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STATE OF OREGON

Public Health Modernization Assessment Report

JUNE 2016

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The State of Oregon's Public Health Advisory Board (PHAB) serves as an advisory body to the Oregon Health Authority. The PHAB advises the Oregon Health Authority on policy matters related to public health programs, provides a review of statewide public health issues, and participates in public health policy development.

Specifically, the PHAB's charter requires the body to make recommendations to the Oregon Health Policy Board on the adoption and updating of the statewide public health modernization assessment. In accordance, the PHAB formally recommended this assessment on June 16, 2016.

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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

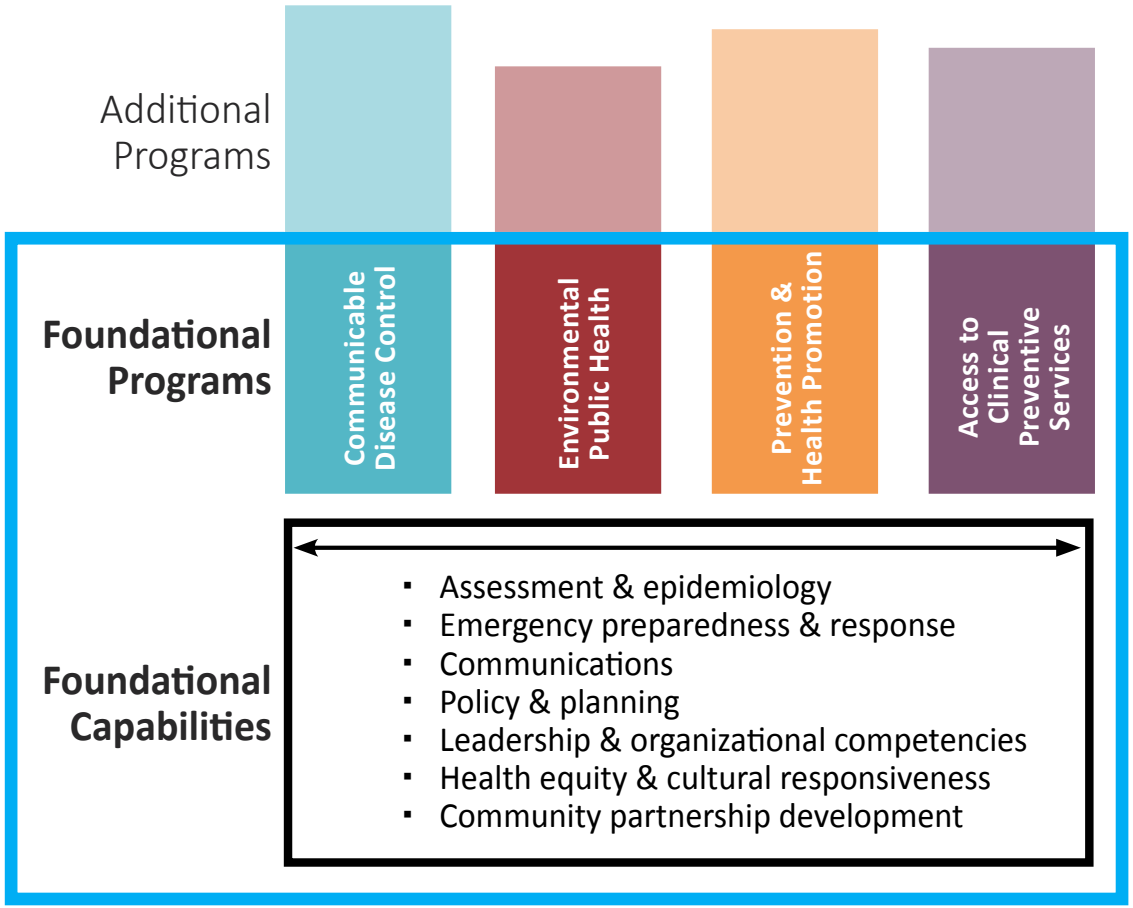
Since 2013, Oregon has been working to modernize its governmental public health system so that a common set of core public health capabilities and programs are present in all communities in the state. The goals of a modern public health system include:

1. Achieving sustainable and measurable improvements in population health;
2. Protecting individuals from injury and disease; and
3. Being fully prepared to respond to any public health threats that may occur.

In July 2015, the Oregon legislature passed House Bill 3100. This bill sets forth a clear path to modernize Oregon's governmental public health system so that it can meet the essential health needs of all people in Oregon.

Public Health Modernization

Foundational Programs and Capabilities present at every health authority



Foundational Programs

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

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

Foundational Capabilities

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

- Assessment and Epidemiology
- Emergency Preparedness and Response
- Communications
- Policy and Planning
- Leadership and Organizational Competencies
- Health Equity and Cultural Responsiveness
- Community Partnership Development

The public health modernization framework differs significantly from Oregon's existing public health structure. The new framework supports the provision of population-based health services uniformly across the state. With health system transformation in Oregon, the role of governmental public health as a clinical service provider of last resort for residents who do not have access to health care in traditional settings is shrinking. Governmental public health can provide more efficient benefits by focusing on population-based health services and programs.

Key Findings

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

PROGRAMMATIC FRAMEWORK AND ASSESSMENT PROCESS

- The assessment provided LPHAs with detailed exposure to the public health modernization framework and was designed to reinforce a consistent interpretation of the framework and to build on collective understanding of it.
- Implementation of public health modernization is intended to be a transformative process that presents an opportunity to identify innovative solutions to improve the efficiency and effectiveness of the governmental public health system.
- The assessment process, though thorough, was not exhaustive. There are additional features that could be explored to identify opportunities to increase efficiency and effectiveness.

PROGRAMMATIC GAPS IN CURRENT PUBLIC HEALTH SYSTEM

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

FULL IMPLEMENTATION COST

- Governmental public health authorities are already significantly executing the public health modernization framework, with $209 million in 2016 dollars being spent annually on the foundational capabilities and programs. This is approximately two-thirds of the cost of full implementation of the framework, with the current service delivery model.
- The preliminary estimated additional spending needed for full implementation is approximately $105 million annually in 2016 dollars. This is a point-in-time, order of magnitude cost estimation based on the current service delivery model, and will require additional analysis and refinement. This preliminary value will be revised as additional efficiencies, like changes to the service delivery model or increased cross-jurisdictional sharing, are implemented.
- For local activities, the largest concentrations of the total additional increment of cost to reach full implementation are in the 4 foundational programs and the Leadership and Organizational Competencies capability.
- For state activities, the highest concentration of the total additional increment of cost to reach full implementation is in the Assessment and Epidemiology capability, which houses the State Public Health Laboratory.
- For all statewide activities, the additional increment of cost to reach full implementation are generally concentrated in the 4 programs and the Leadership and Organizational Competencies capability. However, there is no foundational program or capability that does not have increased additional increment of costs for at least one governmental public health authority.
- An agency with a higher level of implementation of a foundational program or capability does not necessarily need fewer resources to reach full implementation than an agency with lower implementation. Conversely, an agency with limited implementation does not always indicate that a substantial amount of funding is needed to support full implementation.
- The additional increment of spending needed to reach full implementation represents what the incremental increase in capacity and expertise to support full implementation of public health modernization activities will cost. If the current funding paradigm were to change, changing current spending, the additional increment of spending needed would change.

FUTURE IMPLEMENTATION

- Implementation of public health modernization will be a significant undertaking that might require phasing.
- The current governmental public health service delivery model is divided into state activities, provided wholly centrally by PHD, and local activities, provided locally by LPHAs. While this is the current paradigm, there may be more efficient and/or effective service delivery models.
- There are resource-sharing relationships among LPHAs today. These existing sharing arrangements provide examples for future sharing relationships. LPHAs expressed interest in exploring additional opportunities for cross jurisdictional sharing.
- LPHAs have a high degree of local expertise related to their service areas which should

be leveraged to improve the efficiency and effectiveness of implementation. Implementation strategies should allow for some flexibility and local decision making, which could be governed by local implementation plans.

- Implementing public health modernization by waves of LPHAs could be challenging for several reasons, including but not limited to:
  - Risk of creating a two-tiered system (with some LPHAs operating under the public health modernization framework and others not).
  - Potential impacts to health equity (with those served by modernized LPHAs receiving a higher level of service than those being served by non-modernized local public health authorities).
- Implementing by foundational program or capability could also be challenging because current implementation is uneven across LPHAs.
- There are significant service dependencies between state and local public health activities. Some of the state roles and deliverables that support local activities are not fully implemented. If not considered during the implementation process, these service dependencies could become barriers to and inefficiencies in implementation.
- Many of the foundational programs and capabilities support one another. That is, in order to accomplish the goals of one foundational program or capability most effectively and efficiently, one might have to have access to the resources available through implementation of another. This is most intuitive when thinking of the foundational capabilities, for example, communications plays a significant role in addressing tobacco use.

Policy Implications

This public health assessment is the first step of an evolving process, and these results will continue to be refined as implementation progresses. The assessment results presented in this report represent point-in-time, planning-level estimates for the cost of full implementation of the public health modernization framework, as outlined in the December 2015 *Public Health Modernization Manual.* It is important to recognize that that framework is not static because of the evolving nature of public health work, which will need to be reflected. Additionally, these estimates were developed based on the current service delivery model, which may change as opportunities to increase efficiency and effectiveness are identified.

The assessment did identify several policy implications that should be considered throughout the implementation process:

- The assessment was designed to reinforce a consistent interpretation of the public health modernization framework and to build on collective understanding of it. There will be a need to update this collective understanding as the framework evolves.
- Governmental public health authorities should consider additional exploration to identify opportunities for increased efficiency and effectiveness. This may include:
  - Service delivery, including cross jurisdictional sharing
  - Non-governmental public health resources and partnerships that contribute to the implementation of the public health modernization framework
  - Barriers to implementation
  - Short-term or one-time additional costs related to implementation itself

The impacts of any changes related to these opportunities to increase efficiency and effectiveness, especially those that might affect the service delivery paradigm, to the additional increment of spending needed to reach full implementation should be evaluated.

- The current funding paradigm was not evaluated as part of this assessment, however, it is anticipated that it will be as part of the PHAB's work on t**o** develop funding allocation and incentive formulae for public health modernization dollars. The impacts of any changes to the funding paradigm on the additional increment of spending needed to reach full implementation should be evaluated.
- Current implementation varies across governmental public health authorities. Therefore, global strategies for all governmental public health authorities are likely to be difficult and inefficient to implement, and may lead to unintentional consequences like creating service inequities, establishing a tiered system, or creating implementation barriers.
- A flexible implementation strategy that is responsive to specific governmental public health authority contexts is needed. We have identified preliminary criteria for this decision-making strategy, including:
    - **Population Health Impacts:** The degree to which a specific activity will improve population health.
    - **Service Dependencies:** The extent to which state and local governmental public health activities are interdependent.
    - **Coverage Maximization:** The degree to which services are available to the greatest number of Oregonians.
    - **Service Equity:** The degree to which Oregonians living at or below the Federal Poverty Level receive public health services consistent with those received by Oregonians overall.
- There are tensions between these considerations; for example, maximizing coverage by population could be accomplished without increasing the level of implementation of some smaller LPHAs. It will be important to leverage governmental public health authorities' expertise to find balance while using this decision-making framework.

The decision-making framework will allow for flexibility in implementation such that it can be informed by ongoing results, supporting continuous improvement. This framework, and the process by which it is applied, should be refined through a collaborative process that would include all existing governmental public health authorities and other stakeholders.

ASSESSMENT PROCESS

BACKGROUND

Right now, Oregon's communities are not equally equipped to support the health of Oregonians where they live, work, learn, and play. Since 2013, Oregon has been working to modernize its governmental public health system so that a common set of core public health capabilities and programs are present in all communities in the state. The goals of a modern public health system include achieving sustainable and measurable improvements in population health; protecting individuals from injury and disease; and being fully prepared to respond to any public health threats that may occur.

In July 2015, the Oregon legislature passed House Bill 3100. This bill sets forth a clear path to modernize Oregon's governmental public health system so that it can proactively meet the needs of Oregonians. The new law identifies four foundational programs and seven foundational capabilities and that should be present at each public health authority in Oregon.

Foundational Programs

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

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

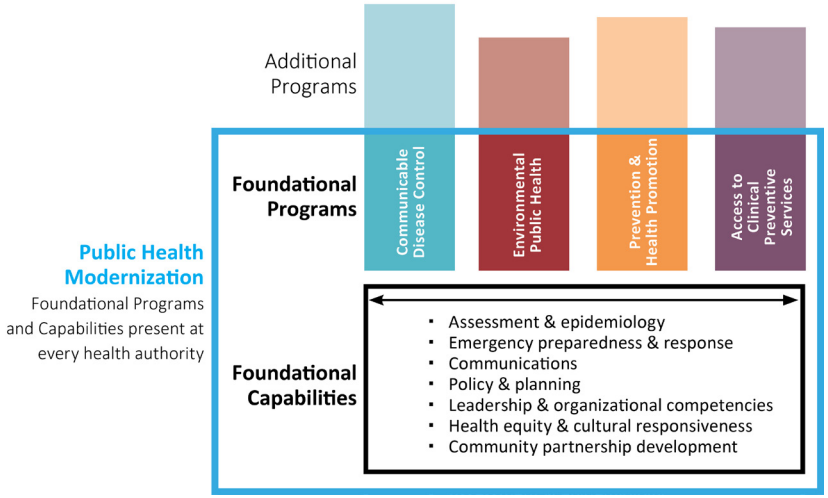
Foundational Capabilities

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

- Assessment and Epidemiology
- Emergency Preparedness and Response
- Communications
- Policy and Planning
- Leadership and Organizational Competencies
- Health Equity and Cultural Responsiveness
- Community Partnership Development

Additional Programs

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



Public Health Modernization: A New Framework for Health in Every Community

The public health modernization framework differs significantly from Oregon's existing public health structure. The new framework supports the provision of population-based health services uniformly across the state. With health system transformation in Oregon, the role of governmental public health as a clinical service provider of last resort for residents who do not have access to health care in traditional settings is shrinking. Governmental public health can

provide more efficient benefits by focusing on population-based health services and programs. However, governmental public health in Oregon still plays a role in providing some additional programs to meet local needs.

SERVICE DELIVERY

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

Governmental Public Health Authorities

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

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

It is important to recognize that this governmental public health authority split is how the system is currently structured, but not the only way to structure it. While currently there is one state public health authority providing centralized state public health services, those services could be delivered through decentralized state public health authorities located across the state. Similarly, although local public health services are delivered in a decentralized manner at the county-level (with the exception of North Central Public Health District), there are opportunities to provide some services in a more centralized manner to allow LPHAs to leverage types of expertise that might not be available systemwide.

Cross Jurisdictional Sharing

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

PUBLIC HEALTH MODERNIZATION ASSESSMENT OVERVIEW

PHD was tasked with developing and stewarding the first statewide public health modernization assessment. The assessment seeks to answer two key questions:

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

Programmatic Framework

Oregon's public health modernization framework is organized around seven foundational capabilities and four foundational programs. The *Public Health Modernization*

Manual[1] provides detailed definitions for each foundational program and capability for governmental public health authorities, under the current service delivery model.

The manual defines each foundational program and capability as it applies specifically to state and LPHAs, who in turn work closely with community members and partners to implement them. Each foundational program and capability definition includes:

- **Core system functions:** work that state and LPHAs must do together as a system;
- **State roles:** the unique responsibilities of the OHA Public Health Division;
- **Local roles:** the unique responsibilities of the LPHAs;
- **Deliverables:** tangible work products created by state and LPHAs; and
- **Critical tools and resources:** items necessary for state and LPHAs to fulfill their roles and produce their deliverables.

Some public health services are not included in this framework, for example, direct services and individualized interventions, like Women, Infants, and Children (WIC). These programs are considered additional programs, to be delivered based on local priorities and outside of the public health modernization framework.

To support our work, BERK leveraged the December 2015 version of the manual to inform our programmatic framework for the public health modernization assessment.

The detailed definitions provided in the *Public Health Modernization Manual* also presented challenges to the assessment. For example, it is impractical to require any state or local public health authority to generate resource estimates at the role or deliverable level as there are almost 400 state roles and deliverables and over 300 local roles and deliverables. As the *Public Health Modernization Manual* was being updated at the time of the assessment, we did not use the numbering system in that document.

It was also difficult for governmental public health authorities to generate estimates at the foundational program and capability level because of the range of roles and deliverables in each. To mitigate these challenges, we developed an intermediate level between the foundational programs and capabilities and the roles and deliverables to support local authorities in their assessments. To do this, the legislative definitions of each foundational program and capability were synthesized with the 302 local roles and deliverables which were assigned to the emerging functional areas on a one-to-one basis. The activities at this intermediate level were dubbed "functional areas" and describe how LPHAs might execute this work. There are 40 functional areas, defined in ***Appendix B: Functional Area Definitions.***

For the purposes of state activities, which are provided by only one governmental public health authority (PHD), we did not develop complementary functional areas.

Assessment Process

PHD engaged BERK Consulting, a public policy consultancy with experience and expertise related to public health modernization, to execute the public health modernization assessment.

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

Based on discussion with LPHAs through the Coalition of Local Health Officials (CLHO), the organization that represents LPHAs, and the CLHO-PHD Joint Leadership Team, PHD determined that an ideal public health modernization assessment would collect data from all 35 governmental public health authorities in Oregon. This presented several challenges:

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

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

- A programmatic self-assessment and resource estimation completed by each LPHA
- A programmatic self-assessment and resource estimation completed by PHD

These processes were designed to reinforce a consistent interpretation of the framework and ensure data collected were accurate, consistent, and non-duplicative. Each process is detailed further in the following sections.

LPHA ASSESSMENT PROCESS

Process Design

The LPHA assessment tool was created to:

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

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

Assessment Tool Development

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

PROGRAMMATIC SELF-ASSESSMENT

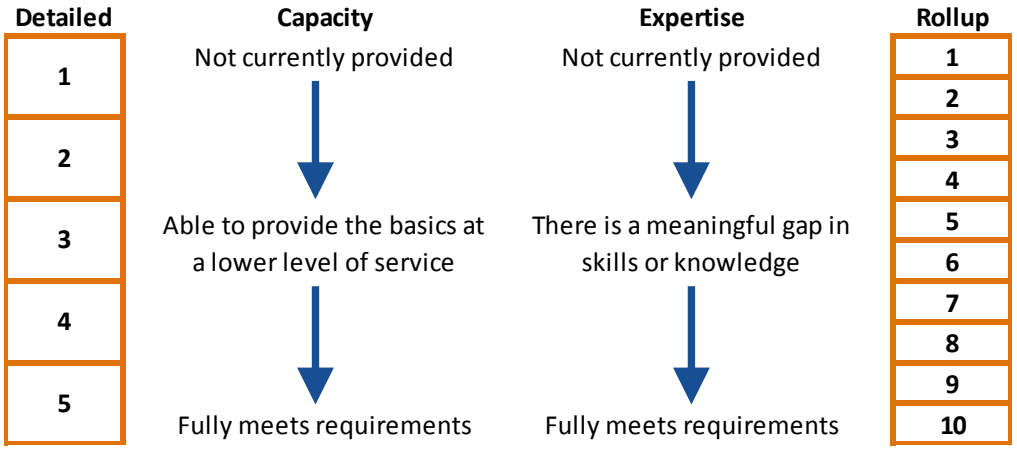
The programmatic self-assessment allowed LPHAs to

1. Assess their current capacity and expertise to meet the requirements of the public health modernization framework;
2. Help LPHAs identify the degree to which they are already executing public health modernization roles; and,
3. Understand the expertise with which they are providing those services as defined as part of public health modernization.

It includes two scales – capacity and expertise.

- **Capacity.** To what degree the organization currently has the staffing and resources necessary to provide the activities dictated. That is, "do I have enough staff to provide the activity for all?"
- **Expertise.** To what degree the organization's current capacity aligns with the appropriate knowledge necessary to implement the services/deliverables dictated. That is, "do I have enough expertise to provide the activity well?"

This section of the tool was a qualitative self-assessment of how closely LPHAs believe they are currently meeting the requirements of the new public health modernization framework.



The programmatic self-assessment had two levels:

- A **detailed assessment** of capacity and expertise for meeting local roles and providing deliverables outlined in the *Public Health Modernization Manual*; and
- A generalized **rollup assessment** for meeting the key functional areas as described in the cost estimation and an overall assessment for this foundational capability or program.

The detailed assessment used a five-point scale, while the rollup assessment used a ten-point scale. These scales are not linear (i.e., a three on the detailed assessment or a six on the rollup assessment do not denote 60% implementation). Rather, the scores map to a scoring rubric provided in the assessment tool, shown on this page.

These scores are used in conjunction with the cost estimations provided by the authorities to help describe the resources needed to fully implement public health modernization.

The programmatic self-assessment results provide an overall indicator of the size, location, and nature of the programmatic gaps that currently exist in providing foundational programs and capabilities in all communities across Oregon.

CURRENT SPENDING

To identify their current annual level of investment in each functional area, LPHA staff reviewed their fiscal year 2015 annual spending and allocated resources to each, generating current spending estimates for each functional area.

FULL IMPLEMENTATION RESOURCE ESTIMATION

Within the assessment tool, LPHAs developed annual cost estimates for each foundational program and capability, as if they were implementing in 2016. These estimates were provided in 2016 dollars.

Cost estimates for 10 of the foundational programs and capabilities (all excluding Leadership and Organizational Competencies) were generated using our basic cost estimation method. Cost estimates for Leadership and Organizational Competencies were generated using our infrastructure cost estimation method. Both cost estimation methods provide initial estimates and an estimation tool powered by an estimation calculator.

The estimation calculator relies on assumptions about:

- The percentage of costs that are fixed, i.e., expenses that do not change as a function of the activity of the foundational capability or program;
- Demand drivers for public health services, factors that cause a change in the overall

demand for a foundational capability or program; and

- The influence each demand driver has in relation to one another.

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

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

LPHA Assessment Completion

Great care was taken to ensure a smooth and high-quality data collection process that would secure good data to inform public health modernization and fulfill House Bill 3100 requirements.

This context made the tool collection and technical support phases of the work very important. The live tool was deployed to LPHAs on January 19, 2016. The collection process was structured in a wave system, so that half of the LPHA tools were due on March 1, 2016, and the other half were due on March 15, 2016. This phased system enabled a steady data validation process and high-touch technical assistance. Data validation occurred throughout the month of March 2016 with members of the BERK team reviewing data in returned tools and, if data were questionable or unclear, contacting LPHA staff to clarify necessary points. Cost analysis was performed once all data were returned.

Throughout this timeline, robust technical assistance efforts were in place with live and personalized support available to each LPHA. All data collection as well as information sharing for the effort was hosted on a SharePoint site, allowing access to information at any time.

Additionally, a comprehensive set of written materials were available to LPHA staff, a series of webinars were hosted throughout the process to address questions, and live phone assistance was provided upon request. LPHA staff were able to send questions and requests via email, and received responses to those inquiries within one business day, with actual response times often being much quicker. By the end of the data collection process, the technical assistance team had successfully responded to over 200 assistance requests.

CLHO TECHNICAL ASSISTANCE

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

Kelly buttressed BERK's technical assistance, helping to build understanding around public health modernization, answer questions, and provide strategies for approaching the work.

PHD ASSESSMENT PROCESS

Assessing state activities which are delivered by one governmental public health authority (PHD) with one budgeting and accounting system allowed for a simpler approach but with the added challenge of a statewide organization with a large service area.

Programmatic Self-Assessment

The programmatic self-assessment allowed PHD to assess its current capacity and expertise to meet the requirements of the public health modernization framework, and to help PHD identify the level to which it is already implementing public health modernization roles and deliverables. This programmatic self-assessment was similar to that provided to the LPHAs in their assessment tools, with the exception that it was based on state activities. Like the LPHA programmatic self-assessment, it included two scales – capacity and expertise.

The tool was a qualitative self-assessment of how well PHD is currently meeting the requirements of the new public health modernization framework.

Like the LPHA programmatic self-assessment, PHDs programmatic self-assessment had two levels: a detailed assessment and a rollup assessment. This assessment used the same levels of detail and the same scales as the LPHAs' assessment.

Current Spending

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

To do this effectively, PHD reviewed spending across its four centers (Office of the State Public Health Director, Center for Health Protection, Center for Prevention and Health Promotion, and the Center for Public Health Practice) and allocated funds across the foundational programs and capabilities.

Full Implementation Resource Estimation

To estimate the resources needed for PHD to fully implement public health modernization, small groups of staff generated estimations for each foundational program and capability, as if they were implementing in 2016. These estimates were provided in 2016 dollars.

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

Limitations

As self-reported data, the information collected through the assessment process has certain inherent limitations. These include respondent biases, an uneven understanding of public health modernization, and differing resource estimation expertise.

With all self-reported data, there is a question of respondent biases, especially if there are perceived benefits, such as favorable future funding decisions. Additionally, attitudes about public health modernization in general and the assessment processes specifically are reflected in the data collected.

Respondents have differing levels of cost estimation backgrounds. Areas of public health modernization are new activities for governmental public health, so some cost estimates had to be done without comparables. This was a particular challenge given the short six to eight week timeline for completion which constrained the time available for staff to learn and understand these complex topics.

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

Completing the assessment tool was an unfamiliar exercise and the public health modernization framework was new for some respondents. This assessment provided LPHAs with detailed exposure to public health modernization as defined in the *Public Health Modernization Manual*.

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

- As a high-level, order of magnitude estimate, accuracy at a budget or line-item level is not expected
- We performed some limited standardization using the data set as a whole and external data sources to correct individual inconsistencies
- As all 34 LPHAs responded, we collected data for the whole population of LPHAs, which means we do not have to correct for sampling issues
- Research suggests that managers tend to underestimate the resources needed to perform new job tasks[2]

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

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

Assessment Results

VALIDATION

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

As suggested by Glen Mays in his recommended methodology for estimating the cost of foundational public health capabilities,[3] BERK incorporated anchoring questions based upon the work of Gary King and Jonathan Wand[4] to correct for issues of inter-rater reliability. By presenting hypothetical situations to respondents, general attitudes about resource needs can be approximated. Some respondents consistently assessed the anchoring questions higher or lower than their peers, which informed identifying and assessing outliers.

BERK has previous experience with this type of cost estimation, working with the Washington State Department of Health to estimate the cost of implementing Washington's version of public health modernization. This previous work, while not directly comparable because of differences

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

[3] Glen Mays, "Estimating the Costs of Foundational Public Health Capabilities: A Recommended Methodology" The Robert Wood Johnson Foundation National Public Health Leadership Forum (2014).

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

in public health modernization frameworks, was incorporated into initial estimates provided to LPHAs and used as a high-level estimate check.

BERK also reviewed the data for internal consistency. For example, if programmatic self-assessment responses indicated full implementation of the activities included in public health modernization but the respondent also reported a large funding need, this would indicate that further information is needed.

PHD collects projected revenue data from LPHAs annually. In an attempt to reduce reporting burden on LPHAs, PHD requested that BERK include this revenue data collection in the assessment tool. While not part of public health modernization, these data allowed BERK to compare public health modernization current spending totals with projected revenue. PHD provided multiple years of revenue data that allowed BERK to identify inconsistencies and work with LPHAs to correct estimates.

STANDARDIZATION

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

FINAL RESULTS

The validated, standardized assessment results were used to develop generate foundational program and capability and functional area level level of implementation and population service results for all governmental public health authorities. The results were also used to compute estimates for current spending on public health modernization activities, the full implementation cost of those activities, and the additional increment of spending needed to reach full implementation under the current service delivery model. These results are all provided in 2016 dollars.

Current spending captured all spending on public health modernization activities based on the existing funding paradigms. The funding sources supporting this current spending were not specifically identified and may include, but are not limited to: OHA intergovernmental agreement for financing public health services, various state and federal funds, Medicaid, county general funds, fees, donations, and other funds.

The additional increment of spending needed to reach full implementation represents what the incremental increase in capacity and expertise to support full implementation of public health modernization activities will cost. If current spending stayed constant, and the current funding paradigm stayed the same, this amount would also be equal to the additional funding needed to reach full implementation based on the current funding paradigm. However, if the current funding paradigm were to change, changing current spending, the additional increment of spending needed would change.

The assessment results presented in this report represent point-in-time, planning-level estimates based on full implementation of the public health modernization framework, as outlined in the December 2015 *Public Health Modernization Manual.* It is important to recognize that that framework is not static because of the evolving nature of public health work, which will need to be reflected. Additionally, these estimates were developed based on the current service delivery model, which may change as opportunities to increase efficiency and effectiveness are identified.

It is important to recognize that this assessment is the first step of an evolving process, and these results will continue to be refined as implementation progresses.

OVERALL ASSESSMENT RESULTS

PUBLIC HEALTH MODERNIZATION ASSESSMENT OVERALL RESULTS

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

- For all governmental public health authorities
  - Overall assessment results
- For PHD
  - Foundational program and capability level results
- For LPHAs
  - Foundational program and capability level results
  - Functional area level results

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

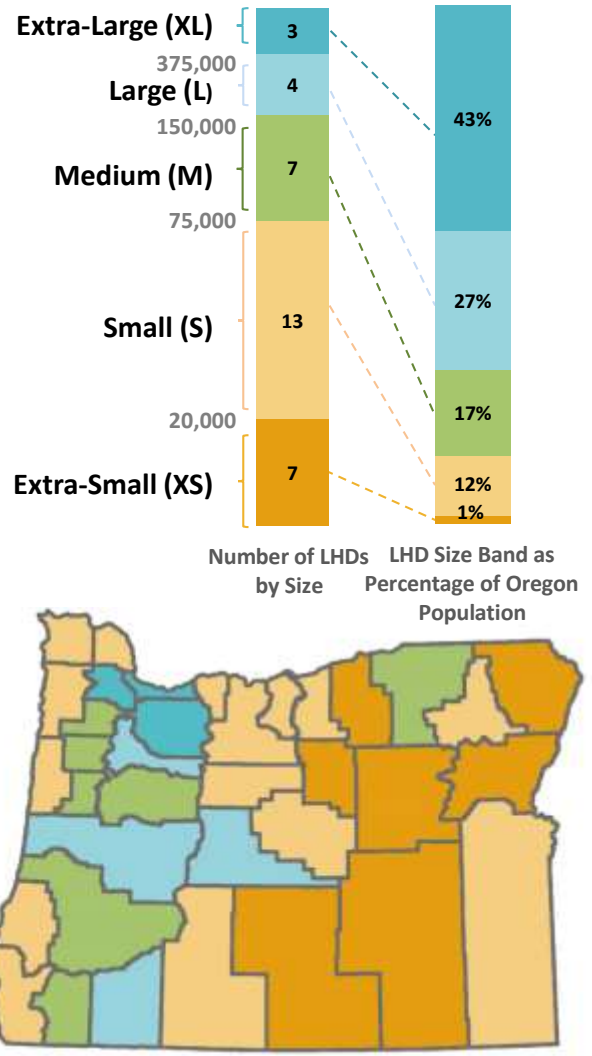
Interpreting Results

Operational Size Construct

We developed an operational sizing construct for LPHAs to allow for a more detailed review of results. The sizing categories were created based on analysis of the self-assessment results. We identified that LPHAs serving similar populations, both in size and demographics, also have similar levels of implementation and common operational characteristics; these trends became the operational size grouping.

This sizing construct is used as an additional categorization to provide a higher level of detail to the assessment results. The sizes are broken down as follows and can also be seen in the image to the right.

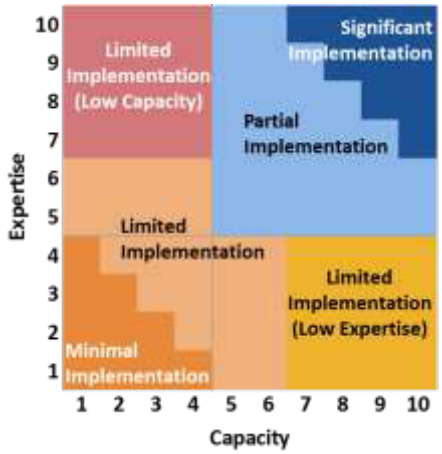
- **Extra-Small:** Population below 20,000
- **Small:** Population between 20,000 and 75,000
- **Medium:** Population between 75,000 and 150,000
- **Large:** Population between 150,000 and 375,000
- **Extra-Large:** Population over 375,000



LEVEL OF IMPLEMENTATION

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

Level of Implementation for Foundational Programs and Capabilities and Functional Areas



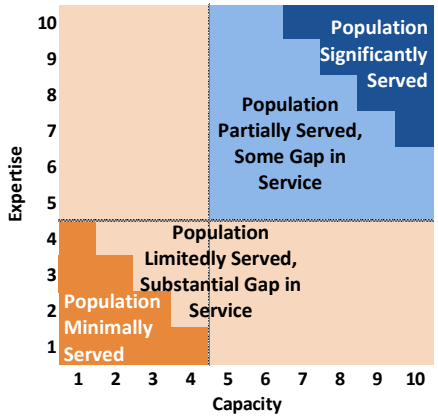
- **Significant Implementation (Dark Blue):** Services are mostly or fully implemented.
- **Partial Implementation (Light Blue):** Services are partially implemented however, some gaps remain.
- **Limited Implementation, Low Expertise (Yellow):** Services are limitedly implemented and, while the governmental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

POPULATION BY LEVEL OF SERVICE

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

The graphic to the right illustrates how programmatic self-assessment results are interpreted to provide insight on governmental public health authorities' population service with capacity on the *x*-axis and expertise on the *y*-axis.

- **Population Significantly Served (Blue):** The



population is mostly or fully served.

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

SERVICE DEPENDENCIES

The activities of state and local governmental public health authorities are interdependent. The state directly and indirectly supports many local activities. In addition, some local activities feed back into PHD's work. We identified clear service dependencies, particularly where state activities are needed to support implementation at the local level. These service dependencies should be considered in implementation to prevent them from becoming barriers to and inefficiencies in implementation.

Results by Foundational Program and Capability

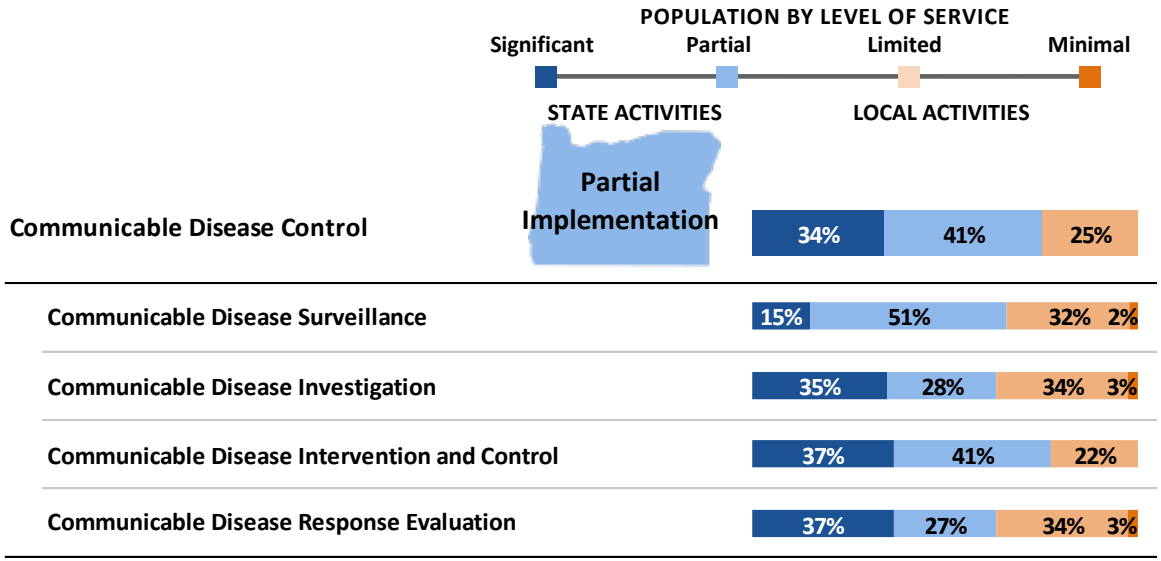
The following pages provide a high-level overview of assessment results by program and capability. Detailed assessment results, which are significantly more granular and reflect additional nuance are available in the "Detailed Assessment Results" section of the full report.

The values presented in these charts were rounded for labeling and those less than 0.5% are not labeled.

Communicable Disease Control

State Communicable Disease Control activities are partially implemented. Additionally, there are several service dependencies where state activities directly support provision of local activities, such as providing technical assistance and surge capacity for LPHAs investigating and controlling reportable diseases and outbreaks.

The level of implementation of local activities is consistent with many other foundational programs and capabilities. Approximately 1 in 4 Oregonians lives in an area where local communicable disease control activities are minimally or limitedly implemented. Service gaps are similar in scale among each of the 4 functional areas.



Environmental Public Health

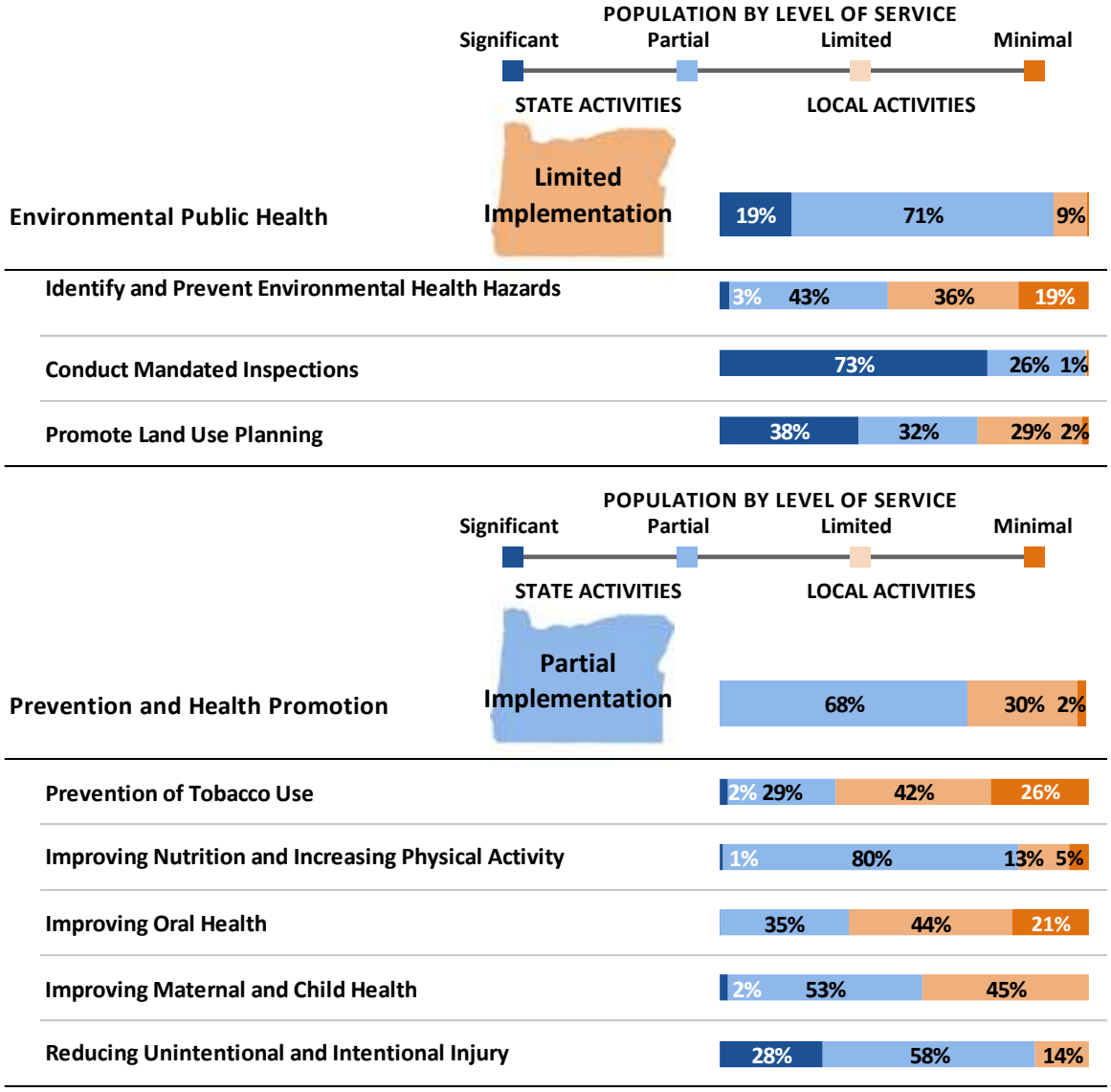
State Environmental Public Health activities are limitedly implemented. However, there are a few service dependencies between state and local governmental public health activities, including the state's maintenance of information systems.

The level of implementation of local activities is higher than that of other foundational programs and capabilities. Only 1 in 10 Oregonians lives in an area where these activities are limitedly or less implemented. While overall implementation of the program is fairly high across all LPHAs, there are sizeable service gaps in 2 functional areas: Identify and Prevent Environmental Health Hazards and Promote Land Use Planning.

