and deliverables that represent *Environmental Public Health* state activities are partially or significantly implemented. In fact, 27 of the 33 roles and 22 of 24 deliverables are partially or significantly implemented.

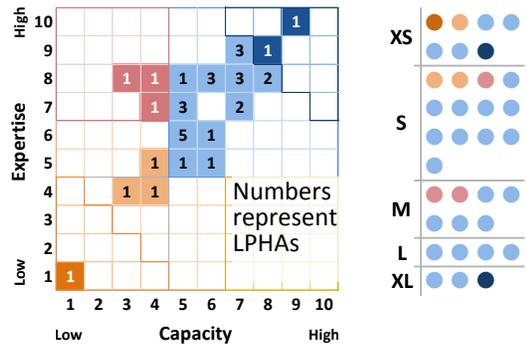
A few of the less implemented roles and deliverables are state activities that directly support the provision of local *Environmental Public Health* activities; these include:

- Serve as a liaison and convener between local public health and state/federal natural

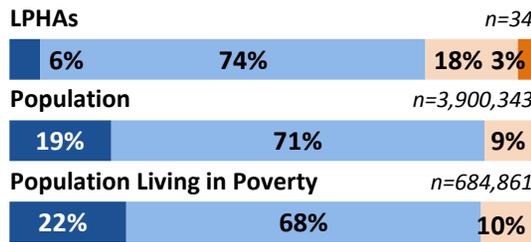
- resource agencies on environmental health issues. (Limitedly implemented.)
- Support capacity-building efforts at the local and regional level to assess and address emerging environmental public health issues. (Partially implemented.)
- Provide decision support on environmental health issues of statewide or cross-jurisdictional importance. (Partially implemented.)
- Conduct health analyses for organizations and recommend approaches to ensure healthy and sustainable built and natural environments. (Limitedly implemented, low capacity.)
- Maintain information systems to provide current and accurate information to support environmental health functions at the state and local level. (Limitedly implemented.)
- Approve local ambulance service area plans. (Partially implemented.)

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

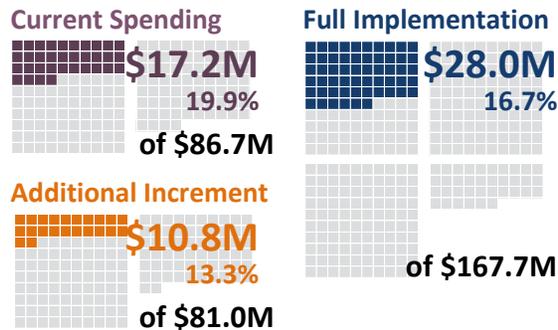


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000



LPHA’s *Environmental Public Health* activities include regulatory capacity to enforce environmental regulations locally. Like in the case of state activities, local activities also include planning and assessment related to environmental public health; development of environmental public health policy and programs; health promotion and outreach around mitigating environmental health risks; and providing environmental consultations.

This program is relatively well-implemented, with 27 (out of 34) LPHAs documenting partial or significant implementation. However, an additional \$10.8M funds are needed to reach significant implementation.

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

One LPHA recorded in the Self-Assessment that there are currently no Environmental Public Health activities in their community, however, upon further investigation we learned that these services are provided in that county by another LPHA.

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

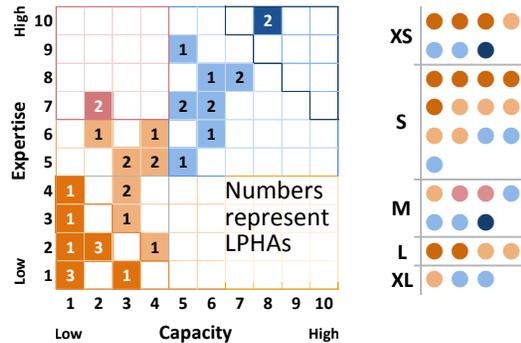
- 1. Identify and Prevent Environmental Health Hazards.** This functional area represents 24% of current local *Environmental Public Health* Activities; its share of local *Environmental Public Health* activities would decrease to 22% at significant implementation.
- 2. Conduct Mandated Inspections.** 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 significant implementation. This functional area also appears to be the most implemented (with all but two LPHAs citing that they have partially 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 significant implementation with the spending in this area increasing 345%.

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

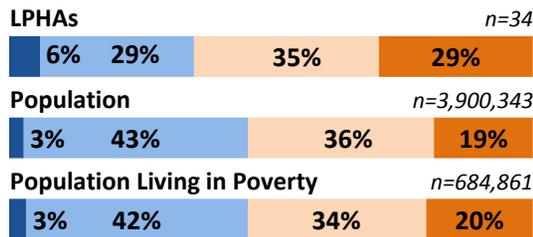
DETAILED ASSESSMENT RESULTS

Environmental Public Health
Identify and Prevent Environmental Health Hazards

LPHA IMPLEMENTATION

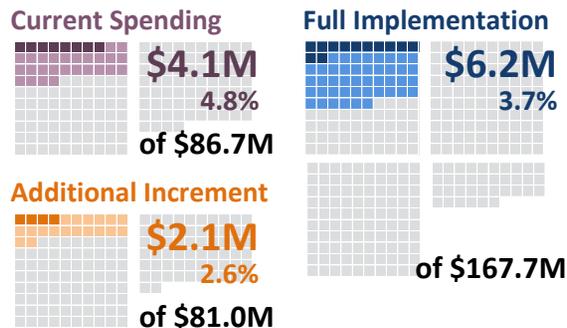


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000
 Functional Area Only
 Total Foundational Program



ENVIRONMENTAL PUBLIC HEALTH FUNCTIONAL AREA 1:

Identify and Prevent Environmental Health Hazards

Identify and Prevent Environmental Health Hazards is one of three functional areas that describes how local *Environmental Public Health* activities are operationalized. This functional area involves preventing and investigating environmental health hazards, including radioactive materials, animal bites, and vector-borne diseases.

This functional area represents nearly one quarter of current local *Environmental Public Health* activities and with the addition of 50% more funding, or \$2.1M, LPHAs could reach significant 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 partially or significantly implemented these activities.

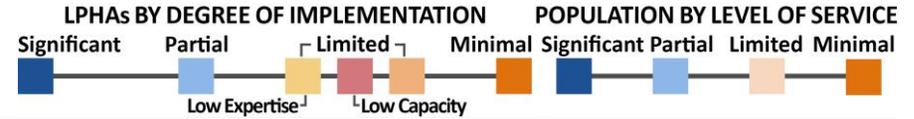
This is more balanced from a population service perspective: 54% of Oregon residents live in a service area where they are underserved or unserved, while 46% live in a service area where these activities are present (however, there is a meaningful gap in service for a large percentage of those services).

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 LPHAs as well as the level of service across Oregon’s population is provided on the following pages.

DETAILED ASSESSMENT RESULTS

Environmental Public Health

Identify and Prevent Environmental Health Hazards

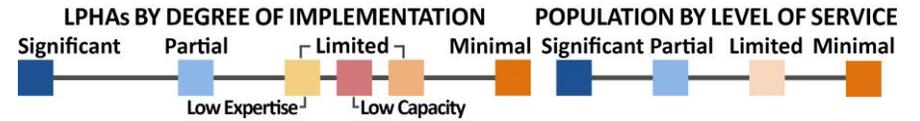


Functional Area	Role	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Identify and Prevent Environmental Health Hazards		6%	29%	6%	29%	29%	3%	43%	36%	19%
Ensure consistent application of health regulations and policies.	Role	41%	53%	3%	3%	57%	41%	1%		
Implement state-mandated programs where appropriate (i.e., small drinking water systems, septic oversight).	Role	26%	59%	3%	12%	35%	2%			
Develop, implement and enforce environmental health regulations.	Role	15%	65%	3%	15%	3%	17%	76%	7%	
Maintain expertise in relevant environmental health topics.	Role	15%	56%	3%	3%	24%	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	6%	32%	15%	38%	9%	8%	71%	25%	1%
Deliver effective and timely outreach on environmental health hazards and protection recommendations to regulated facilities, the public and stakeholder organizations.	Role	18%	35%	21%	18%	9%	24%	48%	26%	2%
Ensure that environmental health is included in the community health assessment every five years.	Role	12%	44%	6%	15%	24%	44%	25%	12%	20%
Assure the development and maintenance of the ambulance service area plan.	Role	9%	26%	9%	18%	38%	17%	43%	12%	28%
Inform decision makers of the impacts to environmental public health based on program, project and policy decisions.	Role	15%	29%	6%	29%	21%	24%	35%	27%	14%
Monitor, investigate, and control infectious and noninfectious vector nuisances and diseases.	Role	9%	32%	9%	44%	6%	20%	28%	51%	1%
Measure the impact of environmental hazards on the health outcomes of priority/focal populations. Analyze and communicate environmental justice concerns and disparities.	Role	3%	18%	6%	26%	47%	27%	22%	32%	
Provide evidence based assessment of the health impacts of environmental hazards or conditions.	Role	29%	6%	35%	29%	44%	32%	24%		
Provide consultation and technical assistance including establishing best practices related to vector control.	Role	6%	32%	12%	35%	15%	19%	24%	36%	21%
Ensure meaningful participation of communities experiencing environmental health threats and inequities in programs and policies designed to serve them.	Role	6%	24%	6%	44%	21%	16%	42%	22%	
Use environmental health expertise to reduce hazardous exposures from air, land, water, and other exposure pathways.	Role	6%	21%	18%	41%	15%	27%	57%	16%	

DETAILED ASSESSMENT RESULTS

Environmental Public Health

Identify and Prevent Environmental Health Hazards



Identify and Prevent Environmental Health Hazards

Functional Area



Document communications on environmental health hazards and protection recommendations to regulated facilities, the public and stakeholder organizations.

Deliverable



Produce policy briefs and other communications on the impacts to environmental public health.

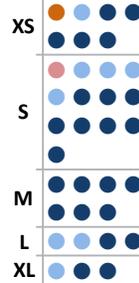
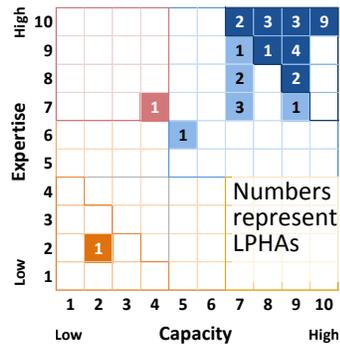
Deliverable



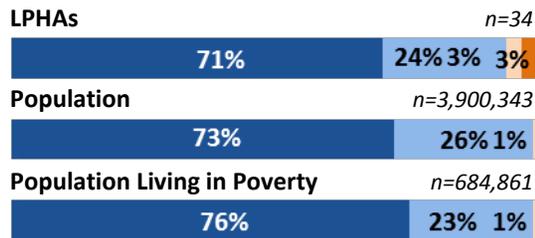
DETAILED ASSESSMENT RESULTS

Environmental Public Health
Conduct Mandated Inspections

LPHA IMPLEMENTATION

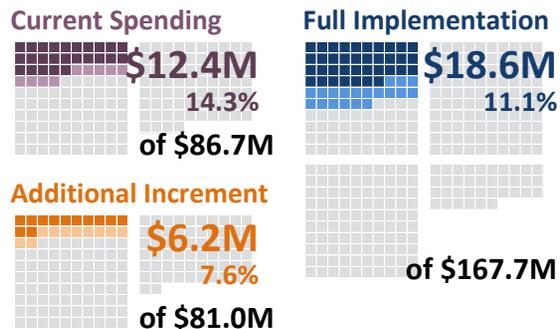


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Program



ENVIRONMENTAL PUBLIC HEALTH FUNCTIONAL AREA 2:

Conduct Mandated Inspections

Conduct Mandated Inspections is the second of three functional areas that describes how *Environmental Public Health* activities are operationalized.

This functional area represents nearly three quarters of *Environmental Public Health* activities and an additional 50% of funding or \$6.2M would allow LPHAs to reach significant implementation.

This functional area is highly implemented across the system. Only two LPHAs – one extra-small and one small – are not at least partially 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 significant implementation suggests that the increase from partially implemented to significantly 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

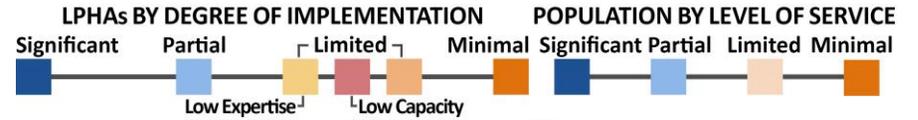
services are delivered such that there is a meaningful gap in service.

The activities included in the *Conduct Mandated Inspections* functional area includes 5 roles and 4 deliverables. The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon’s population is provided on the following page. Only one of these activities is far from significant implementation, this role (role 5) is to “Conduct ongoing environmental and occupational health surveillance.”

DETAILED ASSESSMENT RESULTS

Environmental Public Health

Conduct Mandated Inspections

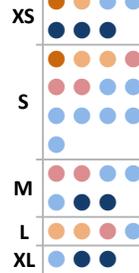
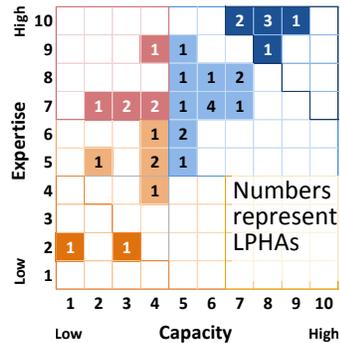


Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Conduct Mandated Inspections		71%		24%	3%	3%		
Provide licensing and certification of recreational facilities, food service facilities and tourist accommodations.	56%			44%				
Conduct timely inspection and review of regulated entities and facilities.	56%			44%				
Perform and assist with outbreak investigations that have an environmental component.	12%		82%		3%	3%		
Enforce regulations.	26%		65%		6%	3%		
Conduct ongoing environmental and occupational health surveillance.	6%	29%	9%	35%	21%			
Document reports of inspection and review of regulated entities and facilities.	62%			35%	3%			
Document provision of licensing and certification of recreational facilities, food service facilities and tourist accommodations.	65%			32%	3%			
Document enforcement of regulations.	56%			38%	3%	3%		
Consult for the food service industry and the general public.	41%			44%	6%	9%		

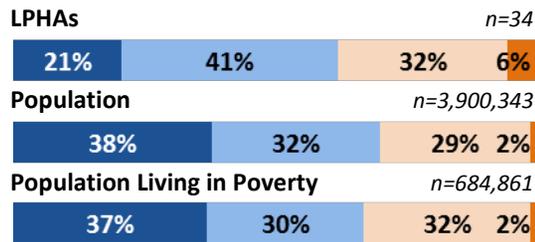
DETAILED ASSESSMENT RESULTS

Environmental Public Health
Promote Land Use Planning

LPHA IMPLEMENTATION

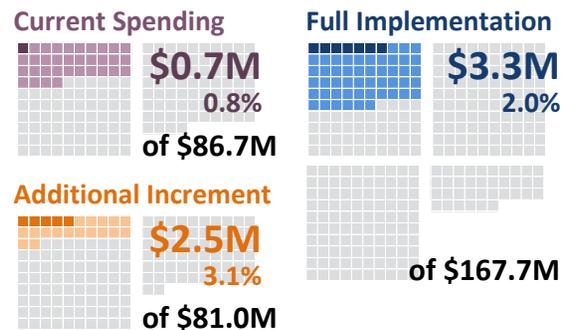


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Program



ENVIRONMENTAL PUBLIC HEALTH FUNCTIONAL AREA 3:

Promote Land Use planning

Promote Land Use Planning is the final of three functional areas that describes how local *Environmental Public Health* activities are operationalized. This functional area involves testing and analysis for purposes related to environmental health and the performance of inspections and education for inspection recipients.

This functional area 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 significant implementation with the spending in this area increasing 345% or \$2.5M.

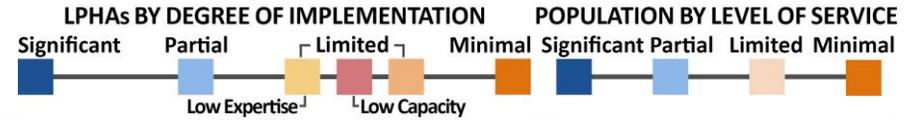
Currently, the degree of implementation of this functional area varies across the system. There is no clear pattern as to which LPHAs are at each level of implementation. A little more than two-thirds of providers have partially or significantly implemented these activities.

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 these roles and deliverables across LPHAs as well as the level of service across Oregon’s population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Environmental Public Health
Promote Land Use Planning



Functional Area	Significant	Partial	Limited	Minimal	Low Expertise	Low Capacity	Significant	Partial	Limited	Minimal
Promote Land Use Planning	21%	41%	18%	15%	6%		38%	32%	29%	2%
Provide consultation and technical assistance to the food service industry and the general public.	44%	53%	3%				48%	52%		
Maintain relationships with partners in local economic development, transportation, parks, and land use agencies.	9%	38%	12%	32%	9%		21%	38%	32%	9%
Provide technical assistance to integrate standard environmental public health practices into facilities that present high risk for harmful environmental exposures or disease transmission.	18%	35%	12%	21%	15%		25%	35%	28%	12%
Understand and participate in local land use and transportation planning processes.	24%	15%	29%	32%			49%	31%	19%	
Conduct health analyses for other organizations and recommend approaches to ensure healthy and sustainable built and natural environments.	24%	12%	26%	38%			49%	26%	26%	
Document integration of standard environmental public health practices into facilities that present high risk for harmful environmental exposures or disease transmission.	18%	38%	3%	26%	15%		39%	39%	19%	3%
Produce community health assessments that includes environmental health produced at least every five years.	12%	32%	9%	32%	15%		35%	26%	31%	8%
Write best practices related to vector control.	6%	24%	12%	24%	35%		19%	30%	24%	27%
Prepare health analyses for other organizations and recommend approaches to ensure healthy and sustainable built and natural environments.	9%	18%	6%	26%	41%		33%	14%	32%	21%
Communicate environmental justice concerns and disparities.	6%	12%	12%	24%	47%		19%	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

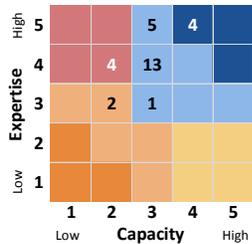
Partially Implemented



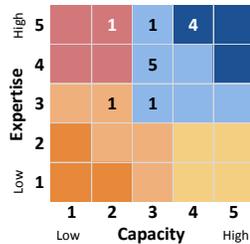
PHD's *Prevention and Health Promotion* activities include 29 roles and 13 deliverables. These activities include collecting and disseminating relevant data, providing accurate statewide and locally relevant information about social, emotional, and physical health and safety, and convening stakeholders to create policies, programs, and strategies.

- Develop multi-faceted strategies designed to address social determinants of health. (Limitedly implemented.)

ROLES



DELIVERABLES



PHD's Self-Assessment shows that it considers this program to have partial implementation. Some of the better implemented roles and deliverables include adhering to state and federal guidance, documenting trainings provided to partners and stakeholders, and making state planning documents available to local public health authorities.

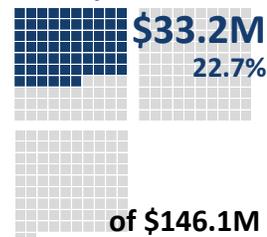
RESOURCES

Each Square Equals \$500,000

Current Spending



Full Implementation



Additional Increment

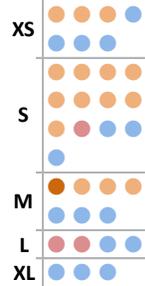
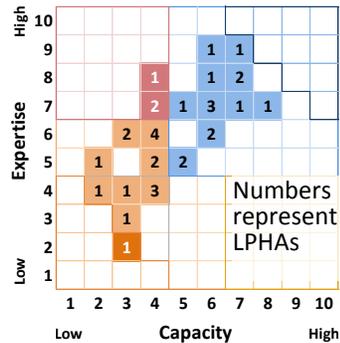


A few of the less implemented roles and deliverables are state activities that directly support the provision of local *Prevention and Health Promotion* activities, including:

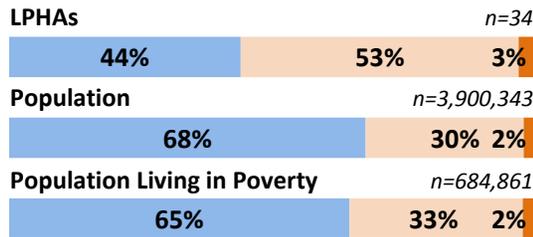
- Monitor knowledge, attitudes, behaviors, and health outcomes related to tobacco; nutrition, oral health, prenatal, natal, and postnatal care; and childhood and maternal health; physical activity; and intentional and unintentional injuries. Make data available at the local level. (Limitedly implemented, low capacity)

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

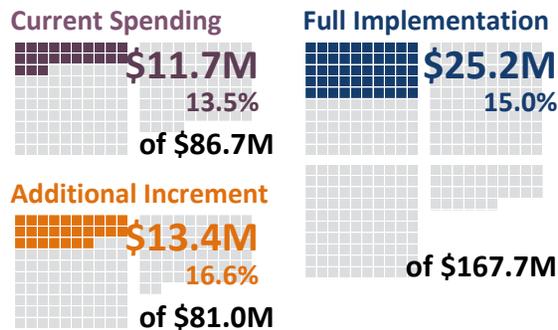


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000



LPHA’s *Prevention and Health Promotion* activities include using data disseminated by PHD; collecting and disseminating local surveillance data; developing a plan to address community health needs; and improving social, emotional, and physical health and safety of local communities.

LPHAs rated this foundational program as not significantly implemented, with only 15 out of 34 LPHAs documenting partial implementation and no LPHAs reporting significant implementation.

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 Unintentional and Intentional Injuries. 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%.

Of the five functional areas, *Reducing Unintentional and Intentional Injuries* is implemented the best.

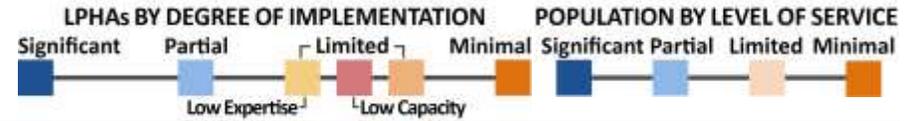
- 83% of Oregon’s LPHAs have partially or significantly implemented the *Reducing Unintentional and Intentional Injuries* functional area, serving 86% of Oregon’s population.

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* span all functional 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 next five pages, followed by profiles for each of the five functional areas.

DETAILED ASSESSMENT RESULTS

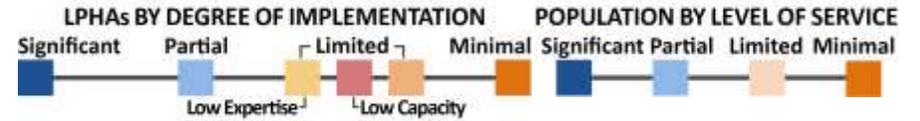
Prevention and Health Promotion



Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Prevention and Health Promotion	44%	9%	44%	3%	68%	30%	2%	
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).	21%	62%	3%	6%	9%	28%	67%	5%
Build relationships with community partners who work with priority/focal populations.	24%	65%	6%	6%	19%	75%	5%	
Use community health assessment data and other relevant data sources to inform or identify priorities and develop planning documents.	18%	53%	26%	3%	27%	66%	7%	
Work with partners, stakeholders, and community members to identify community assets and understand community needs and priorities.	18%	62%	9%	6%	6%	19%	74%	6%
Develop and implement community health improvement plan (CHIP) priorities for prevention and health promotion, revised at least every five years with updates made annually.	18%	59%	24%		27%	63%	10%	
Align prevention and health promotion priorities across the CHIP, the local public health authority's strategic plan, and other relevant internal and community planning documents.	15%	53%	3%	26%	3%	18%	71%	10%
Develop strategic, cross-sector partnerships and collaborations, across systems and settings, related to: i. Tobacco control, nutrition, oral health, prenatal, natal, and postnatal care, and childhood and maternal health, physical activity, and unintentional and intentional injuries; ii. Prevention and Health Promotion programs identified on the community health improvement plan or other local priorities; iii. Behavioral health issues that impact health outcomes for the areas listed above (e.g. trauma, chronic stress, addiction or violence).	18%	50%	9%	21%	3%	27%	59%	13%
Provide input and guidance to the OHA Public Health Division on statewide planning.	15%	38%	6%	35%	6%	56%	14%	1%
Collaborate with partners and engage community leaders to identify and seek funding for prevention and health promotion programs and interventions.	9%	65%	3%	18%	6%	3%	78%	18%
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).	9%	41%	9%	35%	6%	11%	69%	18%

DETAILED ASSESSMENT RESULTS

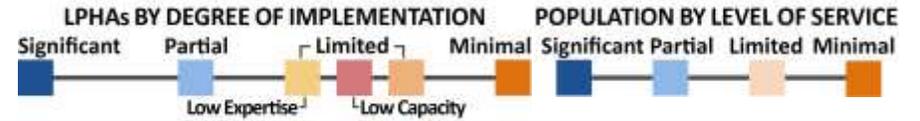
Prevention and Health Promotion



Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal		
Prevention and Health Promotion	44%	9%	44%	3%	68%	30%	2%			
Educate consumers about health impacts of unhealthy products like tobacco or sugary drinks, or health-protective products like car seats.	15%	35%	15%	26%	9%	24%	55%	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.	12%	56%	3%	6%	21%	3%	4%	75%	19%	1%
Communicate information about:	12%	50%	6%	29%	3%	17%	61%	22%		
<ul style="list-style-type: none"> i. Tobacco control, nutrition, oral health, prenatal, natal, and postnatal care, and childhood and maternal health, physical activity, and unintentional and intentional injuries; ii. Prevention and health promotion programs identified on the community health improvement plan or other local priorities; iii. Behavioral health issues that impact health outcomes for the areas listed above (e.g. trauma, chronic stress, addiction or violence). 										
Include policies, programs and strategies for the following areas in the local prioritized plan:	9%	47%	12%	26%	6%	25%	52%	22%		
<ul style="list-style-type: none"> i. Tobacco control, nutrition, oral health, prenatal, natal, and postnatal care, and childhood and maternal health, physical activity, and unintentional and intentional injuries; ii. Prevention and health promotion programs identified on the community health improvement plan or other local priorities; iii. Include behavioral health issues that impact health outcomes for the areas listed above (e.g. trauma, chronic stress, addiction, or violence). 										
Use surveillance data collected by the OHA Public Health Division and use assessment and epidemiology methods for:	6%	56%	3%	32%	3%	71%	26%	1%		
<ul style="list-style-type: none"> i. Tobacco control, nutrition, oral health, prenatal, natal, and postnatal care, and childhood and maternal health, physical activity, and unintentional and intentional injuries; ii. Prevention and health promotion programs identified on the community health improvement plan or other local priorities; iii. Include surveillance of behavioral health issues that impact health outcomes for the areas listed above (e.g. trauma, chronic stress, addiction or violence). 										

