Public Health Division

Oregon Public Health Accountability Metrics Report: 2023

July 2025

OREGON HEALTH AUTHORITY

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Dear colleagues and partners,

In recent years, Oregon communities have faced new and increasingly complex health threats.

- Since the COVID-19 pandemic, communities throughout our state have been harmed by emerging diseases, as well as resurgences of diseases that were once well-controlled, including pertussis and syphilis.
- Eroding trust and barriers to access have led to declines in routine vaccination rates, after years of making steady gains. This leaves people at highest risk of diseases these vaccines prevent vulnerable to illnesses that can have devastating outcomes.
- Each year our communities experience extreme heat and poor air quality due to wildfire smoke. These events that were once uncommon are becoming more frequent and severe because of our changing climate. Our access to safe drinking water is threatened by drought and other factors. Environmental hazards pose a threat to the health and well-being of people across the state.

Within each of these threats, we know that not everyone has the same opportunities for health. Some communities are systematically more exposed to health threats while also having less access to the resources needed to be healthy.

Oregon communities have long taken care of one another and will continue to do so when it comes to health. Oregon's governmental public health system works daily with communities and partners to address new and emerging health challenges like those described above. People working together have the power to create communities where everyone has what they need to thrive.

Since 2015, Oregon's governmental public health system has been working to ensure that critical health protections are in place for every person in the state. To do this, we need a system that is responsive to changing needs, sufficiently resourced to address emerging threats, and accountable for improving health. We call this long-term effort public health modernization.

Oregon's governmental public health system uses accountability metrics to show that we are improving health and eliminating inequities for Oregon communities through investments in public health modernization. These metrics bring attention to urgent health issues and our core work to reach 2030 health improvement goals. Our priorities include:

- Reducing the spread of syphilis and preventing congenital syphilis.
- Protecting people from preventable disease through vaccination.
- Building community resilience for climate impacts on health, in particular for extreme heat and poor air quality due to wildfire smoke.

Public health accountability metrics create opportunities for governmental public health, partners and sectors to work together to address urgent health issues. With sufficient resources and unwavering focus, our goals are achievable. Collectively, Oregon's public health system with partners and communities will continue to improve the health for every person in Oregon.

Naomi Adeline-Biggs
Public Health Director | Oregon Health Authority

Executive summary

Oregon's public health system is improving health and eliminating inequities through public health modernization. Since 2013, Oregon has been modernizing its governmental public health system to be equitable, community-centered and responsive to current and emerging threats to health. A modern public health system supports 4.2 million people in Oregon to achieve optimal health and well-being.

Public health accountability metrics are one way that Oregon's public health system demonstrates and ensures that it is improving health, eliminating inequities and effectively using public dollars.

In the 2023-25 biennium, Oregon's public health system received $112.2 million in state General Fund investments for public health modernization, providing critical funding for public health's core work to prevent the spread of communicable diseases and protect communities from environmental health threats, including those caused by a changing climate. Sustained state investments are essential to making progress toward health improvement goals. And during times of unstable and reduced funds from other sources, these funds ensure that Oregon can maintain the gains that have been made.

In 2023, Oregon's Public Health Advisory Board adopted new public health accountability metrics to align with the areas prioritized with state General Fund investments. Accountability metrics include three inter-connected levels of measures that, when reviewed as a whole, reflect the actions of governmental public health agencies and partners to improve health for people in Oregon.

- **Health outcome indicators** measure urgent health issues that are priorities for the public health system. Making improvements regarding health outcome indicators requires sufficient and sustainable funding, long-term focus and must include other sectors and partners. Indicators are used to show progress toward 2030 goals to improve health outcomes.
- **Local Public Health Authority (LPHA) process measures** bring attention to the core functions of LPHAs to improve health outcomes, including data and epidemiology, communications, partnerships and policy.
- **Oregon Health Authority (OHA) process measures** bring attention to the unique functions of the state public health authority to support the public health system and serve all people in Oregon.

These health outcome indicators and process measures are collectively referred to as public health accountability metrics. Each section of the report highlights key data for accountability metrics.

Oregon's priority areas for accountability metrics include:

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

This report provides baseline 2023 information for accountability metrics.

2023 public health accountability metrics snapshot

The table below provides a snapshot of 2023 data for each priority area and health outcome indicator, along with the 2030 goal. Oregon's 2030 goals are only achievable with sufficient and sustained funding, long-term focus and collaborative work with other sectors and partners, including community-based partners.

Health outcome indicators: 2023 baseline and 2030 goals

Priority area	Health outcome indicator	Baseline (2023/2024)	2030 goal
Reduce the spread of syphilis and prevent syphilis in infants	Rate of congenital syphilis	78.3 cases of congenital syphilis per /100,000 live births	39.2/100,000
	Rate of syphilis (all stages) among people who can become pregnant	72.2 cases of syphilis (all stages) per 100,000 people who can get pregnant	65.0/100,000
	Rate of primary and secondary syphilis	19.2 cases of primary or secondary syphilis per 100,000 people	16.3/100,000
Protect people from preventable diseases through vaccination	Two-year old vaccination rate	68% of two-year-olds in Oregon up-to-date on the 4:3:1:3:3:1:4 series	80%
	Adult influenza vaccination rate in populations 65 and older	47%	60%
Build community resilience for climate impacts on health: extreme heat and wildfire smoke	Emergency department and urgent care visits due to heat	1.79 heat-related illness visits (per 1M) per day at or above 80°F heat index	0.85 heat-related illness visits (per 1M) per day at or above 80°F heat index
	Heat-related hospitalizations	69 heat-related hospitalizations per 4.2M population	28 heat-related hospitalizations per 4.2M population
	Heat-related deaths	8 heat-related deaths	2 heat-related deaths
	Non-infectious respiratory illness emergency department and urgent care visits	1.63 non-infectious respiratory illness visits (per 10,000 population) per day at or above Moderate air-quality index (AQI)	1.3 non-infectious respiratory illness visits (per 10,000 population) per day at or above Moderate air-quality index (AQI)

Process measures

Each LPHA is required to implement work to address a total of six process measures (two process measures in each priority area).

A snapshot of LPHA and OHA reporting on process measures is below. The full report contains detailed information on LPHA and OHA reporting on process measures.

LPHA process measures by priority area, 2023

Priority area: Reduce the spread of syphilis and prevent syphilis in infants

In 2023, baseline data was available for all 33 LPHAs.

LPHA process measures

- Increase in the percentage of congenital syphilis cases averted
- Increase in the percentage of people with syphilis interviewed
- Increase in the percentage completion of CDC core variables
- Increase in the percentage of early cases treated with appropriate regimen within 14 days

Priority area: Protect people from preventable diseases through vaccination

In 2023, 28 of 33 LPHAs were on track to meet process measures.

LPHA process measures

- Demonstrated use of data to identify population(s) of focus
- Demonstrated actions to improve access to influenza vaccination for residents of long-term care facilities (LTCFs)
- Increase in the percentage of health care providers participating in the Immunization Quality Improvement Program (IQIP)
- Demonstrated actions with health care providers to improve access to vaccination
- Demonstrated outreach and educational activities conducted with community partners to increase vaccine access or demand

Priority area: Build community resilience for climate impacts on health: extreme heat and wildfire smoke

In 2023, 26 of 33 LPHAs were on track to meet process measures.

LPHA process measures

- Demonstrated use of data to identify population(s) of focus
- Demonstrated actions in communications to reduce the health impacts of extreme heat and wildfire smoke
- Demonstrated actions in policy to reduce the health impacts of extreme heat and wildfire smoke
- Demonstrated actions in community partnerships to reduce the health impacts of extreme heat and wildfire smoke

OHA process measures by priority area, 2023

Priority area	Process measure	2023 status
Reduce the spread of syphilis and prevent syphilis in infants	Increase in the percentage of congenital syphilis cases averted statewide	65.1%
	Increase in the percentage of prenatal care providers who report screening all pregnant patients in the third trimester	69.0%
	Adoption of CCO/health system metrics to promote syphilis screening at three time points in pregnancy	Baseline not available
Protect people from preventable diseases through vaccination	Develop and maintain data for immunization indicators	Not met (50% of milestones met)
	Implement the IQIP program	Not met (10.5% of milestones met)
	Provide data to coordinated care organizations (CCOs) to meet incentive measures and partner with CCOs on QI program implementation	Met (100%)
	Assure vaccine supply and monitor the state's vaccine finance model to ensure it is sustainable, equitable and adequately funds vaccination programs	Not met (57% of milestones met)
Build community resilience for climate impacts on health: extreme heat and wildfire smoke	Number of dashboards published and updated	Not met (33% of milestones met)
	Provision of technical assistance in support of health outcome indicators	Not tracked in 2023
	Recommendations identified for accountability metrics in development	Not met (0%)
	Documentation of identified policy changes that are needed to reduce health impacts of climate change	Not met (0%)

What's next for public health accountability metrics?

Moving forward, OHA will publish accountability metrics information annually, with 2024 data to be published in 2025. Beginning in 2025, LPHAs are eligible to receive incentive payments based on 2023 and 2024 performance on accountability metrics.

Governmental public health, with partners, has the knowledge and skills to address these priority health issues through evidence-based and promising practices grounded in public health science and approaches. Ongoing focus is needed to ensure the system has continued, sufficient funding and resources for this life-saving work.

Introduction

Oregon's public health system is improving health and eliminating inequities through public health modernization.

Since 2013, Oregon has been modernizing its governmental public health system to be equitable, community-centered and responsive to current and emerging threats to health. Public health modernization is critical for all 4.2 million people in Oregon to achieve optimal health and well-being.

Public health accountability metrics are one way that Oregon's public health system demonstrates and ensures it is improving health, eliminating inequities and effectively using public dollars.

Oregon's Public Health Advisory Board (PHAB) provides leadership to Oregon's governmental public health system. PHAB is responsible for establishing public health accountability metrics and tracking the public health system's progress toward improving health outcomes.[1]

In 2023, PHAB updated Oregon's public health accountability metrics framework and established new metrics to center equity and emphasize that collaborations between sectors and partners are necessary to address root causes of poor health outcomes. The new metrics bring attention to three priority areas representing urgent health issues that the public health system is addressing through state investments in public health modernization.

The three priorities are:

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

State and local public health authorities have a role in improving health outcomes.

Oregon Health Authority (OHA) and local public health authorities (LPHAs) work together to:

- Bring sectors and partners together to work toward solutions that create opportunities for health.
- Collaborate with community partners who provide culturally and linguistically relevant services that are essential for eliminating health inequities.
- Provide core governmental services and actions that are necessary for community responsive programs and services.

Beginning with this report, annual reporting will provide an in-depth look at how Oregon's public health system is doing on key health priorities. Reports will show progress toward goals and identify areas where additional investments are needed.

Public health accountability metrics support health equity.

Making data on health outcomes available is one way that Oregon's public health system brings attention to health inequities and the underlying reasons why certain racial and ethnic groups experience worse outcomes.

The reasons that disparities in health outcomes exist across racial and ethnic groups are complex. They occur because of generations-long social, economic and environmental injustices. These injustices have a greater influence on health outcomes than biological or genetic factors and cannot be attributed to an individual's choices.

Where possible, data are reported by race and ethnicity in this report. This report shows that some groups, including communities of color and those living with fewer financial resources, continue to bear a greater burden of illness and disease. This report does not provide detailed information about existing disparities, but rather identifies where disparities exist based on OHA collected data sources. The summary information provided in this report should be used to guide ongoing discussions and actions to advance health equity.

This report includes data collected through multiple public health data systems. Race and ethnicity categories are not uniform across all public health data systems. In this report, race and ethnicity data are presented using the race and ethnicity categories used for each data system, which may not be comparable across systems.

Some data systems collect and report data using categories that do not adhere to current best practices, including best practices for collecting and reporting data using Race, Ethnicity, Language and Disability (REALD). Over time, data systems are being updated to comply with REALD standards.

- Additional information about Oregon's REALD implementation is available at: https://www.oregon.gov/oha/ei/pages/reald.aspx/

Oregon's public health modernization budget totals $112 million for the 2023-2025 biennium.

This funding directly supports efforts related to communicable disease prevention and control, and environmental health, including climate and health. The majority of the funding directly reaches communities through allocations to LPHAs, federally-recognized Tribes and community-based organizations (CBOs). This allocation model supports local decision-making by allowing each LPHA, federally-recognized Tribe and CBO to identify strategies best suited to serve their unique communities.

While these investments in Oregon's public health system are unprecedented, a 2024 assessment estimated that the system continues to be underfunded to provide the core functions of a modern public health system.[2]

OHA distributes other state and federal funding for programs addressing some, but not all, health priorities being addressed through accountability metrics.[2] Locally, some LPHAs receive county general funds or other funds that can be used to support core work to address these health priorities.

As required in ORS 431.380, beginning in 2025, OHA will begin awarding incentive payments to LPHAs that meet process measures. Incentive payments bring attention to the core strategies being used across Oregon to improve health outcomes, while also driving improved performance over time.[3]

Report layout

This report is organized according to three health priority areas:

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

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

- ***Health outcome indicators*** measure urgent health issues that are priorities for the public health system. Making improvements regarding health outcome indicators requires sufficient and sustainable funding, long-term focus and must include other sectors and partners. Indicators are used to show progress toward 2030 goals to improve health outcomes.
- ***LPHA process measures*** bring attention to the core functions of LPHAs to improve health outcomes, including data and epidemiology, communications, partnerships and policy.
- ***OHA process measures*** bring attention to the unique functions of the state public health authority to support the public health system and serve all people in Oregon.

These health outcome indicators and LPHA and OHA process measures are collectively referred to as public health accountability metrics. Each section of the report highlights key data for accountability metrics.

A description of data sources, methods and public health program information for this report can be found in the Technical Appendix.

Figure 1. Public health accountability metrics for syphilis: process measures and health outcome indicators

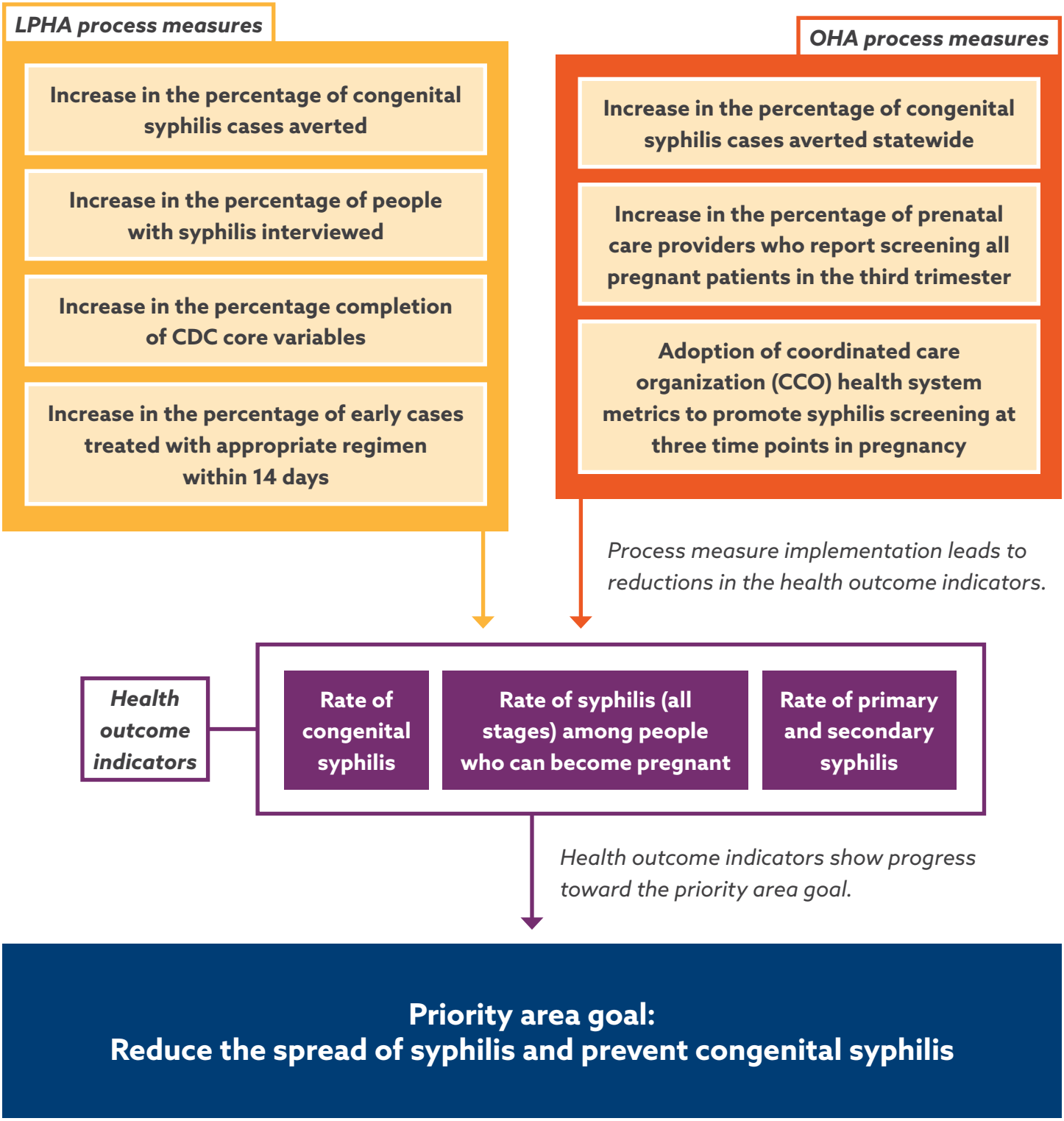


FIgure 2. Public health accountability metrics for immunizations: process measures and health outcome indicators

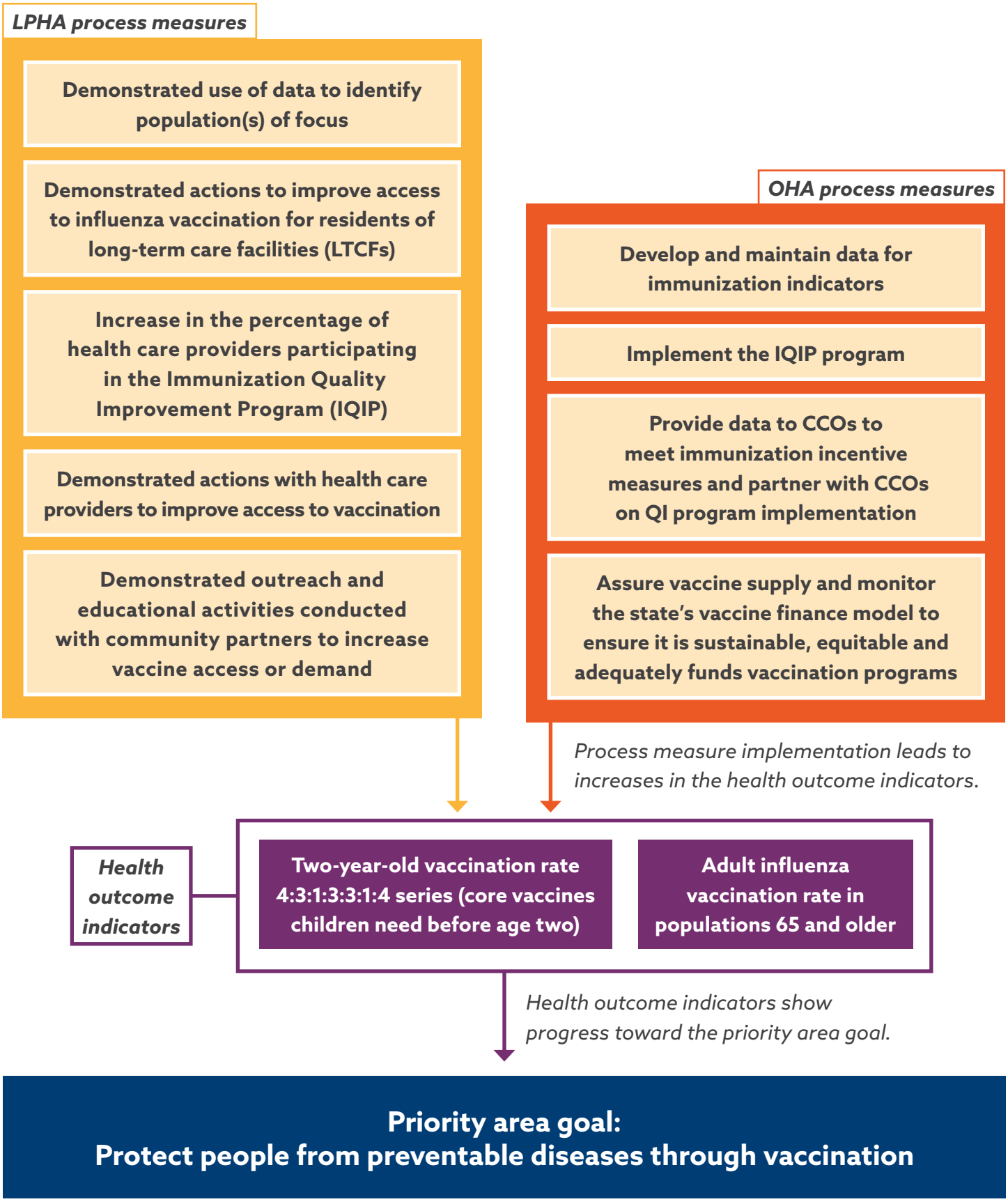
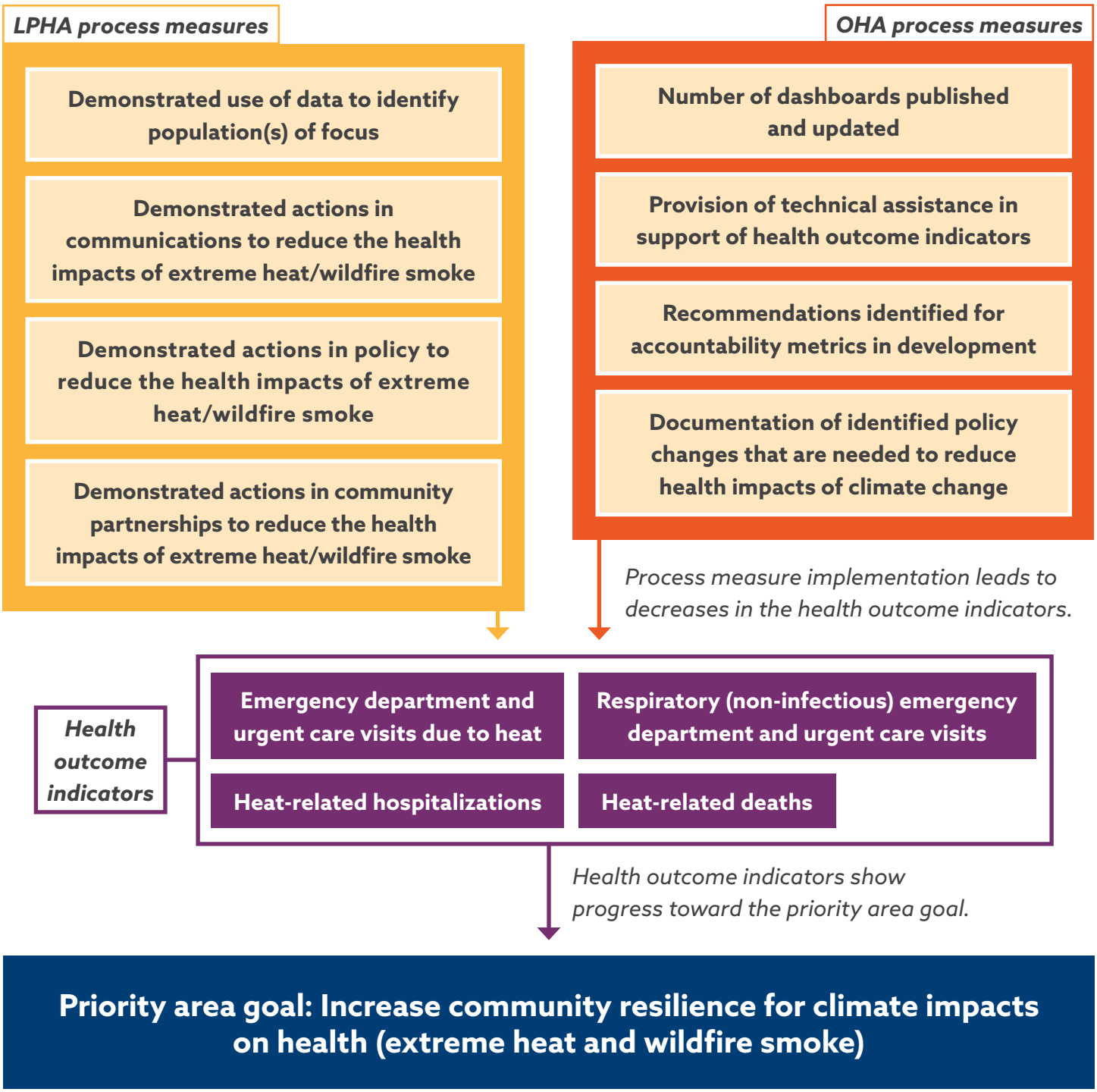


Figure 3. Public health accountability metrics for climate impacts on health: process measures and health outcome indicators



Communicable Disease Control

OREGON HEALTH AUTHORITY

Metrics priority #1: Reduce the spread of syphilis and prevent congenital syphilis

Over the last several years, Oregon and the nation have experienced a steep increase in syphilis among people who can become pregnant and in infants.

Health outcome indicators

Together, the following indicators provide a comprehensive view of the dramatic increase in syphilis cases in Oregon, which groups are most affected and where areas for intervention exist.

