

AGENDA

Public Health Modernization Improvement Workgroup

May 22, 2026, 11:05-11:55 AM

Join Teams Meeting

<https://teams.microsoft.com/meet/232665194020731?p=M8ySJ2U1qCGvt4aOzL>

Meeting ID: 232 665 194 020 731

Passcode: TE7HC76

Workgroup members: OHA participants – Sara Beaudrault, Dolly England, Andrew Epstein, Steven Fiala, Veronica Herrera, Liz Hunt, Kim Tham, Dana Selover, Julie Reeder, Drew Simpson, Kelly McDonald, Emily Wegener; LPHA participants – Kirsten Aird, Marie Boman-Davis, Carrie Brogoitti, Sara Hartstein, Heather Kaisner, Kim LaCroix, Laura Lui, Martha McInnes, Florence Pourtal, Shane Sanderson, Kari Wilhite, Brian Johnson, Sarah Lochner, Allison Mora

Meeting objectives:

- Revisit Oregon’s modernization framework
- Discuss agenda for in-person work session

11:05-11:10 AM	Welcome and agenda review <ul style="list-style-type: none">• Welcome and agenda overview	Steven Fiala, OHA staff
11:10-11:50 AM	Revisit Oregon’s modernization framework <ul style="list-style-type: none">• Revisit modernization framework with key considerations from vision workshops, including:<ul style="list-style-type: none">○ Alignment with national FPHS framework;○ Foundational versus “above the line” public health services	Steven Fiala
11:50-11:55 AM	Discuss agenda for in-person work session <ul style="list-style-type: none">• Discuss agenda for 6/17 optional in-person work session in Portland	Steven Fiala
11:55 AM	Wrap up and adjourn	Steven Fiala

Parking lot

Use the “parking lot” to add potential issues or topics for the Workgroup to address at future meetings. Parking lot topics will be periodically reviewed by the Workgroup to determine whether topics are in scope and, if so, how the topic should be incorporated into Workgroup meetings.

- ...
- ...
- ...

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters.
- Written materials in other languages.
- Braille.
- Large print.
- Audio and other formats.

If you need help or have questions, please contact Sara Beaudrault: at 971-645-5766, 711 TTY, or publichealth.policy@odhsoha.oregon.gov at least 48 hours before the meeting.

Modernization Improvement Workgroup

May 8, 2026

Attendees:

Andrea Krause, Andrew Epstein, Bill Michielsen, Carrie Brogoitti, Drew Simpson, Florence Pourtal, Heather Kaisner, Julie Reeder, Kelly McDonald, Kim La Croix, Kirsten Aird, Liz Hunt,

Martha McInnes, Sara Beaudrault, Sarah Lochner, Shane Sanderson, Steven Fiala, Valori Fleisher, Veronica Herrera

Meeting notes:

- **Updates to Scoping Document:** Steve led the group in the review of the scoping document, solicited input from members on the last section of the document related to revisiting the modernization manual. Steve reviewed considerations from the vision workshops that will inform the modernization manual update, including:
 - **Clarifying Statutory Language:** Steve emphasized the need to reground the manual in statutory language for foundational programs and capabilities, ensuring requirements of the governmental public health system are clearly reflected and reducing jargon for greater accessibility.
 - **Reducing Repetition and Streamlining:** Florence highlighted the excessive repetition between capabilities and programs, especially regarding health equity and cultural responsiveness, and suggested streamlining these sections for clarity and efficiency.
 - **Distinguishing Funding Streams and Systems Change:** Florence and Kirsten discussed the importance of separating modernization as a funding stream from a systems change effort, noting confusion among newcomers and recommending clearer delineation in the manual.
 - **Incorporating Examples and Lessons Learned:** Florence proposed including case studies and lessons learned in the manual to illustrate regional scaling and successful practices, providing guidance and encouragement for local public health authorities.
 - **Flexibility and Community Priorities:** Steve and others stressed the manual should emphasize flexibility, allowing for adaptation to local

priorities and clarifying that not every local public health authority will meet every role, reflecting the original intent of modernization.