DETAILED ASSESSMENT RESULTS

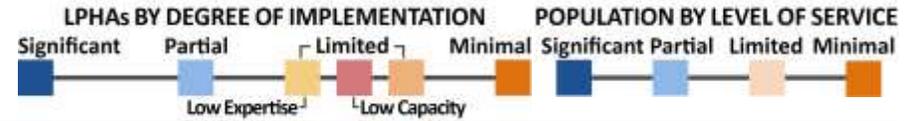
Prevention and Health Promotion



Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Prevention and Health Promotion	44%	9%	44%	3%	68%	30%	2%	
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.	6%	41%	6%	35%	12%	5%	68%	26%
Develop policy, systems and environmental change strategies to improve health outcomes using problem identification, policy analysis, strategy and policy	3%	35%	3%	47%	12%	1%	67%	30%
Collaborate with the OHA Public Health Division to maintain subject matter expertise in:	15%	47%	12%	18%	9%	27%	37%	35%
i. Policy, systems and environmental change;								
ii. Evidence-based and emerging best practices;								
iii. Social determinants of health and the health impact of prenatal/early childhood experiences;								
iv. Prevention and health promotion areas.								
Implement programs and interventions for:	3%	50%	12%	26%	9%	61%	36%	2%
i. Tobacco control, nutrition, oral health, prenatal, natal, and postnatal care, and childhood and maternal health, physical activity, and unintentional and intentional injuries;								
ii. Prevention and health promotion programs identified on the community health improvement plan or other local priorities;								
iii. 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).								
Assess health status across the lifespan.	3%	50%	9%	26%	12%	61%	35%	3%
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.	9%	41%	6%	35%	9%	57%	38%	2%

DETAILED ASSESSMENT RESULTS

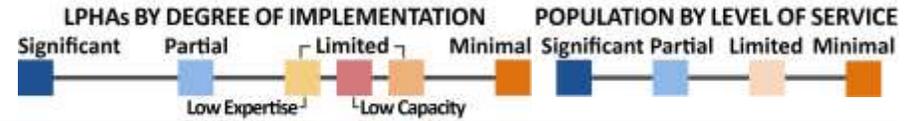
Prevention and Health Promotion



Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Prevention and Health Promotion	44%	9%	44%	3%	68%	30%	2%	
Measure differences and trends in risk factors and burden of disease among diverse populations, or use information provided by the OHA Public Health Division to monitor differences and trends.	6%	38%	3%	6%	38%	9%	15%	45%
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.	3%	32%	9%	47%	9%	1%	55%	43%
Develop multi-faceted strategies designed to address social determinants of health.	9%	29%	9%	32%	21%	17%	34%	34%
Develop, use, and disseminate innovative, emerging, and evidence-based best practices.	3%	35%	18%	24%	21%	1%	48%	40%
With stakeholders, develop and implement an evaluation plan for the programs listed under "a." in this section.	24%	15%	38%	24%	29%	61%	10%	
Provide program funding to community partners to implement identified work.	6%	9%	21%	24%	41%	3%	15%	62%

DETAILED ASSESSMENT RESULTS

Prevention and Health Promotion

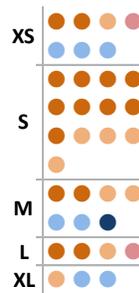
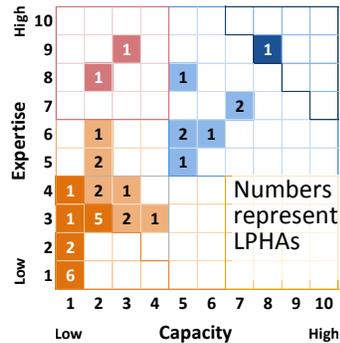


Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Prevention and Health Promotion	44%	9%	44%	3%	68%	30%	2%	
Document participation or leadership in local coalitions.	26%	50%	9%	15%	30%	59%	10%	
Document trainings and other learning opportunities made available to partners, stakeholders and community members.	15%	56%	9%	12%	9%	26%	63%	8%
Document implementation and coordination of policies, programs and strategies for:	6%	50%	12%	24%	9%	16%	67%	15%
Document work with community to build capacity and support community organizing efforts.	18%	50%	6%	12%	15%	14%	66%	7%
Document shared priorities and strategies with partners and stakeholders.	21%	44%	9%	24%	3%	30%	47%	20%
Prepare local summaries, reports and information for:	3%	53%	3%	32%	9%	1%	76%	14%
CHIP includes strategies intended to reduce the burden of health disparities.	9%	68%	3%	18%	3%		50%	24%
Maintain portfolio of partners and stakeholders, including local organizations that work with priority/focal populations.	15%	44%	12%	21%	9%	20%	51%	24%
Implement, monitor and revise the community health improvement plan at least every five years with updates annually.	6%	62%	9%	24%		63%	34%	
Evaluate plans developed and implemented, and share results.	6%	29%	15%	41%	9%	5%	55%	39%
Publish local prioritized plan.	3%	53%	21%	15%	9%	56%	40%	3%
Secure local funds for prevention and health promotion programs and interventions.	3%	35%	21%	38%	3%	47%	50%	1%
Document strategies employed to share data, summaries and reports with communities, partners, policy makers and others.	9%	38%	9%	38%	6%	31%	52%	1%
Document strategies employed to educate consumers about the impact on health of marketing strategies.	3%	24%	12%	41%	21%	36%	49%	15%

DETAILED ASSESSMENT RESULTS

Prevention and Health Promotion
Prevention of Tobacco Use

LPHA IMPLEMENTATION

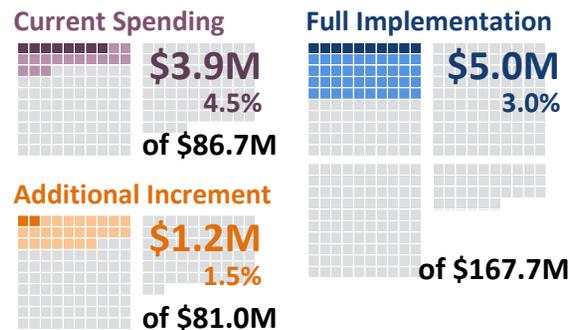


POPULATION BY LEVEL OF SERVICE LPHAs

Category	n	3%	21%	32%	44%
Population	n=3,900,343				
Population Living in Poverty	n=684,861				

RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Foundational Program Total



PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 1:

Prevention of Tobacco Use

This is one of the five functional areas that describes how local *Prevention and Health Promotion* activities are operationalized. The activities in the *Prevention of Tobacco Use* include prevention and control of tobacco use.

This functional area represents one third of current Prevention and Health Promotion activities and the addition of 30% more funding or \$1.2M would allow the LPHAs to reach full implementation.

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 partially or significantly implemented these activities. Almost 45% of LPHAs reported little to no implementation of the Public Health Modernization activities for tobacco use prevention.

PREVENTION OF TOBACCO USE RESULTS

The low degree of implementation identified by LPHAs for this functional area was surprising to participants, who acknowledged that tobacco prevention and education is directly funded by PHD for every LPHA. This is supported by the small additional increment of cost. This suggests that LPHAs might have underscored themselves in this functional area.

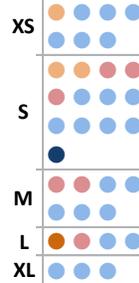
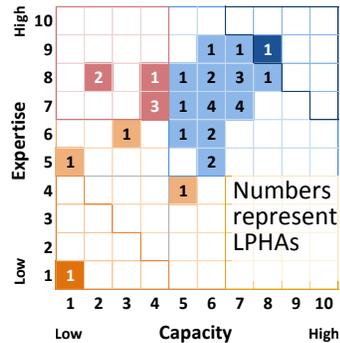
However, during the assessment process some LPHAs suggested that it was difficult to assess their current degree of implementation because the language of the Prevention of Tobacco Use functional area is outcomes-based, such that it suggests that "preventing tobacco use" is the public health modernization activity. LPHAs don't know the degree to which their current activities are actively preventing use of tobacco, making it difficult to assess their degree of implementation.

It might make sense to revisit this language (in both the *Public Health Modernization Manual* and the functional area definition) to make it possible for LPHAs to assess their current degree of implementation against their actual activities, rather than an outcome, in the future.

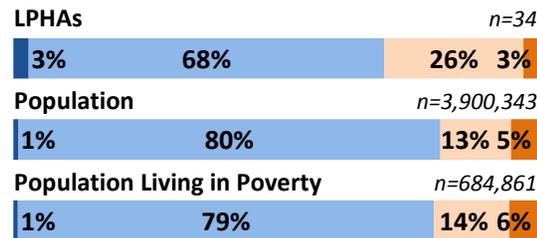
DETAILED ASSESSMENT RESULTS

Prevention and Health Promotion
Improving Nutrition and Increasing Physical Activity

LPHA IMPLEMENTATION

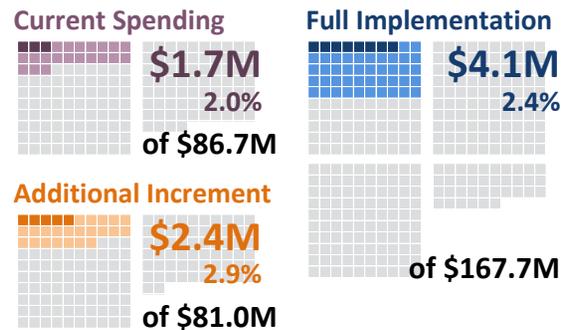


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Foundational Program Total



PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 2:

Improving Nutrition and Increasing Physical Activity

This is another of the five functional areas that describes how local *Prevention and Health Promotion* activities are operationalized. The activities in the *Improving Nutrition and Increasing Physical Activity* functional area include improving nutrition and incentivizing increased physical activity.

This functional area represents about 15% of current local *Prevention and Health Promotion* activities and the addition of 135% more funding (\$2.4M) would allow LPHAs to reach full implementation.

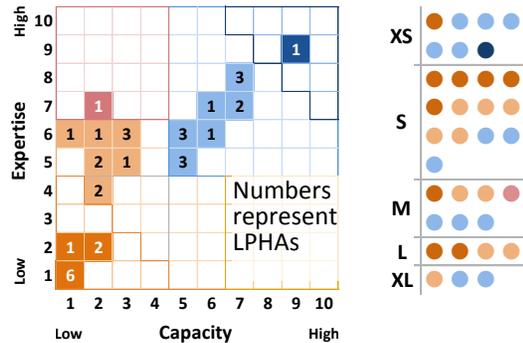
A majority of LPHAs reported partial implementation of *Prevention and Health Promotion* activities relating to *Improving Nutrition and Increasing Physical Activity*. Relatively few LPHAs rated themselves at minimal or significant implementation.

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.

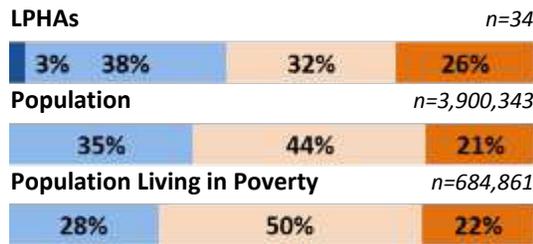
DETAILED ASSESSMENT RESULTS

Prevention and Health Promotion
Improving Oral Health

LPHA IMPLEMENTATION

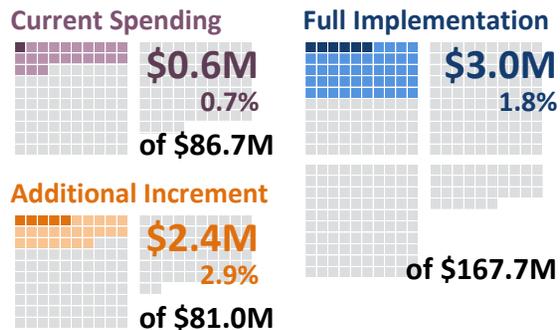


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Foundational Program Total



PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 3:

Improving Oral Health

This is another of the five functional areas that describes how local *Prevention and Health Promotion* activities are operationalized. The activities in the **Improving Oral Health** functional area include using data and strategic partnerships to improve oral health.

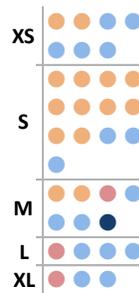
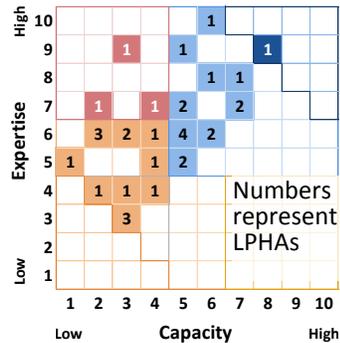
This functional area represents the smallest share of current local *Prevention and Health Promotion* activities and partially because current spending is relatively modest, the additional increment needed to reach full implementation is an increase of 400% (\$2.4M).

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 partially or significantly implemented these activities.

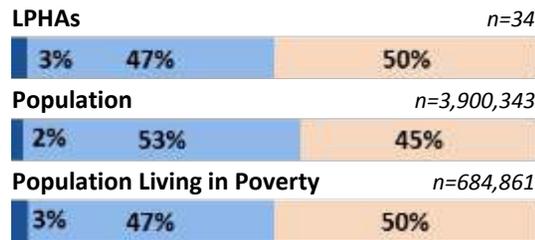
DETAILED ASSESSMENT RESULTS

Prevention and Health Promotion
Improving Maternal and Child Health

LPHA IMPLEMENTATION

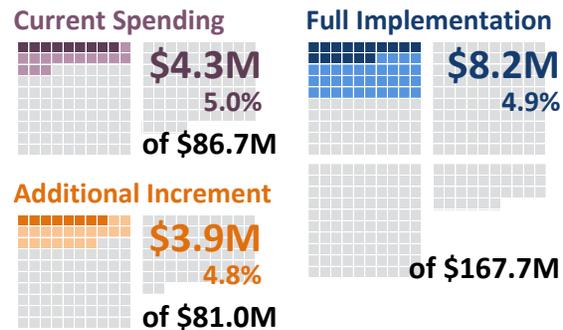


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Foundational Program Total



PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 4:

Improving Maternal and Child Health

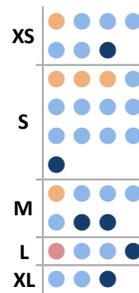
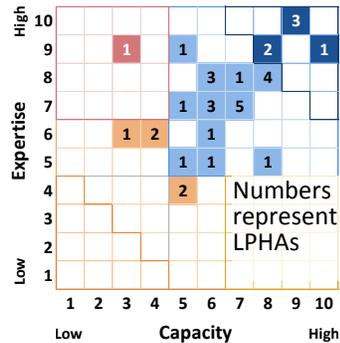
This is the fourth of five functional areas that describes how local *Prevention and Health Promotion* activities are operationalized. The activities in the **Improving Maternal and Child Health** functional area include improving prenatal, natal, and post-natal care, maternal health, and the health of children.

This functional area represents the single largest spending category in the *Prevention and Health Promotion* 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 (\$3.9M) is required to meet full implementation.

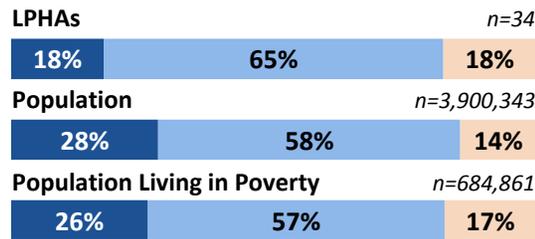
Half of LPHAs rated themselves at partial implementation, although all LPHAs have implemented some activities.

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.

LPHA IMPLEMENTATION

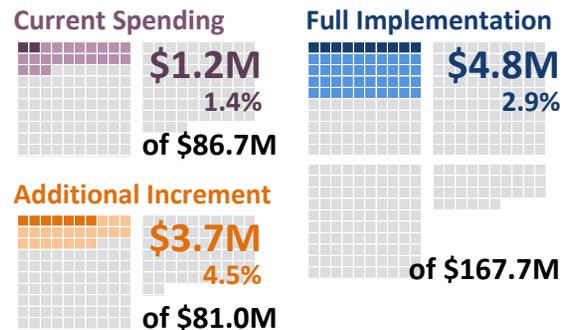


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Foundational Program Total



PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 5:

Reducing Unintentional and Intentional Injuries

This is the fifth and final functional area that describes how local *Prevention and Health Promotion* activities are operationalized. The activities in the **Reducing Unintentional and Intentional Injuries** functional area include decreasing the occurrence and impacts of both unintentional and intentional injuries, such as motor vehicle accidents and suicide.

Within *Prevention and Health Promotion*, *Reducing Unintentional and Intentional Injuries* 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 partial or significant 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 307% increase in costs (\$3.7M) to get to full from limited implementation suggests the activities associated with reducing accident rates have higher marginal costs.

ACCESS TO CLINICAL PREVENTIVE SERVICES

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

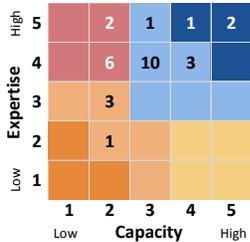
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

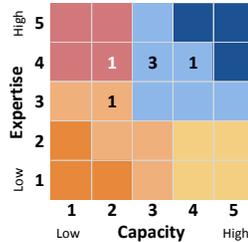
Partially Implemented



ROLES



DELIVERABLES



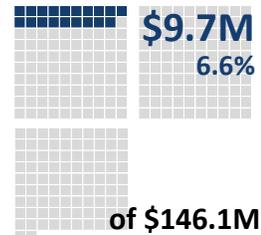
RESOURCES

Each Square Equals \$500,000

Current Spending



Full Implementation



Additional Increment



PHD’s *Clinical Preventive Services* activities include 29 roles and 6 deliverables. These activities include partnering with LPHAs, providing guidance and best practices, implementing federal programs, and supporting information systems for each clinical preventive service area.

PHD’s self-assessment shows that it considers this program to have limited implementation, with low capacity. However, PHD also notes that the majority of the roles and deliverables that represent state activities for *Clinical Preventive Services* are partially or significantly implemented. In fact, 17 of the 29 roles and 4 of 6 deliverables have partial or significant implementation.

Some of the better implemented roles and deliverables include providing access to TB medications, ensuring TB cases are diagnosed and treated, and setting priorities for vaccination during shortages.

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.

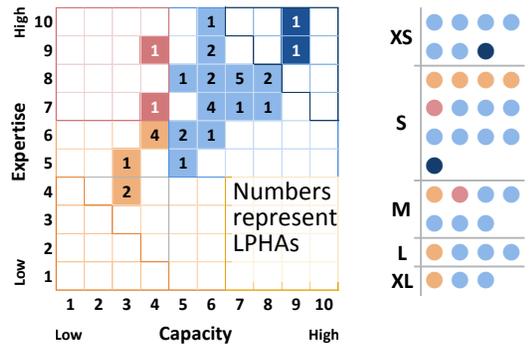
Make data available at the local level. (Limitedly implemented, low capacity.)

- Support information systems that bridge and link public health and health care. (Limitedly implemented.)
- Partner with local public health authorities to identify access barriers and potential solutions. (Partially implemented.)

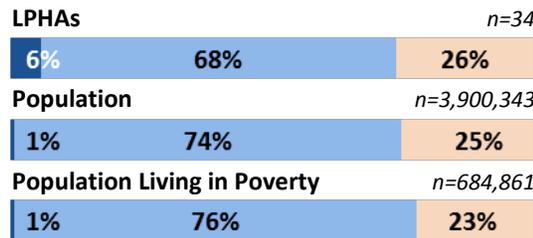
In addition to these *Clinical Preventive Services* activities that directly relate to LPHAs, there are a number of other activities that aren’t yet significantly implemented and could be leveraged by the LPHAs, such as making policies and data created for other stakeholders available to LPHAs where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

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

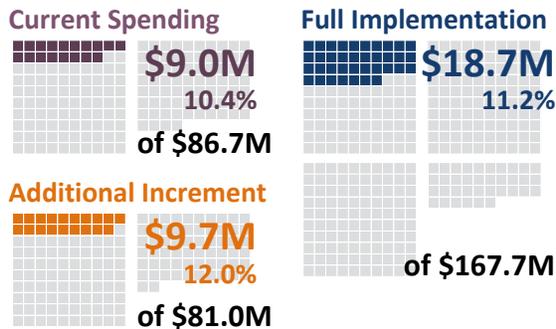


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000



LPHAs' *Clinical Preventive Services* activities include partnering with PHD and regional stakeholders to identify and address barriers to access and supporting policy solutions that increase access to culturally competent clinical preventive services.

This foundational program is relatively well-implemented, with 25 (out of 34) LPHAs documenting partial or significant 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 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.

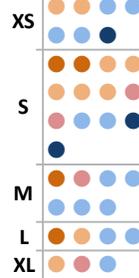
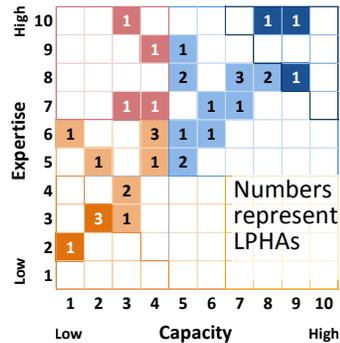
5. Ensure Access to Cost Effective Clinical Care. This is one of two least implemented functional areas. It represents 10% of current local *Clinical Preventive Services* activities. This share is expected to increase to 12% at full implementation, with spending in this area increasing 157%.

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

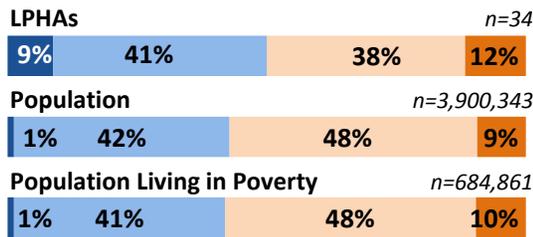
DETAILED ASSESSMENT RESULTS



LPHA IMPLEMENTATION

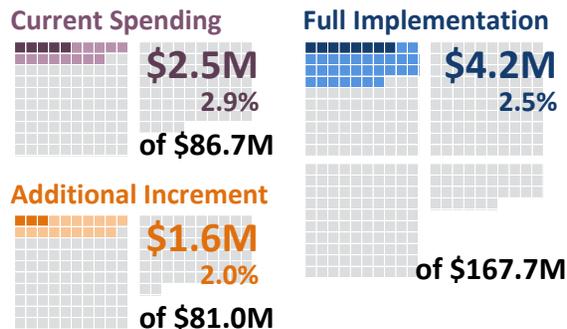


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Program



CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 1:

Ensure Access to Effective Vaccination Programs

This is one of five functional areas that describes how local *Clinical Preventive Services* activities are operationalized. The activities in the **Ensure Access to Effective Vaccination Programs** functional area include 4 roles. This functional area covers the provision of immunizations and vaccinations, and working with partners to ensure access.

