Oregon Public Health Modernization Evaluation Report: 2021-2023 Biennium

Oregon Health Authority

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Letter from OHA's Public Health Director

Every person in Oregon deserves to live in a state where they can have a fair chance at optimal health. We know that health is mostly shaped by things that happen outside the walls of a medical clinic. Health is shaped by things like clean air and water, access to healthy foods, protection from health harms, and supportive community connections. Public health focuses on creating safe and healthy community conditions and high-quality prevention services so that every person has what they need to live a healthy life.

It is overwhelmingly clear that not all people have equal access to life-saving protections. The COVID-19 pandemic and recent climate events highlighted that new, complex health threats do not impact all Oregonians equally. Rural communities, communities of color, Tribal communities, disability communities, communities living with lower incomes and other underserved communities experience worse effects of health problems. These health inequities are avoidable, unfair and unjust.

We can, and we must, do something about this injustice. Since 2013, Oregon has been on a path to achieving a modern public health system that creates thriving communities, rapidly responds to health threats, and directly addresses gaps in our system that result in inequities. Legislative investments in public health modernization have resulted in governmental and community partners coming together to co-create and implement solutions.

This report demonstrates system-wide improvements occurring through 2021-2023 Legislative investments in public health modernization. Investments resulted in strong and sustainable partnerships with community partners that serve communities experiencing the worst effects of health problems. These investments led to changes in our public health workforce to better meet the needs of communities today and into the future.

This report also demonstrates ongoing challenges in our public health system and lays out the clear actions we need to take to address these challenges. Oregon is on the path to achieve an equity-focused and modern public health system, and the findings and recommendations in this report describe the work ahead. It is imperative that we heed this information and re-double our commitments to becoming the public health system that people in Oregon need — we simply cannot aim for anything less.

Sincerely,

Rachael Banks, MPA

Public Health Director

Executive Summary

Oregon Health Authority

Executive Summary

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

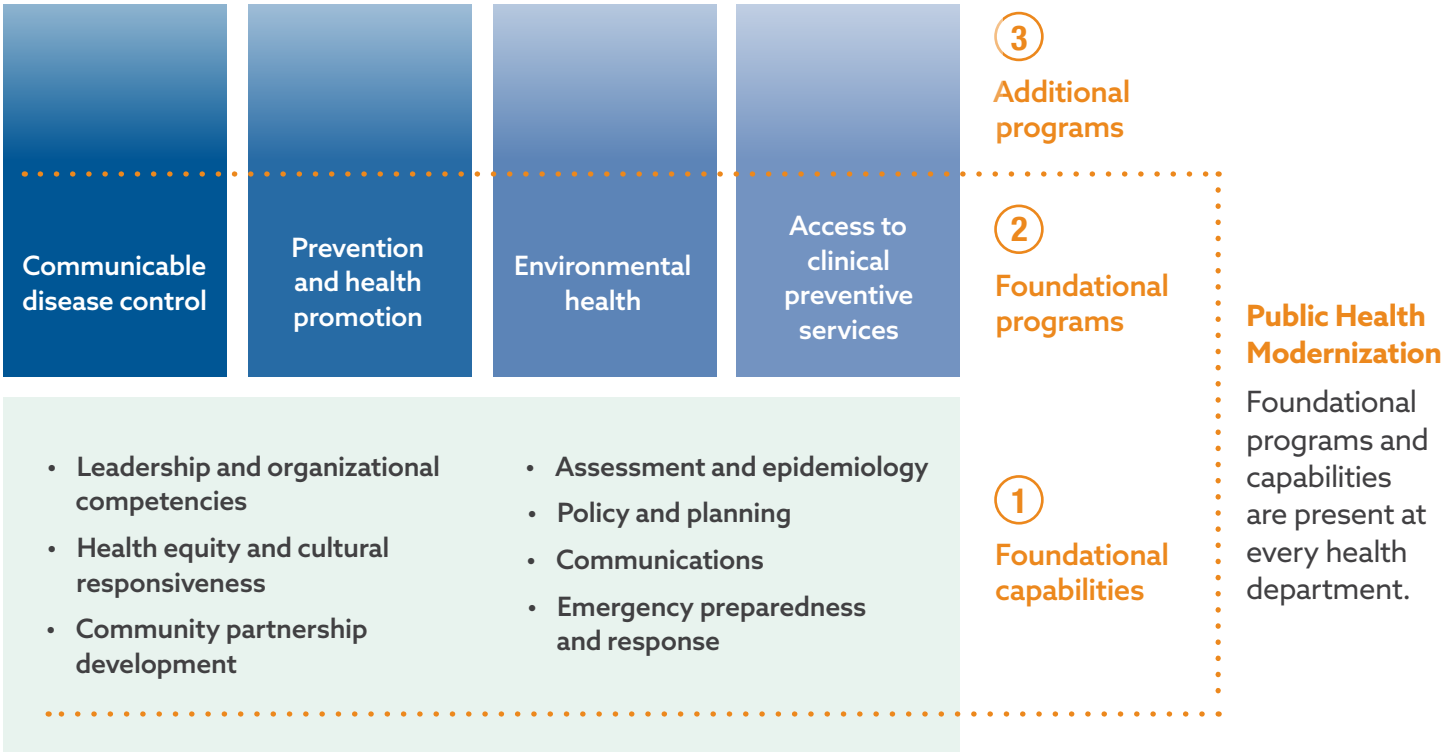
The public health system works daily with partners – including CBOs – to ensure that communities who experience disproportionate burdens of health inequities receive culturally and linguistically responsive interventions. CBOs often provide hyper-local, culturally specific and linguistically appropriate services that complement governmental public health responsibilities.

The 2013 Oregon Legislature recognized the need for significant changes to the public health system as a foundation for health system transformation. And so, the Task Force on the Future of Public Health Services, created by House Bill 2348 (2013), developed a set of recommendations to modernize Oregon's governmental public health system to meet the needs of the population in years to come.

The Task Force on the Future of Public Health Services recommended that Oregon:

1. Adopt a set of foundational capabilities and programs to ensure a core set of public health services is available in every area of the state (framework depicted below).
2. Allocate significant and sustained state funding to support implementation of foundational capabilities and programs.

Modernized framework for governmental public health services



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These recommendations align with the requirements for national public health accreditation and new CDC funding through the Public Health Infrastructure Grant, released in December 2022.

In 2015 Oregon's Legislature passed House Bill 3100, which codified the Modernized Framework for Governmental Public Health Services into law. Since 2017, Oregon's Legislature has steadily increased funding to sustain and accelerate changes needed to achieve an equitable, community-centered and accountable public health system.

This evaluation report examines the effects of public health modernization investments during the 2021-2023 biennium. The investments—$60.6 million in state General Funds—had four overarching goals:

1. Strengthen and expand communicable disease and environmental health emergency preparedness
2. Protect communities from acute and communicable diseases through prevention initiatives that address health inequities
3. Co-create public health interventions that ensure equitable distribution or redistribution of resources and power and that recognize, reconcile and rectify historical and contemporary injustices
4. Protect communities from environmental health threats through public health interventions that support equitable climate adaptation

Partnerships and workforce, both essential to reach these goals, are the focus of this evaluation report. Oregon is on a long-term journey to modernize its public health system and eliminate health inequities. This report reflects two years in that journey to demonstrate that the system is better serving communities and provides forward-looking recommendations to help Oregon better meet the public health challenges ahead. The report includes the process used to develop an evaluation plan and presents evaluation questions with corresponding results to inform recommendations.

Evaluation Collaborators

Two separate groups formed to co-create and guide the evaluation: an Evaluation Working Group and an Evaluation Technical Panel. Both groups had a similar purpose: "To assist Oregon Health Authority (OHA) Program Design and Evaluation Services in co-creating an evaluation of the 2021-2023 state legislative modernization funding." This work included:

- Development of core evaluation domains and questions
- Methodology for the above
- Guidance on data interpretation and analysis
- Dissemination review

The two groups differed in composition and meeting frequency. For more information about committee membership and structure, please see Appendix page 71.

Evaluation Domains and Questions

Oregon's public health system is structured around a set of foundational capabilities:

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

These capabilities are the cross-cutting skills and capacities needed to ensure public health protections and to conduct programs and activities. (Source: Public Health Accreditation Board National Center for Innovations, FPHS Fact Sheet). For more information, please see Oregon's Public Health Modernization Manual.

The evaluation domains focused on understanding two areas:

Advancement in foundational public health capabilities.

The primary evaluation question for this domain was:

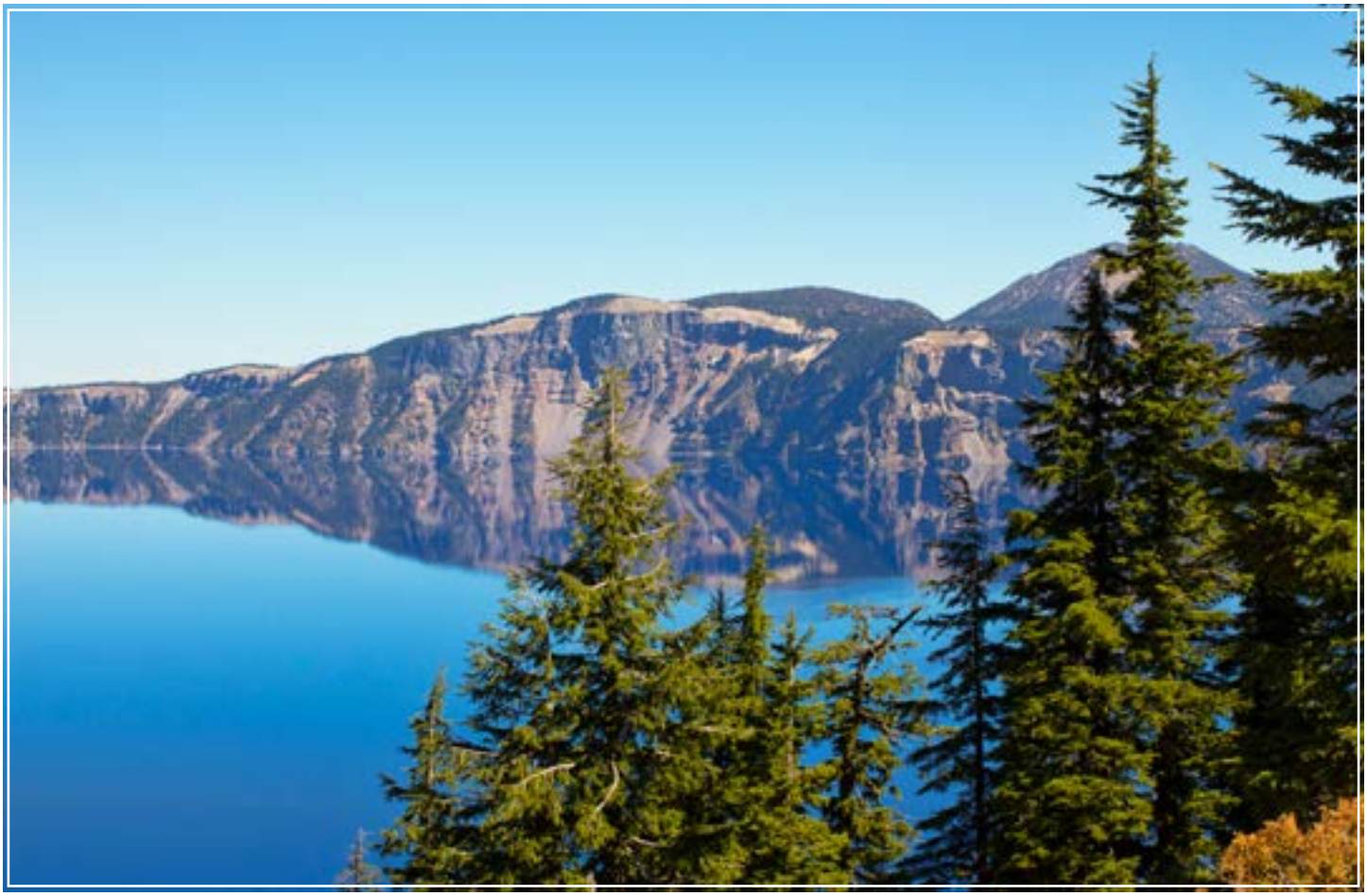
1. **If and how has Oregon's public health system advanced in these foundational capabilities via the relationship between OHA, Local Public Health Authorities (LPHAs) and Community-Based Organizations (CBOs)?**

Public health workforce to support advancement in foundational public health capabilities

The evaluation questions for this domain were:

1. **How has the workforce changed with this funding?**
2. **What have these modernization-funded new staff allowed the public health system to do?**
3. **What are facilitators and barriers to recruitment and retention?**
4. **Where are existing workforce gaps?**

These two overarching evaluation domains were chosen to better understand advancement in the public health foundational capabilities recognizing that a strong governmental public health workforce is necessary to make progress.



Methods in Brief

Evaluation Domain: Public Health Foundational Capabilities

The evaluation team added survey questions to the required activity reporting system for all LPHAs and CBOs receiving public health modernization funds. The CBO survey was open from October 13 to November 21, 2022. The LPHAs responded to survey questions from October 5 to November 30, 2022.

Evaluation Domain: Workforce

The evaluation team used a mixed methods approach including primary and secondary data collection and analysis. Primary data collection included survey questions in LPHA activity reporting and key informant interviews of local public health and state public health leaders. Secondary data analysis included document review such as local and state budgets, position descriptions and Human Resources (HR) analytics, 2021 Association of State and Territorial Health Officials (ASTHO) Profile, 2021 Oregon Epidemiology Capacity Assessment (ECA), and 2021 Public Health Workforce Interest and Needs Survey (PHWINS).

Results in Brief: Key Takeaways and Recommendations

Evaluation Domain: Public Health Foundational Capabilities

Key Takeaways

Strong partnerships were developed or expanded with communities that experience the worst health outcomes. The evaluation found that LPHAs and CBOs focused more on strengthening the Community Partnership Development and Communication foundational capabilities than the Assessment and Epidemiology and the Policy and Planning foundational capabilities.

- **The focused efforts on Community Partnership Development and Communications make sense given the developmental stage of partner collaboration.** Community Partnership Development and Communications work received support from the types of new staff described in the workforce evaluation domain.
- **The Health Equity and Cultural Responsiveness capability and the Community Partnership Development capability integrate throughout all foundational capabilities.** The Health Equity and Cultural Responsiveness capability was harder to measure in procedures or actions. When assessing the growth of each public health foundational capability, it is necessary to account for a natural overlap among the foundational capabilities.
- **More examples emerged of dyad collaboration (i.e., OHA/CBO, LPHA/CBO and OHA/LPHA) than of triad collaboration (i.e., CBO/LPHA/OHA).** One example of triad collaboration was mpox communication responses involving partnership between CBOs, LPHAs and OHA. Also, fewer CBOs reported coalition work with both an LPHA and OHA (n=6) than CBOs who reported partnering with only an LPHA (n=11) or only with OHA (n=11).