- Rate of congenital syphilis
- Rate of all stages of syphilis among people who can become pregnant
- Rate of primary and secondary stages of syphilis among the general population

Reducing syphilis is an urgent health issue.

Syphilis diagnoses in Oregon are higher than ever, including among people who can become pregnant, people who are pregnant and infants. Syphilis is treatable with antibiotics, but can damage the eyes, nerves, brain and heart if left untreated.

Congenital syphilis occurs when syphilis passes to babies during pregnancy.[4] Cases of congenital syphilis can lead to stillbirth, infant death and serious birth defects. Congenital syphilis should never occur in a modern health care system.

Persistent and systemic causes of inequities that impact the syphilis epidemic include poverty, housing instability, racism, stigma, the criminal justice system, substance use and mental and behavioral health challenges.

At the same time, the public health and medical systems have experienced flat or decreasing funding that is insufficient for achieving a robust infrastructure and workforce for sexual health services. Other contributing factors include a recent benzathine penicillin G shortage and a health care workforce inexperienced in the diagnosis, testing and management of syphilis.

In addition to the information presented in this report, sexually transmitted infection (STI) data and county-level data are available at the Oregon Health Authority Sexually Transmitted Disease (STD) Prevention website.

Health outcome indicator #1: Rate of congenital syphilis

This indicator measures the rate of congenital syphilis per 100,000 live births in Oregon.

Statewide snapshot:

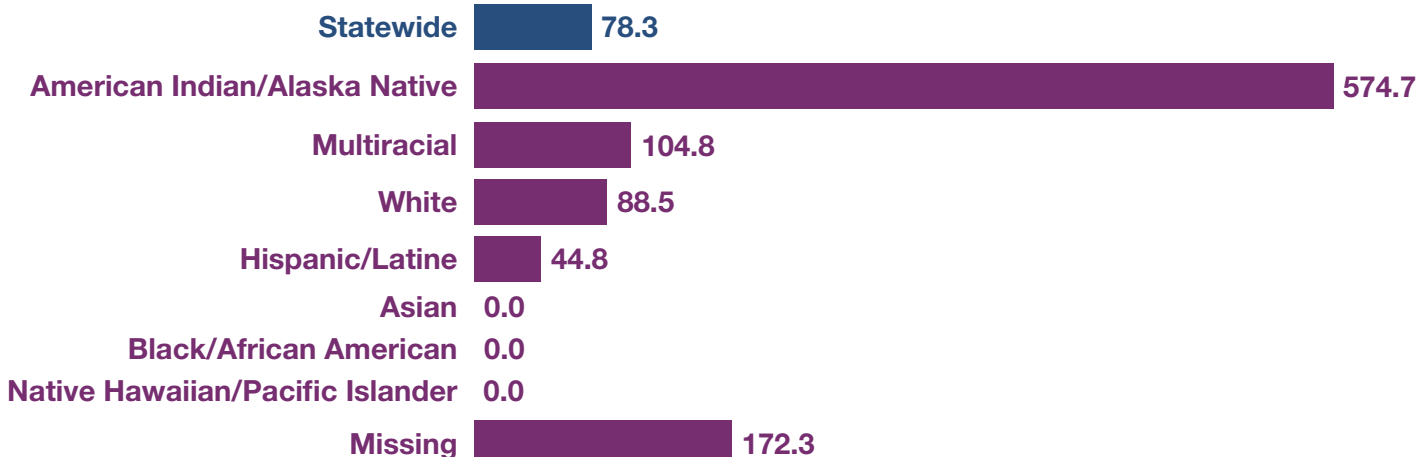
2023 (Baseline): 78.3 cases of congenital syphilis per 100,000 live births

2025 goal: 66.5 cases of congenital syphilis per 100,000 live births (15% decrease from baseline)

2030 goal: 39.2 cases of congenital syphilis per 100,000 live births (50% decrease from baseline)

Source: Oregon Public Health Epidemiologists' User System (ORPHEUS)

Figure 4. 2023 rate of congenital syphilis cases per 100,000 live births, by race and ethnicity



The rates of congenital syphilis among people in Oregon who are American Indian/Alaska Native and multiracial are significantly higher than the rate of congenital syphilis statewide. In 2023, people who are American Indian/Alaska Native made up 0.9% of people who delivered a live birth in Oregon and accounted for 6.7% of people associated with a congenital syphilis case. OHA's Center for Health Statistics gathers race and ethnicity information on live births in Oregon. In 2023, race and ethnicity data was missing or not recorded in 3% of all live births in Oregon and 6.7% of live births associated with a congenital syphilis case.[5] In some cases this information gap can be filled using race and ethnicity data from the birthing parent, but sometimes this information is also missing due to a variety of factors including: non-disclosure by the birthing parent, data collection limitations and data collection tool constraints. Figure 4 does not show data regarding race/ethnicity of pregnant people associated with a congenital syphilis case compared to the proportion of live births among that population in Oregon.

It is critical to understand higher congenital syphilis rates are not inherently linked to race or ethnicity; rather, they stem from the social, economic and environmental contexts that disproportionately affect certain groups, creating barriers to optimal sexual health.

- Additional information about Oregon's REALD implementation is available at: https://www.oregon.gov/oha/ei/pages/reald.aspx/

Health outcome indicator #2: Rate of syphilis (all stages) among people who can become pregnant

This indicator measures the rate of syphilis among people who can become pregnant. For this metric, "people who can become pregnant" refers to people assigned female at birth who are between 15 and 44 years of age.

Statewide snapshot:

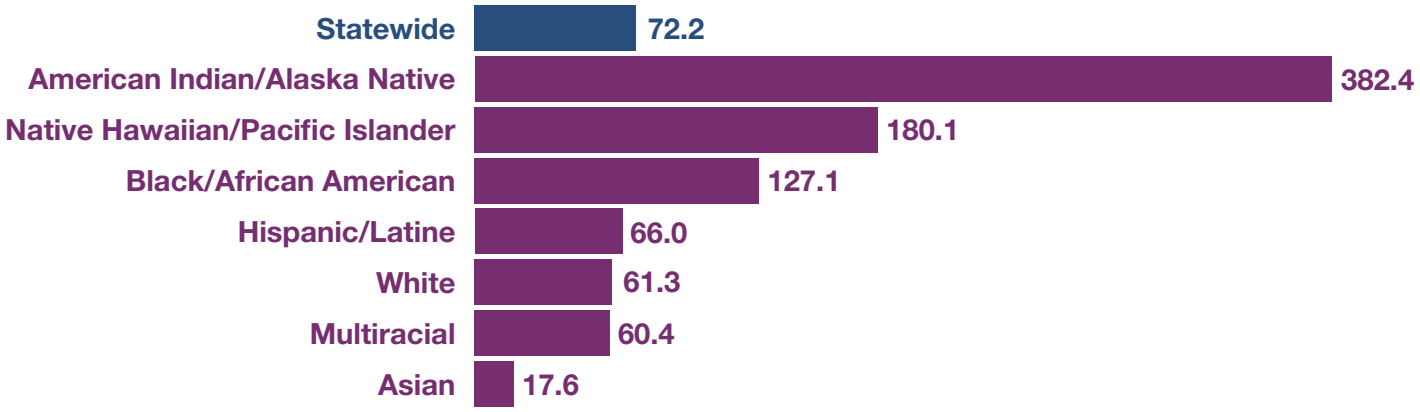
2023 (Baseline): 72.2 cases of syphilis (all stages) per 100,000 people who can become pregnant

2025 goal: 70.8 cases per 100,000 people who can become pregnant (2% decrease from baseline)

2030 goal: 65.0 cases per 100,000 people who can become pregnant (10% decrease from baseline)

Source: ORPHEUS

Figure 5. 2023 rate of syphilis among people who can become pregnant, by race and ethnicity



The rates of syphilis among pregnancy-capable people in Oregon who are American Indian/Alaska Native, Black/African American, and Native Hawaiian/Pacific Islander are significantly higher than the rate of syphilis among pregnancy-capable people statewide. In 2023, people in Oregon who are American Indian/Alaska Native made up 1.2% of people who can become pregnant and accounted for 6.1% of syphilis cases among people who can become pregnant. People in Oregon who are Native Hawaiian/Pacific Islander made up 0.5% of people who can become pregnant and accounted for 1.3% of syphilis cases among people who can become pregnant. People who are Black/African American made up 2.3% of people who can become pregnant in Oregon and accounted for 4.0% of syphilis cases among people who can become pregnant. Figure 5 does not show data regarding race/ethnicity of pregnancy-capable people with syphilis cases compared to the proportion of that population in Oregon.

Differences in syphilis rates are not inherently linked to race or ethnicity; rather, they stem from the social, economic and environmental contexts that disproportionately affect certain groups, creating barriers to optimal sexual health.

- Additional information about Oregon's REALD implementation is available at: https://www.oregon.gov/oha/ei/pages/reald.aspx/

Health outcome indicator #3: Rate of primary and secondary syphilis

This indicator measures the rate of primary and secondary stages of syphilis among the general population.

Statewide snapshot:

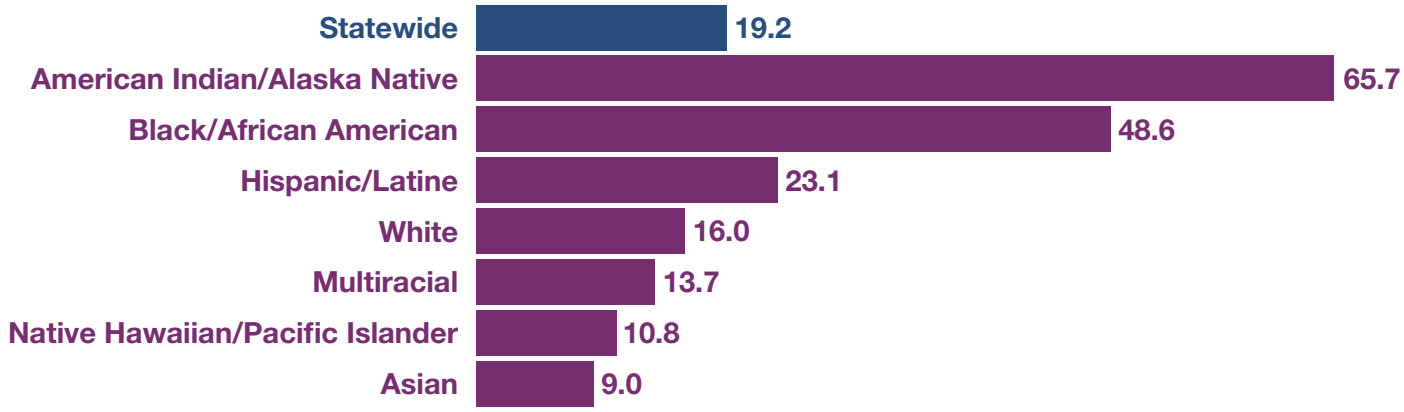
2023 (Baseline): 19.2 cases of primary or secondary syphilis per 100,000 people

2025 goal: 18.8 cases of primary or secondary syphilis per 100,000 people (2% decrease from baseline)

2030 goal: 16.3 cases of primary or secondary syphilis per 100,000 people (15% decrease from baseline)

Source: ORPHEUS

Figure 6. 2023 rate of primary and secondary syphilis by race and ethnicity



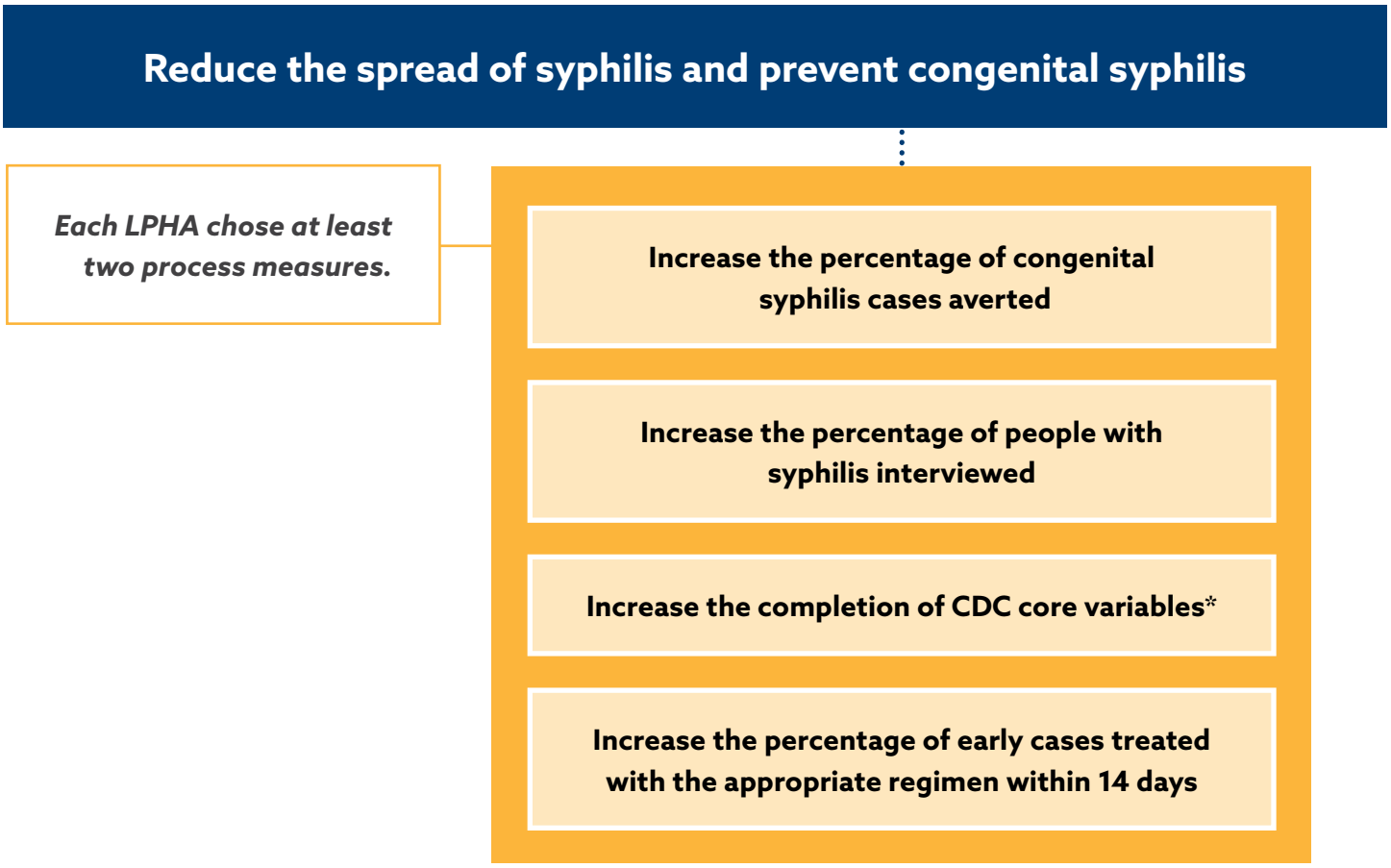
The rates of primary and secondary syphilis among people in Oregon who are American Indian/Alaska Native, Black/African American, and Hispanic/Latine are significantly higher than the rate of primary and secondary syphilis statewide. In 2023, people who are American Indian/Alaska Native made up 1.1% of people who live in Oregon and accounted for 3.7% of primary and secondary syphilis cases. People who are Black/African American made up 2.1% of people who live in Oregon and accounted for 5.3% of primary and secondary syphilis cases. Figure 6 does not show data regarding race/ethnicity of people with primary and secondary syphilis compared to the proportion of that population in Oregon.

Differences in syphilis rates are not inherently linked to race or ethnicity; rather, they stem from the social, economic and environmental contexts that disproportionately affect certain groups, creating barriers to optimal sexual health.

- Additional information about Oregon's REALD implementation is available at: https://www.oregon.gov/oha/ei/pages/reald.aspx/

LPHA process measures: Syphilis and congenital syphilis

Each LPHA selected at least two process measures to assess progress toward reducing the spread of syphilis and preventing congenital syphilis.



*The core variables for syphilis cases are race, ethnicity, pregnancy status, HIV status or date of last test, and sex of sex partners.

This figure shows which process measures each LPHA selected as areas of focus for 2023-25.

Figure 7. LPHA process measure selections

Jurisdiction	% Congenital syphilis cases averted	% People with syphilis interviewed	% Cases with CDC core variables completed	% Early cases treated within 14 days
Baker		X		X
Benton			X	X
Clackamas		X		X
Clatsop		X		X
Columbia		X	X	
Coos		X		X
Crook		X	X	
Curry*				
Deschutes	X			X
Douglas		X		X
Gilliam		X		X
Grant		X	X	
Harney			X	X
Hood River		X		X
Jackson		X		X
Jefferson		X		X
Josephine		X		X
Klamath		X	X	
Lake		X		X
Lane	X			X
Lincoln		X		X
Linn		X		X
Malheur		X	X	
Marion	X			X
Morrow		X		X
Multnomah		X	X	
NCPHD		X		X
Polk		X		X
Tillamook		X	X	
Umatilla		X	X	
Union		X		X
Wallowa*				
Washington			X	X
Wheeler		X		X
Yamhill		X	X	
Total:	**3**	**27**	**12**	**24**

Source: Program reporting

*Not applicable. Curry and Wallowa Counties transferred their public health authority to OHA in 2021 and 2018, respectively.

LPHA process measure #1: Percentage of congenital syphilis cases averted

This process measure assesses the percent of congenital syphilis cases averted by year. Timely testing and adequate treatment of pregnant people with syphilis can help avert potential congenital syphilis cases. This involves screening people at first presentation to receive care in pregnancy and again at 28 weeks' gestation, as well as ensuring that pregnant people with syphilis complete a stage-appropriate treatment regimen that begins at least 30 days before delivery.

This report calculates the number of potential congenital syphilis cases averted by subtracting the number of reported congenital syphilis cases from the number of reported pregnant people with syphilis. We then divide this number by the total number of reported pregnant people with syphilis to calculate the proportion of potential congenital syphilis cases averted.

LPHAs prioritize investigation of syphilis cases among pregnant people. They also educate providers on the importance of timely syphilis testing and timely stage-appropriate treatment during pregnancy.

The table below shows baseline data and 2030 goal for the three LPHAs that picked this process measure. The 2030 goal is a 10 percentage point increase from baseline.

Figure 8. Percentage of congenital syphilis cases averted by jurisdiction

Jurisdiction	Baseline: 2023	2030 goal
Statewide	**65.1**	**75.1**
Deschutes	0.0*	75.1
Lane	50	60
Marion	88.9	98.9

Source: ORPHEUS

*Because baseline = 0, Deschutes County should aim to meet or exceed the benchmarks for Oregon for 2024-2030 established using the 2023 statewide average. Using the statewide baseline of 65.1%, the 2030 goal for Deschutes is 75.1% of congenital syphilis cases averted.

LPHA process measure #2: Percentage of people with syphilis interviewed

LPHAs seek to interview all individuals with early syphilis and all pregnant and pregnancy-capable individuals with any stage of syphilis for partner services. This entails identification of sex partners to ensure their medical evaluation and treatment, as well as provision of health education and referrals to additional services. Interviews for partner services are essential for stopping the spread of syphilis and preventing repeat infections, particularly in pregnancy.

This LPHA process measure assesses the percentage of people with syphilis cases interviewed by jurisdiction.

LPHAs use traditional methods (e.g., calls, texts, mailed letters, field or clinic-based visits) to reach individuals for interviews for partner services. Many LPHAs use, or are exploring the use of, technology-based tools such as social media sites and mobile apps to locate and contact individuals, in accordance with LPHA policies and OHA recommendations. LPHA staff also participate in trainings on trauma-informed approaches to interviewing individuals diagnosed with a highly stigmatized STI. The table below shows baseline data and 2030 goal for the 27 LPHAs that chose this process measure. The 2030 goal is a 10 percentage point increase from baseline.

Figure 9. Percentage of people with syphilis interviewed by jurisdiction

Jurisdiction	Baseline: 2023	2030 goal
Statewide	**66.1**	**76.1**
Baker	41.7	51.7
Clackamas	75.2	85.2
Clatsop	66.7	76.7
Columbia	50.0	60.0
Coos	72.1	82.1
Crook	100.0	100.0
Douglas	65.8	75.8
Gilliam	N/A*	76
Grant	100.0	100.0
Hood River	75.0	85.0
Jackson	72.9	82.9
Jefferson	78.6	88.6
Josephine	60.0	70.0
Klamath	50.0	60.0
Lake	60.0	70.0
Lincoln	29.4	39.4
Linn	60.0	70.0
Marion	57.1	67.1
Morrow	50.0	60.0
Multnomah	66.6	76.6
NCPHD	83.3	93.3
Polk	58.3	68.3
Tillamook	60.0	70.0
Umatilla	75.0	85.0
Union	70.0	80.0
Wheeler	N/A*	76
Yamhill	50.0	60.0

Source: ORPHEUS

*Because baseline = N/A, Gilliam and Wheeler counties will use the statewide benchmark for 2024-2030 if cases are reported.

LPHA process measure #3: Completion of CDC core variables

Core variables, identified by the CDC Division of STD Prevention, are essential for describing trends in reported syphilis cases at the local and state level. The core variables for syphilis cases are race, ethnicity, pregnancy status, HIV status or date of last test, and sex of sex partners.

Improving the completion rate of core variables is necessary to ensure the data on key characteristics of syphilis cases is as accurate as possible for use in planning public health interventions.

LPHA staff use a variety of resources to capture core variables, including case interviews, chart reviews, provider outreach and social media accounts (in accordance with LPHA policies). LPHA staff also participate in trainings on best practices for collecting this data. The table below shows baseline data and 2030 goal for the 12 LPHAs that picked this process measure. The 2030 goal is a 10 percentage point increase from baseline.

Figure 10. Percentage completion of CDC core variables by jurisdiction

Jurisdiction	Baseline: 2023	2030 goal
Statewide	**84.6**	**94.6**
Benton	80.0	90.0
Columbia	76.7	86.7
Crook	92.0	100.0
Grant	75.0	85.0
Harney	75.0	85.0
Klamath	64.3	74.3
Malheur	76.0	86.0
Multnomah	85.8	95.8
Tillamook	88.0	98.0
Umatilla	81.9	91.9
Washington	87.2	97.2
Yamhill	77.1	87.1

Source: ORPHEUS

LPHA process measure #4: Percentage of early cases treated with appropriate regimen within 14 days

Syphilis is transmissible in its early stages — within one year of infection. Timely treatment with CDC-recommended first-line regimens for all individuals with early syphilis is integral to stopping the spread of syphilis. Prompt treatment of pregnant individuals with early syphilis (and their partners) is essential for congenital syphilis prevention—among pregnant individuals with *untreated* early syphilis, 80% of pregnancies will result in stillbirth, infant death or infant health complications.

LPHAs educate community providers on stage-appropriate syphilis treatment and the importance of prompt treatment. Through the OHA Bicillin Access Program, LPHAs provide the first-line drug for syphilis to community providers unable to stock it in order to ensure continuity of care for patients and prevent treatment delays. The table below shows baseline data and 2030 goal for the 24 LPHAs that chose this process measure. The 2030 goal is a 10 percentage point increase from baseline.

Figure 11. Percentage of early cases treated with appropriate regimen within 14 days by jurisdiction

Jurisdiction	Baseline: 2023	2030 goal
Statewide	**67.2**	**77.2**
Baker	50.0	60.0
Benton	50.0	60.0
Clackamas	61.9	71.9
Clatsop	75.0	85.0
Coos	82.7	92.7
Deschutes	81.0	91.0
Douglas	60.9	70.9
Gilliam	N/A*	77.2
Harney	0.0**	77.2
Hood River	50.0	60.0
Jackson	70.8	80.8
Jefferson	63.6	73.6
Josephine	83.3	93.3
Lake	50.0	60.0
Lane	70.2	80.2
Lincoln	62.5	72.5
Linn	54.2	64.2
Marion	62.0	72.0
Morrow	0.0**	77.2
NCPHD	75.0	85.0
Polk	64.7	74.7
Union	85.7	95.7
Washington	73.8	83.8
Wheeler	NA*	77.2

Source: ORPHEUS

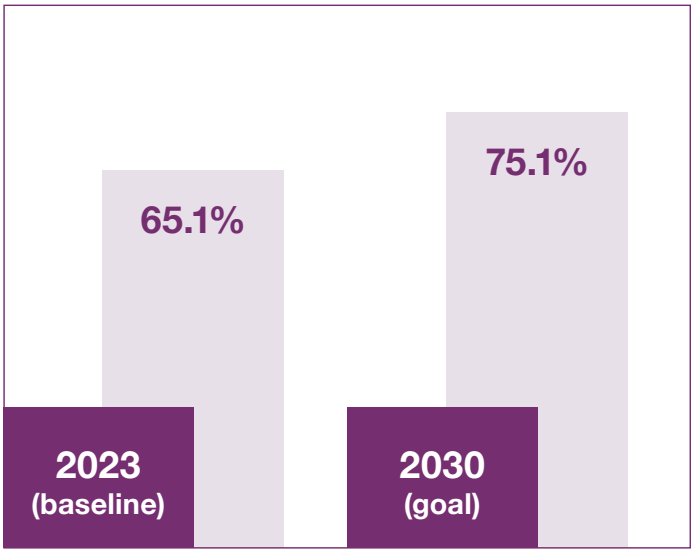
*Because baseline = N/A, Gilliam and Wheeler counties will use statewide benchmark for 2024-2030 if cases are reported.
**Because baseline = 0, Harney and Morrow counties will use statewide benchmark for 2024-2030.

OHA process measures: Syphilis and congenital syphilis

OHA's performance in the syphilis and congenital syphilis priority area is assessed by three process measures.