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 partial or significant implementation of this functional area. There is no clear pattern as to which LPHAs are at each level of implementation, though the data suggests that lack of capacity is a greater issue than lack of expertise.

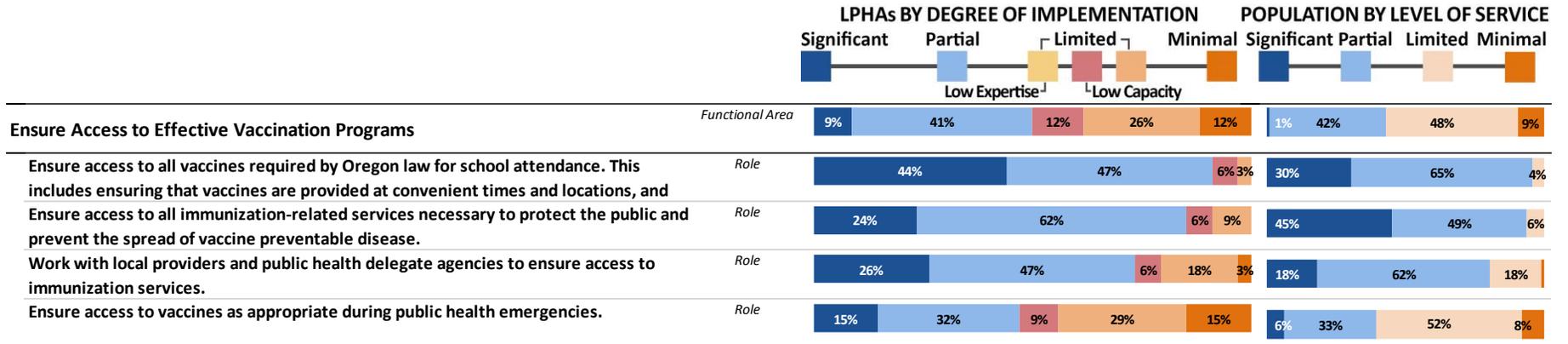
There is a similar lack of service from a population service perspective: 57% of Oregon residents live in a service area where they are underserved or unserved, while 43% live in a service area where these activities are present

(however, there is a meaningful gap in service for a large percentage of those services).

The degree of implementation of the 4 roles across local providers and population by level of service are provided on the following page.

DETAILED ASSESSMENT RESULTS

Clinical Preventive Services
 Ensure Access to Effective Vaccination Programs

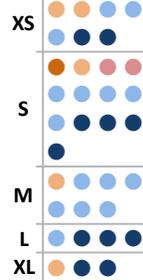
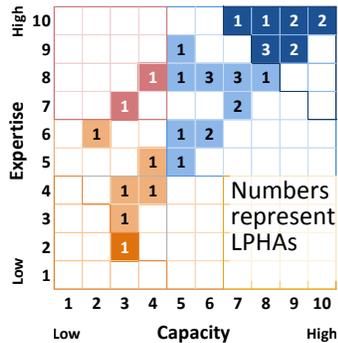


Note: Some roles or deliverables relating to quality standards or recommendations are not represented here. These results are omitted from the analysis due to lack of relevance.

DETAILED ASSESSMENT RESULTS

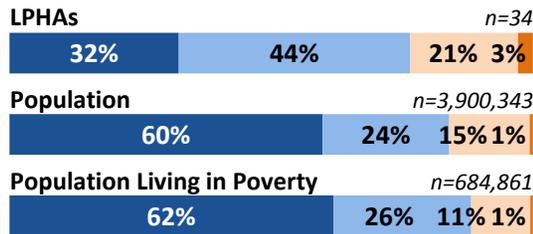
Clinical Preventive Services
 Ensure Access to Preventable Disease Screening Programs

LPHA IMPLEMENTATION



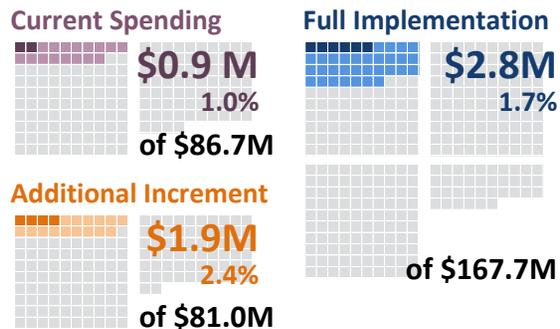
Numbers represent LPHAs

POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Program



CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 2:

Ensure Access to Effective Preventable Disease Screening Programs

This is another of the five functional areas that describes how local *Clinical Preventive Services* activities are operationalized. The activities in the *Ensure Access to Effective Preventable Disease Screening Programs* functional area include three roles. The functional area covers screening for preventable cancers and diseases, and improving access to clinical preventive services.

This functional area represents only 10% of current local *Clinical Preventive Services* activities, and the addition of 217% more funding (\$1.9M) would allow LPHAs to reach full implementation.

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

Taken together with this programmatic finding, the large amount of additional spending (217%) needed to reach full implementation suggests that the increase from partially implemented to significantly implemented has higher marginal

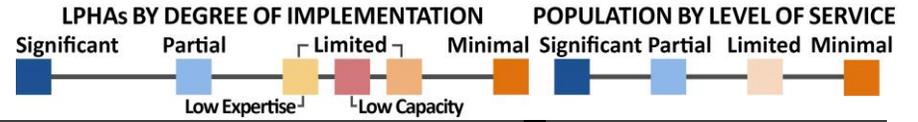
costs than the initial activities needed to reach partial implementation.

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 (59%) of those services are delivered such that there is a meaningful gap in service.

The degree of implementation across local providers and population by level of service of the single role in this functional area and the functional area overall are provided on the following page.

DETAILED ASSESSMENT RESULTS

Clinical Preventive Services
 Ensure Access to Preventable Disease Screening Programs



	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Ensure Access to Effective Preventable Disease Screening Programs	32%	44%	6%	15%	3%	60%	24%	15%
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.	9%	41%	12%	26%	12%	18%	23%	54%

Functional Area

Role

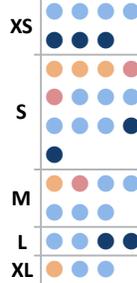
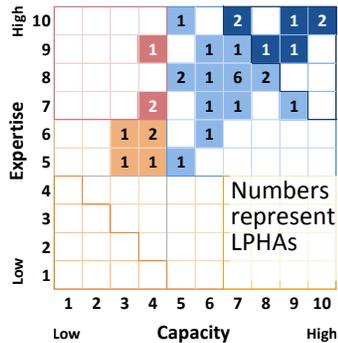
Low Expertise
 Low Capacity

Note: Some roles or deliverables relating to quality standards or recommendations are not represented here. These results are omitted from the analysis due to lack of relevance.

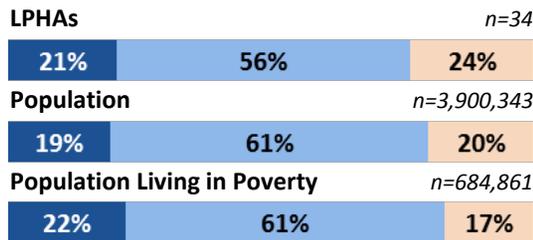
DETAILED ASSESSMENT RESULTS



LPHA IMPLEMENTATION

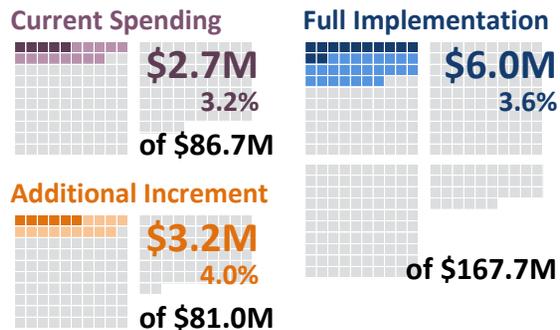


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Program



CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 3:

Ensure Access to Effective STD Screening Programs

This is another of the five functional areas that describes how local *Clinical Preventive Services* activities are operationalized. The activity in the **Ensure Access to Effective STD Screening Programs** functional area includes one role that is well implemented. The functional area covers screening for sexually transmitted infections and improving access to clinical preventive services.

This functional area represents 30% of current local *Clinical Preventive Services* activities, and the addition of 118% more funding (\$3.2M) would allow LPHAs to reach full implementation.

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 partially or significantly implemented these activities, while those that have partially implemented exist across size bands.

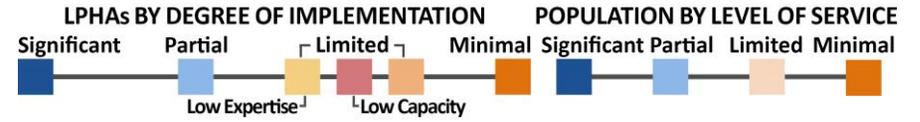
This degree of implementation is consistent from a population service perspective – a little over three-quarters (80%) of Oregon residents live in a service area where these activities are present. However, a significant proportion of those

services (over 70%) are delivered with a meaningful gap in service.

The degree of implementation across local providers and population by level of service for the one role in the functional area and the functional area overall are provided on the following page.

DETAILED ASSESSMENT RESULTS

Clinical Preventive Services
Ensure Access to Effective STD Screening Programs



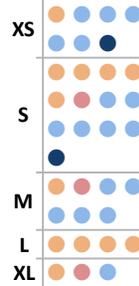
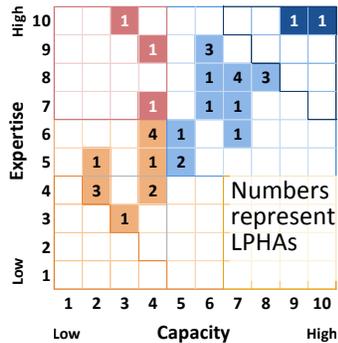
	Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Ensure Access to Effective STD Screening Programs		21%	56%	9%	15%	19%	61%		20%
Assure access to treatment for sexually transmitted infections either as a component of primary care or as specialty care.	Role	29%	44%	12%	15%	39%	23%		37%

Note: Some roles or deliverables relating to quality standards or recommendations are not represented here. These results are omitted from the analysis due to lack of relevance.

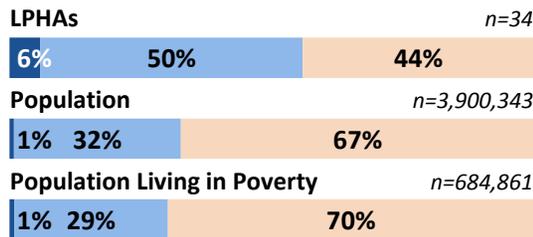
DETAILED ASSESSMENT RESULTS



LPHA IMPLEMENTATION

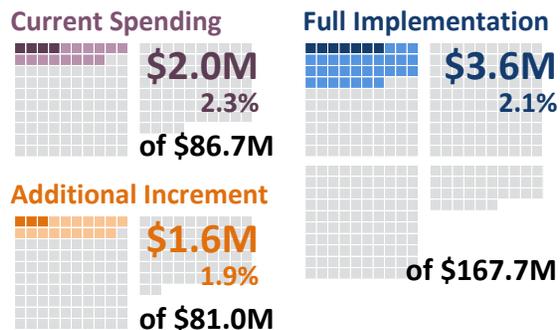


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Program



CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 4:

Ensure Access to Effective TB Treatment Programs

This is another of the five functional areas that describes how local *Clinical Preventive Services* activities are operationalized. The activities in the **Ensure Access to Effective TB Treatment Programs** functional area include 4 roles. The functional area covers evaluation and treatment of tuberculosis, investigating contacts, and improving access to these clinical preventive services.

This functional area represents 22% of current local *Clinical Preventive Services* activities, and the addition of 77% more funding (\$1.6M) would allow LPHAs to reach full implementation.

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 partially or significantly implemented these activities, while a little less than half have not. A concentration of limited implementation exists in the larger LPHAs.

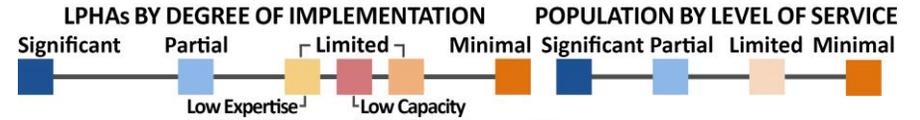
As expected due to the lower implementation in the larger LPHAs, there is a slightly lower implementation from a population service perspective. Approximately one-third (33%) of

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 degree of implementation of the 4 roles across local providers and population by level of service are provided on the following page.

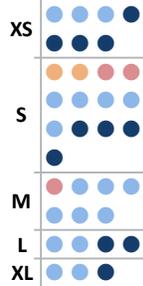
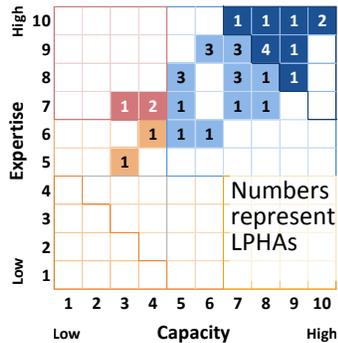
DETAILED ASSESSMENT RESULTS

Clinical Preventive Services
 Ensure Access to Effective TB Treatment Programs

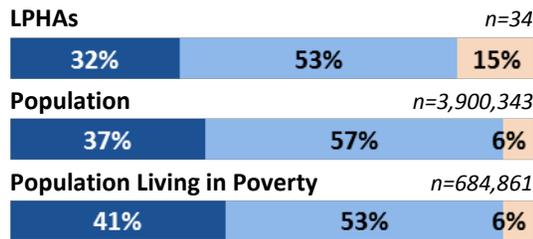


		Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal		
Ensure Access to Effective TB Treatment Programs	Functional Area	6%	50%	9%	35%	1%	32%	67%			
Investigate contacts, including testing and treatment.	Role	32%	50%	6%	9%	3%	32%	34%	33%		
Ensure diagnosis and treatment of those with latent TB infection (including contacts of people with TB, new immigrants, other high-risk populations).	Role	24%	56%	6%	15%		26%	38%	36%		
Ensure that TB cases are diagnosed and treated using directly observed therapy.	Role	24%	53%	6%	18%		26%	29%	45%		
Submit data on TB cases, contacts and new immigrants ("B waiver").	Role	15%	47%	3%	9%	21%	6%	14%	32%	52%	1%

LPHA IMPLEMENTATION

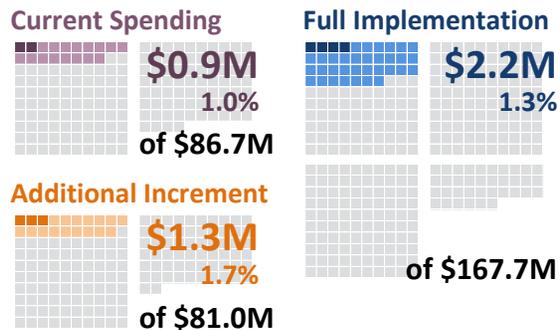


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Program



PREVENTIVE SERVICES FUNCTIONAL AREA 5:

Ensure Access to Cost Effective Clinical Care

This is another of the five functional areas that describes how local *Clinical Preventive Services* activities are operationalized. The activities in the **Ensure Access to Cost Effective Clinical Care** functional area include 8 roles and 7 deliverables. The functional area covers working 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.

This functional area represents just 10% of current local *Clinical Preventive Services* activities, and the addition of 157% more funding (\$1.3M) would allow LPHAs to reach full implementation.

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 limited implementation are small LPHAs. Approximately 38% of LPHAs have significantly implemented this functional area. Despite the high implementation, there is still an anticipated increase in costs of over 157% indicating a higher marginal cost for all LPHAs to reach full implementation.

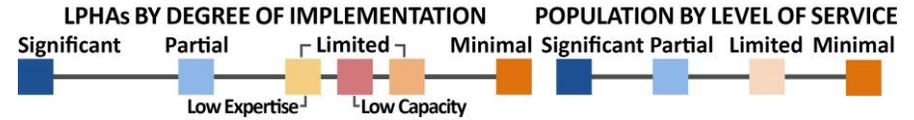
This degree of implementation is consistent from a population service perspective – approximately 94% of Oregon residents live in a service area where these activities are present (however, 62% of those services are delivered such that there is a meaningful gap in service).

The degree of implementation of the 8 roles and 7 deliverables across local providers and population by level of service are provided on the following page.

DETAILED ASSESSMENT RESULTS

Clinical Preventive Services

Ensure Access to Cost Effective Clinical Care



Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Ensure Access to Cost Effective Clinical Care	32%	53%	9%	6%	37%	57%	6%	0%
Engage with regional stakeholders to identify and address barriers to access to clinical preventive care.	6%	59%	6%	24%	6%	1%	62%	35%
Provide information to the health care delivery system about the leading causes of death and disability in Oregon and evidence-based clinical interventions to address	12%	44%	9%	24%	12%	15%	45%	34%
Share data and information about regional access to clinical preventive services with the community, the health care system, policy makers, and other partners and	15%	35%	18%	26%	6%	24%	29%	44%
Collaborate with OHA to identify regional barriers and potential solutions to clinical preventive services.	6%	35%	3%	12%	41%	6%	1%	52%
Provide guidance and best practices related to the provision of clinical preventive services to local organizations, including those that serve community members with	6%	50%	12%	24%	9%	1%	51%	41%
Create and support local policies that increase access to evidence-based, high quality and effective clinical health services.	6%	41%	15%	24%	15%	1%	46%	35%
Support policy solutions that increase access to culturally competent clinical preventive services.	12%	38%	12%	29%	9%	2%	39%	51%
Evaluate the impact of local policies, activities and programs on access to clinical preventive services.	3%	38%	9%	38%	12%	1%	38%	58%
Document compliance with state and federal laws.	26%	59%	3%	6%	6%	32%	42%	25%
Plan for improved access to clinical preventive services, particularly for vulnerable populations.	15%	35%	9%	29%	12%	25%	33%	38%
Document meetings with partners to recommend strategies for improving access to clinical preventive services.	18%	32%	15%	29%	6%	25%	29%	46%
Document implementation of these plans.	15%	21%	12%	38%	15%	17%	30%	48%
Provide resources for clinical and community partners on evidence-based guidelines for the delivery of clinical preventive services.	9%	29%	15%	32%	15%	1%	33%	57%
Produce evaluations of policies implemented to improve access to clinical preventive services.	9%	21%	9%	29%	32%	16%	16%	51%
Produce jurisdictional reports on access to clinical preventive services.	6%	12%	15%	44%	24%	9%	5%	77%

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.

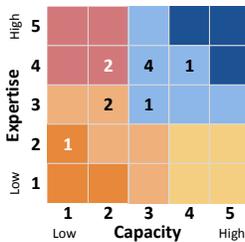
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

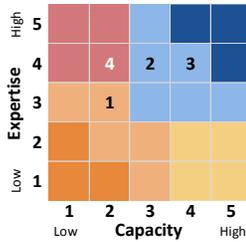
Partially Implemented



ROLES



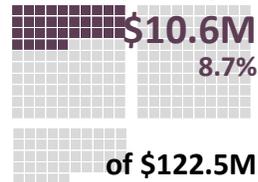
DELIVERABLES



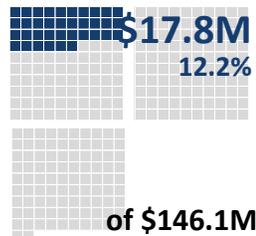
RESOURCES

Each Square Equals \$500,000

Current Spending



Full Implementation



Additional Increment



Considering the *Assessment and Epidemiology* and State Public Laboratory activities separately, PHD’s *Assessment and Epidemiology* activities include 11 roles and 10 deliverables. These activities include maintenance of information and statewide public health surveillance systems; collaboration with and technical assistance for LPHAs; statewide capacity to support identification, analysis, and response to disease exposures, outbreaks, and epidemics; statewide survey and data collection; and completion of a statewide health assessment every five years to identify population health priorities.

PHD’s self-assessment shows it considers this capability to be partially implemented. However, PHD also identified that 48% of the roles and deliverables that represent *Assessment and Epidemiology* state activities are limitedly 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:

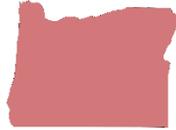
- data collected in statewide data collection systems. (Partially implemented.)
- Maintain information and statewide public health surveillance systems. (Partially implemented.)
- Provide state-level public health informatics capability. (Minimally implemented.)

- Ensure collaboration between state and local public health authorities when conducting assessment and epidemiological efforts. (Partially implemented.)
- Provide technical assistance to local public health authorities, and ensure access to local

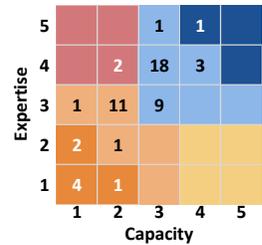
STATE PUBLIC HEALTH LABORATORY

LEVEL OF IMPLEMENTATION

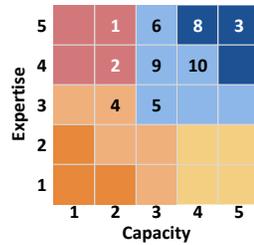
Limitedly Implemented, Low Capacity



CORE FUNCTIONS



DELIVERABLES



RESOURCES

PHD estimated the current level of spending and full implementation resources needed to support the State Public Health Laboratory as part of the Assessment and Epidemiology capability.

PHD’s *State Public Health Laboratory* activities include 54 core system functions and 48 deliverables. These activities include:

- Act as the conduit for scientific data and information in support of public health programs, and use expertise, references, and resources in the areas of biological, chemical, and radiologic issues of public health importance to support other laboratories’ activities.
- Collaborate in detection, monitoring, and response to food safety issues, and promote quality improvement for partner laboratories through training, consultation, and proficiency testing.
- Provide expertise and/or scientific evidence to support policy development, emergency preparedness and response, public health research, training and education, and partnerships and communication.

implementation of core system functions in environmental health and protection.

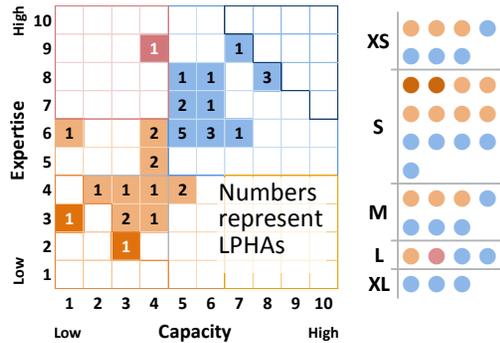
While the State Public Health Laboratory has a vital role in the statewide public health system, none of the local *Assessment and Epidemiology* activities are directly reliant on the State Public Health Laboratory.

PHD’s self-assessment shows that the public health authority considers this program to be limitedly implemented due to a lack of capacity. However, PHD also reported that 60% of the roles are either partially or significantly implemented.

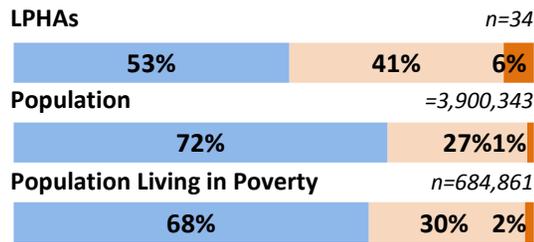
Generally, PHD’s self-assessment showed the highest implementation in food safety; reference and specialized testing; and training and education. PHD reported the lowest

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

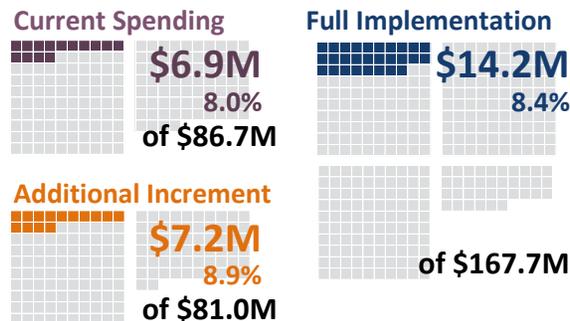


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000



LPHAs' *Assessment and Epidemiology* activities vary widely and include:

- Support collaboration with PHD in assessment and epidemiological efforts.
- Identify and lead outbreak investigations that initiate or primarily occur in their local service area, and participate in those that cross multiple service areas.
- Collect and analyze data to assess population health needs and priorities, including the disproportionate impacts on some communities.

Assessment and Epidemiology is a relatively less-implemented capability, with a little over half of LPHAs reporting partial implementation and no LPHAs reporting significant implementation. This capability is particularly data-intensive, and data availability and access issues were themes that emerged from LPHA self-assessment comments. Substantial funds (\$7.2M) are needed to reach significant implementation.