Recommendations

- **Support understanding and recognition of strengths and unique contributions of government and non-government partners** in each capability, portraying examples of what triad work can accomplish in different areas of the state and by differing capabilities. It is essential to assess common understanding of key terms among funded partners to describe the public health system and how to measure it.
- **Examine when, where and how dyad or triad collaboration seems relevant and most beneficial to the populations served.** What are some barriers and facilitators to triad work?
- **Explore hiring an external facilitator with training in Industrial/Organizational Psychology or a related discipline to better understand all partners' needs and areas for growth and collaboration.** Given less frequent triad collaboration, examine components of organizational trust, as well as what prevents and what supports developing trust across system partners.
- **Invest in developing and sharing stories of how funded partners come together to collaborate in service of their shared communities**. As an example, opportunities exist between LPHAs and CBOs in developing and sharing locally tailored culturally specific interventions.
- **Gain an improved understanding of whether – and how – Oregon residents see public health advancing in these core services and capabilities and ultimately feel better served by the public health system.**

These results support the findings and recommendations from a study of Oregon's public health system's response to the COVID pandemic (Source: Senate Bill 1554 Report: Oregon-Public-Health-Response-COVID-19-Pandemic-Report-2.pdf). Among the gaps CBOs identified in the support they received was a limited understanding of how to operationalize equity in COVID response activities. The report also noted the need to foster and maintain relationships and collaboration between CBOs, OHA and LPHAs.

Evaluation Domain: Workforce

Key Takeaways

- Staffing increased for LPHAs and OHA Environmental Health and OHA Communicable Disease—as did corresponding work in these essential programmatic areas.
- Staffing increased for LPHA and OHA staff working in cross-cutting foundational capabilities.
- Bridging organizational silos and restructuring in OHA and LPHAs took place.
- Administrative challenges include overextended managers, leadership changes, barriers in hiring and need for clear career pathways.
- Leadership is more people-centered and focused on workforce wellness as a result of reported workplace stress and burnout that occurred during the pandemic.
- OHA and LPHAs began – or accelerated – efforts to ensure that their staffing reflects the communities and demographics they serve.

Evaluation Domain: Workforce (continued)

Recommendations

1 Support overextended managers.

Public health managers reported being overextended, with a greater intention to leave and higher levels of burnout, stress and lack of support compared to all staff.

Recommendations for Health of Management

- Recognize that staffing up and building successful teams takes additional work and time, especially in a virtual environment. Hire administrative staff to delegate tasks and contract with Human Resources recruiters to reduce manager workload with hiring and onboarding.
- Consider review of management structure and management staffing needs before hiring additional staff; revisit manager-to-staff ratios.
- For OHA and LPHAs operating in virtual environments, revisit telework policies and guidelines for video conferencing to address burnout from screen time, to identify in-person opportunities for team building and create social support in the workplace.
- Revisit management work hours spent in email correspondence, phone calls, or in person meetings to increase efficiency and reduce workload on management.
- Prioritize workloads and set realistic workplans; identify time-sensitive work vs. work that can be returned to when staff capacity is higher.
- Celebrate accomplishments in building staffing capacity.

Additionally, some recommended organizational supports for worker wellness apply to all staff including but not limited to management.

Recommendations for Health of All Staff including Management

- Prioritize physical and psychological safety. Psychological safety is the shared belief that the team is safe for interpersonal risk taking and can share ideas and opinions freely without fear of negative consequences.[3,4]
- Support individual employees' need to connect personal work motivations with organizational mission.[3]
- Provide ways to see the results of one's work and feel rewarded and encouraged to continue.
- Build a workplace culture that celebrates gratitude, respect, recognition, inclusion and belonging.
- Use tools such as National Association of County and City Health Officials (NACCHO) Joy in Work Toolkit,[8] Surgeon General's Framework for Workplace Mental Health and Well-Being,[10] and National Institute of Occupational Safety and Health (NIOSH) Total Worker Health to guide workplaces towards improving worker health and wellness.[9]
- Engage in organization-led initiatives, including reducing the number of hours or percentage of time public health workers work on an emergency response.[7]
- LPHAs, County leadership and OHA can continue to provide trauma-informed leadership sessions and support for their respective employees[2] and Coalition of Local Health Officials (CLHO) can continue to provide corresponding sessions and support for local health officials.

2 Preserve institutional knowledge and conduct succession planning.

Significant changes in LPHA leadership in the past two years, as well as more OHA Public Health Division (OHA-PHD) employees becoming eligible for retirement, increased the importance and need to preserve institutional knowledge and enhance succession planning. For example, 18 changes took place across 14 LPHAs at the local health administrator/director/manager level since July 1, 2021. This included four LPHAs with multiple leaders turning over. Among the LPHAs with workforce development plans, only one LPHA noted succession planning as a component of their plan. Succession planning will be incorporated into the forthcoming Oregon Public Health System Workforce Development Plan that includes OHA, LPHAs and system partners.

Recommendations

- Dedicate personnel and funding to succession planning; review Office of Personnel Management (OPM) Succession Planning Domains, Activities and Strategies.[15,16]
- Prioritize developing management or leadership skills and identify talent pools.
- Identify competency requirements of leadership and address current gaps.
- Develop or update Standard Operating Procedures for programmatic work in preparation of staff turnover and especially for executive leadership positions.

3 Demonstrate career pathways for core public health work.

In key informant interviews, staff reported a lack of advancement opportunities and clear career pathways. PHWINS data supports this feedback.

Recommendations

- Forge clear and equitable development routes for professionals at all levels to advance, including mentorship and career guidance.[3]
- Align position descriptions and corresponding career tracks to the Core Public Health Competency Framework.[13]
- Create a clearinghouse of position descriptions to assist health departments in determining needed knowledge, skills, abilities and compensation levels when creating new positions.[2]
- Establish new pathways and expand existing ones to significantly increase the number of personnel exchanges between different levels of government and the private sector, to facilitate the sharing of expertise, community knowledge, lessons learned and career opportunities among the many organizations that make up Oregon's public health system.[14]

4 Resolve administrative barriers in hiring, including external Human Resources and lack of specific public health classifications and commensurate pay scales.

> "I've argued that we need to have HR centralized, at least in our own area of expertise. So our recruiters and our labor folks can all get familiar with public health and the content area....What we're missing is our HR team being able to grow with managers and understanding the skill sets that we need moving forward."

Administrative barriers in the hiring process include Human Resources departments external to the public health agency along with the need for specific public health classification and commensurate pay scales. These barriers can lead to staffing shortfalls attracting and hiring staff in finance, environmental health and nursing roles as well as in rural areas.

Recommendations for Public Health Departments

- Support recruiters' familiarity with public health content area so Human Resources teams can grow with managers and advance understanding of the skill sets needed.
- Ensure sufficient Human Resources capacity, especially during periods of rapid growth, considering best practices for Human Resources-to-staffing ratios.
- Partner with leaders in government reform to update merit systems, civil service requirements, position descriptions and HR systems.[1]
- Work with County commissioners and unions to identify solutions for adjusting compensation to be competitive with local industries.[2]
- Revisit position classifications and minimum requirements.[2]
- Build the Strategic Skills in the Government Public Health Workforce into the public health job classifications.[5]

Recommendations for Policymakers

- Modernize existing civil service requirements and institute competitive pay structures to accommodate roles and responsibilities specific or unique to public health.[1]
- Approve budgets that ensure:
  - Training and professional development of the public health workforce involved with implementing core programs and applying all necessary cross-cutting skills.
  - Salary structures commensurate with roles and responsibilities and competitive with salaries for similar positions in nongovernmental agencies.[1]

5 Improve understanding of hiring cycle times, develop process maps and conduct corresponding Quality Assurance/Quality Improvement (QA/QI) activities.

Self-reported LPHA hiring timelines and OHA-PHD HR data indicate a need for improved tracking of the hiring process, clarity of what is and what is not measured in hiring timeliness, and overall data quality. These data points can provide a baseline understanding for the newly required hiring timeliness performance measure for the CDC Public Health Infrastructure Grant.

Recommendations

- Develop process maps and Standard Operating Procedures for hiring.
- Implement QI projects to improve hiring cycle times for process steps under LPHA/OHA control; refer to Public Health Quality Improvement Exchange (PHQIX) for QI tools and related projects.[11]
- Improve understanding of similarities and differences in governmental public health hiring processes across the state, by identifying and sharing best practices, particularly regarding hiring cycle times.

6 Understand the extent to which staff represent the populations served in jurisdictions across the state and the types of positions filled by staff demographics. Invest in training and policy development to support inclusive workplaces.

Insufficient data exist to determine the extent that Oregon's public health workforce represents the populations served and types of positions filled by staff. Collection and use of demographic data are unclear and may vary from jurisdiction to jurisdiction (e.g., race/ethnicity, age, gender, disability status, rural/urban representation).

Key informant interviews showed that facilitators to recruiting and retaining staff who represent the communities they serve included: desire to work with a diverse team, having a manager of color, representative hiring panels, and organizational policies on diversity, equity and inclusion (DEI). Barriers included: sufficient budget to allow for multiple bilingual and bicultural positions, mentoring staff of color in systems still rooted in bias, and the balance and tensions between home growing and diversifying the workforce.

Recommendations

- Align workforce assessments with corresponding population demographics.
- Define measures of success in building a workforce that is representative of populations served.
- Define and measure components of an inclusive workplace for governmental public health agencies.
- Develop or continue affinity spaces and build professional networks among public health employees and leaders of color and from other groups that are underrepresented in the public health workforce.

Conclusion

During the 2021-2023 biennium, state legislative investments in public health modernization led to hiring new and essential public health staff across Oregon, especially employees with a specific focus in Environmental Health and Climate, Communicable Disease, Health Equity & Cultural Responsiveness, Communications and Community Partnership Development. As a result, critical work expanded in these foundational public health programs and capability areas. The mpox response demonstrated how improvements occurring through public health modernization better prepared the system to respond to an emerging communicable disease threat and protect those at risk from disease.

To deepen these advancements and make strategic use of future public health modernization funding, Oregon's public health system needs continued attention on strengthening the local and state governmental public health workforce. One study found in an analytic sample that nearly half of all employees in U.S. state and local public health agencies left between 2017 and 2021, a proportion that rose to three-quarters for those ages 35 and younger or with shorter tenures. If separation trends continue, this could lead to more than 100,000 staff, or as much as half of the nation's governmental public health workforce in total, leaving their organizations by 2025.[5] Focused efforts to address recruitment and retention challenges in Oregon are necessary to meet both the expected and unexpected needs ahead.

Finally, an area emerging from the conversations with both Evaluation Advisory Groups is the importance of organizational trust. Among the priorities moving forward, the evaluation team recommends exploring the components of building organizational trust in the governmental public health system, including what prevents and what supports the development of trust, both internally and with system partners. Organizational trust lies at the foundation of workforce development and partnership advancement.

Background

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Background

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

The governmental public health system works daily with partners – including CBOs – to ensure that communities who experience disproportionate burdens of health inequities receive culturally and linguistically responsive interventions. CBOs often provide hyper-local, culturally specific and linguistically appropriate services that complement governmental public health responsibilities.

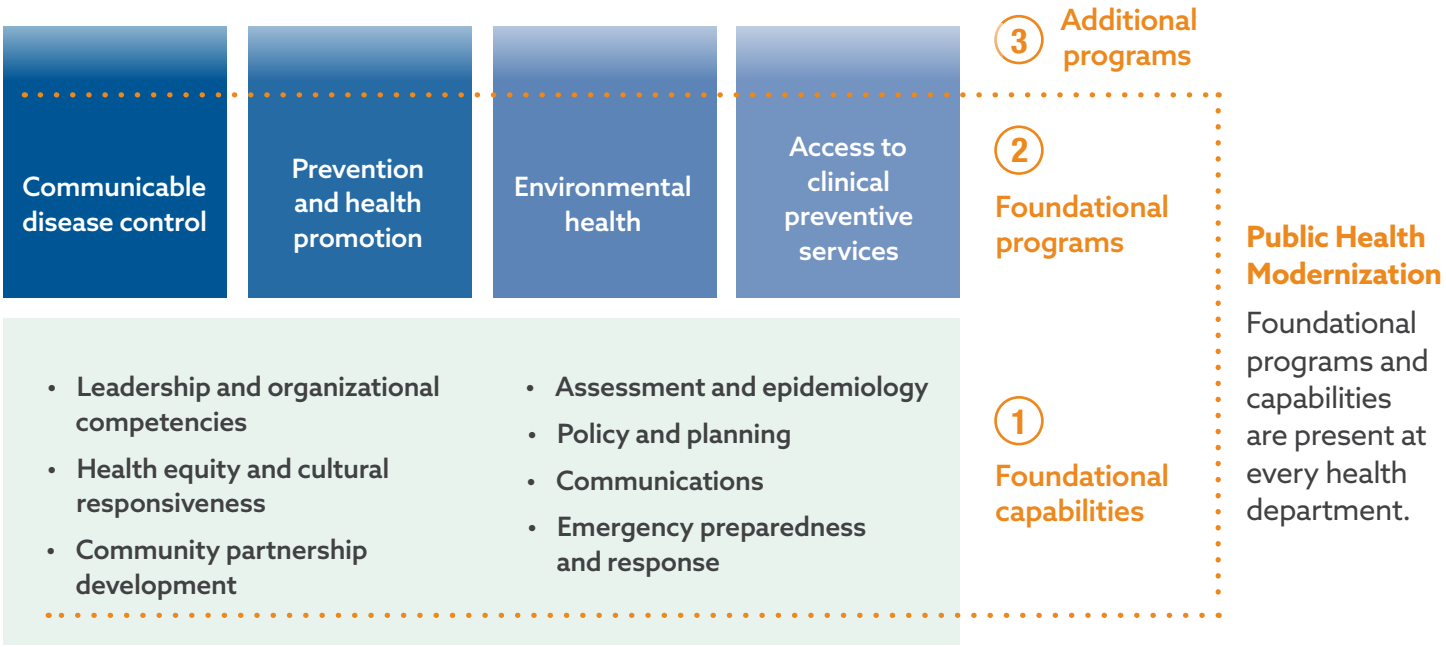
In 2013, the Oregon Legislature recognized the need for significant changes to the governmental public health system as a foundation for health system transformation. And so, the Task Force on the Future of Public Health Services, created by House Bill 2348 (2013), developed a set of recommendations to modernize Oregon's governmental public health system to meet the needs of the population in years to come.