Prevention and Health Promotion

State Prevention and Health Promotion activities are partially implemented but there are only a couple of service dependencies related to the less implemented state roles and deliverables.

The level of implementation of local activities is somewhat lower than that of many other foundational programs and capabilities. Approximately 1 in 3 Oregonians live in an area where local Prevention and Health Promotion activities are minimally or limitedly implemented. Service gaps are concentrated in 3 functional areas: Prevention of Tobacco Use, Improving Oral Health, and Improving Maternal and Child Health.



Access to Clinical Preventive Services

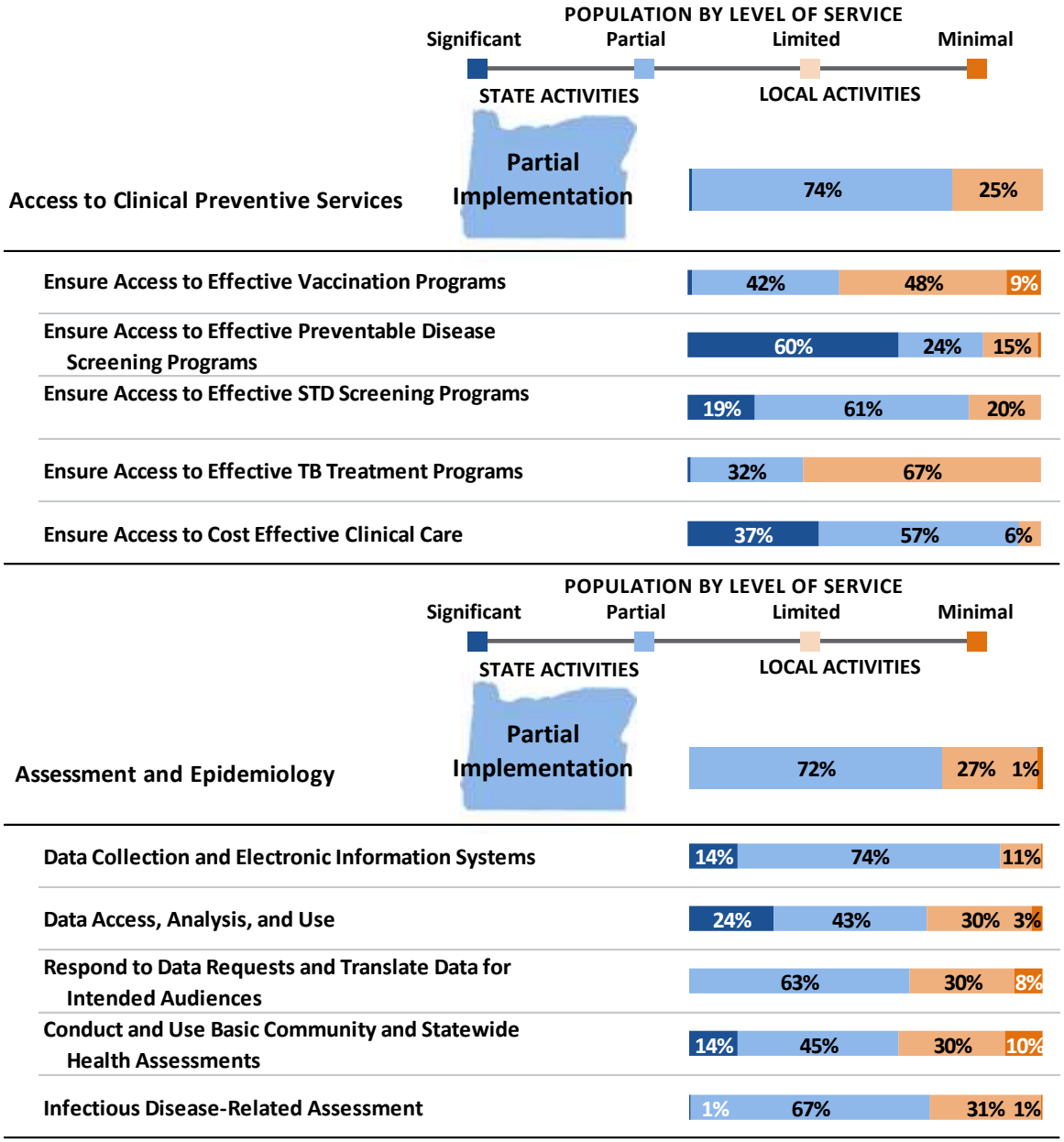
Access to Clinical Preventative Services is partially implemented and there are only a couple of service dependencies related to the less implemented state roles and deliverables.

The level of implementation of local activities is consistent with that of many other foundational programs and capabilities. Approximately 1 in 4 Oregonians live in an area where local Access to Clinical Preventive activities are minimally or limitedly implemented. Service gaps are concentrated in 2 functional areas: Ensure Access to Effective Vaccination Programs and Ensure Access to Effective Tuberculosis Treatment Programs.

Assessment and Epidemiology

State Assessment and Epidemiology activities are partially implemented and include activities performed by the Oregon State Public Health Laboratory.

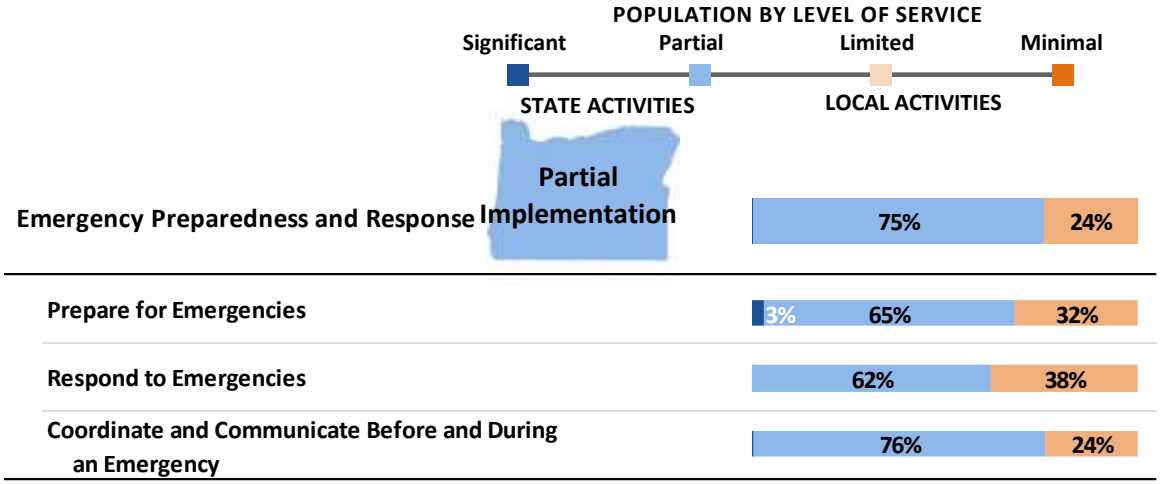
The level of implementation of local activities is similar to that of other foundational programs and capabilities. Approximately 1 in 4 Oregonians lives in an area where Assessment and Epidemiology activities are minimally or limitedly implemented.



Emergency Preparedness and Response

State Emergency Preparedness and Response activities are partially implemented. There are many service dependencies between state and local governmental public health authorities related to this foundational capability.

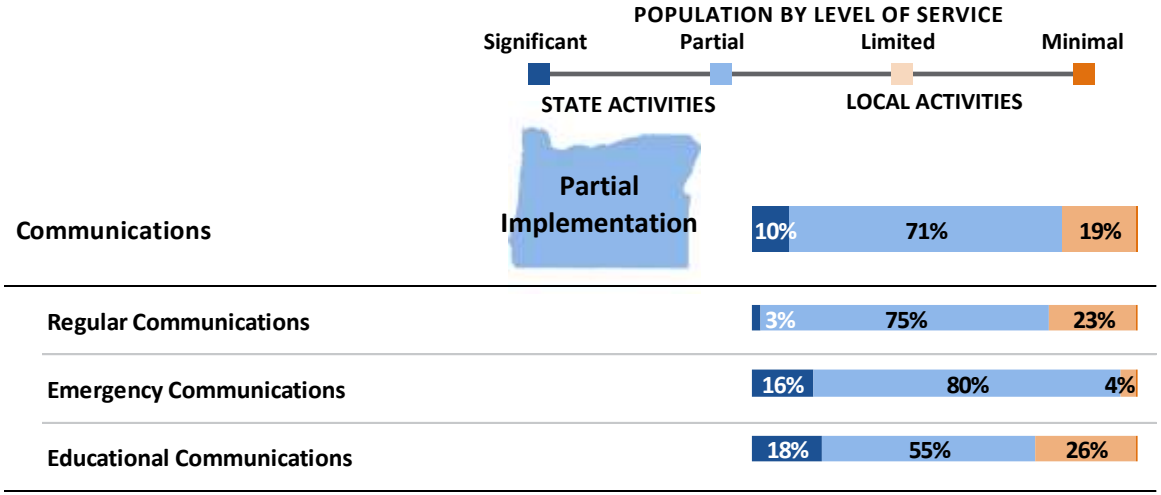
The level of implementation of local activities is similar to that of many other foundational programs and capabilities. Approximately 1 in 4 Oregonians live in an area where Emergency Preparedness and Response activities are minimally or limitedly implemented. Service gaps are fairly similar in scale across each of the 4 functional areas.



Communications

State Communications activities are partially implemented.

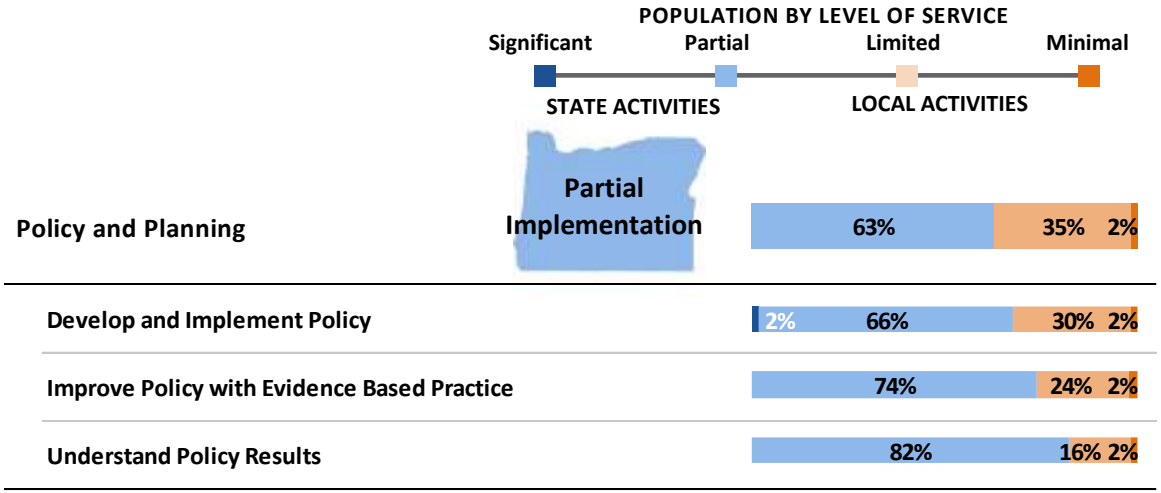
The level of implementation of local activities is somewhat better than that of many other foundational programs and capabilities. Approximately 1 in 5 Oregonians lives in an area where Communications activities are minimally or limitedly implemented. Service gaps are concentrated in 2 functional areas: Educational Communications and Regular Communications.



Policy and Planning

State Policy and Planning activities are partially implemented.

The level of implementation of local activities is somewhat lower than that of many other foundational programs and capabilities. Approximately 1 in 3 Oregonians live in an area where Policy and Planning activities are minimally or limitedly implemented. Development and Implementation of Policies is the functional area with the largest service gap.

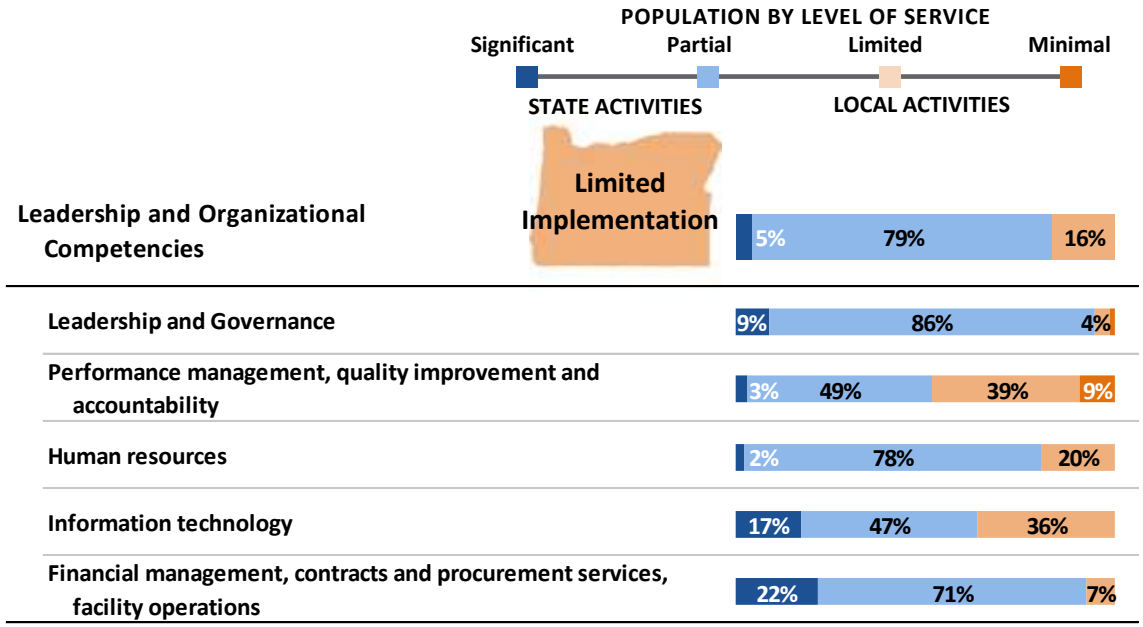


Leadership and Organizational Competencies

State Leadership and Organizational Competency activities are limitedly implemented and there are several service dependencies that are not yet fully implemented, with state roles and deliverables that support local activities.

The level of implementation of local activities is higher than that of many other foundational programs and capabilities. Approximately 1 in 6 Oregonians live in an area where Leadership and Organizational competencies are limited overall. Service gaps are concentrated in 2 functional areas: Performance Management, Quality Improvement and Accountability and Information Technology.

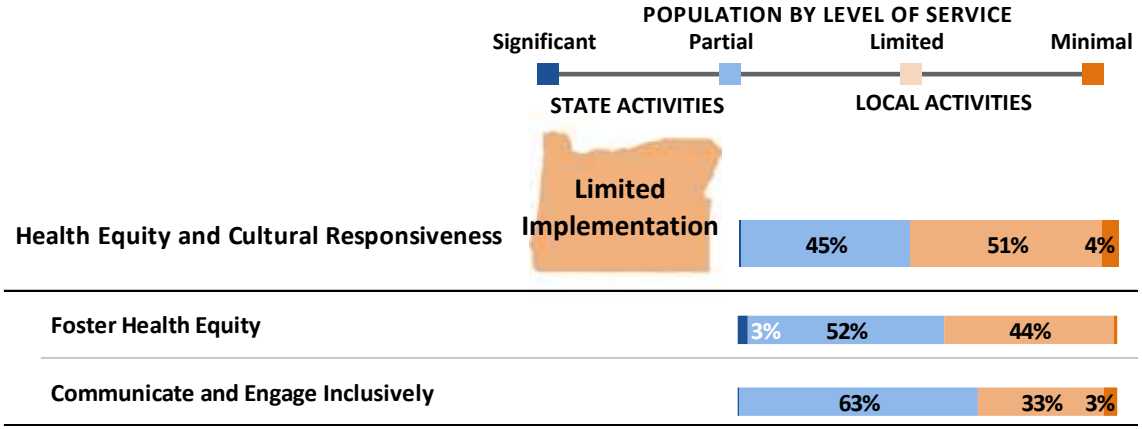
Although this foundational capability is well-implemented, a significant additional increment of resources will be needed to provide infrastructure to support the additional work being done as part of full implementation of public health modernization overall.



Health Equity and Cultural Responsiveness

State Health Equity and Cultural Responsiveness activities are limitedly implemented. This capability has a few service dependencies between the state and local governmenta l public health authorities.

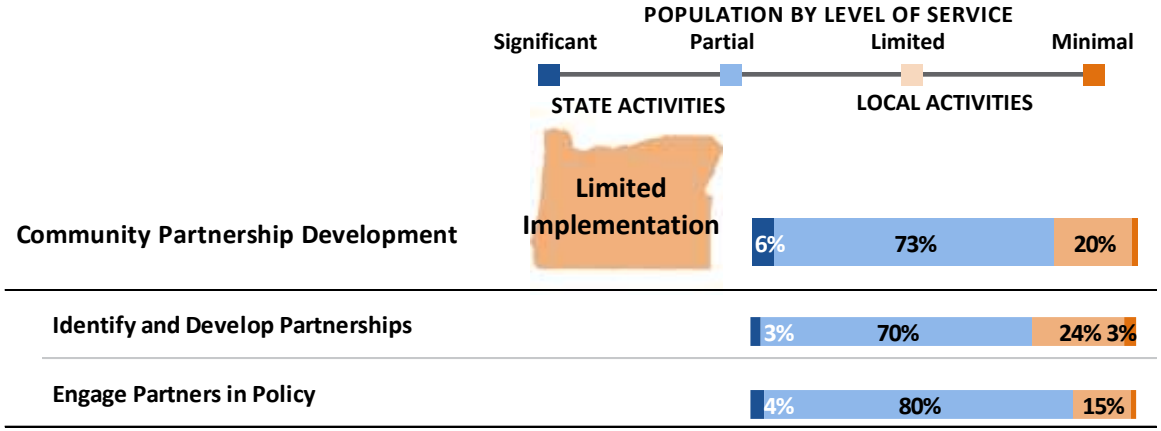
This is one of the least implemented foundational capabilities or programs. More than half of Oregonians live in an area where activities to support Health Equity and Cultural Responsiveness are minimally or limitedly implemented. Service gaps are similar in scale in both functional areas.



Community Partnership Development

State Community Partnership Development activities are limitedly implemented. While there aren't specific service dependences between state and local governmental public health authorities, there are indirect ones such that state activities can augment and support local activities.

The overall level of implementation is somewhat higher than that of many other foundational programs and capabilities. Approximately 1 in 5 Oregonians lives in an area where Community Partnership Development activities are minimally or limitedly implemented. Service gaps are fairly similar in scale among its three functional areas.



Cost of Full Implementation

The public health modernization assessment resource estimates, in 2016 dollars, are presented in the table below.

The $209M in current spending on public health modernization activities represents the best estimate of the money spent by governmental public health authorities on public health modernization activities in fiscal year 2015. The funding sources supporting this current spending were not specifically identified and may include, but are not limited to: OHA intergovernmental agreement for financing public health services, various state and federal funds, Medicaid, county general funds, fees, donations, and other funds.

The preliminary $105M additional increment of cost represents the initial estimate for implementation under the current governmental public health system. This estimate will require additional analysis. This estimate is the first step in an evolving process – it is a point-in-time, planning-level estimate and does not represent the final cost needed to fully implement public health modernization. The preliminary cost estimate will be revised over time as efficiencies in public health service delivery are implemented. The current public health system in Oregon has existing efficiencies; implementation of public health modernization provides an opportunity to leverage and expand upon those efficiencies.

The additional increment of spending needed to reach full implementation represents what the

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

* All values provided in 2016 dollars.

incremental increase in capacity and expertise to support full implementation of public health modernization activities will cost. If current spending stayed constant, and the current funding paradigm stayed the same, this amount would also be equal to the additional funding needed to reach full implementation based on the current funding paradigm. However, if the current funding paradigm were to change, changing current spending, the additional increment of spending needed would change.

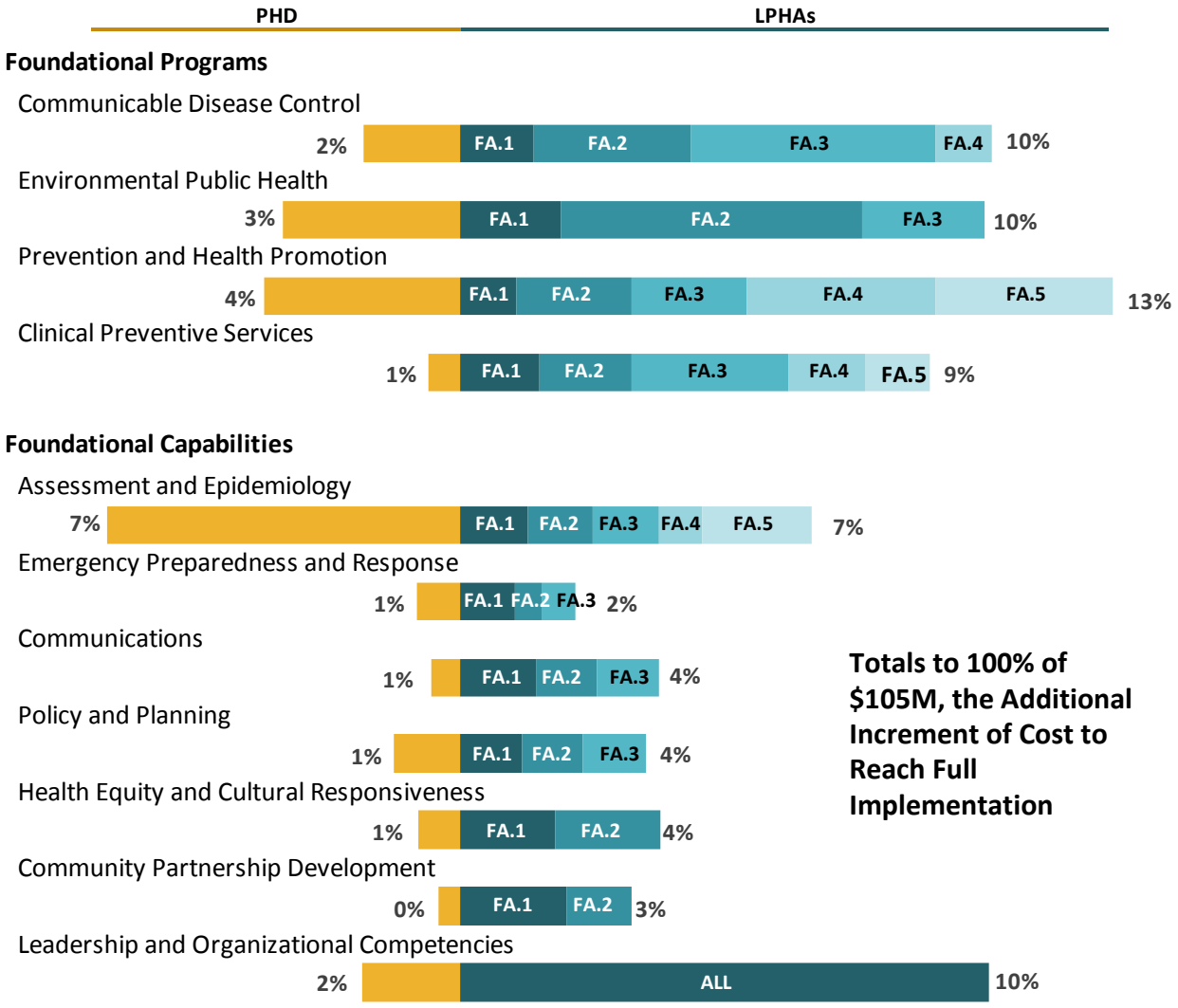
For both current spending and full implementation estimates, foundational programs represent approximately two-thirds of total costs. However, full implementation rebalances some of these costs into foundational capabilities, with a 70% increase in foundational capabilities versus a 35% increase in foundational programs.

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

Distribution of Additional Increment of Service

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

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



Functional Area Code Key

Communicable Disease Control
FA.1: Communicable Disease Control Surveillance
FA.2: Communicable Disease Investigation
FA.3: Communicable Disease Intervention and Control
FA.4: Communicable Disease Response Evaluation

Environmental Public Health
FA.1: Identify and Prevent Environmental Health Hazards
FA.2: Conduct Mandated Inspections
FA.3: Promote Land Use Planning

Prevention and Health Promotion
FA.1: Prevention of Tobacco Use
FA.2: Improving Nutrition and Increasing Physical Activity
FA.3: Improving Oral Health
FA.4: Improving Maternal and Child Health
FA.5: Reducing Unintentional and Intentional Injuries

Access to Clinical Preventive Services
FA.1: Ensure Access to Effective Vaccination Programs
FA.2: Ensure Access to Effective Preventable Disease Screening Programs
FA.3: Ensure Access to Effective STD Screening Programs
FA.4: Ensure Access to Effective TB Treatment Programs
FA.5: Ensure Access to Cost Effective Clinical Care

Emergency Preparedness and Response
FA.1: Prepare for Emergencies
FA.2: Respond to Emergencies
FA.3: Communicate and Coordinate Before and During an Emergency

Functional Area Code Key, Continued

Assessment and Epidemiology
FA.1: Data Collection and Electronic Information Systems
FA.2: Data Access, Analysis, and Use
FA.3: Respond to Data Requests and Translate Data for Intended Audience
FA.4: Conduct and Use Basic Community and Statewide Health Assessments
FA.5: Infectious Disease-Related Assessment

Communications
FA.1: Regular Communications
FA.2: Emergency Communications
FA.3: Educational Communications

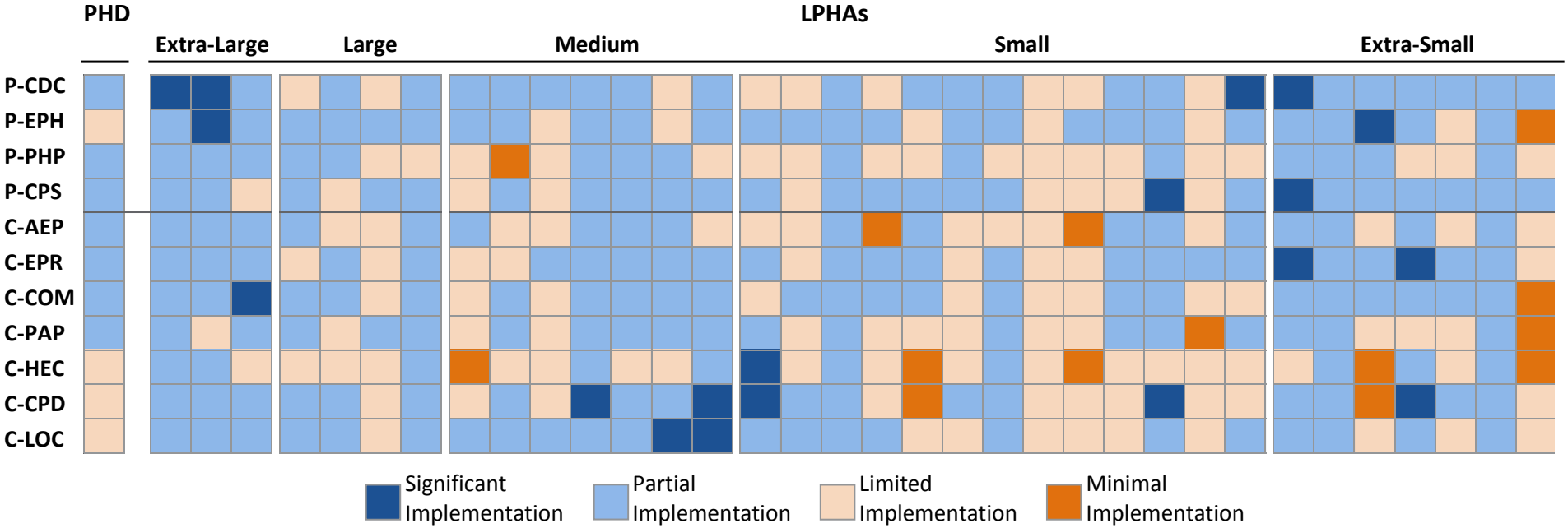
Policy and Planning
FA.1: Develop and Implement Policy
FA.2: Improve Policy with Evidence-Based Practice
FA.3: Understand Policy Results

Health Equity and Cultural Responsiveness
FA.1: Foster Health Equity
FA.2: Communicate and Engage Inclusively

Community Partnership Development
FA.1: Identify and Develop Partnerships
FA.2: Engage Partners in Policy

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

Current Implementation of Foundational Programs and Capabilities



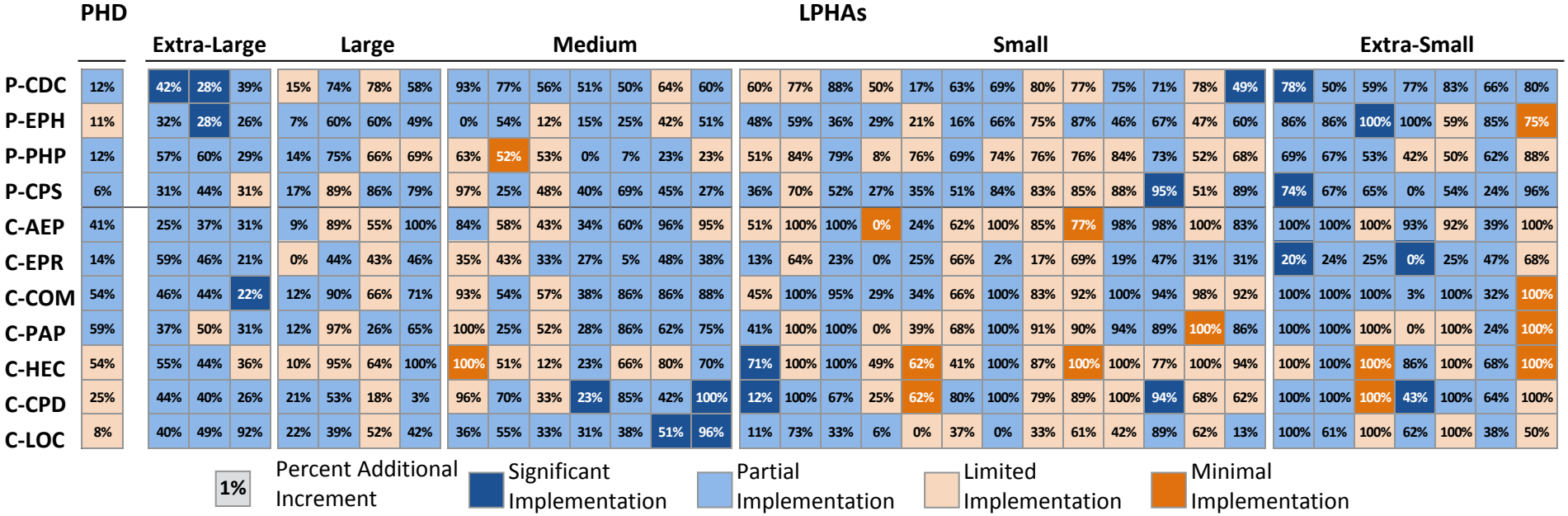
Above are the foundational program and capability implementation levels for PHD and a randomized ordering of the LPHAs by size bands.

Each vertical set of boxes represent one public health authority. There are no foundational programs or capabilities that are significantly implemented universally across all governmental public health authorities. There are some areas with a higher concentration of limited and minimal implementation, such as the Health Equity and Cultural Responsiveness capability and the Prevention and Health Promotion program. Additionally, some governmental public health authorities have larger programmatic gaps than others. However, there are gaps across the system in every size category.

Foundational Programs and Capabilities Code Key

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

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



Above are the foundational program and capability implementation levels and percent of full implementation additional increment of cost for PHD and a randomized ordering of the LPHAs by size bands.

Each vertical set of boxes represent one public health authority. The percentage within each box is the estimated additional increment of cost as a percentage of the full implementation cost for that foundational program or capability.

For example, in the upper left corner, PHD estimated that an additional 12% is needed for full implementation of Communicable Disease Control.

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

Foundational Programs and Capabilities Code Key

P-CDC: Communicable Disease Control
P-EPH: Environmental Public Health
P-PHP: Prevention and Health Promotion
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C-HEC: Health Equity and Cultural Responsiveness
C-CPD: Community Partnership Development
C-LOC: Leadership and Organizational Competencies

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

	PHD	LPHAs																															
		Extra-Large			Large				Medium							Small												Extra-Small							
P-CDC	8%	10%	7%	21%	21%	16%	19%	18%	25%	19%	22%	22%	21%	14%	14%	21%	10%	17%	20%	7%	12%	17%	10%	19%	15%	5%	10%	10%	8%	10%	2%	18%	8%	29%	13%
P-EPH	15%	13%	10%	15%	6%	24%	13%	23%	0%	20%	7%	9%	14%	9%	18%	25%	11%	6%	24%	16%	4%	20%	13%	4%	15%	15%	12%	17%	14%	13%	5%	39%	10%	21%	14%
P-PHP	17%	10%	19%	10%	20%	14%	15%	18%	16%	17%	20%	0%	3%	17%	11%	19%	21%	23%	7%	42%	25%	21%	24%	18%	26%	19%	13%	20%	21%	15%	15%	13%	18%	22%	17%
P-CPS	3%	5%	11%	3%	18%	15%	13%	13%	22%	10%	16%	16%	16%	20%	7%	10%	5%	8%	29%	14%	13%	14%	18%	14%	11%	16%	7%	16%	8%	29%	11%	0%	10%	8%	17%
C-AEP	31%	4%	9%	2%	3%	10%	11%	10%	10%	7%	10%	16%	12%	10%	9%	10%	2%	15%	0%	5%	8%	11%	11%	10%	11%	8%	9%	10%	7%	11%	5%	12%	11%	8%	8%
C-EPR	4%	6%	2%	2%	0%	2%	3%	3%	2%	2%	2%	2%	0%	4%	2%	1%	11%	3%	0%	5%	9%	0%	1%	6%	1%	3%	2%	3%	3%	3%	6%	0%	3%	4%	5%
C-COM	3%	4%	3%	1%	4%	3%	11%	3%	5%	4%	3%	12%	6%	7%	4%	3%	8%	7%	6%	2%	9%	4%	5%	4%	4%	6%	4%	9%	4%	5%	2%	0%	6%	1%	5%
C-PAP	6%	3%	9%	3%	1%	3%	2%	4%	4%	1%	7%	3%	6%	3%	3%	3%	9%	6%	0%	2%	5%	4%	5%	4%	4%	3%	4%	4%	6%	6%	17%	0%	6%	1%	5%
C-HEC	4%	4%	10%	1%	0%	2%	5%	2%	2%	1%	1%	4%	2%	3%	2%	3%	5%	5%	4%	4%	2%	3%	3%	4%	2%	3%	7%	4%	4%	3%	14%	3%	4%	1%	3%
C-CPD	2%	5%	8%	2%	3%	1%	1%	0%	4%	4%	2%	4%	6%	2%	4%	1%	5%	3%	2%	4%	8%	5%	3%	4%	4%	4%	3%	3%	5%	4%	3%	3%	4%	1%	4%
C-LOC	9%	35%	11%	40%	25%	9%	7%	6%	8%	15%	9%	17%	14%	10%	26%	4%	12%	6%	7%	0%	5%	0%	7%	14%	6%	18%	29%	4%	21%	2%	21%	19%	18%	4%	10%

Top Quartile | 50%-75% | 25%-50% | Bottom Quartile

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

For example, in the upper left corner, PHD estimated that of its total additional increment of cost, Communicable Disease Control constituted 8%. Each column represents one public health authority, and sums to 100% (although rounding may lead to slight differences). The boxes have been color-coded by quartile to show patterns in the reported data. This chart shows that the greatest additional increment of costs are concentrated in the programs (the four top rows) and the Leadership and Organizational Competencies capability (the bottom row). PHD has the highest additional increment of costs in the Assessment and Epidemiology capability, which also houses the State Public Health Laboratory.

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

Summary Findings

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

Programmatic Framework and Assessment Process

- The assessment provided LPHAs with detailed exposure to the public health modernization framework as defined in the *Public Health Modernization Manual*. The assessment was designed to reinforce a consistent interpretation of the framework and to build on collective understanding of it.
- The assessment process was designed to be highly detailed and required the participation of all LPHAs. However, many LPHAs found supplying this high level of detail burdensome and the response schedule challenging to manage over six to eight weeks with their existing workloads.
- Implementation of public health modernization is intended to be a transformative process that will reform public health based on the post-Affordable Care Act health context and align funding to a core set of public health services available universally and uniformly statewide. Breaking out of current paradigms to allow for innovative solutions to improve the efficiency and effectiveness of the governmental public health system will be an ongoing process.
- The assessment process, though thorough, was not exhaustive. There is a need to continue exploring particular features of the existing system, to identify opportunities to increase efficiency and effectiveness. These features include:
  - Service delivery, including cross jurisdictional sharing
  - Non-governmental public health assets, resources, and partnerships that contribute to the accomplishment of public health modernization roles and deliverables.
  - Barriers to implementation
  - Short-term or one-time additional costs related to implementation itself
- The "functional areas" defined as part of this process seem to accurately define how the foundational programs and capabilities, as defined through core system functions, roles, and deliverables in the *Public Health Modernization Manual*, will be operationalized by LPHAs.

Programmatic Gaps in Current Public Health System

- There are gaps across the system in all governmental public health authorities. These gaps are not uniform, nor do they appear in the same places in every organization. As such, current implementation of public health modernization can be described as a "patchwork quilt."
  - Some governmental public health authorities have larger programmatic gaps than others.
  - However, there are gaps in implementation across governmental public health authorities of all sizes.
- There are no foundational programs or capabilities that are significantly implemented universally across all governmental public health authorities.

- There are some foundational programs and capabilities with a higher concentration of limited and minimal implementation, such as the Health Equity and Cultural Responsiveness capability and the Prevention and Health Promotion program.

- Every foundational program and capability within the public health modernization framework includes roles and deliverables with varying levels of implementation.
  - There are some functional areas that include roles and deliverables that are well established as governmental public health activities. For some of these activities, LPHAs generally rated themselves highly in expertise, although often lower in capacity.
  - There are other functional areas that are dominated by roles and deliverables that may represent new governmental public health activities. In these areas, LPHAs indicated that they were minimally or limitedly implemented.
- PHD has partially implemented or limitedly implemented all of the foundational programs and capabilities. The least implemented (limitedly implemented) state activities programs are Environmental Public Health, Health Equity and Cultural Responsiveness, Community Partnership Development, and Leadership and Organizational Competencies.
- For each foundational program and capability, over 60% of the population is receiving services from a LPHA that has at least partially implemented it, with the exception of Health Equity and Cultural Responsiveness.
  - The most implemented foundational programs and capabilities across the system are Environmental Public Health and Leadership and Organizational Competencies.
  - The most implemented functional areas are Conduct Mandated Inspections and Ensure Access to Cost Effective Clinical Care.
  - The least implemented are Health Equity and Cultural Responsiveness and Policy and Planning.
  - The least implemented functional areas are Ensure Access to Effective Tuberculosis Treatment Programs and Prevention of Tobacco Use. LPHAs communicated that the latter is an ongoing challenge that will take significant resources, perhaps beyond those this assessment identifies, to solve.

Full Implementation Cost

- Governmental public health authorities are already significantly executing the public health modernization framework, with $209 million in 2016 dollars being spent annually on the foundational programs and capabilities. This is approximately two-thirds of the cost of full implementation of the framework.
- The preliminary estimated additional spending needed for full implementation is approximately $105 million annually in 2016 dollars. This is a point-in-time, order of magnitude cost estimation based on the current service delivery model, and will require ongoing analysis and refinement. This preliminary value will be revised as additional efficiencies, like changes to the service delivery model or increased cross-jurisdictional sharing, are implemented.
- The full implementation cost of public health modernization was developed based on the current service delivery paradigm. Expanding it to allow for additional cross jurisdictional service delivery options could reduce full implementation costs and, therefore, the additional increment of spending needed for full implementation.
- Similarly, while there is some cross-jurisdictional and resource sharing among

LPHAs today, there are opportunities to increase cross-jurisdictional sharing increasing the efficiency of the existing system, also reducing full implementation costs and, therefore, the additional increment of spending needed for full implementation.

- There are existing resource-sharing relationships among LPHAs today. These existing arrangements provide examples for future relationships. LPHAs expressed interest in exploring additional opportunities for cross jurisdictional sharing.
- To reach full implementation, three capabilities will require doubling current spending – Communications, Health Equity and Cultural Responsiveness, and Policy and Planning.
- For local activities, the largest concentrations of the total additional increment of cost to reach full implementation are in the 4 foundational programs and the Leadership and Organizational Competencies capability.
- For state activities, the highest concentration of the total additional increment of cost to reach full implementation is in the Assessment and Epidemiology capability, which houses the State Public Health Laboratory.
- While, for all statewide activities, the additional increment of cost to reach full implementation are generally concentrated in the 4 programs and the Leadership and Organizational Competencies capability, there is no foundational program or capability that does not have increased additional increment of costs for at least one governmental public health authority.
- An agency with a higher level of implementation of a foundational program or capability does not necessarily need fewer resources to reach full implementation than an agency with lower implementation. Conversely, an agency with limited implementation does not always indicate that a substantial amount of funding is needed to support full implementation.
- The additional increment of spending needed to reach full implementation represents what the incremental increase in capacity and expertise to support full implementation of public health modernization activities will cost. If current spending stayed constant, and the current funding paradigm stayed the same, this amount would also be equal to the additional funding needed to reach full implementation based on the current funding paradigm. However, if the current funding paradigm were to change, changing current spending, the additional increment of spending needed would change.