OHA process measure #1: Percentage of congenital syphilis cases averted statewide

Figure 12. Percentage of congenital syphilis cases averted statewide



Source: ORPHEUS

2023 Progress

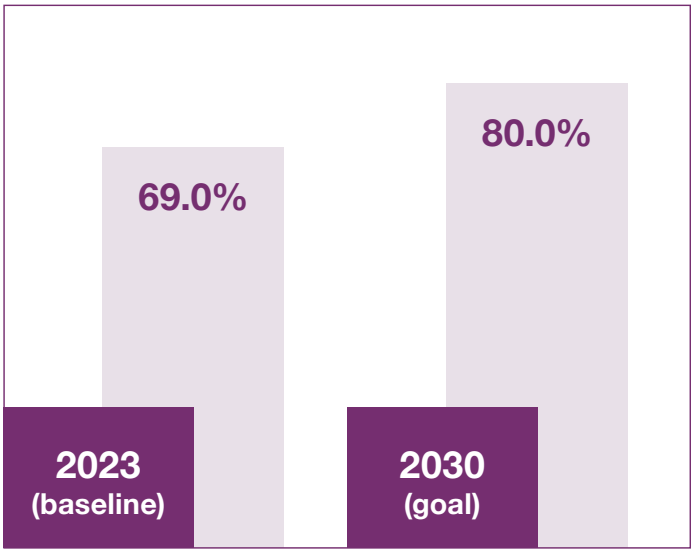
The OHA STD Program continued to provide technical assistance (TA) and trainings focused on congenital syphilis prevention in 2023 to LPHAs and other agencies that work with populations impacted by the syphilis epidemic. The program's quarterly congenital syphilis case/data review meetings featured guest speakers and experts in child welfare, refugee/immigrant resources, jail health services and services for pregnant people with substance use disorders.

OHA has public STI dashboards, including one with rates of congenital syphilis, updated every December with the most recent finalized data.[6] An internal dashboard accessible through the public health surveillance system allows LPHAs to monitor their STI performance metrics, including each county's proportion of congenital syphilis cases averted.

Finally, the OHA STD Program collaborated with a variety of partners to raise awareness about congenital syphilis and the importance of screening for and treating syphilis in pregnancy. Internally, the OHA STD Program collaborated with the OHA Family and Child Health Section. External partners consisted of LPHAs, Tribes, the Oregon Department of Corrections, the Northwest Portland Indian Health Board, and CBOs such as the Oregon Perinatal Collaborative and the AIDS Education and Training Center.

OHA process measure #2: Percentage of prenatal care providers who report screening all pregnant patients in the early third trimester

Figure 13. Percentage of prenatal care providers who report screening all pregnant patients in the early third trimester



Source: ORPHEUS

Work to date

The OHA STD Program conducted a baseline survey of Oregon prenatal providers' screening practices in 2022. The findings were published in a summary report, Emerging Practices for Responding to the Congenital Syphilis Emergency in Oregon: Recommendations for Health Care Providers, in collaboration with the Oregon Perinatal Collaborative in October 2023.[7] OHA has continued to coordinate with the Oregon Perinatal Collaborative to revise the questions and will launch the updated survey in mid-2025.

OHA process measure #3: Adoption of CCO/health system metrics to promote syphilis screening at three time points in pregnancy

Screening three times in pregnancy is necessary to promptly diagnose syphilis and initiate timely treatment. In addition to the medical consequences of missed screening, congenital syphilis has significant costs. Infants hospitalized for congenital syphilis had longer mean lengths of stay (12 days vs. 3 days) and greater mean hospitalization costs ($58,502 vs. $12,592) compared to infants hospitalized for other conditions.

Baseline data: Not available

2030 goal: CCO/health system adoption of metrics to promote syphilis screening at three points in time during pregnancy.

Work to date

The OHA STD Program presented to the Health Share of Oregon Clinical Advisory Panel in April 2023 on the impact of congenital syphilis in Oregon and the importance of appropriate screening and treatment. The OHA STD Program has been developing new relationships with CCO Innovator Agents to identify opportunities to improve provider education and patient care. The Program plans to further discuss actions CCOs can take to prevent congenital syphilis.

Metrics priority #2: Protect people from preventable diseases by increasing vaccination rates

One consequence of the COVID-19 pandemic was a sharp reduction in routine immunization of children, adolescents and adults, leaving groups at higher risk of diseases that are preventable.

Health outcome indicators

The immunization priority area will be assessed by two indicators representing statewide goals to increase rates.

- Two-year-old vaccination rate for the 4:3:1:3:3:1:4 series* (core vaccines children need before age two)
- Adult influenza vaccination rate in populations aged 65 and older

Oregon immunization data is available through the Oregon Immunization Program's Immunization Dashboard: https://public.tableau.com/app/profile/oregon.immunization.program/vizzes

Protecting people from preventable disease through vaccination is an urgent health issue.

Even before the drop in vaccination rates during the COVID-19 pandemic, Oregon experienced vaccination rate disparities for decades, with communities of color less likely to be vaccinated and more likely to experience a disproportionate burden of disease compared to the state average. Systemic barriers to vaccination access contribute to immunization rate disparities.

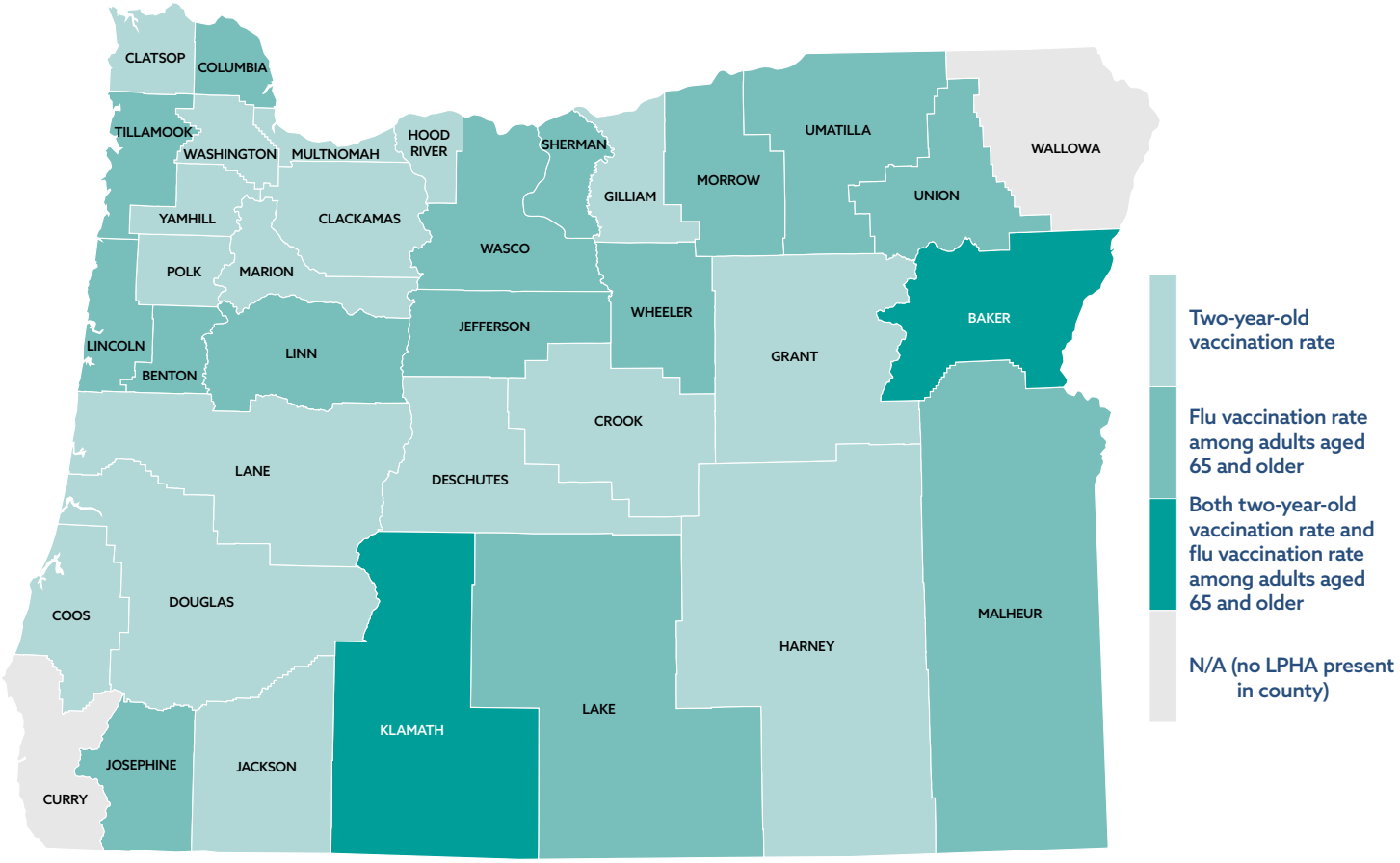
Prior to the COVID-19 pandemic, immunization rates in children and adults had been rising for nearly a decade. This coincided with the implementation of health care incentive measures and significant health care system reform, and resulted in a 10-percentage point increase in vaccination rates for two-year-olds between 2012 and early 2020. Oregon's declining rates following the COVID-19 pandemic are in sharp contrast to that trend.

The public health system can improve vaccination rates by addressing barriers to accessing vaccines, providing culturally relevant outreach and education, and working with health care providers and community partners.

* The 4:3:1:3:3:1:4 series refers to the following vaccines: four doses of diphtheria-tetanus-pertussis (DTap), three doses of polio (IPV), one dose of measles-mumps-rubella (MMR), three doses of Haemophilus influenzae type B (Hib), three doses of hepatitus B (HepB), one dose of varicella (VAR) and four doses of pneumococcal conjugate vaccine (PCV).

Each LPHA chose to focus on two-year-old vaccination rates, flu vaccination rates among adults 65 and older, or both, depending upon the priorities in their community and immunization rate trends at the local level.

Figure 14. LPHA immunization focus areas



Source: Annual LPHA Process Measure Survey

Health outcome indicator #1: Two-year-old vaccination rate (4:3:1:3:3:1:4 series)

This indicator measures the rate of two-year-olds across Oregon who are up-to-date on the 4:3:1:3:3:1:4 series (core vaccines children need before age two).

Statewide snapshot:

2023 (baseline): 68% of two-year-olds in Oregon up-to-date on the 4:3:1:3:3:1:4 series

2025 goal: 72% of two-year-olds in Oregon up-to-date on the 4:3:1:3:3:1:4 series (4 percentage point increase from 2023 baseline)

2030 goal: 80% of two-year-olds in Oregon up-to-date on the 4:3:1:3:3:1:4 series (12 percentage point increase from 2023 baseline)

Source: ALERT Immunization Information System (ALERT IIS)

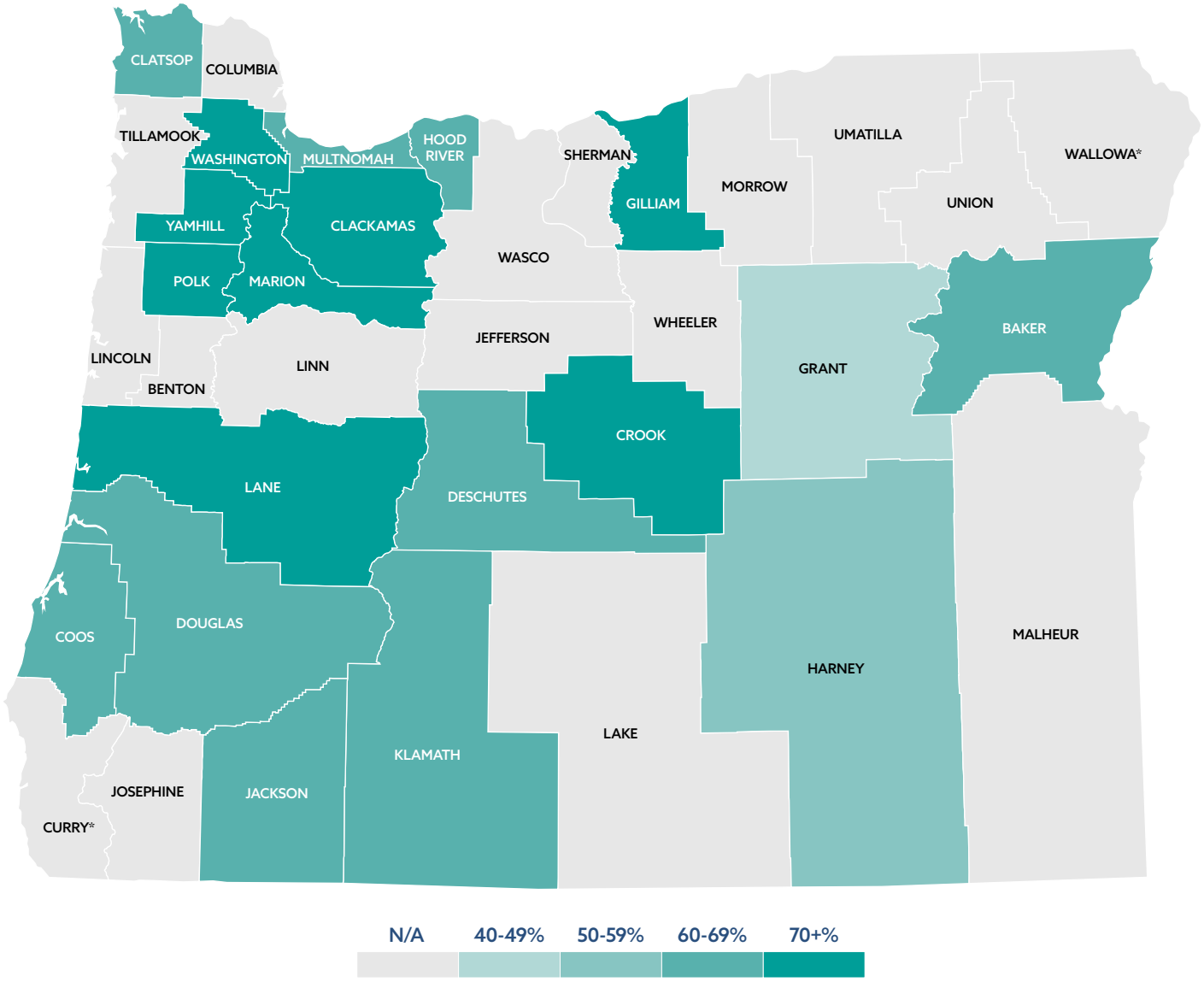
Figure 15. Two-year-old vaccination rate (4:3:1:3:3:1:4 series) by race and ethnicity, 2023

- Additional information about Oregon's REALD implementation is available at: https://www.oregon.gov/oha/ei/pages/reald.aspx/

Two-year-old immunization rates in Oregon have had persistent disparities by race and ethnicity, with Black/African American, Native Hawaiian/Pacific Islander and American Indian/Alaskan Native communities having rates below the state average.

Figure 16. Two-year-old vaccination rates by county, 2023

Figure 16 shows two-year-old vaccination rates (2023) for LPHAs that selected this focus area. Rates are not included for counties that did not select two-year-old vaccines as a focus area.



Source: ALERT IIS

**No LPHA present in county.*

Health outcome indicator #2: Adult influenza vaccination rate in populations ages 65 and older

This indicator measures the rate of influenza vaccination in adults ages 65 and older.

Statewide snapshot: Adult influenza vaccination rate in populations ages 65 and older

2023/2024 flu season (baseline): 47%

2025 goal: 51% (4 percentage point increase from 2023/2024 baseline)

2030 goal: 60% (13 percentage point increase from baseline)

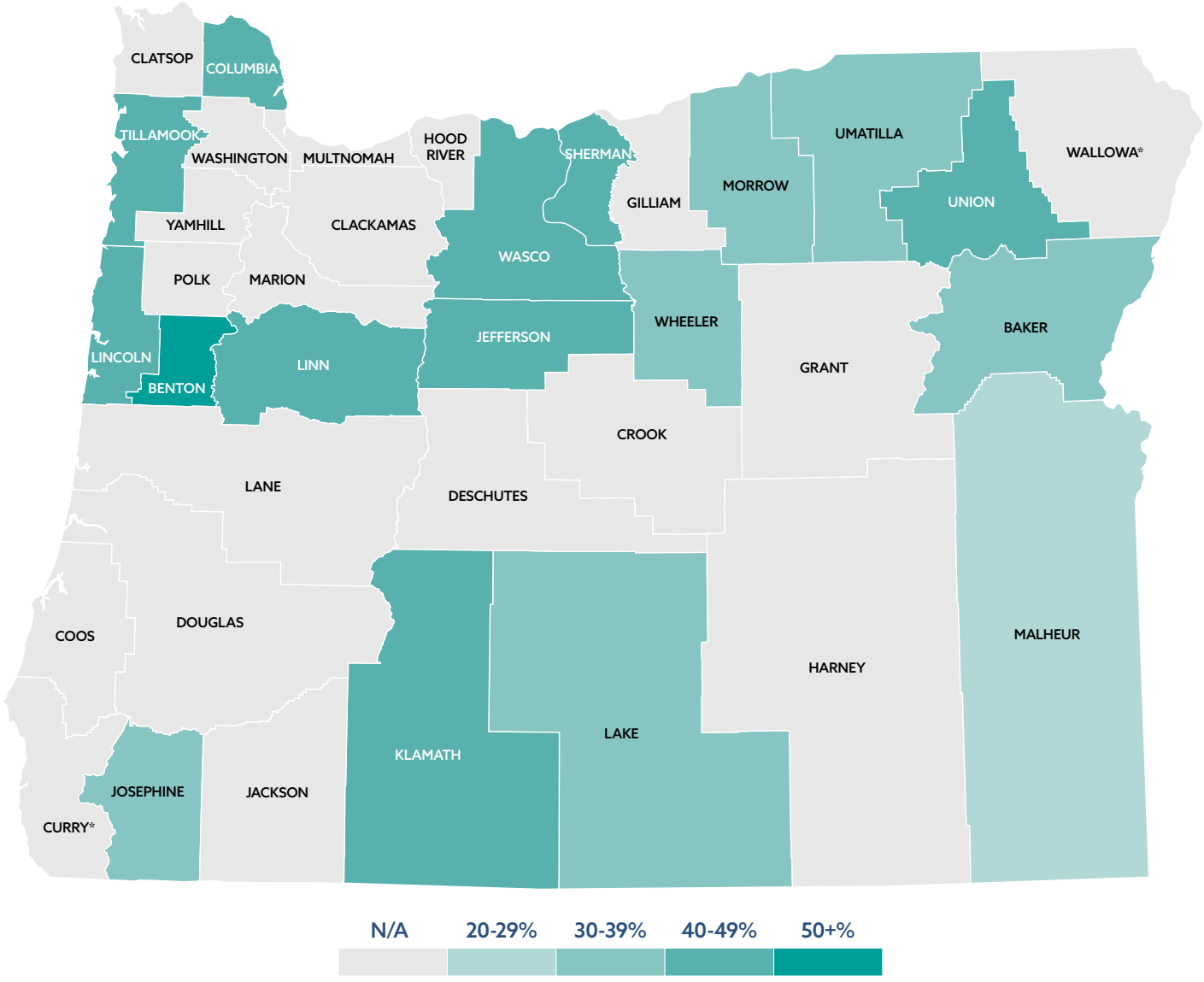
Source: ALERT IIS

Figure 17. Adult influenza vaccination rate in populations 65 and older by race and ethnicity, 2023/2024 flu season

Rates of influenza vaccination in populations 65 and older show significant disparities by race and ethnicity, with Black/African American and Hispanic/Latine communities being vaccinated at rates below the state average.

Figure 18. Adult influenza vaccination rate in populations ages 65 and older by county, 2023/2024 flu season

Figure 18 shows influenza vaccination rates in populations ages 65 and older (2023/2024 flu season) for LPHAs that selected this focus area. Rates are not included for counties that did not select adult influenza vaccination as a focus area.



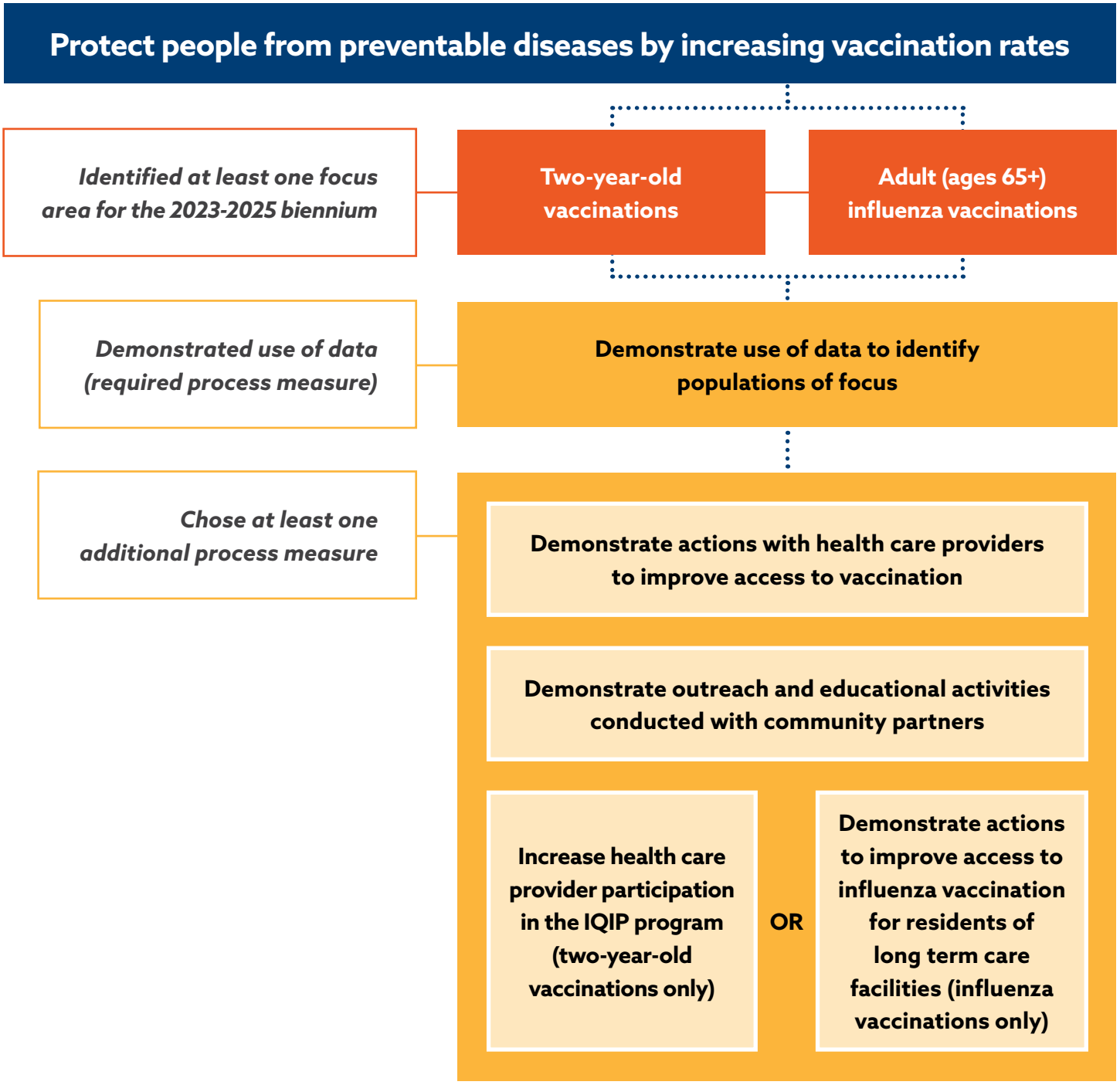
Source: ALERT IIS

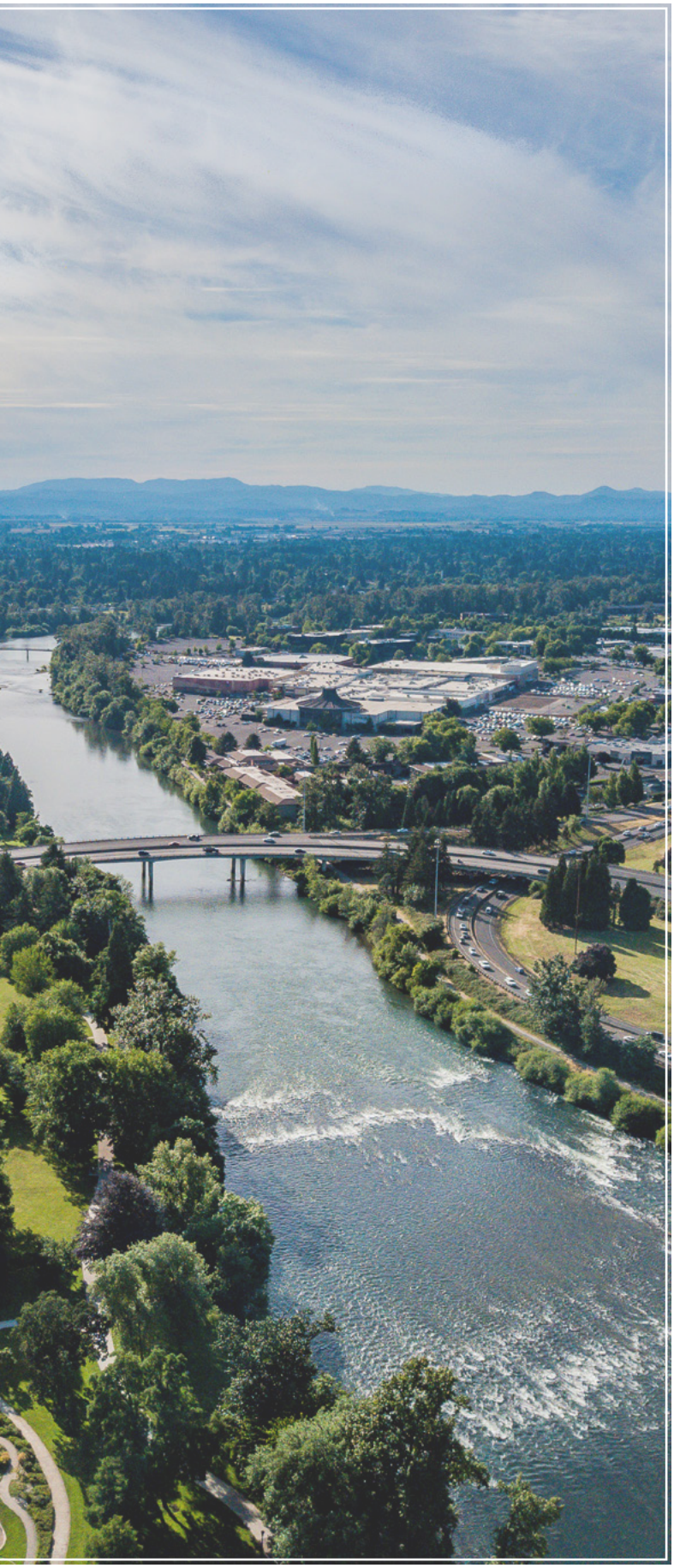
**No LPHA present in county.*

OREGON HEALTH AUTHORITY

LPHA process measures: Immunization

Each LPHA selected at least two process measures to assess progress toward protecting people from preventable diseases by increasing vaccination rates.