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

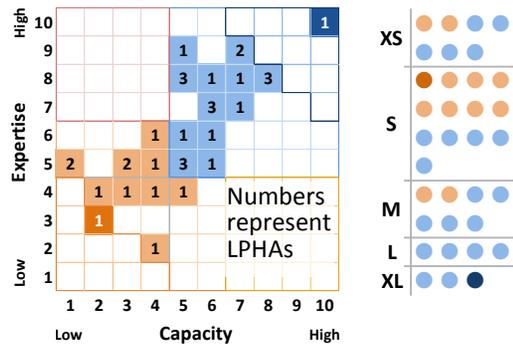
- Data Collection and Electronic Information Systems.** This functional area represents 40% of current local *Assessment and Epidemiology* spending; under full implementation, spending would increase over 50%, but resource allocation would

rebalance the functional areas and it would decrease in share of total spending to 30%.

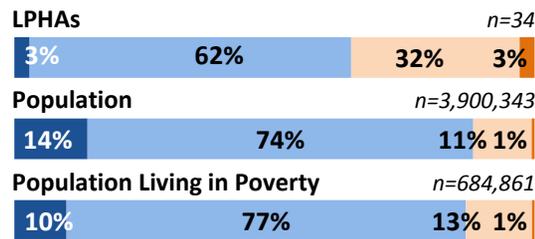
- Data Access, Analysis, and Use.** This area represents 19% of current local *Assessment and Epidemiology* spending and will need an additional 100% of current spending to reach full implementation.
- Respond to Data Requests and Translate Data for Intended Audiences.** This area represents 11% of current local *Assessment and Epidemiology* spending. LPHAs estimate full implementation would require a spending increase of 117%.
- Conduct and Use Basic Community and Statewide Health Assessments.** The smallest spending area under significant implementation, this functional area is also the least available to Oregon residents within *Assessment and Epidemiology*.
- 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.

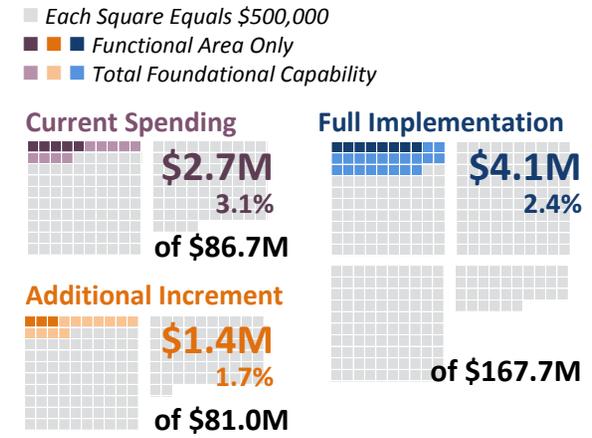
LPHA IMPLEMENTATION



POPULATION BY LEVEL OF SERVICE



RESOURCES



ASSESSMENT AND EPIDEMIOLOGY
FUNCTIONAL AREA 1:

Data Collection and Electronic Information Systems

This is one of five functional areas that describes how *Assessment and Epidemiology* activities are operationalized. Activities within this functional area support the 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.

This functional area represents almost 40% of current *Assessment and Epidemiology* Public Health Modernization spending, and an increment of 53% or \$1.4M is needed to reach significant implementation, although this functional area will remain the largest area of spending.

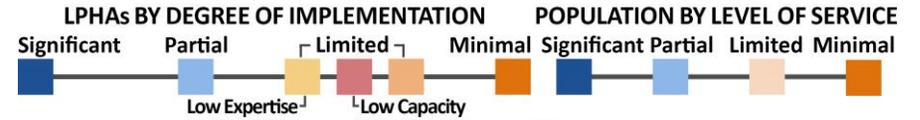
Reflecting the relatively small increase in resources needed for significant implementation, the LPHAs rated this functional area as the most implemented within *Assessment and Epidemiology*, both from the count of providers and the percent of population living in areas with partial or significant implementation.

The activities in the *Data Collection and Electronic Information Systems* functional area include 4 roles and 0 deliverables.

The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon’s population is provided on the following page.

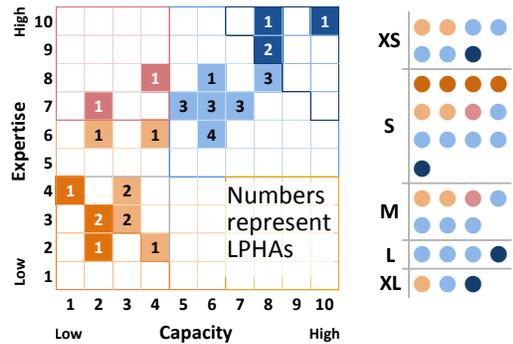
DETAILED ASSESSMENT RESULTS

Assessment and Epidemiology
Data Collection and Electronic Information Systems

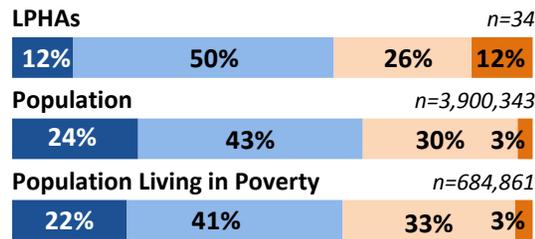


Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Data Collection and Electronic Information Systems	3%	62%	32%	3%	14%	74%	11%	1%	
Access statewide information and surveillance systems and report into these systems in a timely manner.	26%	62%	3%	9%	31%	49%	21%		
Use applied research and evaluation techniques to assure that interventions meet the needs of the community to be served.	12%	35%	41%	12%	17%	47%	30%	6%	
Evaluate the efficacy of public health policies, strategies and interventions.	3%	26%	9%	32%	29%	1%	50%	34%	15%
Provide local public health informatics capability, or access statewide capability.	9%	38%	9%	26%	18%	1%	45%	31%	22%

LPHA IMPLEMENTATION

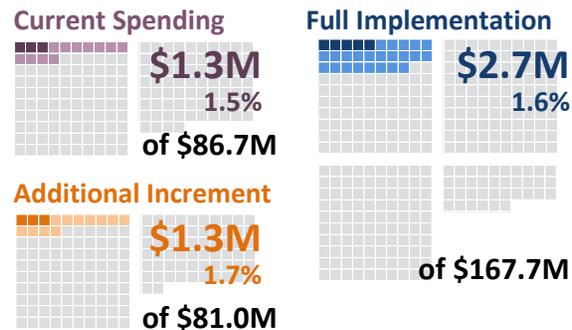


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 2:

Data Access, Analysis, and Use

Data Access, Analysis, and Use is the second of five functional areas that describes how *Assessment and Epidemiology* activities are operationalized. This functional area supports the processing of data from a variety of sources in a manner that is accurate, timely, statistically valid, actionable, usable, and meaningful to the requester.

This functional area represents 19% of LPHA Public Health Modernization spending in the *Assessment and Epidemiology* capability. Doubling the current spending (an additional \$1.3M) would be needed to allow LPHAs to reach significant implementation.

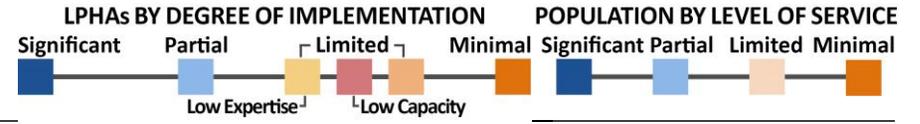
Over 60% of LPHAs rated themselves as having limited or partial implementation of the two activities required in this functional area. There are no clear patterns in the implementation levels across population size categories, nor is implementation strongly connected to the percentage of population living at or below the Federal Poverty Level.

The activities in *Data Access, Analysis, and Use* have 1 role and 1 deliverable. The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across

Oregon’s population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Assessment and Epidemiology
Data Access, Analysis, and Use

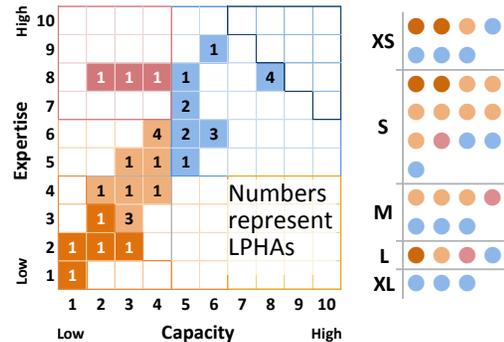


Functional Area	Role	Deliverable	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Data Access, Analysis, and Use			12%	50%	6%	21%	12%	24%	43%	30%	3%
Collect, process and analyze data to assess population health priorities, patterns and needs in the local authority.			9%	41%	12%	29%	9%	26%	24%	48%	2%
Collect, maintain, analyze and report on vital records.			18%	44%	3%	26%	9%	35%	46%	18%	1%

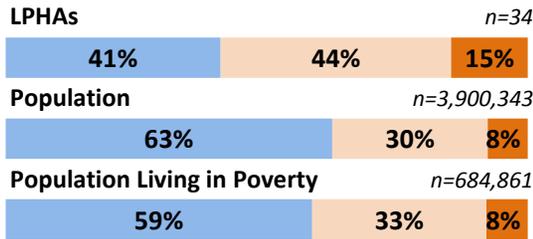
DETAILED ASSESSMENT RESULTS

Assessment and Epidemiology
Respond to Data Requests and Translate Data for Intended Audiences

LPHA IMPLEMENTATION

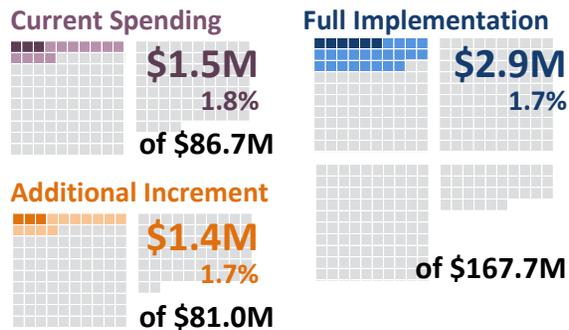


POPULATION BY LEVEL OF SERVICE LPHAs



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



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 third of five functional areas that describes how local *Assessment and Epidemiology* activities are operationalized. Activities in this functional area include prioritizing and responding to requests for data, information, and reporting; and communicating the response in a manner that is accurate, statistically valid, and usable by the requester.

This functional area represents the second largest spending area at 22% of current local *Assessment and Epidemiology*. An increase of 88% or \$1.4M would be needed for LPHAs to reach full implementation.

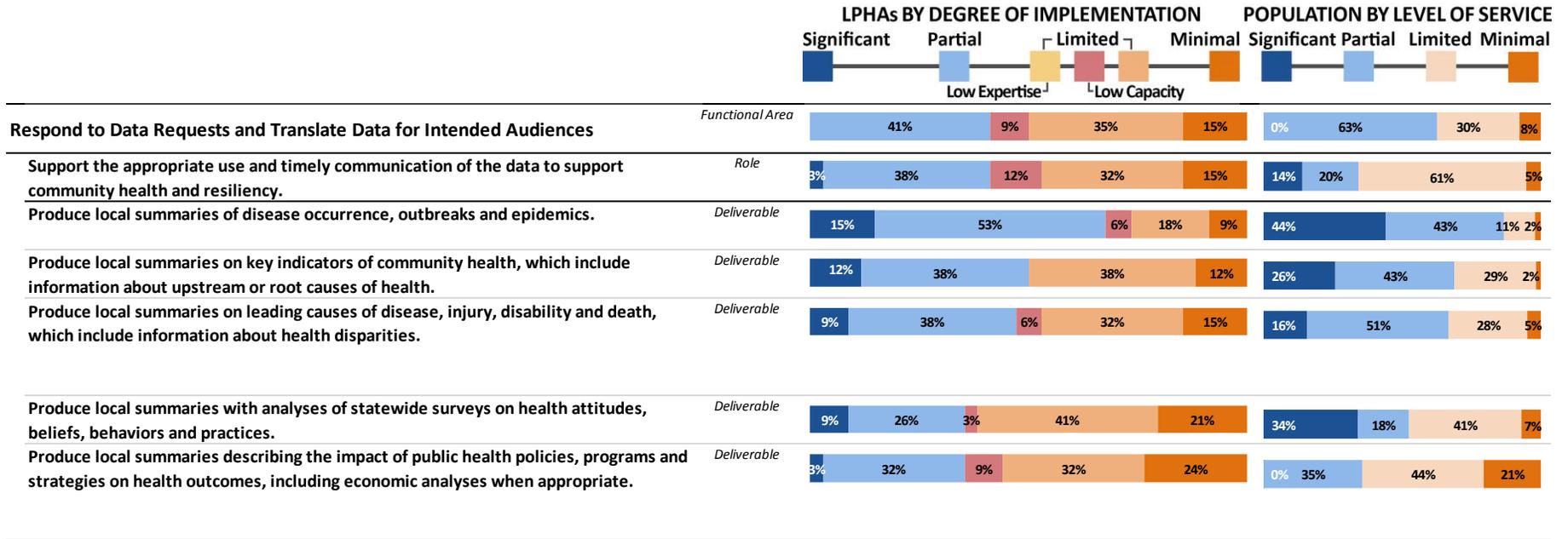
Currently, the degree of implementation of this functional area is varied across all size bands, except for the three most populous jurisdictions, which all reported partial implementation.

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 partial or significant implementation.

The activities in the *Respond to Data Requests and Translate Data for Intended Audiences* functional area include 1 role and 5 deliverables. The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

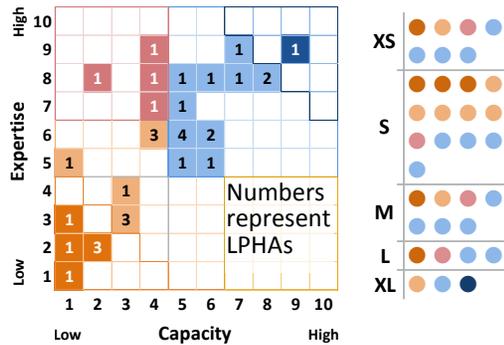
Assessment and Epidemiology
 Respond to Data Requests and Translate Data for Intended Audiences



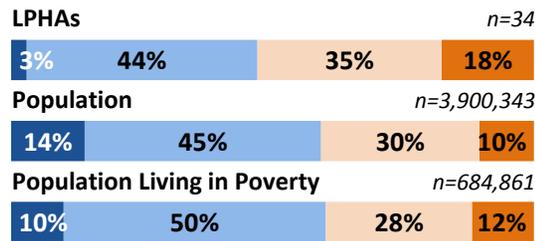
DETAILED ASSESSMENT RESULTS

Assessment and Epidemiology
 Conduct and Use Basic Community and Statewide Health Assessments

LPHA IMPLEMENTATION

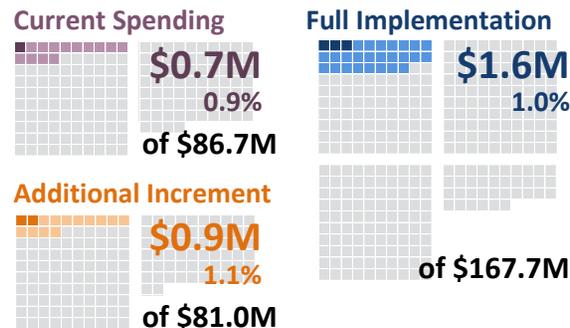


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 4:

Conduct and Use Basic Community and Statewide Health Assessments

Conduct and Use Basic Community and Statewide Health Assessments is the fourth of five functional areas that describes how *Assessment and Epidemiology* activities are operationalized. This functional area represents LPHAs' ability to conduct a basic community health assessment or participate in a statewide health assessment, and identify health priorities arising from that assessment, including analysis of health disparities.

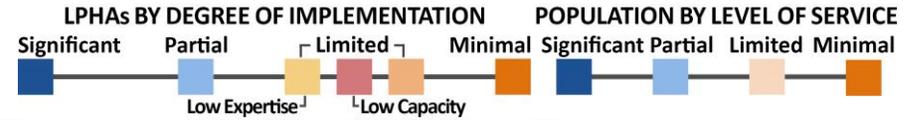
The smallest spending area under significant implementation, this functional area is also the least available to the residents of Oregon within *Assessment and Epidemiology*, representing less than 10% of current local *Assessment and Epidemiology* spending. LPHAs estimate that an additional 117% of current spending or \$0.9M 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 partial or significant 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* foundational capability.

The activities in the *Conduct and Use Basic Community and Statewide Health Assessments* functional area include 2 roles and 2 deliverables. The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Assessment and Epidemiology
 Conduct and Use Basic Community and Statewide Health Assessments

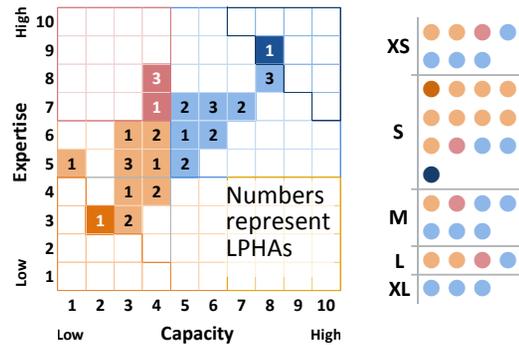


Functional Area	Role	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Conduct and Use Basic Community and Statewide Health Assessments	Functional Area	3%	44%	12%	24%	18%	14%	45%	30%	10%
Ensure collaboration between state and local public health authorities when conducting assessment and epidemiological efforts.	Role	12%	62%	6%	21%	21%	60%	19%		
Conduct a community health assessment and identify priorities arising from that assessment.	Role	18%	50%	29%	3%	27%	49%	22%	1%	
Community health assessment conducted at least every five years.	Deliverable	26%	62%	3%	9%	38%	57%	5%		
Local data used to inform annual updates on community health improvement plan.	Deliverable	24%	44%	9%	24%	28%	38%	34%		

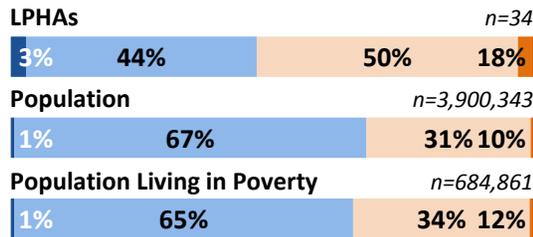
DETAILED ASSESSMENT RESULTS



LPHA IMPLEMENTATION

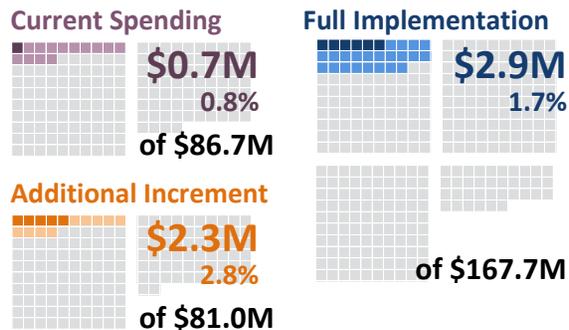


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 5:

Infectious Disease-Related Assessment

Infectious Disease-Related Assessment is the fifth of five functional areas that describes how local *Assessment and Epidemiology* activities are operationalized. This functional area includes: identification and response to disease outbreaks and epidemics; analysis and response to information related to disease outbreaks and epidemics; and maintaining the capacity and staff to provide laboratory services, including diagnostic and screening tests, and to follow protocols established by PHD.

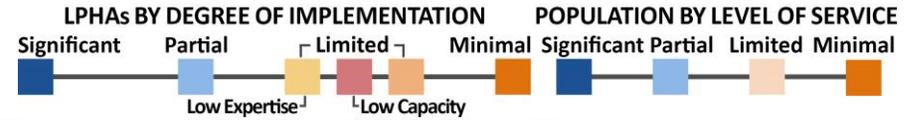
This functional area represents 10% of current LPHA spending in Public Health Modernization *Assessment and Epidemiology* activities and it is the functional area with the greatest resource increase within this capability, with an estimated 347% increase from current spending or \$2.3M required for LPHAs to reach significant implementation.

Most LPHAs rated themselves at a limited or partial level of implementation of the required activities, with only one reporting minimal implementation and one reporting significant implementation. Over two-thirds of Oregon residents live in a service area where these activities are at least limitedly implemented.

The activities included in the *Infectious Disease-Related Assessment* functional area include 3 roles and 1 deliverable. The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Assessment and Epidemiology
Infectious Disease-Related Assessment



Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Infectious Disease-Related Assessment	3%	44%	12%	38%	3%	1%	67%	31%	1%
Promptly identify and lead outbreak investigations that initiate or primarily occur in the local authority. Actively participate in outbreak investigations that cross multiple authorities.	21%	65%	12%	3%	54%	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.	12%	65%	24%		25%	66%	9%		
Ensure local public health capacity to respond to emerging threats to health by maintaining flexibility related to staffing and information systems.	12%	44%	18%	24%	3%	11%	69%	18%	2%
Capacity to interact with the State Public Health Lab on a 24/7 basis.	38%	44%	12%	6%	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.

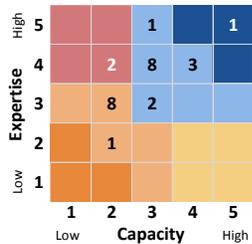
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

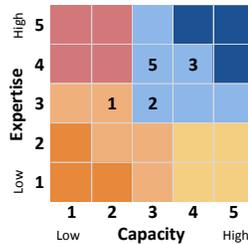
Partially Implemented



ROLES



DELIVERABLES



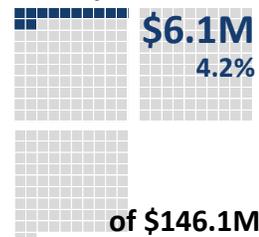
RESOURCES

Each Square Equals \$500,000

Current Spending



Full Implementation



Additional Increment



PHD's *Emergency Preparedness and Response* activities include 26 roles and 11 deliverables. These activities support maintaining and executing a continuity of operations plan; leading and coordinating governmental public health authority recovery planning, training, and exercises; and providing leadership and specific services in the event of an emergency (like issuing and enforcing health orders).

PHD's self-assessment shows that it considers this capability to be partially implemented. However, PHD also notes that the majority of the roles and deliverables that represent *Emergency Preparedness and Response* state activities have only limited implementation. In fact, 11 of the 26 roles and 1 of 11 deliverables are only limitedly implemented.

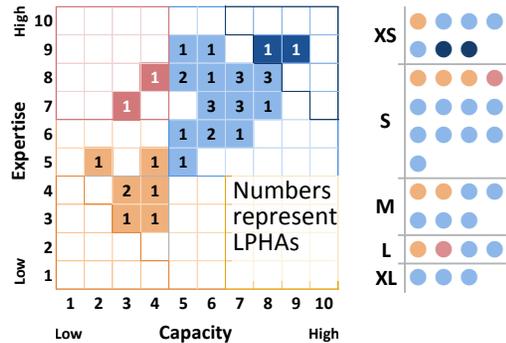
A few of the less implemented roles and deliverables are state activities that indirectly support the provision of local *Emergency Preparedness and Response* activities, for instance by preparing the community or developing partnership networks that can be leveraged by LPHAs. These activities include:

- 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. (Limitedly implemented.)

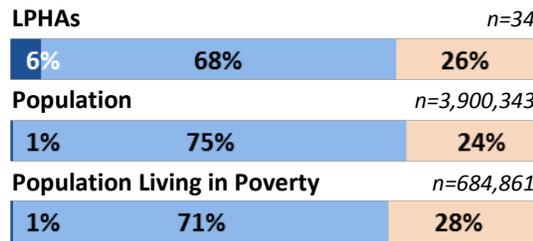
- Promote community preparedness by communicating with the public in advance of an emergency, engaging vulnerable populations proactively, and including steps that can be taken before, during, or after an emergency. (Limitedly implemented.)
- Maintain public health preparedness plans in accordance with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

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

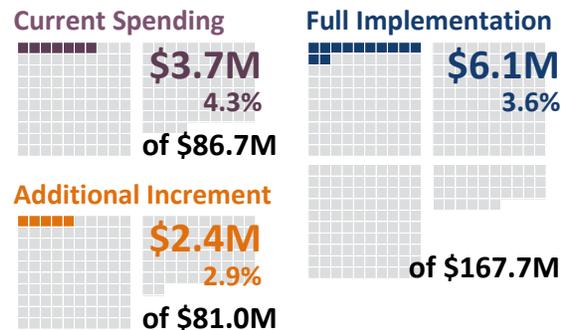


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000



LPHAs' *Emergency Preparedness and Response* activities support maintaining and executing a continuity of operations plan; participating in recovery planning, training, and exercises; and providing specific services (like maintaining pharmaceutical access) in the event of an emergency.

Emergency Preparedness and Response is relatively well-implemented, with 25 (out of 34) LPHAs documenting partial or significant implementation. However, significant funds (\$2.4M) are needed to reach full implementation.