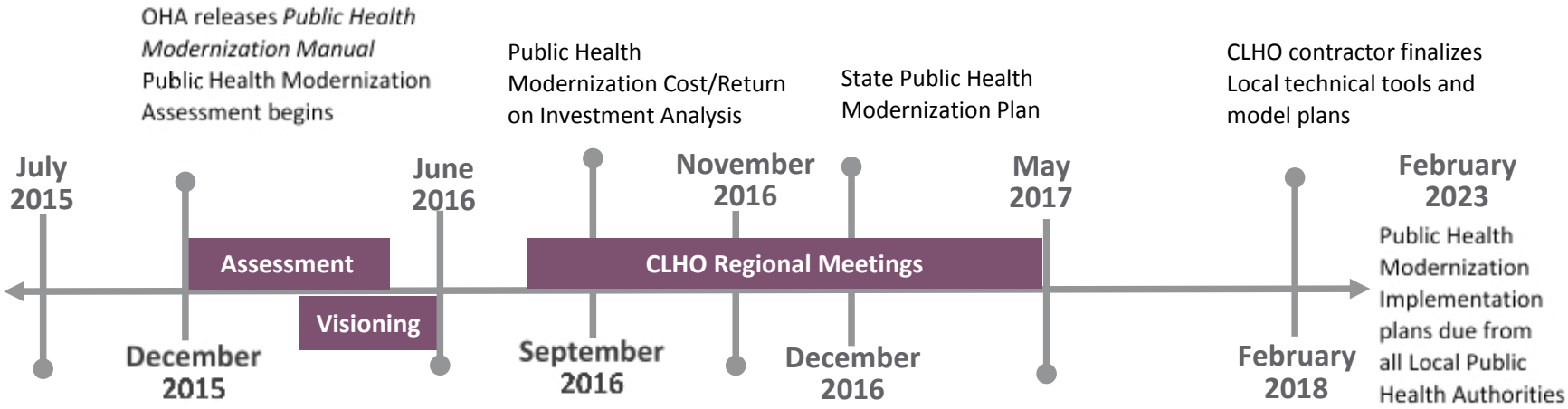
Future Implementation

- The current governmental public health service delivery model is divided into state activities, provided wholly centrally by PHD, and local activities, provided locally by LPHAs. While this is the current paradigm, it could be expanded to allow for additional cross jurisdictional service delivery options.
- There are existing resource-sharing relationships among LPHAs today. These existing arrangements provide examples for future relationships. LPHAs expressed interest in exploring additional opportunities for cross jurisdictional sharing.
- Implementation of public health modernization will be a significant undertaking that might require phasing.
- LPHAs have a high degree of local expertise related to their service areas which should be leveraged to improve the efficiency and effectiveness of implementation. Implementation strategies should allow for some flexibility and local decision making, which could be governed by local implementation plans.

- Implementing public health modernization by waves of LPHAs could be challenging for several reasons, including but not limited to:
  - Risk of creating a two-tiered system (with some LPHAs operating under the public health modernization framework, and others not).
  - Potential impacts to health equity (with those served by modernized LPHAs receiving a higher level of service than those being served by non-modernized LPHAs).
- Implementing by foundational program or capability could be challenging because current implementation is uneven across LPHAs.
- There are significant service dependencies between state and local governmental public health activities. Some of the state roles and deliverables that support local activities are not fully implemented. If not considered during the implementation process, these service dependencies could become barriers to and inefficiencies in implementation.
- Many of the foundational programs and capabilities support one another. That is, in order to accomplish the goals of one foundational program or capability most effectively and efficiently, one might have to have access to the resources available through implementation of another. This is most intuitive when thinking of the foundational capabilities, for example, communications plays a significant role in addressing tobacco use.

POLICY IMPLICATIONS

Development of this assessment is one of many ongoing activities related to public health modernization implementation, as shown in the timeline below.



Oregon Legislature passes HB 3100; included were:

- Implementation of the Task Force report
- Wave structure implementation, allowing local public health authorities to implement separately
- Requirement for Oregon Health Authority to assess current abilities and cost for full implementation

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

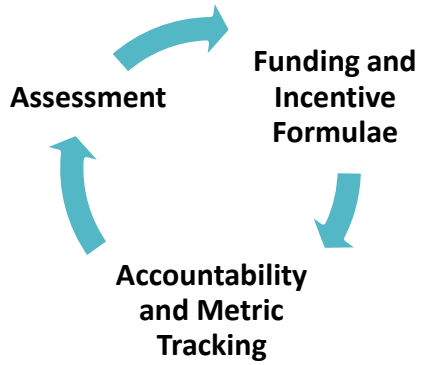
PHAB presents Funding Allocation and Incentives Structure to Legislative Fiscal Office

POLICY IMPLICATIONS

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

- **Public Health Modernization Funding Allocations and Incentives Formulae.** As required under House Bill 3100, PHD, under the guidance of the Oregon Public Health Advisory Board, is developing a funding formula allocation and local funding incentive formulae for any new funds received to support public health modernization.
- **Public Health Modernization Cost/Return of Investment Analysis.** This analysis is being undertaken by Program Design and Evaluation Services to quantify the financial benefit and the benefit to health outcomes of implementation of public health modernization. The assessment results presented in this report and the data collected as part of the assessment process will support this effort.
- **Statewide Public Health Modernization Plan.** The Statewide Public Health Modernization Plan will provide detailed strategies for the implementation of public health modernization in Oregon. The assessment results herein will be used to inform those strategies. Required by House Bill 3100, this plan will be complete by January 1, 2017.
- **CLHO Regional Meetings.** CLHO has received grant funds to host ten regional meetings with LPHAs to discuss and gather perspectives on public health modernization implementation strategies.
- **Local Public Health Modernization Plans.** Each LPHA will develop a Local Public Health Modernization Plan. Required by House Bill 3100, these plans are due no later than December 2023. However, House Bill 3100 also allows that PHD may establish a schedule by which LPHAs will submit their local plans for implementation.

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



- **Assessment.** Updated assessment results will help to identify current level of implementation at future points in time, which will allow for longitudinal review of the impacts of implementation strategies and the remaining gaps in implementation.
- **Funding and Incentive Formulae.** Initial public health modernization dollars are expected to be distributed through the public health modernization funding and incentive formula; updated assessment results will allow for midstream allocation decisions to align funding with implementation strategies.

- **Accountability and Metrics Tracking.** PHD has undertaken work that will identify the economic and health outcomes of implementation of public health modernization, which will help to identify metrics for tracking implementation and its effects on population health. This will help to tie assessment results to population health outcomes to ensure that implementation is creating meaningful change, and also to help inform funding decisions to support implementation strategies.

  PHD's metrics and accountability work will also present an opportunity to ensure that service dependencies are adequately identified and that there is accountability among governmental public health authorities to ensure that those service dependencies do not become barriers to implementation.

Implications for Implementation

This public health assessment is the first step of an evolving process that will continue to be refined as implementation progresses. The assessment results presented in this report represent point-in-time, planning-level estimates for the cost of full implementation of the public health modernization framework, as outlined in the December 2015 *Public Health Modernization Manual.* It is important to recognize that that framework is not static because of the evolving nature of public health work which will need to be reflected. For example, as new communicable diseases and environmental health threats are identified, or as new communications tools are deployed. Additionally, these estimates were developed based on the current service delivery model, which may change as opportunities to increase the efficiency and effectiveness of this work are identified. These realities illustrate why these numbers will necessarily change.

The assessment did identify several policy implications that should be considered throughout the implementation process:

- The assessment was designed to reinforce a consistent interpretation of the public health modernization framework and to build on collective understanding of it. This shared understanding should continue to be reinforced throughout the implementation process. Additionally, there will be a need to update this collective understanding as the framework evolves.
  - The *Public Health Modernization Manual*, which defines the public health modernization framework, is not static and will continue to be updated. This provides an excellent tool for updating governmental public health authorities' understanding of the framework.
- Assessment participants from both PHD and LPHAs expressed a lack of clarity as to who will provide the critical tools and resources (those items necessary for state and LPHAs to produce their deliverables) outlined in the *Public Health Modernization Manual*. Although many of these resources are provided online (and their web addresses provided in the *Public Health Modernization Manual*) many participants asked who would provide those tools and resources. This presents an easy opportunity to improve clarity around public health modernization implementation.
- Many LPHAs communicated that further clarity is needed as to what constitutes additional programs (public health activities implemented locally outside of the foundational programs and capabilities to address specific identified community public health problems or needs). Participants expressed some concerns about their particular local priorities not being included in the public health modernization framework and were unclear as to how that might change support or funding for those services in the future.

- There is a need to continue exploring features of the existing governmental public health system to identify opportunities for increased efficiency and effectiveness. This may include:
  - Service delivery, including cross jurisdictional sharing
  - Non-governmental public health resources and partnerships that contribute to the implementation of the public health modernization framework
  - Barriers to implementation
  - Short-term or one-time additional costs related to implementation itself

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

Service Delivery

One of the primary ways in which these estimates may continue to evolve is through the identification and implementation of additional efficiencies, especially those related to service delivery. Two opportunities for efficiencies include:

- Cross jurisdictional sharing
- Cross jurisdictional delivery

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

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

Cross Jurisdictional Sharing

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

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

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

Cross Jurisdictional Delivery

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

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

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

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

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

Funding

This assessment established the additional increment of spending needed to reach full implementation which represents what the incremental increase in capacity and expertise to support full implementation of public health modernization activities will cost in addition to current spending under the current funding paradigm. If the current funding paradigm were to change, changing current spending, the additional increment of spending needed would change.

The current funding paradigm was not evaluated as part of this assessment, however, it is anticipated that it will be as part of the PHAB's work on t**o** develop funding allocation and incentive formulae for public health modernization dollars. The impacts of any changes to the funding paradigm on the additional increment of spending needed to reach full implementation should be evaluated.

Phasing

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

To minimize these risks and establish the most efficient, effective implementation process possible, a flexible implementation strategy that is responsive to specific governmental public health authority contexts is needed. The variation in the assessment results suggests that a decision-making framework should be developed to support making implementation decisions as implementation proceeds. We have identified preliminary criteria for this decision-making strategy, including:

- **Population Health Impacts:** The degree to which a specific activity will improve population health. This is challenging to measure, as all foundational programs and capabilities are foundational and therefore necessary to support population health. Another approach is comparing the relative severity of the population-wide consequences of inaction on each foundational program and capability, which do vary. Additionally, it is important to remember that many of the cross-cutting capabilities will likely increase the effectiveness of the foundational programs, so their population health impact should be identified accordingly.
- **Service Dependencies:** The activities of state and local governmental public health authorities are interdependent. Many of PHD's roles and deliverables support local activities, and some local activities feed back into the PHD's work. It is necessary to understand service dependencies as part of overall implementation process.
- **Coverage Maximization:** This assessment found that some roles and deliverables are not widely implemented by LPHAs, but are available to significant portions of the population because a few LPHAs with large populations have existing services that meet the modernization requirements.

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

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

The decision-making framework will also allow for flexibility in implementation such that it can be informed by ongoing results, supporting continuous improvement. It will also incentivize continued evaluation of opportunities to increase efficiency and effectiveness, which could be disincentivized or even penalized if strict implementation strategies were already in place.

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

DETAILED ASSESSMENT RESULTS

INTERPRETING DETAILED ASSESSMENT RESULTS

Like our overall assessment results, we present our detailed assessment results at several altitudes:

- For state governmental public health authorities
  - Foundational program and capability level results
- For LPHAs
  - Foundational program and capability level results
  - Functional area level results

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

Foundational Program or Capability Subsection Structure

The detailed assessment results are organized into 11 subsections, one for each foundational program and capability. To aid review, each section has a similar layout and structure, modified only where necessary because of nuances in the data collected (for example, we provide an additional page of PHD results for the State Public Health Laboratory in the Assessment and Epidemiology subsection). This structure is as follows:

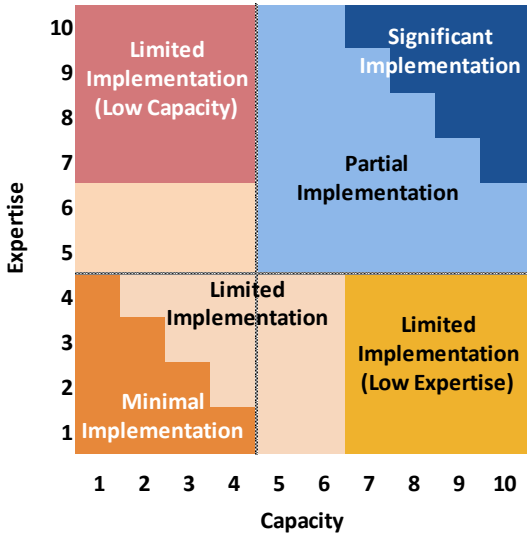
- **PHD foundational program and capability level assessment results.** In most cases, a single page that describes the overall level of implementation of the foundational program or capability, provides a visual of the distribution of scores for the state roles and deliverables included in that foundational program or capability, shows the current spending, additional increment of cost, and full implementation cost, and narrative that describes the state activities, level of implementation, and any less implemented roles and deliverables for activities that represent service dependencies between the state and LPHAs.
- **LPHA foundational program and capability level assessment results.** In most cases, a single page that describes the overall level of implementation of the foundational program or capability, provides a visual of the distribution of scores for all 34 LPHAs for the foundational program or capability, provides a visual that shows the level of service across all LPHAs, population, and the population living in poverty for the foundational program or capability, shows the current spending, additional increment of cost, and full implementation cost, and narrative that describes the local activities, level of implementation, and the functional areas that make up the foundational program or capability.
  - **LPHA functional area assessment results (one for each functional area).** In most cases, a single page that is structured similarly to the LPHA foundational program or capability assessment results page and one or more pages that show the level of implementation and level of service for the roles and deliverables included in the functional area.

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

LEVEL OF IMPLEMENTATION

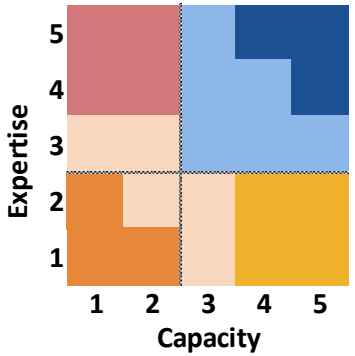
The level of implementation of foundational programs and capabilities and functional areas is illustrated throughout the overall and detailed assessment results with both color-coding and charts. The images to the right illustrate how programmatic self-assessment results are interpreted to provide insight on governmental public health authorities' level of implementation with expertise on the *y*-axis and capacity on the *x*-axis.

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



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

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



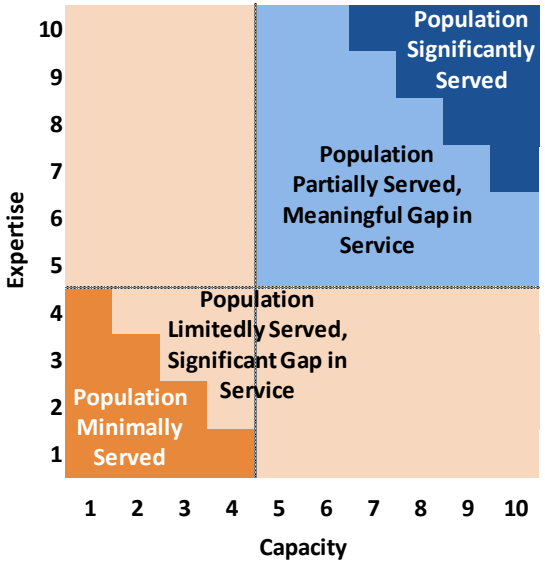
- **Limited Implementation, Low Capacity (Red):** Services are limitedly implemented and, while the governmental public health authority has significant expertise, there are substantial gaps related to a lack of necessary capacity.
- **Limited Implementation (Light Orange):** Services are limitedly implemented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

POPULATION BY LEVEL OF SERVICE

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

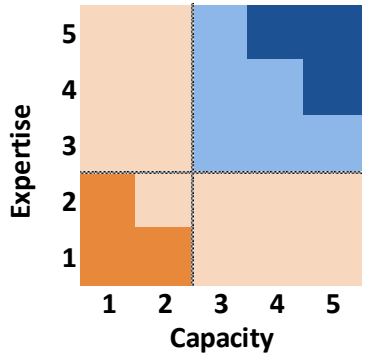
The images to the right illustrate how programmatic self-assessment results are interpreted to provide insight into governmental public health authorities' population service with Expertise on the *y*-axis and Capacity on the *x*-axis.

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



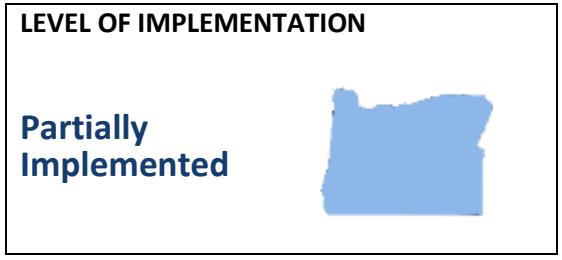
- **Population Significantly Served (Blue):** The population is mostly or fully served.
- **Population Partially Served (Light Blue):** The population is partially served, and there are some gaps in service.
- **Population Limitedly Served (Light Orange):** The population is underserved, and there are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

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



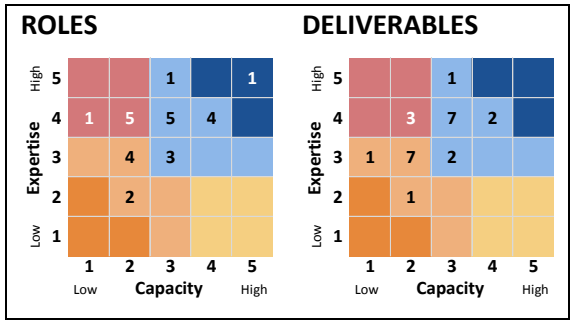
Interpreting PHD Results

LEVEL OF IMPLEMENTATION



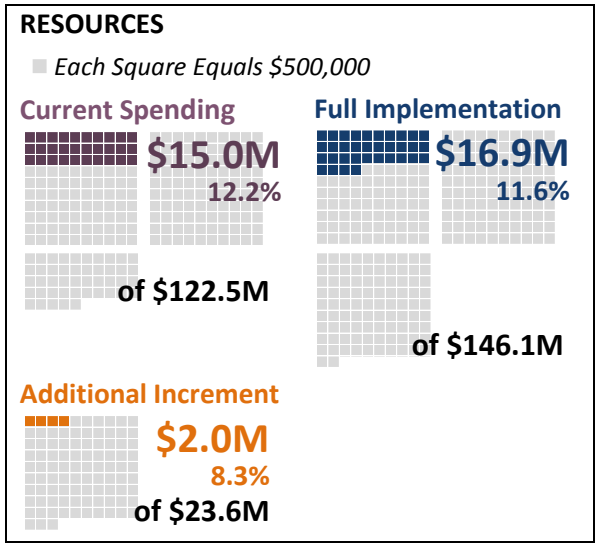
This graphic illustrates PHD's level of implementation for the foundational capability or program.

ROLES AND DELIVERABLES



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

RESOURCES



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

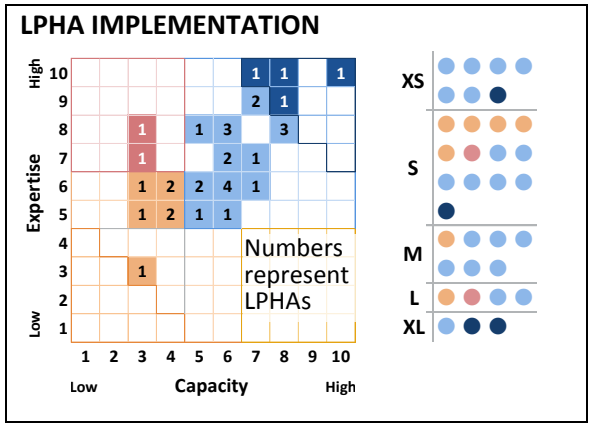
NARRATIVE

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

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

INTERPRETING LPHA RESULTS

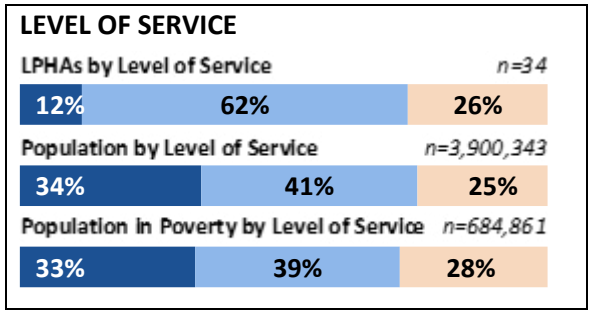
LPHA Implementation



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

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

Level of Service

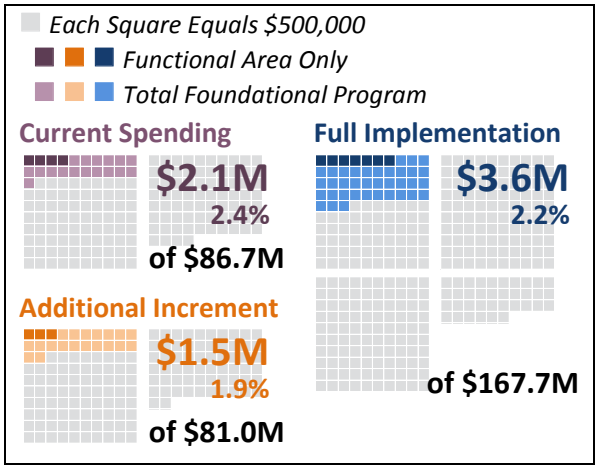


This chart shows LPHAs' level of implementation in relationship to what it means for the overall population of Oregon being served. The first bar shows the level of service being provided by each LPHA. The second bar translates that level of service to population, based on the level of service for each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

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

The values presented in these charts were rounded for labeling and those less than 0.5% are not labeled.

Resources



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

NARRATIVE

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

Foundational Capability or Program

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

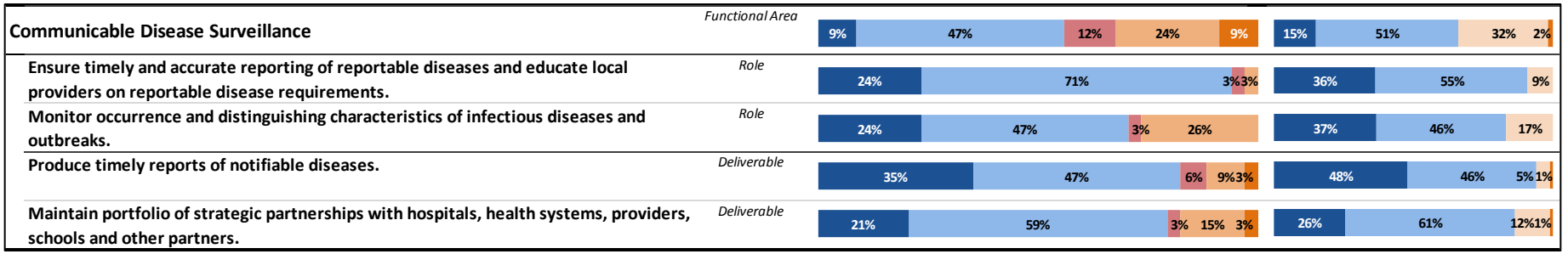
Functional Area

The narrative to the right of the chart column describes the functional area based on its definition (available in ***Appendix B: Functional Area Definitions***), level of implementation, and introduces the roles and deliverables included in the functional area.

ROLES AND DELIVERABLES

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

The values presented in these charts were rounded for labeling and those less than 0.5% are not labeled.



COMMUNICABLE DISEASE CONTROL

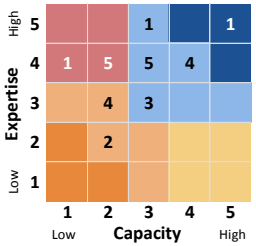
Ensure everyone in Oregon is protected from communicable disease threats.

PUBLIC HEALTH DIVISION

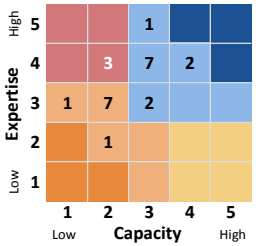
LEVEL OF IMPLEMENTATION

Partially Implemented

ROLES



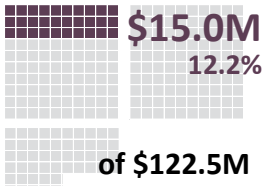
DELIVERABLES



RESOURCES

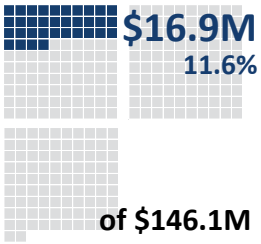
Each Square Equals $500,000

Current Spending



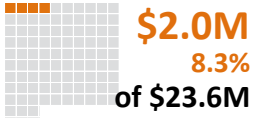
$15.0M
12.2%
of $122.5M

Full Implementation



$16.9M
11.6%
of $146.1M

Additional Increment



$2.0M
8.3%
of $23.6M

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

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

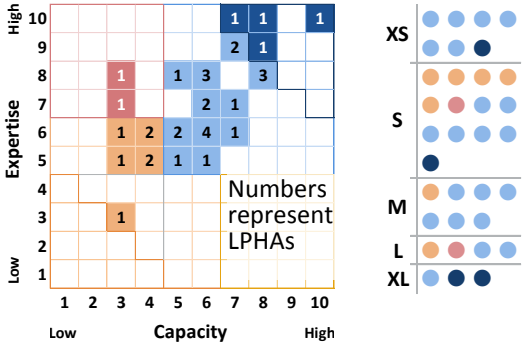
A few of the less than significantly implemented roles and deliverables are state activities that directly support the provision of local *Communicable Disease Control* activities; these include:

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

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

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

12%	62%	26%

Population by Level of Service *n=3,900,343*

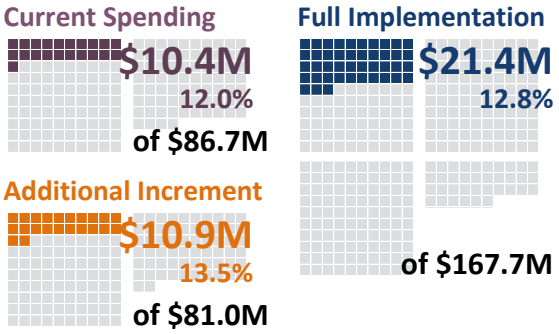
34%	41%	25%

Population in Poverty by Level of Service *n=684,861*

33%	39%	28%

RESOURCES

Each Square Equals $500,000



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

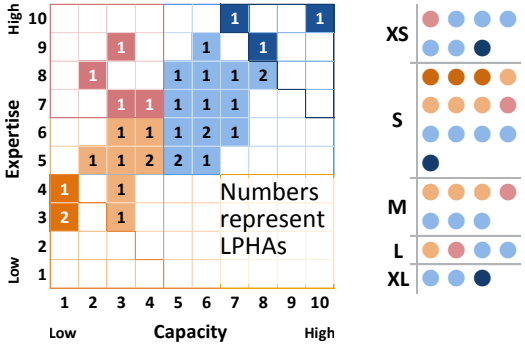
These activities are relatively well-implemented, with 25 (out of 34) LPHAs documenting partial or significant implementation. A large amount of additional spending (105% or $10.9M) is needed to reach full implementation, suggesting a higher marginal cost associated with significant implementation versus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

Local *Communicable Disease Control* activities are broken down into 4 functional areas:

1. **Communicable Disease Surveillance.** This functional area represents 20% of current local *Communicable Disease Control* activities; its share of local Communicable Disease Control activities would decrease to 17% at significant implementation.
2. **Communicable Disease Investigation.** This functional area represents 29% of current local *Communicable Disease Control* activities; at significant implementation its share of local *Communicable Disease Control* activities remain unchanged (29%).
3. **Communicable Disease Intervention and Control.** The most significantly implemented functional area, it represents 39% of current local *Communicable Disease Control* activities. This share is expected to increase to 43% at significant implementation, with spending increasing 125%.
4. **Communicable Disease Response Evaluation.** This is the least significantly implemented functional area. It represents 11% of current local *Communicable Disease Control* activities and will remain relatively unchanged at significant implementation (11%).

Following, we have provided profiles like this page for each of these 4 functional areas.

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

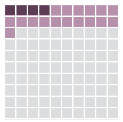
Population by Level of Service *n=3,900,343*

Population in Poverty by Level of Service *n=684,861*

RESOURCES

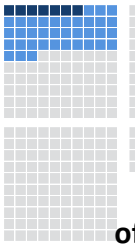
Each Square Equals $500,000
Functional Area Only
Total Foundational Program

Current Spending



$2.1M
2.4%
of $86.7M

Full Implementation



$3.6M
2.2%
of $167.7M

Additional Increment

$1.5M
1.9%
of $81.0M

COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 1:

Communicable Disease Surveillance

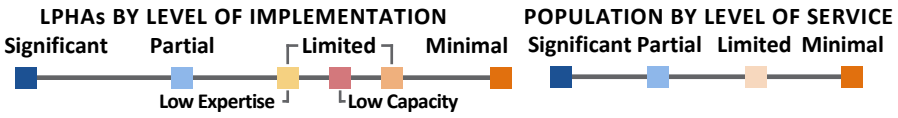
Communicable Disease Surveillance is the first of 4 functional areas that describes how local *Communicable Disease Control* activities are operationalized. These activities support awareness and timely and accurate reporting of notifiable diseases.

This functional area represents one-fifth of current local *Communicable Disease Control* activities, and the addition of 70% more funding or $1.5M would allow LPHAs to reach full implementation.

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

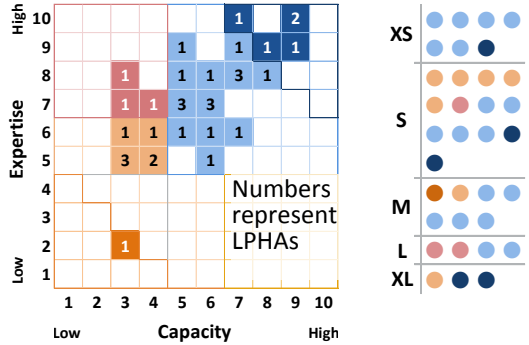
Implementation is similar from both a system and population service perspective. Approximately three-quarters of LPHAs have partially or significantly implemented and approximately three-quarters of residents are being served by an LPHA that is partially or significantly implemented.

The activities in the *Communicable Disease Surveillance* functional area include 2 roles and 2 deliverables. The level of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

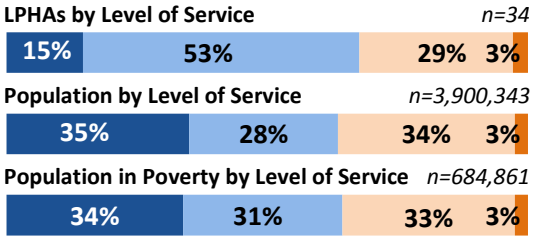


	Functional Area	LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
Communicable Disease Surveillance		9% 47% 12% 24% 9%	15% 51% 32% 2%
Ensure timely and accurate reporting of reportable diseases and educate local providers on reportable disease requirements.	*Role*	24% 71% 3% 3%	36% 55%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

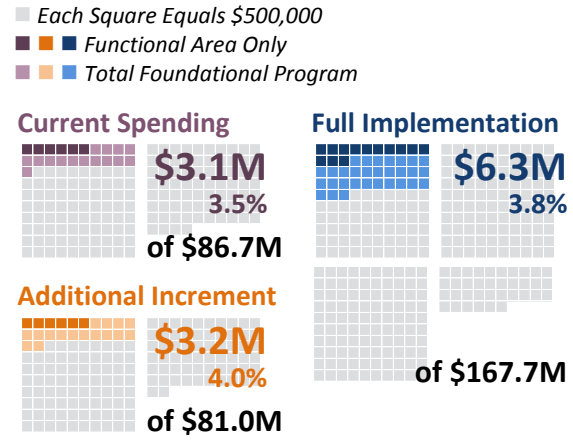
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 2:

Communicable Disease Investigation

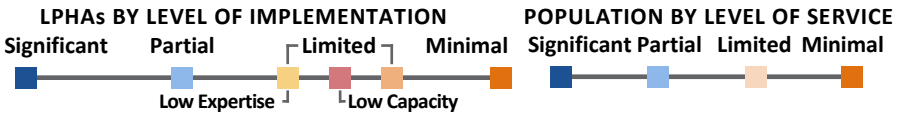
Communicable Disease Investigation is the second of 4 functional areas that describes how *Communicable Disease Control* activities are operationalized. These activities include the development and deploying of communicable disease investigative process and communicating with the public about ongoing communicable disease outbreaks and investigation, while ensuring confidentiality.

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

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

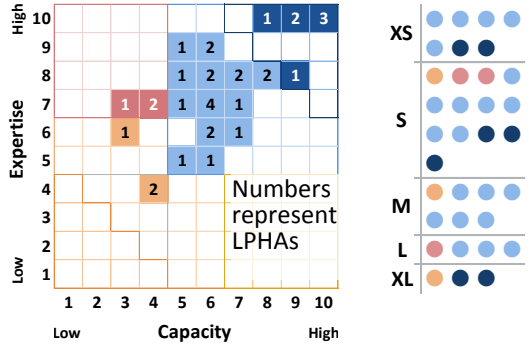
The population is serviced similarly, though to a lesser degree – 63% of Oregon residents live in a service area where these activities are at least partially implemented, while 68% of LPHAs are at least partially implemented.

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



Communicable Disease Investigation	*Functional Area*	LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
		Significant / Partial / Limited / Minimal	Significant Partial / Limited / Minimal
		15% / 53% / 9% / 21% / 3%	35% / 28% / 34% / 3%
Maintain protocols and systems to ensure confidentiality throughout investigation, reporting and maintenance of data.	*Role*	47% / 53%	65% / 35%
Investigate and control disease outbreaks within the authority, in collaboration with partners.	*Role*	21% / 62% / 9% / 6% / 3%	37% / 52% / 11%
Communicate clearly with members of the public in the authority about identified health risks.	*Role*	15% / 74% / 9% / 3%	34% / 53% / 12%
Summarize and share data to determine opportunities for intervention and to guide policy and program decisions.	*Role*	12% / 47% / 3% / 32% / 6%	38% / 33% / 29% / 1%
Collaborate with the state in a culturally responsive way on disease prevention and control initiatives such as antibiotic resistance, sexually transmitted disease prevention messaging, infection control protocols, hand hygiene, field investigations of outbreaks and epidemics, and statewide and local health policies.	*Role*	18% / 50% / 6% / 26%	36% / 32% / 32%
Provide individual communicable disease case and outbreak data, consistent with Oregon statute, rule and program standards.	*Deliverable*	35% / 62% / 3%	60% / 39%
Secure personally identifiable data collected through audits, review, update and verification.	*Deliverable*	50% / 44% / 3% / 3%	77% / 22%
Document implementation of investigative guidelines appropriately.	*Deliverable*	41% / 50% / 3% / 6%	65% / 32% / 3%
Maintain protocols for proper preparation, packaging and shipment of samples of public health importance (e.g., animals and animal products).	*Deliverable*	24% / 65% / 12%	16% / 79% / 5%
Provide communications with the public about outbreak investigations.	*Deliverable*	18% / 65% / 6% / 9% / 3%	35% / 50% / 15%

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

21%	62%	18%

Population by Level of Service *n=3,900,343*

37%	41%	22%

Population in Poverty by Level of Service *n=684,861*

35%	45%	19%

RESOURCES

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

Current Spending
$4.1M
4.7%
of $86.7M

Full Implementation
$9.1M
5.5%
of $167.7M

Additional Increment
$5.0M
6.2%
of $81.0M

COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 3:

Communicable Disease Intervention and Control

Communicable Disease Intervention and Control is the third of 4 functional areas that describes how *Communicable Disease Control* activities are operationalized. This functional area covers several important things:

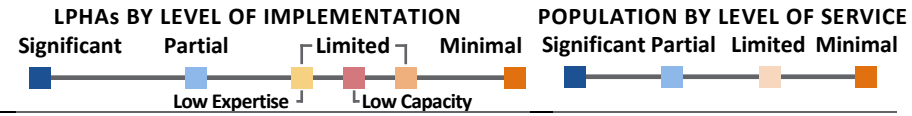
- Providing timely, statewide, and locally relevant and accurate information to the state and community on communicable disease and their control.
- Promoting immunization through education of the public and through collaboration with schools, health care providers, and other community partners.
- Identifying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

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

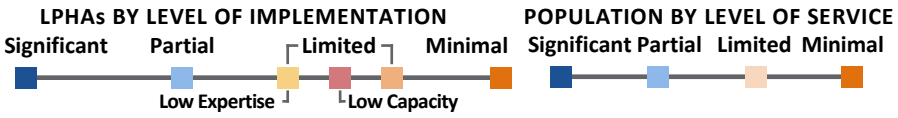
Currently, this functional area has a high level of implementation (83%) with only 18% of LPHAs at limited or minimal implementation. There is no clear pattern as to which LPHAs are at each level of implementation, with the size of those only limitedly implemented varying from small to extra-large.

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

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

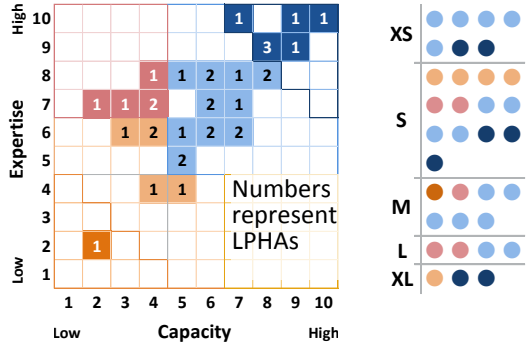


Communicable Disease Intervention and Control	*Functional Area*	LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Limited	Minimal	Significant Partial	Limited	Minimal	
		21%	62%	9%	9%	37%	41%	22%	
Work with partners to enforce public health laws, including isolation and quarantine.	*Role*	18%	68%		15%	23%	71%	6%	
Ensure equitable access to immunizations among people of all ages. Implement culturally responsive strategies to improve access to immunizations.	*Role*	18%	68%	3% 6%	6%	5%	87%	4%	4%
Provide disease-specific and technical expertise regarding epidemiologic and clinical characteristics to health care professionals and others. Advise health care practitioners about evidence-based practices for communicable disease diagnosis, control and prevention.	*Role*	15%	59%	3%	15% 9%	26%	63%	9%	2%
Work with the OHA Public Health Division to provide guidance for the control and prevention of rare diseases and conditions of public health importance.	*Role*	21%	59%	3%	12% 6%	39%	49%	10%	1%
Assure the availability of partner notification services for newly diagnosed cases of syphilis, gonorrhea, and HIV, as recommended by OHA.	*Role*	24%	56%	12%	9%	29%	56%	15%	
Provide input into what diseases should be reportable to the state and subsequent disease investigation and control guidelines.	*Role*	15%	47%	9%	12% 18%	33%	51%	10%	7%
Provide subject matter expertise to inform program design, policies and communications that inform providers, the public and stakeholders about public health risks.	*Role*	15%	59%	9%	18%	22%	60%	19%	
Develop plans for the allocation of scarce resources in the event of an emergency or outbreak.	*Role*	9%	59%	6%	26%	1%	73%	26%	
Develop, engage, and maintain local strategic partnerships with hospitals, health systems, schools, day care centers and others to prevent and control communicable diseases. Ensure engagement of priority/focal populations in efforts to prevent and control communicable diseases.	*Role*	18%	47%	6%	29%	17%	42%	41%	
Provide interventions with communities that are disproportionately non-immunized.	*Role*	15%	47%	21%	6% 12%	3%	55%	38%	5%
Use information about immunization proportions to increase immunization overall for citizens in local jurisdictions.	*Role*	15%	44%	15%	21% 6%	21%	36%	31%	12%

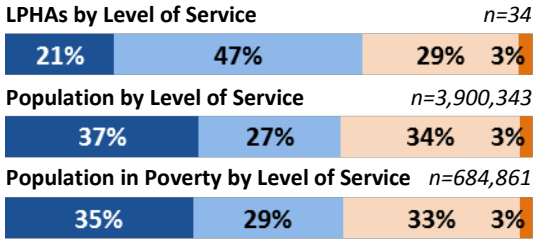


		LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
	Functional Area	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Communicable Disease Intervention and Control		21%	62%	9%	9%	37%	41%	22%	
Provide technical support for enforcement of public health laws (e.g.,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

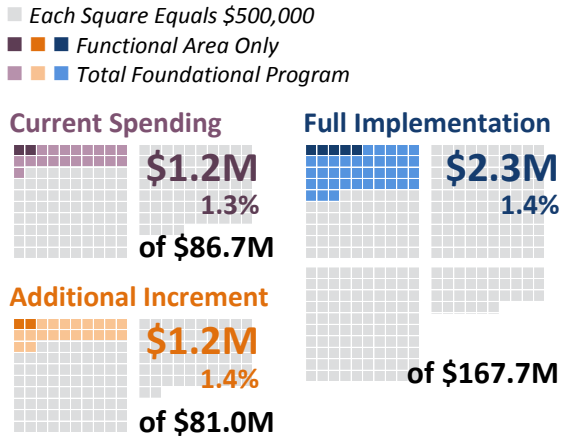
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



COMMUNICABLE DISEASE CONTROL FUNCTIONAL AREA 4:

Communicable Disease Response Evaluation

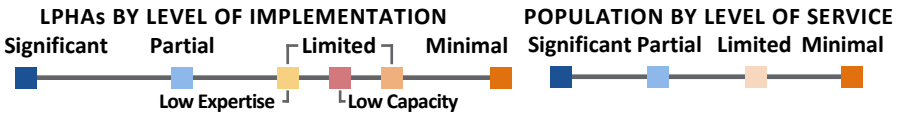
Communicable Disease Response Evaluation is the final of 4 functional areas that describes how local *Communicable Disease Control* activities are operationalized. This functional area includes evaluation and assessment of communicable disease outbreak response and documentation of distinguishing characteristics, and assessment of process improvement initiative, including materials.