The process measures and associated goals are as follows:

LPHA process measure #1: Demonstrated use of data to identify population(s) of focus. All LPHAs must meet this process measure to meet the overall priority area goal.

- **2030 goal: Demonstrated expansion in strategies and engagement**

Using data to identify populations of focus helps identify specific demographic groups or populations experiencing lower vaccination coverage, enabling targeted outreach and direction of resources where they're most needed. Understanding these disparities through data helps health officials address systemic barriers to vaccination access, such as transportation challenges, language barriers or limited clinic hours that may disproportionately affect certain communities. All subsequent process measures and interventions rely on this.

LPHAs can meet this measure by conducting one or more of the following activities: reviewing OHA provided dashboards to identify groups at highest risk, analyzing granular patient level data at the zip code or other local level, or by working with CBOs to identify alternate data sources that may help with measuring disparities and implementing programs to address them.

LPHA process measure #2: Increase in the percent of health care providers participating in the Immunization Quality Improvement Program (IQIP). This process measure applies to two-year-old vaccinations only.

- **2030 goal: 25%, with demonstrated strategies by the LPHA to achieve the benchmark**

Increasing provider participation in the IQIP program helps ensure more consistent implementation of evidence-based strategies proven to improve vaccination rates across all patient populations. When providers participate in IQIP, they receive valuable technical assistance and resources to strengthen their vaccination practices, implement reminder/recall systems, and reduce missed opportunities for vaccination, leading to better immunization coverage throughout the community.

A higher percentage of IQIP-participating providers creates a stronger immunization infrastructure across the county, helping to prevent vaccine-preventable diseases while reducing disparities in vaccination coverage.

LPHAs can meet this measure by assisting with IQIP recruitment, attending IQIP visits with state staff or starting an IQIP project of their own. Several counties have created quality improvement partnerships that provide communities of learning for providers in the county often in partnership with CCOs, with the LPHA serving as a convener.

LPHA process measure #3: Demonstrated actions with health care providers to improve access to vaccination.

- **2030 goal: Demonstrated expansion in strategies and engagement**

Partnering with local health care providers allows the LPHA to leverage existing trusted relationships between patients and their medical homes, making vaccination efforts more effective since people are more likely to accept vaccines recommended by their regular health care providers. These partnerships can help identify and address gaps in vaccine access by combining the county's population-level data and resources with providers' direct knowledge of their patients' needs and barriers to care. Health care provider partnerships also enable better coordination of vaccine distribution, shared educational resources and consistent messaging across the community, creating a more robust and efficient vaccination delivery system.

LPHAs can meet this measure by working with local providers to expand clinic hours, provide weekend access to immunization walk in clinics, host special vaccination clinics at offsite events or identify other potential quality improvement projects with providers such as sending patient reminders.

LPHA process measure #4: Demonstrated outreach and educational activities conducted with community partners to increase vaccine access or demand.

- **2030 goal: Demonstrated expansion in strategies and engagement**

Community partners including CBOs have established trust and deep cultural understanding within specific populations, making them invaluable partners in delivering culturally appropriate vaccine education and addressing unique community concerns and hesitancy. These organizations often serve as crucial bridges between public health systems and harder-to-reach populations, offering familiar spaces, trusted messengers and communication channels that resonate with community members who might be disconnected from traditional health care settings.

By partnering with CBOs, health departments can extend their reach while ensuring that vaccine education and access initiatives are delivered in ways that respect and respond to the diverse needs, values and experiences of different community groups.

LPHAs can meet this measure by hosting vaccination clinics or offsite events with CBOs, by working on promotional campaigns or events, or by partnering with community organizations to develop culturally specific communication materials.

LPHA process measure #5: Demonstrated actions to improve access to influenza vaccination for residents of long-term care facilities (LTCFs). This process measure applies to influenza vaccinations only.

- **2030 goal: Demonstrated expansion in strategies and engagement**

Adults in LTCFs are at significantly higher risk of severe complications from influenza due to their age, underlying health conditions and congregate living environment. By prioritizing influenza vaccine access in LTCFs, LPHAs can help reduce health disparities and protect some of their community's most medically vulnerable members while potentially decreasing seasonal demands on local hospitals and emergency departments.

LPHAs meet this measure by partnering with LTCFs to host vaccination clinics at the facility, either with LPHA staff or with additional clinical partners such as pharmacies. Additionally, some counties may want to partner with facilities to address systemic barriers to access that may prevent residents from getting vaccinated, such as transportation issues, or even work to develop community specific promotional materials and education campaigns.

LPHA process measures: Two-year-old vaccination

Figure 19 shows the status of progress toward process measure requirements for LPHAs that selected two-year-old vaccination as a focus area. While LPHAs report on a limited number of process measures, many LPHAs do work that addresses all process measure areas.

Figure 19. Two-year-old vaccination process measure status, 2023

		Required	Choice of One or More		
County	On track to meet requirement*	Demonstrated use of data	Increased % health care providers participating in IQIP	Demonstrated actions with health care providers to improve access to vaccines	Worked with community partners to increase vaccine access or demand
Baker	✓	Yes	No	Yes	Yes
Benton					
Clackamas	✓	Yes	No	No	Yes
Clatsop	✓	Yes	No	Yes	Yes
Columbia					
Coos	✓	Yes	No	No	Yes
Crook	✓	Yes	No	No	Yes
Curry**					
Deschutes	✓	Yes	Yes	Yes	Yes
Douglas	✓	Yes	No	Yes	Yes
Gilliam	X	No	No	Yes	Yes
Grant	✓	Yes	No	No	Yes
Harney	✓	Yes	No	No	Yes
Hood River	✓	Yes	No	No	Yes
Jackson	✓	Yes	No	Yes	Yes
Jefferson					
Josephine					
Klamath	✓	Yes	No	Yes	Yes
Lake					
Lane	✓	Yes	No	Yes	No
Lincoln					
Linn					
Malheur					
Marion	✓	Yes	No	No	Yes
Morrow					
Multnomah	✓	Yes	No	No	Yes
North Central PH District					
Polk	X	No	No	No	Yes
Sherman***					
Tillamook					
Umatilla					
Union					
Wallowa**					
Wasco***					
Washington	✓	Yes	No	Yes	Yes
Wheeler					
Yamhill	✓	Yes	No	Yes	No

*On track to meet requirement is based on answering "yes" to required process measure 1 (use of data) and "yes" to at least one of the process measures 3 (HCP participation in IQIP), 4 (HCP actions to improve access) or 5 (work with community partners).

**Not applicable. Curry and Wallowa Counties transferred their public health authority to OHA in 2021 and 2018, respectively.

***North Central Public Health District is comprised of Sherman and Wasco counties.

LPHA process measures: Adult influenza vaccination in populations ages 65 and older

Figure 20 shows the status of progress toward process measure requirements for LPHAs that selected influenza vaccination as a focus area. While LPHAs report on a limited number of process measures, many LPHAs do work that addresses all process measure areas.

Figure 20. Adult ages 65+ influenza vaccination process measure status, 2023-2024 flu season

		Required	Choice of One or More		
County	On track to meet requirement**	Demonstrated use of data	Demonstrated actions to improve access for residents in LTCFs	Demonstrated actions with health care providers to improve access to vaccines	Worked with community partners to increase vaccine access or demand
Baker	✓	Yes	Yes	Yes	Yes
Benton	✓	Yes	Yes	No	No
Clackamas					
Clatsop					
Columbia	✓	Yes	Yes	Yes	No
Coos					
Crook					
Curry*					
Deschutes					
Douglas					
Gilliam					
Grant					
Harney					
Hood River					
Jackson					
Jefferson	✓	Yes	Yes	Yes	Yes
Josephine	✓	Yes	Yes	Yes	Yes
Klamath	✓	Yes	No	Yes	Yes
Lake	X	No	Yes	Yes	Yes
Lane					
Lincoln	✓	Yes	Yes	Yes	Yes
Linn	✓	Yes	Yes	Yes	Yes
Malheur	✓	Yes	Yes	No	Yes
Marion					
Morrow	✓	Yes	Yes	Yes	Yes
Multnomah					
North Central PH District	✓	Yes	Yes	Yes	Yes
Polk					
Sherman***					
Tillamook	✓	Yes	No	Yes	Yes
Umatilla	X	No	Yes	Yes	Yes
Union	✓	Yes	Yes	Yes	Yes
Wallowa*					
Wasco***					
Washington					
Wheeler	X	No	Yes	No	Yes
Yamhill					

*On track to meet requirement is based on answering "yes" to required process measure 1 (use of data) and "yes" to at least one of the process measures 3 (HCP participation in IQIP), 4 (HCP actions to improve access) or 5 (work with community partners).
**Not applicable. Curry and Wallowa Counties transferred their public health authority to the OHA in 2021 and 2018, respectively.
***North Central Public Health District is comprised of Sherman and Wasco counties.

OHA process measures: Immunization

OHA's performance in the immunization priority area is assessed by four process measures.

OHA process measure #1: Develop and maintain data for immunization indicators

Developing and providing immunization indicators enables data-driven decision making at both state and local levels, helping LPHAs identify areas of low vaccination coverage, track progress over time and allocate resources where they're most needed. These indicators serve as crucial benchmarks for measuring health equity, allowing the identification of disparities across geographic areas, demographic groups and health care providers that might otherwise go unnoticed. By maintaining and sharing standardized immunization indicators, OHA assists LPHAs with the information they need to design targeted interventions, evaluate their effectiveness and make evidence-based improvements to their immunization programs.

Process measure status: Not met

Process measure		2023 status
Develop and maintain data for immunization indicators (2030 goal: 100% of milestones met)		**Not met (50% of milestones met)**
Milestones (16.6% each)	2-year-old data dashboard available, with data by county and race and ethnicity	**Met**
	2-year-old data dashboard updated quarterly during the year	**Not met**
	Additional data made available to counties at zip code, clinic or patient level upon request	**Not met**
	Influenza dashboard for 65 plus age groups available, with data by county and race and ethnicity	**Met**
	Influenza dashboard updated weekly during flu season	**Met**
	Additional data made available to counties at zip code, clinic or patient level upon request	**Not met**

OHA currently maintains vaccination dashboards for seasonal influenza and two-year-old vaccination rates. Work is currently in progress to implement quarterly updates to the two-year-old vaccination dashboard, increasing from annual updates. Additionally, zip code level data is scheduled to be implemented for both measures by mid-2025.

OHA process measure #2: Provide data to Coordinated Care Organizations (CCOs) to meet immunization incentive measures and partner with CCOs on QI program implementation

Maintaining the data linkage and partnership with CCOs is critical to continuing to improve immunization rates in Oregon. CCOs utilize their member data to facilitate the implementation of numerous quality improvement programs across the state, and often work in partnership with local providers and LPHAs to increase immunization rates in the communities they serve.

Process measure status: Met

Process measure		2023 status
Provide data to CCOs to meet immunization incentive measures and partner with CCOs on QI program implementation (2030 goal: 100% of milestones met)		**Met (100%)**
Milestone	Percent of data files provided to CCOs on a timely basis	**100%**

OHA maintains a routine data feed to CCOs that provides data on all members, as well as the subset of members who fall into the CCO incentive metric. Additionally, OHA provides Alert Immunization Information System (ALERT IIS) access to CCO staff to verify vaccination records of individuals as well as responding to CCO questions about missing or incomplete vaccination records and partnering with CCOs if they have additional needs around immunization quality improvement.

OHA process measure #3: Implement the IQIP Program

The Immunization Quality Improvement for Providers (IQIP) program is a CDC-sponsored quality improvement program that provides education and technical assistance to providers. IQIP site visitors from the state immunization program work with individual clinics to implement evidence-based quality improvement strategies, strengthen vaccination practices and reduce missed opportunities. This program often serves as a foundation for immunization quality improvement work throughout the state, including partnerships with health systems, LPHAs and CCOs.

To meet this process measure, OHA must meet the CDC goal of performing an IQIP visit with 25% of Vaccines for Children (VFC) enrolled providers.

Process measure status: Not met

	Process measure	2023 status
Implement the Immunization Quality Improvement for Providers Program. (2030 goal: IQIP visit performed with 25% of VFC providers)		**Not met (10.5%)**
Milestone	Percentage of VFC enrolled providers who received an IQIP visit	**64/608 (10.5%)**

OHA is currently working to improve clinic recruitment for IQIP, working with health systems, offering incentives such as Continuing Education Credits for participation as well as working to foster local IQIP partnerships with LPHAs and CCOs.

OHA process measure #4: Assure a state vaccine finance model that is sustainable, equitable and adequately funded to provide recommended vaccines to all people in Oregon

Oregon's 30-year-old vaccine finance model is outdated, fragmented and burdensome for both providers and OHA. Vaccine costs are increasing rapidly, immunization rates have decreased, the system is underfunded and growing complexity in managing immunization programs has hindered improvement efforts. Many small and rural providers find it difficult and cost-prohibitive to participate in the Vaccines for Children (VFC) program.

Process measure status: Not met

Process measure		2023 status
Assure vaccine supply and monitor the state's vaccine finance model to ensure it is sustainable, equitable, and adequately funds vaccination programs. (2030 goal: 100% of milestones met)		**Not met (57% of milestones met)**
Milestones	Complete research on other state models.	**Met**
	Convene in-person summit with statewide healthcare partners.	**Met**
	Recruit/convene multidisciplinary vaccine finance reform steering committee.	**Met**
	Committee selection of one or more strategies to move forward.	**Met**
	Fully developed vaccine finance framework proposed by committee.	**Not met**
	Vaccine finance reform implemented.	**Not met**
	Evaluation performed of vaccine finance reform model.	**Not met**

This is a multi-step project that is expected to take several years. OHA convened an in-person vaccine finance summit in 2024. Following the summit, a multidisciplinary steering committee with representation throughout the health care system then convened. The steering committee released a report with recommendations for OHA including to further evaluate and model a Universal Vaccine Purchase program and fully invest in current programs, and direct additional bridge funding to the current programs (Vaccine Access Program and Vaccines for Children) to maintain and expand provider participation until the vaccine finance system can be reformed.[8]

Climate Impacts on Health

OREGON HEALTH AUTHORITY

Metrics priority #3: Increase community resilience for climate impacts on health: extreme heat and wildfire smoke

Through a collaborative planning process, OHA and PHAB partners established indicators to measure the public health system's progress in building community resilience to climate change health impacts specifically in two areas – extreme heat and wildfire smoke.

Data and information from partners and communities demonstrate the increasing need to address climate impacts on health through collective public health action by OHA and other state agencies, federally recognized Tribes, LPHAs and CBOs.

In future years, PHAB partners will develop metrics (indicators and process measures) to assess the health impacts of drinking water security and mental health effects of climate change.

Health outcome indicators

OHA assesses the extreme heat priority area by using three health outcome indicators:

- Emergency department and urgent care visits due to heat
- Hospitalizations due to heat
- Heat deaths

OHA assesses the wildfire smoke priority area with one indicator:

- Respiratory (non-infectious) emergency department and urgent care center visits

Extreme heat, wildfire smoke and drinking water security are urgent health issues with higher impacts to Tribal communities, communities of color, communities with lower incomes and rural communities.[9]

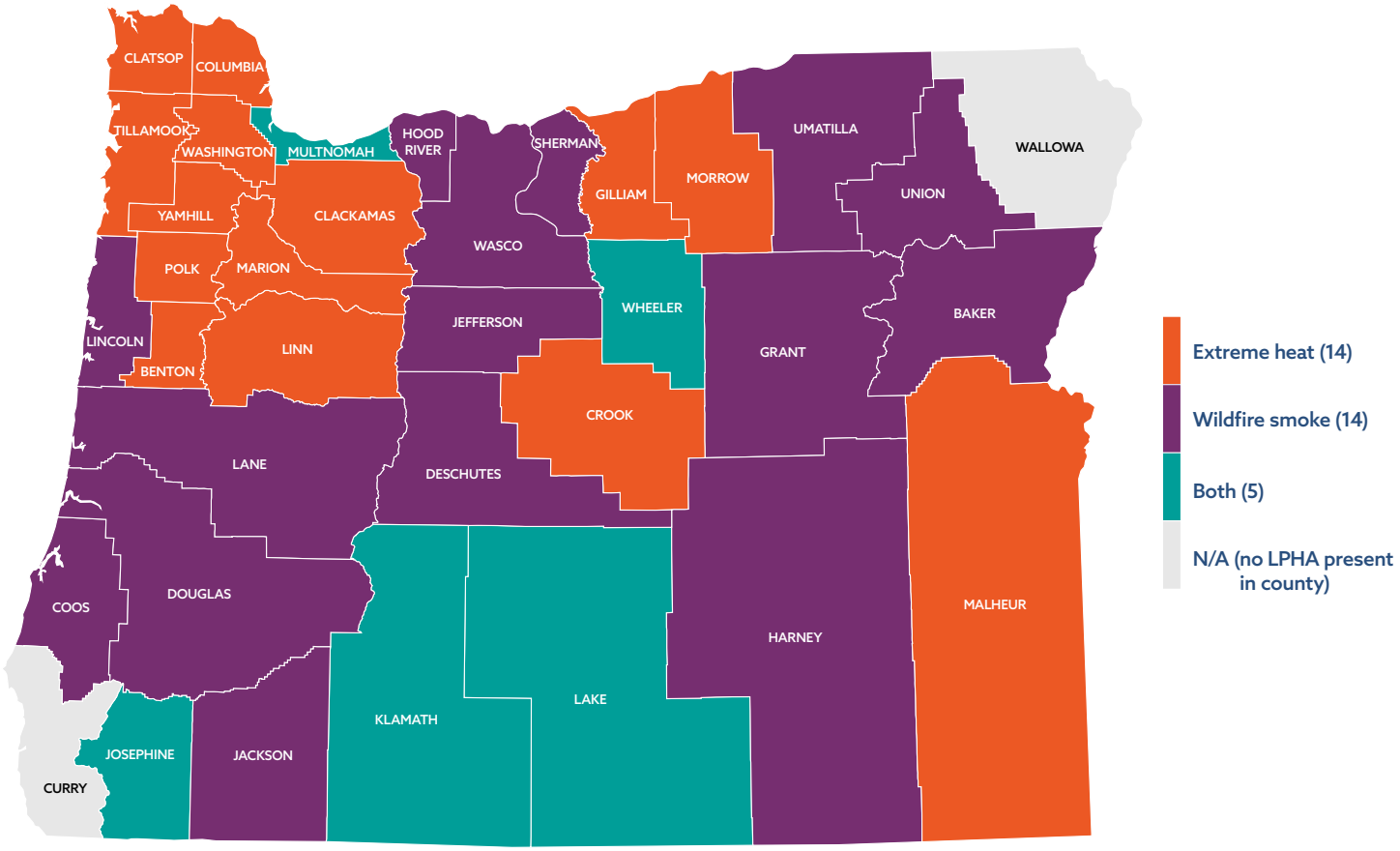
Oregon has experienced severe climate events in recent years, with unprecedented morbidity and mortality impacts to key communities. Data from 2023 help us better understand which populations to prioritize in our public health strategies. In 2023, Oregon saw:

- American Indian/Alaska Native, Black/African American and Native Hawaiian/Other Pacific Islander communities experienced non-infectious (previously known as air quality-related) respiratory illness visits at rates double or near-double the statewide rates.
- Seven counties, mostly rural, experienced 14 or more days with high heat and compromised air quality occurring at the same time. When exposures to heat and smoke happen simultaneously, they can produce health impacts greater than the effects of exposure to just one of these.
- Oregon residents are experiencing health effects from heat on days when the heat index is at or above 80°F. This could be due to people living in regions of the state who are not acclimatized to higher-than-average temperatures for the area.
- Nearly every county in Oregon experienced severe to exceptional drought, with long-term implications for access to safe and reliable drinking water.[9]

In 2023, state and federal leaders also increased investments to protect people in Oregon at highest risk of health impact from climate change-driven health risks. Oregon's public health system works across sectors and with partners to roll out these protections and continue moving policies to mitigate climate impacts on health.

LPHAs selected focus areas for climate-related process measures based on local issues their communities experience. Fourteen chose extreme heat; fourteen chose wildfires. Five LPHAs selected both extreme heat and wildfires.

Figure 21. Map of LPHAs focusing on extreme heat, wildfire smoke or both



Source: Annual LPHA Process Measure Survey

Extreme heat is on the rise.

Summer heat-related morbidity and mortality are rising in Oregon. Exposure to higher temperatures and extreme heat is on the rise because of the frequency, length and intensity of heat events. Increased heat corresponds with greater illness and deaths.

People at higher risk of negative health impacts of extreme heat include:

- People over 64 years of age
- People who are pregnant
- Infants and children
- People experiencing mental illness
- People living with chronic health conditions
- People who live or work in settings that put them at increased risk of health impacts from extreme heat, including:
  - People working outdoors, e.g., migrant and seasonal workers
  - People experiencing houselessness
  - People experiencing poverty
  - Athletes

Other factors that make people more susceptible to heat-related illness include humidity, lack of acclimatization and exposure to consecutive days of heat with limited overnight cooling.[9]

Extreme heat health outcome indicator #1: Emergency department and urgent care visits due to heat

This indicator measures the heat-related illness (HRI) emergency department (ED) and urgent care center visit rate per 1 million population, relative to the number of days at or above 80°F heat index. It is calculated by counting the total number of statewide HRI visits, dividing by the statewide total population between May-September and multiplying by 1M. Statewide rates are reduced further to set benchmarks: Total number HRI visits (per 1M) are divided by the number of days with heat index ≥80°F. A single individual may present to health facilities multiple times for the same complaint. Therefore, rates are not estimations of a true population-based rate.