The Task Force on the Future of Public Health Services recommended that Oregon:

1. Adopt a set of foundational capabilities and programs to ensure a core set of public health services is available in every area of the state
2. Allocate significant and sustained state funding to support implementation of foundational capabilities and programs

These recommendations align with the requirements for health department accreditation and new CDC funding through the Public Health Infrastructure Grant.

The Task Force on the Future of Public Health Services Recommended a Modernized Framework for Governmental Public Health Services



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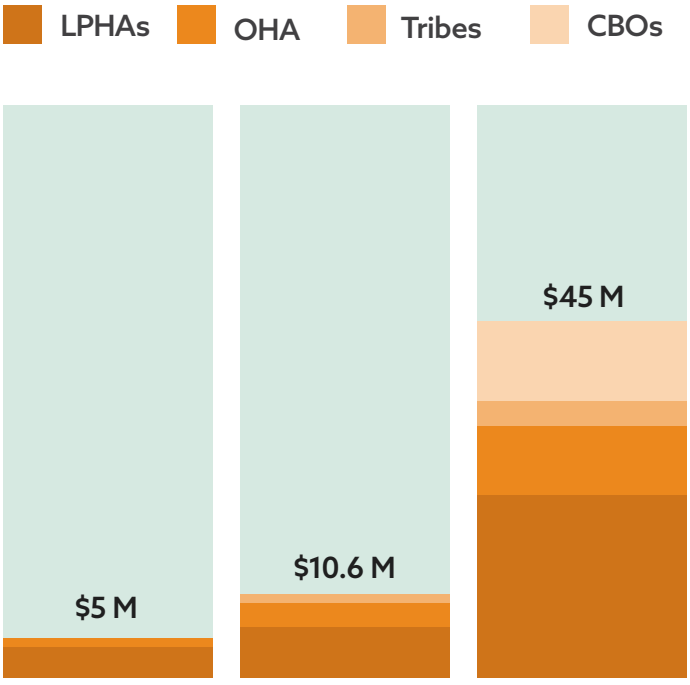
Then, in 2015, the Legislature passed House Bill 3100, which adopted the foundational capabilities and programs for state and local public health authorities. Oregon's Legislature first provided funding to begin implementing foundational capabilities and programs in 2017, with legislative investments increasing in 2019 and 2021. The total budget for public health modernization in 2021-2023 was $60.6 million.

Oregon Legislature Makes New Investments Each Biennium



2017-19
OHA **$1.1 M**
LPHA **$3.9 M**

2019-21
Tribes **$1.1 M**
OHA **$3.1 M**
LPHA **$6.4 M**

2021-23
CBOs **$10 M**
Tribes **$3.3 M**
OHA **$8.7 M**
LPHA **$23.1 M**

Note that CBOs received public health modernization funding to provide community-led, culturally and linguistically responsive services for the first time in 2021. For more information about the CBO Public Health Equity Program, please visit: https://www.oregon.gov/oha/ph/about/pages/public-health-funding-cbo.aspx.

This evaluation report focuses on the 2021-2023 biennium. In this phase, 2021-2023 public health modernization investments had four overarching goals.

- Strengthen and expand communicable disease and environmental health emergency preparedness
- Protect communities from acute and communicable diseases through prevention initiatives that address health inequities
- Co-create public health interventions that ensure equitable distribution or redistribution of resources and power and that recognize, reconcile and rectify historical and contemporary injustices
- Protect communities from environmental health threats through public health interventions that support equitable climate adaptation

The 2021-2023 funding helped expand communicable disease prevention, prepare communities for emergencies and to make statewide investments for the first time in climate and health planning.

Expanded Results

Oregon Health Authority

Expanded Results

Part One: Public Health Foundational Capabilities

If and how has Oregon Public Health advanced in these foundational capabilities via the relationship between OHA, LPHAs and CBOs?

As referenced in the Methods section, the evaluation answered this question by using the required CBO and LPHA Activity reports and the OHA internal modernization reporting as two data sources.

This report organizes and presents the results sorted by foundational capability, with reporting of LPHA results followed by reporting of CBO results. Further information on each Foundational Capability is available in: Oregon's Public Health Modernization Manual.

Foundational Capability: Community Partnership Development

Local Public Health Authorities

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

84% (n=27) of LPHAs reported new or significantly expanded partnerships with CBOs in the past year that were critical for carrying out planned work for achieving priorities.

As shown in the table below, most LPHAs have mechanisms in place to support their work with CBOs. The types of LPHA engagement with CBOs vary with the most frequently reported activity being regular meetings with CBOs, followed by having formal agreements and providing technical assistance. A significant number of LPHAs reported providing training or directly funding CBOs (41% and 38%, respectively).

Most LPHAs Have Mechanisms in Place to Support CBOs

Does your LPHA use any of the following mechanisms to establish and/or provide ongoing support partnerships with community-based organizations? *This includes both public health modernization and other community health initiatives in your response.*	**N (%)**
My LPHA **regularly meets** with CBOs to discuss joint efforts, opportunities to leverage resources and coordination across common goals	25 (78%)
My LPHA **holds memoranda of understanding**, contracts or other formal agreements with CBOs	21 (66%)
My LPHA **provides technical assistance** and other supports to CBOs	20 (63%)
My LPHA **provides training** to CBOs	13 (41%)
My LPHA **directly funds** CBOs	12 (38%)

Community-Based Organizations

More than half of the 47 CBOs reported having projects that involve participating in or facilitating community coalitions. Of the 28 CBOs with projects engaging coalitions, 11 CBOs have one or more LPHA participating and 11 have OHA participating in these coalitions. Six CBOs reported participating in or facilitating coalitions with one or more LPHAs and OHA. Sixty-nine CBOs were funded by public health modernization and 47 responded by the reporting deadline.

Most CBOs Engage in Coalition Work	N (%)
Does your project involve participating or facilitating community coalitions?	28 (60%)
Are one or more local health departments participating in the coalitions?	11 (39%)
Is OHA-PHD participating in the coalition?	11 (39%)

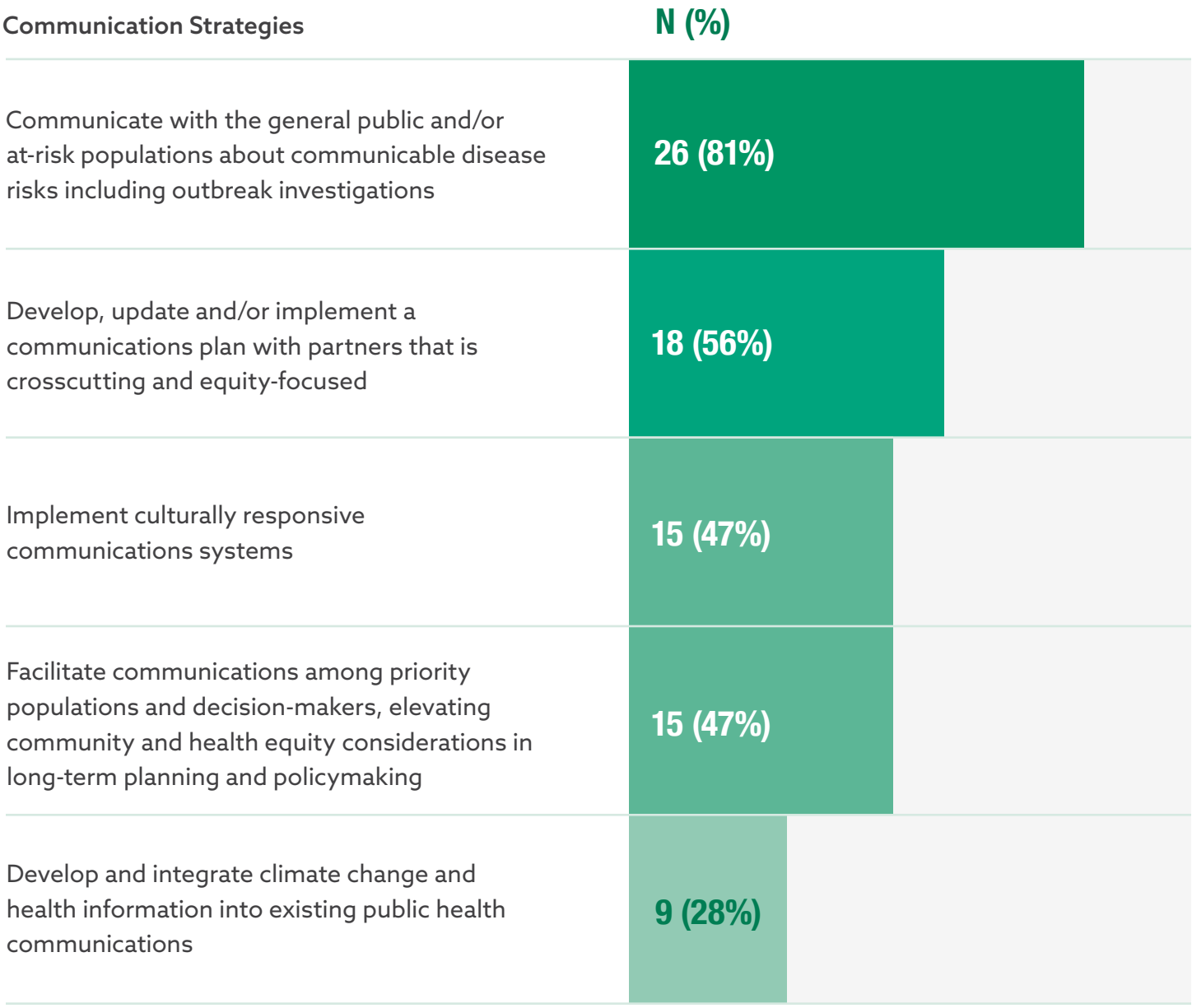
Foundational Capability: Communications

Local Public Health Authorities

LPHAs have a core responsibility to communicate to the public about health risks in their communities, and all LPHAs are strengthening strategies to communicate with the public with public health modernization funds.

Fewer than half of LPHAs reported implementing culturally responsive communication systems and facilitating those communications among priority populations in ways that elevate community priorities and health equity considerations into long-term planning and policy making.

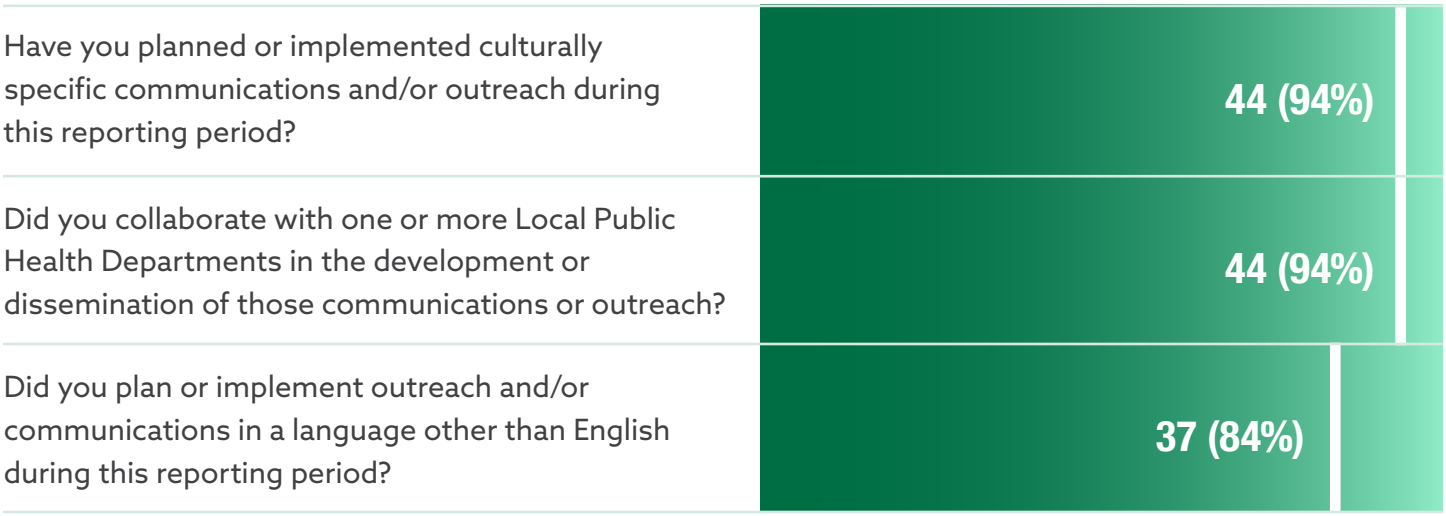
With Funding, Most LPHAs Communicate About Communicable Disease Risks – Fewer Implement Culturally Responsive Communications Systems



Community-Based Organizations

Nearly all modernization-funded CBOs planned or implemented culturally specific communications and collaborated with one or more LPHAs in the development or dissemination of those materials.

Nearly All CBOs Active in Culturally Responsive and Collaborative Communications



CBOs, LPHAs and OHA partnered together in developing and delivering communication materials during the mpox response.