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

Currently, the level of implementation of this functional area varies across the system. The majority of extra-small, medium, large, and extra-large LPHAs have partially or significantly implemented this functional area, while the majority of limitedly or minimally implemented LPHAs are all in the small size category.

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

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



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

ENVIRONMENTAL PUBLIC HEALTH

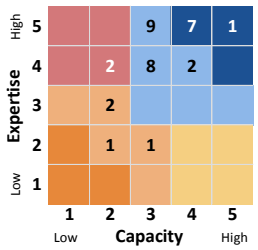
Environmental health works to prevent disease and injury, eliminate disparate impact of environmental health risks and threats on population subgroups, and create health-supportive environments in which everyone in Oregon can thrive.

PUBLIC HEALTH DIVISION

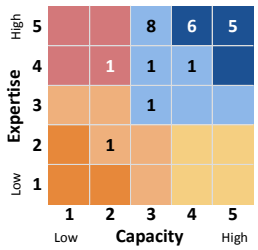
LEVEL OF IMPLEMENTATION

Limitedly Implemented

ROLES



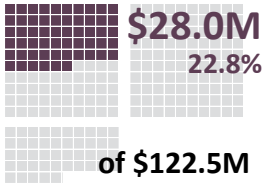
DELIVERABLES



RESOURCES

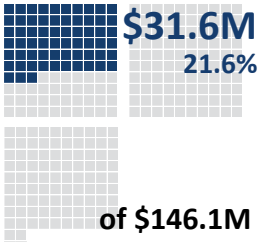
Each Square Equals $500,000

Current Spending



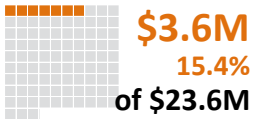
$28.0M
22.8%
of $122.5M

Full Implementation



$31.6M
21.6%
of $146.1M

Additional Increment



$3.6M
15.4%
of $23.6M

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

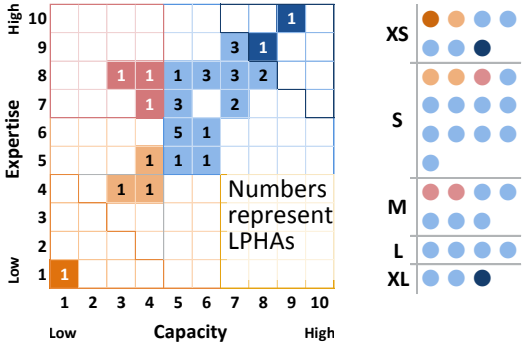
PHD's self-assessment shows that it considers this foundational program to be only limitedly implemented. However, PHD also notes that the majority of the roles and deliverables that represent *Environmental Public Health* state activities are partially or significantly implemented. In fact, 27 of the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

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

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

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

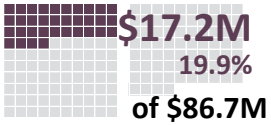
Population by Level of Service *n=3,900,343*

Population in Poverty by Level of Service *n=684,861*

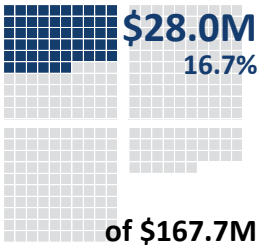
RESOURCES

Each Square Equals $500,000

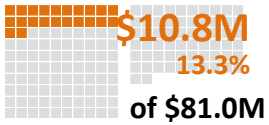
Current Spending



Full Implementation



Additional Increment



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

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

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

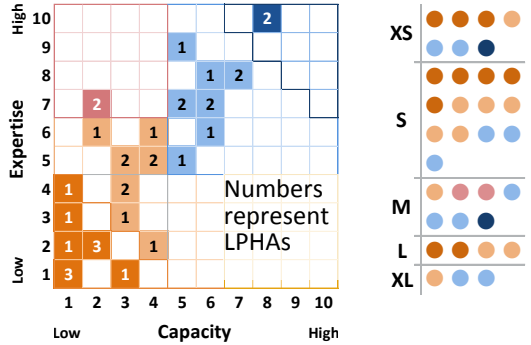
A LPHA reported in the self-assessment that there are currently no Environmental Public Health activities in its community; however, upon further investigation, we learned that these activities are provided in that county by another LPHA.

Local *Environmental Public Health* activities are broken down into 3 functional areas:

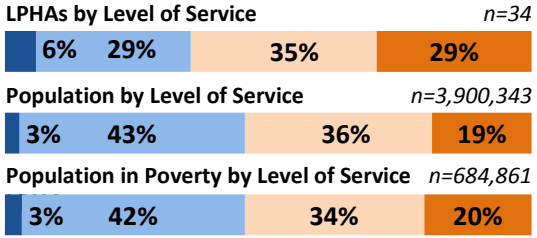
1. **Identify and Prevent Environmental Health Hazards.** This functional area represents 24% of current local *Environmental Public Health* Activities; its share of local *Environmental Public Health* activities would decrease to 22% at significant implementation.
2. **Conduct Mandated Inspections.**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

Following are profiles like this page for each of these 3 functional areas.

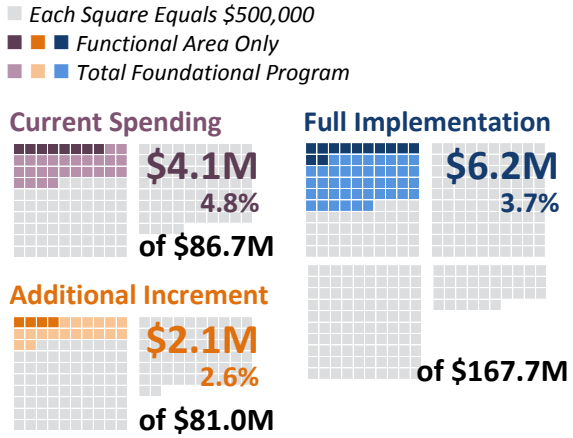
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



ENVIRONMENTAL PUBLIC HEALTH FUNCTIONAL AREA 1:

Identify and Prevent Environmental Health Hazards

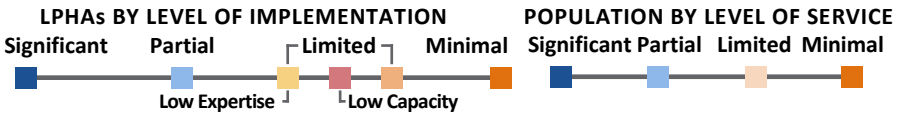
Identify and Prevent Environmental Health Hazards is the first of 3 functional areas that describes how local *Environmental Public Health* activities are operationalized. This functional area involves preventing and investigating environmental health hazards, including radioactive materials, animal bites, and vector-borne diseases.

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

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

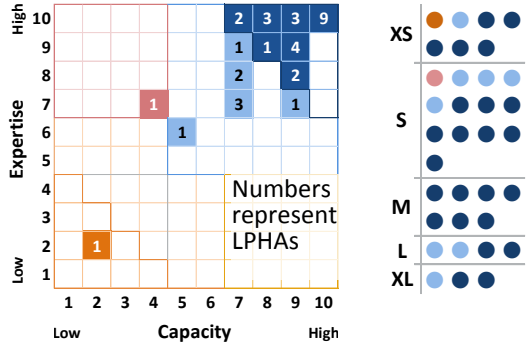
This is more balanced from a population service perspective: 54% of Oregon residents live in a service area where they are underserved or unserved, while 46% live in a service area where these activities are present (however, there is a meaningful gap in implementation for a large percentage of those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

The activities in the ***Identify and Prevent Environmental Health Hazards*** functional area include 15 roles and 2 deliverables. The level of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following pages.

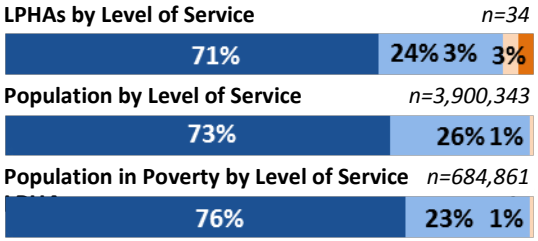


Identify and Prevent Environmental Health Hazards	*Functional Area*	LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
		6% 29% 6% 29% 29%	3% 43% 36% 19%
Ensure consistent application of health regulations and policies.	*Role*	41% 53% 3% 3%	57% 41% 1%
Implement state-mandated programs where appropriate (e.g., small drinking water systems, septic oversight).	*Role*	26% 59% 3% 12%	35% 62% 2%
Develop, implement and enforce environmental health regulations.	*Role*	15% 65% 3% 15% 3%	17% 76% 7%
Maintain expertise in relevant environmental health topics.	*Role*	15% 56% 3% 3% 24%	5% 84% 10%
Use environmental health expertise to address accident and disease prevention in institutional environments (longer-term care, assisted living, child care, etc.).	*Role*	6% 32% 15% 38% 9%	3% 71% 25% 1%
Deliver effective and timely outreach on environmental health hazards and protection recommendations to regulated facilities, the public and stakeholder organizations.	*Role*	18% 35% 21% 18% 9%	24% 48% 26% 2%
Ensure that environmental health is included in the community health assessment every five years.	*Role*	12% 44% 6% 15% 24%	44% 25% 12% 20%
Assure the development and maintenance of the ambulance service area plan.	*Role*	9% 26% 9% 18% 38%	17% 43% 12% 28%
Inform decision makers of the impacts to environmental public health based on program, project and policy decisions.	*Role*	15% 29% 6% 29% 21%	24% 35% 27% 14%
Monitor, investigate, and control infectious and noninfectious vector nuisances and diseases.	*Role*	9% 32% 9% 44% 6%	20% 28% 51% 1%
Measure the impact of environmental hazards on the health outcomes of priority/focal populations. Analyze and communicate environmental justice concerns and disparities.	*Role*	3% 18% 6% 26% 47%	19% 27% 22% 32%
Provide evidence based assessment of the health impacts of environmental hazards or conditions.	*Role*	29% 6% 35% 29%	44% 32% 24%
Provide consultation and technical assistance including establishing best practices related to vector control.	*Role*	6% 32% 12% 35% 15%	19% 24% 36% 21%
Ensure meaningful participation of communities experiencing environmental health threats and inequities in programs and policies designed to serve them.	*Role*	6% 24% 6% 44% 21%	19% 16% 42% 22%
Use environmental health expertise to reduce hazardous exposures from air, land, water, and other exposure pathways.	*Role*	6% 21% 18% 41% 15%	27% 57% 16%
Document communications on environmental health hazards and protection recommendations to regulated facilities, the public, and stakeholder organizations.	*Deliverable*	15% 59% 3% 15% 9%	37% 54% 8% 2%
Produce policy briefs and other communications on the impacts to environmental public health.	*Deliverable*	9% 15% 15% 29% 32%	33% 15% 30% 21%

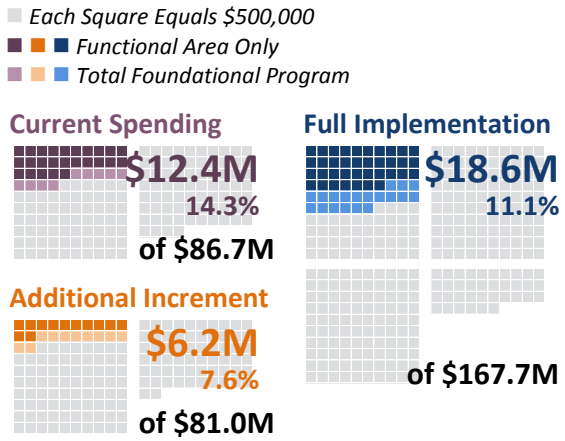
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



ENVIRONMENTAL PUBLIC HEALTH FUNCTIONAL AREA 2:

Conduct Mandated Inspections

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

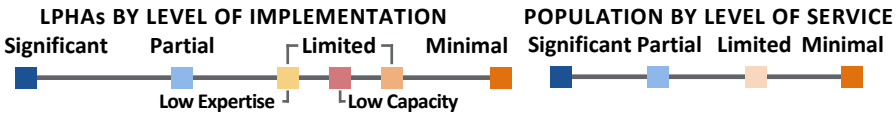
This functional area represents nearly three quarters of *Environmental Public Health* activities and an additional 50% of funding or $6.2M would allow LPHAs to reach significant implementation.

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

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

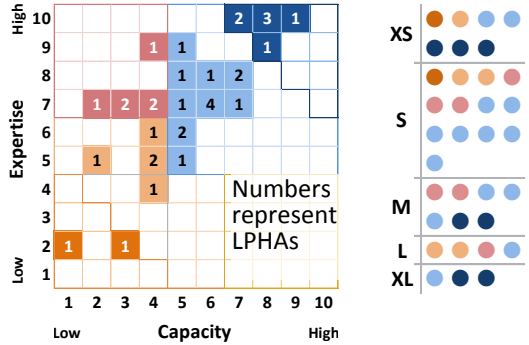
This is consistent from a population service perspective – 99% of Oregon residents live in a service area where these activities are present. However, about a one-quarter (26%) of those activities are delivered such that there is a gap in implementation.

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



		LPHAs BY LEVEL OF IMPLEMENTATION					POPULATION BY LEVEL OF SERVICE			
Conduct Mandated Inspections	*Functional Area*	Significant	Partial	Limited	Low Expertise	Low Capacity	Significant	Partial	Limited	Minimal
		71%	24%	3%		3%	73%	26%		
Provide licensing and certification of recreational facilities, food service facilities, and tourist accommodations.	*Role*	56%	44%				47%	53%		
Conduct timely inspection and review of regulated entities and facilities.	*Role*	56%	44%				44%	56%		
Perform and assist with outbreak investigations that have an environmental component.	*Role*	12%	82%		3%	3%	35%	64%		
Enforce regulations.	*Role*	26%	65%		6%	3%	41%	55%	4%	
Conduct ongoing environmental and occupational health surveillance.	*Role*	6%	29%	9%	35%	21%	46%	42%	11%	
Document reports of inspection and review of regulated entities and facilities.	*Deliverable*	62%	35%		3%		69%	30%		
Document provision of licensing and certification of recreational facilities, food service facilities and tourist accommodations.	*Deliverable*	65%	32%		3%		79%	20%		
Document enforcement of regulations.	*Deliverable*	56%	38%		3%	3%	65%	33%	3%	
Consult for the food service industry and the general public.	*Deliverable*	41%	44%	6%	9%		61%	24%	14%	

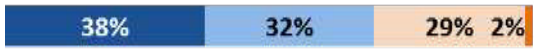
LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

Population by Level of Service *n=3,900,343*



Population in Poverty by Level of Service *n=684,861*

RESOURCES

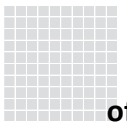
Each Square Equals $500,000
Functional Area Only
Total Foundational Program

Current Spending

$0.7M
0.8%
of $86.7M

Full Implementation

$3.3M
2.0%



of $167.7M

Additional Increment

$2.5M
3.1%
of $81.0M

ENVIRONMENTAL PUBLIC HEALTH FUNCTIONAL AREA 3:

Promote Land Use planning

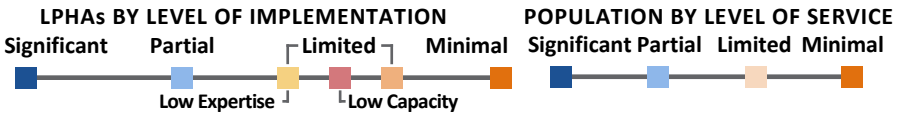
Promote Land Use Planning is the final of three functional areas that describes how local *Environmental Public Health* activities are operationalized. This functional area involves testing and analysis for purposes related to environmental health and the performance of inspections and education for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

This functional area is the least implemented functional area, representing just 4% of current local *Environmental Public Health* activities. This share is expected to increase to 12% at significant implementation with the spending in this area increasing 345% or $2.5M.

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

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

The activities included in the *Promote Land Use Planning* functional area include 5 roles and 5 deliverables. The level of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.



Promote Land Use Planning	*Functional Area*	21%	41%	18%	15%	6%	38%	32%	29%	2%
Provide consultation and technical assistance to the food service industry and the general public.	*Role*	44%	53%	3%			48%	52%		
Maintain relationships with partners in local economic development, transportation, parks, and land use agencies.	*Role*	9%	38%	12%	32%	9%	21%	38%	32%	9%
Provide technical assistance to integrate standard environmental public health practices into facilities that present high risk for harmful environmental exposures or disease transmission.	*Role*	18%	35%	12%	21%	15%	25%	35%	28%	12%
Understand and participate in local land use and transportation planning processes.	*Role*	24%	15%	29%	32%		49%	31%	19%	
Conduct health analyses for other organizations and recommend approaches to ensure healthy and sustainable built and natural environments.	*Role*	24%	12%	26%	38%		49%	26%	26%	
Document integration of standard environmental public health practices into facilities that present high risk for harmful environmental exposures or disease transmission.	*Deliverable*	18%	38%	3%	26%	15%	39%	39%	19%	3%
Produce community health assessments that includes environmental health produced at least every five years.	*Deliverable*	12%	32%	9%	32%	15%	35%	26%	31%	8%
Write best practices related to vector control.	*Deliverable*	6%	24%	12%	24%	35%	19%	30%	24%	27%
Prepare health analyses for other organizations and recommend approaches to ensure healthy and sustainable built and natural environments.	*Deliverable*	9%	18%	6%	26%	41%	33%	14%	32%	21%
Communicate environmental justice concerns and disparities.	*Deliverable*	6%	12%	12%	24%	47%	19%	17%	17%	46%

PREVENTION AND HEALTH PROMOTION

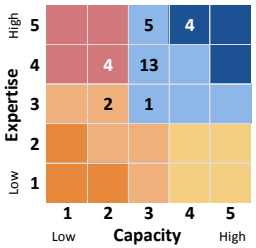
The public health system prevents and reduces harms from chronic diseases and injuries through policy change, enhanced community systems and practices, and improved health equity that support the health and development of Oregonians across the lifespan.

PUBLIC HEALTH DIVISION

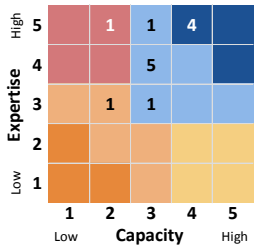
LEVEL OF IMPLEMENTATION

Partially Implemented

ROLES



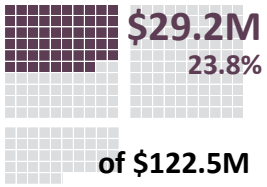
DELIVERABLES



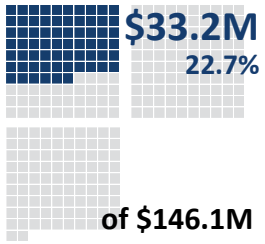
RESOURCES

Each Square Equals $500,000

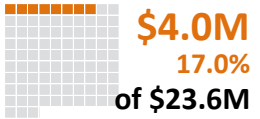
Current Spending



Full Implementation



Additional Increment



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

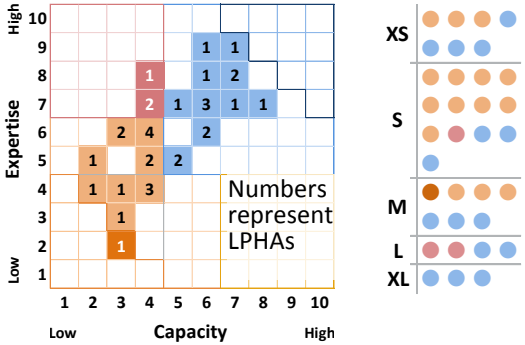
PHD's Self-Assessment shows that it considers this foundational program to have partial implementation. Some of the better implemented roles and deliverables include adhering to state and federal guidance, documenting trainings provided to partners and stakeholders, and making state planning documents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

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

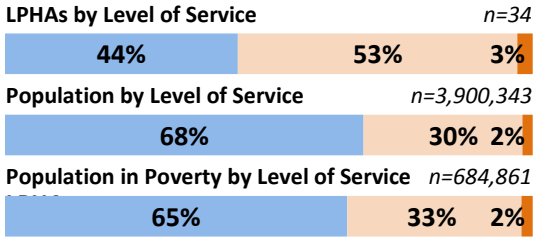
- Monitor knowledge, attitudes, behaviors, and health outcomes related to tobacco; nutrition, oral health, prenatal, natal, and postnatal care; and childhood and maternal health; physical activity; and intentional and unintentional injuries. Make data available at the local level. (Limitedly implemented,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

LOCAL PUBLIC HEALTH AUTHORITIES

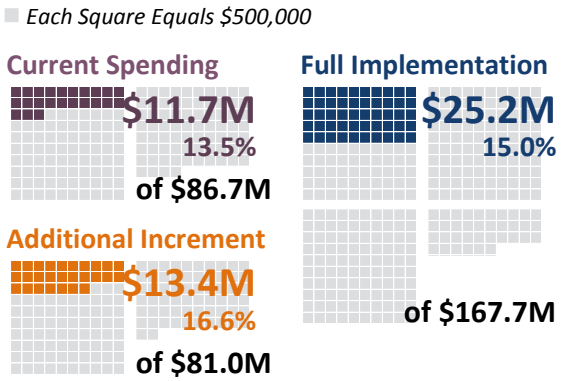
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



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

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

Local *Prevention and Health Promotion* activities are broken down into 5 functional areas:

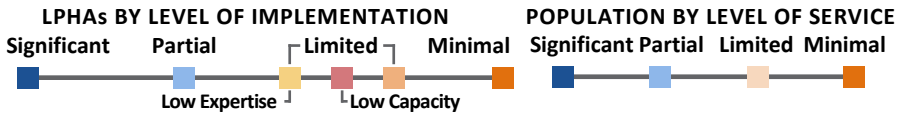
1. **Prevention of Tobacco Use.** This functional area represents 33% of current local *Prevention and Health Promotion* activities; its share would decrease to 20% at full implementation. The activities included in *Prevention of Tobacco Use* are the least implemented of the 5 functional areas.
2. **Improving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

Of the 5 functional areas, *Reducing Unintentional and Intentional Injuries* is the best implemented.

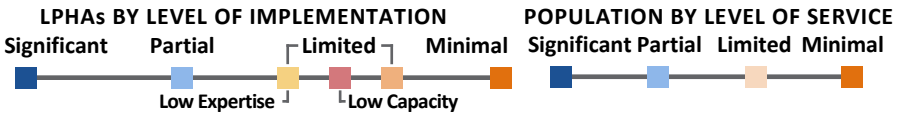
- 83% of Oregon's LPHAs have partially or significantly implemented the *Reducing Unintentional and Intentional Injuries* functional area, serving 86% of Oregon's population.

Unlike the other foundational programs and capabilities, the roles and deliverables within *Prevention and Health Promotion* were not assigned to functional areas. The Public Health Modernization activities required for *Prevention and Health Promotion* span all functional areas.

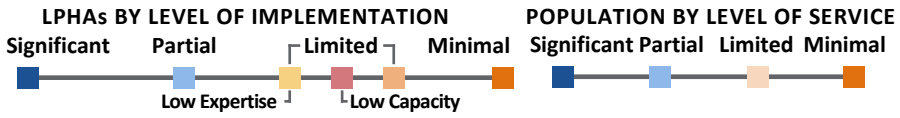
The level of implementation of all 27 roles and 14 deliverables across LPHAs and population by level of service are provided on the next 3 pages, followed by profiles for each of the 5 functional areas.



Prevention and Health Promotion	*Foundational Program*	LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
		44% 9% 44% 3%	68% 30% 2%
Adhere to local, state, and federal guidance, standards, and laws (e.g., or state guidelines for healthy eating and active living).	*Role*	21% 62% 3% 6% 9%	28% 67% 5%
Build relationships with community partners who work with priority/focal populations.	*Role*	24% 65% 6% 6%	19% 75% 5% 1%
Use community health assessment data and other relevant data sources to inform or identify priorities and develop planning documents.	*Role*	18% 53% 26% 3%	27% 66% 7%
Work with partners, stakeholders, and community members to identify community assets and understand community needs and priorities.	*Role*	18% 62% 9% 6% 6%	19% 74% 6% 1%
Develop and implement community health improvement plan (CHIP) priorities for prevention and health promotion, revised at least every 5 years and updated annually.	*Role*	18% 59% 24%	27% 63% 10%
Align prevention and health promotion priorities across the CHIP, the LPHA's strategic plan, and other relevant internal and community planning documents.	*Role*	15% 53% 3% 26% 3%	18% 71% 10%
Develop strategic, cross-sector partnerships and collaborations, across systems and settings, related to prevention and health promotion programs.	*Role*	18% 50% 9% 21% 3%	27% 59% 13% 1%
Provide input and guidance to the OHA Public Health Division on statewide planning.	*Role*	15% 38% 6% 35% 6%	28% 56% 14% 1%
Collaborate with partners and engage community leaders to identify and seek funding for prevention and health promotion programs and interventions.	*Role*	9% 65% 3% 18% 6%	3% 78% 18%
Demonstrate to communities, partners, policy makers, and others the connection between early prevention and outcomes in health, education, etc.	*Role*	9% 41% 9% 35% 6%	11% 69% 18%
Educate consumers about health impacts of unhealthy products like tobacco or sugary drinks, or health-protective products like car seats.	*Role*	15% 35% 15% 26% 9%	24% 55% 18% 2%
Work with partners and stakeholders to develop and advance a common set of priorities, strategies and outcome measures, employing coalition building, community organizing, capacity building and providing technical assistance to partners.	*Role*	12% 56% 3% 6% 21% 3%	4% 75% 19% 1%
Communicate information about prevention and health promotion programs.	*Role*	12% 50% 6% 29% 3%	17% 61% 22%
Include policies, programs, and strategies for prevention and health promotion programs in the local prioritized plan.	*Role*	9% 47% 12% 26% 6%	25% 52% 22% 2%

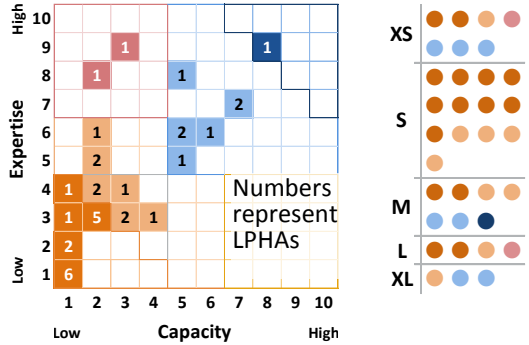


Prevention and Health Promotion	*Foundational Program*	LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
		44% 9% 44% 3%	68% 30% 2%
Use surveillance data collected by the OHA Public Health Division and use assessment and epidemiology methods for prevention and health promotion programs.	*Role*	6% 56% 3% 32% 3%	3% 71% 26%
Develop and implement strategies in the CHIP intended to reduce the burden of health disparities; include indicators to monitor the impact of health equity interventions.	*Role*	6% 41% 6% 35% 12%	3% 68% 26% 3%
Develop change strategies to improve health outcomes using problem identification and the analysis, development, implementation, and evaluation of policy.	*Role*	3% 35% 3% 47% 12%	67% 30% 1%
Collaborate with the OHA Public Health Division to maintain subject matter expertise in prevention and health promotion programs.	*Role*	15% 47% 12% 18% 9%	27% 37% 35% 1%
Implement programs and interventions for prevention and health promotion programs.	*Role*	3% 50% 12% 26% 9%	61% 36% 2%
Assess health status across the lifespan.	*Role*	3% 50% 9% 26% 12%	61% 35% 3%
Work with communities to build capacity, empowerment, and organizing. Support community action to assure policies that promote health and protection.	*Role*	9% 41% 6% 35% 9%	3% 57% 38% 2%
Measure or use information provided by the OHA PHD to monitor differences and trends in disease risk factors and burden among diverse populations.	*Role*	6% 38% 3% 6% 38% 9%	15% 45% 39% 1%
Use data provided by the OHA PHD or by conducting surveillance to monitor knowledge, attitudes, behaviors, and health outcomes related to tobacco; nutrition; oral health; prenatal, natal and postnatal care, and childhood and maternal health; physical activity; and injuries.	*Role*	3% 32% 9% 47% 9%	55% 43% 2%
Develop multi-faceted strategies designed to address social determinants of health.	*Role*	9% 29% 9% 32% 21%	17% 34% 34% 15%
Develop, use, and disseminate innovative, emerging, and evidence-based best practices.	*Role*	3% 35% 18% 24% 21%	48% 40% 11%
With stakeholders, develop and implement an evaluation plan for prevention and health promotion programs.	*Role*	24% 15% 38% 24%	29% 61% 10%
Provide program funding to community partners to implement identified work.	*Role*	6% 9% 21% 24% 41%	3% 15% 62% 21%



Prevention and Health Promotion	*Foundational Program*	LPHAs BY LEVEL OF IMPLEMENTATION: Significant	Partial	Limited	Minimal	POPULATION BY LEVEL OF SERVICE: Significant Partial	Limited	Minimal
	Foundational Program	44%	9%	44%	3%	68%	30%	2%
Document participation or leadership in local coalitions.	*Deliverable*	26%	50%	9%	15%	30%	59%	10%
Document trainings and other learning opportunities made available to partners, stakeholders and community members.	*Deliverable*	15%	56%	9%	12%	9%	26%	63%	8%	3%
Document implementation and coordination of policies, programs, and strategies for prevention and health promotion programs.	*Deliverable*	6%	50%	12%	24%	9%	16%	67%	15%	2%
Document work with community to build capacity and support community organizing efforts.	*Deliverable*	18%	50%	6%	12%	15%	14%	66%	7%	13%
Document shared priorities and strategies with partners and stakeholders.	*Deliverable*	21%	44%	9%	24%	3%	30%	47%	20%	3%
Prepare local summaries, reports and information for prevention and health promotion programs.	*Deliverable*	3%	53%	3%	32%	9%	76%	14%	10%
CHIP includes strategies intended to reduce the burden of health disparities.	*Deliverable*	9%	68%	3%	18%	3%	25%	50%	24%
Maintain portfolio of partners and stakeholders, including local organizations that work with priority/focal populations.	*Deliverable*	15%	44%	12%	21%	9%	20%	51%	24%	4%
Implement, monitor and revise the community health improvement plan at least every five years with updates annually.	*Deliverable*	6%	62%	9%	24%	3%	63%	34%
Evaluate plans developed and implemented, and share results.	*Deliverable*	6%	29%	15%	41%	9%	3%	55%	39%	3%
Publish local prioritized plan.	*Deliverable*	3%	53%	21%	15%	9%	56%	40%	3%
Secure local funds for prevention and health promotion programs and interventions.	*Deliverable*	3%	35%	21%	38%	3%	2%	47%	50%
Document strategies employed to share data, summaries and reports with communities, partners, policy makers and others.	*Deliverable*	9%	38%	9%	38%	6%	16%	31%	52%	1%
Document strategies employed to educate consumers about the impact on health of marketing strategies.	*Deliverable*	3%	24%	12%	41%	21%	36%	49%	15%

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

3% 21% | 32% | 44%

Population by Level of Service *n=3,900,343*

2% 29% | 42% | 26%

Population in Poverty by Level of Service *n=684,861*

3% 22% | 47% | 28%

RESOURCES

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

Current Spending

$3.9M
4.5%
of $86.7M

Full Implementation

$5.0M
3.0%
of $167.7M

Additional Increment

$1.2M
1.5%
of $81.0M

PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 1:

Prevention of Tobacco Use

This is the first of the 5 functional areas that describes how local *Prevention and Health Promotion* activities are operationalized. The activities in the ***Prevention of Tobacco Use*** include prevention and control of tobacco use.

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

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

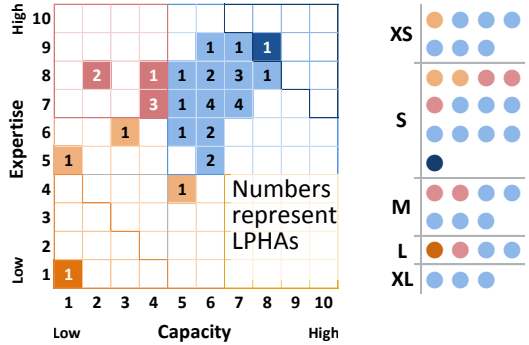
PREVENTION OF TOBACCO USE RESULTS

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

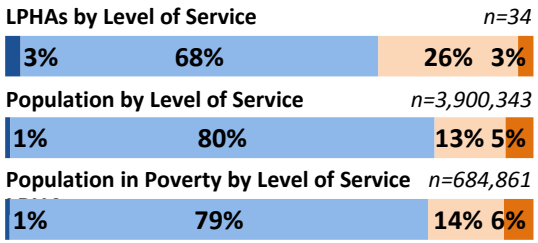
However, during the assessment process some LPHAs suggested that it was difficult to assess their current level of implementation because the language of the Prevention of Tobacco Use functional area is outcomes-based, such that it suggests that "preventing tobacco use" is the public health modernization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

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

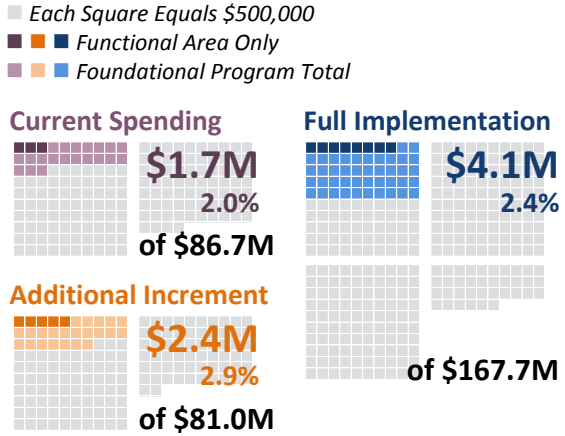
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 2:

Improving Nutrition and Increasing Physical Activity

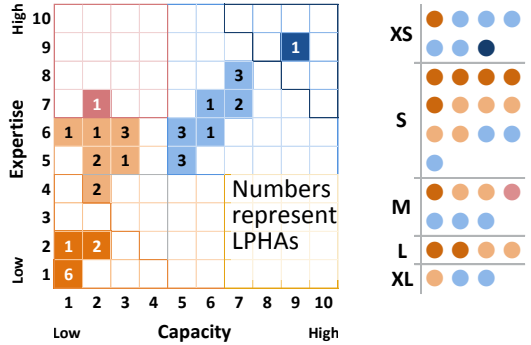
This is the second of the 5 functional areas that describes how local *Prevention and Health Promotion* activities are operationalized. The activities in the ***Improving Nutrition and Increasing Physical Activity*** functional area include improving nutrition and incentivizing increased physical activity.

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

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

There were 6 LPHAs that indicated a high expertise but low capacity, and another 2 LPHAs indicated mid-level expertise and low capacity, the highest number in these categories in the *Prevention and Health Promotion* program.

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

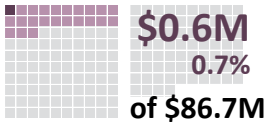
Population by Level of Service *n=3,900,343*

Population in Poverty by Level of Service *n=684,861*

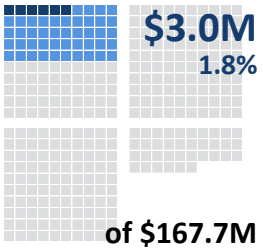
RESOURCES

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

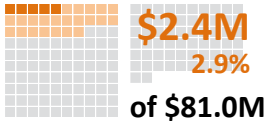
Current Spending



Full Implementation



Additional Increment



PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 3:

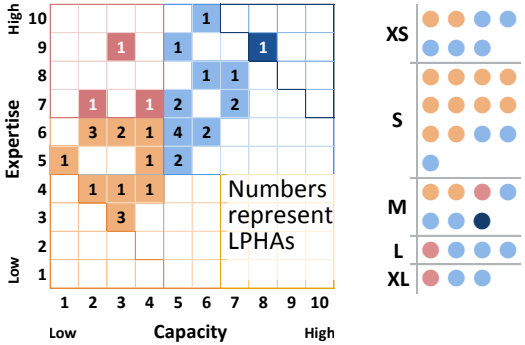
Improving Oral Health

This is the third of the 5 functional areas that describes how local *Prevention and Health Promotion* activities are operationalized. The activities in the ***Improving Oral Health*** functional area include using data and strategic partnerships to improve oral health.

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

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

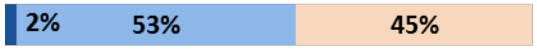
LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

Population by Level of Service *n=3,900,343*

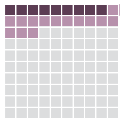


Population in Poverty by Level of Service *n=684,861*

RESOURCES

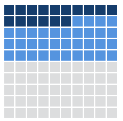
Each Square Equals $500,000
Functional Area Only
Foundational Program Total

Current Spending



$4.3M
5.0%
of $86.7M

Full Implementation



$8.2M
4.9%
of $167.7M

Additional Increment

$3.9M
4.8%
of $81.0M

PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 4:

Improving Maternal and Child Health

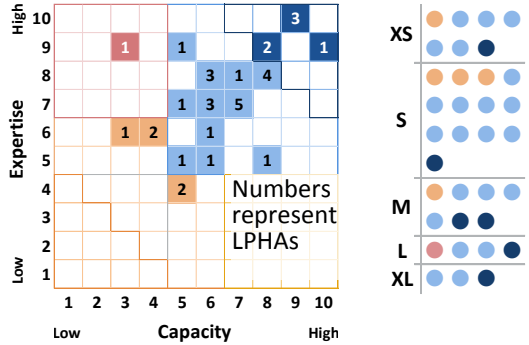
This is the fourth of 5 functional areas that describes how local *Prevention and Health Promotion* activities are operationalized. The activities in the ***Improving Maternal and Child Health*** functional area include improving prenatal, natal, and post-natal care, maternal health, and the health of children.

This functional area represents the single largest spending category in the *Prevention and Health Promotion* program. Of the spending aligned with Public Health Modernization in the 5 functional areas, 37% goes to *Improving Maternal and Child Health*. LPHAs estimated that a 90% increase in spending ($3.9M) is required to meet full implementation.

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

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

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

18%	65%	18%

Population by Level of Service *n=3,900,343*

28%	58%	14%

Population in Poverty by Level of Service *n=684,861*

26%	57%	17%

RESOURCES

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

Current Spending
$1.2M
1.4%
of $86.7M

Full Implementation
$4.8M
2.9%
of $167.7M

Additional Increment
$3.7M
4.5%
of $81.0M

PREVENTION AND HEALTH PROMOTION FUNCTIONAL AREA 5:

Reducing Unintentional and Intentional Injuries

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

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

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

The 307% increase in costs ($3.7M) to get to full from limited implementation suggests the activities associated with reducing accident rates have higher marginal costs.

ACCESS TO CLINICAL PREVENTIVE SERVICES

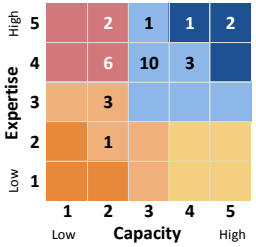
Assure Oregonians receive recommended, cost-effective, clinical preventive services.