Statewide snapshot: Heat-related illness ED and urgent care center visit rate

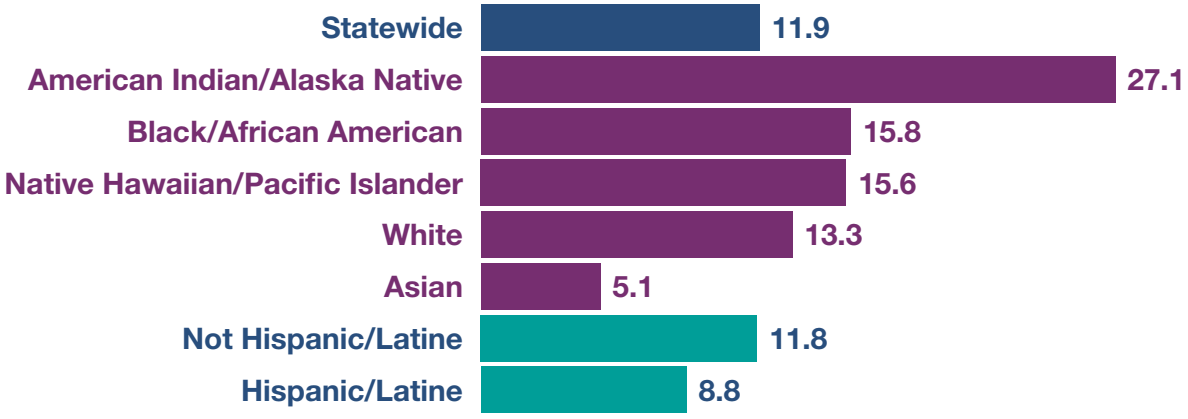
2023 (baseline): 1.79 HRI visits (per 1M) per day ≥80°F heat index

2025 goal: 1.61 HRI visits (per 1M) per day ≥80°F heat index (10% reduction from 2023 baseline)

2030 goal: 0.85 HRI visits (per 1M) per day ≥80°F heat index (50% reduction from 2023 baseline)

Source: Oregon ESSENCE

Figure 22. Heat-related emergency department and urgent care center visit rates per 50,000 population by race and ethnicity, Oregon 2023

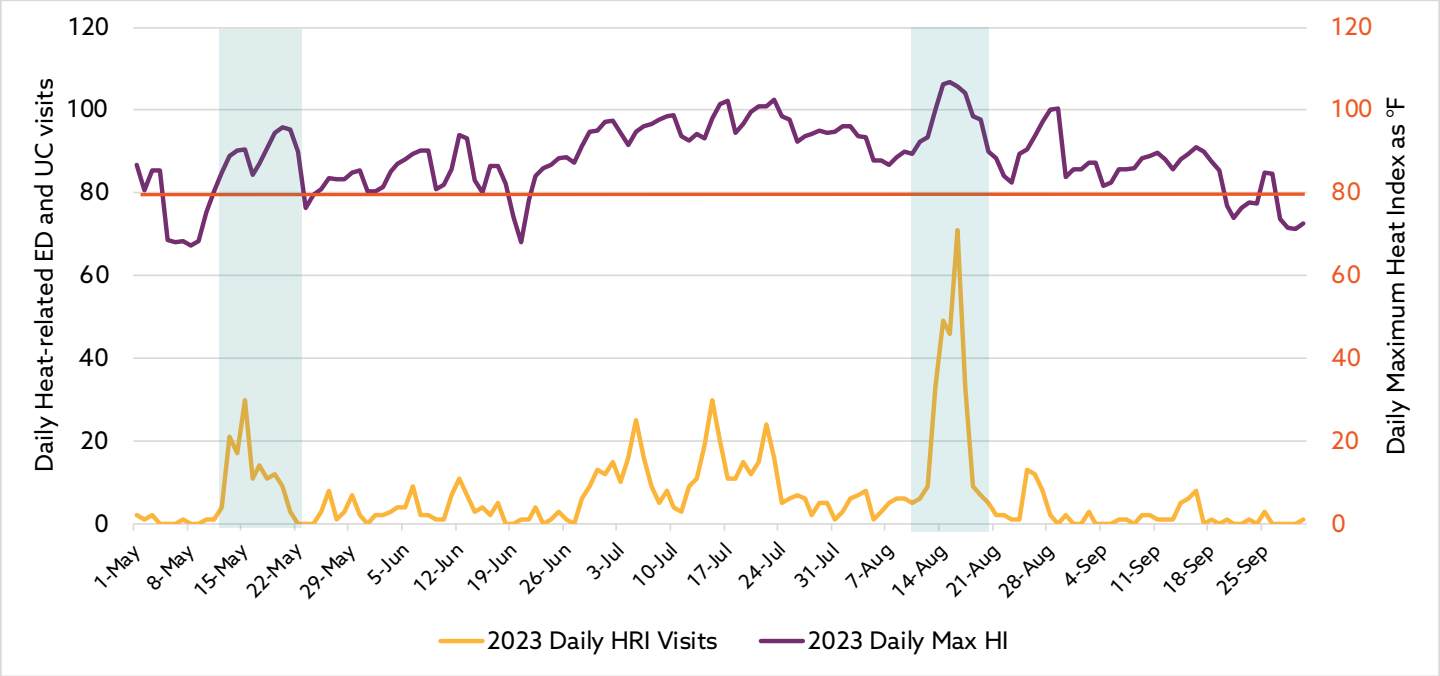


Race/ethnicity categories provided by Oregon ESSENCE are not mutually exclusive. One individual may contribute to one or more categories.

Heat-related ED and urgent care center visit rates were highest among people who are American Indian or Alaska Native, Black or African American, and Native Hawaiian or Pacific Islander when compared to other race/ethnicity categories and the statewide visit rate for the entire population.

- Additional information about Oregon's REALD implementation is available at: https://www.oregon.gov/oha/ei/pages/reald.aspx/

Figure 23. Daily heat-related illness emergency department and urgent care center visits and maximum daily heat index, Oregon, May to September 2023



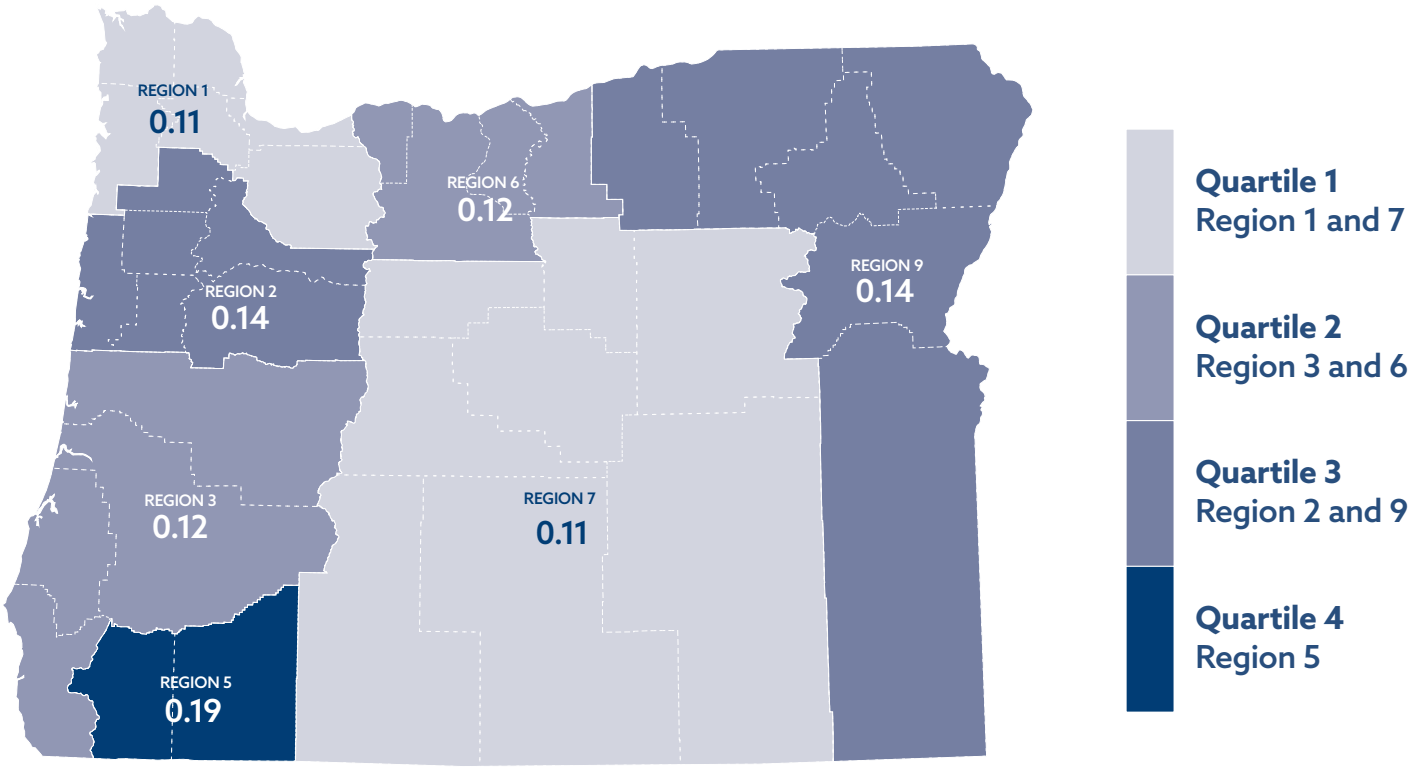
Source: Oregon ESSENCE

OHA is seeing health effects from heat on days when the heat index is at or above 80°F. In May 2023, Oregon experienced twelve consecutive days when the maximum heat index was between 80°F and 89°F, coinciding with increases in statewide early season HRI ED and urgent care center visits. This could be due to a lack of acclimatization to temperatures that are higher than average for a particular location in early summer compared to the middle to late summer. In June-August 2023, consecutive heat index days at or above 90°F and 100°F coincided with increases in statewide HRI visits. In mid-August, a heat wave of five consecutive heat index days greater than 100°F caused a spike in statewide HRI.

Heat-related emergency department and urgent care center visit rates per 50,000 population by region

Data for this health outcome indicator is presented by region, as defined by OHA's Health Security, Preparedness and Response (HSPR) section, due to low visit counts by county.

Figure 24. Map of heat-related illness emergency department and urgent care center visits per 50,000 population per day at or above 80°F, by HSPR region, Oregon 2023



Sources: Oregon ESSENCE, Portland State University Population Research Center certified population estimates

Region 1
- Clackamas
- Clatsop
- Columbia
- Multnomah
- Tillamook
- Washington

Region 2
- Benton
- Lincoln
- Linn
- Marion
- Polk
- Yamhill

Region 3
- Coos
- Curry
- Douglas
- Lane

Region 5
- Josephine
- Jackson

Region 6
- Gilliam
- Hood River
- Sherman
- Wasco

Region 7
- Crook
- Deschutes
- Grant
- Harney
- Jefferson
- Klamath
- Lake
- Wheeler

Region 9
- Baker
- Malheur
- Morrow
- Umatilla
- Union
- Wallowa

Extreme heat health outcome indicator #2: Heat-related hospitalizations

This health outcome indicator measures the heat-related hospitalization rate per 4.2 million population. It is calculated by counting the total number of heat-related hospitalizations in a specified geographic area (by state or county), dividing by the total population of the same geographic area within a specified time period (May-September) and multiplying by 4.2M (the rough total population of Oregon).

Statewide snapshot: Heat-related hospitalization rate

2023 (baseline): 69 heat-related hospitalizations per 4.2m population (crude rate)

2025 goal: 52 heat-related hospitalizations per 4.2M population (25% reduction from 2023 baseline)

2030 goal: 28 heat-related hospitalizations per 4.2M population (60% reduction from 2023 baseline)

Source: Oregon Oregon Health Authority Hospital Reporting Program, Oregon Hospital Discharge Data

Figure 25. Annual rate of heat-related hospitalizations per 4.2M population, Oregon, 2021-2023

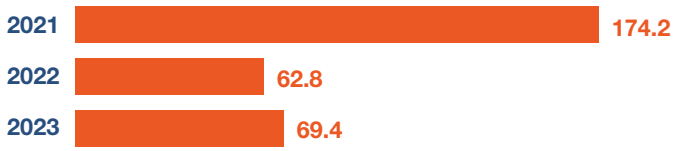


Figure 26. Number of days ≥80°F heat index, Oregon, 2021-2023

Summer heat-related illness hospitalizations in Oregon rose significantly during the 2021 heat dome year, when Oregon experienced 132 days at or above 80°F. Heat-related hospitalization rates in 2023 were lower than in 2021, despite more heat index days at or above 80°F (133 days). A possible reason for lower rates in 2023 is improvements in protective public health communications messaging and state-funded air conditioner distribution through Program Section 7 of Senate Bill 1536, 2022. Other factors affecting year-to-year health outcomes from excessive heat are regional differences in heat index and temperature ranges, acclimatization, consecutive days of heat and overnight cooling.

Extreme heat health outcome indicator #3: Heat-related deaths

This health outcome indicator measures the number of heat-related deaths occurring in Oregon, each May to September.

Statewide snapshot: Heat-related deaths

2023 (baseline): 8 heat-related deaths

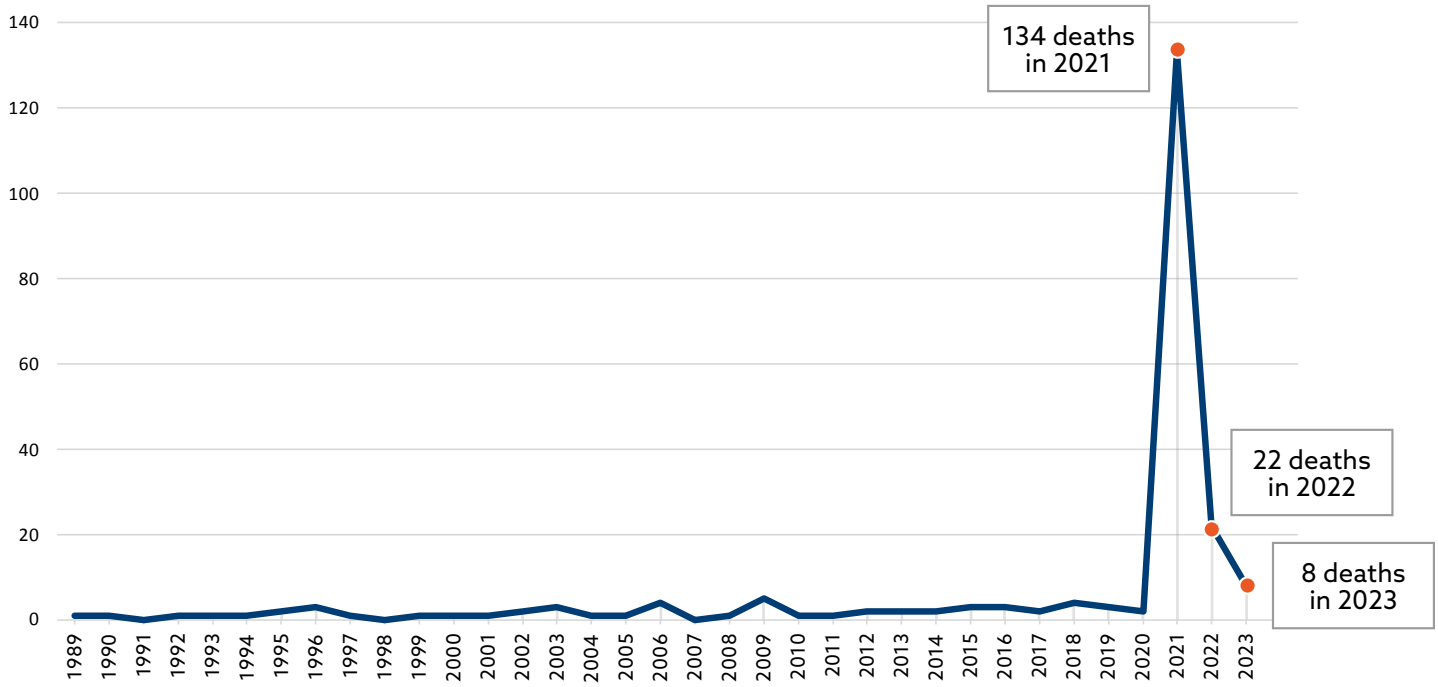
2025 goal: 6 heat-related deaths (30% reduction from 2023 baseline)

2030 goal: 2 heat-related deaths (70% reduction from 2023 baseline)

Source: Oregon Center for Health Statistics, Vital Records

Figure 27. Heat-related deaths in Oregon, 1989 – 2023

Deaths from excessive heat did not exceed four per year in the decade prior to 2021 (when the heat dome occurred).



Wildfires are the primary contributor to summer air pollution across Oregon.

The frequency and intensity of wildfires in Oregon and many other western U.S. states is on the rise. Many areas in Oregon experience cumulative wildfire smoke impacts and community members are exposed to hazardous air pollution year after year.

Communities of color and Tribal communities in Oregon have experienced disproportionate health impacts of wildfire smoke, as measured by respiratory ED and Urgent Care visits in Oregon.

These inequities, rooted in systemic racism, exist due to unequal access to community resources, higher community exposures and individual conditions that increase vulnerabilities, such as those tied to employment.

People at higher risk of negative health effects of smoke exposure include:

- People with chronic respiratory, cardiovascular and other chronic conditions
- People over 64 years of age
- Infants, children and youth
- People who are pregnant (and their fetus)
- People who smoke tobacco
- People who live or work in settings that put them at increased risk of smoke exposure, including:
  - People working outdoors, e.g., migrant and seasonal agricultural workers
  - People experiencing homelessness
  - People experiencing poverty
  - People exposed to high temperatures (heat)

Wildfire smoke health outcome indicator #1: Non-infectious respiratory illness emergency department and urgent care visits

This health outcome indicator is calculated by counting the total number of non-infectious respiratory illness emergency department or urgent care visits in a specified geographic, and dividing by the total population for the same geographic area during a specified time period (May to October) and multiplying by 10,000. (The crude rate = number of visits/total population x 10,000.) A single individual may present to health facilities multiple times for the same complaint. Therefore, rates are not estimations of a true population-based rate. The rate is divided by the number of days at or above Moderate AQI (PM2.5 ≥9.1ug/m3) to account for year-to-year variability in wildfire season smoke.

Statewide snapshot: Non-infectious respiratory illness visit rate

2023 (baseline): 1.63 non-infectious respiratory illness visits (per 10,000 population) per day at or above Moderate air-quality index (AQI)

2025 goal: 1.55 non-infectious respiratory illness visits (per 10,000 population) per day at or above Moderate AQI (5% reduction from 2023 baseline)

2030 goal: 1.30 non-infectious respiratory illness visits (per 10,000 population) per day at or above Moderate AQI (20% reduction from 2023 baseline)

Source: Oregon ESSENCE

Figure 28. Non-infectious respiratory illness visit rates per 10,000 population by race and ethnicity, Oregon, May-October 2023

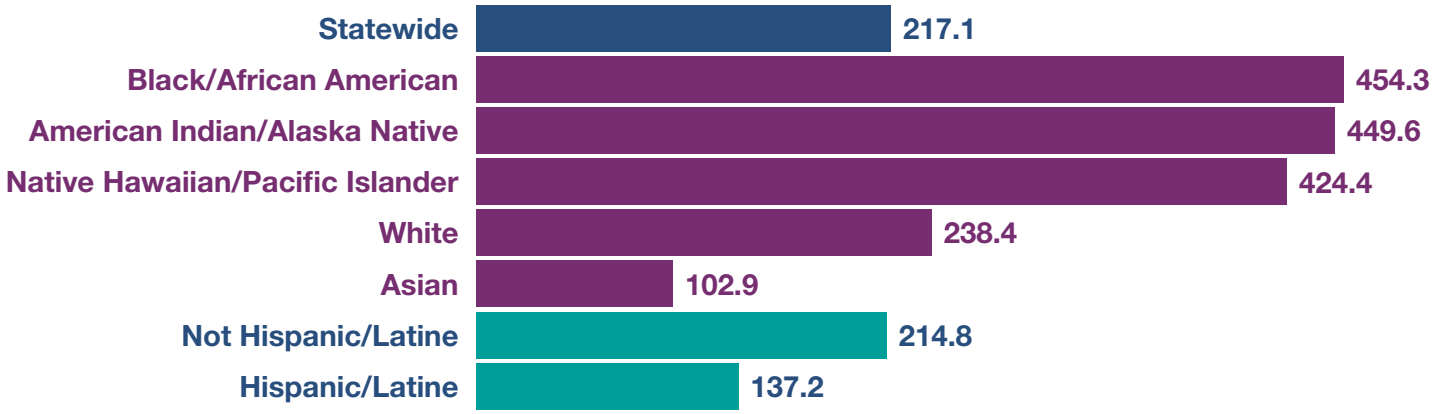
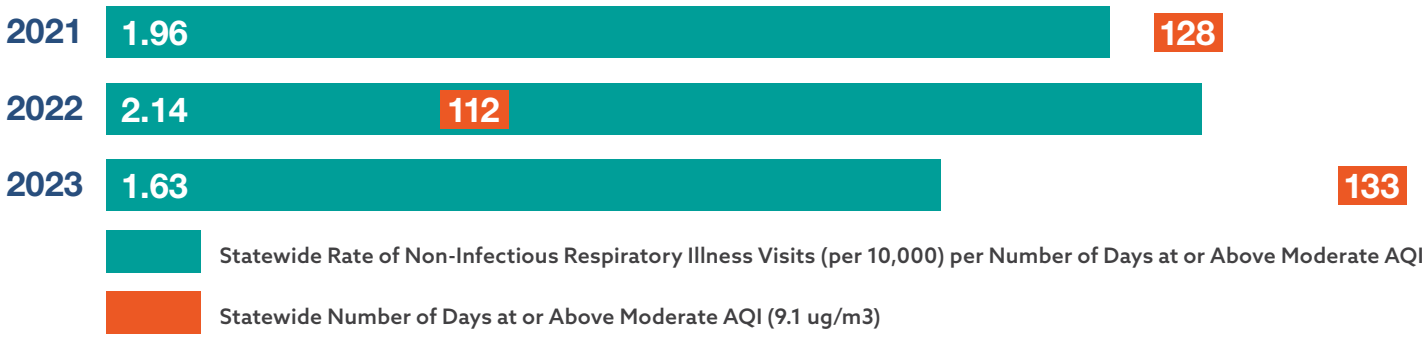


Figure 29. Non-infectious respiratory illness visit rates per 10,000 population, Oregon 2021-2023

This figure displays the rate of non-infectious respiratory visits to emergency departments and participating urgent care centers statewide from May 1 to October 31 of each year. Visit rates for non-infectious respiratory illnesses to emergency departments and urgent care centers across the state decreased from 2021 (250.3 visits per 10,000) to 2023 (217.1 visits per 10,000). The largest decrease from one season to another occurred from 2022 to 2023, where the rates of visits decreased by 22.6 visits per 10,000.

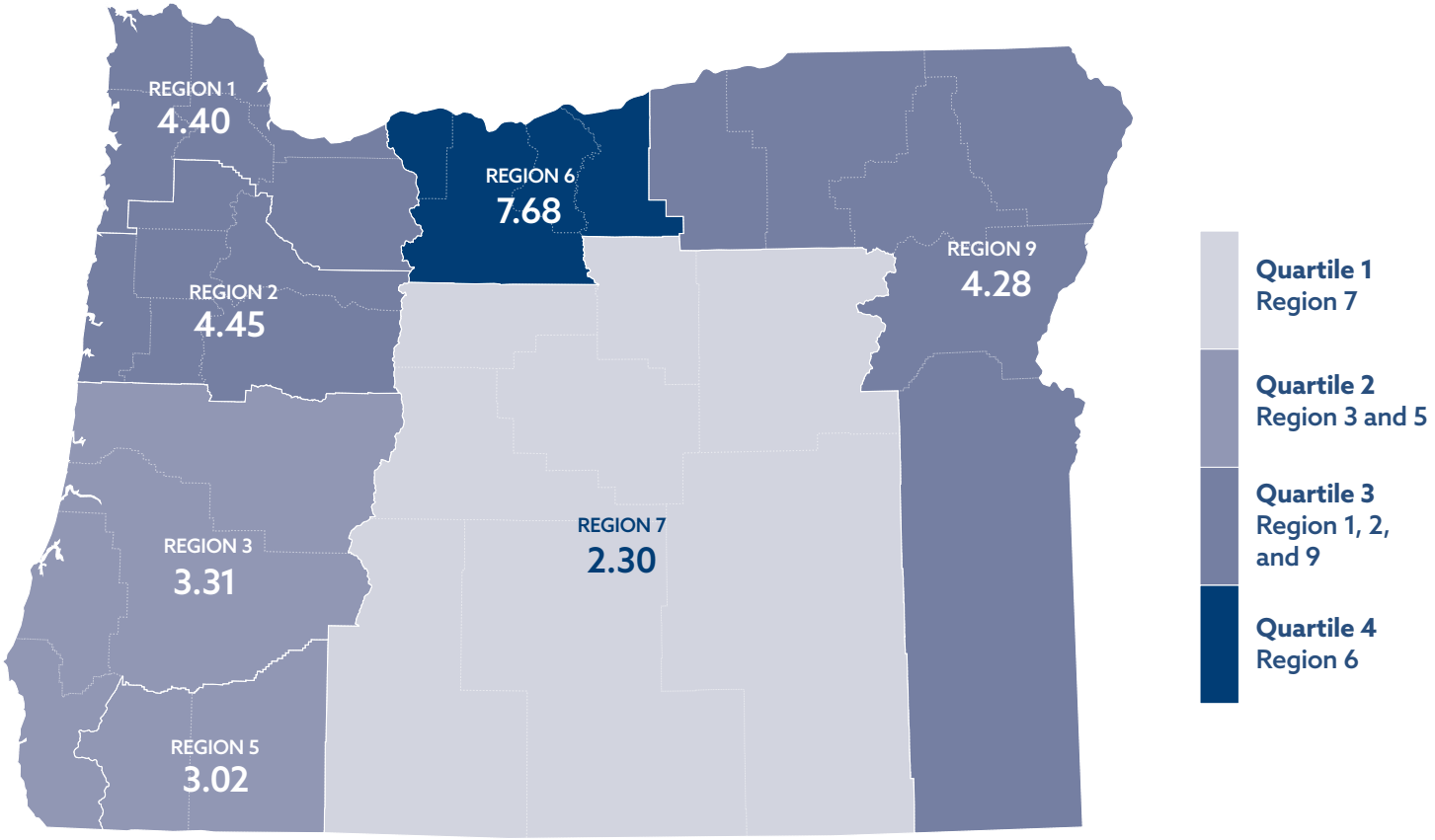
Figure 30. Non-infectious respiratory illness visit rates, per days at or above Moderate AQI, Oregon 2021-2023



This figure displays the rate of non-infectious respiratory visits to emergency departments and participating urgent care centers statewide from May 1 to October 31 of each year, divided by the number of days at or above Moderate AQI, in the blue bars. This accounts for year-to-year variability in seasonal air quality and wildfire events when comparing rates of ED and urgent care center visits. The numbers in the orange boxes represent the number of days statewide when air quality was at or above Moderate AQI (≥9.1 ug/m3 PM2.5) from May 1 to October 31 of each year. Please note: all years of air quality data were analyzed by the 2024 NAAQS PM2.5 AQI categories, which may result in differences from previously reported air quality data.

Days at or above Moderate AQI decreased from 2021 (128 days) to 2022 (112 days), then increased in 2023 (133 days). Possible reasons for lower rates in 2023 despite an increase in days at or above Moderate AQI include improvements in protective public health communications messaging and state-funded air filter distribution through Program Section 7 of Senate Bill 1536, 2022. Other factors affecting year-to-year health outcomes from poor air quality are regional differences in weather patterns, acclimatization, consecutive days of air quality at or above Moderate AQI and cumulative and concurrent impacts from other seasonal hazards such as heat.