- **Early Modernization History and Statutory Overview:** Sara and Liz provided an overview of the origins of modernization in Oregon, including task force recommendations, legislative actions, and detailed statutory requirements.
 - **Task Force Recommendations:** Sara described the five key recommendations from the Task Force on the Future of Public Health Services, including adopting foundational capabilities and programs, ensuring sustained funding, phased implementation, flexibility in operationalization, and accountability metrics.
 - **Statutory Responsibilities of OHA and LPHAs:** Liz explained statutory sections outlining OHA's responsibility for statewide and local application of foundational capabilities, administrative duties, and the powers and duties of local public health authorities and their governing bodies, including requirements for assessments, plans, and monitoring.
 - **Advisory Bodies and Decision-Making Roles:** Liz and Florence clarified the roles of advisory bodies such as the Public Health Advisory Board (PHAB), Oregon Health Policy Board, and Conference of Local Health Officials (CLHO), noting PHAB's recommending—not decision-making—status and the process for distributing funds and establishing metrics.
 - **Statutory Flexibility and Rulemaking:** Liz highlighted statutory provisions allowing OHA to establish new programs or activities by rule and adopt evidence-based best practices, providing mechanisms for adapting to evolving public health needs.
 - **Opportunities for Statutory Updates:** Sara and Liz discussed the possibility of updating statutes to reflect current priorities, such as broadening the scope of prevention and health promotion or addressing environmental health issues like climate, using rulemaking and legislative processes.
- **Planning for Future Meetings and Framework Discussion:** Steve facilitated a discussion on the agenda for upcoming meetings, including whether to invite National PHAB for a brief presentation, with input from Florence, Kirsten, and Sara on balancing presentation time with conversation and preparing materials for review.
 - **National PHAB Presentation Consideration:** Steve asked the group if a brief presentation from National PHAB on the national framework would be helpful, and Florence raised concerns about limited meeting time and

the availability of materials online, suggesting a recorded presentation for review instead.

- **Framework Conversation Readiness:** Steve and others discussed readiness to jump into the framework conversation at the next meeting, agreeing to send materials in advance and prioritize discussion over presentations to maximize engagement and critical review.
- **Landscape Assessment and State Collaboration Updates:** Steve updated the group on connecting with the National Public Health Accreditation Board's 21st Century Learning Community.
 - **State Collaboration Plans:** Steve reported recommendations to connect with Minnesota and Wisconsin for insights on role clarity, framework alignment, and systems strengthening language, and invited interested group members to join these conversations. Sarah Lochner indicated interest in joining the conversations with other states.
 - **Landscape Assessment Materials:** Steve shared that updated materials from other states working on foundational public health services would be posted in the Teams channel, providing a starting point for the group's landscape assessment.

Follow-up tasks:

- **Connecting with Minnesota and Wisconsin:** Confirm interest and add Sarah Lochner and any other interested members to the meetings with Minnesota and Wisconsin to learn about their modernization work. (Steve)
- **Scoping Document Updates:** Incorporate feedback from Florence, Kirsten, and Andrea regarding manual repetition, clarity between modernization and public health practice, funding stream distinctions, scaling examples, and considerations into the scoping document and upload to Teams folder for group review. (Steve)
- **National Framework Presentation Preparation:** Send materials and links about the national PHAB framework to the group ahead of the next meeting and request a brief recorded presentation from PHAB for members to review prior to discussion. (Steve)

Workgroup to Revisit the Modernization Framework, Name, and Manual | Updated May 13, 2026

Background. During last year's CLHO In-Person Retreat, we identified several opportunities to improve modernization in small group conversations organized around implementation barriers identified in the most recent evaluation. These opportunities were affirmed by other groups (Public Health Advisory Board members, OHA staff, community-based organizations) in visioning refresh workshops over the past 6 months.

Priorities. During the CLHO meeting on December 18th, it was recommended that OHA and CLHO prioritize opportunities related to revisiting the modernization framework, name, and manual. CLHO also recommended the convening of a Workgroup of state and local public health staff to advance this priority. The proposed scope and sequencing of the Workgroup is below, with considerations for each stage of the process gathered from the vision refresh workshops.