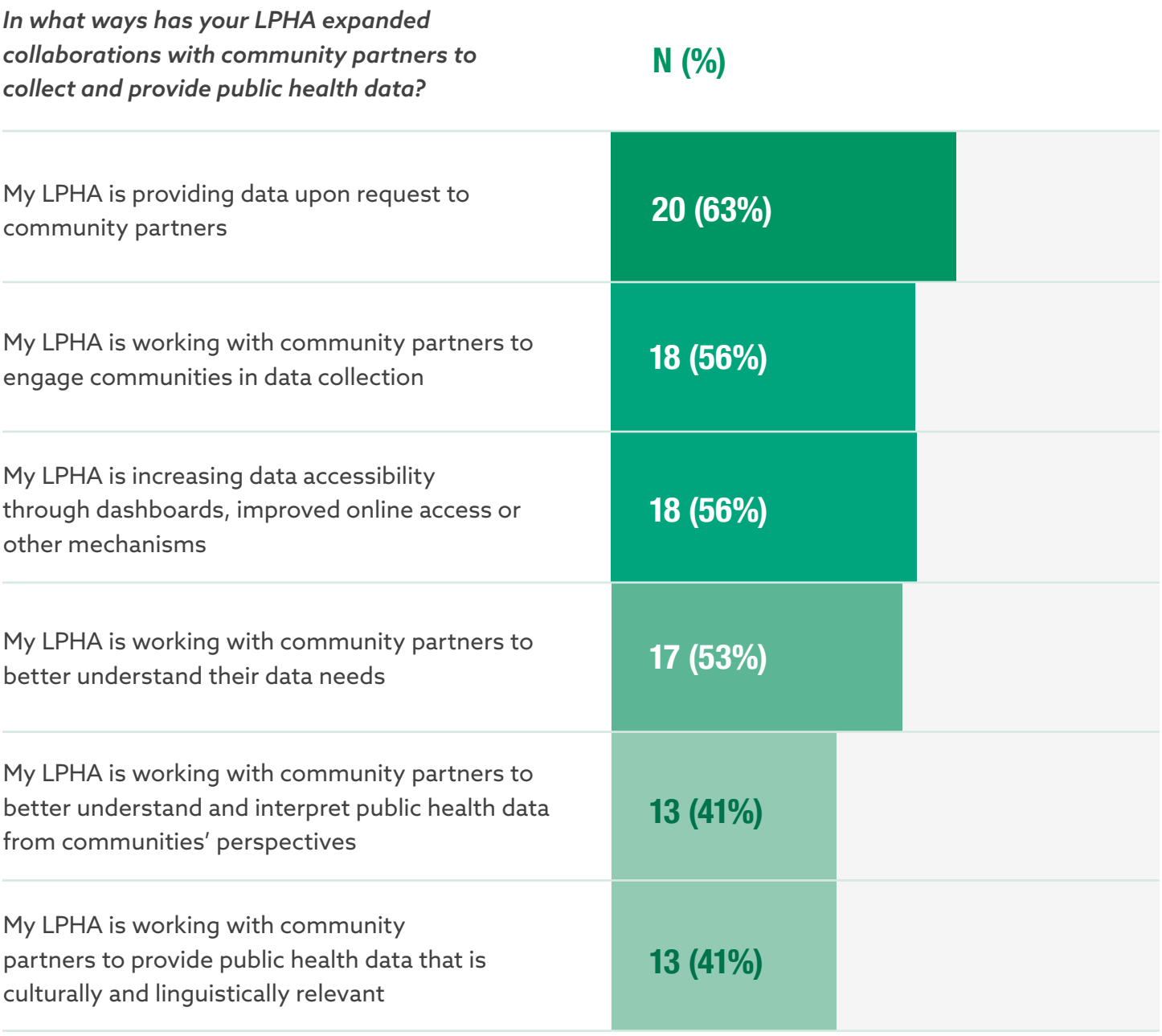
Foundational Capability: Assesment and Epidemiology

Local Public Health Authorities

LPHAs reported expanding collaborations with community partners to collect and provide public health data. Roughly 60% of LPHAs provide data upon request to community partners, engage them in data collection and work to increase data accessibility.

Less frequently, LPHAs worked to understand community partner data needs, interpret data from a community perspective and provide data that is culturally and linguistically relevant.

Many LPHAs Provide Data on Request to Community Partners—or Engage Partners on Data Collection in Other Ways



Community-Based Organizations

Among modernization-funded CBOs, 60% (n=28) reported they currently use or plan to use public health data provided by their local health department to carry out their project workplan. And, roughly 50% (n=23) currently use or plan to use public health data provided by OHA to carry out their project workplan.

CBOs Use Governmental Public Health Data for Project Workplans

60% of CBOs (n=28) currently use or plan to use public health data provided by their local health department to carry out their project work plan.

51% of CBOs (n=23) currently use or plan to use public health data provided by OHA to carry out their project work plan.

As an example, an Oregon county is co-creating solutions with CBOs and communities experiencing the greatest burden of disease, by hosting "data parties."

- A data party involves sharing data and asking partners (CBOs as well as individuals) to help with interpretation. It is also known as "participatory analysis."
- Data parties ask participants: "What's missing? What do we want to know that's not here?" Data parties are both an opportunity to improve data literacy in the community as well as to engage community members in identifying priorities and solutions.
- They also host twice monthly CBO meetings, during which CBOs share their work as well as what kind of county support they need. The county team conducts listening sessions with CBO partners as well as internal partners and they jointly identify the priorities for the work.

Foundational Capability: Policy and Planning

Local Public Health Authorities

Among LPHAs, 50% (n=16) reported working with, or planning to work with, new partners on policy development or implementation related to their modernization priorities.

Community-Based Organizations

One third of CBOs (n=16) reported their project involves developing or implementing policy changes. Among those 16 CBOs, half (n=8) work with OHA, one third (n=5) work with another state agency and one fourth (n=4) work with their LPHA on policy development and implementation.

One Third of CBOs Work on Policy Change

34% of CBOs (n=16) report their project involves developing or implementing policy changes.

Among the CBO partnerships focused on policy development or implementation:

50% of CBOs (n=8) work with OHA-PHD.

25% of CBOs (n=4) work with their LPHA.

31% of CBOs (n=5) work with other states.

Key Takeaways

Strong partnerships were developed or expanded with communities that experience the worst health outcomes.

- The evaluation found that LPHAs and CBOs are most focused on strengthening the Community Partnership Development and Communication foundational capabilities. The focused efforts on Community Partnership Development and Communications make sense given the developmental stage of partner collaboration. Community Partnership Development and communications work received support from the types of new staff described in the workforce evaluation domain.
- The Health Equity and Cultural Responsiveness capability and the Community Partnership Development capability integrate throughout all foundational capabilities. The Health Equity and Cultural Responsiveness capability was harder to measure in procedures and actions. When assessing the growth of each public health foundational capability, it is necessary to account for a natural overlap among the foundational capabilities.
- More examples emerged of dyad collaboration (i.e., OHA/CBO, LPHA/CBO and OHA/LPHA) than of triad collaboration (i.e., CBO/LPHA/OHA). One example of triad collaboration was mpox communication responses involving partnership between CBOs, LPHAs and OHA. Also, fewer CBOs reported coalition work with both an LPHA and OHA (n=6) than CBOs who reported partnering with only an LPHA (n=11) or only with OHA (n=11).

Recommendations

- Support understanding and recognition of strengths and unique contributions of government and non-government partners in each capability, portraying examples of what triad work can accomplish in different areas of the state and by differing capabilities. It is essential to assess common understanding of key terms among funded partners to describe the public health system and how to measure it.
- Examine when, where and how dyad or triad collaboration seems relevant and most beneficial to the populations served. What are some barriers and facilitators to triad work?
- Explore hiring an external facilitator with training in Industrial/Organizational Psychology or a related discipline to better understand all partners' needs and areas for growth and collaboration. Given less frequent triad collaboration, examine components of organizational trust, as well as what prevents and what supports developing trust across system partners.
- Invest in developing and sharing stories of how funded partners come together to collaborate in service of their shared communities. As an example, based on reporting of the Assessment and Epidemiology and Communications capabilities, opportunities exist between LPHAs and CBOs in developing and sharing locally tailored culturally specific interventions.
- Gain an improved understanding of whether – and how – Oregon residents see public health advancing in these core services and capabilities and ultimately feel better served by the public health system.

When assessing the growth of each public health foundational capability, it is necessary to account for a natural overlap among the foundational capabilities.

These results support the findings and recommendations from a study of Oregon's public health system's response to the COVID pandemic (Source: Senate Bill 1554 Report: Oregon-Public-Health-Response-COVID-19-Pandemic-Report-2.pdf). Among the gaps CBOs identified in the support they received was a limited understanding of how to operationalize equity in COVID response activities. The report also noted the need to foster and maintain relationships and collaboration between CBOs, OHA and LPHAs.

Part Two: Evaluation on Workforce

A strong governmental public health workforce is necessary to make progress on the foundational capabilities previously described. The COVID-19 pandemic placed unprecedented pressures on the public health workforce and strained an already underfunded system.[14]

This section evaluates the answers to the following questions:

1. **How has the workforce changed with this funding?**
2. **What have these modernization-funded new staff allowed the public health system to do?**
3. **What are facilitators and barriers to recruitment and retention?**
4. **Where are existing workforce gaps?**

Understanding how this workforce has changed, and the supports that the public health workforce needs, will help Oregon better meet the public health challenges ahead.

> The 2021-2023 Public Health Modernization funds supported more than 300 LPHA positions.

1) How has the workforce changed with this funding?

The governmental public health workforce in Oregon changed in several key ways over the course of the 2021-2023 biennium of modernization funding. Key workforce changes include:

- Increased LPHA and OHA Environmental Health and Communicable Disease staff
- Increased LPHA and OHA staff working in foundational capabilities
- Bridged organizational silos and restructured to foster collaboration, share capacity and improve system-wide performance
- More people-centered workforce with increased focus on the well-being of public health staff
- Began and accelerated efforts to reflect communities served with health department staffing

For a sampling of the types of positions hired in the 2021-2023 biennium, please see the table below for examples in the two funded foundational program areas — Communicable Disease and Environmental Health — at the local, regional and state levels. Future evaluation will work toward quantifying the impact of these additional positions.

2021-2023 Modernization-Funded Governmental Public Health Workforce: Sample Job Titles from Foundational Programs

	LPHA Sample Position Titles	Regional Sample Position Titles	OHA Sample Position Titles
Communicable Disease	• Population Health Epidemiologist • Communicable Disease (CD) Control Investigator • Senior Community Health Analyst, CD • Infectious Disease Control & Prevention Program Manager	• CD Control Investigator • COVID Health Educator, Bilingual • Congregate Settings Outreach Nurse • Long-Term Facilities Outreach Nurse • Public Health Nurse, On-Call	• Manager for Disease in Carceral Settings • Surge Capacity Epidemiologist
Environmental Health	• Environmental Health Specialist (EHS) II – Vulnerable Population Outbreak Response and Prevention • Climate Justice Coordinator • Climate Policy Lead • Climate & Health, Program Planner	• Environmental Hazards Preparedness Coordinator • Climate Planning Coordinator	• Emerging Environmental Health Risks Lead • Environmental Epidemiologist (Water & Climate) • Climate & Health Equity Strategist • Land Use & Health Policy Specialist • Healthy Homes Operations & Policy Analyst

In addition to an increase in program specific staff, OHA and LPHA staff working in the public health foundational capabilities also increased.

OHA Workforce: Foundational Capabilities

As expected, natural overlap exists among several of the public health foundational capabilities. Below are sample positions hired in OHA-PHD, listed by the primary area or foundational capability housing most of the work.

- **Number of distinct job positions:**
  - 18 total (new and existing)
- **Sample position titles:**
  - Leadership and Organizational Competencies Positions
    - Public Health Modernization Lead
    - Budget Contracts Coordinator
    - Strategic Operations Lead
    - Interoperability Coordinator
  - Health Equity and Cultural Responsiveness Positions
    - Health Equity Coordinator
  - Community Partnership Development Positions
    - Operations Strategist Community of Practice
    - Community Engagement Program Manager
    - Community Engagement Coordinators (10 positions)
  - Policy and Planning Positions
    - Legislative Policy Lead

Most LPHAs created new staff positions: 69%

LPHA Workforce: Foundational Capabilities

(n=22) of LPHAs created new staff positions for the foundational capabilities that span program areas. Most frequently, they reported hiring for the Assessment and Epidemiology capability (73%).

LPHAs Add to the Work Force:

- **69%** of LPHAs (n=22) created new staff positions for foundational capabilities that span program areas
- **Which foundational capabilities did they hire for?**
  - **Assessment and Epidemiology: 73%** (n=16)
  - **Health Equity and Cultural Responsiveness: 64%** (n=14)
  - **Community Partnership Development: 55%** (n=12)
  - **Communications: 55%** (n=12)
  - **Policy and Planning: 50%** (n=11)
  - **Other: 27%** (n=6)

Least often, they reported hiring for Policy and Planning (50%).

In addition to LPHAs hiring for specific capabilities, 10 LPHAs hired modernization coordinators in this past biennium to facilitate the work conducted through these funds.

Bridging Organizational Silos and Restructuring

Another workforce change in this past biennium is the bridging of organizational silos and restructuring.

From LPHAs:

44% **(n=14) are restructuring teams to align with modernization priorities.**

44% **(n=14) are increasing management positions to support teams and progress toward priorities.**

Examples of cross-program restructuring:

- Restructuring to create foundational capability-specific work groups or creating a lead for each foundational capability
- Restructured teams so all foundational capability-specific staff report to the same leadership and serve across all program areas
- Expanding teams and/or changing position descriptions and responsibilities of staff to include deliverables outside of program-specific areas

Examples of program-specific restructuring:

- Created a new Communicable Disease-only team that expanded capacity for communications and partnership development
- Created a new Environmental Health team under a modernization supervisor

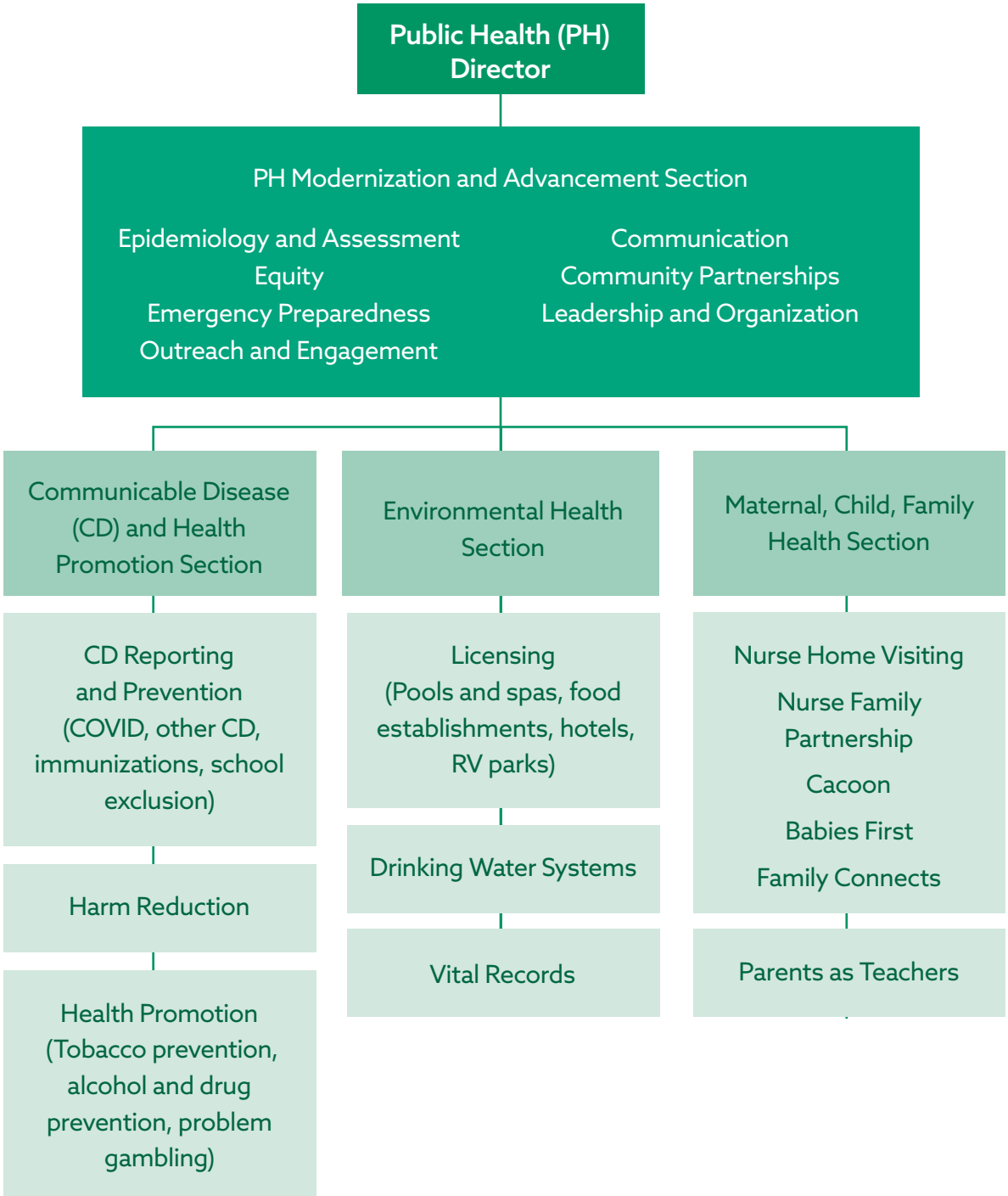
> "It's really nice to be able to start to see multiple capabilities across a classification across different programs, which I really think is the goal with modernization: We're less siloed; we're more flexible, nimble and collaborative; and we have more shared capacities and capabilities."