PUBLIC HEALTH DIVISION

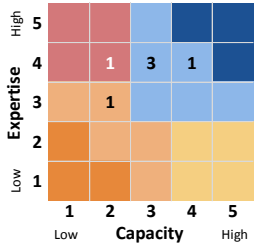
LEVEL OF IMPLEMENTATION

Partially Implemented

ROLES



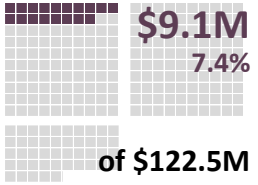
DELIVERABLES



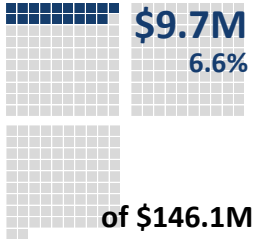
RESOURCES

Each Square Equals $500,000

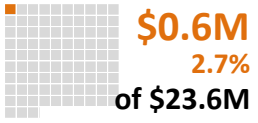
Current Spending



Full Implementation



Additional Increment



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

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

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

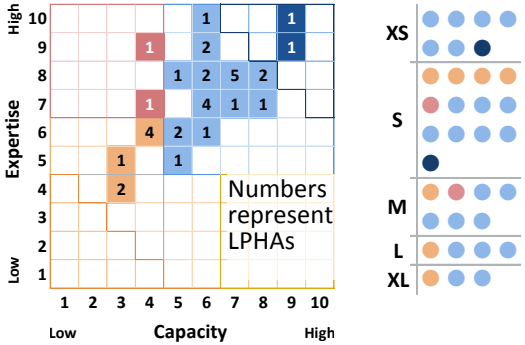
A few of the less than significantly implemented roles and deliverables are state activities that directly support the provision of local *Access to Clinical Preventive Services* activities; these include:

- Collect, analyze, and report on data on access to clinical preventive services. Analyze data to identify regional differences in access to clinical preventive services. Make data available at the local level. (Limitedly implemented, low capacity.)
- Support information systems that bridge and link public health and health care. (Limitedly implemented.)
- Partner with LPHAs to identify access barriers and potential solutions. (Partially implemented.)

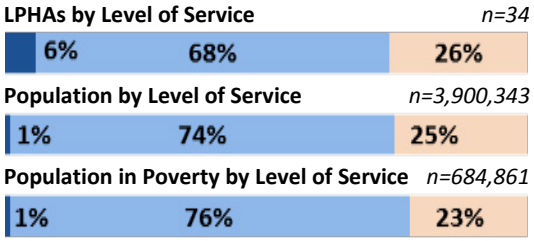
In addition to these *Access to Clinical Preventive Services* activities that directly relate to LPHAs, there are a number of other activities that aren't yet significantly implemented and could be leveraged by the LPHAs, such as making policies and data created for other stakeholders available to LPHAs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

LOCAL PUBLIC HEALTH AUTHORITIES

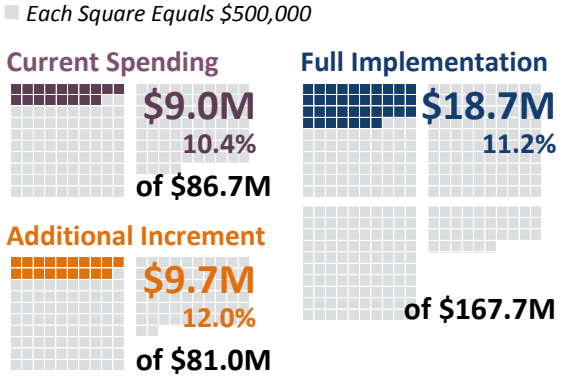
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



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

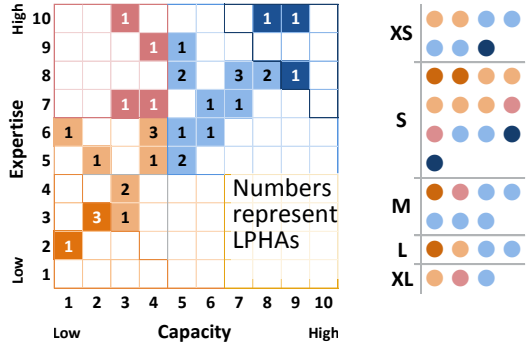
This foundational program is relatively well-implemented, with 25 (out of 34) LPHAs documenting partial or significant implementation.

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

1. **Ensure Access to Effective Vaccination Programs.** This functional area represents 28% of current local *Access to Clinical Preventive Services* activities; its share of local *Access to Clinical Preventive Services* activities would decrease to 22% at full implementation.
2. **Ensure Access to Effective Preventable Disease Screening Programs.** This is one of two least-implemented functional areas. It represents 10% of current local *Access to Clinical Preventive Services* activities. This share is expected to increase to 15% at full implementation, with spending in this area increasing 217%.
3. **Ensure Access to Effective STD Screening Programs.** This is the most implemented area and represents 30% of current local *Access to Clinical Preventive Services* activities. This share is expected to increase to 32% at full implementation, with spending in this area increasing by $3.2M.
4. **Ensure Access to Effective TB Treatment Programs.** This functional area represents 22% of current local *Access to Clinical Preventive Services* activities; its share of local *Access to Clinical Preventive Services* activities would decrease to 19% at full implementation.
5. **Ensure Access to Cost Effective Clinical Care.** This is one of two least implemented functional areas. It represents 10% of current local *Access to Clinical Preventive Services* activities. This share is expected to increase to 12% at full implementation, with spending in this area increasing 157%.

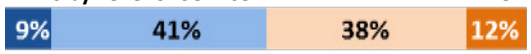
Following, we have provided profiles like this page for each of these five functional areas.

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*



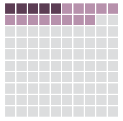
Population by Level of Service *n=3,900,343*

Population in Poverty by Level of Service *n=684,861*

RESOURCES

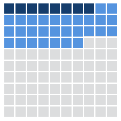
Each Square Equals $500,000
Functional Area Only
Total Foundational Program

Current Spending



$2.5M
2.9%
of $86.7M

Full Implementation



$4.2M
2.5%
of $167.7M

Additional Increment

$1.6M
2.0%
of $81.0M

ACCESS TO CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 1:

Ensure Access to Effective Vaccination Programs

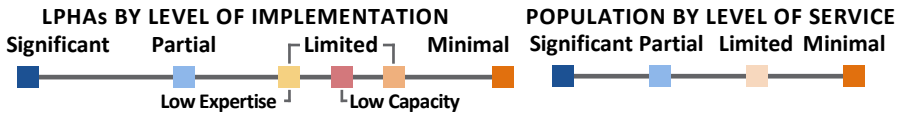
This is the first of 5 functional areas that describes how local *Access to Clinical Preventive Services* activities are operationalized. The activities in the ***Ensure Access to Effective Vaccination Programs*** functional area include 4 roles. This functional area covers the provision of immunizations and vaccinations, and working with partners to ensure access.

This functional area represents 28% of current local *Access to Clinical Preventive Services* activities; its share of local *Access to Clinical Preventive Services* activities would decrease to 22% with the addition of 64% more funding ($1.6M) to reach full implementation.

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

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

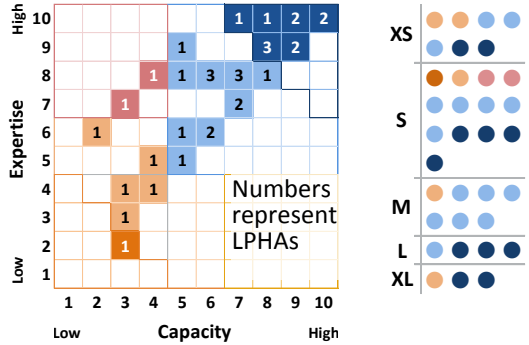
The level of implementation of the 4 roles across LPHAs and population by level of service are provided on the following page.



		LPHAs BY LEVEL OF IMPLEMENTATION					POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Low Expertise	Low Capacity	Minimal	Significant	Partial	Limited	Minimal
Ensure Access to Effective Vaccination Programs	*Functional Area*	9%	41%	12%	26%	12%	1%	42%	48%	9%
Ensure access to all vaccines required by Oregon law for school attendance. This includes ensuring that vaccines are provided at convenient times and locations, and	*Role*	44%	47%	6%	3%		30%	65%	4%	
Ensure access to all immunization-related services necessary to protect the public and prevent the spread of vaccine preventable disease.	*Role*	24%	62%	6%	9%		45%	49%	6%	
Work with local providers and public health delegate agencies to ensure access to immunization services.	*Role*	26%	47%	6%	18%	3%	18%	62%	18%	
Ensure access to vaccines as appropriate during public health emergencies.	*Role*	15%	32%	9%	29%	15%	6%	33%	52%	8%

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

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

32% | 44% | 21% | 3%

Population by Level of Service *n=3,900,343*

60% | 24% | 15% | 1%

Population in Poverty by Level of Service *n=684,861*

62% | 26% | 11% | 1%

RESOURCES

Each Square Equals $500,000

Functional Area Only

Total Foundational Program

Current Spending

$0.9 M
1.0%
of $86.7M

Full Implementation

$2.8M
1.7%
of $167.7M

Additional Increment

$1.9M
2.4%
of $81.0M

ACCESS TO CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 2:

Ensure Access to Effective Preventable Disease Screening Programs

This is the second of the 5 functional areas that describes how local *Access to Clinical Preventive Services* activities are operationalized. The ***Ensure Access to Effective Preventable Disease Screening Programs*** functional area includes 1 roles The functional area covers screening for preventable cancers and diseases, and improving access to clinical preventive services.

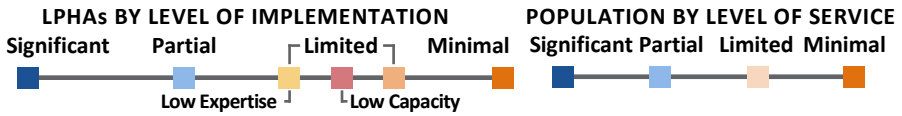
This functional area represents only 10% of current local *Access to Clinical Preventive Services* activities, and the addition of 217% more funding ($1.9M) would allow LPHAs to reach full implementation.

This functional area is highly implemented across the system. Only 2 medium, large, or extra-large LPHAs are not at least partially implemented. Similarly, only 30% of extra-small and small LPHAs are not at least partially implemented.

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

This is consistent from a population service perspective – 84% of Oregon residents live in a service area where these activities are present. However, over half (59%) of those activities are delivered at a limitedly or minimally implemented level.

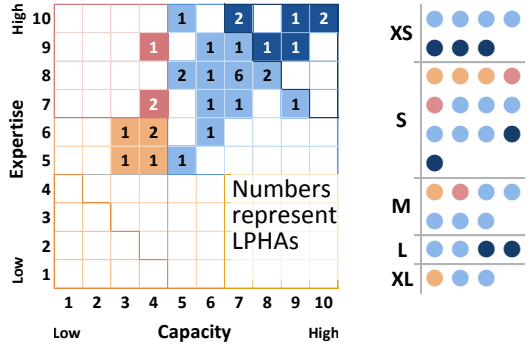
The level of implementation across LPHAs and population by level of service of the single role in this functional area and the functional area overall are provided on the following page.



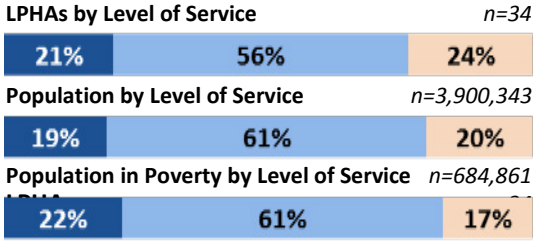
		LPHAs BY LEVEL OF IMPLEMENTATION					POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Low Expertise	Low Capacity	Minimal	Significant	Partial	Limited	Minimal
Ensure Access to Effective Preventable Disease Screening Programs	*Functional Area*	32%	44%	6%	15%	3%	60%	24%	15%	1%
Support provision of evidence based programs and treatments that reduce the impact and costs associated with the leading causes of disease and disability in Oregon.	*Role*	9%	41%	12%	26%	12%	18%	23%	54%	5%

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

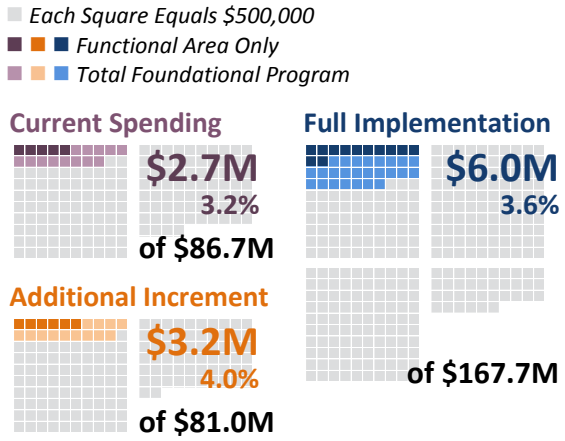
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



ACCESS TO CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 3:

Ensure Access to Effective STD Screening Programs

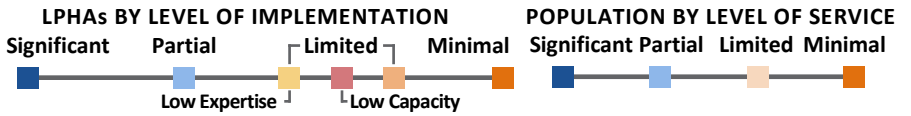
This is the third of the 5 functional areas that describes how local *Access to Clinical Preventive Services* activities are operationalized. The activity in the ***Ensure Access to Effective STD Screening Programs*** functional area includes 1 role that is well implemented. The functional area covers screening for sexually transmitted infections and improving access to clinical preventive services.

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

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

This level of implementation is consistent from a population service perspective – a little over three-quarters (80%) of Oregon residents live in a service area where these activities are present. However, a significant proportion of those activities (over 70%) are implemented at or below a limited level.

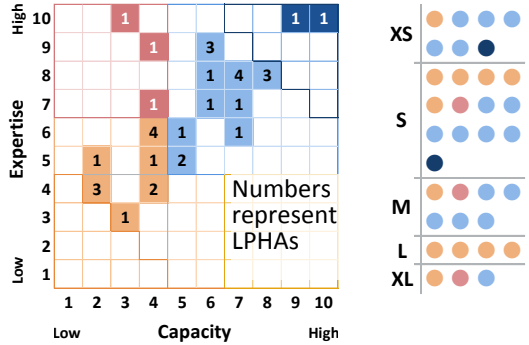
The level of implementation across LPHAs and population by level of service for the 1 role in the and the overall functional area are provided on the following page.



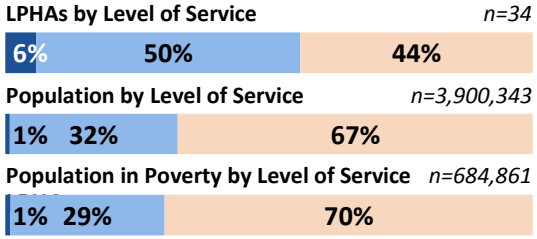
		LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Ensure Access to Effective STD Screening Programs	*Functional Area*	21%	56%	9%	15%	19%	61%		20%
Assure access to treatment for sexually transmitted infections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

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

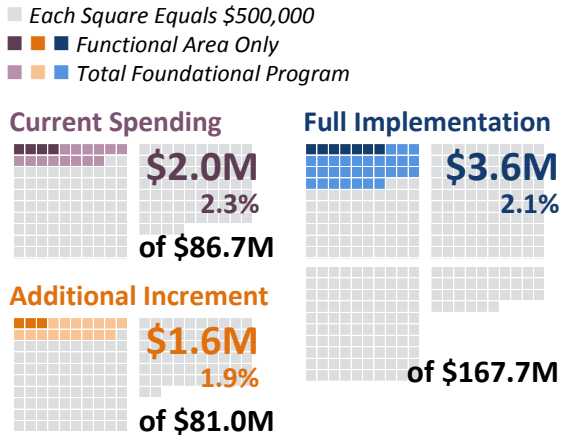
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



ACCESS TO CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 4:

Ensure Access to Effective TB Treatment Programs

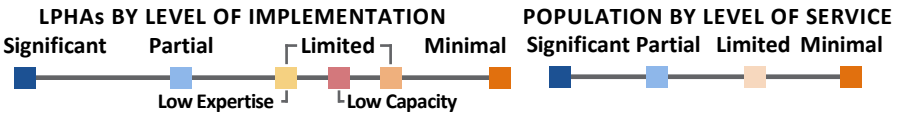
This is the fourth of the 5 functional areas that describes how local *Access to Clinical Preventive Services* activities are operationalized. The activities in the ***Ensure Access to Effective TB Treatment Programs*** functional area include 4 roles. The functional area covers evaluation and treatment of tuberculosis, investigating contacts, and improving access to these clinical preventive services.

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

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

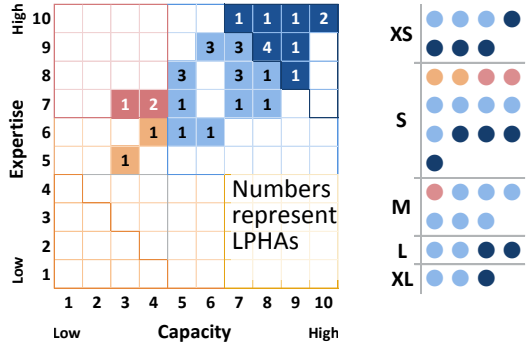
As expected due to the lower implementation in the larger LPHAs, there is a slightly lower implementation from a population service perspective. Approximately one-third (33%) of Oregon residents live in a service area where these activities are present, however, almost 90% of those activities are delivered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

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

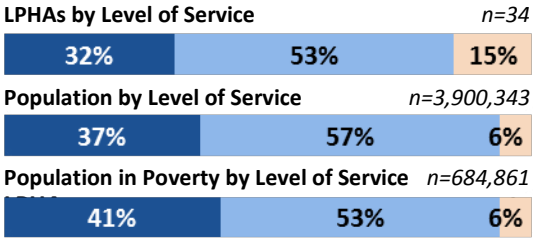


		LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
Ensure Access to Effective TB Treatment Programs	*Functional Area*	6% 50% 9% 35%	1% 32% 67%
Investigate contacts, including testing and treatment.	*Role*	32% 50% 6% 9% 3%	32% 34% 33%
Ensure diagnosis and treatment of those with latent TB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

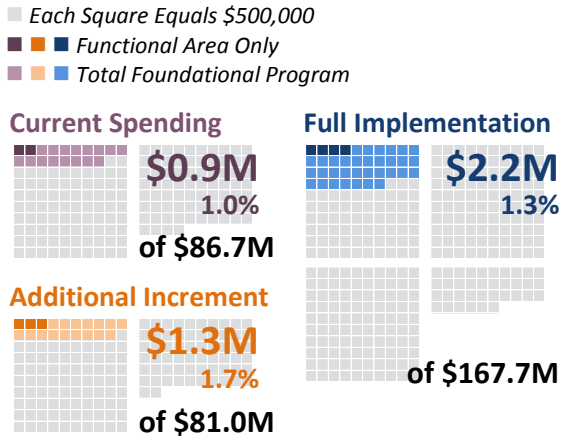
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



ACCESS TO CLINICAL PREVENTIVE SERVICES FUNCTIONAL AREA 5:

Ensure Access to Cost Effective Clinical Care

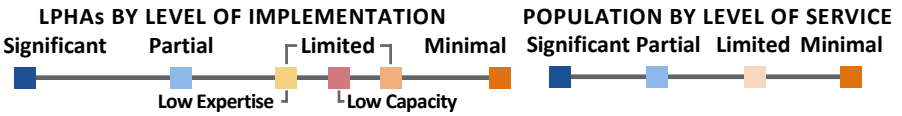
This is the fifth and final of the 5 functional areas that describes how local *Access to Clinical Preventive Services* activities are operationalized. The activities in the ***Ensure Access to Cost Effective Clinical Care*** functional area include 8 roles and 7 deliverables. The functional area covers working with health care providers to support provision of evidence-based programs and treatments that are proven to reduce the impact and costs associated with the leading causes of disease and disability in Oregon.

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

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

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

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



		LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Limited	Minimal	Significant Partial	Limited	Minimal	
Ensure Access to Cost Effective Clinical Care	*Functional Area*	32%	53%	9%	6%	37%	57%	6%	
Engage with regional stakeholders to identify and address barriers to access to clinical preventive care.	*Role*	6%	59%	6%	24%	6%	62%	35%	2%
Provide information to the health care delivery system about the leading causes of death and disability in Oregon and evidence-based clinical interventions to address	*Role*	12%	44%	9%	24%	12%	15%	45%	34% 5%
Share data and information about regional access to clinical preventive services with the community, the health care system, policy makers, and other partners and	*Role*	15%	35%	18%	26%	6%	24%	29%	44% 3%
Collaborate with OHA to identify regional barriers and potential solutions to clinical preventive services.	*Role*	6%	35%	12%	41%	6%	1%	52%	45% 3%
Provide guidance and best practices related to the provision of clinical preventive services to local organizations, including those that serve community members with	*Role*	6%	50%	12%	24%	9%	1%	51%	41% 7%
Create and support local policies that increase access to evidence-based, high quality and effective clinical health services.	*Role*	6%	41%	15%	24%	15%	1%	46%	35% 18%
Support policy solutions that increase access to culturally competent clinical preventive services.	*Role*	12%	38%	12%	29%	9%	2%	39%	51% 8%
Evaluate the impact of local policies, activities and programs on access to clinical preventive services.	*Role*	3%	38%	9%	38%	12%	38%	58%	3%
Document compliance with state and federal laws.	*Deliverable*	26%	59%	3%	6%	6%	32%	42%	25% 1%
Plan for improved access to clinical preventive services, particularly for vulnerable populations.	*Deliverable*	15%	35%	9%	29%	12%	25%	33%	38% 4%
Document meetings with partners to recommend strategies for improving access to clinical preventive services.	*Deliverable*	18%	32%	15%	29%	6%	25%	29%	46%
Document implementation of these plans.	*Deliverable*	15%	21%	12%	38%	15%	17%	30%	48% 6%
Provide resources for clinical and community partners on evidence-based guidelines for the delivery of clinical preventive services.	*Deliverable*	9%	29%	15%	32%	15%	1%	33%	57% 8%
Produce evaluations of policies implemented to improve access to clinical preventive services.	*Deliverable*	9%	21%	9%	29%	32%	16%	16%	51% 17%
Produce jurisdictional reports on access to clinical preventive services.	*Deliverable*	6%	12%	15%	44%	24%	9%	5%	77% 9%

ASSESSMENT AND EPIDEMIOLOGY

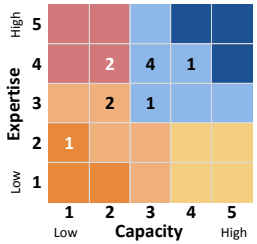
Apply the principles and skilled practice of epidemiology, laboratory investigation and program evaluation to support planning, policy, and decision making across the foundational program areas in Oregon's governmental public health system.

PUBLIC HEALTH DIVISION

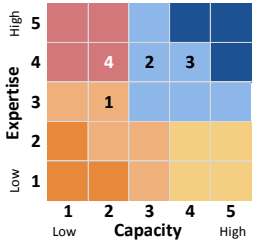
LEVEL OF IMPLEMENTATION

Partially Implemented

ROLES



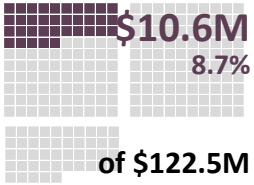
DELIVERABLES



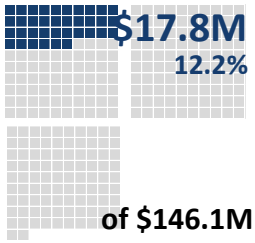
RESOURCES

Each Square Equals $500,000

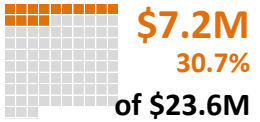
Current Spending



Full Implementation



Additional Increment



Considering the ***Assessment and Epidemiology*** and State Public Laboratory activities separately, PHD's *Assessment and Epidemiology* activities include 11 roles and 10 deliverables. These activities include maintenance of information and statewide public health surveillance systems; collaboration with and technical assistance for LPHAs; statewide capacity to support identification, analysis, and response to disease exposures, outbreaks, and epidemics; statewide survey and data collection; and completion of a statewide health assessment every 5 years to identify population health priorities.

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

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

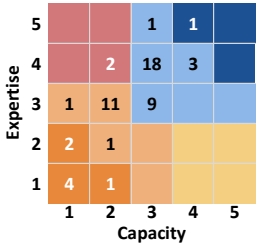
- Ensure collaboration between the state and LPHAs when conducting assessment and epidemiological efforts. (Partially implemented.)
- Provide technical assistance to LPHAs, and ensure access to local data collected in statewide data collection systems. (Partially implemented.)
- Maintain information and statewide public health surveillance systems. (Partially implemented.)
- Provide state-level public health informatics capability. (Minimally implemented.)

STATE PUBLIC HEALTH LABORATORY

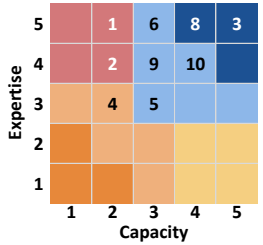
LEVEL OF IMPLEMENTATION

Limitedly Implemented, Low Capacity

CORE FUNCTIONS



DELIVERABLES



RESOURCES

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

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

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

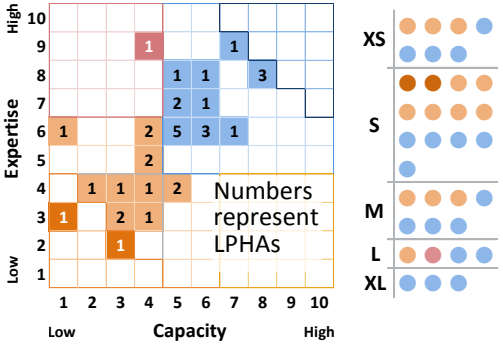
PHD's self-assessment shows that it consider the public health modernization requirements for the State Public Health Laboratory to be limitedly implemented due to a lack of capacity However, PHD also reported that 60% of the roles are either partially or significantly implemented.

Generally, PHD's self-assessment showed the highest implementation in food safety; reference and specialized testing; and training and education. PHD reported the lowest implementation of core system functions in environmental health and protection.

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

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

53% | 41% | 6%

Population by Level of Service *n=3,900,343*

72% | 27% | 1%

Population in Poverty by Level of Service *n=684,861*

68% | 30% | 2%

RESOURCES

Each Square Equals $500,000

Current Spending

$6.9M
8.0%
of $86.7M

Full Implementation

$14.2M
8.4%
of $167.7M

Additional Increment

$7.2M
8.9%
of $81.0M

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

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

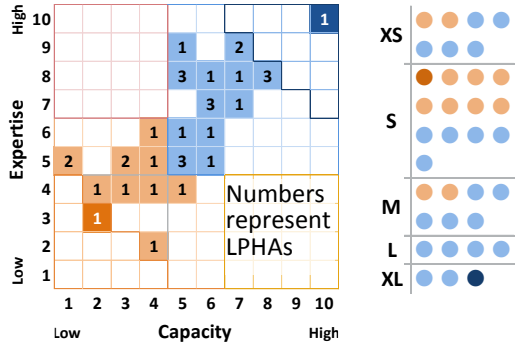
Assessment and Epidemiology is a relatively less-implemented capability, with a little over half of LPHAs reporting partial implementation and no LPHAs reporting significant implementation. This foundational capability is particularly data-intensive, and data availability and access issues were themes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

Local *Assessment and Epidemiology* activities are broken down into 5 functional areas:

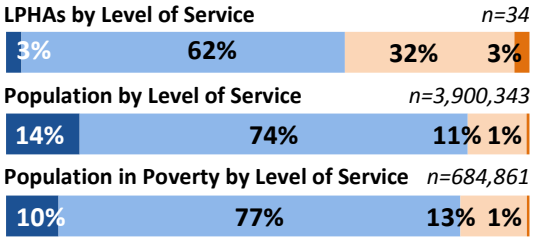
1. **Data Collection and Electronic Information Systems.** This functional area represents 40% of current local *Assessment and Epidemiology* spending; under full implementation, spending would increase over 50%, but resource allocation would rebalance the functional areas and it would decrease in share of total spending to 30%.
2. **Data Access, Analysis, and Use.** This area represents 19% of current local *Assessment and Epidemiology* spending and will need an additional 100% of current spending to reach full implementation.
3. **Respond to Data Requests and Translate Data for Intended Audiences.** This area represents 11% of current local *Assessment and Epidemiology* spending. LPHAs estimate full implementation would require a spending increase of 117%.
4. **Conduct and Use Basic Community and Statewide Health Assessments.** The smallest spending area under significant implementation, this functional area is also the least available to Oregon residents within *Assessment and Epidemiology*.
5. **Infectious Disease-Related Assessment.** This is the least resourced functional area within *Assessment and Epidemiology*, representing less than 10% of current spending, but increasing to 21% in full implementation, with an additional 350% of current spending.

Profiles of each of these 5 functional areas follow.

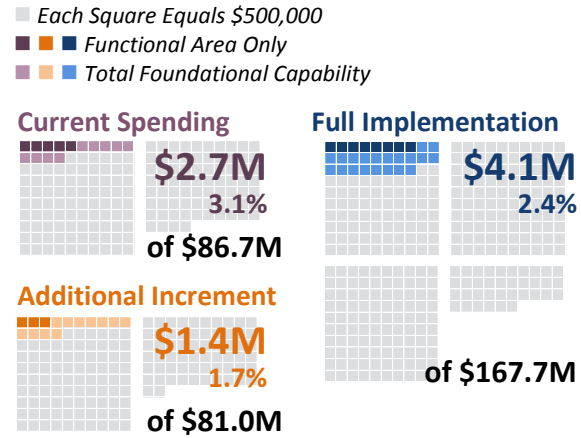
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 1:

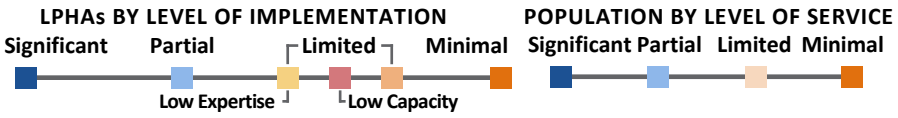
Data Collection and Electronic Information Systems

This is the first of 5 functional areas that describes how *Assessment and Epidemiology* activities are operationalized. Activities within this functional area support the ability to collect sufficient statewide data to develop and maintain electronic information systems to guide public health planning and decision making at the state and local level.

This functional area represents almost 40% of the LPHAs' current *Assessment and Epidemiology* public health modernization spending, and an increment of 53% or $1.4M is needed to reach significant implementation. This functional area will remain the largest area of spending at full implementation.

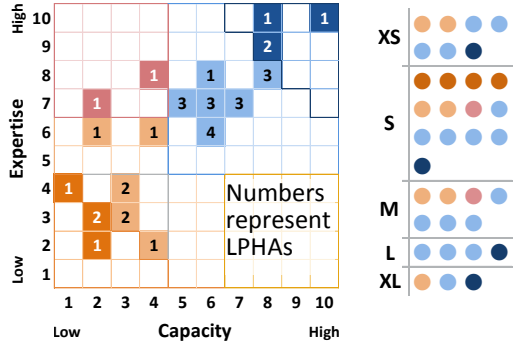
Reflecting the relatively small increase in resources needed for significant implementation, the LPHAs rated this functional area as the most implemented within *Assessment and Epidemiology*, both from the count of LPHAs and the percent of population living in areas with partial or significant implementation.

The activities in the *Data Collection and Electronic Information Systems* functional area include 4 roles and no deliverables. The level of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

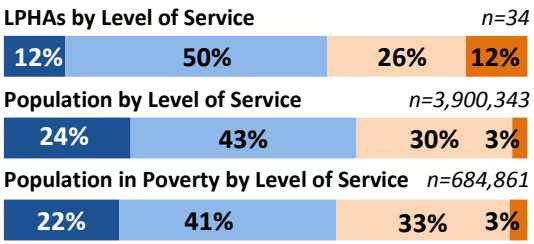


		LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Data Collection and Electronic Information Systems	*Functional Area*	3%	62%	32%	3%	14%	74%	11%	1%
Access statewide information and surveillance systems and report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

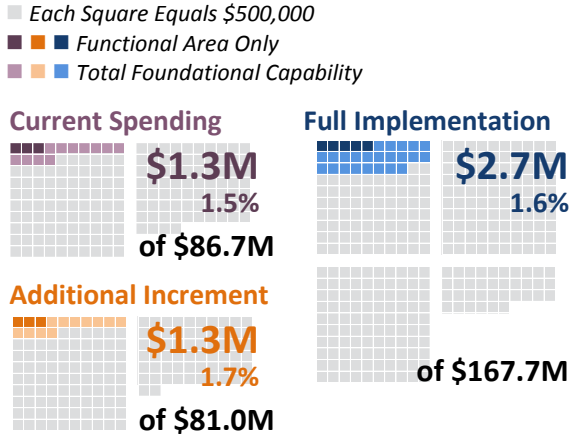
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 2:

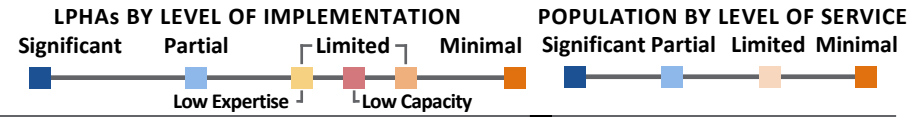
Data Access, Analysis, and Use

Data Access, Analysis, and Use is the second of 5 functional areas that describes how *Assessment and Epidemiology* activities are operationalized. This functional area supports the processing of data from a variety of sources in a manner that is accurate, timely, statistically valid, actionable, usable, and meaningful to the requester.

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

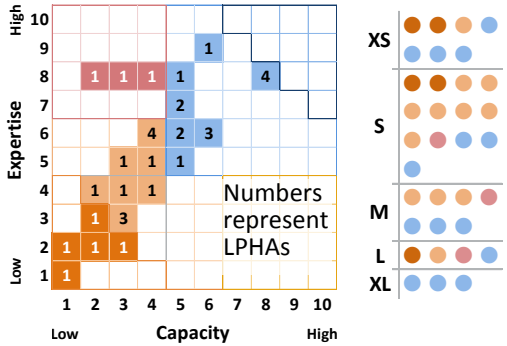
Over 60% of LPHAs rated themselves as having limited or partial implementation of the two activities required in this functional area. There are no clear patterns in the implementation levels across population size categories, nor is implementation strongly connected to the percentage of population living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

The activities in ***Data Access, Analysis, and Use*** have 1 role and 1 deliverable. The level of implementation of the role and deliverable across LPHAs as well as the level of service across Oregon's population is provided on the following page.



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

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

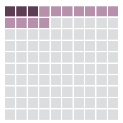
Population by Level of Service *n=3,900,343*

Population in Poverty by Level of Service *n=684,861*

RESOURCES

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

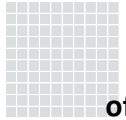
Current Spending



$1.5M
1.8%
of $86.7M

Full Implementation

$2.9M
1.7%



of $167.7M

Additional Increment

$1.4M
1.7%
of $81.0M

ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 3:

Respond to Data Requests and Translate Data for Intended Audiences

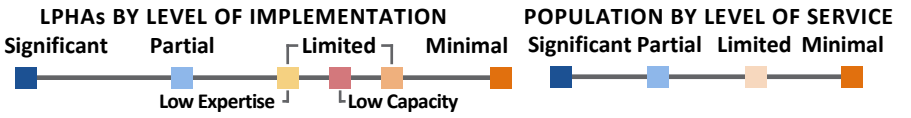
Respond to Data Requests and Translate Data for Intended Audiences is the third of 5 functional areas that describes how local *Assessment and Epidemiology* activities are operationalized. Activities in this functional area include prioritizing and responding to requests for data, information, and reporting; and communicating the response in a manner that is accurate, statistically valid, and usable by the requester.

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

Currently, the level of implementation of this functional area is varied across all size bands, except for the 3 most populous jurisdictions, which all reported partial implementation.

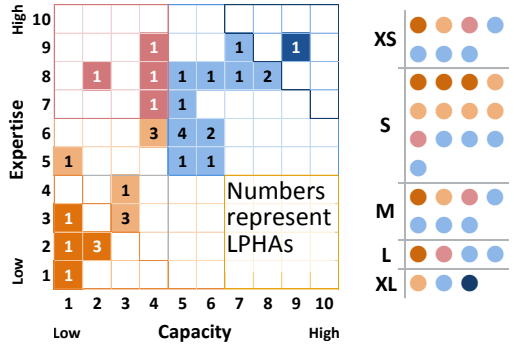
Two-thirds of LPHAs reported a high level of implementation for producing local summaries of disease occurrence, outbreaks, and epidemics, but the 4 other deliverables were less implemented, with 50% or less of LPHAs reporting partial or significant implementation.

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

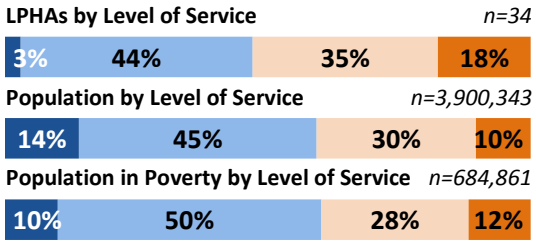


		LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Respond to Data Requests and Translate Data for Intended Audiences	*Functional Area*	41%	9%	35%	15%	63%	30%		8%
Support the appropriate use and timely communication of the data to support community health and resiliency.	*Role*	3%	38%	12%	32%	15%	14%	20%	61%	5%
Produce local summaries of disease occurrence, outbreaks and epidemics.	*Deliverable*	15%	53%	6%	18%	9%	44%	43%	11%	2%
Produce local summaries on key indicators of community health, which include information about upstream or root causes of health.	*Deliverable*	12%	38%	38%	12%	26%	43%	29%	2%
Produce local summaries on leading causes of disease, injury, disability and death, which include information about health disparities.	*Deliverable*	9%	38%	6%	32%	15%	16%	51%	28%	5%
Produce local summaries with analyses of statewide surveys on health attitudes, beliefs, behaviors and practices.	*Deliverable*	9%	26%	3%	41%	21%	34%	18%	41%	7%
Produce local summaries describing the impact of public health policies, programs and strategies on health outcomes, including economic analyses when appropriate.	*Deliverable*	3%	32%	9%	32%	24%	35%	44%	21%

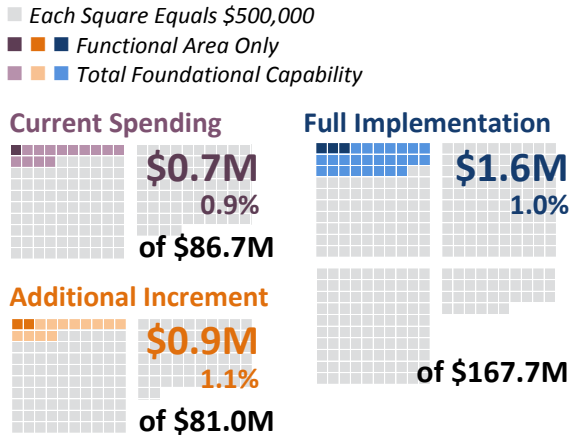
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 4:

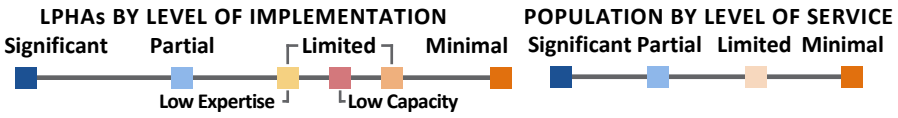
Conduct and Use Basic Community and Statewide Health Assessments

Conduct and Use Basic Community and Statewide Health Assessments is the fourth of 5 functional areas that describes how *Assessment and Epidemiology* activities are operationalized. This functional area represents LPHAs' ability to conduct a basic community health assessment or participate in a statewide health assessment, and identify health priorities arising from that assessment, including analysis of health disparities.

The smallest spending area under current implementation, this functional area is also the least available to the residents of Oregon within *Assessment and Epidemiology*, representing less than 10% of current local *Assessment and Epidemiology* spending. LPHAs estimate that an additional 117% of current spending or $0.9M will be required to meet full implementation of the activities in this functional area.

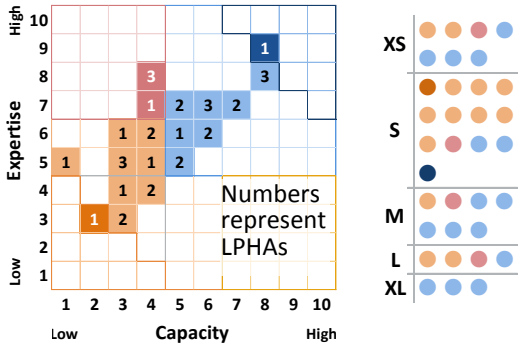
Almost 60% of Oregon's population live in a jurisdiction that has partial or significant implementation. However, 10% of Oregonians live in areas that have little to no implementation of these activities, which is the highest in the *Assessment and Epidemiology* foundational capability.