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 significant 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 significant 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 significant implementation.

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

The functional area *Coordinate and Communicate Before and During an Emergency* is better implemented than *Prepare for Emergencies* and *Respond to Emergencies*.

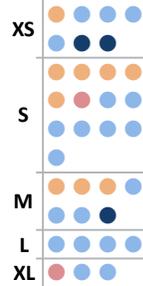
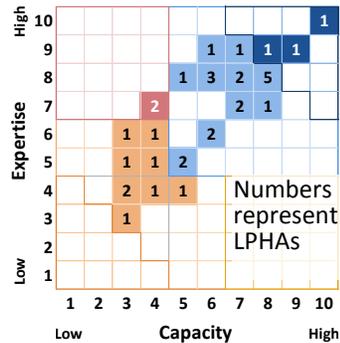
- 68% of Oregon's LPHAs have partially or significantly implemented the *Prepare for Emergencies* functional area, serving 68% of Oregon's population.
- 68% of Oregon's LPHAs have partially or significantly implemented the *Respond to Emergencies* functional area, serving 62% of Oregon's population.
- 77% of Oregon's LPHAs have partially or significantly implemented *Coordinate and Communicate Before and During an Emergency* functional area, serving 77% of Oregon's population.

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

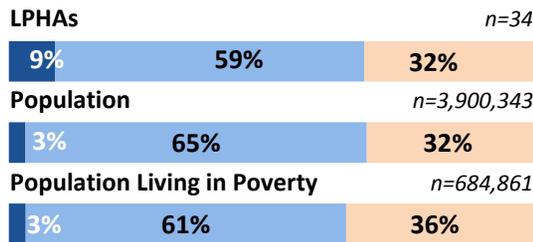
DETAILED ASSESSMENT RESULTS

Emergency Preparedness and Response
Prepare for Emergencies

LPHA IMPLEMENTATION

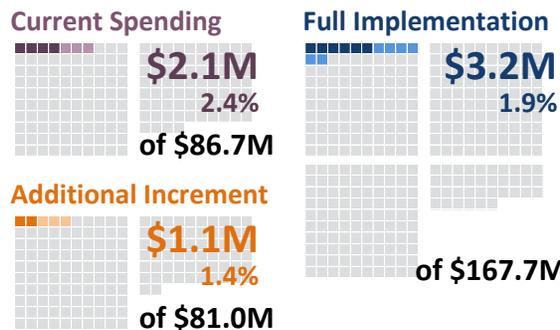


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



EMERGENCY PREPAREDNESS AND RESPONSE FUNCTIONAL AREA 1:

Prepare for Emergencies

This is one of three functional areas that describes how local *Emergency Preparedness and Response* activities are operationalized. The activities in the **Prepare for Emergencies** functional area include 8 roles and 5 deliverables.

This functional area represents over half of current local *Emergency Preparedness and Response* activities, and the addition of 55% more funding (\$1.1M) would allow LPHAs to reach full implementation.

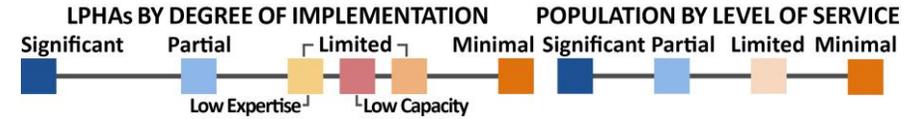
The degree of implementation of this functional area varies across the system. There is no clear pattern as to which LPHAs are at each level of implementation. 23 of 34 providers (68%) have partially or significantly implemented these activities.

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 degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Emergency Preparedness and Response Prepare for Emergencies

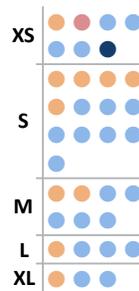
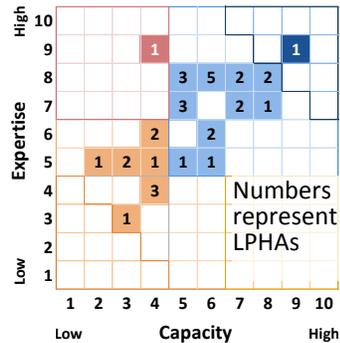


Functional Area	Role	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Prepare for Emergencies		9%	59%	6%	26%	3%	65%	32%		
Conduct jurisdictional assessment of risk, resources, and priority of public health preparedness capabilities.	Role	15%	68%	3%	15%	3%	87%	6%	2%	
Maintain continuity of operations plan for the authority.	Role	9%	74%	15%	3%	85%	13%			
Maintain public health preparedness plans in accordance with the 15 core public health capabilities (1) 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.	Role	12%	65%	3%	21%	3%	81%	15%	0%	
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.).	Role	9%	68%	21%	3%	3%	81%	15%		
Maintain public health surveillance and response plans inclusive of disaster epidemiology and an active epidemiological surveillance plan.	Role	12%	68%	21%		15%	53%	32%		
Maintain public health surveillance and response plans inclusive of disaster epidemiology and an active epidemiological surveillance plan. (9)	Role	6%	53%	3%	29%	9%	3%	59%	33%	5%
Develop public health short term and long term goals for recovery operations.	Role	3%	56%	3%	21%	18%	0%	45%	49%	6%
Maintain pharmaceutical access.	Role	3%	38%	6%	32%	21%	0%	43%	48%	9%
Prepare public health emergency preparedness plans in accordance with established guidelines.	Deliverable	21%	68%	3%	9%		21%	75%	4%	
Document emergency preparedness exercises.	Deliverable	32%	56%	3%	9%		35%	61%	5%	
Produce continuity of operations plan for the local health authority.	Deliverable	12%	71%	3%	15%		5%	88%	6%	
Plan emergency preparedness exercise.	Deliverable	21%	62%	18%			7%	81%	12%	
Plan for the distribution of pharmaceuticals in the event of an emergency.	Deliverable	9%	56%	6%	21%	9%	1%	72%	23%	4%

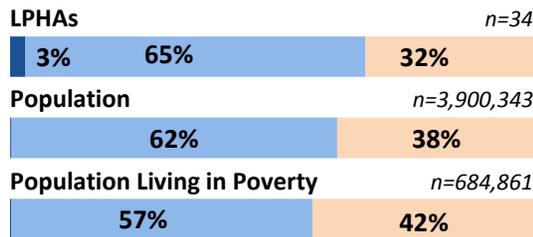
DETAILED ASSESSMENT RESULTS

Emergency Preparedness and Response
Emergency Communications

LPHA IMPLEMENTATION

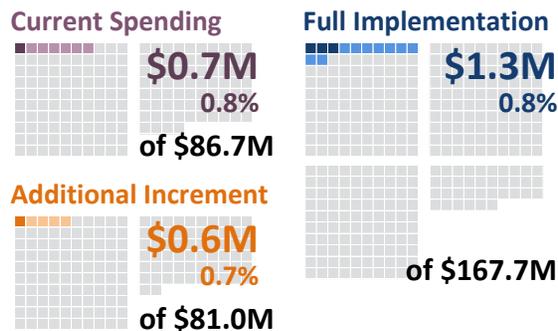


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



EMERGENCY PREPAREDNESS AND RESPONSE FUNCTIONAL AREA 2:

Respond To Emergencies

This is the second of three functional areas that describes how local *Emergency Preparedness and Response* activities are operationalized. The activities included in the **Respond to Emergencies** functional area include 1 role and 4 deliverables.

This functional area represents one-fifth of current local *Emergency Preparedness and Response* activities, and the addition of 77% more funding (\$0.6M) would allow LPHAs to reach significant 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 partially or significantly implemented.

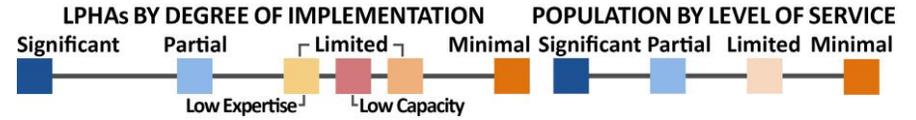
Population service is a bit lower, with only 62% of residents living in a service area where these activities are present. However, almost all of those services are delivered such that there is a meaningful gap in service.

This is one area with a difference between degree of service for the overall population and the population living in poverty. 62% percent of the population is currently served by an LPHA that is partially or significantly implemented, compared to 57% of those living in poverty.

The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Emergency Preparedness and Response
Emergency Communications

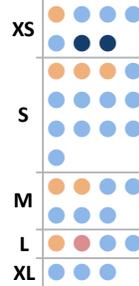
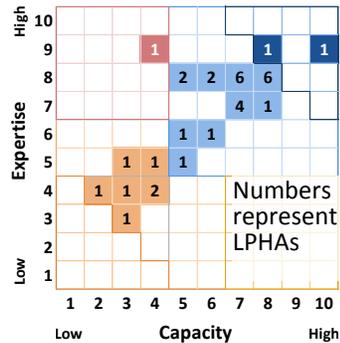


Functional Area	Role	Deliverable	Deliverable	Deliverable	Deliverable
Respond to Emergencies					
	Provide efficient and appropriate situation assessment, determine objectives to address the health needs of those affected, allocating resources to address those needs, and return to routine operations.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

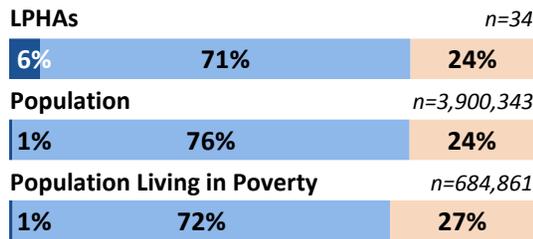
DETAILED ASSESSMENT RESULTS

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

LPHA IMPLEMENTATION

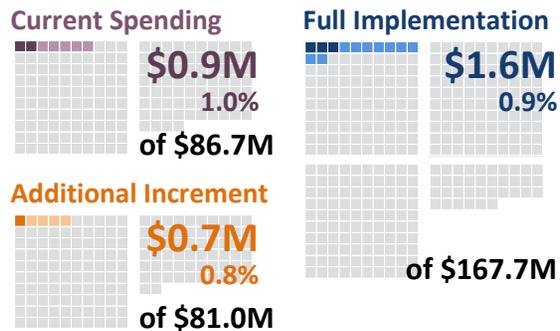


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



EMERGENCY PREPAREDNESS AND RESPONSE FUNCTIONAL AREA 3:

Coordinate and Communicate Before and During an Emergency

This is the final of three functional areas that describes how local *Emergency Preparedness and Response* activities are operationalized. The activities included in the **Coordinate and Communicate Before and During an Emergency** functional area include 1 role and 2 deliverables.

This functional area represents nearly one-fourth of current local *Emergency Preparedness and Response* activities, and the addition of 76% more funding (\$0.7M) would allow LPHAs to reach significant implementation.

Currently, three-quarters of providers have partially or significantly 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 significantly implemented this functional area are both extra small. It is likely that they are able to consider this area significantly 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.

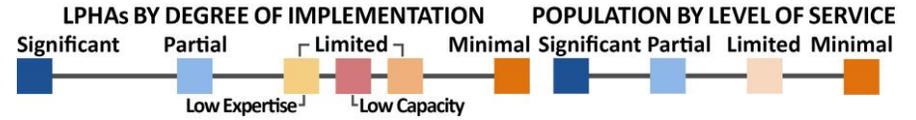
This degree of implementation is consistent from a population service perspective – a little over three-quarters (77%) of Oregon residents

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 degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon’s population is provided on the following page.

DETAILED ASSESSMENT RESULTS

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



		Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Coordinate and Communicate Before and During an Emergency	<i>Functional Area</i>	6%	71%	3%	21%	1%	76%	24%	
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.	<i>Role</i>	9%	65%	18%	9%	2%	79%	10%	9%
Deliver health alerts and preparedness communications to partners and the general public.	<i>Deliverable</i>	32%	50%	3%	12%	3%	24%	62%	13%
Maintain a portfolio of community partnerships to support preparedness and recovery efforts.	<i>Deliverable</i>	24%	50%	3%	21%	3%	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.

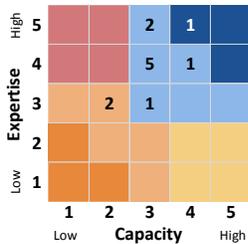
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

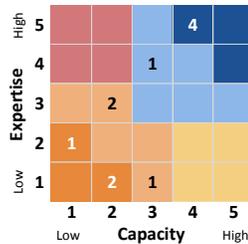
Partially Implemented



ROLES

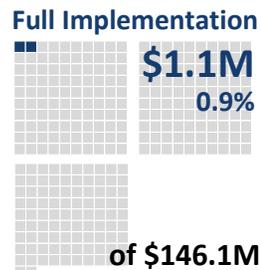
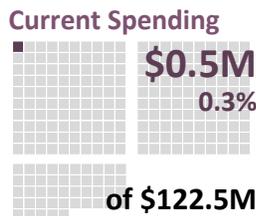


DELIVERABLES



RESOURCES

Each Square Equals \$500,000



PHD's *Communications* activities include 12 roles and 11 deliverables. These activities include development and use of a strategic communications plan; development and dissemination of communications products in accordance with that plan; evaluation of the effectiveness of statewide communication efforts; and support for and coordination of communications among LPHAs and between governmental public health authorities and the general public.

The results of PHD's self-assessment show it considers this program significantly implemented. PHD also notes that over half of its deliverables in this area are partially or significantly implemented. Some of the better implemented roles and deliverables include communicating with the public through news releases and a public-facing website, and maintaining two-way communication with local public health authorities.

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.

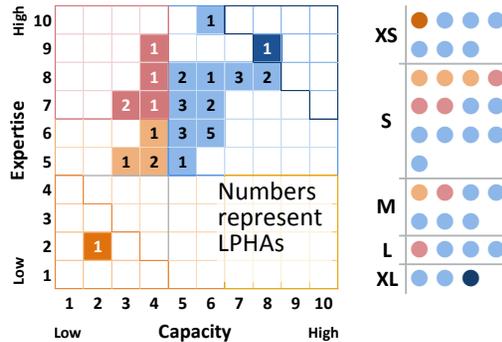
Several of the state *Communications* roles and deliverables support local services; all of these

are at least partially implemented. While it is likely that further implementation would continue to support local *Communications* activities, it is not likely that the degree of implementation of these service dependencies is creating a barrier to local implementation.

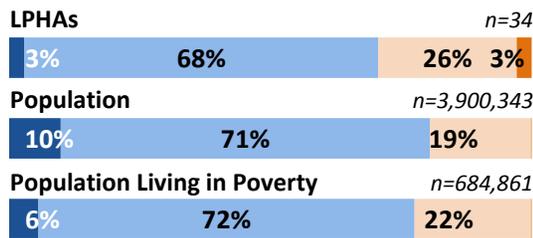
Additionally, it is likely that the state's ability to complete its own activities related to *Communications* are critical to alignment of communications throughout the system, and that implementation of the strategic communications plan would support LPHAs in their *Communications* activities.

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

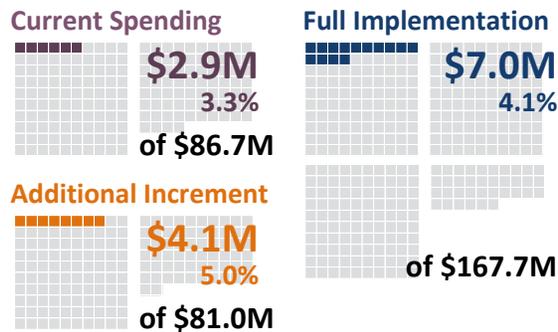


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000



LPHAs' **Communications** activities include the development of a local strategic communications plan; development and dissemination of communications products for local audiences in accordance with that plan; evaluation of the effectiveness of their communication efforts; and engagement with PHD in the event of a significant public health risk.

Programmatically, this foundational program is relatively well-implemented, with 24 (out of 34) LPHAs (serving 81% of the population overall) reporting partial or significant implementation.

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

Local **Communications** activities are broken down into three functional areas:

1. Regular Communications. This functional area represents 44% of current local **Communications** activities; this share would decrease to 41% at full implementation.

- 2. Emergency Communications.** This represents 12% of current local **Communications** activities and will remain the smallest (23%) share of local activities in this foundational capability at full implementation.
- 3. Educational Communications.** This represents 44% of current local **Communications** activities. This share is expected to decrease to 36% at full implementation.

The functional area **Emergency Communications** is the most implemented of the three:

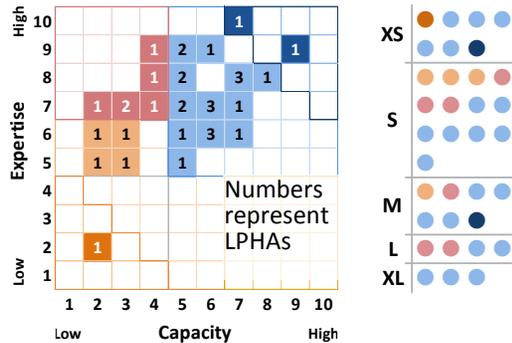
- 68% of Oregon's LPHAs have partially implemented the **Regular Communications** functional area, serving 78% of Oregon's population.
- 62% of Oregon's LPHAs have partially or significantly implemented the **Emergency Communications** functional area, serving 73% of Oregon's population.
- 83% of Oregon's LPHAs have partially or significantly implemented the **Educational Communications** functional area, serving 87% of Oregon's population.

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

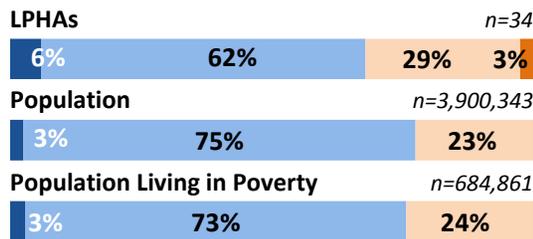
DETAILED ASSESSMENT RESULTS

Regular Communications

LPHA IMPLEMENTATION

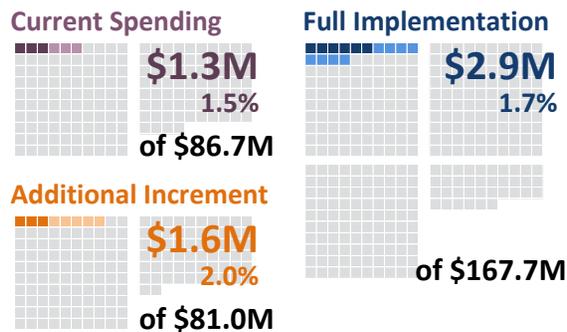


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



COMMUNICATIONS FUNCTIONAL AREA 1:

Regular Communications

This is one of three functional areas that describe how local *Communications* activities are operationalized. The activities in the **Regular Communications** functional area include 5 roles and 9 deliverables. This functional area includes developing and implementing a strategic communication plan, evaluating the effectiveness of those efforts, and adjusting communication strategies accordingly.

This functional area represents 44% of current *Communications* activities, and the addition of 124% more funding (\$1.6M) would allow the LPHAs to reach significant implementation.

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

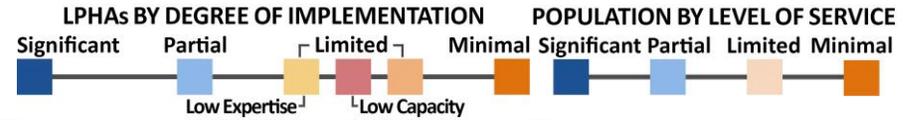
The system implementation and population service perspectives are relatively balanced in this functional area.

The degree of implementation of these roles and deliverables across LPHAs as well as the level of

service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

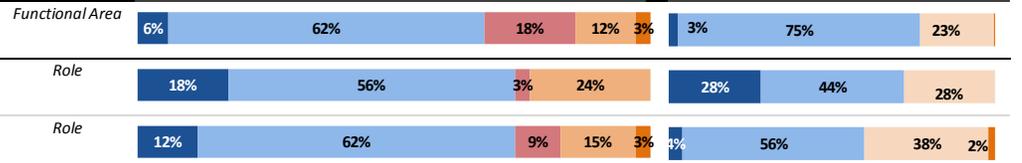
Regular Communications



Regular Communications

Local public health authorities shall maintain a public-facing website with updates made to content no less than annually.

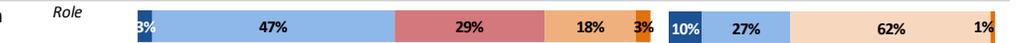
Local public health authorities shall be a reputable source of health information, through public health branding, by disseminating news releases and public meeting notices in a timely and transparent fashion. Local public health authorities shall support ongoing interaction with the public by offering and inviting two-way communications with the public; (e.g. contact information, surveys, comment boxes, etc.)



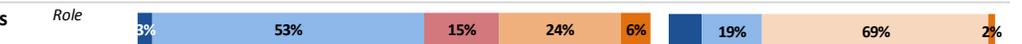
Local public health authorities shall regularly evaluate the effectiveness of communications efforts using tools such as web analytics, surveys, panel surveys and polls. Local public health authorities shall use evaluation findings to adjust communications and communications strategies accordingly.



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. Local public health authorities shall develop and disseminate communications on emerging public health issues.

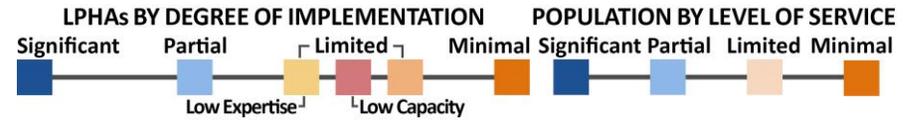


Local public health authorities shall develop and disseminate print and media materials in accordance with the strategic communications plan and risk communication needs. Local public health authorities can also adopt or customize statewide print and media materials provided by the OHA Public Health 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.



DETAILED ASSESSMENT RESULTS

Communications
Regular Communications

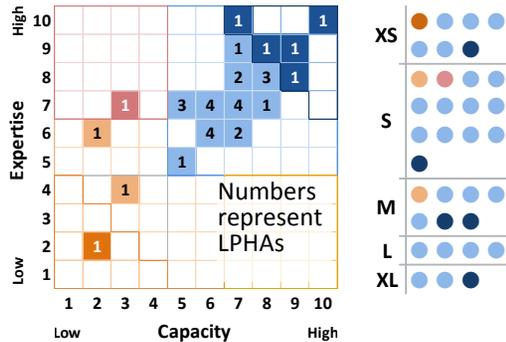


Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Regular Communications	6%	62%	18%	12%	3%	75%	23%	
News releases and public meeting notices.	21%	71%	6%	3%	20%	76%	4%	
Evidence of two-way communications with the public.	18%	53%	24%	6%	21%	60%	17%	3%
Public-facing website with updates made to content regularly.	21%	50%	6%	18%	6%	40%	32%	25%
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).	9%	50%	3%	18%	21%	23%	48%	24%
Policy briefs and other policy-related communications.	6%	41%	9%	32%	12%	3%	64%	31%
Strategic communication plan that articulates the local public health authority's mission, value, role, and responsibilities in its community, and support department and community leadership in communicating these messages. The strategic communications plan should include high priority issues that require proactive communications with the public.	6%	50%	15%	24%	6%	2%	57%	39%
Print and media materials in accordance with the strategic communications plan and risk communication needs. Communications for the public consider the end user and Document two-way communications with the OHA Public Health Division. Evaluation Communications evaluation plan that is structured around health equity and literacy.	9%	44%	9%	32%	6%	11%	43%	45%
	3%	38%	3%	29%	26%	23%	50%	27%
Evaluation reports documenting the effectiveness of communications efforts using tools such as web analytics, surveys, panel surveys and polls; use of evaluation findings to adjust communications and communications strategies accordingly.	3%	24%	6%	29%	38%	21%	52%	27%

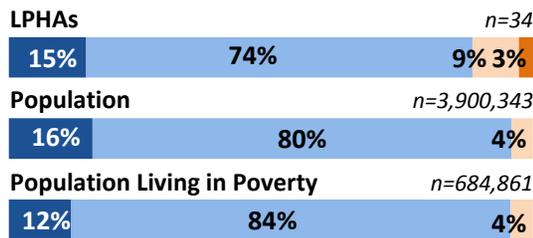
DETAILED ASSESSMENT RESULTS

Communications
Emergency Communications

LPHA IMPLEMENTATION

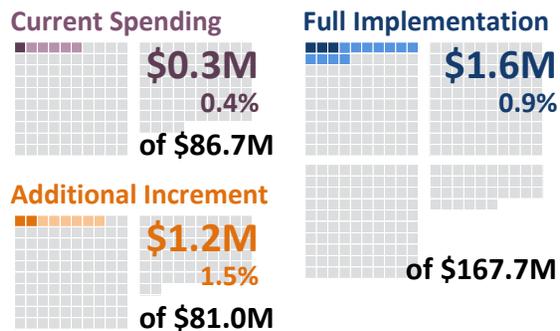


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



COMMUNICATIONS FUNCTIONAL AREA 2:

Emergency Communications

This is another of the three functional areas that describe how local *Communications* activities are operationalized. Only one role is included in the **Emergency Communication** functional area. The functional area maintains that accurate, timely, and understandable information and instructions be provided to the public during a disease outbreak or other disaster or emergency.