1. **Understand current landscape** of foundational public health services, including:
 - a. Researching other state models for FPHS implementation
 - i. Prioritize states with systems of government similar to Oregon to ensure relevance
 - ii. Consider funding per capita of states in assessment to understand lessons learned in a specific funding context
 - b. Gathering updates on the Public Health Accreditation Board's 21st Century Learning Community of states implementing FPHS
 - i. Apply a critical lens in review of recommendations from PHAB and 21C Learning Communities (may not all be relevant for Oregon's context)
 - ii. Prioritize learning from other states' experiences over broad recommendations from the PHAB

- iii. Consider value of 21C Learning Community insights in identifying what “core” public health looks like
- c. Re-grounding ourselves in modernization statutes, early history of modernization, and current expertise and capacity.
- d. Other considerations:
 - i. Identify states that are set up similarly to Oregon so it is most relevant to us.

2. Revisit current framework/approach for modernization, including:

- a. Re-affirm modernization is focused on governmental public health system given statutory requirements to provide and/or ensure access to public health services and accountability to funding;
- b. Determine how we want to characterize/describe the role of cross-sector and community partners, including CBOs (building on the work of the CBO-LPHA PHAB Workgroup on role clarity and the recent CBO companion document developed by PHAB);
- c. Discuss whether we continue to use the modernization framework or align with the national FPHS framework (similar but there are differences); and
- d. Revisit what are foundational versus “above the line” public health services given different interpretations of what it means to “ensure access” to services, varying perceptions of whether certain programs are “foundational” (e.g., WIC/nurse home visiting), the expanded scope of practice during the pandemic to provide immunizations, and newer public health programs (e.g., psilocybin)
- e. Clarify modernization as “core” public health versus an "expansion" of public health services (meaning more of our core work included in foundational)

- i. Consider original intent of modernization to fully fund governmental public health system to deliver required foundational public health services.
- 3. Based on decisions in steps 1 and 2, **determine whether we continue to use the term “modernization”** to describe FPHS implementation. Consider:
 - a. Terms/framing/branding for FPHS that work well in other states
 - b. Consider approaches discussed to date:
 - i. Recommendation from CLHO retreat to use “foundational” or “essential” public health services as a simpler, straightforward way to communicate
 - ii. Hybrid approach in which we use a combination of “modernization” and “FPHS” or “essential public health services” (What are the pros and cons of moving away from the name from modernization?)
 - c. Opportunity to respond to critique that term “modernization” feels time-bound (“isn’t that done yet?”) rather than an ongoing effort to garner full funding for core public health services.
 - d. Goal of changing the term/language is to make this systems change initiative more concrete and easier to describe what the funding is doing/can do.
 - e. Avoiding the perception that a name change means modernization has failed and we needed to rebrand
 - i. Conduct message testing with legislators/other decision-makers to discuss preferences for naming convention and key messages; opportunity for message testing at informational events for legislators prior to session
- 4. **Update the modernization manual** to reflect current public health practice and scope of modernization established in step 2. Consider:

- a. Ground in statutory language for foundational programs and capabilities
- b. Reduce jargon and make more plain language
- c. Specify “must haves” (defined in statute and/or clear community priorities from local leaders and decision makers) from “nice to haves”¶¶
- e.d. Clarify that implementation strategies listed for each foundational program and capability are "potential" strategies and depend on context-specific approaches and needs (e.g., program areas, like nutrition and tobacco prevention, listed in prevention and health promotion foundational program area may feel restrictive, so include language that these are examples of possible work rather than the only work that can be done in this area).
- d. Make more “nebulous” sections as concrete as possible (e.g., environmental health)¶¶
- e. Opportunity to streamline the health equity and cultural responsiveness foundational capability given it is cross-cutting and reflected in the foundational program and other foundational capability roles as well.¶¶
- f. Ensure state and local government roles reflect current practice and authority (e.g., are all state roles in the manual appropriate?)¶¶
- g. Opportunity to better reflect the strategies needed in each foundational program and capability to get to our desired “end state” for modernization; conversation should be less about roles and more about how we get to the end state and how we scale and sustain¶¶
- e.h. Consider including lessons learned or case examples in the manual to encourage exploration of what has worked in

other areas of the state; understanding that examples may not be applicable for every LPHA but offer as food for thought.