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



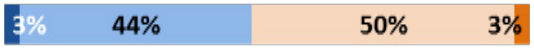
		LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Conduct and Use Basic Community and Statewide Health Assessments	*Functional Area*	3%	44%	12%	24%	18%	14%	45%	30%	10%
Ensure collaboration between state and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

LPHA IMPLEMENTATION

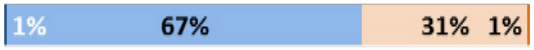


LEVEL OF SERVICE

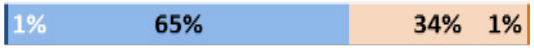
LPHAs by Level of Service *n=34*



Population by Level of Service *n=3,900,343*



Population in Poverty by Level of Service *n=684,861*

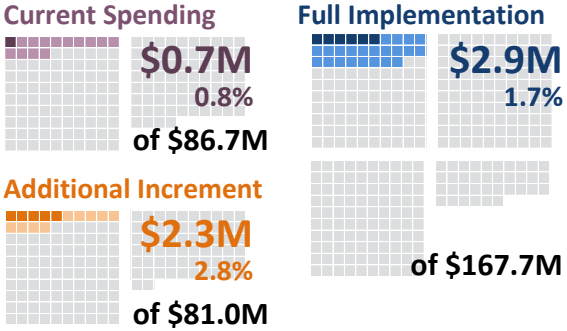


RESOURCES

Each Square Equals $500,000

Functional Area Only

Total Foundational Capability



ASSESSMENT AND EPIDEMIOLOGY FUNCTIONAL AREA 5:

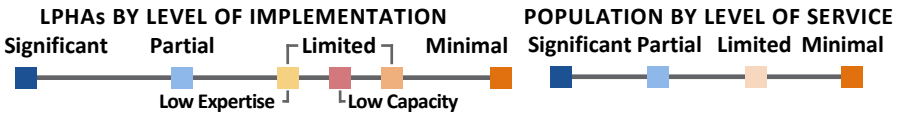
Infectious Disease-Related Assessment

Infectious Disease-Related Assessment is the fifth of 5 functional areas that describes how local *Assessment and Epidemiology* activities are operationalized. This functional area includes: identification and response to disease outbreaks and epidemics; analysis and response to information related to disease outbreaks and epidemics; and maintaining the capacity and staff to provide laboratory services, including diagnostic and screening tests, and to follow protocols established by PHD.

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

Most LPHAs rated themselves at a limited or partial level of implementation of the required activities, with only 1 reporting minimal implementation and 1 reporting significant implementation. Over two-thirds of Oregon residents live in a service area where these activities are at least limitedly implemented.

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



		LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
Infectious Disease-Related Assessment	*Functional Area*	Significant	Partial	Limited	Minimal	Significant Partial	Limited	Minimal	
		3%	44%	12%	38%	3%	1%	67%	31%
Promptly identify and lead outbreak investigations that initiate or primarily occur in the local authority. Actively participate in outbreak investigations that cross multiple authorities.	*Role*	21%	65%	12%	3%		54%	41%	4%
Maintain the capacity and staff to provide laboratory services including diagnostic and screening tests, and follow protocols established by the OHA Public Health Division.	*Role*	12%	65%	24%			25%	66%	9%
Ensure local public health capacity to respond to emerging threats to health by maintaining flexibility related to staffing and information systems.	*Role*	12%	44%	18%	24%	3%	11%	69%	18% 2%
Capacity to interact with the State Public Health Lab on a 24/7 basis.	*Deliverable*	38%	44%	12%	6%		57%	19%	24%

EMERGENCY PREPAREDNESS AND RESPONSE

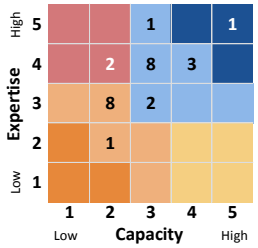
A healthy community is a resilient community, which is prepared and able to respond to and recover from public health threats and emergencies.

PUBLIC HEALTH DIVISION

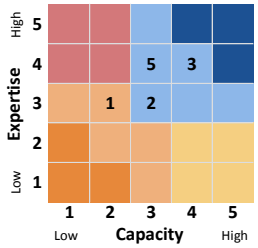
LEVEL OF IMPLEMENTATION

Partially Implemented

ROLES



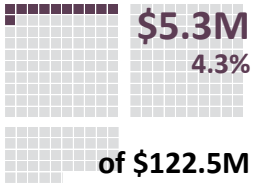
DELIVERABLES



RESOURCES

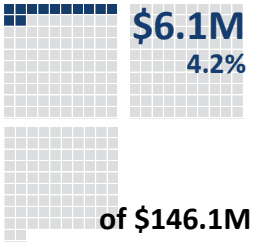
Each Square Equals $500,000

Current Spending



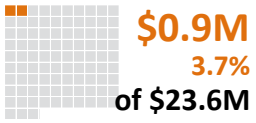
$5.3M
4.3%
of $122.5M

Full Implementation



$6.1M
4.2%
of $146.1M

Additional Increment



$0.9M
3.7%
of $23.6M

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

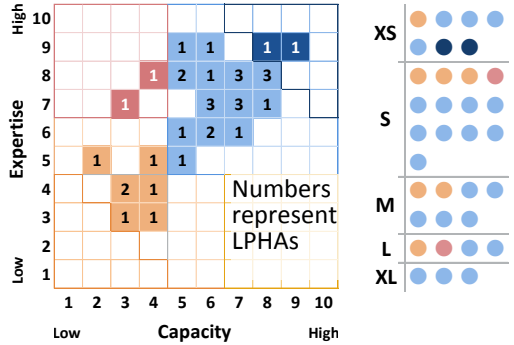
PHD's self-assessment shows that it considers this foundational capability to be partially implemented. However, PHD also notes that many of the roles and deliverables that represent *Emergency Preparedness and Response* state activities have only limited implementation. In fact, 12 of the 37 roles and deliverables are only limitedly implemented.

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

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

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

6%	68%	26%

Population by Level of Service *n=3,900,343*

1%	75%	24%

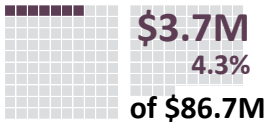
Population in Poverty by Level of Service *n=684,861*

1%	71%	28%

RESOURCES

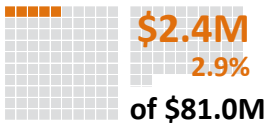
Each Square Equals $500,000

Current Spending



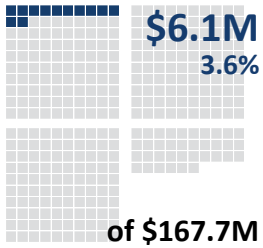
$3.7M
4.3%
of $86.7M

Additional Increment



$2.4M
2.9%
of $81.0M

Full Implementation



$6.1M
3.6%
of $167.7M

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

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

Local *Emergency Preparedness and Response* activities are broken down into 3 functional areas:

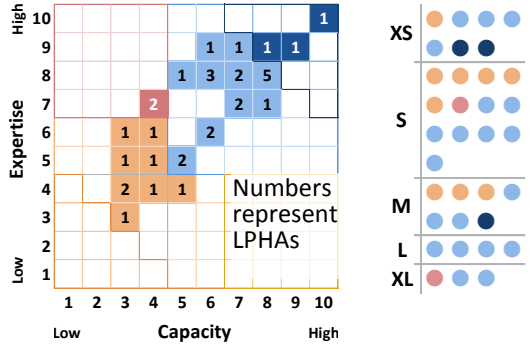
1. **Prepare for Emergencies.** This functional area represents 56% of current local *Emergency Preparedness and Response* activities; its share of local *Emergency Preparedness and Response* activities would decrease to 53% at significant implementation.
2. **Respond to Emergencies.** This functional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

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

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

Profiles for each of the 3 functional areas can be found on the following pages.

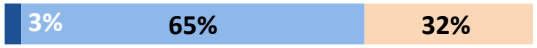
LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

Population by Level of Service *n=3,900,343*

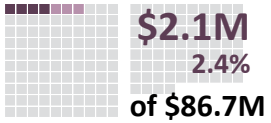


Population in Poverty by Level of Service *n=684,861*

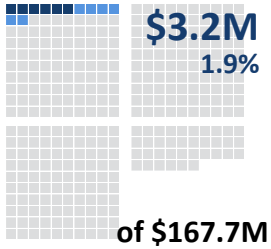
RESOURCES

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

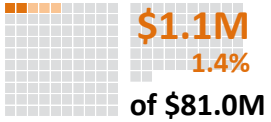
Current Spending



Full Implementation



Additional Increment



EMERGENCY PREPAREDNESS AND RESPONSE FUNCTIONAL AREA 1:

Prepare for Emergencies

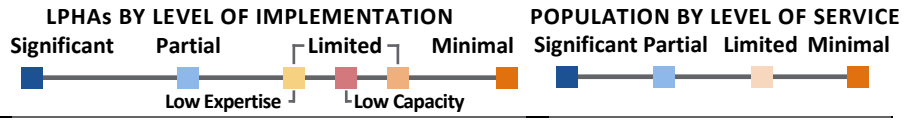
This is the first of 3 functional areas that describes how local *Emergency Preparedness and Response* activities are operationalized. The activities in the ***Prepare for Emergencies*** functional area include 8 roles and 5 deliverables. These activities are focused around developing, exercising, improving, and maintaining preparedness and response plans in the event of a natural or human-created disasters and emergencies.

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

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

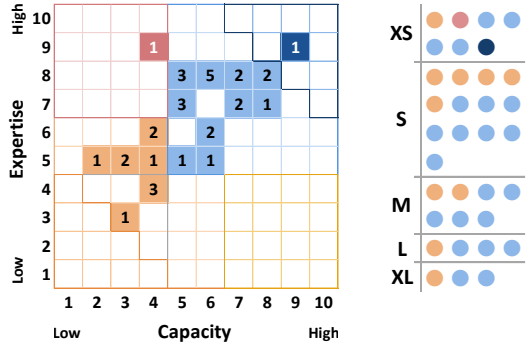
This is balanced from a population service perspective: 68% of Oregon residents live in a service area where these activities are present (however, there is a meaningful gap in implementation for a large percentage of those activities).

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



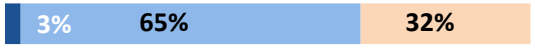
Prepare for Emergencies	*Functional Area*	LPHAs BY LEVEL OF IMPLEMENTATION: Significant / Partial / Limited / Minimal	POPULATION BY LEVEL OF SERVICE: Significant Partial / Limited / Minimal
		9% / 59% / 6% / 26%	3% / 65% / 32%
Conduct jurisdictional assessment of risk, resources, and priority of public health preparedness capabilities.	*Role*	15% / 68% / 15% / 3%	5% / 87% / 6% / 2%
Maintain continuity of operations plan for the authority.	*Role*	9% / 74% / 15% / 3%	85% / 13%
Maintain public health preparedness plans in accordance with the 15 core public health capabilities (1) including but not limited to public health surveillance and disaster epidemiology, identifying and initiating medical countermeasures dispensing strategies, communications with public and partners, outlining public health's role in fatality management, and monitoring mass care/population health.	*Role*	12% / 65% / 3% / 21%	3% / 81% / 15%
Build community partnerships to support health preparedness, recovery and resilience efforts, including training and exercising with community partners per federal guidelines, and the ongoing training and support provided by local public health authorities (e.g. schools, hospitals, emergency medical, community organizations, organizations serving priority/focal populations, etc.).	*Role*	9% / 68% / 21% / 3%	3% / 81% / 15%
Maintain continuity of operations plan for the authority.	*Role*	12% / 68% / 21%	15% / 53% / 32%
Incorporate health considerations in to recovery planning	*Role*	6% / 53% / 3% / 29% / 9%	3% / 59% / 33% / 5%
Develop public health short term and long term goals for recovery operations.	*Role*	3% / 56% / 3% / 21% / 18%	45% / 49% / 6%
Maintain pharmaceutical access.	*Role*	3% / 38% / 6% / 32% / 21%	43% / 48% / 9%
Prepare public health emergency preparedness plans in accordance with established guidelines.	*Deliverable*	21% / 68% / 3% / 9%	21% / 75% / 4%
Document emergency preparedness exercises.	*Deliverable*	32% / 56% / 3% / 9%	35% / 61% / 5%
Produce continuity of operations plan for the local health authority.	*Deliverable*	12% / 71% / 3% / 15%	5% / 88% / 6%
Plan emergency preparedness exercise.	*Deliverable*	21% / 62% / 18%	7% / 81% / 12%
Plan for the distribution of pharmaceuticals in the event of an emergency.	*Deliverable*	9% / 56% / 6% / 21% / 9%	1% / 72% / 23% / 4%

LPHA IMPLEMENTATION

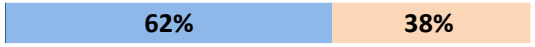


LEVEL OF SERVICE

LPHAs by Level of Service *n=34*



Population by Level of Service *n=3,900,343*

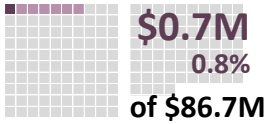


Population in Poverty by Level of Service *n=684,861*

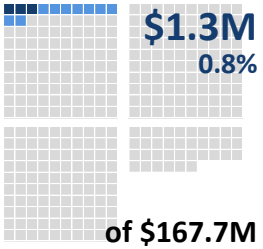
RESOURCES

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

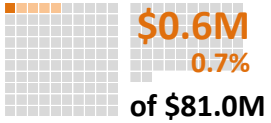
Current Spending



Full Implementation



Additional Increment



EMERGENCY PREPAREDNESS AND RESPONSE FUNCTIONAL AREA 2:

Respond To Emergencies

This is the second of 3 functional areas that describes how local *Emergency Preparedness and Response* activities are operationalized. The activities included in the ***Respond to Emergencies*** functional area include 1 role and 4 deliverables. The functional area includes activities around activating emergency response personnel during a disaster or emergency and recognizing if public health has a primary, secondary, or ancillary role in response activities.

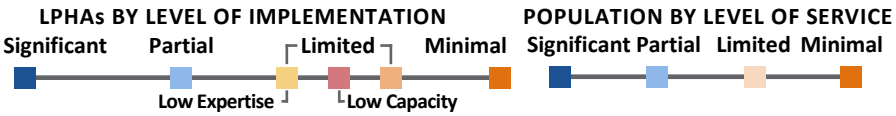
This functional area represents one-fifth of current local *Emergency Preparedness and Response* activities, and the addition of 77% more funding ($0.6M) would allow LPHAs to reach significant implementation.

This functional area's level of implemented varies across the system. There is not a clear pattern by LPHA size. Approximately two-thirds of LPHAs are partially or significantly implemented.

Population service is a bit lower, with only 62% of residents living in a service area where these activities are present. However, almost all of those activities are partially implemented or less.

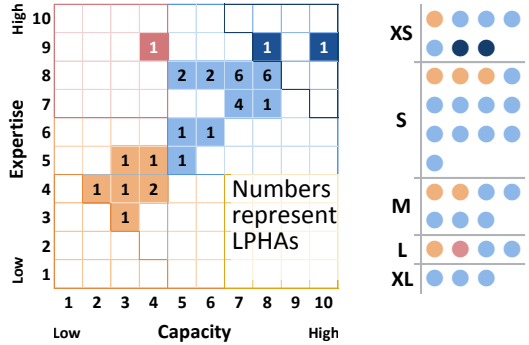
This is one area with a difference between level of service for the overall population and the population living in poverty. 62% percent of the population is currently served by an LPHA that is partially or significantly implemented, compared to 57% of those living in poverty.

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



		LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
Respond to Emergencies	*Functional Area*	3% 65% 3% 29%	62% 38%
Provide efficient and appropriate situation assessment, determine objectives to address the health needs of those affected, allocating resources to address those needs, and return to routine operations.	*Role*	9% 59% 3% 26% 3%	3% 76% 19% 2%
Document participation in emergency response efforts.	*Deliverable*	26% 62% 3% 9%	19% 76% 5%
Document enforcement of emergency public health orders.	*Deliverable*	15% 62% 3% 12% 9%	15% 76% 7% 2%
Develop situational assessments and resulting operational plans, including objectives, resources needed and how to resume routine operations.	*Deliverable*	18% 44% 3% 26% 9%	15% 49% 31% 4%
Produce disaster epidemiology reports.	*Deliverable*	32% 6% 32% 29%	43% 43% 13%

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

6%	71%	24%

Population by Level of Service *n=3,900,343*

1%	76%	24%

Population in Poverty by Level of Service *n=684,861*

1%	72%	27%

RESOURCES

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

Current Spending
$0.9M 1.0%
of $86.7M

Full Implementation
$1.6M 0.9%
of $167.7M

Additional Increment
$0.7M 0.8%
of $81.0M

EMERGENCY PREPAREDNESS AND RESPONSE FUNCTIONAL AREA 3:

Coordinate and Communicate Before and During an Emergency

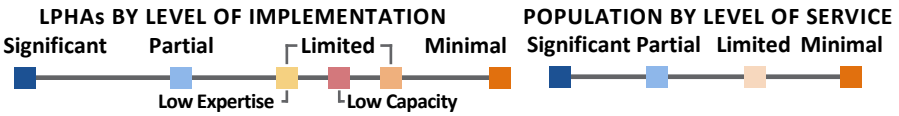
This is the final of 3 functional areas that describes how local *Emergency Preparedness and Response* activities are operationalized. The activities included in the ***Coordinate and Communicate Before and During an Emergency*** functional area include 1 role and 2 deliverables focused on communicating and coordinating with health care providers, emergency service providers, and other agencies and organizations that respond to disasters and emergencies.

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

Currently, three-quarters of LPHAs have partially or significantly implemented these activities. There is no clear pattern as to which LPHAs are at each level of implementation. In fact, the 2 LPHAs who said they have significantly implemented this functional area are both extra-small. Given the size of these LPHAs, it is likely that they are able to consider this area significantly implemented because they would have access to sufficient additional resources from other LPHAs if they had a public health emergency.

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

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



		LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
Coordinate and Communicate Before and During an Emergency	*Functional Area*	6% 71% 3% 21%	1% 76% 24%
Act as the jurisdictional administrator of public health notification systems (e.g. alert networks, hospital capacity programs, etc.), Oregon's logistical ordering system and syndromic surveillance system.	*Role*	9% 65% 18% 9%	2% 79% 10% 9%
Deliver health alerts and preparedness communications to partners and the general public.	*Deliverable*	32% 50% 3% 12% 3%	24% 62% 13% 1%
Maintain a portfolio of community partnerships to support preparedness and recovery efforts.	*Deliverable*	24% 50% 3% 21% 3%	25% 60% 14% 2%

COMMUNICATIONS

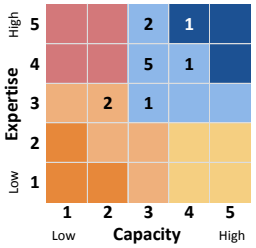
Governmental public health is a trusted source of clear, consistent, accurate and timely health information. Governmental public health consistently uses health communication strategies, interventions and tools to eliminate health disparities and achieve equity.

PUBLIC HEALTH DIVISION

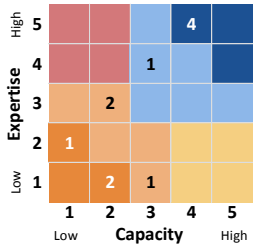
LEVEL OF IMPLEMENTATION

Partially Implemented

ROLES



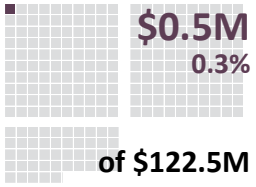
DELIVERABLES



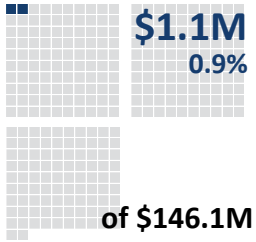
RESOURCES

Each Square Equals $500,000

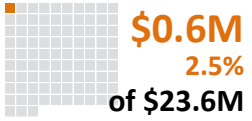
Current Spending



Full Implementation



Additional Increment



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

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

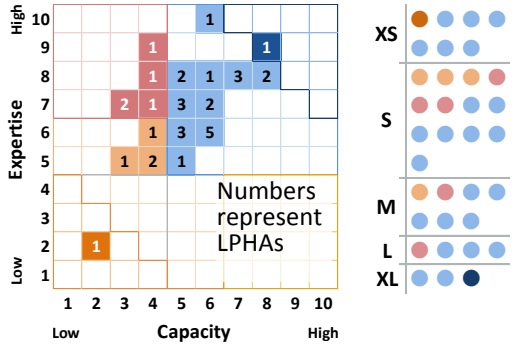
The focus of PHD's less than significantly implemented roles and deliverables are around developing, implementing, and generating content in alignment with a strategic communications plan. Based on the scores it appears that PHD does not have a strong plan of this type at this time. This is likely an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

Several of the state *Communications* roles and deliverables support local activities; all of these are at least partially implemented. While it is likely that further implementation would continue to support local *Communications* activities, it is not likely that the level of implementation of these service dependencies is creating a barrier to local implementation.

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

LOCAL PUBLIC HEALTH AUTHORITIES

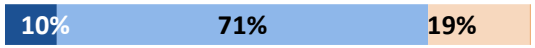
LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

Population by Level of Service *n=3,900,343*

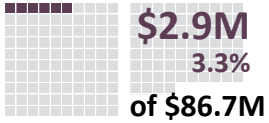


Population in Poverty by Level of Service *n=684,861*

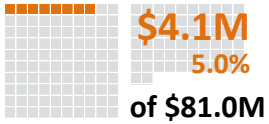
RESOURCES

Each Square Equals $500,000

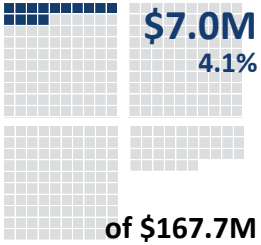
Current Spending



Additional Increment



Full Implementation



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

This foundational capability is relatively well implemented, with 24 of 34 LPHAs (serving 81% of the population overall) reporting partial or significant implementation.

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

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

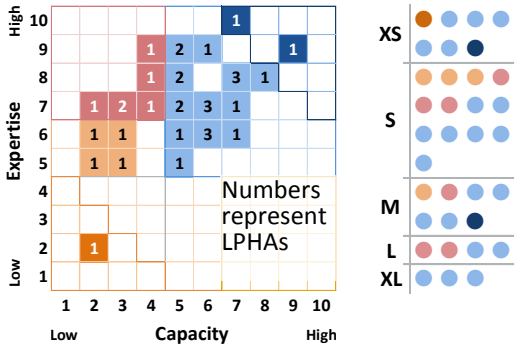
1. **Regular Communications.** This functional area represents 44% of current local *Communications* activities; this share would decrease to 41% at full implementation.
2. **Emergency Communications.** This represents 12% of current local *Communications* activities and will remain the smallest (23%) share of local activities in this foundational capability at full implementation.
3. **Educational Communications.** This represents 44% of current local *Communications* activities. This share is expected to decrease to 36% at full implementation.

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

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

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

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

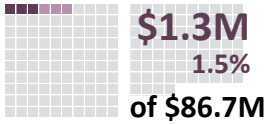
Population by Level of Service *n=3,900,343*

Population in Poverty by Level of Service *n=684,861*

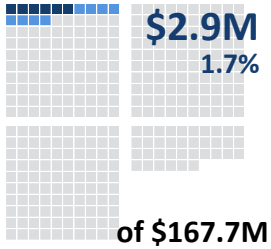
RESOURCES

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

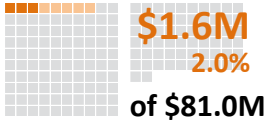
Current Spending



Full Implementation



Additional Increment



COMMUNICATIONS FUNCTIONAL AREA 1:

Regular Communications

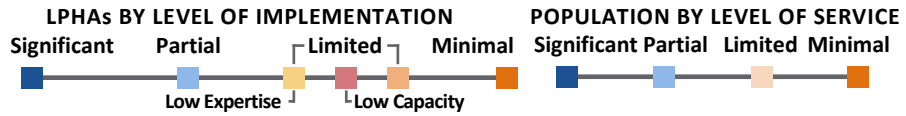
This is the first of 3 functional areas that describes how local *Communications* activities are operationalized. The activities in the ***Regular Communications*** functional area include 5 roles and 9 deliverables. This functional area includes developing and implementing a strategic communication plan, evaluating the effectiveness of those efforts, and adjusting communication strategies accordingly.

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

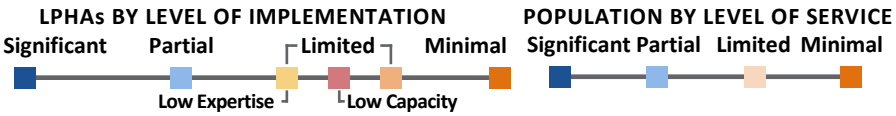
The level of implementation of this functional area seems to be concentrated in the limited (low capacity) and partial sections of the scoring matrix. There is no clear pattern as to what size LPHA is most likely to be more or less implemented. However, it does appear that lack of capacity is a greater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

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

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

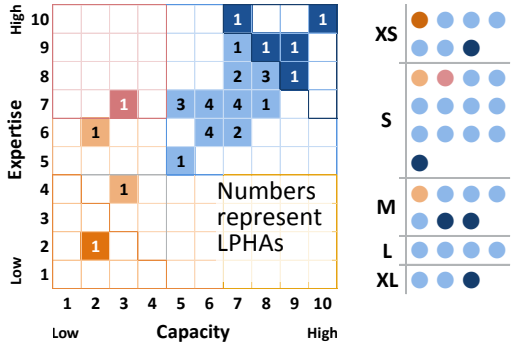


Regular Communications		
	Functional Area	6% 62% 18% 12% 3% / 3% 75% 23%
Local public health authorities shall maintain a public-facing website with updates made to content no less than annually.	*Role*	18% 56% 3% 24% / 28% 44% 28%
Local public health authorities shall be a reputable source of health information, through public health branding, by disseminating news releases and public meeting notices in a timely and transparent fashion. Local public health authorities shall support ongoing interaction with the public by offering and inviting two-way communications with the public; (e.g. contact information, surveys, comment boxes, etc.)	*Role*	12% 62% 9% 15% 3% / 4% 56% 38% 2%
Local public health authorities shall regularly evaluate the effectiveness of communications efforts using tools such as web analytics, surveys, panel surveys and polls. Local public health authorities shall use evaluation findings to adjust communications and communications strategies accordingly.	*Role*	32% 21% 24% 24% / 38% 45% 16%
Local public health authorities shall develop and implement a strategic communication plan that articulates the local public health authority's mission, value, role, and responsibilities. Local public health authorities shall develop and disseminate communications on emerging public health issues.	*Role*	3% 47% 29% 18% 3% / 27% 62% 1%
Local public health authorities shall develop and disseminate print and media materials in accordance with the strategic communications plan and risk communication needs. Local public health authorities can also adopt or customize statewide print and media materials provided by the OHA Public Health Division. Materials shall be in compliance with ADA Section 508 and consider health literacy needs, and communications for the public shall consider the end user and use appropriate communication format(s) and language(s). Communications shall be tailored for specific audiences, such as policymakers, stakeholders, local public health authorities, health care providers, the public and specific population groups.	*Role*	3% 53% 15% 24% 6% / 10% 19% 69% 2%

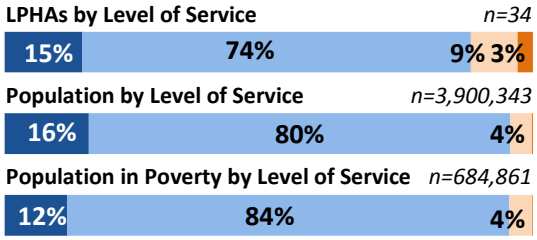


Regular Communications	*Functional Area*	LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
		6% 62% 18% 12% 3%	3% 75% 23%
News releases and public meeting notices.	*Deliverable*	21% 71% 6% 3%	20% 76% 4%
Evidence of two-way communications with the public.	*Deliverable*	18% 53% 24% 6%	21% 60% 17% 3%
Public-facing website with updates made to content regularly.	*Deliverable*	21% 50% 6% 18% 6%	40% 32% 25% 3%
Document communications support for any staff beyond the public information officer who communicate with the public about public health issues (e.g. media content reviewed by the public information officer).	*Deliverable*	9% 50% 3% 18% 21%	23% 48% 24% 5%
Policy briefs and other policy-related communications.	*Deliverable*	6% 41% 9% 32% 12%	3% 64% 31% 2%
Strategic communication plan that articulates the local public health authority's mission, value, role, and responsibilities in its community, and support department and community leadership in communicating these messages. The strategic communications plan should include high priority issues that require proactive communications with the public.	*Deliverable*	6% 50% 15% 24% 6%	2% 57% 39% 3%
Print and media materials in accordance with the strategic communications plan and risk communication needs. Communications for the public consider the end user and use appropriate communication format(s) and language(s). Communications shall be culturally competent, shall incorporate health literacy principles, and shall address the needs of priority/focal populations.	*Deliverable*	9% 44% 9% 32% 6%	11% 43% 45% 1%
Document two-way communications with the OHA Public Health Division. Evaluation Communications evaluation plan that is structured around health equity and literacy.	*Deliverable*	3% 38% 3% 29% 26%	23% 50% 27%
Evaluation reports documenting the effectiveness of communications efforts using tools such as web analytics, surveys, panel surveys and polls; use of evaluation findings to adjust communications and communications strategies accordingly.	*Deliverable*	3% 24% 6% 29% 38%	21% 52% 27%

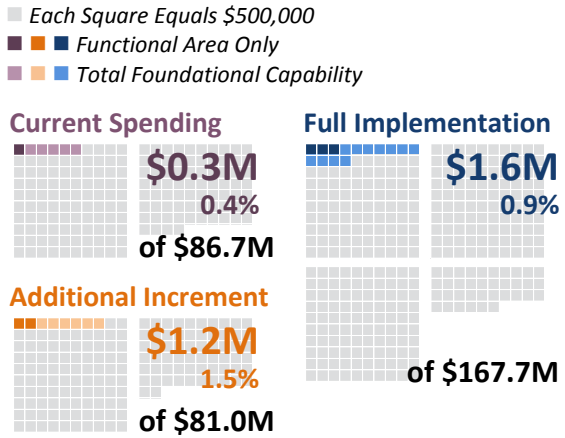
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



COMMUNICATIONS FUNCTIONAL AREA 2:

Emergency Communications

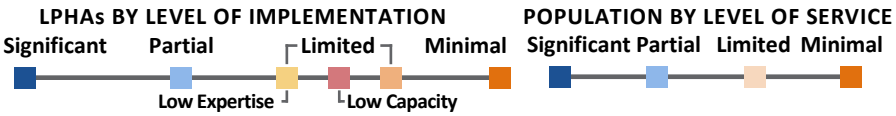
This is the second of 3 functional areas that describes how local *Communications* activities are operationalized. Only 1 role is included in the ***Emergency Communication*** functional area. The functional area maintains that accurate, timely, and understandable information and instructions be provided to the public during a disease outbreak or other disaster or emergency.

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

This functional area is highly implemented across the system. Only 4 LPHAs—1 extra-small, 2 small, and 1 medium—are not at least partially implemented.

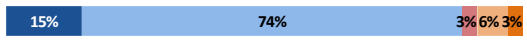
The level of implementation from a population service perspective is high, with 96% of Oregonians living in a service area where these activities are present. This, paired with the large additional spending needed to reach significant implementation, suggests that the increase to significant implementation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

The level of implementation across LPHAs as well as the level of service across Oregon's population for the single role in this functional area is provided on the following page.



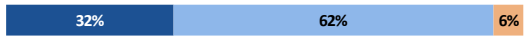
Emergency Communications

Functional Area

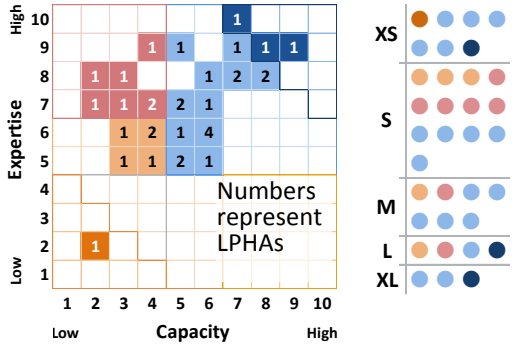


Local public health authorities shall engage with the OHA Public Health Division when an outbreak or significant public health risk is identified to determine the scope of the health risk and all potential populations impacted (i.e., neighborhood or county-level risk versus statewide risk). Based on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

Role



LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

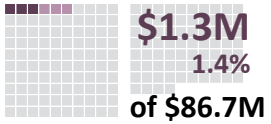
Population by Level of Service *n=3,900,343*

Population in Poverty by Level of Service *n=684,861*

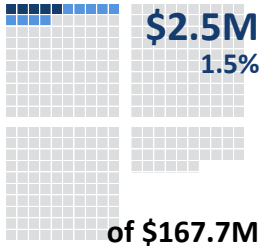
RESOURCES

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

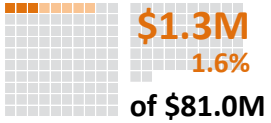
Current Spending



Full Implementation



Additional Increment



COMMUNICATIONS FUNCTIONAL AREA 3:

Educational Communications

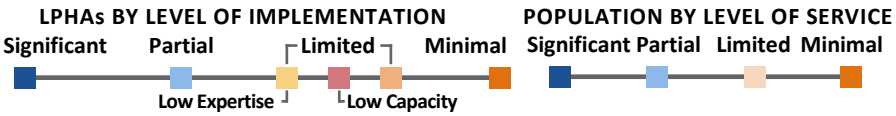
This is the final of 3 functional areas that describes how local *Communications* activities are operationalized is ***Educational Communications***, which is defined as developing and implementing educational programs and preventive strategies. No specific roles and deliverables are included in this functional area; however, as a cross-cutting capability it is likely that this functional area supports educational communications for many of the foundational programs.

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

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

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

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



	Functional Area									
Educational Communications	9%	53%	21%	15%	3%	18%	55%	26%		

POLICY AND PLANNING

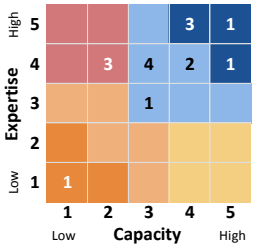
The public health system will implement policies, systems and environmental changes that meet the community's changing needs and align with state and federal policies that aim to eliminate health disparities, reduce leading causes of death and disability and improve health outcomes for all people in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

PUBLIC HEALTH DIVISION

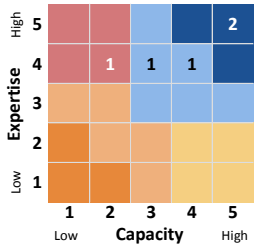
LEVEL OF IMPLEMENTATION

Partially Implemented

ROLES



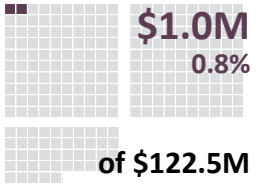
DELIVERABLES



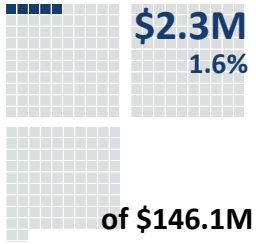
RESOURCES

Each Square Equals $500,000

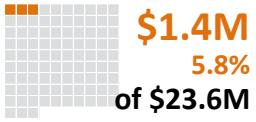
Current Spending



Full Implementation



Additional Increment



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

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

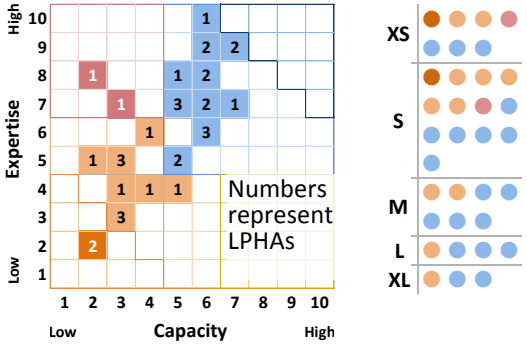
The state has identified that most of its roles and deliverables that specifically support LPHAs are significantly implemented. However, there are 3 roles that directly support the provision of local *Policy and Planning* activities that are less than significantly implemented; they are:

- Coordinate state and local public health policy agendas and support local public health positions on legislation where appropriate. (Partially implemented.)
- Make information and state health data readily available to community members. (Limitedly implemented, low capacity.)
- Make available economic analyses (e.g. cost/risk of non-investment, return on investment) for proposed policy changes at the state or local level. (Minimally implemented.)

While this final role does not directly identify LPHAs as its beneficiary, LPHAs are more likely to interface with residents seeking this data, which means LPHAs are likely shouldering some of this burden for PHD at this time.

LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

56% | 38% | 6%

Population by Level of Service *n=3,900,343*

63% | 35% | 2%

Population in Poverty by Level of Service *n=684,861*

59% | 39% | 2%

RESOURCES

Each Square Equals $500,000

Current Spending

$3.5M
4.0%
of $86.7M

Full Implementation

$7.3M
4.4%
of $167.7M

Additional Increment

$3.8M
4.7%
of $81.0M

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

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

Local *Policy and Planning* activities are grouped into 3 functional areas:

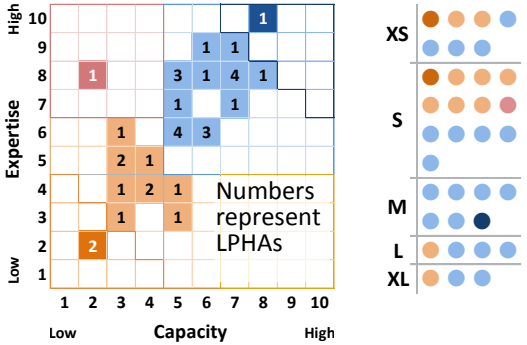
1. **Develop and Implement Policy.** This area represents 36% of current local *Policy and Planning* activities; its share of local *Policy and Planning* activities would decrease to 35% at full implementation.
2. **Improve Policy with Evidence Based Practice.** This area represents 31% of current local *Policy and Planning* activities, and would increase nominally to 32% at full implementation.
3. **Understand Policy Results.** This area represents 33% of current local *Policy and Planning* activities. This share is expected to nominally increase to 34% at full implementation.

Each of these functional areas has varied levels of implementation across the system, and seems to be more implemented in larger LPHAs.

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

Following, we have provided profiles like this page for each of these 3 functional areas.

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

3% 59% 32% 6%

Population by Level of Service *n=3,900,343*

2% 66% 30% 2%

Population in Poverty by Level of Service *n=684,861*

2% 62% 34% 2%

RESOURCES

Each Square Equals $500,000

Functional Area Only

Total Foundational Capability

Current Spending

$1.2M
1.4%
of $86.7M

Full Implementation

$2.5M
1.5%
of $167.7M

Additional Increment

$1.3M
1.6%
of $81.0M

POLICY AND PLANNING FUNCTIONAL AREA 1:

Develop and Implement Policy

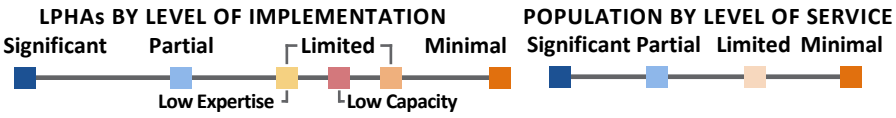
Develop and Implement Policy is 1 of 3 functional areas that together describes local *Policy and Planning* activities. The activities in the *Develop and Implement Policy* functional area include 8 roles and 3 deliverables. This functional area supports development of a policy strategy for the LPHA, development of policy concepts, and coordination with the state and partners on policy agendas.

This functional area represents 36% of current local *Policy and Planning* activities and the addition of 104% more funding ($1.3M) would allow LPHAs to reach full implementation.

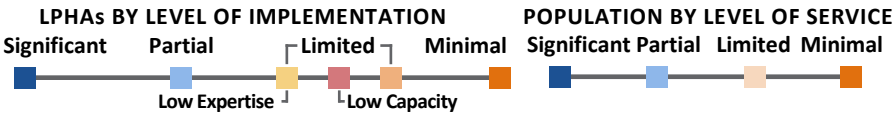
While the level of implementation of this functional area varies across the system, there is a clear pattern as to which LPHAs are at each level of implementation. The majority of medium, large, and extra-large LPHAs have partially or significantly implemented this functional area, while the majority of limitedly or minimally implemented LPHAs are small or extra-small.