This functional area currently represents 12% of local communications activities. A large additional increment of funding relative to their current spending (367% or \$1.2M) is needed to reach significant implementation.

This functional area is highly implemented across the system. Only four LPHAs—one extra small, two small, and one medium—are not at least partially implemented.

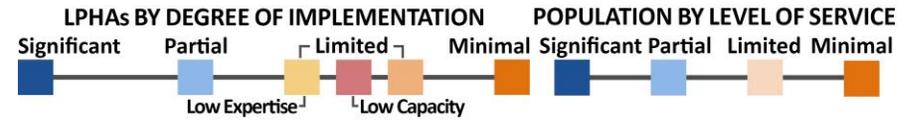
The degree of implementation from a population service perspective is high, with 96% of Oregonians living in a service area where these activities are present. This, paired with the large additional spending needed to reach significant implementation, suggests that the increase to significant implementation from partial implementation has a high marginal cost. It is

likely this has to do with allocation of additional resources to support surge capacity.

The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon’s population is provided on the following page.

DETAILED ASSESSMENT RESULTS

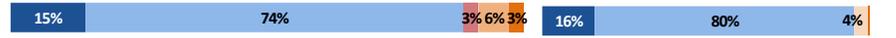
Communications
Emergency Communications



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 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.

Functional Area



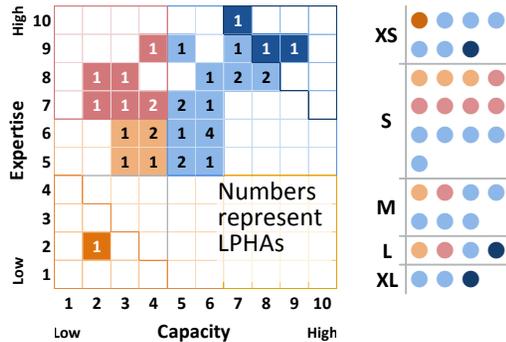
Role



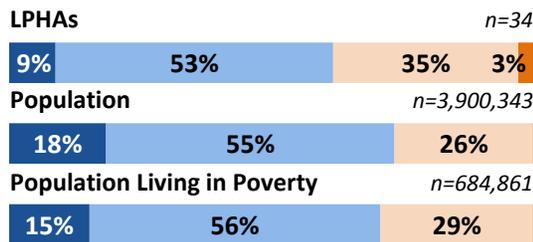
DETAILED ASSESSMENT RESULTS

Communications
Educational Communications

LPHA IMPLEMENTATION

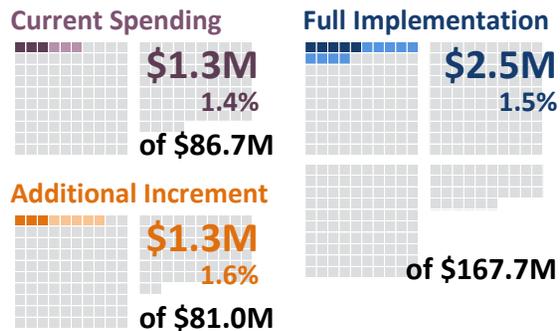


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



COMMUNICATIONS FUNCTIONAL AREA 3:

Educational Communications

The third functional area that describes how local *Communications* activities are operationalized is **Educational Communications**, which is defined as developing and implementing educational programs and preventive strategies. 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.

This functional area represents about 44% of current local *Communications* activities. Doubling current spending with an additional increment of \$1.3M would allow LPHAs to reach significant implementation.

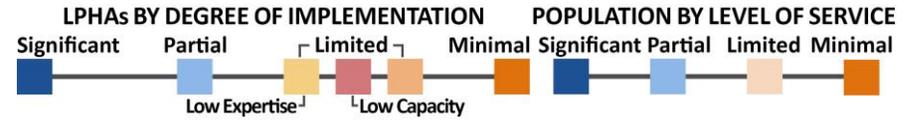
The degree of implementation of this functional area seems to be concentrated in the limited implementation, low capacity, and partial implementation sections of the scoring matrix. There is no clear pattern as to what size LPHA is most likely to be more or less implemented. However, it appears that lack of capacity is a greater issue than lack of expertise.

The percentage of the population in a service area for an LPHA that is partially or significantly 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 partially or significantly implemented.

The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS



Educational Communications

Functional Area



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

Partially Implemented

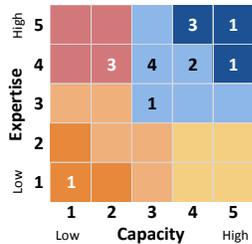


PHD's *Policy and Planning* activities include 16 roles and 5 deliverables. These activities support the development and implementation of policy strategies to improve population health statewide, responding to policy initiatives that may impact health, and ensuring statewide community and partner engagement in policy initiatives that may impact health.

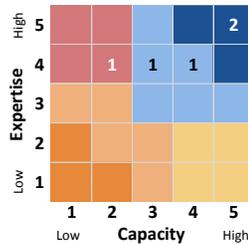
- Make available economic analyses (e.g. cost/risk of non-investment, return on investment) for proposed policy changes at the state or local level. (Minimally implemented.)

While this final role does not 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.

ROLES



DELIVERABLES

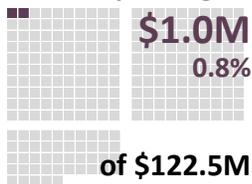


PHD's self-assessment shows that it considers this program to be significantly implemented. This is supported by more detailed self-assessment scores showing that the majority of the roles and deliverables that represent state activities for *Policy and Planning* are partially or significantly implemented. In fact, 12 of the 16 roles and 4 of 5 deliverables are partially or significantly implemented.

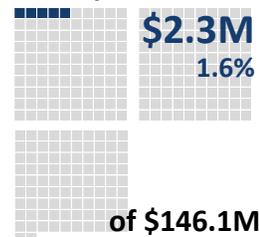
RESOURCES

Each Square Equals \$500,000

Current Spending



Full Implementation



Additional Increment

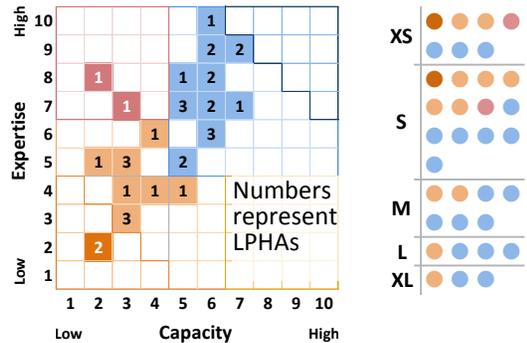


The state has identified that most of its roles and deliverables that specifically support LPHAs are significantly implemented. However, there are three roles that directly support the provision of local *Policy and Planning* activities that are less than significantly implemented; they are:

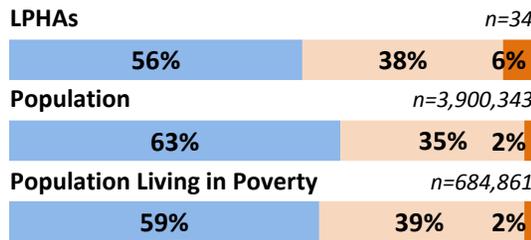
- Coordinate state and local public health policy agendas and support local public health positions on legislation where appropriate. (Partially implemented.)
- Make information and state health data readily available to community members. (Limitedly implemented, low capacity.)

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

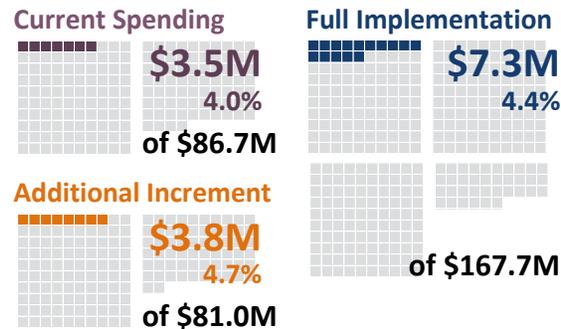


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000



LPHAs' **Policy and Planning** activities include the development and implementation of localized policy strategies to improve health in their service areas, responding to policy initiatives that may impact health in their service areas, and ensuring that the local community and partners are engaged in policy initiatives that may impact health in their service areas.

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 for implementation than lack of expertise.

Local **Policy and Planning** activities are broken down into three approximately evenly-sized functional areas:

- 1. Develop and Implement Policy.** This area represents 36% of current local *Policy and Planning* activities; its share of local *Policy and Planning* activities would decrease to 35% at full implementation.
- 2. Improve Policy with Evidence Based Practice.** This area represents 31% of current local *Policy and Planning* activities, and would increase nominally to 32% at full implementation.

- 3. Understand Policy Results.** This area 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.

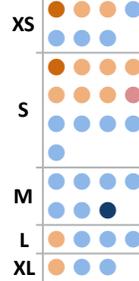
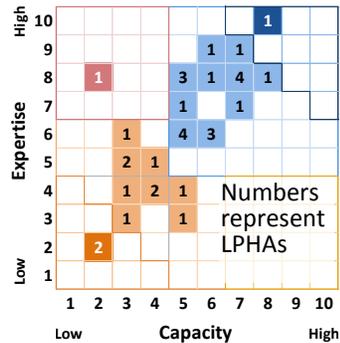
- 62% of Oregon's LPHAs have partially or significantly implemented the *Develop and Implement Policy* functional area, serving 68% of Oregon's population.
- 50% of Oregon's LPHAs have partially or significantly implemented the *Improve Policy with Evidence Based Practice* functional area, serving 74% of Oregon's population.
- 62% of Oregon's LPHAs have partially or significantly implemented the *Understand Policy Results* functional area, serving 82% of Oregon's population.

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

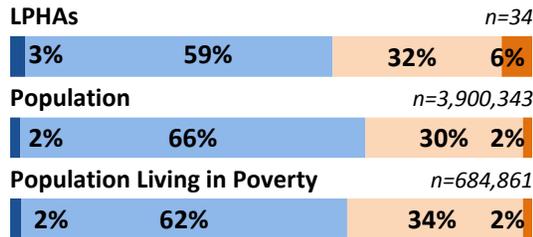
DETAILED ASSESSMENT RESULTS



LPHA IMPLEMENTATION

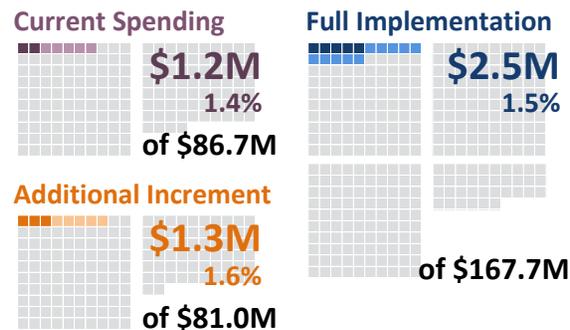


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



POLICY AND PLANNING FUNCTIONAL AREA 1:

Develop and Implement Policy

Develop and Implement Policy is one of three functional areas that together describes local *Policy and Planning* activities. The activities in the *Develop and Implement Policy* functional area include 8 roles and 3 deliverables. This functional area supports development of a policy strategy for the LPHA, development of policy concepts, and coordination with the state and partners on policy agendas.

This functional area represents 36% of current local *Policy and Planning* Activities and the addition of 104% more funding (\$1.3M) would allow LPHAs 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 LPHAs have partially or significantly implemented this functional area, while the majority of limitedly or minimally implemented LPHAs are small or extra-small.

Implementation is similar from both a system and population service perspective. Approximately two-thirds of LPHAs have partially or significantly implemented, and approximately two-thirds of residents are being

served by an LPHA that is partially or significantly implemented.

The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following pages.

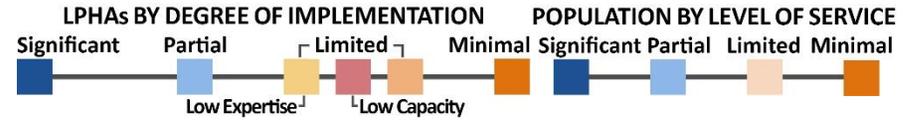
DETAILED ASSESSMENT RESULTS

Policy and Planning
Develop and Implement Policy



DETAILED ASSESSMENT RESULTS

Policy and Planning
Develop and Implement Policy

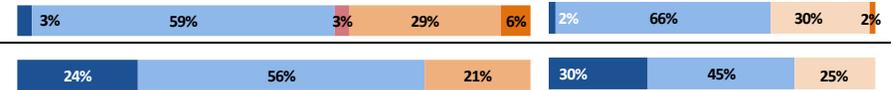


Develop and Implement Policy

Functional Area

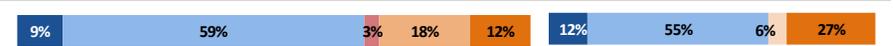
Develop, implement, monitor, evaluate, and modify a community health improvement plan at least every five years that is built on the community health assessment and considers the state health improvement plan where appropriate.

Deliverable



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. The strategic plan must be reviewed and updated at least annually.

Deliverable



Develop and amend rules and regulations necessary to implement state and local statutes or ordinances or federal statutes, rules or regulations

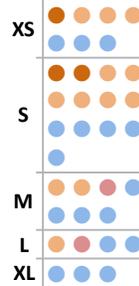
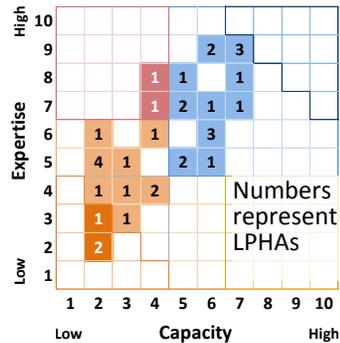
Deliverable



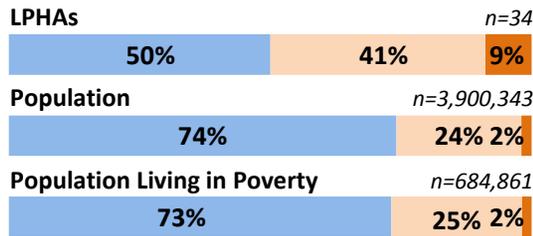
DETAILED ASSESSMENT RESULTS



LPHA IMPLEMENTATION

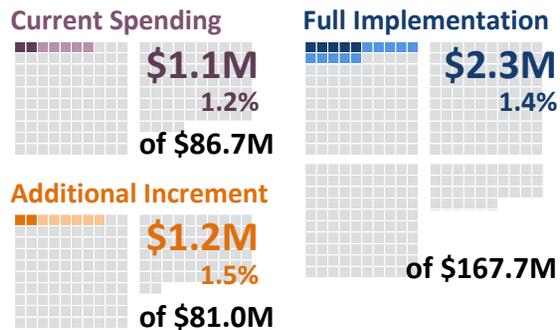


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



POLICY AND PLANNING FUNCTIONAL AREA 2:

Improve Policy with Evidence Based Practice

Improve Policy with Evidence Based Practice is the second of three functional areas that together describes local *Policy and Planning* activities. There is one role included in the *Improve Policy with Evidence Based Practice* functional area and no deliverables. This activity enables LPHAs to serve as primary and expert resources for using science- and evidence-based best practices to inform the development and implementation of public health policies.

This functional area is not highly implemented across the system. Approximately half of providers are partially implemented, while the other half are only limitedly or minimally implemented. It is notable that no LPHAs identified that they had significantly 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.

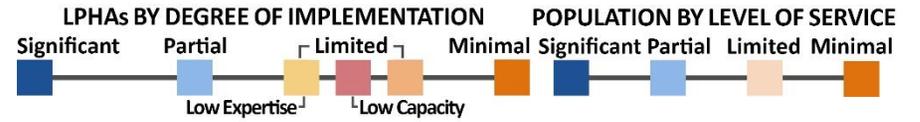
While half of providers are significantly implemented, three-quarters of residents live in a service area where these activities are present on at least a limited basis. This skew is likely because all three extra-large providers scored themselves as partially implemented.

The activities included in the *Improve Policy with Evidence Based Practice* functional area includes only 1 role, however cross-cutting capabilities support the foundational programs, so it is likely that many LPHAs are improving policies in other foundational capability and program areas based on evidence based practice.

The degree of implementation for the one role across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Policy and Planning
 Improve Policy with Evidence Based Practice

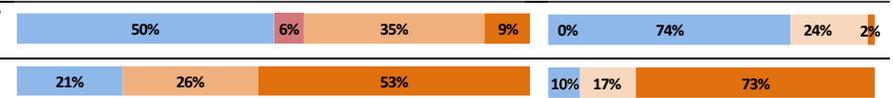


Improve Policy with Evidence Based Practice

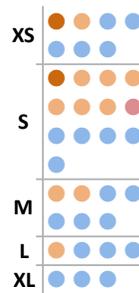
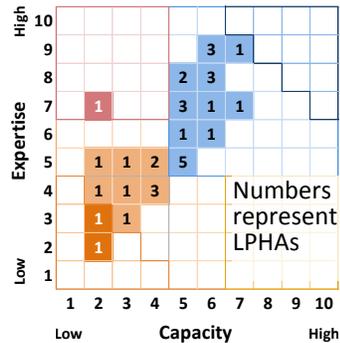
Coordinate with the state on development of economic analyses (e.g. analysis of cost/risk of non-investment return on investment) for proposed policy changes in the authority.

Functional Area

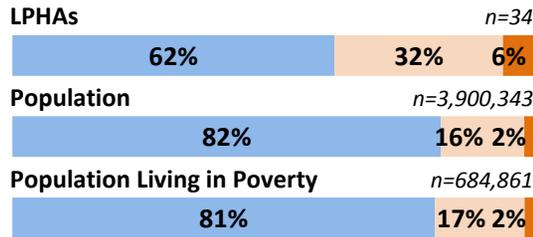
Role



LPHA IMPLEMENTATION

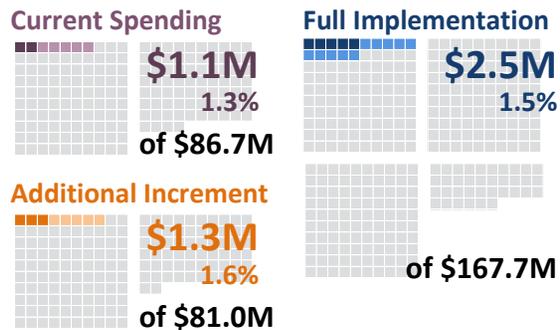


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



POLICY AND PLANNING
FUNCTIONAL AREA 3:

Understand Policy Results

Understand Policy Results is the third and last functional area that describes local *Policy and Planning* activities. The activities in the *Understand Policy Results* functional area include 5 roles and 2 deliverables. These activities help LPHAs to analyze and disseminate findings about the intended and unintended impacts of public health policies, and implement, monitor, evaluate, and modify state and community health improvement plans.

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 partially implemented. It is notable that no LPHAs identified that they had significantly 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 partial implementation relative to residents living in service areas where this functional area is partially implemented) to the previous functional area. While it is less pronounced in this example, it is again likely

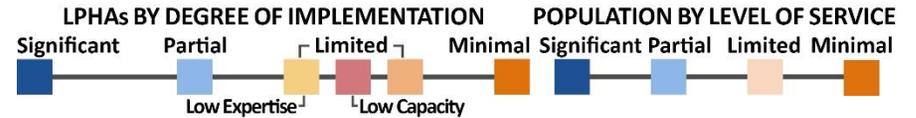
because all three extra-large providers scored themselves as significantly implemented.

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.

The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Policy and Planning
Understand Policy Results



Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Understand Policy Results	62%	3%	29%	6%	0%	82%	16%	2%
Make information and community health data readily available to community members.	18%	56%	6%	15%	6%	81%	10%	0%
Identify and convene strategic partners, as needed.	26%	59%	3%	12%	0%	0%	0%	0%
Assume a leadership role for communicating with the community about how policy changes may impact health.	9%	50%	3%	32%	6%	7%	42%	3%
Make intentional efforts to engage priority/focal populations and their partner organizations.	15%	50%	9%	26%	8%	43%	49%	0%
Engage traditional and nontraditional partners in conversations about efforts to improve health outcomes.	15%	59%	18%	9%	17%	56%	25%	2%
Make information about the community health improvement plan available to the public at least annually. This may include updating information on the local public health authority's website.	21%	59%	9%	12%	31%	60%	9%	0%
Share information with the governing body (e.g. Board of Commissioners or sub designee) to whom the local health authority is accountable about progress on the community health improvement plan at least twice a year.	12%	62%	9%	15%	3%	17%	66%	14%

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.

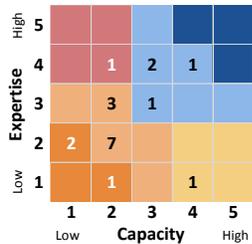
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

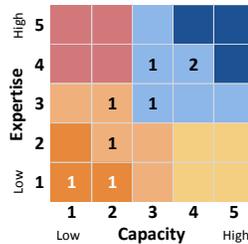
Limitedly Implemented



ROLES



DELIVERABLES



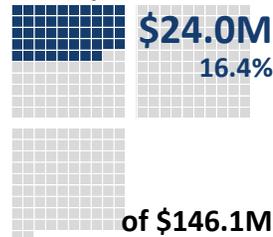
RESOURCES

Each Square Equals \$500,000

Current Spending



Full Implementation



Additional Increment



Leadership and Organizational Competencies activities include 19 roles and 8 deliverables. These activities support authority leadership and governance; performance management, quality improvement, and accountability; human resources; information technology; and financial management, contracts, procurement services, and facility operations.

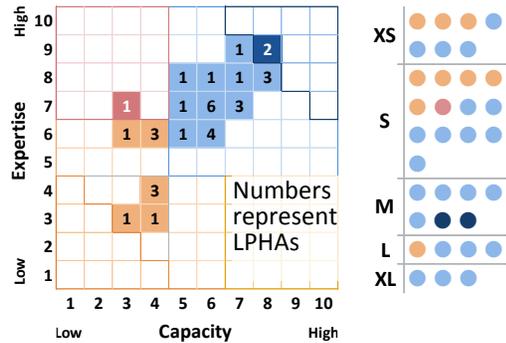
PHD’s self-assessment shows that it considers this program to be only limitedly implemented. PHD reported generally high levels of implementation in *Leadership and Governance* and lower implementation in the public health modernization activities of *Human Resources* and *Information Technology*.

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:

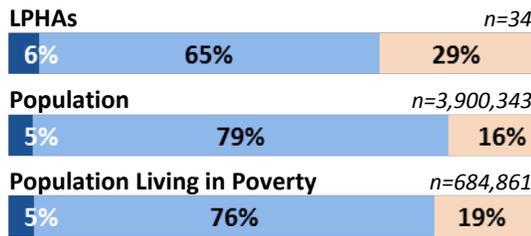
- Coordinate, or perform when necessary, assessments to capture the skills, knowledge, and abilities of the Oregon public health workforce (state, tribal and LPHAs), and develop workforce strategies to address gaps. (Limitedly implemented.)
- Ensure a high quality public health workforce by promoting workforce development and capacity building, and by building relationships with public health programs in higher education as part of planning for future public health workforce needs. (Limitedly implemented.)
- Engage with local health authorities to define a strategic direction for public health initiatives. (Partially implemented.)
- Develop, operate, and maintain interoperable technology that meets current and future public health practice needs. (Limitedly implemented.)
- Assess public health information assets and needs; develop and implement a strategic plan with LPHAs, health system, and other partners to address information needs. (Limitedly implemented.)
- Provide guidance, training, and technical assistance to local and tribal authorities to promote and protect the health of all Oregonians. (Partially implemented.)
- Convene local health and tribal authorities to create opportunities to work together to improve the health of the community. (Limitedly implemented, low expertise.)

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

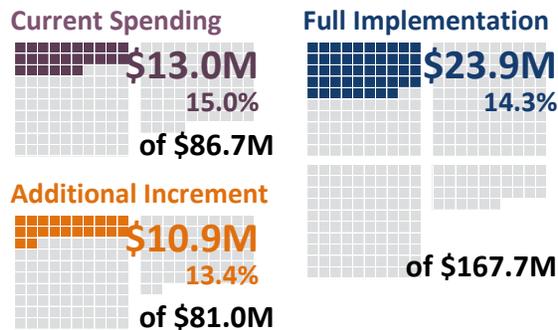


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000



LPHAs' **Leadership and Organizational Competencies** activities support each LPHA's leadership and governance; performance management, quality improvement, and accountability; human resources; information technology; and financial management, contracts, procurement services, and facility operations.