Figure 31. Map of non-infectious respiratory illness rates per 10,000 population, per days at or above Moderate AQI, by HSPR region, Oregon 2023



Sources: Oregon ESSENCE, Portland State University Population Research Center certified population estimates

Region 1
- Clackamas
- Clatsop
- Columbia
- Multnomah
- Tillamook
- Washington

Region 2
- Benton
- Lincoln
- Linn
- Marion
- Polk
- Yamhill

Region 3
- Coos
- Curry
- Douglas
- Lane

Region 5
- Josephine
- Jackson

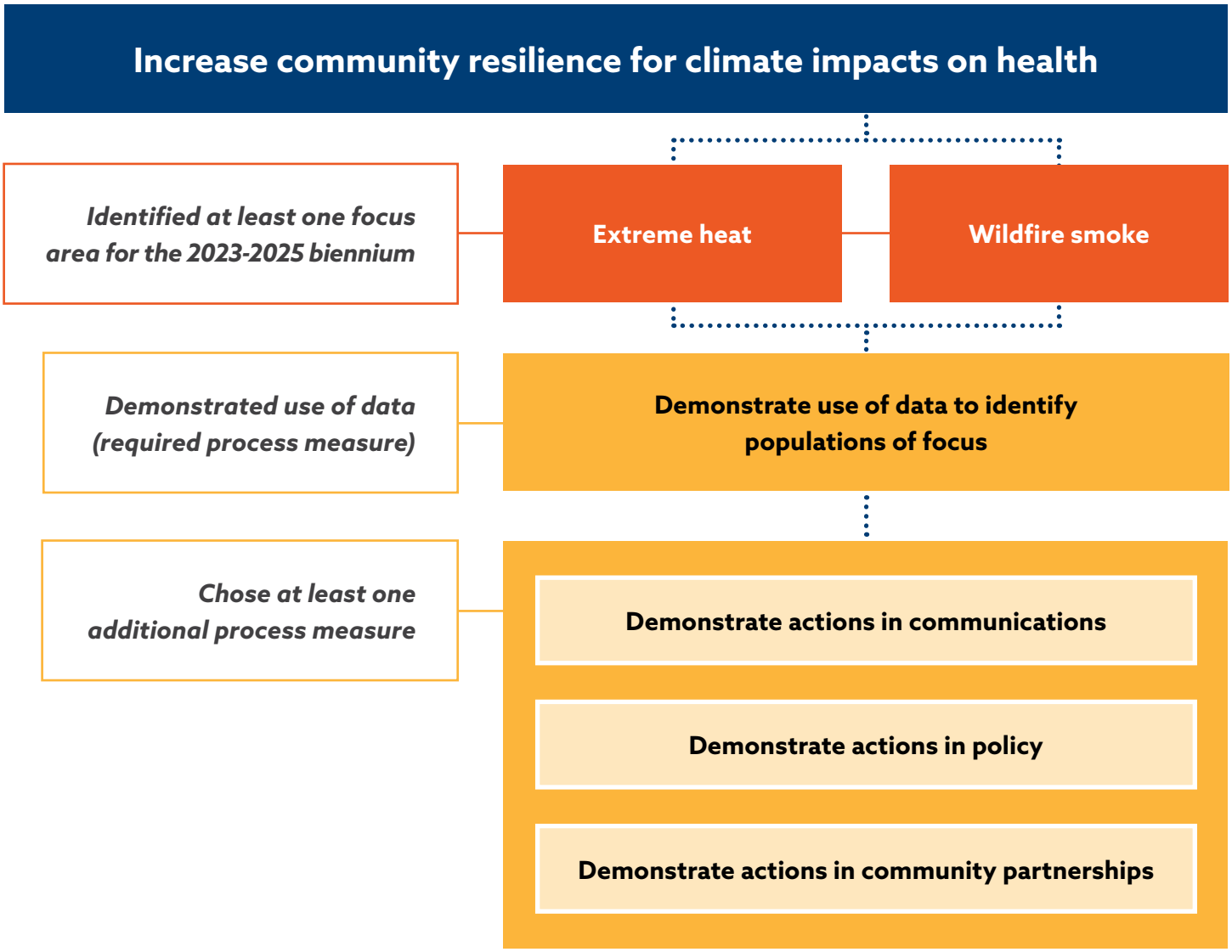
Region 6
- Gilliam
- Hood River
- Sherman
- Wasco

Region 7
- Crook
- Deschutes
- Grant
- Harney
- Jefferson
- Klamath
- Lake
- Wheeler

Region 9
- Baker
- Malheur
- Morrow
- Umatilla
- Union
- Wallowa

LPHA process measures: Climate impacts on health

Each LPHA selected at least two process measures to assess progress toward increasing community resilience for climate impacts on health.



The process measures for climate impacts on health are as follows:

LPHA process measure #1: Demonstrated use of data to identify population(s) of interest (required process measure)

- **2030 goal:** Demonstrated expansion in strategies and engagement

Utilizing data to identify populations of focus allows for identification of specific demographic groups or populations at highest risk during extreme heat or air quality events, enabling targeted outreach and direction of resources where they're most needed. Understanding these disparities through data helps LPHAs address systemic barriers such as access to health-protective information that is culturally and linguistically relevant, and access to services during extreme heat and air quality events. All subsequent process measures and interventions rely on this. LPHAs meet this measure by reviewing data provided by OHA through multiple platforms, or by using national or local data. Federal, state and local data allow LPHAs to identify groups at highest risk, by analyzing granular patient level and community data.

LPHA process measure #2: Demonstrated actions in communications to reduce the health impacts of extreme heat/wildfire smoke

- **2030 goal:** Demonstrated expansion in strategies and engagement

LPHAs have an important role before and during heat and air quality events to make sure people have the information they need to stay safe.

During events, LPHAs often work with partners to develop culturally and linguistically relevant communications, outreach and/or education. LPHAs also proactively develop communications plans to ensure they are prepared to provide culturally and linguistically relevant materials to all people within their jurisdiction.

LPHA process measure #3: Demonstrated actions in policy to reduce the health impacts of extreme heat/wildfire smoke

- **2030 goal:** Demonstrated expansion in strategies and engagement

To prepare people and communities before extreme heat and air quality events occur, LPHAs focus on planning in advance to minimize impacts when events occur.

This may include conducting an assessment of policies within the county to identify the policies that create barriers and challenges during extreme heat and air quality events, engaging communities to participate in planning efforts, and providing data and subject matter expertise to leaders responsible for county policies.

LPHA process measure #4: Demonstrated actions in community partnerships to reduce the health impacts of extreme heat/wildfire smoke

- **2030 goal:** Demonstrated expansion in strategies and engagement

Partnerships are vital when working to protect communities from extreme heat and air quality events, creating bridges to reach communities and bringing together resources and coordination both before and during events. By expanding and strengthening partnerships, LPHAs increase access to cooling centers or programs that provide air conditioning devices to households that need them, and ensure systems are in place to reach older adults or other vulnerable groups who live alone. Also, LPHAs work with partners to reduce extreme heat and air quality effects for outdoor workers, reduce urban heat islands and increase energy efficiency in schools.

LPHA process measures: Extreme heat

Figure 32 shows the status of progress toward process measure requirements for LPHAs who selected extreme heat as a focus area. While LPHAs report on a limited number of process measures, many LPHAs do work that addresses all process measure areas.

Figure 32. LPHA extreme heat process measure status, 2023

		REQUIRED	Choice of One or More		
County	On track to meet requirement**	Demonstrated use of data	Demonstrated actions in communications	Demonstrated actions in policy	Demonstrated actions with community partners
Baker					
Benton	✓	Yes	Yes	Yes	Yes
Clackamas	✓	Yes	No	No	Yes
Clatsop	✓	Yes	Yes	No	No
Columbia	✓	Yes	Yes	No	Yes
Coos					
Crook	✓	Yes	Yes	No	No
Curry*					
Deschutes					
Douglas					
Gilliam	X	No	Yes	No	No
Grant					
Harney					
Hood River					
Jackson					
Jefferson					
Josephine	✓	Yes	Yes	Yes	Yes
Klamath	✓	Yes	Yes	Yes	Yes
Lake	X	No	Yes	No	Yes
Lane					
Lincoln					
Linn	✓	Yes	Yes	No	Yes
Malheur	✓	Yes	No	No	Yes
Marion	✓	Yes	Yes	No	No
Morrow	✓	Yes	Yes	No	Yes
Multnomah	✓	Yes	Yes	Yes	Yes
Polk	X	No	Yes	No	No
Sherman					
Tillamook	✓	Yes	Yes	No	No
Umatilla					
Union					
Wallowa*					
Wasco					
Washington	✓	Yes	Yes	No	Yes
Wheeler	X	No	No	No	Yes
Yamhill	✓	Yes	Yes	No	Yes

* Not applicable. Curry and Wallowa Counties transferred their public health authority to the OHA in 2021 and 2018, respectively.

** On track to meet requirement is based on answering "yes" to required process measure 1 (use of data) and "yes" to at least one of the process measures 2 (communications), 3 (policy) or 4 (community partners).

LPHA process measures: Wildfire smoke

Figure 33 shows the status of progress toward process measure requirements for LPHAs who selected wildfire smoke as a focus area. While LPHAs report on a limited number of process measures, many LPHAs do work that addresses all process measure areas.

Figure 33. LPHA wildfire smoke process measure status, 2023

		REQUIRED	Choice of One or More		
County	On track to meet requirement**	Demonstrated use of data	Demonstrated actions in communications	Demonstrated actions in policy	Demonstrated actions with community partners
Baker	X	No	Yes	No	Yes
Benton					
Clackamas					
Clatsop					
Columbia					
Coos	✓	Yes	No	No	Yes
Crook					
Curry*					
Deschutes	✓	Yes	Yes	Yes	Yes
Douglas	✓	Yes	Yes	No	Yes
Gilliam					
Grant	✓	Yes	Yes	No	Yes
Harney	✓	Yes	Yes	No	No
Hood River	✓	Yes	Yes	No	Yes
Jackson	✓	Yes	Yes	Yes	Yes
Jefferson	✓	Yes	Yes	Yes	Yes
Josephine	✓	Yes	Yes	No	Yes
Klamath	✓	Yes	Yes	Yes	Yes
Lake	X	No	Yes	No	Yes
Lane	✓	Yes	No	No	Yes
Lincoln	✓	Yes	No	No	Yes
Linn					
Malheur					
Marion					
Morrow					
Multnomah	✓	Yes	Yes	Yes	Yes
Polk					
Sherman	X	No	Yes	No	Yes
Tillamook					
Umatilla	X	No	No	Yes	Yes
Union	✓	Yes	Yes	No	Yes
Wallowa*					
Wasco	X	No	Yes	No	Yes
Washington					
Wheeler	X	No	No	No	Yes
Yamhill					

* Not applicable. Curry and Wallowa Counties transferred their public health authority to the OHA in 2021 and 2018, respectively.

** On track to meet requirement is based on answering "yes" to required process measure 1 (use of data) and "yes" to at least one of the process measures 2 (communications), 3 (policy) or 4 (community partners).

OHA process measures: Climate impacts on health

OHA identified corresponding state-level process measures to which the state public health authority is accountable.

OHA process measure #1: Number of dashboards published and updated

This process measure tracks the number of dashboards related to climate health outcome indicators that OHA makes available to organizations within the state public health system and to the public.

The Oregon Electronic Surveillance System for the Early Notification of Community-Based Epidemics (OR-ESSENCE) is a dashboard available to OHA and LPHAs that tracks emergency department and urgent care visits in near-real time. The OR-ESSENCE Summer Hazards dashboard includes data on ED and urgent care visits related to non-infectious respiratory illnesses and heat-related illnesses.

Internal ESSENCE dashboards provide access to indicator data for local public health jurisdictions to track health impacts related to heat and smoke. Public-facing dashboards provide access to data that can be used by community partners and the public.

Data are presented by county and demographics where possible to be actionable for LPHAs and other users.

Current status

2023 (baseline): One dashboard related to climate health outcome indicators accessible to ESSENCE users.

2030 goal: Three dashboards related to climate health outcome indicators either published on EPH tracking website or accessible to ESSENCE users.

OHA's Data and Epidemiology team is currently focused on developing an air quality dashboard. The dashboard will include data on air quality, non-infectious respiratory ED and urgent care center visits and mental health visits. The Data and Epidemiology team started this work in the second half of 2024 and expect the pilot release by summer 2025.

OHA process measure #2: Provision of technical assistance in support of health outcome indicators

This process measure supports capacity-building and resource-sharing among LPHAs and OHA programs, and helps align data sources and methods across jurisdictions.

Figure 34. Provision of technical assistance in support of climate health indicators

Process measure	Milestones	2023 baseline	2030 goal
Provision of technical assistance in support of climate health outcome indicators	Percentage of technical assistance requests from LPHAs completed by EPH Climate Team	0 tracked	100% completed
	Number of workshops delivered and guidance documents produced to build LPHA capacity to assess and address health impacts of climate change	0 workshops, 0 guidance documents	3 workshops, 3 guidance documents

OHA receives technical assistance requests from LPHAs most commonly through direct requests from LPHA staff or through the OHA-led bimonthly meetings of the LPHA Climate and Health Community of Practice. Examples of technical assistance requests:

- Consultation on climate and health adaptation planning processes
- Data access, analysis or resources

OHA develops supportive training, guidance and materials in response to collective needs identified by public health partners. Examples of workshops and guidance documents:

- Climate and Health Adaptation Plan Guidance
- Workshops on accessing, analyzing and using public health data; risk communication and community resilience

OHA process measure #3: Recommendations developed for developmental metrics (public health indicators for drinking water security and mental health effects of climate change)

This process measure tracks progress toward the identification of indicators and goals for the two metrics priorities currently under development – drinking water security and mental health impacts of climate change.

Figure 35. Recommendations developed for public health indicators for metrics in development

Process measure		2023 baseline	2030 goal
Recommendations developed for public health indicators for drinking water security and mental health impacts of climate change		**0**	**2**
Milestones	Indicator/benchmark pair developed (drinking water security priority area)	0	1
	Indicator/benchmark pair developed (mental health impacts of climate change priority area)	0	1

To inform the development of mental health metrics, OHA has incorporated three questions on youth mental health and climate change into the 2024 student health survey, which will reach 11th graders across 85 districts in 29 counties. Results from the survey will be available for analysis mid-2025.

Limited action was taken in 2024 to develop metrics for the drinking water security priority area in 2024. OHA Drinking Water Services manages data in this subject area.

OHA process measure #4: Documentation of identified policy changes that are needed to reduce health impacts of climate change

This process measure tracks progress toward policy change that reduces the health impacts of climate change – beginning with extreme heat and wildfire smoke – developed with internal and external partners.

Current status

2023 (baseline): Zero OHA plans that include areas of policy change needed.

2030 benchmark: Three OHA plans that include areas of policy change needed.

OHA facilitates several public health planning processes to identify climate and health impacts, priorities and recommendations with partners. These planning processes are iterative and typically are updated every five years. Examples of plans that include areas of policy change:

- **OHA Resilience Plan** – OHA worked with community and public health partners to identify the policies, systems and environments needed to promote long-term health protections for those most impacted by climate. These strategies and policy priorities are directed toward state, local and Tribal public health practitioners and partners.
- **Climate Change Adaptation Framework** – The framework is an interagency planning effort led by the Oregon Department of Land Conservation and Development to develop collective strategies to adapt to and mitigate the impacts of climate change. It includes a section on public health priorities and recommended actions.
- **OHA Strategic Plan** – OHA's strategic plan details how the agency strives to eliminate health inequities, and it includes climate considerations in specific goals to foster healthy families and environments as well as eliminate health inequities.

Acknowledgements

This report fulfills statutory requirements under ORS 431.139 for reporting on public health accountability metrics. OHA acknowledges and thanks the following people and groups for their contributions to developing public health accountability metrics.

Oregon Public Health Advisory Board

The Public Health Advisory Board (PHAB) is responsible for establishing accountability metrics and monitoring the performance of OHA and local public health authorities in making progress toward health improvement goals. OHA specifically recognizes Veronica Irvin, who served as the PHAB Chair from 2021-2024, the time period during which current accountability metrics were adopted and during the data collection period for this report.

The following PHAB members and community partners served on the Accountability Metrics Subcommittee from 2021-23, during the time that these metrics were established.

Muriel DeLaVergne-Brown, Crook County Health Department

Olivia Gonzalez, Willamette Valley Education Service District

Kat Mastrangelo, Volunteers in Medicine Clinic of the Cascades

Cristy Muñoz, United Way of the Columbia-Willamette

Ryan Petteway, OHSU-PSU School of Public Health

Sarah Poe, Malheur County Health Department

Sarah Present, Clackamas County Public Health, Housing and Human Services

Jeanne Savage, Trillium Community Health Plan

Jocelyn Warren, Lane County Health and Human Services

OHA Public Health Division

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Appendix

OREGON HEALTH AUTHORITY

Overview

This is the technical appendix to the report, “Oregon Public Health Accountability Metrics Report 2025.” It provides data sources, measure specifications, and data tables for all health outcome measures, local public health authority process measures, and Oregon Health Authority process measures for baseline year 2023.

Common abbreviations used in this document:

OHA – Oregon Health Authority

LPHA – Local public health authority

PHAB – Public health advisory board

CDC – Centers for Disease Control and Prevention

Orpheus – Oregon Public Health Epidemiologists’ User System

HIV – Human immunodeficiency virus

STD – Sexually transmitted disease

TB – Tuberculosis

NH – Non-Hispanic

NA or N/A – Not applicable

CCO – Coordinated Care Organization

OHP – Oregon Health Plan

Communicable Disease Control: Syphilis

Congenital Syphilis

Health Outcome Measure: Congenital syphilis rate per 100,000 live births

Data source

Oregon Public Health Epidemiologists' User System (Orpheus)

Goals

2025: 66.5 per 100,000 live births, a 15% decrease from baseline

2030: 39.2 per 100,000 live births, a 50% decrease from baseline

Measure specification

All rates shown are crude rates (not age-adjusted rates) and are calculated by counting the total number of congenital syphilis cases reported in a specified geographic area (e.g., state, county) and dividing by the total live births for the same geographic area, multiplied by 100,000 (i.e., crude rate = number of disease reports/total population x 100,000). Numerator and denominator data are shown in Table 1.

Number of congenital syphilis cases were obtained from the Oregon Public Health Epidemiologists' User System (Orpheus).

Population data for race/ethnicity and county were obtained from U.S. Census Bureau Population Estimates.

Race-single mention shows each person in only one (mutually exclusive) race category; persons reporting more than one race are shown as a group under "Multiracial."

Additional notes

- Baseline year is 2023.
- Rates based on 1–5 events are considered unreliable because of the greater influence of random variability.

- Additional information about case incidence can be obtained from the Oregon HIV, STD, and TB Section website at: https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/STD/Pages/index.aspx.
- Syphilis incidence is based on the 2018 CSTE surveillance case definition for syphilis: https://ndc.services.cdc.gov/case-definitions/syphilis-2018/.
- Congenital syphilis data: Oregon Public Health Epidemiologists' User System (Orpheus).
- Oregon live birth data: https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/ANNUALREPORTS/Pages/index.aspx.

Congenital Syphilis

Health Outcome Measure: Rate of congenital syphilis per 100,000 live births

Table 1

	2023 Crude rate	Numerator*	Denominator*
STATEWIDE	78.3	30	38,295
RACE/ETHNICITY†			
American Indian/Alaska Native	574.7‡	2	348
Asian	0.0	0	1977
Black/African American	0.0	0	1001
Hispanic/Latine	44.8‡	4	8936
Multiracial	104.8‡	2	1909
Native Hawaiian/Pacific Islander	0.0	0	370
Missing	172.3‡	2	1161
White	88.5	20	22593
COUNTY			
Baker	800.0‡	1	125
Benton	0.0	0	562
Clackamas	107.4‡	4	3723
Clatsop	0.0	0	298
Columbia	0.0	0	462
Coos	0.0	0	520
Crook	0.0	0	242
Curry	699.3‡	1	143
Deschutes	111.0‡	2	1802
Douglas	0.0	0	962
Gilliam	0.0	0	18
Grant	0.0	0	60

Harney	0.0	0	80
Hood River	0.0	0	190
Jackson	99.9‡	2	2003
Jefferson	367.6‡	1	272
Josephine	0.0	0	766
Klamath	151.7‡	1	659
Lake	0.0	0	71
Lane	139.6‡	4	2866
Lincoln	0.0	0	321
Linn	0.0	0	1418
Malheur	277.8‡	1	360
Marion	25.9‡	1	3862
Morrow	0.0	0	161
Multnomah	159.4	11	6903
Polk	0.0	0	821
Sherman	0.0	0	23
Tillamook	460.8‡	1	217
Umatilla	0.0	0	905
Union	0.0	0	242
Wallowa	0.0	0	62
Wasco	0.0	0	257
Washington	0.0	0	5896
Wheeler	0.0	0	16
Yamhill	0.0	0	1007

*Numerator syphilis counts source: Orpheus. Denominator population estimates: Oregon live birth data by single mention.

†Population data for race/ethnicity were obtained from Oregon live birth data by single mention of race and ethnicity. Race-single mention shows each person in only one (mutually exclusive) race category; persons reporting more than one race are shown as a group under “Multiracial.” There were 0 congenital syphilis cases in Oregon in 2023 among Asian, Black/African American, and Native Hawaiian/Pacific Islander populations.

‡Rates based on 1-5 events are considered unreliable.

Syphilis All Stages

Health Outcome Measure: Rate of syphilis (all stages) among people who can become pregnant

Data source

Oregon Public Health Epidemiologists' User System (Orpheus)

Goals

2025: 70.8 per 100,000 population, a 2% decrease from baseline

2030: 65.0 per 100,000 population, a 10% decrease from baseline

Measure specification

All rates shown are crude rates (not age-adjusted rates) and are calculated by counting the total number of syphilis (all stages) cases among people who can become pregnant (people assigned female at birth aged 15-44 years old at the time of diagnosis) in a specified geographic area (e.g., state, county) and dividing by the total female population for the same geographic area, multiplied by 100,000 (i.e., crude rate = number of disease reports/total population x 100,000). Numerator and denominator data are shown in Table 2.

Number of syphilis (all stages) cases were obtained from the Oregon Public Health Epidemiologists' User System (Orpheus).

Population data for race/ethnicity and county were obtained from U.S. Census Bureau Population Estimates.

Race-single mention shows each person in only one (mutually exclusive) race category; persons reporting more than one race are shown as a group under “Multiracial.”

Additional notes

- Baseline year is 2023.
- Rates based on 1–5 events are considered unreliable because of the greater influence of random variability.

- Additional information about case incidence can be obtained from the Oregon HIV, STD, and TB Section website at: https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/STD/Pages/index.aspx.
- Syphilis incidence is based on the 2018 CSTE surveillance case definition for syphilis: https://ndc.services.cdc.gov/case-definitions/syphilis-2018/.
- Syphilis (all stages) data for people assigned female at birth aged 15-44 years old at the time of diagnosis: Oregon Public Health Epidemiologists' User System (Orpheus).
- Population data for race/ethnicity and county were obtained from U.S. Census Bureau Population Estimates.

Syphilis All Stages

Health Outcome Measure: Rate of syphilis (all stages) among people who can become pregnant

Table 2

	2023 Crude rate	Numerator*	Denominator*
STATEWIDE	72.2	603	834726
RACE/ETHNICITY†			
American Indian/Alaska Native	382.4	37	9675
Asian	17.6	9	51155
Black/African American	127.1	24	18890
Hispanic/Latine	66.0	99	149986
Multiracial	60.4	22	36417
Native Hawaiian/Pacific Islander	180.1	8	4442
White	61.3	346	564161
COUNTY			
Baker	119.0‡	3	2520
Benton	21.5‡	5	23275
Clackamas	64.5	50	77515
Clatsop	28.5‡	2	7023
Columbia	53.2‡	5	9393
Coos	294.5	29	9846
Crook	46.4‡	2	4307
Curry	181.6‡	5	2754
Deschutes	54.5	21	38546
Douglas	66.1	12	18147
Gilliam	0.0	0	281
Grant	0.0	0	1038
Harney	0.0	0	1132

Hood River	45.4‡	2	4401
Jackson	55.6	22	39586
Jefferson	209.8	9	4289
Josephine	65.3	9	13786
Klamath	114.6	14	12216
Lake	84.8‡	1	1179
Lane	94.8	74	78032
Lincoln	82.7	6	7258
Linn	44.4	11	24778
Malheur	93.6‡	5	5341
Marion	108.8	75	68914
Morrow	43.7‡	1	2287
Multnomah	84.8	154	181554
Polk	75.5	14	18548
Sherman	0.0	0	308
Tillamook	24.3‡	1	4116
Umatilla	54.8	8	14593
Union	40.6‡	2	4922
Wallowa	0.0	0	1187
Wasco	63.3‡	3	4736
Washington	39.8	50	125738
Wheeler	0.0	0	175
Yamhill	38.1	8	21005

*Numerator syphilis counts source: Orpheus. Denominator population estimates: U.S. Census Bureau.

†Population data for race/ethnicity and county were obtained from U.S. Census Bureau Population Estimates for people assigned female at birth aged 15-44 years old at time of diagnosis. Race-single mention shows each person in only one (mutually exclusive) race category; persons reporting more than one race are shown as a group under “Multiracial.”

‡Rates based on 1-5 events are considered unreliable.

Primary & Secondary Syphilis

Health Outcome Measure: Rate of primary and secondary syphilis per 100,000 population

Data source

Oregon Public Health Epidemiologists' User System (Orpheus)

Goals

2025: 18.8 per 100,000 population, a 2% decrease from baseline

2030: 16.3 per 100,000 population, a 15% decrease from baseline

Measure specification

All rates shown are crude rates (not age-adjusted rates) and are calculated by counting the total number of primary and secondary cases in a specified geographic area (e.g., state, county) and dividing by the total population for the same geographic area, multiplied by 100,000 (i.e., crude rate = number of disease reports/total population x 100,000). Numerator and denominator data are shown in Table 3.