f.i. Consider aligning with new State Health Improvement Plan focus on public health issues within direct control of governmental public health or that can be reasonably advanced through cross-sector partnerships

g.j. Specify the roles of partners (or develop complementary documents if want to maintain the current focus on governmental public health; reflect recent work on CBO Companion Document to the modernization manual)

h.k. Include language that:

i. Modernization will evolve over time and look differently in each community based on local priorities

ii. Not every LPHA will meet every role in the modernization manual (reground in original intent that community members have access to and are served by foundational programs and capabilities, but this can look different across different communities)

~~iii.~~ Clarifies modernization as both a dedicated funding stream to implement work under Program Element 51 and a systems change initiative that pulls from multiple funding streams (opportunity to make this distinction less confusing, especially for folks new to modernization).

iii. ¶

~~iv.~~ Distinguishes modernization from general public health practice; indicate how modernization reflects an “update” to the public health system or different way of working (modernization as both “what” we are doing and “how” we are doing it that may be different than in the past).¶

v.iv. Highlights various funding streams that contribute to modernization and the importance of flexible, state general

Notes: ¶

- The considerations in this document are simple a starting point and can evolve and contain other considerations as we move forward. ¶
- The Workgroup may recommend changes to the modernization framework, language and/or manual that require updates to statute(s). This type of recommendation is within the Workgroup's scope, but would need to consider the timing of when statutory changes can be made.



OREGON
HEALTH
AUTHORITY

May 22, 2026

Public Health Modernization

Improvement Workgroup

Agenda

- Revisit modernization framework
- Discuss agenda for 6/17 optional in-person work session

Updates

- Final scoping document in Teams channel
- Held informational meeting with Wisconsin; still scheduling meeting with Minnesota

Group Practices

DRAFTS → COMMUNITY AGREEMENTS — look for...

SELF AWARENESS & REFLECTION

- CREATE TIME FOR REFLECTION. PAUSE.
- BE WILLING TO SLOW DOWN.
- DELAY DECISION MAKING IF PROCESSING & INTEGRATION ARE NEEDED.
- CHECK IN WITH YOURSELF—ESPECIALLY WHEN YOU FEEL REACTIVE
- HONESTY IS IMPORTANT.
- ADMIT WHEN YOU ARE WRONG...

CURIOSITY

- PRACTICE CURIOSITY OF OUR OWN REACTIONS AND FEELINGS.
- ADMIT WHEN YOU DON'T KNOW.
- SEEK TO UNDERSTAND
- BE OPEN TO DIFFERENT WAYS OF DOING THINGS.
- LISTENING MORE THAN TALKING.
- CREATE SPACE TO REIMAGINE, LEARN & CREATE TOGETHER.
- ASK WHAT PEOPLE NEED.
- USE PROMPTS: "TELL ME MORE"
- CULTIVATE A LEARNING CULTURE.

CHALLENGING SELF/ BRAVERY

- ASK FOR WHAT WE NEED.
- NOT NEEDING PERFECTION.
- WILLING TO SAY WHEN YOU DISAGREE.
- ADMIT WHEN YOU ARE WRONG.
- ALLOW SMALLER VULNERABLE SPACES TO PRACTICE.
- INVITE ALTERNATE VIEWPOINTS.
- FAILING & FORWARD.
- EMBRACE DISCOMFORT—IDENTIFY, DISCUSS, LEARN FROM MISTAKES.
- ACCEPTING YOU MAY NOT KNOW.
- NOT TAKING MYSELF TOO SERIOUSLY!

TRANSFORMATIONAL ACCOUNTABILITY

- HAVE CLEAR EXPECTATIONS.
- START WITH TRUST.
- SHARED RESPONSIBILITY & SHARED DECISION MAKING.
- FIGURE OUT HOW TO BRING IN ALL VOICES.
- ASK: DID WE HEAR FROM EVERYONE AT THE CLOSE OF THE MEETING?
- LEAN INTO OUR COLLECTIVE STRENGTHS.
- STAY IN THE CONFLICT WITH GRACE & HUMILITY.
- SHARED CELEBRATIONS

SPEAK YOUR TRUTH

- DISTINGUISH FACTS FROM FEELING AND OPINIONS.
- INVITATION TO HUMILITY.
- LISTEN TO UNDERSTAND.
- USE THE MEETING—NO MEETING AFTER THE MEETINGS.
- USE "I" STATEMENTS.
- ASK YOURSELF: "IS THIS MY BURDEN TO SHARE?"
- PRACTICE SELF CONTROL.
- NAME ASSUMPTIONS.
- RECOGNIZE THAT TRUTH MAY BE SOMEONE'S TRUTH—BUT MAY NOT BE A FACT.