This foundational capability is relatively well-implemented, with 24 out of 34 LPHAs reporting partial or significant 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.

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

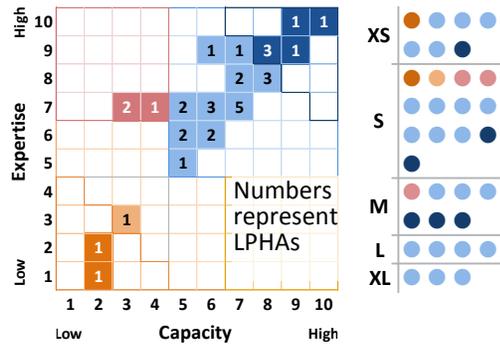
5. Financial Management, Contracts and Procurement Services, and Facility Operations

Following are profiles for each of these five functional areas. However, unlike the functional areas for other programs, LPHAs were not asked to estimate resource needs for each functional area, so those estimates are not provided.

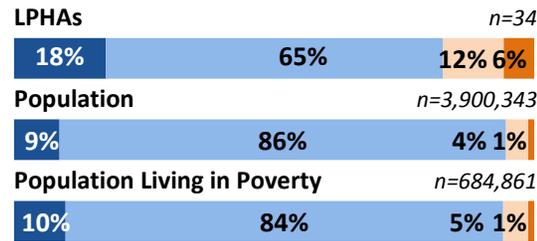
DETAILED ASSESSMENT RESULTS

Leadership and Governance

LPHA IMPLEMENTATION



POPULATION BY LEVEL OF SERVICE



RESOURCES

LPHAs estimated the current level of spending and full implementation resources needed to support the State Public Health Laboratory as part of the Leadership and Organizational Competencies 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

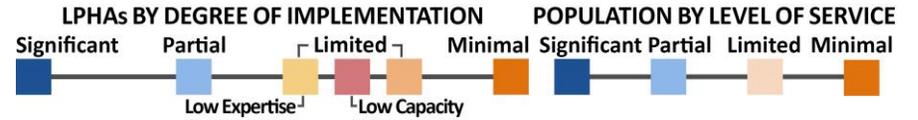
Leadership and Governance is one of five functional areas that describes local Leadership and Organizational Competencies activities. These activities include 3 roles and 2 deliverables. *Leadership and Governance* activities help to define the strategic direction necessary to achieve public health goals, and align and lead stakeholders in achieving goals.

This functional area is well implemented with more than 80% of LPHAs reporting partial or significant implementation covering 95% of the residents of Oregon.

The degree of implementation of the 2 deliverables in this functional area across LPHAs as well as the level of service across Oregon's population is provided on the following page. Due to an oversight, the three roles were not included in the self-assessment survey.

DETAILED ASSESSMENT RESULTS

Leadership and Organizational Competencies
Leadership and Governance



Leadership and Governance

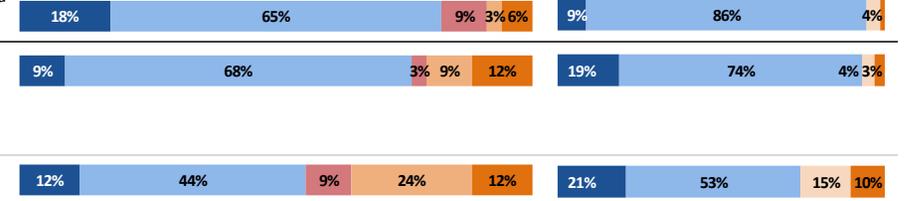
Functional Area

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 1

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.

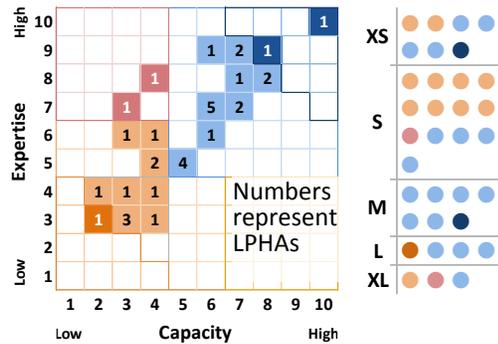
Deliverable 2



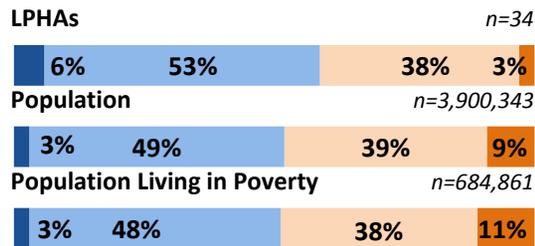
DETAILED ASSESSMENT RESULTS

Leadership and Organizational Competencies
Performance Management, Quality Improvement and Accountability

LPHA IMPLEMENTATION



POPULATION BY LEVEL OF SERVICE



RESOURCES

LPHAs estimated the current level of spending and full implementation resources needed to support the State Public Health Laboratory as part of the Leadership and Organizational Competencies 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

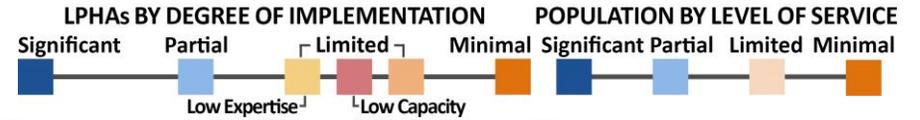
Performance Management, Quality Improvement, and Accountability is the second functional area within *Leadership and Organization Competencies*. This functional area includes using the principles of public health law, including relevant agency rules and the constitutional guarantee of due process, in planning, implementing, and enforcing public health initiatives.

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 significant implementation. Limited and partial implementation were reported by all LPHAs with populations between 50,000 and 150,000, with greater service gaps in small and extra-large jurisdictions.

These activities include 3 roles and 1 deliverable. The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon’s population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Leadership and Organizational Competencies
 Performance Management, Quality Improvement and Accountability

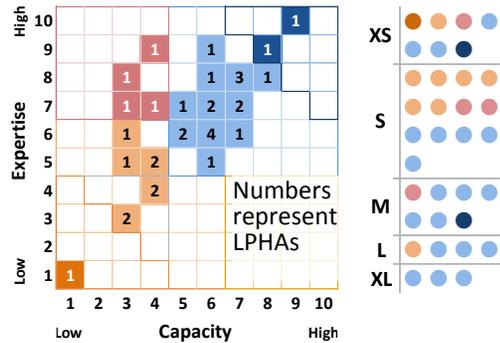


Functional Area	Role	Deliverable	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Performance Management, Quality Improvement, and Accountability	Role 1	Use principles of public health law, agency rules, and constitutional guarantee of due process to plan, implement and enforce public health orders.	18%	59%	3%	18%	3%	22%	70%	7%
	Role 2	Use performance management, quality improvement tools and coaching to promote and monitor organizational objectives and sustain a cultural of quality.	9%	62%	12%	12%	6%	17%	65%	18%
	Role 3	Ensure the management of organizational change (e.g., refocusing a program or an entire organization, etc.)	15%	68%	3%	6%	9%	20%	57%	23%
	Deliverable 1	Implementation of a performance management system to monitor achievement of public health objectives using nationally recognized framework and quality improvement tools and methods.	9%	47%	3%	15%	26%	23%	38%	6%

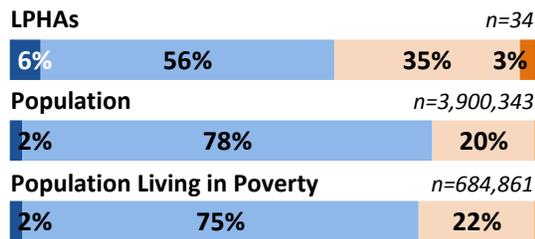
DETAILED ASSESSMENT RESULTS



LPHA IMPLEMENTATION



POPULATION BY LEVEL OF SERVICE



RESOURCES

LPHAs estimated the current level of spending and full implementation resources needed to support the State Public Health Laboratory as part of the Leadership and Organizational Competencies 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

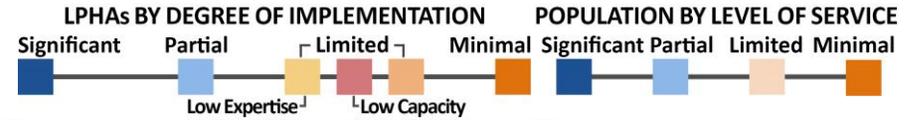
Human Resources is the third functional area within *Leadership and Organization Competencies*. This functional area includes maintaining a competent workforce necessary to ensure the effective and equitable provision of public health services.

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 the minimally and limitedly implemented jurisdictions slightly concentrated in those with smaller populations.

These activities include 5 roles and 1 deliverable. The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Human Resources Leadership and Organizational Competencies

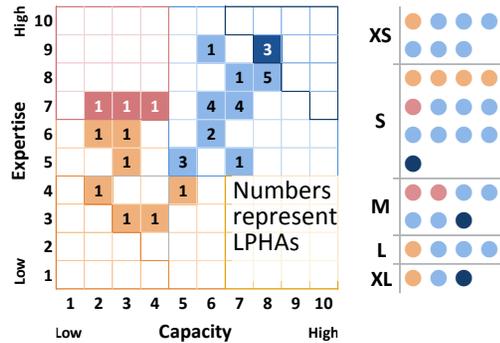


Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Human Resources	6%	56%	12%	24%	3%	78%	12%	3%	
Develop and implement a workforce development plan that identifies needed technical and/or informatics skills, competencies and/or positions. The plan should include strategies for recruiting, hiring and/or developing existing staff to meet the needs.	3%	53%	12%	24%	9%	70%	28%	2%	
Coordinate, or convene when necessary, efforts to assess leadership and organizational capabilities within their local authority to understand capacity and to identify gaps.	9%	68%	12%	12%	15%	51%	30%	4%	
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.	6%	44%	18%	24%	9%	62%	34%	2%	
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.	9%	59%	12%	18%	3%	34%	46%		
Collaborate and share workforce development planning resources with the state, tribal and other local authorities.	3%	47%	6%	29%	15%	1%	44%	33%	23%
Assessment of staff competencies; the provision of individual training and professional development and the provision of a supportive work environment.	12%	59%	6%	18%	6%	23%	37%	38%	2%

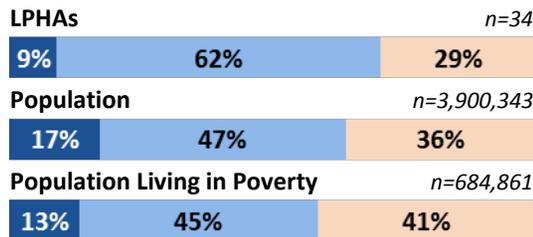
DETAILED ASSESSMENT RESULTS

Information Technology

LPHA IMPLEMENTATION



POPULATION BY LEVEL OF SERVICE



RESOURCES

LPHAs estimated the current level of spending and full implementation resources needed to support the State Public Health Laboratory as part of the Leadership and Organizational Competencies 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

Information Technology is the fourth functional area within *Leadership and Organization Competencies*. This functional area includes implementing and maintaining the technology needed to support public health operations while simultaneously protecting personally identifiable information and other confidential health information.

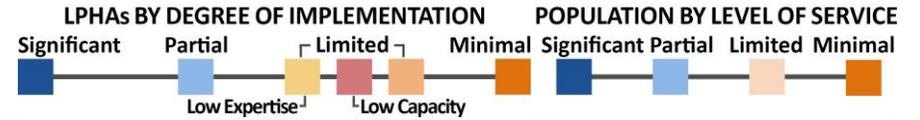
LPHAs assess their overall implementation level as relatively high, with 70% reporting partial or significant implementation. The functional area *Information Technology* has the least implemented roles and deliverables within the *Leadership and Organizational Competencies*. Implementation does not have a clear connection with size, although this functional area seems 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 3 roles and 2 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

these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Information Technology Leadership and Organizational Competencies

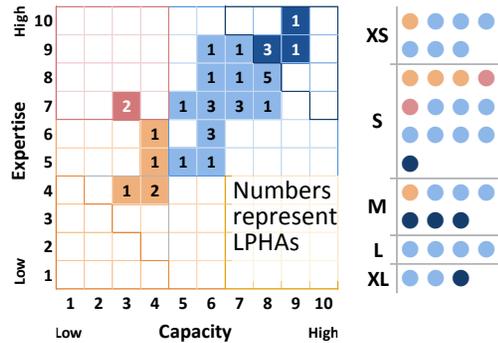


Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Information Technology	9%	62%	9%	21%	17%	47%	36%	
Ensure privacy and protection of personally identifiable and/or confidential health information in data systems and information technology.	44%	56%			43%	57%		
Develop and maintain local public health technology and resources to support current and emerging public health practice needs. Document that 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.	3%	53%	12%	21%	12%	0%	39%	57%
								3%
		35%		24%	24%	2%	30%	44%
								24%
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.		56%		21%	21%	0%	44%	41%
								15%
Implementation of a technical support plan that provides users of local public health technology systems and technology resources with appropriate training.	3%	50%	6%	21%	21%	0%	34%	39%
								27%

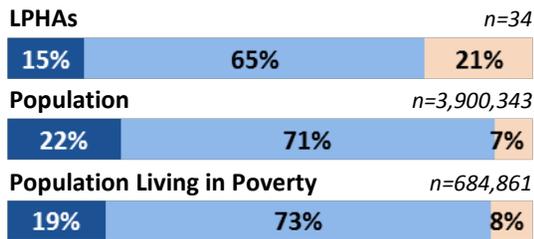
DETAILED ASSESSMENT RESULTS

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

LPHA IMPLEMENTATION



POPULATION BY LEVEL OF SERVICE



RESOURCES

LPHAs estimated the current level of spending and full implementation resources needed to support the State Public Health Laboratory as part of the Leadership and Organizational Competencies 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

Financial Management, Contracts and Procurement Services, and Facility Operations is the fifth and final functional area within *Leadership and Organization Competencies*. This functional area includes using accounting and business best practices in budgeting, tracking finances, billing, auditing, securing grants, and other source of funding and distributing monies to governmental and non-governmental partners.

This functional area is well implemented across the system – almost 80% of LPHAs report partial or significant implementation of the activities required. Of the six LPHAs that reported limited implementation, all but one are jurisdictions with less than 40,000 residents.

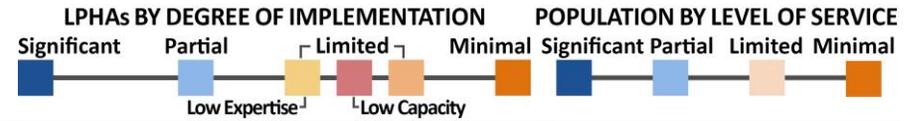
More than 90% of Oregon’s population is living in jurisdictions that have partially or significantly implemented these activities.

The *Financial Management, Contracts and Procurement Services, and Facility Operations* functional area has 2 roles and 1 deliverable. The degree of implementation of these roles

and deliverables across LPHAs as well as the level of service across Oregon’s population is provided on the following page.

DETAILED ASSESSMENT RESULTS

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



Functional Area	Role	Deliverable	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Financial Management, Contracts and Procurement Services, and Facility Operations			15%	65%	6%	15%	22%	71%	7%		
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.	Role 1		18%	56%	3%	15%	9%	27%	47%	20%	6%
	Role 2		15%	47%	9%	18%	12%	39%	32%	27%	3%
Policies and procedures that protect personally identifiable and/or confidential health information.		Deliverable 1	50%	47%	3%		73%	26%	1%		

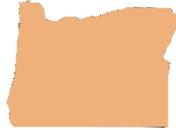
HEALTH EQUITY AND CULTURAL RESPONSIVENESS

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.

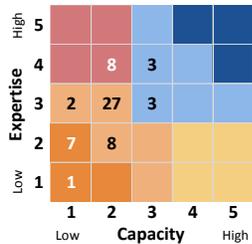
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

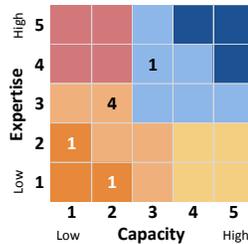
Limitedly Implemented



ROLES



DELIVERABLES



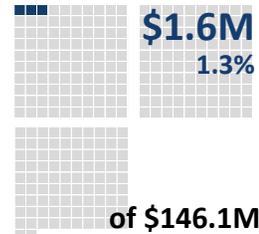
RESOURCES

Each Square Equals \$500,000

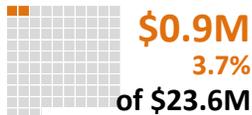
Current Spending



Full Implementation



Additional Increment



PHD’s *Health Equity and Cultural Responsiveness* activities includes many disparate activities that all strive to foster a shared understanding and will to achieve health equity and cultural responsiveness; engage with the community to identify and eliminate health inequities; and develop public health policies and plans intended to achieve health equity, protect people from health hazards, and prevent health problems.

PHD’s *Health Equity and Cultural Responsiveness* activities include 59 roles and 7 deliverables. PHD’s Self-Assessment shows that they consider this capability to have limited implementation. Additionally, PHD notes that the majority of the roles and deliverables that represent *Health Equity and Cultural Responsiveness* state activities only have limited or minimal implementation (53 of the 59 roles and 6 of the 7 deliverables).

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. (Limitedly implemented.)
- Promote community engagement task forces to develop and recommend strategies to

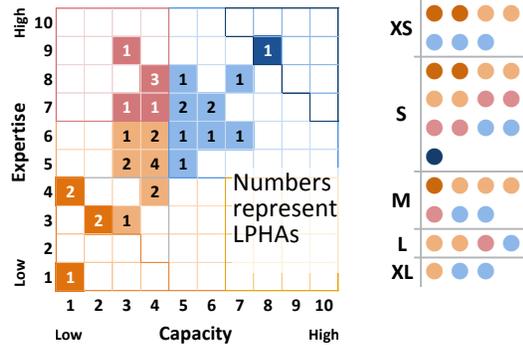
engage low income, racial/ethnic and disabled community members in state and local government. (Minimally implemented.)

- Work collaboratively with local public health authorities on state and local policies, programs, and strategies intended to ensure health equity. (Limitedly implemented, low capacity.)
- Develop and implement assessment and training programs to improve staff knowledge and capabilities about health inequity for local public health authorities. (Limitedly implemented.)
- Develop and provide health equity and cultural responsiveness best practices, technical assistance, and tools to local public health authorities. (Limitedly implemented.)

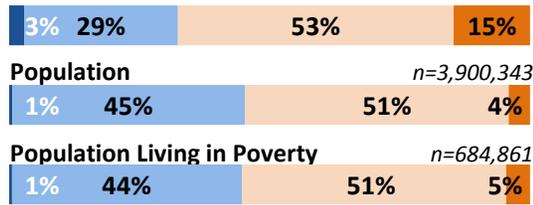
Additionally, PHD is intended to play a significant role in promoting a common understanding of cultural responsiveness, the extent and consequences of systems of oppression, and the economic case for health equity, all of which will help buttress LPHA’s health equity efforts.

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

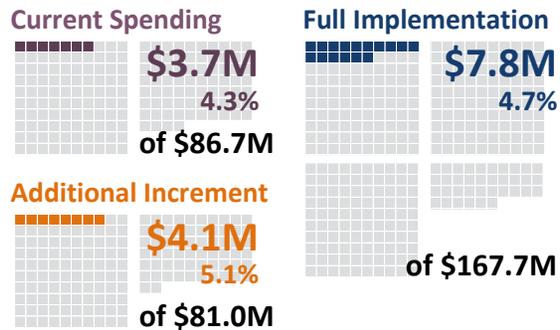


POPULATION BY LEVEL OF SERVICE LPHAs



RESOURCES

Each Square Equals \$500,000



LPHA’s *Health Equity and Cultural Responsiveness* activities are very similar to PHD’s, but at the local level. Like PHD’s they strive to foster a shared understanding and will to achieve health equity and cultural responsiveness; engage with the community to identify and eliminate health inequities; and develop public health policies and plans intended to achieve health equity, protect people from health hazards, and prevent health problems.

Currently, this capability is not generally implemented across the state. Out of 34 LPHAs, 11 reported partial or significant implementation. Five LPHAs reported that overall they have minimal implementation of 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.

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

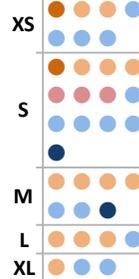
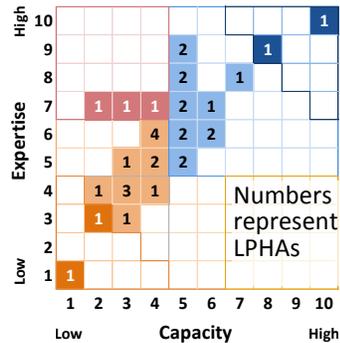
- Foster Health Equity.** This functional area represents 61% of current local *Health Equity and Cultural Responsiveness* spending; its share of local *Health Equity and Cultural Responsiveness* activities would decrease to 54% at significant implementation.
- Communicate and Engage Inclusively.** The 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.

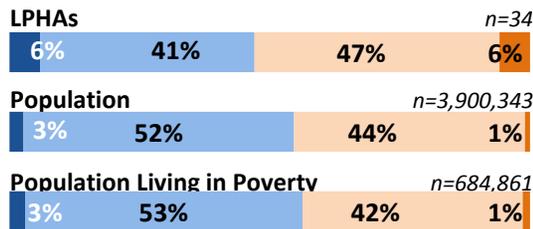
DETAILED ASSESSMENT RESULTS

Health Equity and Cultural Responsiveness
Foster Health Equity

LPHA IMPLEMENTATION

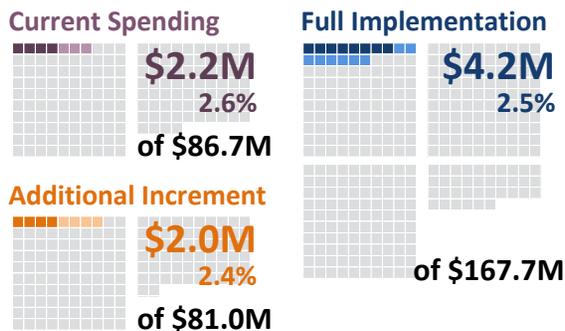


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



EQUITY AND CULTURAL RESPONSIVENESS FUNCTIONAL AREA 1:

Foster Health Equity

This is one of two functional areas that describes how local *Health Equity and Cultural Responsiveness* activities are operationalized. The activities in the **Foster Health Equity** functional area include 44 roles and 6 deliverables. The functional area covers supporting health policies and implementing processes that promote health equity, and engaging with the community to identify and eliminate health inequities. In addition, the functional area includes recognizing and addressing health inequities specific to certain populations.