Number of primary and secondary syphilis cases were obtained from the Oregon Public Health Epidemiologists' User System (Orpheus).

Population data for race/ethnicity and county were obtained from U.S. Census Bureau Population Estimates.

Race-single mention shows each person in only one (mutually exclusive) race category; persons reporting more than one race are shown as a group under “Multiracial.”

Additional notes

- Baseline year is 2023.
- Rates based on 1–5 events are considered unreliable because of the greater influence of random variability.

- Additional information about case incidence can be obtained from the Oregon HIV, STD, and TB Section website at: https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/STD/Pages/index.aspx.
- Syphilis incidence is based on the 2018 CSTE surveillance case definition for syphilis: https://ndc.services.cdc.gov/case-definitions/syphilis-2018/.
- Number of primary and secondary cases were obtained from the Oregon Public Health Epidemiologists' User System (Orpheus).
- Population data for race/ethnicity and county were obtained from U.S. Census Bureau Population Estimates.

Primary & Secondary Syphilis

Health Outcome Measure: Rate of primary and secondary syphilis per 100,000 population

Table 3

	2023 Crude rate	Numerator*	Denominator*
STATEWIDE	19.2	811	4233358
RACE/ETHNICITY†			
American Indian/Alaska Native	65.7	30	45658
Asian	9.0	19	212273
Black/African American	48.6	43	88506
Hispanic/Latine	23.1	146	631559
Multiracial	13.7	21	153339
Native Hawaiian/Pacific Islander	10.8‡	2	18577
White	16.0	492	3083446
COUNTY			
Baker	29.6‡	5	16912
Benton	3.1‡	3	97713
Clackamas	18.2	77	423173
Clatsop	4.9‡	2	41102
Columbia	24.1	13	53880
Coos	74.8	48	64212
Crook	11.1‡	3	26952
Curry	8.6‡	2	23296
Deschutes	13.4	28	208513
Douglas	13.3	15	112435
Gilliam	0.0	0	2026
Grant	13.9‡	1	7215
Harney	13.4‡	1	7440
Hood River	8.4‡	2	23745

Jackson	8.6	19	220768
Jefferson	19.6‡	5	25454
Josephine	5.7‡	5	87821
Klamath	10.0	7	70003
Lake	24.1‡	2	8293
Lane	29.1	111	381181
Lincoln	13.8	7	50821
Linn	13.7	18	131496
Malheur	9.4‡	3	32044
Marion	25.7	89	346741
Morrow	16.3‡	2	12302
Multnomah	31.0	245	789698
Polk	14.5	13	89805
Sherman	0.0	0	1951
Tillamook	7.3‡	2	27417
Umatilla	10.0	8	80053
Union	15.4‡	4	25944
Wallowa	0.0	0	7674
Wasco	26.6	7	26333
Washington	9.7	58	598865
Wheeler	0.0	0	1436
Yamhill	5.5	6	108644

*Numerator syphilis counts source: Orpheus. Denominator population estimates: U.S. Census Bureau.

†Population data for race/ethnicity were obtained from U.S. Census Bureau Population Estimates. Race-single mention shows each person in only one (mutually exclusive) race category; persons reporting more than one race are shown as a group under “Multiracial.”

‡Rates based on 1-5 events are considered unreliable.

LPHA Process Measures - Syphilis

LPHA Process Measures

1. **Percentage of congenital syphilis cases averted**
2. **Percentage of people with syphilis interviewed**
3. **Completion of CDC core variables**
4. **Percentage of early cases treated with appropriate regimen within 14 days**

Data source

Oregon Public Health Epidemiologists' User System (Orpheus)

Goals

Measure 1 goal for 2030: 10-percentage point increase from baseline

Measure 2 goal for 2030: 10-percentage point increase from baseline

Measure 3 goal for 2030: 10-percentage point increase from baseline

Measure 4 goal for 2030: 10-percentage point increase from baseline

Measure specification

Overall: The Oregon Public Health Advisory Board establishes accountability metrics for the purpose of evaluating the progress of OHA and LPHAs in achieving statewide public health goals (ORS 431.123). Process measures are developed as a menu so that each LPHA can choose the areas that are priorities within their agency and community. OHA required LPHAs to select two of the four process measures to be assessed.

Measure 1: Percentage of congenital syphilis cases averted is calculated by subtracting the number of reported congenital syphilis cases from the number of reported pregnant people with syphilis, then dividing this number by the total number of reported pregnant people with syphilis and multiplying by 100 (Table 4).

Measure 2: Percentage of people with syphilis interviewed is calculated by dividing the number of interviewed cases by the total number of reported cases and multiplying by 100 (Table 5).

Measure 3: Percentage completion of CDC core variables is calculated by summing the completion percentages of all core variables and dividing that sum by the number of core variables (n=5). The completion rate of each core variable is determined by dividing the number of cases with core variables completed by the total reported cases. The pregnancy status core variable only applies to cases for individuals assigned females at birth aged 15-44. The denominator for the pregnancy status core variable completion rate is restricted to reported cases for people assigned female at birth aged 15-44 (Table 6).

Measure 4: Percentage of early syphilis cases treated with an appropriate regimen within 14 days is calculated by dividing the number of cases that received an appropriate penicillin-based treatment regimen within 14 days of the specimen collection date by the total number of reported early syphilis cases (Table 7).

Additional notes

- Baseline year is 2023.
- Additional information about calculation of core variable completion rates can be found in the STD Metrics Dashboard Data Dictionary available as a Tableau report in the Oregon Public Health Epidemiologists' User System (Orpheus).
- Additional information about case incidence can be obtained from the Oregon HIV, STD, and TB Section website at: https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/STD/Pages/index.aspx.
- Syphilis incidence is based on the 2018 CSTE surveillance case definition for syphilis: https://ndc.services.cdc.gov/case-definitions/syphilis-2018/.
- The numerator and denominator were obtained from the Oregon Public Health Epidemiologists' User System (Orpheus).

Percentage Syphilis Cases Averted

LPHA Process Measure: Percentage congenital syphilis cases averted among LPHAs that selected this measure

Table 4

	2023		
	Percent[§]	Numerator	Denominator
STATEWIDE	65.1	56	86
COUNTY			
Baker			
Benton			
Clackamas			
Clatsop			
Columbia			
Coos			
Crook			
Curry[*]			
Deschutes[‡]	0.0	0	2
Douglas			
Gilliam			
Grant			
Harney			
Hood River			
Jackson			
Jefferson			
Josephine			
Klamath			
Lake			
Lane	50.0	4	8
Lincoln			
Linn			
Malheur			

Marion	88.9	8	9
Morrow			
Multnomah			
North Central PH District			
Polk			
Sherman[†]			
Tillamook			
Umatilla			
Union			
Wallowa[*]			
Wasco[†]			
Washington			
Wheeler			
Yamhill			

[*]Not applicable. Curry and Wallowa Counties transferred their public health authority to the Oregon Health Authority in 2021 and 2018, respectively.

[†]North Central Public Health District is comprised of Sherman and Wasco counties.

[‡]Baseline=0. Will use Oregon state benchmarks for 2024-2030.

[§]Percent of congenital syphilis averted is dependent on date of delivery when congenital syphilis case status is usually determined. The congenital syphilis averted percentage is *not* based on dyads (the pregnant person diagnosed with syphilis and the associated baby).

Percentage of People Interviewed

LPHA Process Measure: Percentage of people with syphilis interviewed among LPHAs that selected this measure

Table 5

	2023		
	Percent	Numerator	Denominator
STATEWIDE	66.1	1358	2056
COUNTY			
Baker	41.7	5	12
Benton			
Clackamas	75.2	112	149
Clatsop	66.7	4	6
Columbia	50.0	9	18
Coos	72.1	49	68
Crook	100.0	5	5
Curry*			
Deschutes			
Douglas	65.8	25	38
Gilliam‡	N/A		
Grant	100.0	1	1
Harney			
Hood River	75.0	3	4
Jackson	72.9	35	48
Jefferson	78.6	22	28
Josephine	60.0	6	10
Klamath	50.0	13	26
Lake	60.0	3	5
Lane			
Lincoln	29.4	5	17
Linn	60.0	24	40
Malheur			

Marion	57.1	129	226
Morrow	50.0	1	2
Multnomah	66.6	453	680
North Central PH District	83.3	10	12
Polk	58.3	14	24
Sherman[†]			
Tillamook	60.0	3	5
Umatilla	75.0	24	32
Union	70.0	7	10
Wallowa[*]			
Wasco[†]			
Washington			
Wheeler[‡]	N/A		
Yamhill	50.0	17	34

[*]Not applicable. Curry and Wallowa Counties transferred their public health authority to the Oregon Health Authority in 2021 and 2018, respectively.

[†]North Central Public Health District is comprised of Sherman and Wasco counties

[‡]Baseline=N/A. Will use Oregon state benchmarks for 2024-2030 if cases reported.

Completion of CDC Core Variables

LPHA Process Measure: Percentage completion of CDC core variables among LPHAs that selected this measure

Table 6

2023

	Percent	Percent Race % (n)	Percent Ethnicity %(n)	Percent HIV Status % (n)	Percent Sex of Sex Partner % (n)	Percent Pregnancy Status % (num./den.) ‡	Denominator
STATEWIDE	84.6	93.0 (1913)	87.5 (1799)	80.2 (1649)	69.0 (1419)	93.4 (1384/1482)	2056
COUNTY							
Baker							
Benton	80.0	69.2 (9)	84.6 (11)	76.9 (10)	69.2 (9)	100.0 (5/5)	13
Clackamas							
Clatsop							
Columbia	76.7	88.9 (16)	72.2 (13)	66.7 (12)	55.6 (10)	100.0 (5/5)	18
Coos							
Crook	92.0	100.0 (5)	100.0 (3)	80.0 (4)	80.0 (4)	100.0 (2/2)	5
Curry*							
Deschutes							
Douglas							
Gilliam							
Grant	75.0	0.0 (0)	100.0 (1)	100.0 (1)	100.0 (1)	0 (N/A)	1
Harney	75.0	100.0 (1)	0.0 (0)	100.0 (1)	100.0 (1)	0 (N/A)	1
Hood River							
Jackson							
Jefferson							
Josephine							
Klamath	64.3	61.5 (16)	76.9 (20)	57.7 (15)	53.8 (14)	71.4 (10/14)	26
Lake							
Lane							
Lincoln							

Linn							
Malheur	76.0	87.5 (14)	87.5 (14)	62.5 (10)	62.5 (10)	80.0 (4/5)	16
Marion							
Morrow							
Multnomah	85.8	94.6 (644)	88.5 (603)	85.4 (582)	68.5 (466)	92.2 (142/154)	681
North Central PH District							
Polk							
Sherman[†]							
Tillamook	88.0	80.0 (4)	80.0 (4)	100.0 (5)	80.0 (4)	100.0 (1/1)	5
Umatilla	81.9	90.6 (29)	90.6 (29)	71.9 (23)	68.8 (22)	87.5 (7/8)	32
Union							
Wallowa[*]							
Wasco[†]							
Washington	87.2	87.6 (191)	95.9 (209)	88.1 (192)	64.2 (140)	100.0 (50/50)	218
Wheeler							
Yamhill	77.1	88.2 (30)	70.6 (24)	76.5 (26)	50.0 (17)	100.0 (8/8)	34

[*]Not applicable. Curry and Wallowa Counties transferred their public health authority to the Oregon Health Authority in 2021 and 2018, respectively.

[†]North Central Public Health District is comprised of Sherman and Wasco counties

[‡]Pregnancy status is collected only for people assigned female at birth aged 15-44 years old. The denominator for the percent pregnancy status is restricted to reported cases for people assigned female at birth aged 15-44.

Percentage of Early Cases Treated

LPHA Process Measure: Percentage of early cases treated with appropriate regimen within 14 days among LPHAs that selected this measure

Table 7

	2023		
	Percent	Numerator	Denominator
STATEWIDE	67.2	819	1219
COUNTY			
Baker	50.0	3	6
Benton	50.0	4	8
Clackamas	61.9	65	105
Clatsop	75.0	3	4
Columbia			
Coos	82.7	43	52
Crook			
Curry*			
Deschutes	81.0	34	42
Douglas	60.9	14	23
Gilliam§	N/A		
Grant			
Harney‡	0.0	0.0	1
Hood River	50.0	1	2
Jackson	70.8	17	24
Jefferson	63.6	7	11
Josephine	83.3	5	6
Klamath			
Lake	50.0	1	2
Lane	70.2	120	171
Lincoln	62.5	5	8
Linn	54.2	13	24

Malheur			
Marion	62.0	67	108
Morrow‡	0.0	0	2
Multnomah			
North Central PH District	75.0	6	8
Polk	64.7	11	17
Sherman†			
Tillamook			
Umatilla			
Union	85.7	6	7
Wallowa*			
Wasco†			
Washington	73.8	90	122
Wheeler§	N/A		
Yamhill			

*Not applicable. Curry and Wallowa Counties transferred their public health authority to the Oregon Health Authority in 2021 and 2018, respectively.

†North Central Public Health District is comprised of Sherman and Wasco counties

‡Baseline=0. Will use Oregon state benchmarks for 2024-2030.

§Baseline=N/A. Will use Oregon state benchmarks for 2024-2030 if cases reported.

OHA Process Measures - Syphilis

OHA Process Measures

1. **Percentage of congenital syphilis cases averted**
2. **Percentage of prenatal care providers who report routinely screening of all pregnant patients in the early third trimester**
3. **Adoption of CCO/health system metrics to promote syphilis screening at three time points in pregnancy**

Data sources

Oregon Public Health Epidemiologists' User System (Orpheus)

Oregon HIV, STD and TB Section program reporting

Goals

Measure 1 goal for 2030: 75.0%

Measure 2 goal for 2030: 80.0%

Measure 3 goal for 2030: CCO/health system adoption of metrics to promote syphilis screening at three points in time during pregnancy

Measure specification

Measure 1: Percentage of congenital syphilis cases averted is calculated by subtracting the number of reported congenital syphilis cases from the number of reported pregnant people with syphilis. This number is then divided by the total number of reported pregnant people with syphilis to calculate the proportion of potential congenital syphilis cases averted (Table 8).

Measure 2: Percentage of prenatal care providers who report routinely screening of all pregnant patients in the early third trimester is calculated by dividing the number of providers who report routinely screening all pregnant patients in the early third trimester by the total number of respondents in a survey of the perceptions, screening practices, and management of syphilis in pregnancy by providers in Oregon (Table 9).

Measure 3: Adoption of CCO/health system metrics to promote syphilis screening at three time points in pregnancy (Table 9).

Additional notes

- Measure 1 baseline is 65.1% (2023)
- Measure 2 baseline is 69.0% (2023)
- Measure 3 baseline is “Not available” (2023)
- The numerator and denominator for averted congenital syphilis cases were obtained from the Oregon Public Health Epidemiologists’ User System (Orpheus).

Percentage of Syphilis Cases Averted

OHA Process Measure: Percentage of congenital syphilis cases averted*

Table 8

	2023		
	Percent	Numerator	Denominator
STATEWIDE	65.1	56	86
COUNTY			
Baker	50.0	1	2
Benton	N/A§		
Clackamas	42.9	3	7
Clatsop	100.0	1	1
Columbia	100.0	1	1
Coos	100.0	1	1
Crook	N/A§		
Curry†	50.0	1	2
Deschutes	0.0	0	2
Douglas	100.0	1	1
Gilliam	N/A§		
Grant	N/A§		
Harney	N/A§		
Hood River	N/A§		
Jackson	33.3	1	3
Jefferson	N/A§		
Josephine	100.0	2	2
Klamath	0.0	0	1
Lake	N/A§		
Lane	50.0	4	8
Lincoln	100.0	1	1
Linn	100.0	1	1
Malheur	50.0	1	2

Marion	88.9	8	9
Morrow	N/A[§]		
Multnomah	65.6	21	32
North Central PH District	N/A[§]		
Polk	N/A[§]		
Sherman[‡]	N/A[§]		
Tillamook	N/A[§]		
Umatilla	100.0	1	1
Union	100.0	1	1
Wallowa[†]	N/A[§]		
Wasco[‡]	N/A[§]		
Washington	100.0	3	3
Wheeler	N/A[§]		
Yamhill	100.0	5	5

[*]Percent of congenital syphilis averted is dependent on date of delivery when congenital syphilis case status is usually determined. The congenital syphilis averted percentage is *not* based on dyads (the pregnant person diagnosed with syphilis and the associated baby).

[†]Not applicable. Curry and Wallowa Counties transferred their public health authority to the Oregon Health Authority in 2021 and 2018, respectively.

[‡]North Central Public Health District is comprised of Sherman and Wasco counties.

[§]N/A indicates counties with no data.

Routine Screening & CCO/Health System Adoption of Metrics

OHA Process Measures:

Percentage of prenatal care providers who report routinely screening of all pregnant patients in the early third trimester

Adoption of CCO/health system metrics to promote syphilis screening at three time points in pregnancy

Table 9

	2023		
	Percent	Numerator	Denominator
Percent of prenatal care providers who report routinely screening of all pregnant patients in the early third trimester	69.0	66	99

	2023		
	Metrics Adopted		
Adoption of CCO/health system metrics to promote syphilis screening at three time points in pregnancy	Not available		

Communicable Disease Control: Vaccines

2-Year-Old Vaccination Rate

Health Outcome Measure: Two-year old vaccination rate for 4:3:1:3:3:1:4 series

Data source

ALERT Immunization Information System (ALERT IIS)

Goals

2025: 72%, a 4-percentage point increase from baseline

2030: 80%, a 12-percentage point increase from baseline

Measure specification

Percentage is calculated by dividing the number of children 24-35 months of age who received the vaccination series (numerator) by number of children 24-35 months of age (denominator). Numerator and denominator data are not released publicly. ALERT IIS is an immunization registry, not a population enumeration tool (Table 10).

Rates produced by race and ethnicity reflect alone or in combination methodology. Race and ethnicity categories are not mutually exclusive, and a single person may contribute to one or more categories. Due to this, the number of individuals contributing to race and ethnicity categories added together are larger than the county population total. For example, an individual with an indication of Hispanic, White, and Asian will contribute to the rate calculation for each of these population subgroups.

Additional notes

- Baseline year is 2023.
- 2024 data processing year reflects 2023 two-year-old annual population-based rate.
- Local public health authorities (LPHA) were given the option to prioritize and report on 2-year-old vaccination rate, 65+ influenza vaccine rate, or both. Table 10 shows rates for LPHAs that prioritized and reported 2-year-old vaccination rate.

- The vaccine series used is 4 doses of DTaP, 3 doses IPV, 1 dose MMR, 3 doses Hib, 3 doses Hep B, 1 dose Varicella, and 4 doses PCV (4:3:1:3:3:1:4 series).

- Rates are displayed for population groups with 10 or more individuals in accordance with Immunization Program policy.

- Oregon immunization rates measure vaccination levels among two-year-olds in a given year. Rates are based on ALERT IIS data for all two-year-olds with an Oregon address and a post-birth immunization record. Over 95% of all childhood immunizations given in Oregon since 1999 are in ALERT IIS and reporting levels have been higher in recent years.

2-Year-Old Vaccination Rate

Health Outcome Measure: Two-year old vaccination rate for 4:3:1:3:3:1:4 series

Table 10

	2023 Percent	Numerator*	Denominator*
STATEWIDE	68.3		
RACE/ETHNICITY†			
American Indian/Alaska Native	64.5		
Asian	74.7		
Black/African American	61.2		
Hispanic/Latine	71.4		
Native Hawaiian/Pacific Islander	63.7		
White	69.2		
COUNTY‡			
Baker	63.8		
Benton			
Clackamas	70.9		
Clatsop	65.8		
Columbia			
Coos	66.6		
Crook	72.7		
Curry§			
Deschutes	68.4		
Douglas	64.7		
Gilliam	64.7		
Grant	42.4		
Harney	57.8		
Hood River	64.2		

Jackson	60.4		
Jefferson			
Josephine			
Klamath	68.1		
Lake			
Lane	70.3		
Lincoln			
Linn			
Malheur			
Marion	70.1		
Morrow			
Multnomah	68.2		
North Central PH District[¶]			
Polk	71.6		
Sherman[¶]			
Tillamook			
Umatilla			
Union			
Wallowa[§]			
Wasco[¶]			
Washington	71.5		
Wheeler			
Yamhill	72.0		

[*]Numerator and denominator data are not released publicly. ALERT IIS is an immunization registry, not a population enumeration tool.

[†]Race and ethnicity categories reflect alone or in combination methodology, which allows individuals to contribute to one or more racial and/or ethnic subgroup.

[‡]Table shows rates for LPHAs that chose to prioritize and report 2-year-old vaccination rate.

[§]Not applicable. Curry and Wallowa Counties transferred their public health authority to the Oregon Health Authority in 2021 and 2018, respectively.

[¶]North Central Public Health District is comprised of Sherman and Wasco counties.

Influenza Vaccine Age 65+

Health Outcome Measure: Adult influenza vaccination rate in populations aged 65 and older

Data source

ALERT Immunization Information System (ALERT IIS)

Goals

2025: 51%, a 4-percentage point increase from baseline

2030: 60%, a 13-percentage point increase from baseline

Measure specification

Percentage is calculated by dividing the number of adults aged 65 and older who received the influenza vaccine in the most recently completed flu season (numerator) by number of adults aged 65 and older who have had any immunization recorded in Oregon's immunization registry in the past 5 years (denominator). Numerator and denominator data are not released publicly. ALERT IIS is an immunization registry, not a population enumeration tool (Table 11).

Rates produced by race and ethnicity reflect alone or in combination methodology. Race and ethnicity categories are not mutually exclusive, and a single person may contribute to one or more categories. Due to this, the number of individuals contributing to race and ethnicity categories added together are larger than the county population total. For example, an individual with an indication of Hispanic, White, and Asian will contribute to the rate calculation for each of these population subgroups.

Additional notes

- Baseline year is 2023 and reflects the 2023-2024 flu season.
- Flu immunization rate is measured at flu week 34.

- Local public health authorities (LPHA) were given the option to prioritize and report on 2-year-old vaccination rate, 65+ influenza vaccine rate, or both. Table 11 shows rates for LPHAs that prioritized and reported 65+ influenza vaccination rate.

Influenza Vaccine Age 65+

Health Outcome Measure: Adult influenza vaccination rate in populations aged 65 and older

Table 11

	2023 Percent	Numerator*	Denominator*
STATEWIDE	47.4		
RACE/ETHNICITY[†]			
American Indian/Alaska Native	50.4		
Asian	54.5		
Black/African American	42.6		
Hispanic/Latine	42.2		
Native Hawaiian/Pacific Islander	54.5		
White	50.6		
COUNTY[‡]			
Baker	39.7		
Benton	57.6		
Clackamas			
Clatsop			
Columbia	45.3		
Coos			
Crook			
Curry[§]			
Deschutes			
Douglas			
Gilliam			
Grant			
Harney			
Hood River			

Jackson			
Jefferson	44.7		
Josephine	39.0		
Klamath	40.6		
Lake	34.0		
Lane			
Lincoln	45.6		
Linn	45.4		
Malheur	29.5		
Marion			
Morrow	36.9		
Multnomah			
North Central PH District[¶]			
Polk			
Sherman[¶]	41.4		
Tillamook	44.9		
Umatilla	38.2		
Union	42.9		
Wallowa[§]			
Wasco[¶]	47.6		
Washington			
Wheeler	38.9		
Yamhill			

[*]Numerator and denominator data are not released publicly. ALERT IIS is an immunization registry, not a population enumeration tool.

[†]Race and ethnicity categories reflect alone or in combination methodology, which allows individuals to contribute to one or more racial and/or ethnic subgroup.

[‡]Table shows rates only for LPHAs that chose to prioritize and report 65+ influenza vaccination rate.

[§]Not applicable. Curry and Wallowa Counties transferred their public health authority to the Oregon Health Authority in 2021 and 2018, respectively.

[¶]North Central Public Health District is comprised of Sherman and Wasco counties. Influenza rates reported separately.

LPHA Process Measures - Vaccines

LPHA Process Measures

1. **Demonstrated use of data to identify population(s) of focus (2-year-old vaccine series or age 65+ influenza vaccine) (required)**
2. **Increase in the percent of health care providers (HCP) participating in the Immunization Quality Improvement Program (IQIP)**
3. **Demonstrated outreach and educational activities conducted with community partners to increase vaccine access or demand**
4. **Demonstrated actions with health care providers to improve access to vaccinations**
5. **Demonstrated actions to improve access to influenza vaccination for residents of long-term care (LTC) facilities**

Data sources

Immunization Process Measure for Accountability Metrics Survey

Immunization Quality Improvement Program (IQIP) database

Goals

Measure 1 goal for 2030: demonstrated expansion in strategies and engagement.

Measure 2 goal for 2030: 25%, with demonstrated strategies by the LPHA to achieve the goal.

Measure 3 goal for 2030: demonstrated expansion in strategies and engagement.

Measure 4 goal for 2030: demonstrated expansion in strategies and engagement.

Measure 5 goal for 2030: demonstrated expansion in strategies and engagement.

Measure specification

Immunization Process Measure for Accountability Metrics Survey: LPHAs were sent an email with a link to complete the survey by June 2024. The reporting period for the survey was calendar year 2023.

For 2-year-old vaccination, “on track to meet requirement” is based on answering "yes" to REQUIRED process measure 1 (use of data) and "yes" to at least one of the process measures 3 (HCP participation in IQIP), 4 (HCP actions to improve access), or 5 (work with community partners).

For 65+ influenza vaccination, “on track to meet requirement” is based on answering "yes" to REQUIRED process measure 1 (use of data) and "yes" to at least one of the process measures 2 (improve access in LTC facilities), 4 (HCP actions to improve access), or 5 (work with community partners).