PRACTICE
these
PRACTICES!
①—THE GOAL IS NOT PERFECTION,
IT'S LEARNING.

Revisiting the Modernization Framework

Considerations from Visioning Workshops

- Re-affirm modernization is **focused on governmental public health system** given statutory requirements to provide and/or ensure access to public health services
- Determine how we want to **characterize/describe the role of cross-sector and community partners**
- Discuss whether we continue to use the modernization framework **or align with the national FPHS framework** (similar but there are differences)

Considerations from Visioning Workshops

- Revisit **foundational versus “above the line” public health services** given:
 - Different interpretations of what it means to “ensure access” to services
 - Different perceptions of whether certain programs are “foundational” (e.g., WIC/nurse home visiting)
 - Expanded scope of practice during the pandemic to provide immunizations
 - Newer public health programs (e.g., psilocybin)
- Clarify modernization as **“core” public health versus an “expansion”** of public health services

Modernized framework for governmental public health services



Framework & Manual Definitions

- **Foundational capabilities** are the knowledge, skills and abilities needed to successfully implement foundational programs.
- **Foundational programs** include topic- and disease-specific work to achieve improved health outcomes, such as a decrease in the prevalence of a particular disease or health risk behavior.

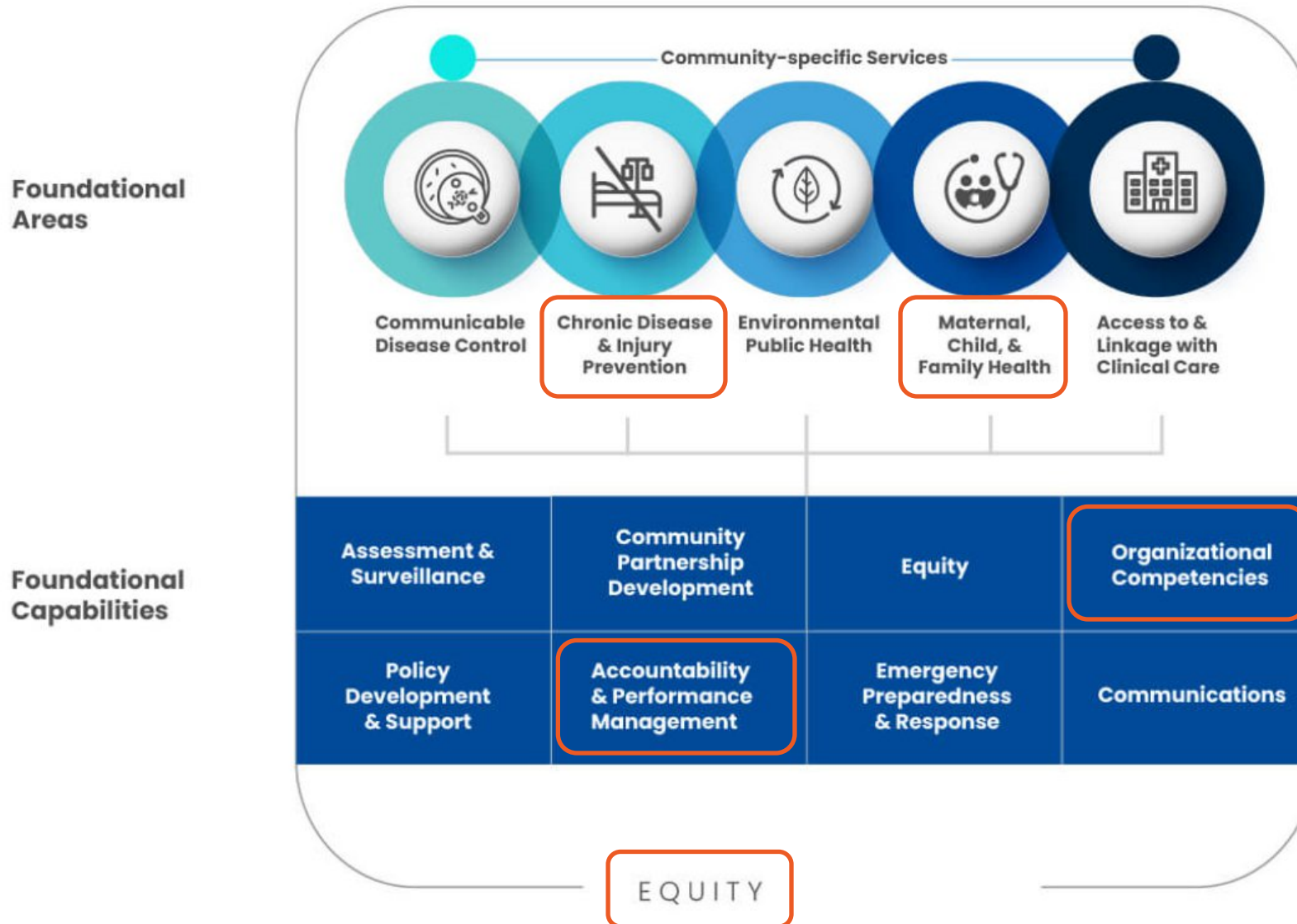
Framework & Manual Framing and Use

- Before Oregon's public health modernization, foundational capabilities were **not consistently present** to support effective foundational programs.
- The public health system will fall short in meeting its charge to improve the health of everyone in Oregon **without robust foundational capabilities.**

Framework & Manual Framing and Use

- The Public Health Modernization Manual is **intended to guide administrators and staff** of state and local public health authorities in implementing each foundational capability and program.
- This manual **defines how these apply specifically to state and local public health authorities**, who in turn work closely with community members and partners to implement them.
- Moving forward, this manual **provides a roadmap for the day-to-day work** of Oregon's public health system