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

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

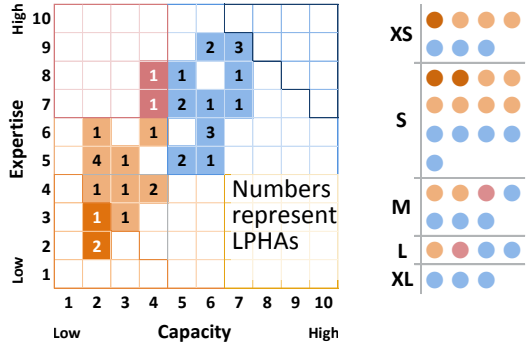


Develop and Implement Policy	*Functional Area*	LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
		3% 59% 3% 29% 6%	2% 66% 30% 2%
Interpret, respond to, and implement federal, state, and local policy changes. Coordinate enforcement of federal and state policy and regulatory activities when delegated to do so.	*Role*	18% 71% 12%	22% 75% 3%
Monitor and respond to state and local public health issues that impact local authorities and, upon request, participate in policy initiatives that include multiple authorities.	*Role*	3% 71% 6% 12% 9%	2% 84% 11% 2%
Assume a leadership role and coordinate with the state on policy initiatives, such as: coordination on policies that impact health; coordination of enforcement of Federal, state, and local policy and regulate activities; and sharing information about implementation of public health best practices or innovative strategies.	*Role*	3% 41% 6% 32% 18%	14% 56% 25% 5%
Use information from the community health assessment to develop and revise the community health improvement plan (CHIP) at least every five years. The CHIP may be built around components of the state health improvement plan (SHIP), but also may include health issues that are of specific concern to an authority.	*Role*	26% 44% 12% 18%	31% 31% 37%
Work with the Oregon Legislature to provide high quality bill analyses, testimony and data and information as requested by lawmakers.	*Role*	3% 50% 6% 24% 18%	2% 61% 29% 9%
Develop policy, systems, and environmental change strategies to improve health outcomes, using an established policy change framework.	*Role*	6% 38% 6% 32% 18%	49% 45% 6%
Develop policy concepts, as appropriate, for public health issues to be addressed by city and county governments in the authority.	*Role*	6% 35% 15% 29% 15%	3% 42% 50% 5%
Develop a strategic policy plan for the authority that includes specific strategies to reduce or eliminate health disparities. A strategic policy plan is a document that identifies and guides the strategic policy priorities and policy goals for the authority and can align with other local public health plans (e.g. CHIP or strategic plan), but can also include policy goals not related to other plans, if appropriate. This plan must be reviewed and updated at least once a year.	*Role*	3% 29% 9% 24% 35%	2% 19% 61% 18%

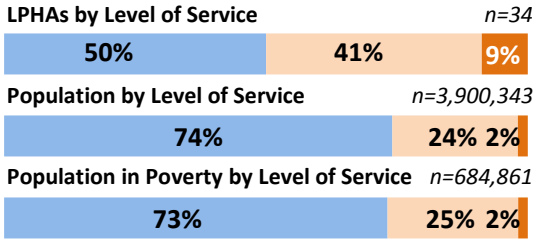


Develop and Implement Policy	*Functional Area*	3% 59% 3% 29% 6%	2% 66% 30% 2%
Develop, implement, monitor, evaluate, and modify a community health improvement plan at least every five years that is built on the community health assessment and considers the state health improvement plan where appropriate.	*Deliverable*	24% 56% 21%	30% 45% 25%
Develop and implement a strategic policy plan for the authority that is coordinated with the community health improvement plan and other state and local plans where appropriate. The strategic plan must be reviewed and updated at least annually.	*Deliverable*	9% 59% 3% 18% 12%	12% 55% 6% 27%
Develop and amend rules and regulations necessary to implement state and local statutes or ordinances or Federal statutes, rules, or regulations.	*Deliverable*	12% 47% 24% 18%	26% 29% 36% 9%

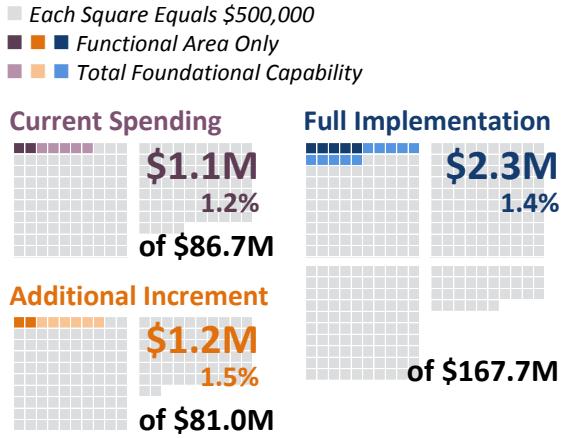
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



POLICY AND PLANNING FUNCTIONAL AREA 2:

Improve Policy with Evidence Based Practice

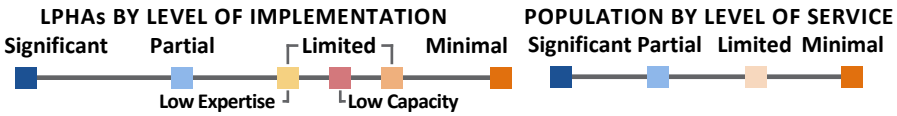
Improve Policy with Evidence Based Practice is the second of 3 functional areas that together describes local *Policy and Planning* activities. There is 1 role included in the *Improve Policy with Evidence Based Practice* functional area and no deliverables. This activity enables LPHAs to serve as primary and expert resources for using science- and evidence-based best practices to inform the development and implementation of public health policies.

This functional area is not highly implemented across the system. Approximately half of LPHAs are partially implemented, while the other half are only limitedly or minimally implemented. It is notable that no LPHAs identified that they had significantly implemented this functional area. This could be because this is a proactive capability that requires adequate resources in other, more reactive public health activities before funding can be allocated to improving policy.

While half of LPHAs are significantly implemented, three-quarters of residents live in a service area where these activities are present on at least a limited basis. This skew is likely because all 3 extra-large LPHAs scored themselves as partially implemented.

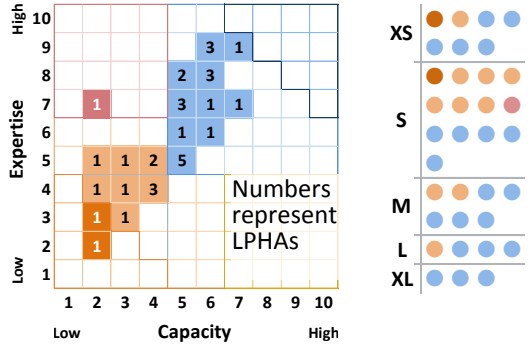
The *Improve Policy with Evidence Based Practice* functional area includes only 1 role; however cross-cutting capabilities support the foundational programs, so it is likely that many LPHAs are improving policies in other foundational capability and program areas based on evidence-based practice.

The level of implementation for the 1 role across LPHAs as well as the level of service across Oregon's population is provided on the following page.

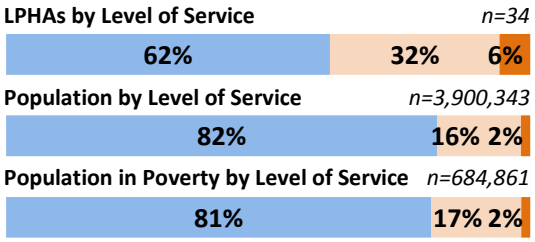


Improve Policy with Evidence Based Practice	*Functional Area*	50% / 6% / 35% / 9%	74% / 24% / 2%
Coordinate with the state on development of economic analyses (e.g. analysis of cost/risk of non-investment return on investment) for proposed policy changes in the authority.	*Role*	21% / 26% / 53%	10% / 17% / 73%

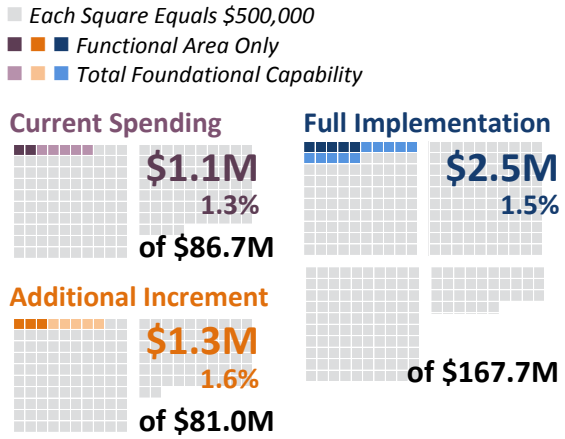
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



POLICY AND PLANNING FUNCTIONAL AREA 3:

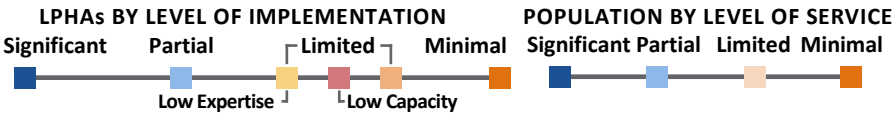
Understand Policy Results

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

Currently, while the level of implementation of this functional area varies across the system, it seems that medium, large, and extra-large LPHAs are more likely to be partially implemented. It is notable that no LPHAs identified that they had significantly implemented this functional area. This could be because this is a proactive capability that requires adequate resources in other, more reactive public health activities before funding can be allocated to improving policy.

There is a similar pattern in implementation by size as the previous functional area – a lower percentage of LPHAs at partial implementation relative to residents living in service areas where this functional area is partially implemented. While it is less pronounced in this functional area, it is again likely because all 3 extra-large LPHAs scored themselves as significantly implemented.

The activities included in the ***Understand Policy Results*** functional area include 5 roles and 2 deliverables. The level of implementation of each of these roles and deliverables is fairly consistent across local LPHAs, as shown on the following page.



Understand Policy Results	*Functional Area*	LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
		62%	3%	29%	6%	82%	16%	2%	
Make information and community health data readily available to community members.	*Role*	18%	56%	6%	15%	6%	9%	81%	10%
Identify and convene strategic partners, as needed.	*Role*	26%	59%	3%	12%		21%	67%	12%
Assume a leadership role for communicating with the community about how policy changes may impact health.	*Role*	9%	50%	3%	32%	6%	7%	49%	42%	3%
Make intentional efforts to engage priority/focal populations and their partner organizations.	*Role*	15%	50%	9%	26%		8%	43%	49%	
Engage traditional and nontraditional partners in conversations about efforts to improve health outcomes.	*Role*	15%	59%	18%	9%		17%	56%	25%	2%
Make information about the community health improvement plan available to the public at least annually. This may include updating information on the local public health authority's website.	*Deliverable*	21%	59%	9%	12%		31%	60%	9%	
Share information with the governing body (e.g. Board of Commissioners or sub designee) to whom the local health authority is accountable about progress on the community health improvement plan at least twice a year.	*Deliverable*	12%	62%	9%	15%	3%	17%	66%	14%	3%

LEADERSHIP AND ORGANIZATIONAL COMPETENCIES

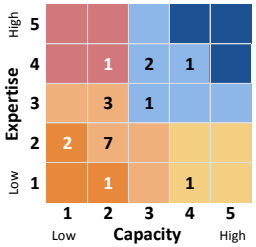
Provide team-based leadership within public health departments at the state and local level that defines strategic direction necessary to achieve public health goals including health equity and lead stakeholders in achieving those goals.

PUBLIC HEALTH DIVISION

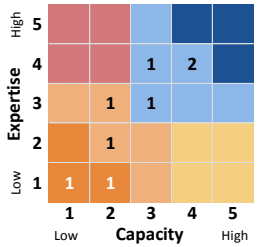
LEVEL OF IMPLEMENTATION

Limitedly Implemented

ROLES



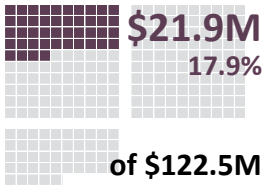
DELIVERABLES



RESOURCES

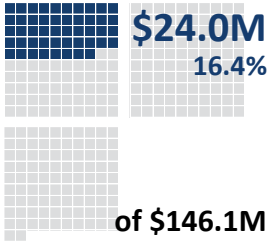
Each Square Equals $500,000

Current Spending



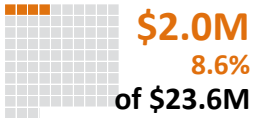
$21.9M
17.9%
of $122.5M

Full Implementation



$24.0M
16.4%
of $146.1M

Additional Increment



$2.0M
8.6%
of $23.6M

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

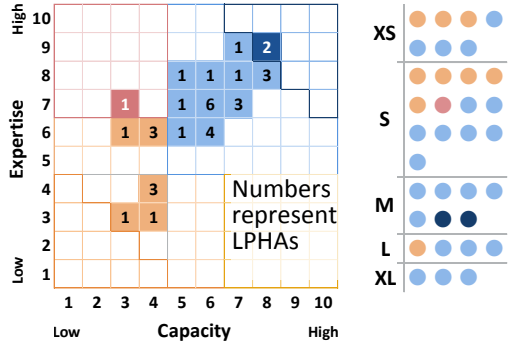
PHD's self-assessment shows that it considers this foundational capability to be only limitedly implemented. PHD reported generally high levels of implementation in *Leadership and Governance* and lower implementation in the public health modernization activities of *Human Resources* and *Information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

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

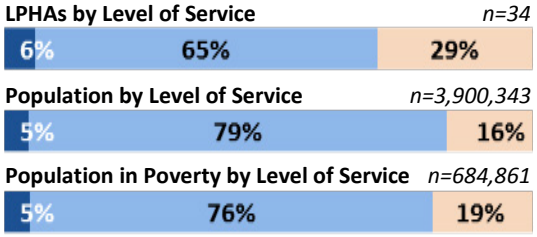
- Provide guidance, training, and technical assistance to local and tribal authorities to promote and protect the health of all Oregonians. (Partially implemented.)
- Convene local health and tribal authorities to create opportunities to work together to improve the health of the community. (Limitedly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

LOCAL PUBLIC HEALTH AUTHORITIES

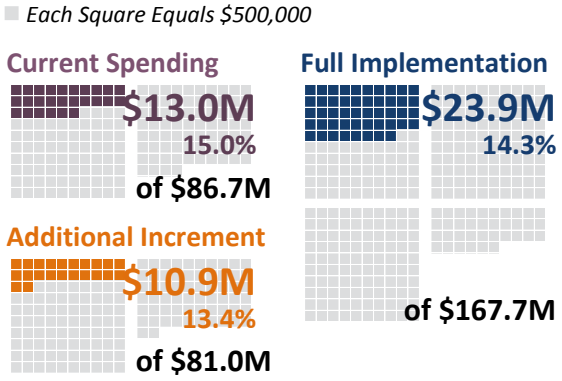
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



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

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

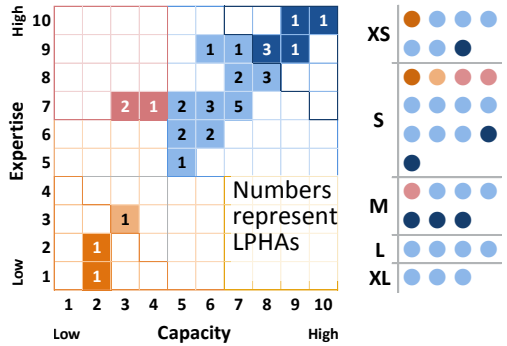
Taken together with the programmatic self-assessment findings, the large amount (84%) of additional spending needed to reach full implementation suggests that the increase from significantly implemented to fully implemented has higher marginal costs than the initial activities needed to reach significant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

Local *Leadership and Organizational Competencies* activities are broken down into 5 functional areas:

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

Following are profiles for each of these 5 functional areas. However, unlike the functional areas for other foundational programs and capabilities, LPHAs were not asked to estimate resource needs for each functional area and are presented for the overall foundational capability.

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

Population by Level of Service *n=3,900,343*

Population in Poverty by Level of Service *n=684,861*

RESOURCES

LPHAs estimated the current level of spending and full implementation resources needed to support the State Public Health Laboratory as part of the Leadership and Organizational Competencies capability as a whole. LPHAs were not required to estimate resource needs for each functional area.

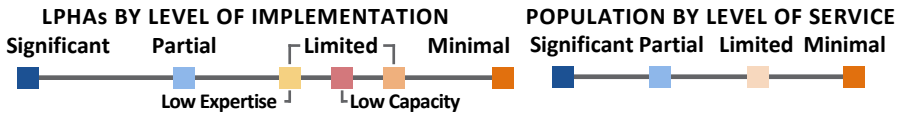
LEADERSHIP AND ORGANIZATIONAL COMPETENCIES FUNCTIONAL AREA 1:

Leadership and Governance

Leadership and Governance is the first of 5 functional areas that describes local Leadership and Organizational Competencies activities. These activities include 3 roles and 2 deliverables. *Leadership and Governance* activities help to define the strategic direction necessary to achieve public health goals, and align and lead stakeholders in achieving goals.

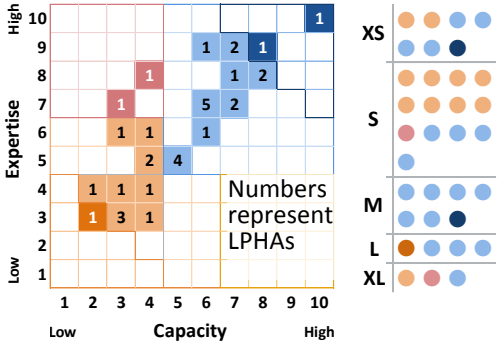
This functional area is well implemented with more than 80% of LPHAs reporting partial or significant implementation covering 95% of the residents of Oregon.

The level of implementation of the 2 deliverables in this functional area across LPHAs as well as the level of service across Oregon's population is provided on the following page. Due to an oversight, the 3 roles in this functional area were not included in the self-assessment survey.



		LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
Leadership and Governance	*Functional Area*	18% 65% 9% 3% 6%	9% 86% 4% 1%
Evidence of engagement with appropriate governing entity about public health's legal authorities and what new legislative concepts, laws, and policies may be needed.	*Deliverable 1*	9% 68% 3% 9% 12%	19% 74% 4% 3%
Evidence of engagement in health policy development, discussion and adoption with the OHA Public Health Division to define a strategic plan for public health initiatives.	*Deliverable 2*	12% 44% 9% 24% 12%	21% 53% 15% 10%

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

Population by Level of Service *n=3,900,343*

Population in Poverty by Level of Service *n=684,861*

RESOURCES

LPHAs estimated the current level of spending and full implementation resources needed to support the State Public Health Laboratory as part of the Leadership and Organizational Competencies capability as a whole. LPHAs were not required to estimate resource needs for each functional area.

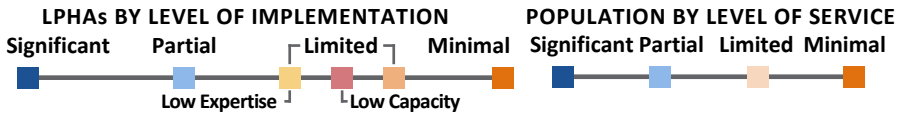
LEADERSHIP AND ORGANIZATIONAL COMPETENCIES FUNCTIONAL AREA 2:

Performance Management, Quality Improvement, and Accountability

Performance Management, Quality Improvement, and Accountability is the second of 5 functional areas within *Leadership and Organization Competencies.* This functional area includes using the principles of public health law, including relevant agency rules and the constitutional guarantee of due process, in planning, implementing, and enforcing public health initiatives.

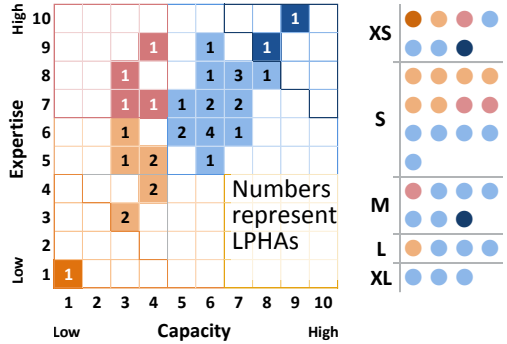
This functional area includes activities that are generally implemented, as reported by LPHAs, but as a whole this area has service gaps, with only two LPHAs reporting significant implementation. Limited and partial implementation were reported by all LPHAs with populations between 50,000 and 150,000, with greater service gaps in small and extra-large jurisdictions.

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



		LPHAs BY LEVEL OF IMPLEMENTATION					POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Limited	Low Expertise	Low Capacity	Significant	Partial	Limited	Minimal
Performance Management, Quality Improvement, and Accountability	*Functional Area*	6%	53%	6%	32%	3%	3%	49%	39%	9%
Use principles of public health law, agency rules, and constitutional guarantee of due process to plan, implement and enforce public health orders.	*Role 1*	18%	59%	3%	18%	3%	22%	70%		7%
Use performance management, quality improvement tools and coaching to promote and monitor organizational objectives and sustain a cultural of quality.	*Role 2*	9%	62%	12%	12%	6%	17%	65%		18%
Ensure the management of organizational change (e.g., refocusing a program or an entire organization, etc.)	*Role 3*	15%	68%	3%	6%	9%	20%	57%		23%
Implementation of a performance management system to monitor achievement of public health objectives using nationally recognized framework and quality improvement tools and methods.	*Deliverable 1*	9%	47%	3%	15%	26%	23%	38%	6%	33%

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

6%	56%	35%	3%

Population by Level of Service *n=3,900,343*

2%	78%	20%

Population in Poverty by Level of Service *n=684,861*

2%	75%	22%

RESOURCES

LPHAs estimated the current level of spending and full implementation resources needed to support the State Public Health Laboratory as part of the Leadership and Organizational Competencies capability as a whole. LPHAs were not required to estimate resource needs for each functional area.

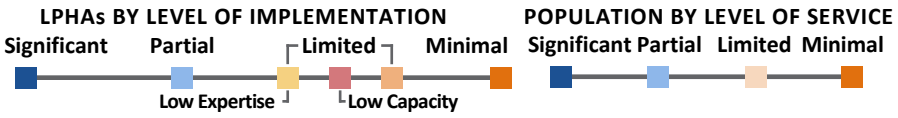
LEADERSHIP AND ORGANIZATIONAL COMPETENCIES FUNCTIONAL AREA 3:

Human Resources

Human Resources is the third of 5 functional areas within *Leadership and Organization Competencies.* This functional area includes maintaining a competent workforce necessary to ensure the effective and equitable provision of public health services.

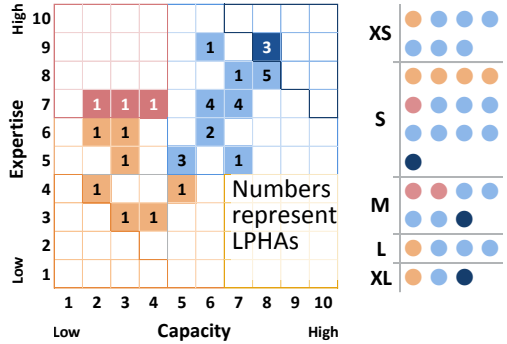
Approximately two-thirds of LPHAs report implementing the activities that make up the *Human Resources* functional area. Currently, the level of implementation of this functional area varies across the system, with the minimally and limitedly implemented jurisdictions slightly concentrated in those with smaller populations.

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



		LPHAs BY LEVEL OF IMPLEMENTATION					POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Low Expertise	Low Capacity	Minimal	Significant	Partial	Limited	Minimal
Human Resources	*Functional Area*	6%	56%	12%	24%	3%	2%	78%		20%
Develop and implement a workforce development plan that identifies needed technical and/or informatics skills, competencies and/or positions. The plan should include strategies for recruiting, hiring and/or developing existing staff to meet the needs.	*Role 1*	3%	53%	12%	24%	9%		70%	28%	2%
Coordinate, or convene when necessary, efforts to assess leadership and organizational capabilities within their local authority to understand capacity and to identify gaps.	*Role 2*	9%	68%		12%	12%	15%	51%	30%	4%
Ensure nimble human resources support for public health work, including composition and maintenance of up-to-date job classifications suitable for the above listed roles and activities, use of temporary staffing and other methods to expand and contract staff to meet immediate public health demands.	*Role 3*	6%	44%	18%	24%	9%	3%	62%	34%	2%
Ensure a high quality public health workforce by promoting workforce development and capacity building and assure a future public health workforce by building relationships with public health programs in higher education.	*Role 4*	9%	59%		12%	18% 3%	19%	34%	46%	
Collaborate and share workforce development planning resources with the state, tribal and other local authorities.	*Role 5*	3%	47%	6%	29%	15%	1%	44%	33%	23%
Assessment of staff competencies; the provision of individual training and professional development and the provision of a supportive work environment.	*Deliverable 1*	12%	59%	6%	18%	6%	23%	37%	38%	2%

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

9%	62%	29%

Population by Level of Service *n=3,900,343*

17%	47%	36%

Population in Poverty by Level of Service *n=684,861*

13%	45%	41%

RESOURCES

LPHAs estimated the current level of spending and full implementation resources needed to support the State Public Health Laboratory as part of the Leadership and Organizational Competencies capability as a whole. LPHAs were not required to estimate resource needs for each functional area.

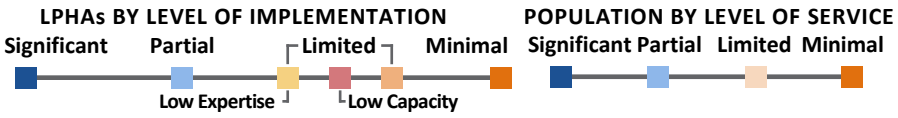
LEADERSHIP AND ORGANIZATIONAL COMPETENCIES FUNCTIONAL AREA 4:

Information Technology

Information Technology is the fourth of 5 functional areas within *Leadership and Organization Competencies.* This functional area includes implementing and maintaining the technology needed to support public health operations while simultaneously protecting personally identifiable information and other confidential health information.

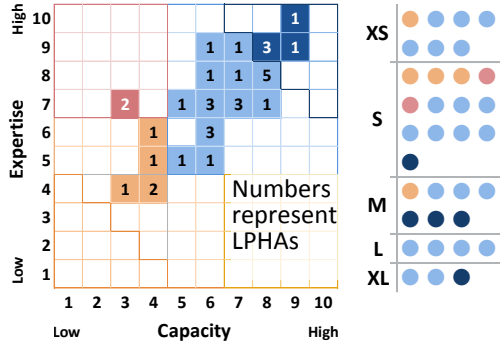
LPHAs assess their overall implementation level as relatively high, with 70% reporting partial or significant implementation. The functional area *Information Technology* has the least implemented roles and deliverables within the *Leadership and Organizational Competences*. Implementation does not have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

The activities included in the *Information Technology* functional area include 3 roles and 2 deliverables. With the exception of ensuring the privacy of health information, which all LPHAs reported as being significantly or fully implemented, more than half of Oregon's population live in service areas with significant service gaps. The level of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.

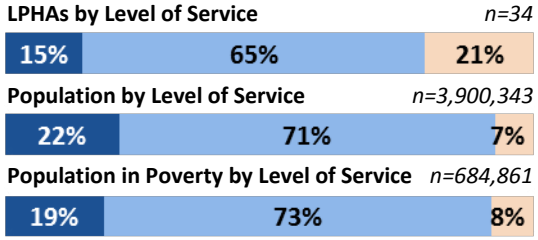


		LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
Information Technology	*Functional Area*	Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
		9%	62%	9%	21%	17%	47%	36%	
Ensure privacy and protection of personally identifiable and/or confidential health information in data systems and information technology.	*Role 1*	44%	56%			43%	57%		
Develop and maintain local public health technology and resources to support current and emerging public health practice needs. Document that information technology	*Role 2*	3%	53%	12%	21%	12%	39%	57%	3%
In collaboration with health systems and other partners, use the information assets/needs assessment to develop and implement a vision and strategic plan. The plan should include a funding strategy and appropriate governance processes to address information management and supportive information systems.	*Role 3*	9%	35%	9%	24%	24%	2%	30%	44%	24%
Implementation of a current, interoperable technology that meets current and future public health practice needs and maintenance of those resources. Assurance that technology systems and technology resources are sufficient to support current and future local public health practice needs and ability to maintain those systems.	*Deliverable 1*	56%	3%	21%	21%	44%	41%	15%	
Implementation of a technical support plan that provides users of local public health technology systems and technology resources with appropriate training.	*Deliverable 2*	3%	50%	6%	21%	21%	34%	39%	27%

LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES

LPHAs estimated the current level of spending and full implementation resources needed to support the State Public Health Laboratory as part of the Leadership and Organizational Competencies capability as a whole. LPHAs were not required to estimate resource needs for each functional area.

LEADERSHIP AND ORGANIZATIONAL COMPETENCIES FUNCTIONAL AREA 5:

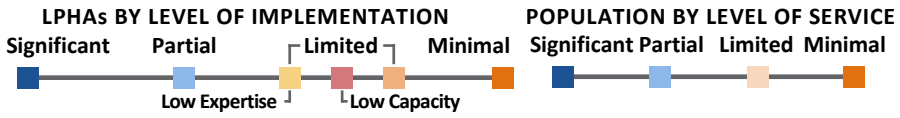
Financial Management, Contracts and Procurement Services, and Facility Operations

Financial Management, Contracts and Procurement Services, and Facility Operations is the final of 5 functional areas within *Leadership and Organization Competencies.* This functional area includes using accounting and business best practices in budgeting, tracking finances, billing, auditing, securing grants, and other source of funding and distributing monies to governmental and non-governmental partners.

This functional area is well implemented across the system – almost 80% of LPHAs report partial or significant implementation of the activities required. Of the 6 LPHAs that reported limited implementation, all but 1 are jurisdictions with less than 40,000 residents.

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

The *Financial Management, Contracts and Procurement Services, and Facility Operations* functional area has 2 roles and 1 deliverable. The level of implementation of these roles and deliverables across LPHAs as well as the level of service across Oregon's population is provided on the following page.



		LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Limited	Minimal	Significant	Partial	Limited	Minimal
Financial Management, Contracts and Procurement Services, and Facility Operations	*Functional Area*	15%	65%	6%	15%	22%	71%		7%
Ensure use of financial analysis methods to make decisions about policies, programs and services and ensure that all are managed within current and projected budgets.	*Role 1*	18%	56%	3%	15%	9%	27%	47%	20%	6%
Work with partners to seek and sustain funding for additional public health priority work.	*Role 2*	15%	47%	9%	18%	12%	39%	32%	27%	3%
Policies and procedures that protect personally identifiable and/or confidential health information.	*Deliverable 1*	50%	47%		3%		73%		26%	

HEALTH EQUITY AND CULTURAL RESPONSIVENESS

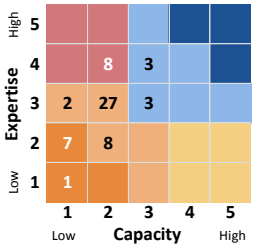
Ensure the equal opportunity to achieve the highest attainable level of health for all populations through implementation of policies, programs, and strategies that respond to the factors within culture that impact health and seek to correct historic injustices borne by certain populations. Make development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

PUBLIC HEALTH DIVISION

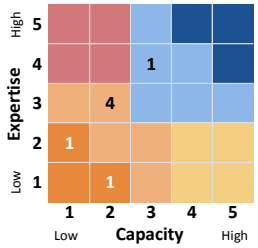
LEVEL OF IMPLEMENTATION

Limitedly Implemented

ROLES



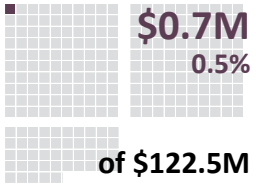
DELIVERABLES



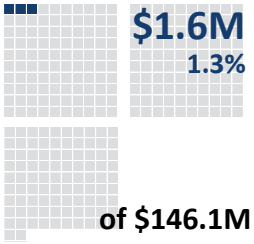
RESOURCES

Each Square Equals $500,000

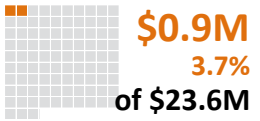
Current Spending



Full Implementation



Additional Increment



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

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

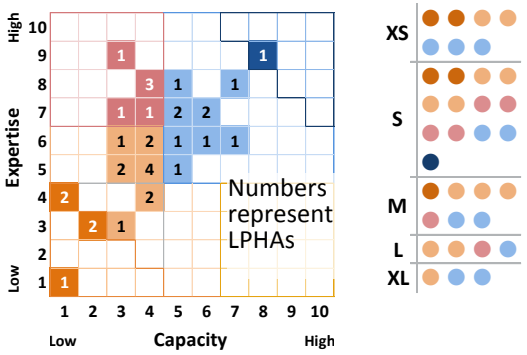
A few of the less than significantly implemented roles and deliverables are state activities that directly support the provision of local *Health Equity and Cultural Responsiveness* activities. These include:

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

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

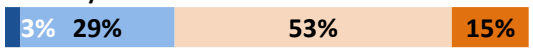
LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION



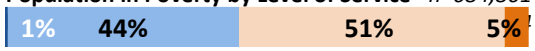
LEVEL OF SERVICE

LPHAs by Level of Service *n=34*



Population by Level of Service *n=3,900,343*

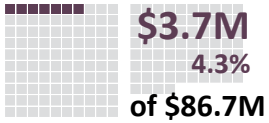
Population in Poverty by Level of Service *n=684,861*



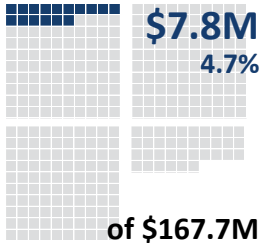
RESOURCES

Each Square Equals $500,000

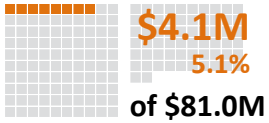
Current Spending



Full Implementation



Additional Increment



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

This foundational capability is not generally implemented across the state. Out of 34 LPHAs, 11 reported partial or significant implementation. Overall minimal implementation of the activities outlined in *Health Equity and Cultural Responsiveness* capability was reported by 5 LPHAs.

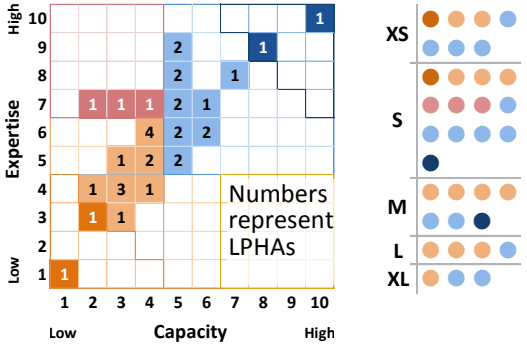
There are no clear patterns in implementation by population size, and overall, 55% of the population live in areas with significant service gaps within this foundational capability.

Local *Health Equity and Cultural Responsiveness* activities are broken down into 2 functional areas:

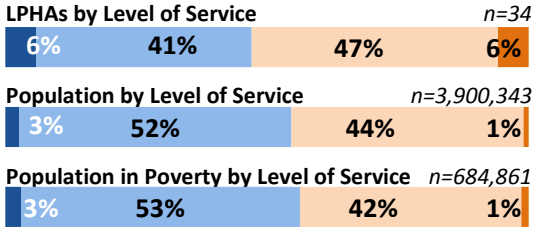
1. **Foster Health Equity.** This functional area represents 61% of current local *Health Equity and Cultural Responsiveness* spending; its share of local *Health Equity and Cultural Responsiveness* activities would decrease to 54% at significant implementation.
2. **Communicate and Engage Inclusively.**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

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

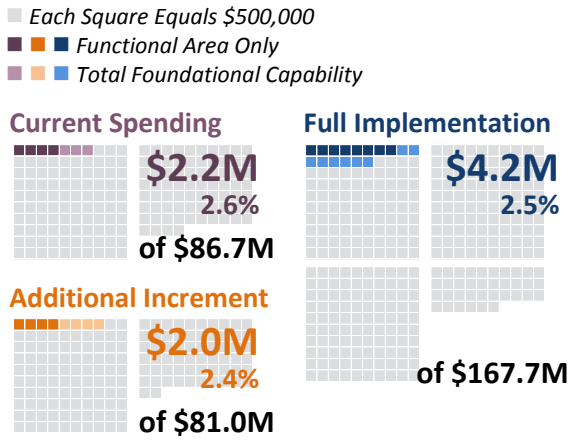
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



EQUITY AND CULTURAL RESPONSIVENESS FUNCTIONAL AREA 1:

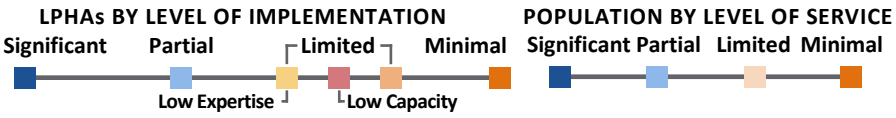
Foster Health Equity

This is first of 2 functional areas that describes how local *Health Equity and Cultural Responsiveness* activities are operationalized. The activities in the ***Foster Health Equity*** functional area include 44 roles and 6 deliverables. The functional area covers supporting health policies and implementing processes that promote health equity, and engaging with the community to identify and eliminate health inequities. In addition, the functional area includes recognizing and addressing health inequities specific to certain populations.

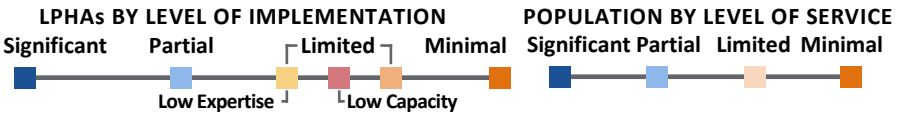
This functional area represents 61% of current local *Health Equity and Cultural Responsiveness Activities*; its share of activities would decrease to 54% with the addition of 88% more funding ($2.0M) to reach significant implementation.

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

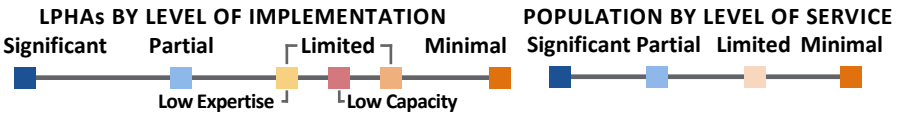
The level of implementation of these roles and deliverables across local authorities and population by level of service are provided on the following pages.