"We reorganized into two units – Healthy Communities and Health Protection. Each unit is supported by a program manager who reports to the Public Health Division Manager. The unit managers are familiar with the full scope of public health services and act as Public Health Manager/Health Administrator as needed. The development of the unit managers also contributes to the number of people in the state with public health leadership skills and expertise, a number that has been eroded through retirement and resignation over the past few years. We also added an Operations Section which centralized many of the support functions for the Public Health Division. The Operations Section has been critical for providing support in hiring and resource management and for maintaining good communication across the division."

The two organizational charts that follow demonstrate this bridging of silos and restructuring.

The first chart is from an LPHA that created a "Modernization and Advancement Section" founded on the integration of cross-cutting foundational capabilities.

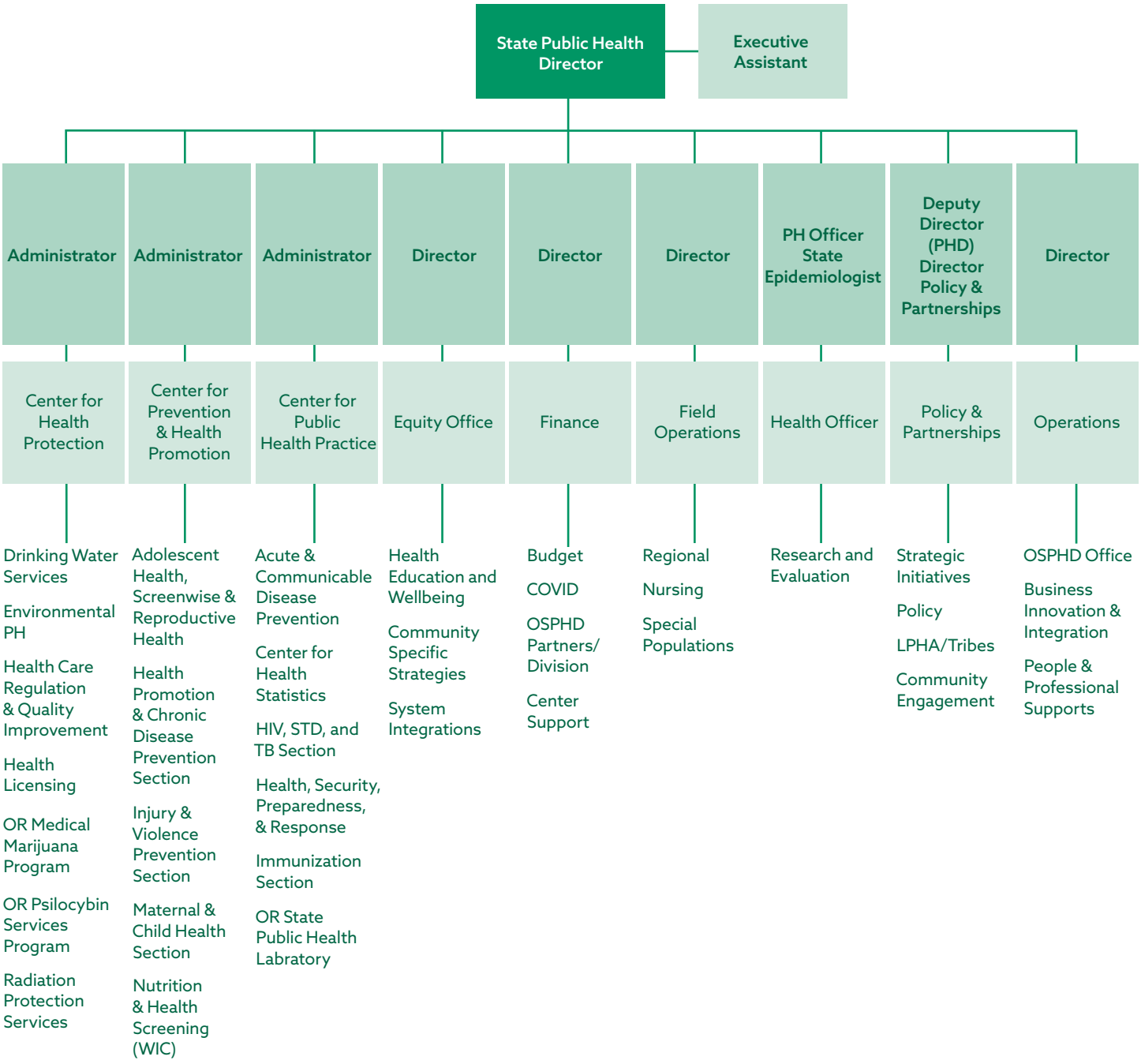
LPHA Public Health Division Structure
October 2022



The second organizational chart is from the OHA-PHD Director's office, which made key changes to structurally leverage focus areas to build infrastructure.

This included adding an Equity unit, splitting Finance and Operations into two units, and building greater capacity in Community Engagement and cross-programmatic work.

Oregon Public Health Division Office of the State Public Health Director



Reducing burnout with a people-centered public health workforce

Recent numerous reports noted an increase in the public health workforce's stress and burnout resulting from the pandemic. The Public Health Workforce Interests and Needs Survey (PHWINS) has been conducted every three years since 2014 and supports the governmental public health workforce by measuring strengths and gaps to inform future investments in funding, training, recruitment and retention. Data provided by the 2021 PHWINS (below) describes the well-being of Oregon's public health workforce. Further details on Oregon's PHWINS data can be found in the appendix.

Nationally	OHA
More than 1 in 5 employees rate their mental health as "Poor" or "Fair"	**1 in 3** employees rate their mental health as "Poor" or "Fair"
55% of employees reported at least one symptom of Post Traumatic Stress Disorder (PTSD)	**70%** of employees report at least one symptom of PTSD
25% of employees reported 3 or more symptoms, indicating probable PTSD	**34%** of employees reported 3 or more symptoms, indicating probable PTSD
Top reasons for leaving: 1. Pay 2. Work overload/burnout 3. Stress	**Top reasons for leaving:** 1. Work overload/burnout 2. Lack of support 3. Lack of advancement opportunities, organizational culture and stress

As a result of this workplace stress and burnout, a theme emerged in the key informant interviews about focused efforts to create a people-centered workplace.

> "I do think a lot of shifting has taken place in the pandemic: Center people first and work second."

> "Really trying to shift to a culture and a space of welcoming and belonging, creating a sense of belonging for folks."

"The expectation is, when you're away, it's OK to have your life. It's OK to unzip your work suit and have your home life. You can step out and it's the way to go. It's very healthy and I think a lot of us have learned the hard way through overwork and suffering the trauma of this pandemic. It's important for retention to not only care for people when they're working, but holistically that they are well."

"I'm trying to walk the walk of balance and self-care. And really encourage managers to do the same."

"I've really been intentional with myself and with managers to create and ensure that everyone knows that we have a culture of caring and hearing others. We have a pretty diplomatic, nonhierarchical mode of operation here where all voices are heard. We put humanity first. That's really what drives us and it's going to allow us to be successful."

"Overall, we have a customer service model and understanding that we're going to meet every customer where they're at and give them what they need in the very best way that we can, always giving them kind of the benefit of the doubt and presenting them with a friendly demeanor. We've been able to encourage staff to embrace that model and I think that it has a positive impact on our staff, peer-to-peer interactions as well. And, because everybody's got stuff going on outside these walls, we try to be more compassionate to one another as well."

Beginning and accelerating efforts for health department staff to reflect communities served

Approximately 40% (n=12) of LPHAs noted a commitment to the recruitment and hiring of a diverse workforce that is representative of the community. This includes developing an ongoing plan for workforce diversity with goals and metrics to track progress.

"Other government agencies in Oregon have a better way of compensating folks for their lived experience, which is necessary because it's an important part of the skills that are brought to the table. We've done some work to try to better quantify and value lived experience throughout the hiring process. But we're not necessarily paying for that in salaries outside of language differentials."

"For some of these positions, we modified what had been historic requirements to give allowance for work experience or life experiences to compensate for a degree requirement. For so many of the positions that we funded with modernization, a degree was not required. It was one of the options. But, experiences that felt relevant to the hiring committee were also allowed to be taken into account as equivalent to a degree for these positions."

"I find that minimum qualifications are a barrier and what little we can do really includes experience in lieu of various degrees and I feel like those are barriers that are there, sometimes unrealistic or insurmountable, and we don't have the opportunity to look at lived experience as much as I would like."

2) What have these modernization-funded new staff allowed the public health system to do?

Adding staff through the 2021-2023 public health modernization investment allowed for:

1. Increased climate and health focused work
2. Work in cross-cutting foundational capabilities
3. Funding for essential public health employees

Climate and health focused work

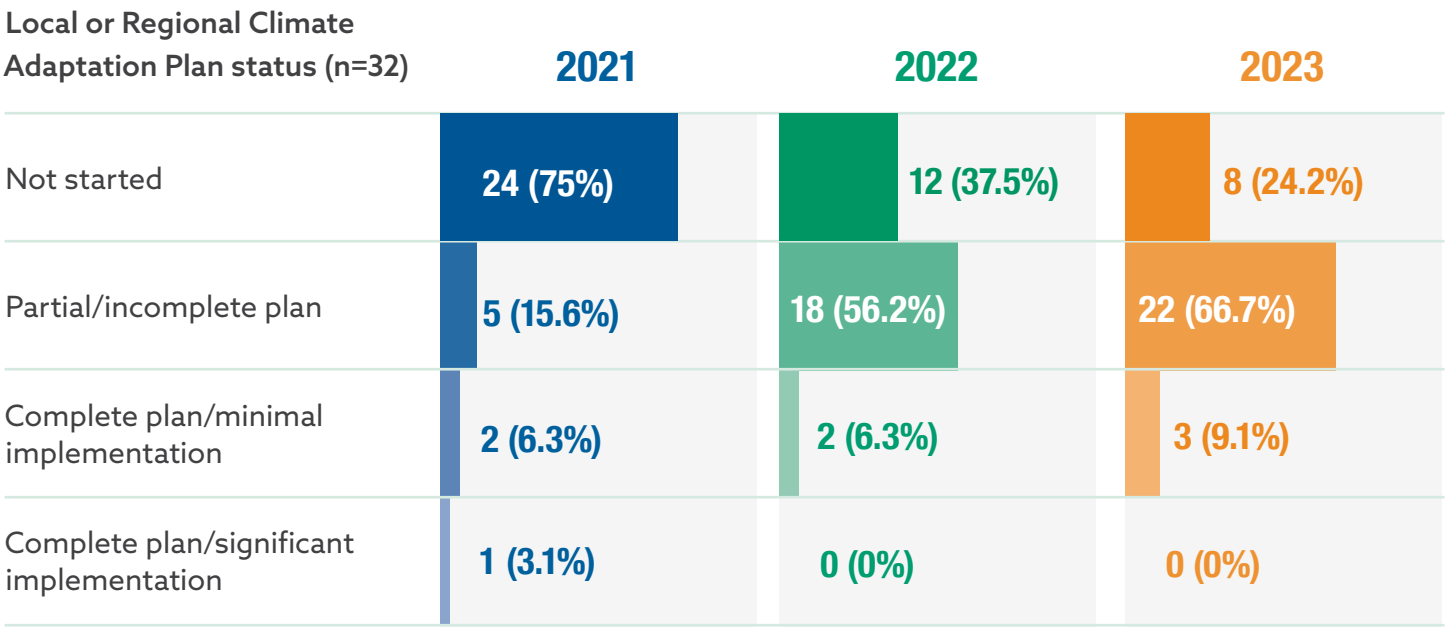
Key informant interviews demonstrated that hiring new staff is allowing many LPHAs to begin working on climate adaptation efforts for the first time.

> "The environmental epidemiology position is going to allow us to address and respond to legislative requests and media requests on a broader set of issues that we just haven't had the capacity to do—and to put out reports and studies that we haven't been able to do that draw the connection in particular between climate and health."

> "This allows us to engage across multiple policy issues and external agencies including the Department of Land Conservation Development, Department of Energy and Department of Environmental Quality on built environment issues that have a nexus with health."

LPHAs also demonstrated progress toward engaging partners to develop a climate adaptation plan. The percentage of LPHAs that report having a partial or complete plan increased from 22% in 2021 to 76% in 2023, while the percentage who had not started the assessment and plan decreased from 75% to 24% respectively.

With Increased Staffing, LPHAs Made Progress on Engaging Partners on Climate Adaptation



Note: 32 LPHAs (100%) reported in 2021 and 2022. In 2023, a new LPHA was established, and all 33 LPHAs reported on the status of their local or regional Climate Plan.

> "We hired a climate and health coordinator. Really, really exciting to open up environmental health beyond its traditional siloed regulatory work."