Aligning with Foundational Public Health Services Framework

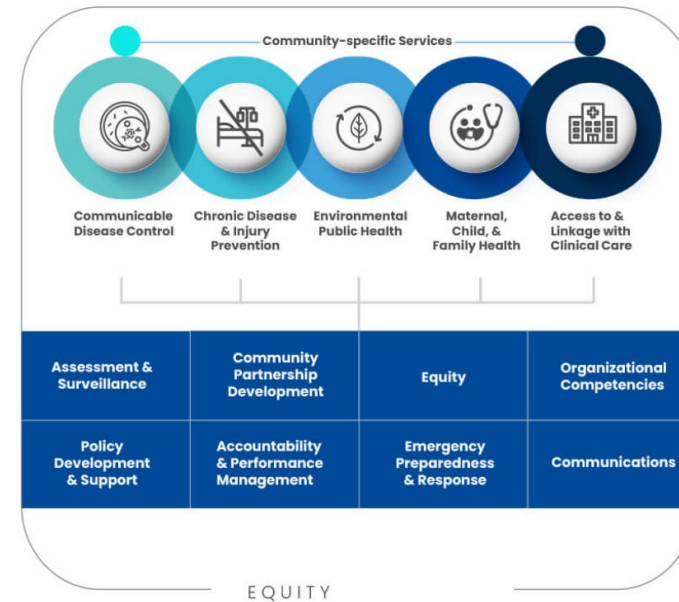


Differences between Oregon & FPHS Frameworks

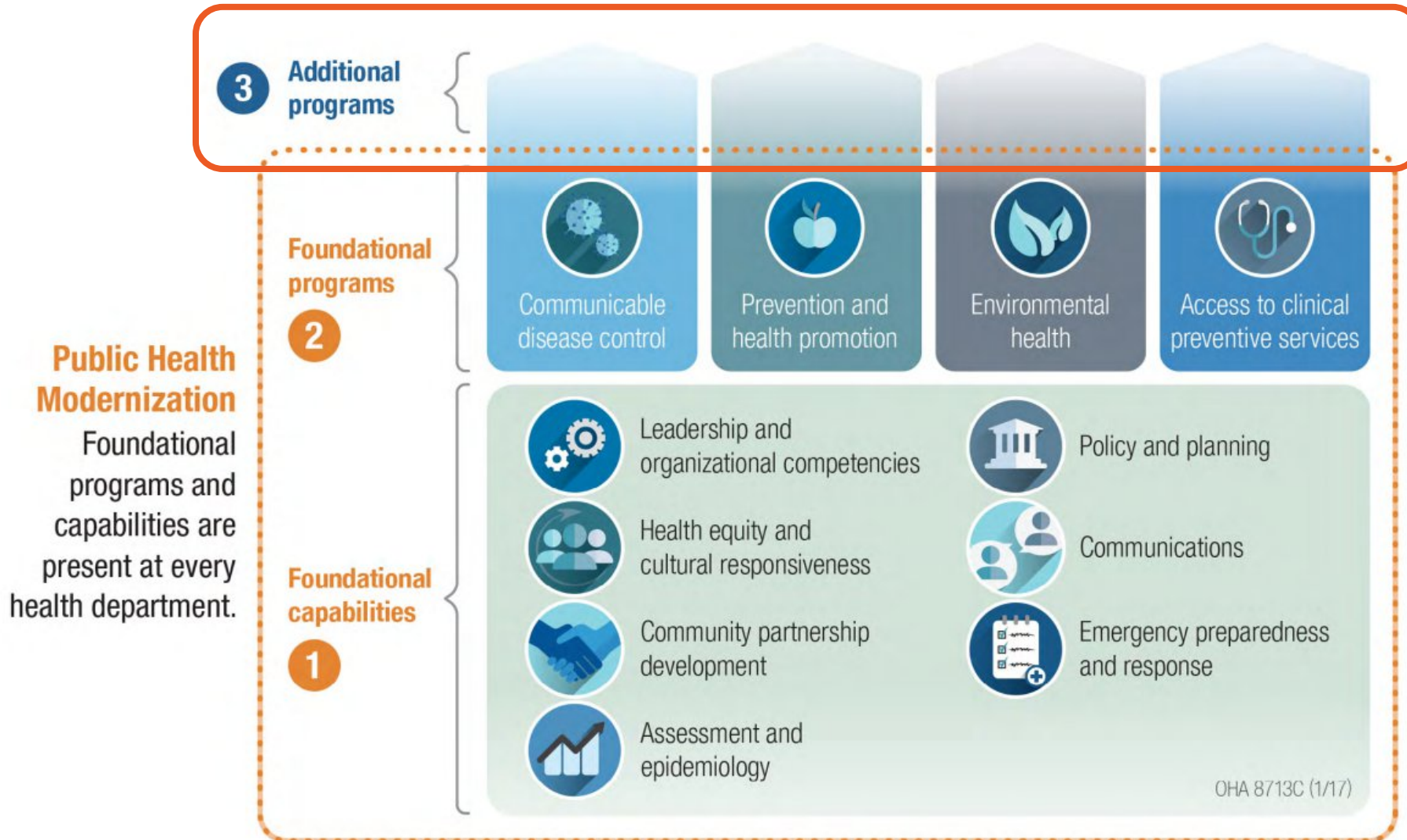
Oregon Modernization Framework	National FPHS Framework
Health Equity and Cultural Responsiveness as stand-alone foundational capability	Equity as stand-alone foundational capability and cross-cutting principle for all foundational programs and capabilities
One Prevention and Health Promotion foundational program, inclusive of maternal and child health; health promotion and chronic disease prevention; and injury and violence prevention	Two separate foundational program areas: (1) Chronic Disease and Injury Prevention; and (2) Maternal, Child, and Family Health
Leadership and Organizational Competencies foundational capability with roles for leadership and governance, performance management/quality improvement, human resources, information technology, financial management, contracts and procurement services	Two separate foundational capabilities: (1) Organizational Competencies (e.g., governance, IT, HR, contracts, legal); and (2) Accountability and Performance Management (i.e., quality improvement)

Aligning with the National FPHS Framework

- What are the strengths/value-add of aligning with the FPHS framework?
- What are the weaknesses or potential unintended consequences of aligning with the FPHS framework?
- Do we need more information before making a recommendation?
- Other thoughts?



Foundational vs. “above the line”



From Modernization Manual: “State and local public health authorities may have **additional programs** based on local needs and available resources, but the foundational capabilities and programs establish a common set of essential services that must be available in all areas of the state.”