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

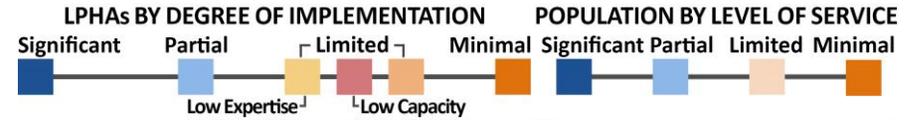
In comparison to *Health Equity and Cultural Responsiveness* overall implementation and the second functional area in this capability, LPHAs' activities in the *Foster Health Equity* functional area are more implemented: 47% of LPHAs reported partial or significant implementation, covering 55% of the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

The degree of implementation of these roles and deliverables across local authorities and

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

DETAILED ASSESSMENT RESULTS

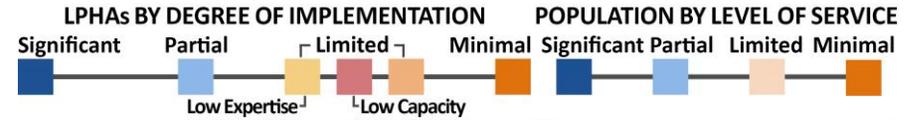
Health Equity and Cultural Responsiveness
Foster Health Equity



Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Foster Health Equity	6%	41%	9%	38%	6%	52%	44%	1%
Provide public health services that are effective, equitable, understandable, respectful, and responsive to diverse cultural health beliefs and practices, preferred	15%	71%	12%	3%	7%	80%	13%	0%
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	3%	53%	24%	9%	12%	1%	80%	15%
Ensure health equity and cultural responsiveness are fully integrated in local strategic priorities and plans, including community health improvement plans.	9%	53%	6%	26%	6%	31%	48%	21%
Develop and promote shared understanding of the determinants of health, health equity and lifelong health with local partners and the community.	3%	62%	6%	21%	9%	2%	76%	20%
Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic wellbeing, and environmental quality) with	3%	50%	15%	18%	15%	1%	75%	20%
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	3%	44%	15%	24%	15%	1%	70%	24%
Work collaboratively with the OHA Public Health Division on state and local policies, programs and strategies intended to assure health equity.	6%	56%	12%	15%	12%	3%	67%	20%
Partner to enhance multi-disciplinary and multi-sector capacity to address health equity. Support health equity in all policies.	12%	41%	12%	26%	9%	4%	63%	23%
Advocate for comprehensive policies that improve physical, environmental, social, and economic conditions in the community that affect the public's health. 0	3%	56%	9%	18%	15%	2%	65%	25%
Develop or use an existing assessment of and training to improve staff knowledge and capabilities about health inequity.	6%	56%	3%	26%	9%	16%	51%	32%
Develop or use an existing anti-discrimination training as part of building a competent workforce.	9%	65%	24%	3%	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, including its organizational structure and	35%	6%	35%	24%	55%	33%	13%	
Promote a common understanding of cultural responsiveness.	6%	50%	6%	29%	9%	50%	46%	1%
Stay current with the literature on health equity, synthesize research, and disseminate findings as they are applicable to staff and community.	41%	15%	32%	12%	50%	48%	2%	
Make available to people data and information on health status and conditions that influence health status by race, ethnicity, language, geography, disability, and income.	3%	50%	9%	21%	18%	0%	47%	40%

DETAILED ASSESSMENT RESULTS

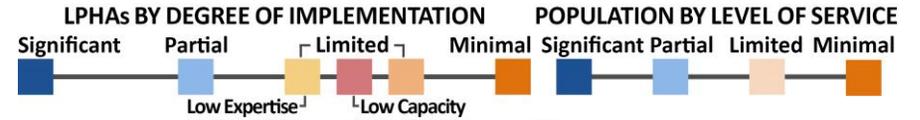
Health Equity and Cultural Responsiveness
Foster Health Equity



Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Foster Health Equity	6%	41%	9%	38%	6%	52%	44%	1%	
Play a leadership role in reducing or mitigating social and economic inequities and conditions that exist locally that lead to inequities in the distribution of disease, Increase awareness and practice of health equity among hiring managers and supervisors so that sensitivities to and understanding of root causes of health	6%	50%	6%	26%	12%	3%	44%	45%	8%
Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improving workplace equity.	6%	41%	6%	35%	12%	1%	45%	53%	2%
Leverage health reform funding for health equity and to build cultural responsiveness into health care delivery.	38%	6%	29%	26%	0%	46%	39%	15%	
Leverage health reform funding for health equity and to build cultural responsiveness into funding mechanisms.	35%	6%	26%	32%	0%	43%	36%	21%	
Use existing evidence-based measures or develop public health measures of neighborhood conditions, institutional power, and social inequalities that lead to	3%	32%	9%	21%	35%	1%	42%	39%	19%
Ensure all local programs integrate achieving health equity as a measureable outcome through cultural responsiveness of staff and program delivery.	3%	32%	6%	38%	21%	3%	36%	53%	9%
Make the economic case for health equity, including the value of investment in cultural responsiveness.	41%	9%	24%	26%	0%	35%	29%	36%	
Promote understanding of the extent and consequence of systems of oppression.	6%	26%	3%	38%	26%	3%	28%	37%	32%
Promote public and private investments in community infrastructure to sustain and improve community health, such as education, childhood development, mass transit,	6%	41%	9%	29%	15%	3%	27%	66%	4%
Support, implement, and evaluate strategies that tackle the root causes of health inequities, in strategic, lasting partnerships with public and private organizations and	6%	41%	12%	29%	12%	3%	24%	64%	10%
Monitor funding allocations to ensure sustainable impact on health equity.	32%	32%	35%	18%	51%	31%			
Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities.	24%	6%	38%	32%	9%	66%	25%		
Increase flexible categorical and non-categorical funding to address health equity.	24%	9%	24%	44%	9%	35%	56%		
Establish parity goals and create specific metrics with benchmarks to track progress.	3%	18%	15%	29%	35%	4%	62%	32%	

DETAILED ASSESSMENT RESULTS

Health Equity and Cultural Responsiveness
Foster Health Equity

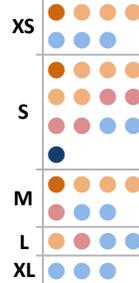
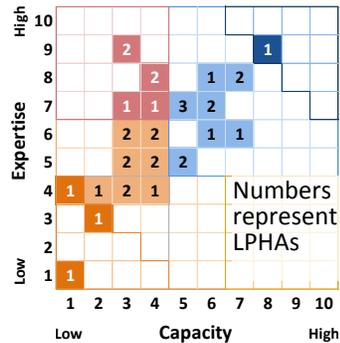


Functional Area	LPHAs BY DEGREE OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE					
	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal		
Foster Health Equity	6%	41%	9%	38%	6%	3%	52%	44%	1%	
Develop and implement annual training plan to increase local public health authority staff capacity to address the causes of health inequities, promote health equity, and	Deliverable	53%	6%	35%	6%	56%	44%	1%		
Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of public health policies, programs, and strategies on health equity, health	Deliverable	3%	35%	3%	41%	18%	14%	36%	45%	5%
Develop and implement an annual training plan to increase local public health authority staff capacity to address the causes of health inequities, promote health equity and	Deliverable	3%	41%	6%	35%	15%	41%	46%	12%	
Conduct an internal assessment of the local public health authority's overall capacity to apply a health equity lens to programs and services; overall capacity to provide	Deliverable	44%	12%	26%	18%	30%	66%	4%		
Develop an action plan resulting from the internal assessment to ensure an equity lens to policies, programs, and strategies and capacity to provide culturally responsive	Deliverable	26%	15%	29%	29%	25%	57%	18%		

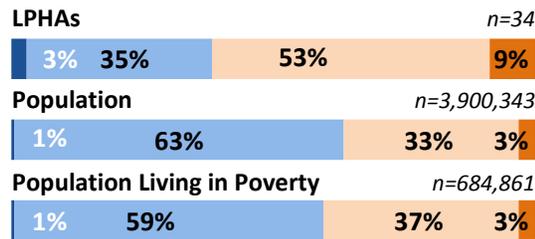
DETAILED ASSESSMENT RESULTS

Health Equity and Cultural Responsiveness
Communicate and Engage Inclusively

LPHA IMPLEMENTATION

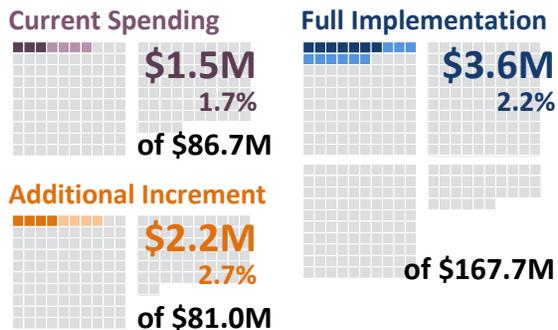


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Only
- Total Foundational Capability



HEALTH EQUITY AND CULTURAL RESPONSIVENESS FUNCTIONAL AREA 2:

Communicate and Engage Inclusively

Communicate and Engage Inclusively is the second functional area that describes how local *Health Equity and Cultural Responsiveness* activities are operationalized. The functional area covers communicating with the public and stakeholders in a transparent and inclusive manner, as well as engaging the community, including diverse populations, in community health planning.

This functional area represents 40% of current local *Health Equity and Cultural Responsiveness* spending. Significant implementation would increase its share of spending to 46%. To reach significant implementation, LPHAs reported that they need a comparatively large additional increment of funding (150% of current spending or \$2.2M).

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

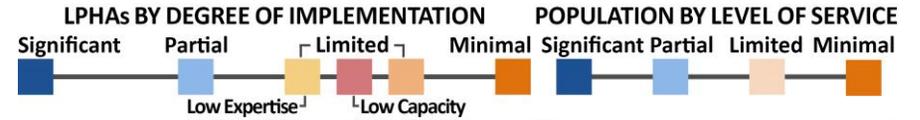
The activities in the *Communicate and Engage Inclusively* functional area include 14 roles and one deliverable. The degree of implementation

appears higher from a population service perspective: 64% of Oregonians live in a service area where these activities are at least partially or significantly implemented.

The degree of implementation of each role and deliverable across local authorities and population by level of service are provided on the following page.

DETAILED ASSESSMENT RESULTS

Health Equity and Cultural Responsiveness
Communicate and Engage Inclusively



Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
Communicate and Engage Inclusively	3%	35%	18%	35%	9%	1%	63%	33%	3%
Engage with community members to learn about the values, needs, major concerns, and resources of the community in order to effectively prioritize resources and Promote community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local	15%	41%	18%	21%	6%	22%	51%	27%	
Routinely invite and involve community members and representatives from community-based organizations in public health authority planning, procedures, Develop mechanisms for drawing on the skills and knowledge of staff who are members of communities most affected by inequities.	6%	38%	3%	32%	21%	10%	52%	19%	19%
Engage in dialogue with people, governing bodies, and elected officials regarding governmental policies responsible for health inequities, improvements being made in	6%	47%	6%	32%	9%	3%	59%	32%	6%
Provide clear mechanisms and invitations for community contributions to public health authority planning, procedures, and policies.	6%	44%	12%	24%	15%	3%	54%	35%	8%
Learn about the culture, values, needs, major concerns, and resources of the community. Respect local community knowledge and seek to understand and formally	6%	38%	6%	35%	15%	3%	38%	51%	8%
Hire staff with the skills, knowledge, and abilities to take part in community organizing, negotiation, and power dynamics and the ability to mobilize people, particularly those	3%	38%	6%	35%	18%	2%	39%	37%	22%
Evaluate and disseminate knowledge of findings and efforts related to health equity (e.g., conduct ongoing assessments of the organization's C LAS-related activities and	9%	35%	3%	50%	3%	1%	40%	58%	2%
Increase racial and ethnic representation on councils and committees.	18%	32%	9%	38%	3%	14%	26%	50%	10%
Make easily and quickly available clear and transparent communications with their constituents on issues related to the health of their authority, especially regarding	29%	6%	38%	26%	33%	33%	59%	9%	
Provide technical assistance to communities with respect to analyzing data, setting priorities, identifying levers of power, and developing policies, programs, and	3%	44%	41%	12%	1%	31%	63%	5%	
Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory	35%	15%	29%	21%	20%	71%	8%		
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	6%	24%	18%	29%	24%	8%	69%	11%	
Develop, implement and monitor a community health improvement plan, in collaboration with community members and partner organizations.	15%	6%	35%	44%	8%	65%	27%		
	21%	9%	35%	35%	7%	69%	24%		
	18%	65%	3%	12%	3%	28%	66%	7%	

COMMUNITY PARTNERSHIP DEVELOPMENT

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

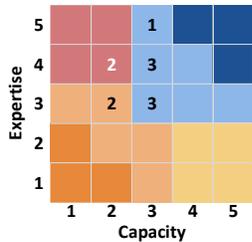
PUBLIC HEALTH DIVISION

LEVEL OF IMPLEMENTATION

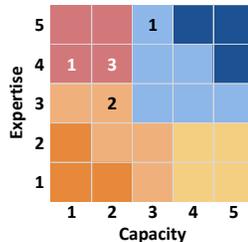
Limitedly Implemented



ROLES



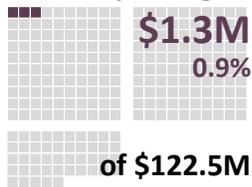
DELIVERABLES



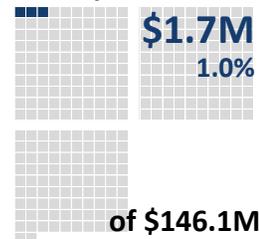
RESOURCES

Each Square Equals \$500,000

Current Spending



Full Implementation



Additional Increment



PHD’s *Community Partnership Development* activities include 11 roles and 7 deliverables. These activities support development of statewide partnerships; funding, training, and technical assistance to support LPHAs and partners in partnership development; and engagement of the community, including those disproportionately affected by health issues, in state health assessments and other efforts.

PHD’s self-assessment shows that it considers this capability to have limited implementation. Some of the better implemented roles and deliverables, which are still only partially implemented, include engaging partners as part of the state health assessment process and supporting local public health in the development of local strategic partnerships.

None of these roles and deliverables are significantly implemented. In addition, some of the state activities that directly support local *Community Partnership Development* activities are only minimally or limitedly implemented; these activities include:

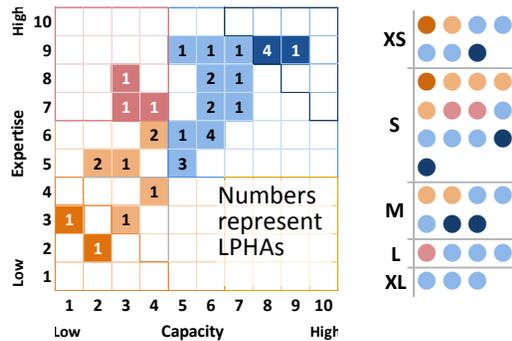
- Dedicated funding to community partnership development and support for this funding with technical assistance. (Limitedly implemented.)
- Provide training, provide technical assistance, and document funding that has been dedicated to community partnership

development and technical assistance to local public health authorities to forge stronger community partnerships. (Limitedly implemented.)

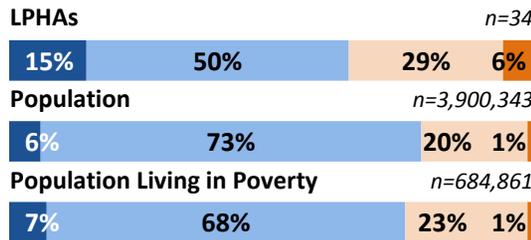
Additionally, it is likely that the state’s ability to complete its own activities related to partners are critical to the ability of LPHAs to attract and engage their partners. A strong state partner network is likely a critical component of a strong local partner network.

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION

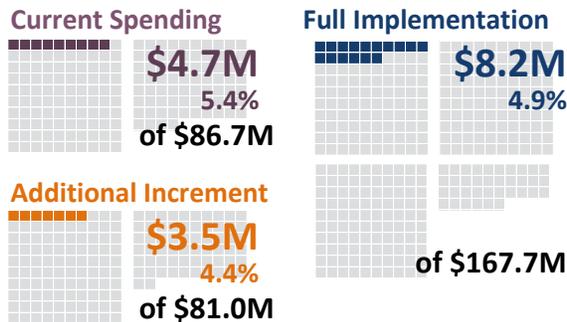


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000



LPHAs' **Community Partnership Development** activities support the development of cross-sector partnerships, coordination of programming with those partners, engagement of the local community, including those disproportionately affected by health issues, in local planning, and documentation of partner relationships and community engagement.

Programmatically, this foundational capability is relatively well implemented, with approximately two-thirds of LPHAs documenting partial or significant implementation.

Local **Community Partnership Development** activities are broken down into 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.
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 share of local activities (35%) in this foundational capability at full implementation.

The functional area **Engage Partners in Policy** is slightly better implemented than **Identify and Develop Partnerships**.

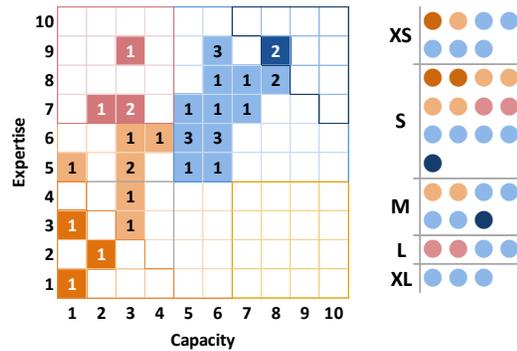
- 58% of Oregon's LPHAs have partially or significantly implemented the **Identify and Develop Partnerships** functional area, serving 74% of Oregon's population.
- 74% of Oregon's LPHAs have partially or significantly implemented the **Engage Partners in Policy** functional area, serving 84% of Oregon's population.

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

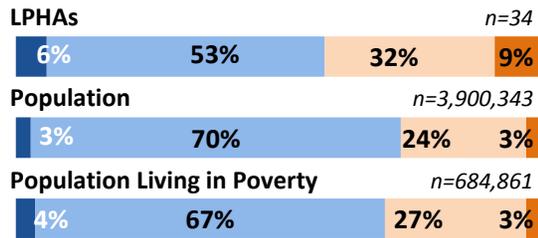
DETAILED ASSESSMENT RESULTS

Community Partnership Development
Identify and Develop Partnerships

LPHA IMPLEMENTATION

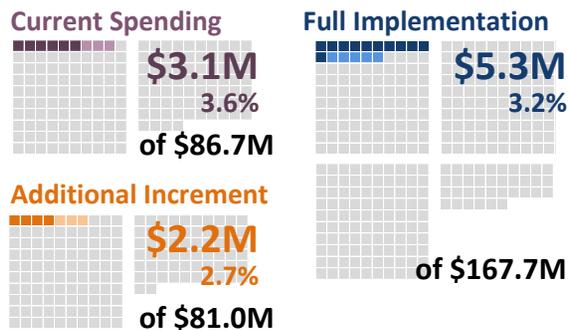


POPULATION BY LEVEL OF SERVICE



RESOURCES

Each Square Equals \$500,000
 Functional Area Spending
 Functional Area Spending



COMMUNITY PARTNERSHIP DEVELOPMENT FUNCTIONAL AREA 1:

Identify and Develop Partnerships

This is one of two functional areas that describe how local *Community Partnership Development* activities are operationalized. The activities in the *Identify and Develop Partnerships* functional area include 3 roles and 6 deliverables. The functional area covers convening and sustaining relationships with traditional and nontraditional partners and stakeholders, as well as developing, strengthening, and expanding connections across disciplines.

This functional area represents two-thirds of current *Community Partnership Development* activities, and the addition of 72% more funding (\$2.2M) would allow the LPHAs 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.

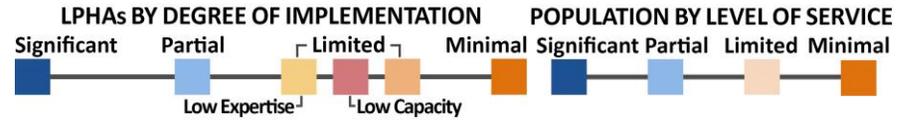
The degree of implementation appears higher from a population service perspective: 73% of Oregonians live in a service area where these activities are present (however, there is a

meaningful gap in service for a large percentage of those services).

The degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Community Partnership Development
Identify and Develop Partnerships

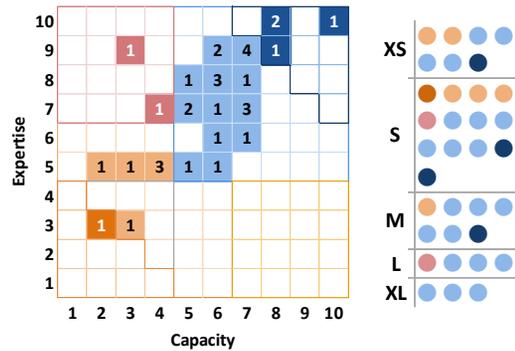


Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Identify and Develop Partnerships	6%	53%	12%	21%	9%	70%	24%	3%
Support and maintain cross-sector partnerships with health-related organizations; organizations representing priority/focal populations; private businesses; and local government agencies and non-elected officials.	18%	68%	3%	9%	3%	87%	5%	
Coordinate programmatic activities with those of partner organizations to advance cross-cutting, strategic goals.	12%	65%	6%	18%		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.	3%	53%	9%	26%	9%	75%	23%	1%
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.	12%	44%	12%	26%	6%	16%	54%	29%
List all key regional health-related organizations with whom the LPHA has developed relationships. 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.	12%	47%	12%	24%	6%	16%	51%	33%
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.	9%	44%	15%	26%	6%	15%	50%	34%
List all community groups or organizations representing priority/focal populations the LPHA has developed relationships with so that public health goals are effectively and efficiently attainable for all populations. Address successes, lessons learned, recognized barriers to such collaboration, and strategies to overcome these barriers.	9%	44%	12%	26%	9%	5%	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.	9%	41%	18%	24%	9%	5%	41%	53%
Evaluate reports on the effectiveness of partnerships.	3%	29%	18%	29%	21%	30%	59%	10%

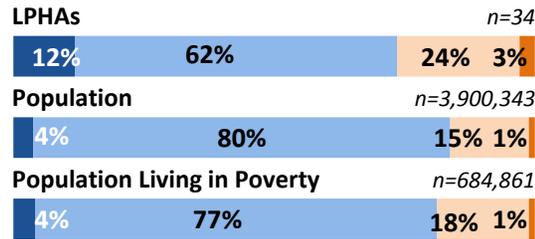
DETAILED ASSESSMENT RESULTS

Community Partnership Development
Engage Partners in Policy

LPHA IMPLEMENTATION

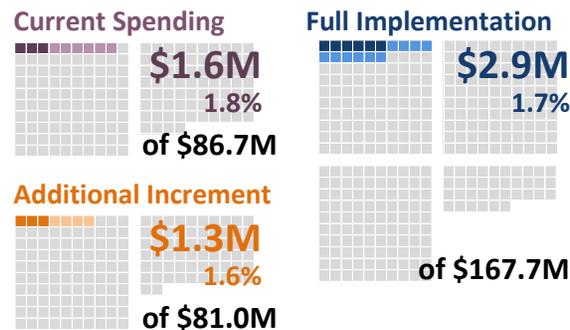


POPULATION BY LEVEL OF SERVICE



RESOURCES

- Each Square Equals \$500,000
- Functional Area Spending
- Functional Area Spending



COMMUNITY PARTNERSHIP DEVELOPMENT FUNCTIONAL AREA 2:

Engage Partners in Policy

This is the second functional area that describes how local *Community Partnership Development* activities are operationalized. The activities in the *Engage Partners in Policy* functional area include 4 roles and 1 deliverable. The functional area covers fostering and supporting community involvement and partnerships in developing, adopting, and implementing public health policies. As well, the functional area includes engaging members of the community in implementing, monitoring, evaluating, and modifying state health improvement plans or community health improvement plans.

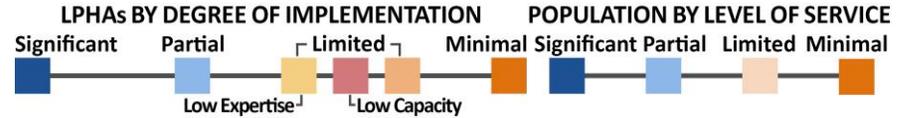
This functional area represents about one-third (34%) of current local *Community Partnership Development* activities, and the addition of 83% more funding (\$1.3M) would allow LPHAs to reach full implementation. This functional area is more implemented in larger LPHAs. Overall, 25 of 34 LPHAs consider themselves to have partially or significantly 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 degree of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

DETAILED ASSESSMENT RESULTS

Community Partnership Development
Engage Partners in Policy



Engage Partners in Policy	Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal	
		12%	62%	6%	18%	3%	4%	80%	15%	1%
Ensure that community partners can participate fully in local and state public health planning efforts.	Role 1	6%	59%	12%	18%	6%	3%	86%	10%	2%
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.	Role 2	21%	62%	3%	12%	3%	16%	69%	14%	
Earn and maintain the trust of community residents by engaging them at the grassroots level.	Role 3	9%	62%	3%	3%	21%	3%	2%	79%	19%
Specifically engage priority/focal populations so they can actively participate in planning and funding opportunities to address their communities' needs.	Role 4	12%	38%	9%	29%	12%	4%	50%	44%	3%
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.	Deliverable 1	9%	44%	9%	26%	12%	4%	57%	36%	3%

APPENDICES

APPENDIX A: GLOSSARY AND ACRONYMS

Abbreviations/Acronyms

Term	Abbreviation/Acronym
Governmental Public Health Providers	Providers
State Governmental Public Health Authorities	State Public Health Authorities
Local Public Health Authorities	LPHAs
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, and 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 to the public about outbreak investigations. Communicate clearly with members of the public 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 educate 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

Prevent and investigate 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

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; and 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

Promote 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, including environmental health, 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

Prevent and control 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 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

Improve nutrition and incentivize increased physical activity.

- Use surveillance data collected by the OHA Public Health Division and use assessment and epidemiology methods to improve nutrition and 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 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 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 to develop planning documents around oral health.
- Educate consumers about 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 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

Improve 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 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

Decrease 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 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 to all 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

- Provide 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

- Provide screening for sexually transmitted infections.
- Ensure 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

- Provide 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 ensure 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 the following 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

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 the 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 a 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, and 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 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 policy makers, 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 either (i) an excess burden of adverse health or socioeconomic outcomes; or (ii) an excess burden of environmental health threats.
- Foster shared understanding and will to achieve health equity and cultural responsiveness.
- Make available 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 clear and transparent communications easily and quickly available to 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 on civil rights implementation using tracked findings to report ways to decrease civil rights violations.
- Promote community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic minorities, 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 of 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 culture 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, and 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, professional development, and 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 how 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. Ensure that technology systems and 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 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.