> "One of the other regional positions is what we've titled a Climate Planning Coordinator. This is a brand new area of work for us. We've not really done anything in climate of any consequence in the past, nor have to our knowledge any of the partners in the regional collaborative on this side of the state."

Cross-cutting foundational capabilities

Modernization investments also supported positions focusing on cross-cutting capabilities. The sample functions from position descriptions below provide context to the position titles previously noted and describe the types of work conducted in public health.

Policy:

Supports public health policy and legislative strategy development for the Public Health Division.

Leads legislatively-mandated workgroups, ensures fulfillment of legislative deliverables and provides guidance to sections and programs on legislative policy using equity, community engagement, the State Health Improvement Plan and community need as guideposts for policy priorities.

Communications:

Manage linguistically and culturally specific communication pathways and content.

Community Engagement:

Part of a team providing day-to-day support to CBO grantees conducting community engagement, health education and public health program implementation. Supports CBOs providing culturally and linguistically responsive services in the community.

Supports development of grant agreements, reporting and quality. Helps identify and relieve barriers to CBOs accessing the supports they need from OHA, local public health and state agencies so they can effectively serve their communities.

Operations/Fiscal:

Develop, coordinate and analyze program budgets, coordinate the awarding and monitoring of grants/contract planning and development, contract negotiation, grant/contract administration, budget and fiscal oversight, and provide technical assistance to staff and grantees/contracts.

Funding for essential public health employees

As a result of funding for public health modernization, LPHAs are finding ways to ensure compensation for essential public health employees and to have the full-time equivalency (FTE) staff for their workloads.

> "It's allowed us a little more flexibility in how we use our or how we pay for the services for our health officer because a lot of that was just donated time before. That certainly will be very difficult to replace when our current health officer decides it's time to retire. People don't like to work for free."

> "You know it's hard enough to get the federal grants to cover the supervising managers who are supervising staff."

Examples of being able to hire an FTE in emergency preparedness:

"For some of the positions that we've desperately needed, like our coordinator for public health emergency preparedness, this is the first time that we've been able to post that as a 1 FTE position given the funding that we had in the needs that we had. And so, it certainly is a lot easier to recruit a 1 FTE than looking to recruit a part-time employee."

"Our emergency preparedness position sits within the Emergency Management Office of the county. Until approximately two months ago, they were only able to give us 50% FTE. We've been able to bring up some money to have a full-time person to really help us grow our capacity in terms of preparedness."

"We've always received preparedness funding, but it's never been at a level that has let us fund a full-time person. It was always a half-time job that was passed around to whoever had a little bit of time. And so, we paired these two funding sources together to create a whole position. We've hired somebody to be the lead in connecting with community partners and other folks doing the work out there."

3) What are facilitators and barriers to recruitment and retention?

This section addresses recruitment and retention, particularly in recognition of the need for the public health workforce to reflect the communities served, respond to burnout and do the succession planning necessary for anticipated retirements in the workforce.

Recruitment

Facilitators to Recruitment:

Strategies and Methods

- Hiring from internal candidates and staffing via work out-of-class assignment (in which management approves an employee performing duties not normally part of their job classification, for a temporary period)
- Opening OHA-PHD positions to those out of state and some LPHAs hiring outside the county lines
- Offering lump sum payments or signing bonuses for some management positions
- Offering relocation assistance and allowing remote/hybrid work flexibility
- Expanding reach of job postings through community partners, higher education, professional resources, the agency website
- Contracting work to external entities
- Using organizational reputation as a facilitator
- Advertising on paid media including digital platforms like Indeed and Facebook as well as local radio

Barriers to Recruitment

Administrative Barriers

- Relying on external human resources to understand public health skills needed
- Inability to obtain specific public health classifications and commensurate pay scales

The following represent examples from key informant interviews of their experiences with specific types of administrative barriers:

Pay Scales

> "We do have a union, so we can't promote additional salary, any bonuses, anything like that. So, it's kept us limited in kind of how we can recruit."

> "That's why we're limited. I would argue any state who is unionized is probably looking at similar things. You're going to be able to do some stuff with management that you can't do for represented staff."

> "All of our employees are union employees and pay scales are set by union negotiations. They evaluate those pay scales against other government entities similar to our County. When the only way that you ever evaluate how well you pay people is to compare against other very limited-funded government agencies, it doesn't ever present a real opportunity for increased pay. We have advocated maybe not super successfully to look at other agencies within our community that are hiring for the same types of positions. Examples would be our school districts, hiring school nurses. We can't compete with our hospital system. It will never happen. We do not have the funding to support that, but we do have a federally qualified health center here and we've used their wages for comparison. 2016 was the last time that we were able to use community partner agency wages to compare. And that did result in a significant—like a 30%—increase across the board, but we have not been able to do that since."

Compensation/Salary

> "It becomes a tricky thing when you're asking people to give you feedback on what they need and what they need is more money, and you continuously cannot meet the demand."

> "I don't think our pay equity is super helpful for people who are new to state government. They don't think we pay enough. While the benefits are really, really great, not everyone's looking for benefits, so those don't always balance out as a selling point or they certainly haven't seemed to. So, we're really limited by pay. We just can't pay people what we want to retain the good candidates that do apply. It's hard to get them at a pay scale that's appealing."

On a related note, findings from the 2021 Oregon Epidemiology Capacity Assessment (ECA) also identified compensation as a barrier to recruitment. ECA noted Oregon salaries are generally lower than in western states, medium population states and all states, especially for mid-level and senior level epidemiology positions.

Hiring Timelines

> "Trying to get positions through class and comp... when we have legislators asking us why we aren't implementing stuff nine months after they gave us the money to do it."

Applicant Pool

Interviewees described applicant pools as "hit or miss" dependent on content area. They noted fiscal, nursing and environmental health positions as especially challenging. Some interviewees recalled failed recruitments.

> "There have been some positions where we had very, very few applicants. Sometimes just one applicant and we were just so lucky that this applicant was the person we wanted."

> "The environmental health manager position that I mentioned has been a real challenge. It's been open since June of last year."

Location - Rural Counties

> "When we talk to people from out of Oregon and then we say we're in Oregon, they often think Portland in their minds and where we are at is not the same. It is very different. And so sometimes that's a barrier, especially if it's somebody who's not familiar with our area or who hasn't been here before. And as the county is still holding to no remote work policies, it does require people to move to the area to be hired on."

External Human Resources

> "I've argued that we need to have [Human Resources] centralized, at least our own area of expertise, so our recruiters and our labor folks can all get familiar with public health and the content area. I think we see glimmers of that, but we've not been able to clearly establish that strongly. They get pulled in other directions to work with other divisions or to cover or do whatever. And what we're missing is our HR team being able to grow with managers and understand the skill sets that we need moving forward."

> "I have a guess that we, as an enterprise, haven't invested sufficiently in shared services. So those things that we all rely on now, we have a cost allocation that goes to shared services."

Hiring Timelines ("Time to Fill")

In the activity reports, LPHAs provided information about the time it takes to fill a position. LPHAs listed the time from posting the position to the candidate beginning employment in months, entered "vacant" if the position was not yet filled and entered "N/A" if they did not track this information.

Of the 55 positions entered by LPHAs:

- 17 vacant
- 10 data not available
- 28 positions filled in a range of 1 to 13 months

Note the reporting does not disclose whether any applicants were internal candidates or direct appointments.

Between July 1, 2021, and April 5, 2023, the median number of calendar days it took to fill a position in OHA-PHD – from the date the job description was posted, to a new hire's first day of work – was 86 days. In January 2023, Governor Kotek issued a letter to agency directors stating that the average time to fill a position should not exceed 50 days. It is important to note that this definition of time to fill does not include key process steps that occur before a job description is posted such as review of the position description, internal approval to hire, amount of time to post a position, etc. (Source: OHA Human Resources Data, April 2023).

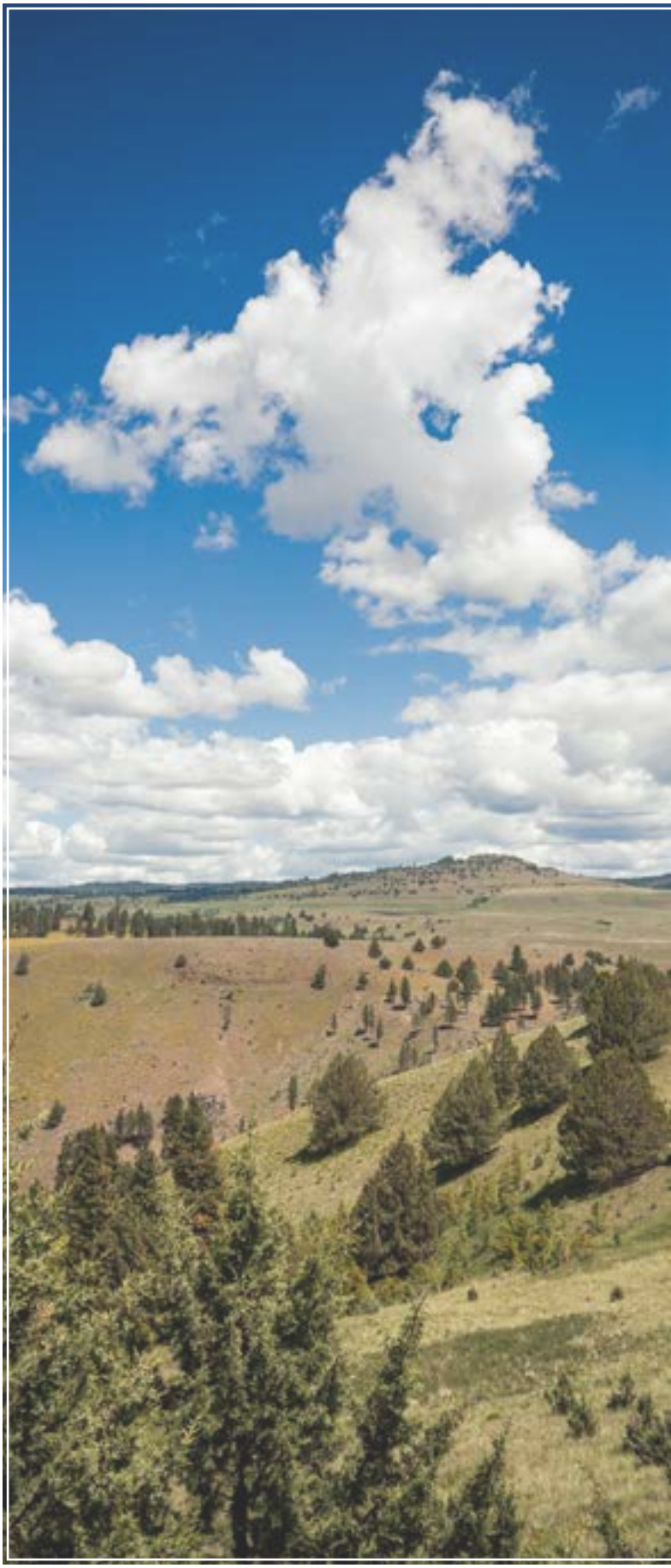
Additionally, ASTHO Profile data supported the key informant interviews in describing administrative barriers in the hiring process, asking:

If adequate funding were available to hire desired staff, which of the following non-financial barriers may impede or block the hiring process?

The 2021 Oregon ASTHO Profile included the following non-financial barriers in the hiring process:

- Administrative barriers in the hiring process (e.g., HR requirements, procedures and timelines)
- Challenges in receiving authorizations for positions (e.g., barriers to requisition, lack of direct hire/appointment authority and hiring freezes)
- Lack of capacity to hire, onboard, train or supervise desired staff
- Difficulty in converting temporary staff positions to permanent positions
- Difficulty of competing in the labor market (e.g., unable to offer competitive salary and benefits)
- Policy barriers which constrain hiring (e.g., funding restrictions disallow certain hirings)
- Difficulty in advertising or engaging with quality applicants
- Lack of physical office space or equipment available to hire desired staff

Source: 2021 Oregon ASTHO Profile



Retention

Retention Barriers

1. Overextended managers and needs for support.
2. Specific public health classifications (e.g., foundational public health capabilities, cross-program system-wide work, informatics, and operations and policy analysts).
3. Career pathways for core public health work and corresponding salary.

Overextended managers and needs for support

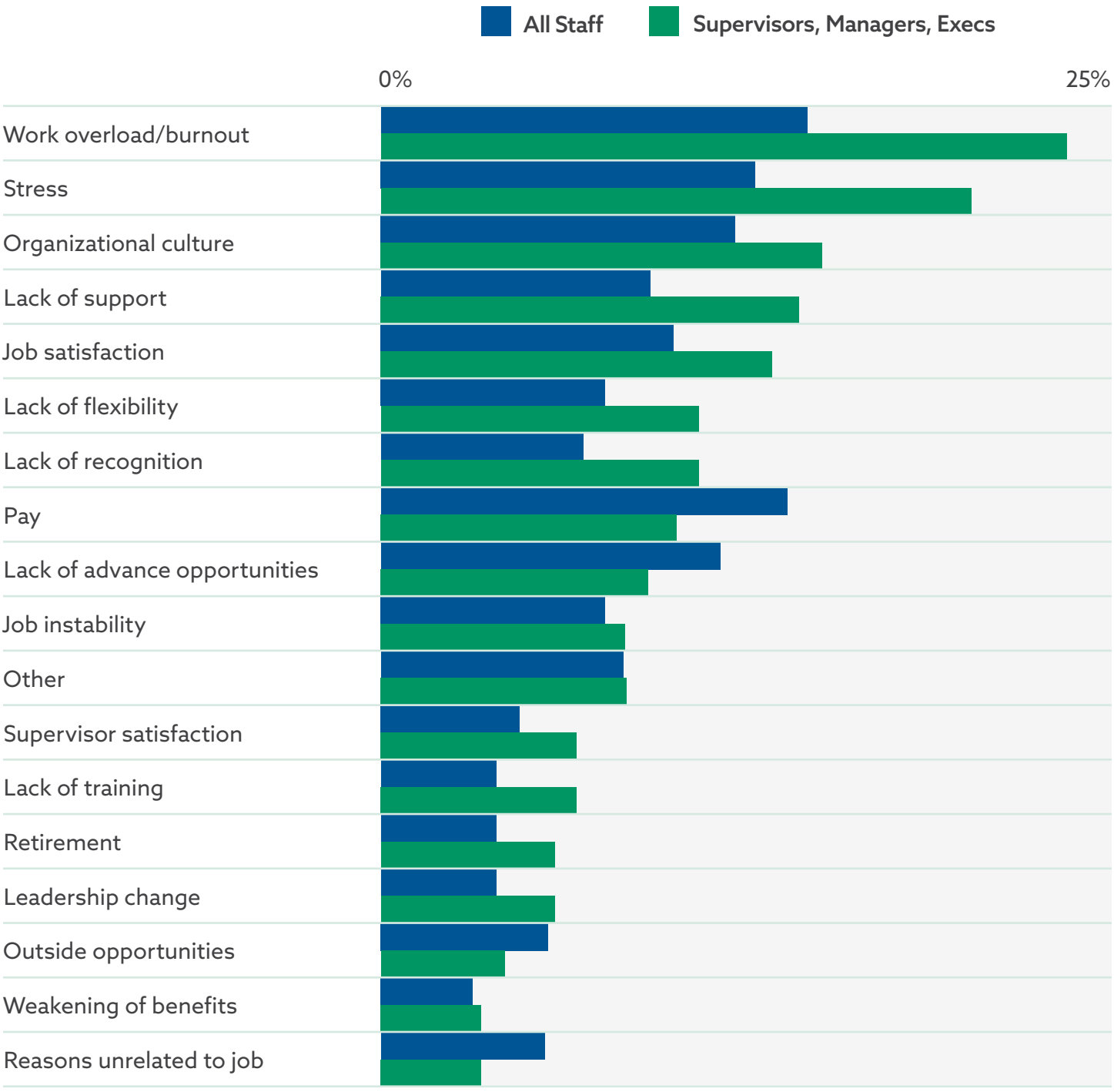
> "I've had two managers step down from management positions. Burnout is a phenomenon across public health. I think of the administrative burdens on managers and the idea that managers are both subject matter experts specialized in the policy and the program's content and must carry enormous bureaucratic burdens with systems that don't work."