Additional notes

- Baseline year is 2023.

OHA Process Measures - Vaccines

OHA Process Measures

1. **Develop and maintain data for immunization indicators**
2. **Provide data to CCOs to meet immunization incentive measures and partner with CCOS on QI program implementation**
3. **Implement the Immunization Quality Improvement for Providers (IQIP) program**
4. **Assure vaccine supply and monitor the state's vaccine finance model to ensure it is sustainable, equitable, and adequately funds vaccination programs**

Data sources

Immunization Quality Improvement Program (IQIP)

Oregon Immunization Program reporting

Goals

Measure 1: 2030: 100%

Measure 2: 2030: 100%

Measure 3: 2030: 100%

Measure 4: 2030: 100%

Measure specification

Measure 1: each milestone met is worth 16.6%; expectation is for OHA to meet 100%.

Measure 2: percent of data files provided to CCOs on a timely basis.

Measure 3: percent of Vaccines for Children (VFC) providers that received quality improvement technical assistance from the IQIP program multiplied by 4.

Measure 4: each milestone is worth 14.3%; expectation is for OHA to meet 100%.

Additional notes

- Baseline year for all measures is 2023.

Environmental Public Health: Extreme Heat & Wildfire Smoke

Extreme Heat

Health Outcome Measure: Emergency department and urgent care visits due to heat

Data source

Oregon ESSENCE

Goals

2025: 1.61 HRI visits (per 1M) per day ≥80°F Heat Index, 10% reduction from 2023 baseline

2030: 0.90 HRI visits (per 1M) per day ≥80°F Heat Index, 50% reduction from 2023 baseline

Measure specification

Rates shown are calculated by counting the total number of heat-related illness emergency department and urgent care visits in a specified geographic area (state, HSPR Region, etc.) and dividing by the total population for the same geographic area (for a specified period, May-September) and multiplied by 1M (i.e., Rate = number of heat-related illness visits/total population x 1,000,000). Statewide rates reduced further to set benchmarks: Total number heat-related illness visits (per 1M)/number of days with heat index ≥80°F.

Data from Oregon ESSENCE are visit-based. A single individual may present to health facilities multiple times for the same complaint. Therefore, data cannot be used to calculate a true rate and only represent an estimation of a population-based rate.

HSPR Region rates are multiplied by 50,000 population. County rates are not calculated due to visit counts.

Numerator and denominator data are shown in Table 12 and Table 13.

Population data for 2023 were obtained from Portland State University Population Research Center Certified Population Estimates. Source for 2023 race/ethnicity population estimates: 2022 ACS 5-Year population estimates.

Race/ethnicity categories provided by Oregon ESSENCE are not mutually exclusive, one individual may contribute to one or more categories.

Additional notes

- Baseline year is 2023.
- Oregon ESSENCE emergency department and urgent care data, 2023. Data were retrieved on September 17, 2024. These data are subject to change if more information is received.
- Regions are based on OHA Health Security, Preparedness and Response Regions.
- Heat-related illness visits from Oregon ESSENCE include visits to non-Federal emergency departments (ED) and participating urgent care centers. The CDC Heat Related Illness v2 definition is applied to the Chief Complaint Discharge Diagnosis (CCDD) field to query discharge diagnosis codes and chief complaint term free text. The definition identifies visits with words like “heat,” “sun stroke,” and “hyperthermia” and HRI codes (including ICD-9 code 992 and ICD-10 code T67) among ED and urgent care patient chief complaints and discharge diagnoses. The query is also applied to the fields of Chief Complaint History and Discharge Diagnosis.
- Information about the National Weather Service Heat Index can be found here: https://www.weather.gov/safety/heat-index

Extreme Heat

Health Outcome Measure: Emergency department and urgent care visits due to heat

Table 12

	2023				
	Visit rate per 1,000,000 (*rate per 50,000*)	Visit rate per days with heat index at or above 80°F	Numerator*	Denominator*†¶	Number of days with heat index at or above 80°F
STATEWIDE	**238 (*11.9*)**	**1.79**	**1,024**	**4,296,626**	**133**
RACE					
Black/African American	*(15.8)*		24	75,790	
American Indian/Alaska Native	*(27.1)*		17	31,339	
Asian	*(5.1)*		19	185,149	
Native Hawaiian/Pacific Islander	*(15.6)*		5-9	16,000	
White	*(13.3)*		825	3,100,790	
Unknown Race			7		
ETHNICITY					
Hispanic/Latine	*(8.8)*		103	583,066	
Not Hispanic/Latine	*(11.8)*		860	3,646,308	
Unknown Ethnicity			8		
AGE GROUP					
0-4	*(5.0)*		20	199,388	
5-17	*(6.2)*		77	620,219	
18-44	*(13.0)*		415	1,596,849	
45-64	*(11.3)*		241	1,064,981	
65+	*(16.0)*		261	815,189	
SEX					
Male	*(14.1)*		601	2,137,236	
Female	*(9.7)*		420	2,159,390	

*Category visit totals may be less than statewide totals due to missing data.

† Source for 2023 race/ethnicity population estimates: 2022 ACS 5-Year population estimates.

§ Source for 2023 age and sex population estimates: Portland State University Population Research Center certified population estimates.

¶Denominator data is unavailable. Rate not calculated.

Extreme Heat

Health Outcome Measure: Emergency department and urgent care visits due to heat

Table 13

		2023				
		Visit rate per 1,000,000 (*rate per 50,000*)	Visit rate (per 50,000) per days with heat index at or above 80°F	Numerator	Denominator*	Number of days with heat index at or above 80°F
STATEWIDE		**238 (*11.9*)**	**1.79**	**1,024**	**4,296,626**	**133**
HSPR Region County						
Region 1		***(10.1)***	***(0.11)***	**395**	**1,962,533**	**92**
	Clackamas					
	Clatsop					
	Columbia					
	Multnomah					
	Tillamook					
	Washington					
Region 2		***(14.1)***	***(0.14)***	**236**	**837,214**	**103**
	Benton					
	Lincoln					
	Linn					
	Marion					
	Polk					
	Yamhill					
Region 3		***(11.4)***	***(0.12)***	**134**	**589,506**	**97**
	Coos					
	Curry					
	Douglas					
	Lane					
Region 5		***(16.8)***	***(0.19)***	**105**	**311,576**	**90**
	Josephine					
	Jackson					
Region 6		***(13.5)***	***(0.12)***	**15**	**55,437**	**116**

	Gilliam					
	Hood River					
	Sherman					
	Wasco					
Region 7		***(10.5)***	***(0.11)***	**76**	**361,634**	**97**
	Crook					
	Deschutes					
	Grant					
	Harney					
	Jefferson					
	Klamath					
	Lake					
	Wheeler					
Region 9		***(17.6)***	***(0.14)***	**63**	**178,726**	**123**
	Baker					
	Malheur					
	Morrow					
	Umatilla					
	Union					
	Wallowa					

*Source for 2023 statewide and regional population estimates: Portland State University Population Research Center certified population estimates.

Extreme Heat

Health Outcome Measure: Heat-related hospitalizations

Data source

Oregon Health Authority Hospital Reporting Program, Oregon Hospital Discharge Data

Goals

2025: 52 heat-related hospitalizations, 25% reduction from 2023 baseline

2030: 28 heat-related hospitalizations, 60% reduction from 2023 baseline

Measure specification

Rates shown are calculated by counting the total number of heat-related hospitalizations in a specified geographic area (state, county, etc.) and dividing by the total population for the same geographic area (for a specified period, May-September) and multiplied by 4.2 million (i.e., Rate = number of heat-related hospitalizations/total population x 4,200,000).

Numerator and denominator data are shown in Table 14 and Table 15.

Population data for 2023 were obtained from Portland State University Population Research Center Certified Population Estimates. Source for 2023 race/ethnicity population estimates: 2022 ACS 5-Year population estimates.

Race/ethnicity categories provided by Health Analytics are not mutually exclusive, one individual may contribute to one or more categories.

Additional notes

- Baseline year is 2023.
- Oregon Health Authority Hospital Reporting Program (2023), Oregon Hospital Discharge Data, Portland, OR: Oregon Health Authority
- ICD-10 and ICD-9 Codes for Heat illness= Effects of heat and light (ICD 10=T67.), Heatstroke and sunstroke (ICD 10=T67.0), Heat syncope (ICD 10=T67.1), Heat cramp (ICD-10=T67.2), Heat exhaustion, anhydrotic (ICD-10=T67.3), Heat exhaustion due to salt depletion (ICD-10=T67.4), Heat exhaustion, unspecified (ICD-10=T67.5), Heat fatigue, transient (ICD 10=T67.6), Heat edema (ICD 10=T67.7), Other effects of heat and light (ICD-10=T67.8), Effect of heat and light, unspecified (ICD-10=T67.9), Exposure to excessive

natural heat (ICD 10=X30.), Exposure to sunlight (ICD 10=X32.). Excluded records having ICD-10-CM code W92 (exposure to excessive heat of man-made origin) as a cause of injury or other diagnosis.

- Information about the National Weather Service Heat Index can be found here: https://www.weather.gov/safety/heat-index

Extreme Heat

Health Outcome Measure: Heat-related hospitalizations

Table 14

	2023		
	Rate per 4,200,000	Numerator	Denominator*†§
STATEWIDE	**69**	**71**	**4,296,626**
RACE			
Black/African American		1	75,790
American Indian or Alaska Native		2	31,339
Asian		4	185,149
Native Hawaiian/Pacific Islander		0	16,000
White		56	3,100,790
Unknown		3	
Another Race		3	
Patient did not answer		2	
ETHNICITY			
Hispanic/Latine		5	583,066
Not Hispanic/Latine		63	3,646,308
Unknown		3	
AGE GROUP			
0-4		0	199,388
5-17		1	620,219
18-44		21	1,596,849
45-64		18	1,064,981
65+		31	815,189
SEX			
Male		51	2,137,236
Female		19	2,159,390
Unknown		1	

[*] Source for 2023 statewide population estimates: Portland State University Population Research Center certified population estimates.

[†] Source for 2023 race/ethnicity population estimates: 2022 ACS 5-Year population estimates.

[§] Denominator data is unavailable. Rate not calculated.

Extreme Heat

Health Outcome Measure: Heat-related hospitalizations

Table 15

	2023		
	Rate per 4,200,000	Numerator*	Denominator†§
STATEWIDE	**69**	**71**	**4,296,626**
COUNTY			
Baker		0	16,927
Benton		*	99,355
Clackamas		*	424,043
Clatsop		*	42,095
Columbia		0	53,143
Coos		*	66,945
Crook		0	26,583
Curry		0	24,439
Deschutes		*	212,141
Douglas		*	113,748
Gilliam		0	2,062
Grant		0	7,418
Harney		0	7,600
Hood River		*	24,406
Jackson		*	222,762
Jefferson		0	25,878
Josephine		*	88,814
Klamath		0	71,919
Lake		0	8,562
Lane		*	384,374
Lincoln		0	51,930
Linn		*	131,984
Malheur		0	32,981
Marion		*	353,649

Morrow		0	13,010
Multnomah		16	805,007
Polk		0	90,553
Sherman		0	1,917
Tillamook		0	28,000
Umatilla		0	81,842
Union		0	26,335
Wallowa		0	7,631
Wasco		*	27,052
Washington		14	610,245
Wheeler		0	1,533
Yamhill		*	109,743

*Hospitalization count is between 1 and 9.

† Source for 2023 statewide and county population estimates: Portland State University Population Research Center certified population estimates.

§ Source for 2023 race/ethnicity population estimates: 2022 ACS 5-Year population estimates.

Extreme Heat

Health Outcome Measure: Heat-related deaths

Data source

Oregon Center for Health Statistics, Vital Records

Goals

2025: 6 deaths, 30% reduction from 2023 baseline

2030: 2 deaths, 70% reduction from 2023 baseline

Measure specification

Number of heat-related deaths occurring in Oregon, May-September 2023

Numerator and denominator data are shown in Table 16.

Population data for 2023 were obtained from Portland State University Population Research Center Certified Population Estimates. Source for 2023 race/ethnicity population estimates: 2022 ACS 5-Year population estimates.

The race and ethnicity categories provided by the Oregon Center for Health Statistics; Vital Records are mutually exclusive. Decedents of Hispanic or Latino/a/x/e ethnicity may belong to any race but have been removed from all race categories in this table.

Additional notes

- Baseline year is 2023.
- 2023 Oregon Center for Health Statistics, 2023 Vital Records death data are final.

Extreme Heat

Health Outcome Measure: Heat-related deaths

Table 16

	2023	
	Numerator*	Denominator†§
STATEWIDE	**8**	**4,296,626**
RACE		
Black/African American	0	75,790
American Indian Alaska Native	0	31,339
Asian	0	185,149
Native Hawaiian/Pacific Islander	0	16,000
White	6	3,100,790
Two or More Races	2	389,281
ETHNICITY		
Hispanic/Latine	1	583,066
Not Hispanic/Latine	7	3,646,308
AGE GROUP		
0-4	1	199,388
5-17	0	620,219
18-44	2	1,596,849
45-64	2	1,064,981
65+	3	815,189
SEX		
Male	7	2,137,236
Female	1	2,159,390
COUNTY		
Baker	0	16,927

Benton	0	99,355
Clackamas	1	424,043
Clatsop	0	42,095
Columbia	0	53,143
Coos	0	66,945
Crook	0	26,583
Curry	0	24,439
Deschutes	0	212,141
Douglas	0	113,748
Gilliam	0	2,062
Grant	0	7,418
Harney	0	7,600
Hood River	0	24,406
Jackson	0	222,762
Jefferson	0	25,878
Josephine	0	88,814
Klamath	0	71,919
Lake	1	8,562
Lane	0	384,374
Lincoln	0	51,930
Linn	1	131,984
Malheur	0	32,981
Marion	1	353,649
Morrow	0	13,010
Multnomah	4	805,007
Polk	0	90,553
Sherman	0	1,917
Tillamook	0	28,000
Umatilla	0	81,842
Union	0	26,335
Wallowa	0	7,631
Wasco	0	27,052
Washington	0	610,245
Wheeler	0	1,533

Yamhill	0	109,743

*2023 vital stats data are final.

†Source for 2023 statewide population estimates: Portland State University Population Research Center certified population

§Source for 2023 race/ethnicity population estimates: 2022 ACS 5-Year population estimates.

Wildfire Smoke

Health Outcome Measure: Non-infectious respiratory illness emergency department and urgent care visits

Data source

Oregon ESSENCE

Goals

2025: 1.55 Non-Infectious Respiratory Illness visits (per 10,000) per day at or above Moderate AQI (PM2.5 ≥9.1ug/m3); 5% reduction from 2023 baseline

2030: 1.30 Non-Infectious Respiratory Illness visits (per 10,000) per day at or above Moderate AQI (PM2.5 ≥9.1ug/m3); 20% reduction from 2023 baseline

Measure specification

Rates shown are calculated by counting the total number of non-infectious respiratory illness emergency department or urgent care visits in a specified geographic area (state, county, etc.) and dividing by the total population for the same geographic area (for a specified period, May-October) and multiplying by 10,000 (i.e., Rate = number of visits/total population x 10,000).

Data from Oregon ESSENCE are visit-based. A single individual may present to health facilities multiple times for the same complaint. Therefore, data cannot be used to calculate a true rate and only represent an estimation of a population-based rate.

Numerator and denominator data are shown in Tables 17-19.

Population data for 2023 were obtained from Portland State University Population Research Center Certified Population Estimates.

Population data for race/ethnicity were obtained from U.S. Census Bureau Population Estimates.

Race/ethnicity categories provided by Oregon ESSENCE are not mutually exclusive, one individual may contribute to one or more categories.

Additional notes

- Baseline year is 2023.

- Oregon ESSENCE emergency department and urgent care data, 2023. Data were retrieved on September 18, 2024. These data are subject to change if more information is received.
- Race and ethnicity denominators for rates were derived by applying ACS 5-year 2022 OMB
- Visits from Oregon ESSENCE include non-Federal hospital emergency department and urgent care center visits. The Non-Infectious Respiratory Illness query looks for words and codes for respiratory illnesses that can be exacerbated by worsening air quality, including asthma and chronic obstructive pulmonary disease, as well as words like “wheezing” and “shortness of breath.” The query does not include search terms for air quality.
- Air Quality Index (AQI) days at or above Moderate AQI (PM2.5 ≥9.1ug/m3) value reflects the updated EPA AQI that became effective in May 2024.
- Regional counts of days at or above Moderate AQI will not equal the sum of the counts of county days at or above Moderate AQI within that region. This is because multiple counties may be at or above Moderate AQI on the same day. This also applies to the statewide count of days at or above Moderate AQI.

Wildfire Smoke

Health Outcome Measure: Non-infectious respiratory illness emergency department and urgent care visits

Table 17

	2023				
	Visit rate (per 10,000)	Visit rate per days at or above Moderate AQI*	Numerator	Denominator†§	Number of days at or above Moderate AQI*
STATEWIDE	**217.1**	**1.63**	**93,273**	**4,296,626**	**133**
RACE					
Black/African American	454.3		3,443	75,790	
American Indian/Alaska Native	449.6		1,409	31,339	
Asian	102.9		1,905	185,149	
Native Hawaiian/Pacific Islander	424.4		679	16,000	
White	238.4		73,920	3,100,790	
Unknown Race			1,166	¶	
ETHNICITY					
Hispanic/Latine	137.2		8,002	583,066	
Not Hispanic/Latine	214.8		78,331	3,646,308	
Unknown Ethnicity			54	¶	
AGE GROUP					
0-4	190.1		3,791	199,388	
5-17	74.3		4,608	620,219	
18-44	140.5		22,435	1,596,849	
45-64	231.5		24,651	1,064,981	
65+	462.5		37,702	815,189	
SEX					

Female	237.6		51,313	2,159,390	
Male	196.2		41,932	2,137,236	

*Moderate AQI= Maximum Daily Concentration of PM2.5 ≥9.1µg/m^3 (micrograms per cubic meter)

†Source for 2023 age and sex population estimates: Portland State University Population Research Center certified population estimates.

§Source for 2023 race/ethnicity population estimates: 2022 ACS 5-Year population estimates.

¶Denominator data is unavailable. Rate not calculated.

Wildfire Smoke

Health Outcome Measure: Non-infectious respiratory illness emergency department and urgent care visits

Table 18

		2023				
		Rate (per 10,000)	Rate per days at or above Moderate AQI*	Numerator	Denominator†	Number of days at or above Moderate AQI*
STATEWIDE		**217.1**	**1.63**	**93,273**	**4,296,626**	**133**
HSPR Region	**County**					
Region 1		**198.0**	**4.40**	**38,849**	**1,962,533**	**45**
	Clackamas					
	Clatsop §					
	Columbia					
	Multnomah					
	Tillamook					
	Washington					
Region 2		**227.1**	**4.45**	**19,017**	**837,214**	**51**
	Benton					
	Lincoln					
	Linn					
	Marion					
	Polk					
	Yamhill					
Region 3		**251.8**	**3.31**	**14,842**	**589,506**	**76**
	Coos					
	Curry					
	Douglas					
	Lane					
Region 5		**211.5**	**3.02**	**6,589**	**311,576**	**70**

	Jackson					
	Josephine					
Region 6		**161.3**	**7.68**	**894**	**55,437**	**21**
	Gilliam [§]					
	Hood River					
	Sherman [§]					
	Wasco					
Region 7		**258.1**	**2.30**	**9,334**	**361,634**	**112**
	Crook					
	Deschutes					
	Grant					
	Harney					
	Jefferson					
	Klamath					
	Lake					
	Wheeler [§]					
Region 9		**209.7**	**4.28**	**3,748**	**178,726**	**49**
	Baker					
	Malheur					
	Morrow [§]					
	Umatilla					
	Union					
	Wallowa					

[*]Moderate AQI= Maximum Daily Concentration of PM2.5 ≥9.1µg/m^3 (micrograms per cubic meter)

[†]Source for 2023 statewide, county and regional population estimates: Portland State University Population Research Center certified population estimates.

[§]These counties do not have air quality monitor data available: Clatsop, Gilliam, Morrow, Sherman, and Wheeler.

Wildfire Smoke

Health Outcome Measure: Non-infectious respiratory illness emergency department and urgent care visits

Table 19

		2023				
		Visit rate (per 10,000)	Visit rate per days at or above Moderate AQI*	Numerator	Denominator†	Number of days at or above Moderate AQI*
STATEWIDE		**217.1**	**1.63**	**93,273**	**4,296,626**	**133**
HSPR Region	**County**					
Region 1		**198.0**		**38,849**	**1,962,533**	**45**
	Clackamas	206.9		8,773	424,043	30
	Clatsop §	235.2		990	42,095	§
	Columbia	149.8		796	53,143	20
	Multnomah	197.9		15,934	805,007	33
	Tillamook	183.9		515	28,000	8
	Washington	194.0		11,841	610,245	35
Region 2		**227.1**		**19,017**	**837,214**	**51**
	Benton	125.0		1,242	99,355	11
	Lincoln	326.4		1,695	51,930	8
	Linn	286.6		3,783	131,984	40
	Marion	216.5		7.657	353,649	42
	Polk	176.6		1,599	90,553	14
	Yamhill	277.1		3,041	109,743	14
Region 3		**251.8**		**14,842**	**589,506**	**76**
	Coos	488.5		3,270	66,945	12
	Curry	340.8		833	24,439	17
	Douglas	467.2		5,314	113,748	39
	Lane	141.1		5,425	384,374	70
Region 5		**211.5**		**6,589**	**311,576**	**70**
	Jackson	207.3		4,617	222,762	55
	Josephine	222.0		1,972	88,814	62

Region 6		**161.3**		**894**	**55,437**	**21**
	Gilliam [§]	160.0		33	2,062	§
	Hood River	113.1		276	24,406	19
	Sherman [§]	166.9		32	1,917	§
	Wasco	204.4		553	27,052	17
Region 7		**258.1**		**9,334**	**361,634**	**112**
	Crook	486.0		1,292	26,583	35
	Deschutes	253.6		5,380	212,141	102
	Grant	223.8		166	7,418	29
	Harney	384.2		292	7,600	36
	Jefferson	350.9		908	25,878	43
	Klamath	140.6		1,011	71,919	57
	Lake	281.5		241	8,562	43
	Wheeler [§]	287.0		44	1,533	§
Region 9		**209.7**		**3,748**	**178,726**	**49**
	Baker	146.5		248	16,927	25
	Malheur	101.6		335	32,981	11
	Morrow [§]	246.7		321	13,010	§
	Umatilla	250.6		2,051	81,842	40
	Union	237.3		625	26,335	31
	Wallowa	220.2		168	7,631	26

[*]Moderate AQI day is a day with a maximum 24-hr average concentration of PM2.5 ≥9.1µg/m^3 (micrograms per cubic meter)

[†]Source for 2023 statewide, county and regional population estimates: Portland State University Population Research Center certified population estimates.

[§]These counties do not have air quality monitor data available: Clatsop, Gilliam, Morrow, Sherman, and Wheeler.

LPHA Process Measures – Extreme Heat & Wildfire Smoke

LPHA Process Measures

1. **Demonstrated use of data to identify population(s) of interest (required process measure)**
2. **Demonstrated actions in communications to reduce the health impacts of extreme heat/wildfire smoke**
3. **Demonstrated actions in policy to reduce the health impacts of extreme heat/wildfire smoke**
4. **Demonstrated actions in community partnerships to reduce the health impacts of extreme heat/wildfire smoke**

Data sources

LPHA Environmental Health Process Measure for Accountability Metrics Survey

Goals

2030: Demonstrated expansion in strategies and engagement (all measures)

Measure specification

Environmental Health Process Measure for Accountability Metrics Survey: LPHAs were sent an email with a link to complete the survey by June 2024. The reporting period for the survey was calendar year 2023.

“On track to meet requirement” is based on answering "yes" to REQUIRED process measure 1 (use of data) and "yes" to at least one of the process measures 2 (communications), 3 (policy), or 4 (community partnerships).

Additional notes

- Baseline year is 2023.

OHA Process Measures – Environmental Public Health

OHA Process Measures

1. **Number of data dashboards published and updated**
2. **Demonstrated provision of provision of technical assistance in support of health outcome indicators: (a) percentage of technical assistance requests from LPHAs completed, (b) number of workshops delivered and guidance documents produced**
3. **Recommendations developed for developmental metrics (public health indicators for drinking water security and mental health effects of climate change)**
4. **Documentation of identified policy changes that are needed to reduce health impacts of climate change**

Data sources

Oregon Environmental Public Health Program reporting

Oregon ESSENCE

Goals

Measure 1 goal for 2030: 3 dashboards published on EPH website

Measure 2 goal for 2030: 2(a) 100% requests completed; 2(b) 3 workshops, 3 guidance documents

Measure 3 goal for 2030: 2 recommendations developed

Measure 4 goal for 2030: 3 OHA plans that include areas of policy change needed

Measure specification

Measure 1: Number of dashboards related to PHAB indicators either published on EPH Tracking website or accessible to ESSENCE users. Data are disaggregated by county and demographics where possible to be actionable for LPHAs and other users.

Measure 2a: Percent response to LPHA requests for technical assistance related to EH indicators, Climate and Health Adaptation Plans, integrating EH data into Community Health Improvement Plans (CHIPs) and Community Health Assessments (CHAs). Develop narrative component to capture relational aspects.

Measure 2b: Number of technical assistance products, including workshops and guidance documents.

Measure 3: Indicator/benchmark pairs developed for drinking water security and mental health impacts of climate change.

Measure 4: Number of OHA plans that include areas of policy change needed (e.g. OHA Resilience Plan, Climate Change Adaptation Framework, OHA Strategic Plan).

Additional notes

- Baseline for all measures is 2023.

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