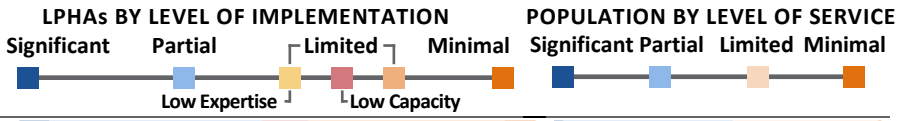
Foster Health Equity	*Functional Area*	LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
		Significant / Partial / Limited / Minimal	Significant Partial / Limited / Minimal
	Functional Area	6% 41% 9% 38% 6%	3% 52% 44%
Provide public health services that are effective, equitable, understandable, respectful, and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	*Role*	15% 71% 12% 3%	7% 80% 13%
Collect and maintain data, or use data provided by the OHA Public Health Division, that reveal inequities in the distribution of disease. Focus on information that characterizes the social conditions (including strengths, assets, and protective factors) under which people live that influence health.	*Role*	3% 53% 24% 9% 12%	80% 15% 4%
Ensure health equity and cultural responsiveness are fully integrated in local strategic priorities and plans, including community health improvement plans.	*Role*	9% 53% 6% 26% 6%	31% 48% 21%
Develop and promote shared understanding of the determinants of health, health equity and lifelong health with local partners and the community.	*Role*	3% 62% 6% 21% 9%	2% 76% 20% 2%
Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic wellbeing, and environmental quality) with local partners, or use information collected and provided by the OHA Public Health Division.	*Role*	3% 50% 15% 18% 15%	75% 20% 4%
Identify local population subgroups or geographic areas characterized by (i) either an excess burden of adverse health or socioeconomic outcomes; (ii) an excess burden of environmental health threats; and (iii) inadequacies in health resources that affect human health (e.g., quality parks and schools).	*Role*	3% 44% 15% 24% 15%	70% 24% 5%
Work collaboratively with the OHA Public Health Division on state and local policies, programs and strategies intended to assure health equity.	*Role*	6% 56% 12% 15% 12%	3% 67% 20% 10%
Partner to enhance multi-disciplinary and multi-sector capacity to address health equity. Support health equity in all policies.	*Role*	12% 41% 12% 26% 9%	4% 63% 23% 10%
Advocate for comprehensive policies that improve physical, environmental, social, and economic conditions in the community that affect the public's health.	*Role*	3% 56% 9% 18% 15%	2% 65% 25% 8%
Develop or use an existing assessment of and training to improve staff knowledge and capabilities about health inequity.	*Role*	6% 56% 3% 26% 9%	16% 51% 32% 1%
Develop or use an existing anti-discrimination training as part of building a competent workforce.	*Role*	9% 65% 24% 3%	4% 59% 35% 1%
Conduct an internal assessment of the local public health authority's overall capacity to act on the root causes of health inequities, including its organizational structure and culture and its capacity to respond to culture.	*Role*	35% 6% 35% 24%	55% 33% 13%



		LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
Foster Health Equity	*Functional Area*	6%	41%	9%	38%	6%	3%	52%	44%	1%
Promote a common understanding of cultural responsiveness.	*Role*	6%	50%	6%	29%	9%	3%	50%	46%	1%
Stay current with the literature on health equity, synthesize research, and disseminate findings as they are applicable to staff and community.	*Role*		41%	15%	32%	12%		50%	48%	2%
Make available to people data and information on health status and conditions that influence health status by race, ethnicity, language, geography, disability, and income.	*Role*	3%	50%	9%	21%	18%		47%	40%	13%
Play a leadership role in reducing or mitigating social and economic inequities and conditions that exist locally that lead to inequities in the distribution of disease, premature death, and illness.	*Role*	6%	50%	6%	26%	12%	3%	44%	45%	8%
Increase awareness and practice of health equity among hiring managers and supervisors so that sensitivities to and understanding of root causes of health inequities are part of hiring, including willingness to learn, cultural humility, creativity, and listening skills to address cultural dominance.	*Role*	3%	59%	6%	12%	21%	9%	37%	39%	15%
Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improving workplace equity.	*Role*	6%	41%	6%	35%	12%	1%	45%	53%	2%
Leverage health reform funding for health equity and to build cultural responsiveness into health care delivery.	*Role*		38%	6%	29%	26%		46%	39%	15%
Leverage health reform funding for health equity and to build cultural responsiveness into funding mechanisms.	*Role*		35%	6%	26%	32%		43%	36%	21%
Use existing evidence-based measures or develop public health measures of neighborhood conditions, institutional power, and social inequalities that lead to prevention strategies focused on the social and environmental determinants of health.	*Role*	3%	32%	9%	21%	35%		42%	39%	19%
Ensure all local programs integrate achieving health equity as a measureable outcome through cultural responsiveness of staff and program delivery.	*Role*	3%	32%	6%	38%	21%	3%	36%	53%	9%
Make the economic case for health equity, including the value of investment in cultural responsiveness.	*Role*		41%	9%	24%	26%		35%	29%	36%
Promote understanding of the extent and consequence of systems of oppression.	*Role*	6%	26%	3%	38%	26%	3%	28%	37%	32%
Promote public and private investments in community infrastructure to sustain and improve community health, such as education, childhood development, mass transit, employment, healthy design in the built environment, and neighborhood grocery stores.	*Role*	6%	41%	9%	29%	15%	3%	27%	66%	4%

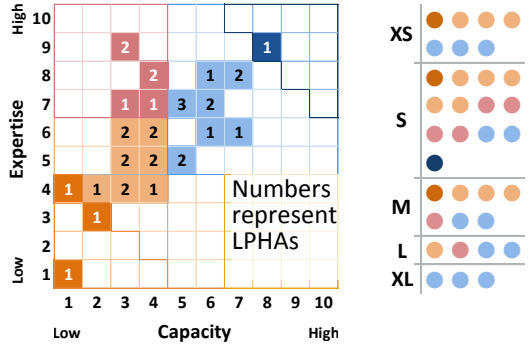


		LPHAs BY LEVEL OF IMPLEMENTATION					POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Limited	Low Expertise	Low Capacity	Significant	Partial	Limited	Minimal
Foster Health Equity	*Functional Area*	6%	41%	9%	38%	6%	3%	52%	44%	1%
Support, implement, and evaluate strategies that tackle the root causes of health inequities, in strategic, lasting partnerships with public and private organizations and social movements.	*Role*	6%	41%	12%	29%	12%	3%	24%	64%	10%
Monitor funding allocations to ensure sustainable impact on health equity.	*Role*	32%		32%		35%	18%		51%	31%
Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities.	*Role*	24%	6%	38%		32%	9%		66%	25%
Increase flexible categorical and non-categorical funding to address health equity.	*Role*	24%	9%	24%		44%	9%		35%	56%
Establish parity goals and create specific metrics with benchmarks to track progress.	*Role*	3%	18%	15%	29%	35%	2%	4%	62%	32%

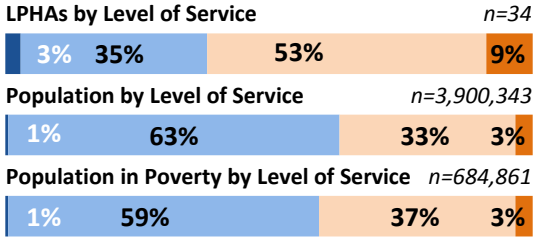


		LPHAs BY LEVEL OF IMPLEMENTATION				POPULATION BY LEVEL OF SERVICE			
		Significant	Partial	Limited	Minimal	Significant Partial	Limited	Minimal	
Foster Health Equity	*Functional Area*	6%	41%	9%	38%	6%	3%	52%	44%
Develop, implement and monitor a community health improvement plan, in collaboratiion with community members and partner organizations.	*Deliverable*	53%		6%	35%	6%	56%		44%
Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of public health policies, programs, and strategies on health equity, health outcomes and to inform public health action moving forward.	*Deliverable*	3%	35%	3%	41%	18%	14%	36%	45% 5%
Develop and implement an annual training plan to increase local public health authority staff capacity to address the causes of health inequities, promote health equity and implement culturally responsive programs.	*Deliverable*	3%	41%	6%	35%	15%	41%	46%	12%
Conduct an internal assessment of the local public health authority's overall capacity to apply a health equity lens to programs and services; overall capacity to provide culturally responsive programming and services; and status of health department's organizational structure and culture as a barrier or facilitator for achieving health equity.	*Deliverable*	44%		12%	26%	18%	30%	66%	4%
Develop an action plan resulting from the internal assessment to ensure an equity lens to policies, programs, and strategies and capacity to provide culturally responsive programming and services. Include internal organizational changes that may be needed to better support a health equity lens and cultural responsiveness.	*Deliverable*	26%	15%	29%	29%		25%	57%	18%

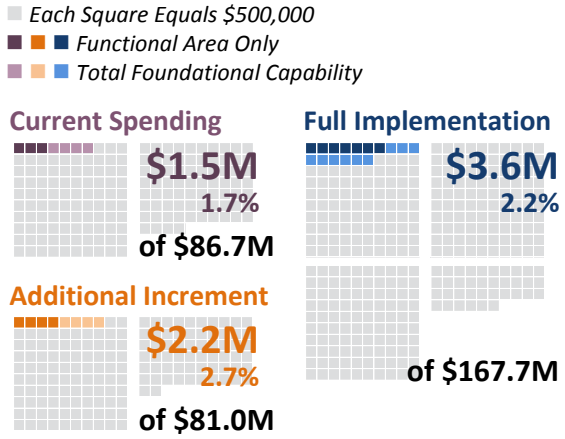
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



HEALTH EQUITY AND CULTURAL RESPONSIVENESS FUNCTIONAL AREA 2:

Communicate and Engage Inclusively

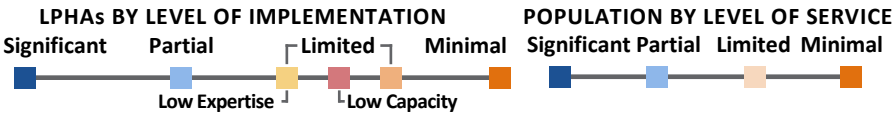
Communicate and Engage Inclusively is the second functional area that describes how local *Health Equity and Cultural Responsiveness* activities are operationalized. The functional area covers communicating with the public and stakeholders in a transparent and inclusive manner, as well as engaging the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

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

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

The activities in the *Communicate and Engage Inclusively* functional area include 14 roles and 1 deliverable. The level of implementation appears higher from a population service perspective: 64% of Oregonians live in a service area where these activities are at least partially implemented.

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



Communicate and Engage Inclusively	*Functional Area*	LPHAs BY LEVEL OF IMPLEMENTATION (Significant / Partial / Limited / Minimal)	POPULATION BY LEVEL OF SERVICE (Significant Partial / Limited / Minimal)
	Functional Area	3% 35% 18% 35% 9%	63% 33% 3%
Engage with community members to learn about the values, needs, and resources of the community in order to effectively prioritize services to address health inequities.	*Role*	15% 41% 18% 21% 6%	22% 51% 27%
Promote community engagement task forces to develop and recommend strategies to engage low-income, racial/ethnic, and disabled community members in government.	*Role*	6% 38% 3% 32% 21%	10% 52% 19% 19%
Involve community members and representatives in planning, procedures, evaluation, and policies. Offer means of engagement that respond to unique cultures.	*Role*	6% 47% 6% 32% 9%	3% 59% 32% 6%
Develop mechanisms for drawing on the skills and knowledge of staff who are members of communities most affected by inequities.	*Role*	6% 44% 12% 24% 15%	3% 54% 35% 8%
Engage in dialogue with people, governing bodies, and officials regarding policies responsible for health inequities and priority issues not yet adequately addressed.	*Role*	6% 38% 6% 35% 15%	3% 38% 51% 8%
Provide clear mechanisms and invitations for community contributions to public health authority planning, procedures, and policies.	*Role*	3% 38% 6% 35% 18%	2% 39% 37% 22%
Learn about the culture, values, needs, concerns, and resources of the community. Respect community knowledge and seek to understand and formally evaluate it.	*Role*	9% 35% 3% 50% 3%	1% 40% 58% 2%
Hire staff with the skills, knowledge, and abilities to take part in community organizing and negotiation and mobilize people, particularly those from communities served.	*Role*	18% 32% 9% 38% 3%	14% 26% 50% 10%
Evaluate and disseminate knowledge of findings and efforts related to health equity (e.g., conduct ongoing assessments of the organization's C LAS-related activities).	*Role*	29% 6% 38% 26%	33% 59% 9%
Increase racial and ethnic representation on councils and committees.	*Role*	3% 44% 41% 12%	31% 63% 5%
Make clear and transparent communications easily available to constituent on issues related to the health of their authority, especially regarding policies and decisions	*Role*	35% 15% 29% 21%	20% 71% 8%
Provide technical assistance to communities with respect to analyzing data, setting priorities, and developing policies, programs, and strategies.	*Role*	6% 24% 18% 29% 24%	12% 8% 69% 11%
Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community Engagement Principles and the National Environmental Justice Advisory Council's community collaboration principles.	*Role*	15% 6% 35% 44%	8% 65% 27%
Promote the analysis of and advocacy for policies and activities that will lead to the elimination of health inequities.	*Role*	21% 9% 35% 35%	7% 69% 24%
Develop, implement and monitor a community health improvement plan, in collaboration with community members and partner organizations.	*Deliverable*	18% 65% 3% 12% 3%	28% 66% 7%

COMMUNITY PARTNERSHIP DEVELOPMENT

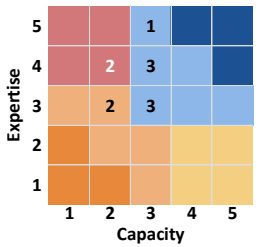
Relationships with diverse partners allow the governmental public health system to define and achieve collaborative public health goals.

PUBLIC HEALTH DIVISION

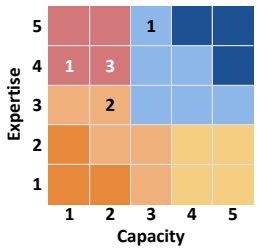
LEVEL OF IMPLEMENTATION

Limitedly Implemented

ROLES



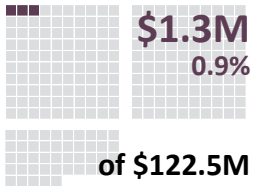
DELIVERABLES



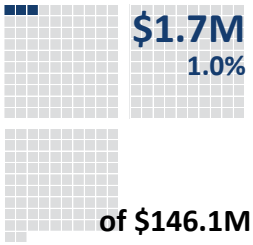
RESOURCES

Each Square Equals $500,000

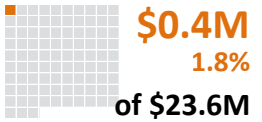
Current Spending



Full Implementation



Additional Increment



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

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

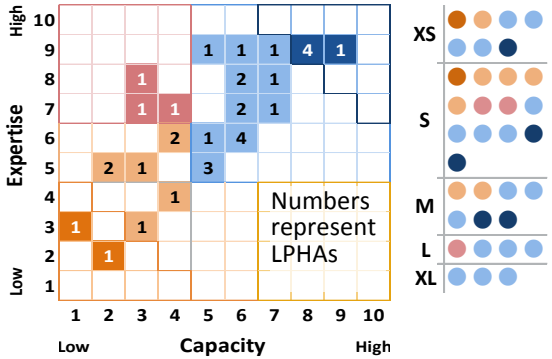
None of these roles and deliverables are significantly implemented. In addition, some of the state activities that directly support local *Community Partnership Development* activities are only minimally or limitedly implemented; these activities include:

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

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

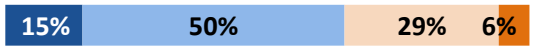
LOCAL PUBLIC HEALTH AUTHORITIES

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

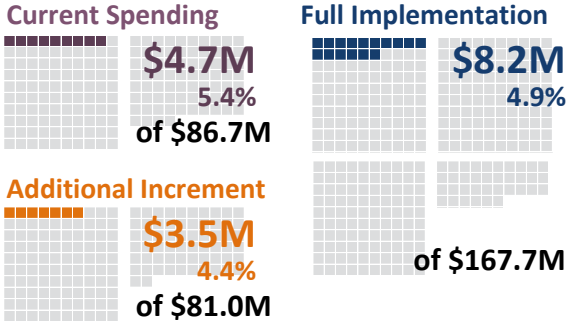


Population by Level of Service *n=3,900,343*

Population in Poverty by Level of Service *n=684,861*

RESOURCES

Each Square Equals $500,000



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

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

Local *Community Partnership Development* activities are broken down into 2 functional areas:

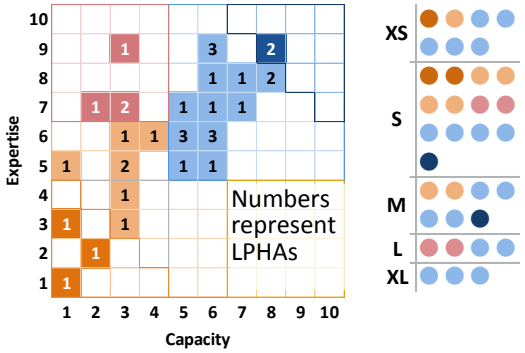
1. **Identify and Develop Partnerships.** This functional area represents 66% of local *Community Partnership Development* activities; its share of local *Community Partnership Development* activities would remain relatively unchanged (65%) at full implementation.
2. **Engage Partners in Policy.** This functional area represents the other one-third (34%) of current local *Community Partnership Development* activities by spending, and will remain approximately the same share of local activities (35%) in this foundational capability at full implementation.

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

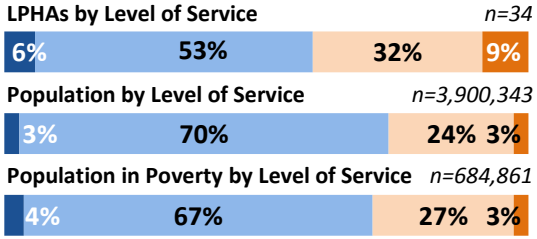
- 58% of Oregon's LPHAs have partially or significantly implemented the *Identify and Develop Partnerships* functional area, serving 74% of Oregon's population.
- 74% of Oregon's LPHAs have partially or significantly implemented the *Engage Partners in Policy* functional area, serving 84% of Oregon's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

Following are profiles like this page for each of the 2 functional areas in this foundational capability.

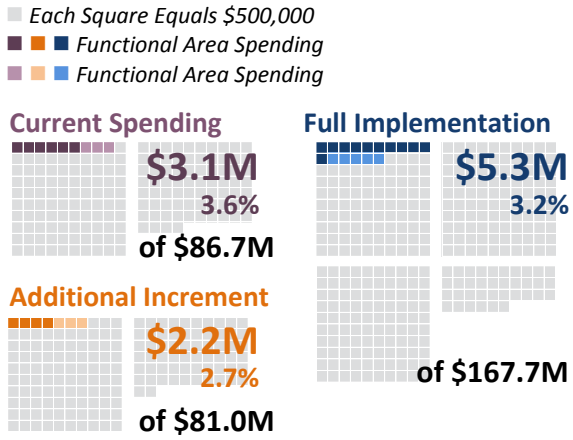
LPHA IMPLEMENTATION



LEVEL OF SERVICE



RESOURCES



COMMUNITY PARTNERSHIP DEVELOPMENT FUNCTIONAL AREA 1:

Identify and Develop Partnerships

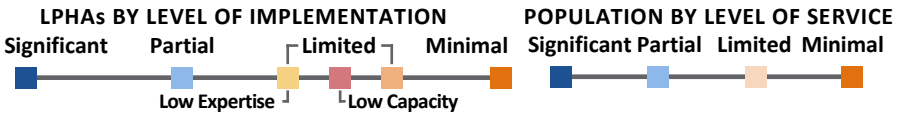
This is the first of 2 functional areas that describes how local *Community Partnership Development* activities are operationalized. The activities in the ***Identify and Develop Partnerships*** functional area include 3 roles and 6 deliverables. The functional area covers convening and sustaining relationships with traditional and nontraditional partners and stakeholders, as well as developing, strengthening, and expanding connections across disciplines.

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

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

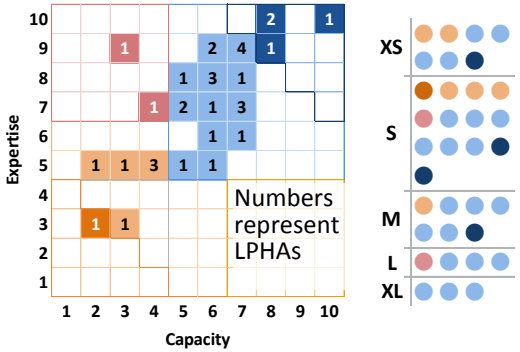
The level of implementation appears higher from a population service perspective: 73% of Oregonians live in a service area where these activities are present (however, there is a meaningful gap in implementation for a large percentage of those roles and deliverables).

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



Identify and Develop Partnerships	*Functional Area*	LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
		6% 53% 12% 21% 9%	3% 70% 24% 3%
Support and maintain cross-sector partnerships with health-related organizations; organizations representing priority/focal populations; private businesses; and local government agencies and non-elected officials.	*Role 1*	18% 68% 3% 9% 3%	8% 87% 5%
Coordinate programmatic activities with those of partner organizations to advance cross-cutting, strategic goals.	*Role 2*	12% 65% 6% 18%	3% 81% 16%
Promote the use of evidence-based strategies to improve population health by providing training, technical assistance, and other forms of support to partners.	*Role 3*	3% 53% 9% 26% 9%	75% 23% 1%
List all community partners involved in local and regional health needs, health impact, and health hazard vulnerability assessments; include descriptions of partners involved, their roles, and contributions to the effort.	*Deliverable 1*	12% 44% 12% 26% 6%	16% 54% 29% 2%
List all key regional health-related organizations with whom the LPHA has developed relationships. Document these efforts, resulting areas of collaboration, and benefits to the public's health resulting from the collaboration in relevant grant progress reports and other summaries of activities.	*Deliverable 2*	12% 47% 12% 24% 6%	16% 51% 33%
The portfolio of cross-sector partnerships should include a description of partnering organizations and how the partnership supports population health. Specifically describe, if at all, how the partnership addresses health disparities.	*Deliverable 3*	9% 44% 15% 26% 6%	15% 50% 34%
List all community groups or organizations representing priority/focal populations the LPHA has developed relationships with so that public health goals are effectively and efficiently attainable for all populations. Address successes, lessons learned, recognized barriers to such collaboration, and strategies to overcome these barriers.	*Deliverable 4*	9% 44% 12% 26% 9%	2% 52% 42% 4%
Document training, technical assistance, and other forms of support provided to partners, along with evaluation if the effectiveness of this support in promoting population health.	*Deliverable 5*	9% 41% 18% 24% 9%	5% 41% 53%
Evaluate reports on the effectiveness of partnerships.	*Deliverable 6*	3% 29% 18% 29% 21%	30% 59% 10%

LPHA IMPLEMENTATION



LEVEL OF SERVICE

LPHAs by Level of Service *n=34*

Population by Level of Service *n=3,900,343*

Population in Poverty by Level of Service *n=684,861*

RESOURCES

Each Square Equals $500,000

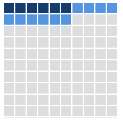
Functional Area Spending

Functional Area Spending

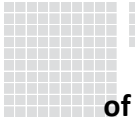
Current Spending

$1.6M
1.8%
of $86.7M

Full Implementation



$2.9M
1.7%



of $167.7M

Additional Increment

$1.3M
1.6%
of $81.0M

COMMUNITY PARTNERSHIP DEVELOPMENT FUNCTIONAL AREA 2:

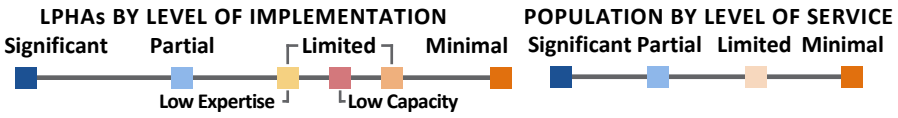
Engage Partners in Policy

This is the second of 2 functional areas that describes how local *Community Partnership Development* activities are operationalized. The activities in the ***Engage Partners in Policy*** functional area include 4 roles and 1 deliverable. The functional area covers fostering and supporting community involvement and partnerships in developing, adopting, and implementing public health policies. Additionally, the functional area includes engaging members of the community in implementing, monitoring, evaluating, and modifying state health improvement plans or community health improvement plans.

This functional area represents about one-third (34%) of current local *Community Partnership Development* activities, and the addition of 83% more funding ($1.3M) would allow LPHAs to reach full implementation. This functional area is more implemented in larger LPHAs. Overall, 25 of 34 LPHAs consider themselves to have partially or significantly implemented this functional area.

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

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



Engage Partners in Policy	*Functional Area*	LPHAs BY LEVEL OF IMPLEMENTATION	POPULATION BY LEVEL OF SERVICE
		Significant / Partial / Limited / Minimal	Significant Partial / Limited / Minimal
		12% / 62% / 6% / 18% / 3%	4% / 80% / 15% / 1%
Ensure that community partners can participate fully in local and state public health planning efforts.	*Role 1*	6% / 59% / 12% / 18% / 6%	3% / 86% / 10% / 2%
Join with partners in health assessments, using their input to develop a community health improvement plan to guide implementation work with partners and to coordinate activities and use of resources.	*Role 2*	21% / 62% / 3% / 12% / 3%	16% / 69% / 14%
Earn and maintain the trust of community residents by engaging them at the grassroots level.	*Role 3*	9% / 62% / 3% / 3% / 21% / 3%	2% / 79% / 19%
Specifically engage priority/focal populations so they can actively participate in planning and funding opportunities to address their communities' needs.	*Role 4*	12% / 38% / 9% / 29% / 12%	4% / 50% / 44% / 3%
Document engagement through meetings, communications or other means with communities disproportionately affected by health issues so they can actively participate in planning and funding opportunities to address their communities' needs.	*Deliverable 1*	9% / 44% / 9% / 26% / 12%	4% / 57% / 36% / 3%

APPENDICES

APPENDIX A: GLOSSARY AND ACRONYMS

Abbreviations/Acronyms

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

Definitions

Term	Definition
Public Health System	All public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction. These systems are a network of entities with differing roles, relationships, and interactions that contribute to the health and well-being of the community or state.
Governmental Public Health System	State and local governmental public health authorities
Current Spending	The amount of resources supporting existing public health modernization activities.

Full Implementation	The amount of resources needed to support full implementation of public health modernization activities.
Capacity	To what degree the organization currently has the staffing and resources necessary to provide the services/deliverables dictated.
Expertise	To what degree the organization's current capacity aligns with the appropriate knowledge necessary to implement the services/deliverables dictated.
Detailed Self-Assessment	Assesses capacity and expertise for meeting roles and providing deliverables as outlined in the *Public Health Modernization Manual*.
Rollup Self-Assessment	Assesses capacity and expertise for meeting foundational capabilities and programs, and where applicable, functional areas.
Drivers	Demand factors that causes a change in the overall cost of a foundational capability or program.
Cost Factors	Units of cost directly proportional to the independent variables (in this case, cost drivers).
Fixed Costs	Costs that that do not change as a function of the activity of the foundational capability or program.
Variable Costs	Costs that change as a function of the activity of the foundational capability or program.
Labor Costs	The salaries and benefits of staff that are employed within each program.
Non-Labor Costs	The costs of supporting the program's functions. Examples include materials, supplies, small equipment such as computers or lab equipment, professional services, and other contracted services.
Overhead Costs	Facility costs such as rent, maintenance, or utilities and other overhead costs like fleet.

APPENDIX B: FUNCTIONAL AREA DEFINITIONS

In 2015, the Oregon legislature passed House Bill 3100 which created a new framework for governmental public health services. This framework, known as public health modernization, includes four foundational programs and seven foundational capabilities. To support implementation of this framework, a workgroup produced a manual outlining the necessary activities and tools for state and local governmental public health authorities to operationalize it. This document, the *Oregon Public Health Modernization Manual*, established over 800 roles and deliverables for both the state and local public health authorities (LPHAs).

To assist LPHAs in estimating their resource needs to meet the requirements of public health modernization, BERK Consulting created an intermediary structure between their 302 roles and deliverables and the 11 foundational programs and capabilities. This structure defined 40 functional areas which were designed to group the roles and deliverables in a way similar to the way LPHAs execute their work. To do this, we synthesized the legislative definitions of each foundational program and capability with the 302 local roles and deliverables, which were assigned to the emerging functional areas on a one-to-one basis. For readability, and to minimize duplication, the full text of each role and deliverable may not appear in the functional area definition.

Following are the 40 functional areas, grouped by foundational program and capability, as they appeared in the assessment tool completed by each LPHA.

Foundational Programs

Communicable Disease Control

Communicable Disease Surveillance

Produce timely reports of notifiable diseases.

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

Communicable Disease Control (continued)

Communicable Disease Investigation

Develop and deploy a communicable disease investigative process.

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

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

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

Communicable Disease Intervention and Control

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

- Provide health education resources for the general public, health care providers, long-term care facility staff, infection control specialists, and others regarding vaccine-preventable diseases, healthcare associated infections, antibiotic resistance, and other issues.
- Provide vaccination interventions for communities that are disproportionately non-immunized.
- Use information about immunization proportions to increase immunization overall for citizens in local jurisdictions.
- Ensure equitable access to immunizations among people of all ages. Implement culturally responsive strategies to improve access to immunizations.

Identify statewide and local communicable disease control community assets, develop processes for information sharing between providers to reduce disease transmission, and maintain emergency/outbreak plans.

- Develop protocols or process maps for information sharing between providers to reduce disease transmission.
- Maintain plans for the allocation of scarce resources in the event of an emergency or outbreak.
- Produce reports about acute and communicable disease gaps and opportunities for mitigation of identified risks.
- Provide technical support for enforcement of public health laws (e.g., isolation and quarantine, school exclusion laws).
- Ensure timely and accurate reporting of reportable diseases and educate local providers on reportable disease requirements.
- Develop, engage, and maintain local strategic partnerships with hospitals, health systems, schools, day care centers, and others to prevent and control communicable diseases. Ensure engagement of priority/focal populations in efforts to prevent and control communicable diseases.
- Provide subject matter expertise to inform program design, policies, and communications that educate providers, the public, and stakeholders about public health risks.
- Provide disease-specific and technical expertise regarding epidemiologic and clinical characteristics to health care professionals and others. Advise health care practitioners about evidence-based practices for communicable disease diagnosis, control, and prevention.
- Work with partners to enforce public health laws, including isolation and quarantine.
- Work with the OHA Public Health Division to provide guidance for the control and prevention of rare diseases and conditions of public health importance.

Assure the appropriate treatment of individuals who have active communicable diseases, including HIV, STD, and TB cases. Develop reporting and partner notification services for relevant diseases.

- Provide appropriate screening and treatment for HIV, STD, and TB cases, including pre- and post- exposure prophylaxis for HIV.
- Collaborate with the state in a culturally responsive way on disease prevention and control initiatives such as antibiotic resistance, sexually transmitted disease prevention messaging, infection control protocols, hand hygiene, field investigations of outbreaks and epidemics, and statewide and local health policies.
- Provide input into what diseases should be reportable to the state and subsequent disease investigation and control guidelines.
- Assure the availability of partner notification services for newly diagnosed cases of syphilis, gonorrhea, and HIV, as recommended by OHA.

Communicable Disease Control (continued)

Communicable Disease Response Evaluation

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

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

Assess process improvement initiatives, including materials.

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

Environmental Public Health

Identify and Prevent Environmental Health Hazards

Prevent and investigate environmental health hazards, including radioactive materials, animal bites, and vector-borne diseases.

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

Environmental Public Health (continued)

Conduct Mandated Inspections

Perform inspections and educate recipients of inspections, including for: restaurants and other food service establishments; recreation sites, lodges, and swimming pools; septic systems; portable water systems; radiological equipment; and hospital and other health care facilities.

- Conduct timely inspection and review of regulated entities and facilities.
- Enforce regulations through inspections.
- Perform and assist with outbreak investigations that have an environmental component.
- Conduct ongoing environmental and occupational health surveillance.
- Document communications on environmental health hazards and protection recommendations to regulated facilities, the public, and stakeholder organizations.
- Consult for the food service industry and the general public.
- Document provision of licensing and certification of recreational facilities, food service facilities, and tourist accommodations.
- Document reports of inspection and review of regulated entities and facilities.
- Document enforcement of regulations.

Promote Land Use Planning

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

- Conduct health analyses for other organizations and recommend approaches to ensure healthy and sustainable built and natural environments.
- Understand and participate in local land use and transportation planning processes.
- Maintain relationships with partners in local economic development, transportation, parks, and land use agencies.
- Provide consultation and technical assistance to the food service industry and the general public.
- Provide technical assistance to integrate standard environmental public health practices into facilities that present high risk for harmful environmental exposures or disease transmission.
- Produce community health assessments, including environmental health, at least every five years.
- Prepare health analyses for other organizations and recommend approaches to ensure healthy and sustainable built and natural environments.
- Communicate environmental justice concerns and disparities.
- Write best practices related to vector control.
- Document integration of standard environmental public health practices into facilities that present high risk for harmful environmental exposures or disease transmission.

Prevention and Health Promotion

Prevention of Tobacco Use

Prevent and control tobacco use.

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

Prevention and Health Promotion (continued)

Improving Nutrition and Increasing Physical Activity

Improve nutrition and incentivize increased physical activity.

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

Prevention and Health Promotion (continued)

Improving Oral Health

Improve oral health.

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

Prevention and Health Promotion (continued)

Improving Maternal and Child Health

Improve prenatal, natal, and postnatal care, maternal health, and the health of children.

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

Prevention and Health Promotion (continued)

Reduce Unintentional and Intentional Injuries

Decrease the occurrence and impacts of both unintentional and intentional injuries, such as motor vehicle accidents and suicide.

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

Access to Clinical Preventive Services

Ensure Access to Effective Vaccination Programs

Immunizations

- Ensure access to all vaccines required by Oregon law for school attendance. This includes ensuring that vaccines are provided at convenient times and locations, and that no child is denied immunizations due to inability to pay. (ORS 433.269)
- Ensure access to all immunization-related services necessary to protect the public and prevent the spread of vaccine preventable disease.
- Work with local providers and public health delegate agencies to ensure access to immunization services.
- Ensure access to vaccines as appropriate during public health emergencies.
- Document meetings with partners to recommend strategies for improving access to clinical preventive services.
- Produce jurisdictional reports on access to clinical preventive services.
- Provide resources for clinical and community partners on evidence-based guidelines for the delivery of clinical preventive services.
- Plan for improved access to clinical preventive services, particularly for vulnerable populations.
- Document implementation of these plans.
- Produce evaluations of policies implemented to improve access to clinical preventive services.

Ensure Access to Effective Preventable Disease Screening Programs

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

Ensure Access to Effective STD Screening Programs

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

Access to Clinical Preventive Services (continued)

Ensure Access to Effective TB Treatment Programs

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

Ensure Access to Cost-Effective Clinical Care

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

Foundational Capabilities

Assessment and Epidemiology

Data Collection and Electronic Information Systems

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

- Access statewide information and surveillance systems and report into these systems in a timely manner.
- Use applied research and evaluation techniques to ensure that interventions meet the needs of the community to be served.
- Use relevant data to implement, monitor, evaluate, and modify state health improvement plans or community health improvement plans.
- Evaluate the efficacy of public health policies, strategies, and interventions.
  - Evaluate the effectiveness, accessibility, and quality of population-based health services.
  - Perform or access expertise needed to conduct economic analysis of public health strategies (e.g. economic analyses including the cost/risk of non-investment, return on investment).
  - Assist in the development of and evaluate public health interventions.
- Provide local public health informatics capability, or access statewide capability.

Data Access, Analysis, and Use

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

- Collect, process, and analyze data to assess population health priorities, patterns, and needs in the local authority.
- Collect, maintain, and analyze vital records and statistics.
- Input local data in state data systems to support a statewide understanding of population health and coordination between health authorities.
- Analyze key indicators of a community's health.
- Use demographic information (e.g. census, vital records) to understand the population and the characteristics of that population.
- Conduct and assess surveys about health behaviors and practices.
- Analyze data related to the causes and burdens of disease, injury, disability, and death.
- Identify populations experiencing a disproportionate burden of death, injury, and disease. Identify how disease, injury, disability, and death disproportionately affect certain populations, including populations specific to sex, race, ethnicity, and socioeconomic status.
- Using quantitative and qualitative data, identify how disease, injury, disability, and death disproportionately affect specific populations (e.g. populations grouped by sex, sexual orientation, gender identity, race, ethnicity, urban/rural residence, immigration status, and socioeconomic status).

Assessment and Epidemiology (continued)

Respond to Data Requests and Translate Data for Intended Audiences

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

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

Conduct and Use Basic Community and Statewide Health Assessments

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

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

Infectious Disease-Related Assessment

Identify and respond to disease outbreaks and epidemics.

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

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

Emergency Preparedness and Response

Prepare for Emergencies

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

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

Respond to Emergencies

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

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

Coordinate and Communicate Before and During an Emergency

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

- Build community partnerships to support health preparedness, and recovery and resilience efforts, including training and exercising with community partners per federal guidelines, and the ongoing training and support provided by local public health authorities (e.g. schools, hospitals, emergency medical, community organizations, organizations serving priority/focal populations, etc.).
- Maintain a portfolio of community partnerships to support preparedness and recovery efforts.
- Act as the jurisdictional administrator of public health notification systems (e.g. alert networks, hospital capacity programs, etc.), Oregon's logistical ordering system, and syndromic surveillance system.

Use communications systems effectively and efficiently during a disaster or emergency.

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

Communications

Regular Communications

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

- Engage in two-way communications with the public through the use of a variety of accessible communication channels:
  - Effectively use mass media and social media to transmit communications to and receive communications from the public.
  - Local public health authorities shall maintain a public-facing website with updates made to content no less than annually.
  - News releases and public meeting notices.
  - Policy briefs and other policy-related communications.
- Engage in two-way communications with the public through the use of a variety of accessible content:
  - Local public health authorities shall develop and disseminate communications on emerging public health issues.
  - Local public health authorities shall develop and disseminate print and media materials in accordance with the strategic communications plan and risk communication needs.
  - Local public health authorities can also adopt or customize statewide print and media materials provided by the OHA Public Health Division. Materials shall be in compliance with ADA Section 508 and consider health literacy needs, and communications for the public shall consider the end user and use appropriate communication format(s) and language(s). Communications shall be tailored for specific audiences, such as policy makers, stakeholders, local public health authorities, health care providers, the public, and specific population groups.
  - Local public health authorities shall be a reputable source of health information, through public health branding, by disseminating news releases and public meeting notices in a timely and transparent fashion. Local public health authorities shall support ongoing interaction with the public by offering and inviting two-way communications with the public (e.g. contact information, surveys, comment boxes, etc.).
- Communicate with specific populations in a manner that is culturally and linguistically appropriate.
- Local public health authorities shall regularly evaluate the effectiveness of communications efforts using tools such as web analytics, surveys, panel surveys, and polls. Local public health authorities shall use evaluation findings to adjust communications and communications strategies accordingly.
- Communication training and capacity building.
- Document communications support for any staff beyond the public information officer who communicate with the public about public health issues (e.g. media content reviewed by the public information officer).
- Document two-way communications with the OHA Public Health Division. Evaluation Communications evaluation plan that is structured around health equity and literacy.

Emergency Communications

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

Educational Communications

- Develop and implement educational programs and preventive strategies.

Policy and Planning

Development and Implement Policy

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

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

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

Improve Policy with Evidence Based Practice

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

- Coordinate with the state on development of economic analyses (e.g. analysis of cost/risk of non-investment return on investment) for proposed policy changes in the authority.
- Provide coordination among local agencies and other organizations on policies that impact health, including those that address health equity and the social determinants of health.
- Inform federal policy work through NACCHO or other organizations.
- Coordinate enforcement of federal, state, and local policy and regulate activities when delegated to do so.
- Coordinate local public health policy agendas with the state policy agenda and support the state public health position on legislation, when appropriate.
- Share information about implementation of public health best practices or innovative strategies that may be relevant to the OHA Public Health Division or other local public health authorities.
- Participate in state-led discussions to identify, analyze, and develop or revise systems or rules that are needed to address an identified public health issue (e.g. review of existing rules).
- Respond to policy initiatives that may impact health.

Policy and Planning (continued)

Understand Policy Results

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

- Assume a leadership role for communicating with the community about how policy changes may impact health.
- Engage traditional and nontraditional partners in conversations about efforts to improve health outcomes.
- Implement, monitor, evaluate and modify state health improvement plans or community health improvement plans
- Ensure communication with the governing body (e.g. Board of Commissioners or sub designee) to whom the health authority is accountable for progress on the CHIP at least twice a year.
- Make information about the community health improvement plan available to the public.

Heath Equity and Cultural Responsiveness

Foster Health Equity

Support public health policies that promote health equity.

- Develop and promote shared understanding of the determinants of health, health equity, and lifelong health with local partners and the community.
- Make the economic case for health equity, including the value of investment in cultural responsiveness.
- Engage with the community to identify and eliminate health inequities.
- Implement processes within public health programs that create health equity.
- Promote a common understanding of cultural responsiveness.
- Promote understanding of the extent and consequence of systems of oppression.
- Recognize and address health inequities that are specific to certain populations, including differences stemming from race, class, gender, disability, and/or national origin
- Collect and maintain data, or use data provided by the OHA Public Health Division that reveal inequities in the distribution of disease. Focus on information that characterizes the social conditions (including strengths, assets, and protective factors) under which people live that influence health.
- Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic wellbeing, and environmental quality) with local partners, or use information collected and provided by the OHA Public Health Division.
- Identify local population subgroups or geographic areas characterized by either (i) an excess burden of adverse health or socioeconomic outcomes; or (ii) an excess burden of environmental health threats.
- Foster shared understanding and will to achieve health equity and cultural responsiveness.
- Make available data and information on health status and conditions that influence health status by race, ethnicity, language, geography, disability, and income. Consider health literacy, preferred languages, cultural health beliefs and practices, and other communication needs when issuing data and information.

Communicate and Engage Inclusively

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

- Make clear and transparent communications easily and quickly available to constituents on issues related to the health of their authority, especially regarding policies and decisions relating to health equity priorities.
- Provide technical assistance to communities with respect to analyzing data, setting priorities, identifying levers of power, and developing policies, programs, and strategies.
- Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community Engagement Principles and the National Environmental Justice Advisory Council's community collaboration principles.
- Engage the community, including diverse populations, in community health planning.
- Engage with community members to learn about the values, needs, major concerns, and resources of the community in order to effectively prioritize resources and services to best address health inequities.
- Learn about the culture, values, needs, major concerns, and resources of the community. Respect local community knowledge and seek to understand and formally evaluate it.
- Promote the community's analysis of and advocacy for policies and activities that will lead to the elimination of health inequities. Share, discuss, and respond to feedback on civil rights implementation using tracked findings to report ways to decrease civil rights violations.
- Promote community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic minorities, and disabled community members in state and local government.
- Routinely invite and involve community members and representatives from community-based organizations in public health authority planning, procedures, evaluation, and policies. Offer means of engagement that respond to unique cultures of community members.
- Increase racial and ethnic representation on councils and committees.

Community Partnership Development

Identify and Develop Partnerships

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

- Coordinate programmatic activities with those of partner organizations to advance cross-cutting, strategic goals.
- Promote the use of evidence-based strategies to improve population health by providing training, technical assistance, and other forms of support to partners.
- List all community partners involved in local and regional health needs, health impact, and health hazard vulnerability assessments; include descriptions of partners involved, their roles, and contributions to the effort.
- List all key regional health-related organizations with whom the health department has developed relationships with about public health issues of mutual interest. Document these efforts, resulting areas of collaboration, and benefits to the public's health resulting from the collaboration in relevant grant progress reports and other summaries of activities.
- Document training, technical assistance, and other forms of support provided to partners, along with evaluation of the effectiveness of this support in promoting population health.
- Evaluate reports on the effectiveness of partnerships.
- Develop, strengthen, and expand connections across disciplines, such as education and health care, and with members of the community who work in those disciplines.
- Support and maintain cross-sector partnerships with health-related organizations, organizations representing priority/focal populations, private businesses, and local government agencies and non-elected officials.
- The portfolio of cross-sector partnerships should include a description of partnering organizations and how the partnership supports population health. If applicable, specifically describe how the partnership addresses health disparities.
- List all local community groups or organizations representing priority/focal populations, including private businesses, healthcare organizations, and relevant tribal, regional, and local government agencies the local public health authority has developed relationships with, so that public health goals are effectively and efficiently attainable for all populations. As part of program evaluation efforts, address successes, lessons learned, recognized barriers to such collaboration, and strategies to overcome these barriers.

Engage Partners in Policy

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

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

Leadership and Organizational Competencies

Leadership and Governance

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

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

Performance Management, Quality Improvement, and Accountability

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

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

Human Resources

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

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

Leadership and Organizational Competencies (continued)

Information Technology

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

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

Financial Management, Facility Operations, and Contracts and Procurement Services

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

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