> "Supervisors and managers report greater intention to leave compared to all OHA-PHD employees."

> "I would say for me personally as a manager, it's really hard to feel like I'm doing that work enough or well. Obviously, I have to rely heavily on a person's colleagues to help support them. I have about 13 people who I directly supervise and it's just a lot on top of the other things."

> "One of the places we've struggled with retention is on the management side because there's a lot of extra things you get to deal with as a manager that are not fun."

Oregon LPHA Managers/Supervisors are More Likely than All Staff to Report Burnout, Stress, Lack of Support and Lack of Recognition as Reasons for Leaving



*Note: Combined file of 18 Oregon LPHAs who participated in 2021 PHWINS; n=611 LPHA employees.

"The best way for me to retain and support staff is to support my supervisors, because the most important relationship for any staff person is their relationship with their supervisor. If they're feeling supported by their supervisor, and their supervisor is feeling supported by their supervisor, then everybody's happy."

"Managers have to do all the work ourselves. We have to upload the recruitments. We have to process all the recruitments. We have to enter when we want differentials and all that stuff. HR processes it on the back-end. But we have to do it."

For context, OHA-PHD managers supervise one to five employees (26%), six to 10 employees (46%) and more than 10 employees (28%), based on OHA-PHD HR Data for 103 managers.

Job classifications and career pathways

Among the top reasons for considering leaving (after work overload and lack of support) was the lack of advancement opportunities noted by 39% of OHA-PHD PHWINS respondents.

> "We realized that, for some of our positions, we don't necessarily have a lot of opportunities for growth. So, what we've been doing and what we'll continue to do is open up positions. 'This is how you get there after however many years of service.' We're trying to give a sense of progression."

> "We have been looking at whether we're always opening up only the highest level in a series. If we have a program specialist, a program coordinator and a senior program coordinator in a series, are we only opening up the senior program coordinators? Then, there's very few opportunities to advance. What do we really need?"

> "People are really left to their own devices. There's no kind of coaching or training, not the way you'd have a career counselor or academic counselor in college who maps out what you might do based on your interests and strengths. I could see that as a helpful change and something that would address frustrations."

Facilitators and Barriers to Recruiting and Retaining Staff that Represent Their Communities

Key informant interviewees shared thoughts on what promotes and prevents recruiting and retaining staff that represent their communities.

Facilitators to recruiting staff that reflect the community

- Desire to work with a diverse Community Engagement team
- Having a manager of color shapes who applies

"We're trying to demonstrate not only the job description, but why do you want to be here with us in this county and what does it mean as far as where we stand with equity, diversity and inclusion (EDI) and the culture of our organization. Also in the job duties, in the classification and the criteria, we call out Health Equity and EDI skills and expectations."

"Our organization has a variety of places we post including with community partners. This provides us an opportunity to post the job with trusted community partners who have access to community and trust with community. Also, talking about our LinkedIn posts, making sure our professional network has trust and rapport with BIPOC professionals means they are willing to step out and personally recommend us, saying 'you want to work with this organization, you want to work with this team.'"

"We also look to make sure that the hiring panel reflects members of the community so that applicants can see themselves"

"OHA's clear external facing communication of equity as a value in our 2030 goal to eliminate health inequities are things that staff of color and people who were interviewing for positions have named as specifically why they want to come and work at OHA."

"A way we draw people in, including people of color, would be to lean on our relationships. You know that, in public health, our relationships are the foundation of everything."

"We train people in-house and we provide workforce development for them in-house. That has been a benefit to us in being able to recruit a more diverse workforce because that has allowed us to have people who are from this area, who know this area and are representative of our community, have opportunities in a career path that they might not have otherwise because they can receive the training in-house. Training takes time, but in the end, it has created more diversity among our workforce."

Barriers to recruiting and retaining staff that represent the community

"One of the barriers we're identifying is that the majority of our funding sources look for staff who are bilingual and bicultural in Spanish because the Latino/Latina/Latinx community is the largest here. However, we don't have funding for staffing for multiple bilingual, bicultural positions. Thinking about the communities that speak Russian and other Slavic languages, for example, we have so many communities here that are just not seeing themselves represented in our staff."

"This is not a surprise to anyone, but it's really hard to mentor and supervise people of color and feel like I'm doing my job supporting them in advancement when the structures are as they are. I feel like it's inadequate."

"I think that we've done a better job of recruiting and hiring staff of color, but retention and advancement of staff of color has been more of a challenge."

"There's this balance between home growing juxtaposed with needing to diversify our workforce, perpetuating the systematic racism that this state was built on."

"What happens when you recruit this person from out of state? That is one of very few people of color in your community. You're welcoming them into your community and celebrating that you hired them. And then, what are you doing to make them feel safe or welcome in your community?"

"The hoops that they've [staff of color] had to jump through to stay in one organization and be promoted feel so oppressive and unfair. I know we're not the only department that has a hard time with internal recruitments, but I feel terrible having someone here for a decade who has learned so much about policy, understands the basic tenets of public health better than anyone here, yet has to work out of class for a year or two with a 5% increase in pay and take a 9 month class to qualify for the minimum qualifications of a management position. I feel like that's opportunistic and unjust."

"I really take to heart having a workforce that represents our county."

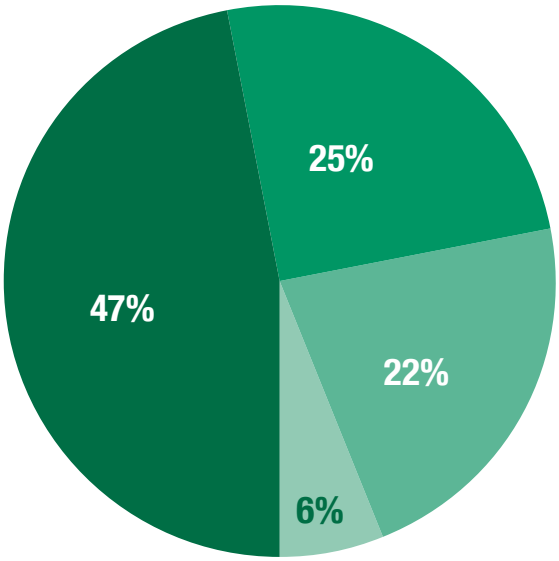
"We need to show and tell that it's OK to come to Oregon. And here's the team that you'll meet that's here to support you. We need to be proactively reaching out. But, I feel like there's a barrier to that, because we want to home grow. It's a weird dynamic. I still don't understand it, but I think that as a public health system, we really need to be thinking internally about what people think about us externally: How do we help shift or shape that narrative? How do we extend that olive branch? There is a value to being internal and to being an outsider."

Workforce Development Plans

The OHA-PHD 2023-2025 Workforce Development Plan is currently in development and an initial draft was submitted for reaccreditation. Major components will include:

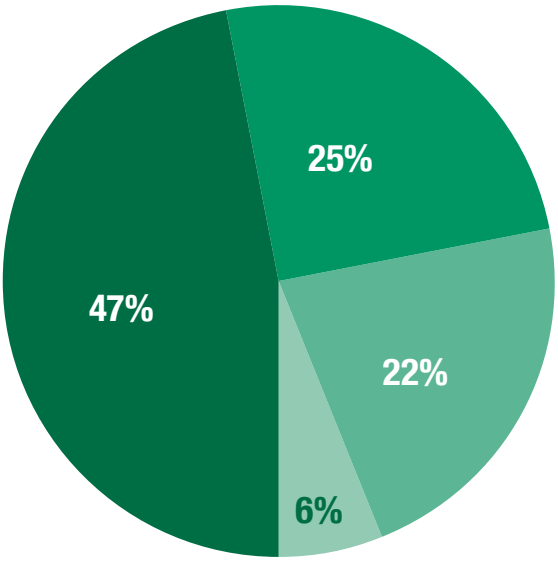
- Culture of belonging
- Professional development and training
- Workforce supports
- Manager training and supports
- Recruitment strategies
- Retention strategies
- Succession planning

Nearly Half of LPHAs Have Workforce Development Plans Underway—with Training and Professional Development a Priority



LPHA has a Workforce Development Plan N(%)

- No 15 (47%)
- Yes, complete 8 (25%)
- Yes, in development 7 (22%)
- Unsure 1 (6%)



Workforce Developent Plan components among 15 with plan complete or in development N(%)

- Training and professional development strategies 15 (47%)
- Recruitment strategies for diversifying the workforce 8 (25%)
- Strategies for staff and management retention 7 (22%)
- Strategies for succession planning 1 (6%)

Succession Planning

The past two years presented significant changes in LPHA leadership. Additionally, more OHA-PHD employees became eligible for retirement, increasing the importance and need for retaining institutional knowledge and succession planning.

LPHA Leadership Changes in the 2021-2023 Biennium

Oregon's 33 LPHAs experienced significant leadership changes in the past two years.

- **18 health administrator/director/manager changes since July 1, 2021, across 14 LPHAs**
  - 4 LPHAs had multiple leaders turn over
- **13 health officer changes since July 1, 2021, across 11 LPHAs**
  - 2 LPHAs had multiple health officers turn over
- **12 LPHA administrators as defined in the Oregon Revised Statutes 431.418, changed in the biennium**

(Source: CLHO and ORS designated LPHA Administrator list)

OHA-PHD Staff Eligible for Retirement

The percentage of current, full-time employees eligible for retirement is growing rapidly:

- Fiscal year 2022: 5.5%
- Fiscal year 2023: 9.7%
- Fiscal year 2024: 11.8%

(Source: ASTHO Profile 2021)

"I was given a 2-page list of meetings that the former Administrator attended and told these are the meetings you'll have to attend. That was about it."

"We structured ourselves in 2018. I'm the director, but I have a deputy director, so we have an internal succession. If I'm not here, she has the authority to speak as me, which can help because you don't have one person holding everything."

"I don't feel like people have been here to help train someone else or have that overlap. Typically, the individual leaves, and if and when another person is hired, they have to learn on their own. Something we're working on is trying to develop the process itself."

"We are also working managers. So, we all can sit in the seats of the individuals that we manage and perform their job functions. They might not get to cross train with the person they're replacing."

"Anyone on the team you come to should be able to hold institutional knowledge. We document things and we have standard operating procedures. We're really trying to move away from one person knows it all. And the second they're gone, we're all out of luck. No healthy organization survives in that mentality."

Several interviewees mentioned practices they use to ease the transition when an employee is leaving.

"We can overlap now. For example, our suicide prevention coordinator is leaving at the end of March. We're able to hire that position in advance, thankfully because he knows so much and I don't know how we would bring somebody else up to speed without him. A lot of people come back as extra help and then they do the training. That's pretty common."

"One of the things that I've been asking people to do is, when they leave their position, they write a handover report."

"It's called a request for double fill, so we do have a process. We have a process and tools that we use to be able to request a double fill to be able to open up a recruitment in advance of a vacancy. There is a procedure and I'm not sure if it's written, but it's definitely a procedure that we are able to do. However, it's up to the supervisor to request it. We've had a couple of retirements recently. Sometimes the request for a double fill is successful and you can get a candidate here in time and sometimes you can't. But, there is an opportunity for that."

4) Where are existing workforce gaps?

The next pages provide details and recommendations for six gaps.

1. **Support overextended managers.**

2. **Preserve institutional knowledge (given turnover and retirements) and conduct succession planning.**

3. **Demonstrate career pathways for core public health work.**

4. **Resolve administrative barriers in hiring, including external Human Resources and lack of specific public health classifications and commensurate pay scales.**

5. **Improve understanding of hiring cycle times, develop process maps and conduct corresponding Quality Assurance/Quality Improvement (QA/QI) activities.**

6. **Understand the extent to which staff represent the populations served in jurisdictions across the state and the types of positions filled by staff demographics.**

Existing Gaps and Recommendations

1 Gap: Overextended managers

Recommendations: Support overextended managers.

Public health managers reported being overextended, with a greater intention to leave and higher levels of burnout, stress and lack of support compared to all staff.

Recommendations for Health of Management

- Recognize that staffing up and building successful teams takes additional work and time, especially in a virtual environment. Hire administrative staff to delegate tasks and contract with Human Resources recruiters to reduce manager workload with hiring and onboarding.
- Consider review of management structure and management staffing needs before hiring additional staff; revisit manager-to-staff ratios.
- For OHA and LPHAs operating in virtual environments, revisit telework policies and guidelines for video conferencing to address burnout from screen time, to identify in-person opportunities for team building and create social support in the workplace.
- Revisit management work hours spent in email correspondence, phone calls, or in person meetings to increase efficiency and reduce workload on management.
- Prioritize workloads and set realistic workplans; identify time-sensitive work vs. work that can be returned to when staff capacity is higher.
- Celebrate accomplishments in building staffing capacity.

Recommendations for Health of All Staff including Management

Additionally, some recommended organizational supports for worker wellness apply to all staff *including but not limited to* management.

- Prioritize physical and psychological safety. Psychological safety is the shared belief that the team is safe for interpersonal risk taking and can share ideas and opinions freely without fear of negative consequences.[3,4]
- Support individual employees' need to connect personal work motivations with organizational mission.[3]
- Provide ways to see the results of one's work and feel rewarded and encouraged to continue.
- Build a workplace culture that celebrates gratitude, respect, recognition, inclusion and belonging.
- Use tools such as National Association of County and City Health Officials (NACCHO) Joy in Work Toolkit,[8] Surgeon General's Framework for Workplace Mental Health and Well-Being,[10] and National Institute of Occupational Safety and Health (NIOSH) Total Worker Health to guide workplaces towards improving worker health and wellness.[9]
- Engage in organization-led initiatives, including reducing the number of hours or percentage of time public health workers work on an emergency response.[7]
- LPHAs, County leadership and OHA can continue to provide trauma-informed leadership sessions and support for their respective employees[2] and Coalition of Local Health Officials (CLHO) can continue to provide corresponding sessions and support for local health officials.

2 Gap: Turnover including retirements

Recommendation: Preserve institutional knowledge and conduct succession planning.

Significant changes in LPHA leadership in the past two years, as well as more OHA-PHD employees becoming eligible for retirement, increased the importance and need to preserve institutional knowledge and enhance succession planning. For example, 18 changes took place across 14 LPHAs at the local health administrator/director/manager level since July 1, 2021. This included four LPHAs with multiple leaders turning over. Among the LPHAs with workforce development plans, only one LPHA noted succession planning as a component of their plan. Succession planning is one component of the new 2023-2025 OHA-PHD Workforce Development Plan, currently in development.

Recommendations

- Dedicate personnel and funding to succession planning; review Office of Personnel Management (OPM) Succession Planning Domains, Activities and Strategies.[15,16]
- Prioritize developing management or leadership skills and identify talent pools.
- Identify competency requirements of leadership and address current gaps.
- Develop or update Standard Operating Procedures for programmatic work in preparation of staff turnover and especially for executive leadership positions.

3 Gap: Unclear career pathways for core public health work

Recommendation: Demonstrate career pathways for core public health work.

In key informant interviews, staff reported a lack of advancement opportunities and clear career pathways. PHWINS data supports this feedback.

Recommendations

- Forge clear and equitable development routes for professionals at all levels to advance, including mentorship and career guidance.[3]
- Align position descriptions and corresponding career tracks to the Core Public Health Competency Framework.[13]
- Create a clearinghouse of position descriptions to assist health departments in determining needed knowledge, skills, abilities and compensation levels when creating new positions.[2]
- Establish new pathways and expand existing ones to significantly increase the number of personnel exchanges between different levels of government and the private sector, to facilitate the sharing of expertise, community knowledge, lessons learned and career opportunities among the many organizations that make up Oregon's public health system.[14]

4 Gap: Administrative barriers in hiring, including Human Resources external to public health agency and lack of specific public health classifications and commensurate pay scales

Recommendation: Resolve administrative barriers in hiring, including external Human Resources and lack of specific public health classifications and commensurate pay scales.

Administrative barriers in the hiring process include Human Resources departments external to the public health agency along with the need for specific public health classification and commensurate pay scales. These barriers can lead to staffing shortfalls attracting and hiring staff in fiscal, environmental health and nursing roles as well as in rural areas.

Recommendations for Public Health Departments:

- Support recruiters' familiarity with public health content area so Human Resources teams can grow with managers and advance understanding of the skill sets needed.
- Ensure sufficient Human Resources capacity, especially during periods of rapid growth, considering best practices for Human Resources-to-staffing ratios.
- Partner with leaders in government reform to update merit systems, civil service requirements, position descriptions and HR systems.[1]
- Work with county commissioners and unions to identify solutions for adjusting compensation to be competitive with local industries.[2]
- Revisit position classifications and minimum requirements.[2]
- Build the Strategic Skills in the Government Public Health Workforce into the public health job classifications.[5]

Recommendations for Policymakers:

- Modernize existing civil service requirements and institute competitive pay structures to accommodate roles and responsibilities specific or unique to public health.[1]
- Approve budgets that ensure:
  - Training and professional development of the public health workforce involved with implementing core programs and applying all necessary cross-cutting skills.
  - Salary structures commensurate with roles and responsibilities and competitive with salaries for similar positions in nongovernmental agencies.[1]

5 Gap: Uncertainty surrounding hiring cycle times, process maps and Quality Assurance/Quality Improvement (QA/QI)

Recommendation: Improve understanding of hiring cycle times, develop process maps and conduct Quality Assurance/Quality Improvement (QA/QI) activities.

Self-reported LPHA hiring timelines and OHA-PHD HR data indicate a need for improved tracking of the hiring process, clarity of what is and what is not measured in hiring timeliness, and overall data quality.

Recommendations

- Develop process maps and Standard Operating Procedures for hiring.
- Implement QI projects to improve hiring cycle times for process steps under LPHA/OHA control; refer to Public Health Quality Improvement Exchange (PHQIX) for QI tools and related projects.[11]
- Improve understanding of similarities and differences in governmental public health hiring processes across the state, by identifying and sharing best practices, particularly regarding hiring cycle times.

6 Gap: Underrepresentation of the populations served by staff, both in terms of jurisdictions across the state and in the types of positions filled

Recommendation 1: Understand the extent to which staff represent the populations served in jurisdictions across the state and the types of positions filled by staff demographics.

Recommendation 2: Invest in training and policy development to support inclusive workplaces.

Insufficient data exists to determine the extent that Oregon's public health workforce represents the populations served and types of positions filled by staff. Demographic data can be unclear and variable from jurisdiction to jurisdiction (e.g., race/ethnicity, age, gender, disability status, rural/urban representation).

Key informant interviews showed that facilitators to recruiting and retaining staff who represent the communities they serve included: desire to work with a diverse team, having a manager of color, representative hiring panels, and organizational policies on diversity, equity and inclusion (DEI). Barriers included: sufficient budget to allow for multiple bilingual and bicultural positions, mentoring staff of color in systems still rooted in bias, and the balance and tensions between home growing and diversifying the workforce.

Recommendations

- Align workforce assessments with corresponding population demographics.
- Define measures of success in building a workforce that is representative of populations served.
- Define and measure components of an inclusive workplace for governmental public health agencies.
- Develop or continue affinity spaces and build professional networks among public health employees and leaders of color and from other groups that are underrepresented in the public health workforce.

Conclusion

Oregon Health Authority

Conclusion

During the 2021-2023 biennium, state legislative investments in public health modernization led to hiring new and essential public health staff across Oregon, especially employees with a specific focus in Environmental Health and Climate, Communicable Disease, Health Equity & Cultural Responsiveness, Communications and Community Partnership Development. As a result, critical work expanded in these foundational public health programs and capability areas. The mpox response demonstrated how improvements occurring through public health modernization better prepared the system to respond to an emerging communicable disease threat and protect those at risk from disease.

To deepen these advancements and make strategic use of future public health modernization funding, Oregon's public health system needs continued attention on strengthening the local and state governmental public health workforce. One study found in their analytic sample that nearly half of all employees in U.S. state and local public health agencies left between 2017 and 2021, a proportion that rose to three-quarters for those ages 35 and younger or with shorter tenures. If separation trends continue, this could lead to more than 100,000 staff, or as much as half of the nation's governmental public health workforce in total, leaving their organizations by 2025.[5] Focused efforts to address recruitment and retention challenges in Oregon are necessary to meet both the expected and unexpected needs ahead.

Finally, an area emerging from the conversations with both Evaluation Advisory Groups is the importance of organizational trust. Among the priorities moving forward, the evaluation team recommends exploring the components of building organizational trust in the governmental public health system, including what prevents and what supports the development of trust, both internally and across system partners. Organizational trust lies at the foundation of workforce development and partnership advancement.

Appendix

Oregon Health Authority

Appendix

Acknowledgements

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Modernization Evaluation Working Group Members

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- Oregon CLHO: Laura Daily
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- Oregon Public Health Advisory Board representative: Veronica Irvin
- Legislative representative: Cynthia Branger-Muñoz
- Tribal representative: Taw Foltz (Warm Springs)
- National representatives: Liza Corso (Centers for Disease Control and Prevention) and Reena Chudgar (Public Health National Center for Innovations)

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Methods

In Fall 2021, OHA staff met to review and adjust the prior program logic model to guide the work and understand Oregon's progress as a public health system. In December 2021, key state staff met to discuss evaluation given the increased funding to partners, including CBOs for the first time, for expanded programmatic areas.

Evaluation teams co-created and guided the evaluation

Two separate groups formed, both with charters expressing a similar purpose: "To assist Oregon Health Authority Public Health Division in co-creating an evaluation of the 2021-2023 state legislative modernization funding. This work will include development of core evaluation domains and questions, respective methodology, and guidance on data interpretation and analysis."

1. Evaluation Working Group

The Evaluation Working Group consisted of 10-12 representatives of the public health system including: Local Public Health, Oregon CLHO, OHA Acute and Communicable Disease Prevention Section, OHA Environmental Health Section and OHA Community Engagement and Operations teams. Members had diverse experiences in the areas of communicable disease prevention, planning and response, environmental health and impacts of climate related emergencies, community engagement, public health workforce and measurement of governmental public health agency performance. This Evaluation Working Group met every other week or less frequently.

2. Evaluation Technical Panel

The Evaluation Technical Panel consisted of 10-12 representatives of the public health system including local, state and tribal governmental public health; one member from the Oregon Public Health Advisory Board (PHAB); two public health modernization funded CBOs; and two national public health partners. Members had diverse experiences in the areas of communicable disease prevention, planning and response, environmental health and impacts of climate related emergencies, community engagement and measurement of governmental public health agency performance. This Evaluation Technical Panel met quarterly or more frequently.

Evaluation Domains, Questions and Methods

The discussion and guidance from the Evaluation Working Group and Technical Panel led to finalizing two evaluation domains in Spring 2022 that reflected key program priorities for this 2021-2023 biennium. The evaluation domains focused on understanding two areas: 1) advancement in the foundational public health capabilities and 2) public health workforce to support that advancement. The primary evaluation question for foundational capabilities domain was: 1) If/how has Oregon Public Health advanced in these foundational capabilities via the relationship between OHA Public Health Division, LPHAs and CBOs? The respective evaluation questions for the public health workforce domain were: 1) How has the workforce changed with this funding? 2) What have these modernization-funded new staff allowed us to do that we couldn't do before? 3) What are facilitators and barriers to recruitment and retention? and 4) Where are existing workforce gaps?

Evaluation Domain - Foundational Capabilities

Public Health Modernization funded CBO and LPHA Activity Reports

The evaluation team added specific evaluation questions to the required activity reporting for LPHAs and modernization-funded CBOs to reduce the reporting burden for foundational capabilities. The CBO survey was open from October 13 to November 21, 2022, via Survey Gizmo, with data then transferred to SPSS statistical software for further analysis.

Evaluation Domain - Workforce

The evaluation team used a mixed methods approach including primary and secondary data collection and analysis. Primary data collection included evaluation questions in LPHA activity reporting and key informant interviews of local public health and state public health leaders. Secondary data analysis included document review such as local and state budgets, position descriptions and HR analytics, 2021 ASTHO Profile, 2021 Oregon ECA, and 2021 PHWINS Survey.

Primary Data Collection

1. LPHA Activity Report

The evaluation team added specific evaluation questions to the required funding activity reporting, again to reduce reporting burden for LPHAs. The team collected data via Smartsheet from October 5 to November 30, 2022, for both evaluation domains (Foundational Capabilities and Workforce) and transferred data to SPSS for further analysis.

2. Key Informant Interviews of OHA staff and LPHA staff

The evaluation team developed a Key Informant Interview Guide with the Evaluation Working Group from August to September 2022 to address Workforce content areas pertaining to recruitment and retention. The Evaluation Technical Panel reviewed the interview questions. Five OHA managers who have modernization funded staff positions participated in interviews between October 2022 and January 2023. Eight local public health authority administrators represented geographic variation in the state as well as tenured and newer local public health administrators, in interviews occurring between January and February 2023. Each virtual interview with state and local public health managers and administrators was one hour.

Secondary Data Analysis and Review

1. Document review

The evaluation team collected and reviewed a variety of documents to answer Workforce Evaluation questions including modernization funded position descriptions in LPHA and OHA-PHD Modernization budgets, ASTHO Profile, and corresponding analytics conducted by HR.

2. 2021 Public Health Workforce Interest and Needs Survey (PHWINS)

The evaluation team reviewed the 2021 PHWINS data for OHA-PHD and 18 LPHAs in Oregon for workforce recruitment and retention and used the deBeaumont Foundation data dashboard specific to OHA-PHD PHWINS for analysis. The response rate for OHA-PHD was 35.4% with a sample size of 281 employees. Nationally, 44,732 individuals completed the survey, with a 35% response rate. In comparison, 18 LPHAs in Oregon participated in the 2021 PHWINS representing a total of 611 employees with response rates ranging from 14.3% to 76.9%. The Northwest Center for Public Health Practice kindly conducted the requested analysis of the LPHA Oregon PHWINS data. More detailed methodology for the PHWINS survey is available through the deBeaumont Foundation, found here. (Source: deBeaumont Foundation and Association of State and Territorial Health Officials, Public Health Workforce Interests and Needs Survey: 2021 Dashboard. August 3, 2022.)

3. 2021 Association of State and Territorial Health Officials (ASTHO) Profile – Oregon Public Health Division

The ASTHO Profile aims to define the scope of state and territorial public health services, identify variations in practice among state and territorial public health agencies, and contribute to the development of best practices in governmental public health. More information on the ASTHO Profile is available here.

4. 2021 Epidemiology Capacity Assessment (ECA) – Oregon Public Health Division

The ECA monitors the numerical strength and functional applied epidemiology capacity in state and territorial health departments. More information on the ECA is available here.

Data Analysis and Interpretation

The Evaluation Working Group and Technical Panel guided all stages of data analysis and interpretation.

Limitations

Please consider the following limitations when reviewing this work. Self-reported data from LPHAs and CBOs may not fully reflect activities conducted by both organizations. Reporting by LPHAs includes work with all CBOs—not specifically with modernization-funded CBOs.

Data collection from several of the 2021 secondary data sources (e.g., PHWINS, ASTHO Profile, ECA) occurred at times of rapid organizational change and growth from the pandemic, resulting in data representing a very specific and short time period. It is unclear how representative they are of the current situation. While these data sources undergo routine updates (e.g., every 3 years), health departments may benefit from more frequent updates during times of rapid growth.

Finally, an original intent was to match LPHAs and CBOs by county location. However, due to significant missing data on county locations served by CBOs, matching by county could not occur.

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