Foundational vs. “above the line”

- **Operational definitions from Capacity and Cost Assessment (2024):** Additional Programs include direct services or individual services being provided through the public health responsibility of ensure access to clinical preventive services when no other entity exists in the community to provide them.
- **FPHS Framework Definition:** Community-specific Services are local protections and services that are unique to the needs of a community. These services are essential to that community’s health and vary by jurisdiction.

Foundational vs. “above the line”

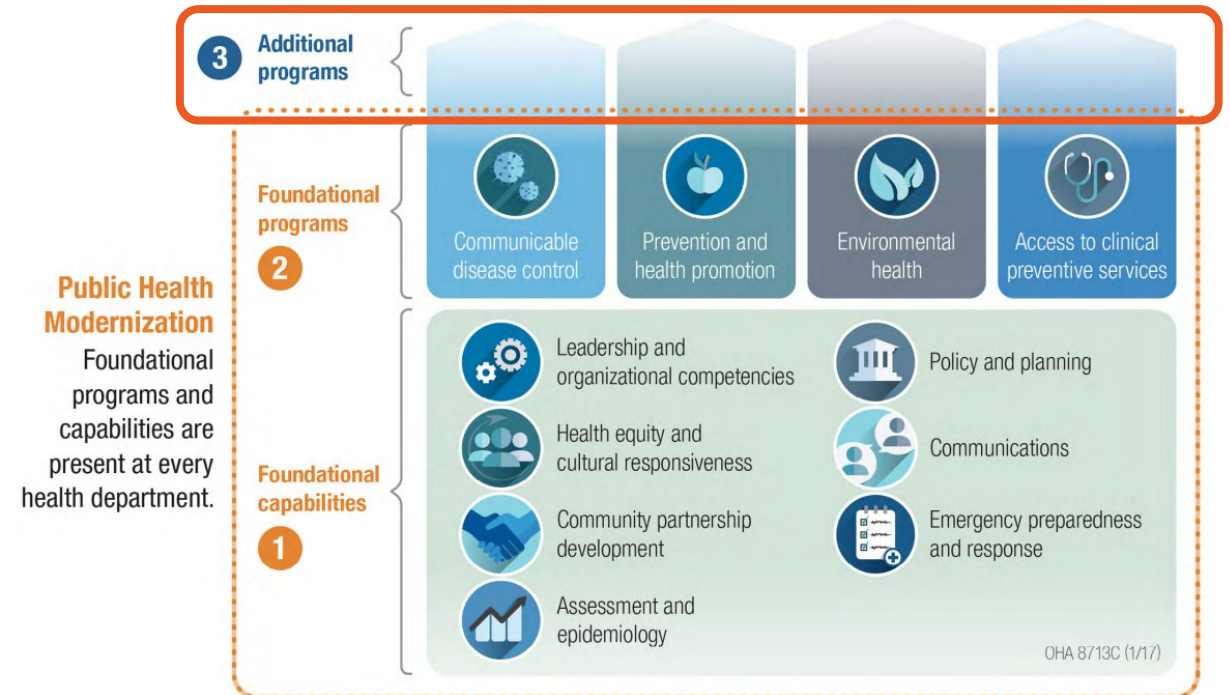
- **Considerations from Capacity and Cost Assessment:**
 - Different interpretations of what it means to “ensure access” to services
 - Expanded scope of practice during the pandemic to provide immunizations (do we continue to fill a gap?)
 - Different perceptions of whether certain programs are “foundational” or community-specific (e.g., WIC/nurse home visiting)
 - Newer public health programs (e.g., psilocybin)

Foundational vs. “above the line”

- **Additional Programs identified in CCA:**
 - Home Visiting Programs (excluding Universal Newborn Home Visiting)
 - Universal Newborn Home Visiting / Family Connects
 - Harm reduction services
 - HIV services
 - STD services
 - Immunizations
 - Reproductive health (excluding PE 46)
 - WIC

Foundational vs. “Above the Line”

- What are the strengths/value-add of expanding what is considered “foundational” public health?
- What are the weaknesses or potential unintended consequences of expanding what is considered “foundational” public health?
- Do we need more information before making a recommendation?
- Other thoughts?

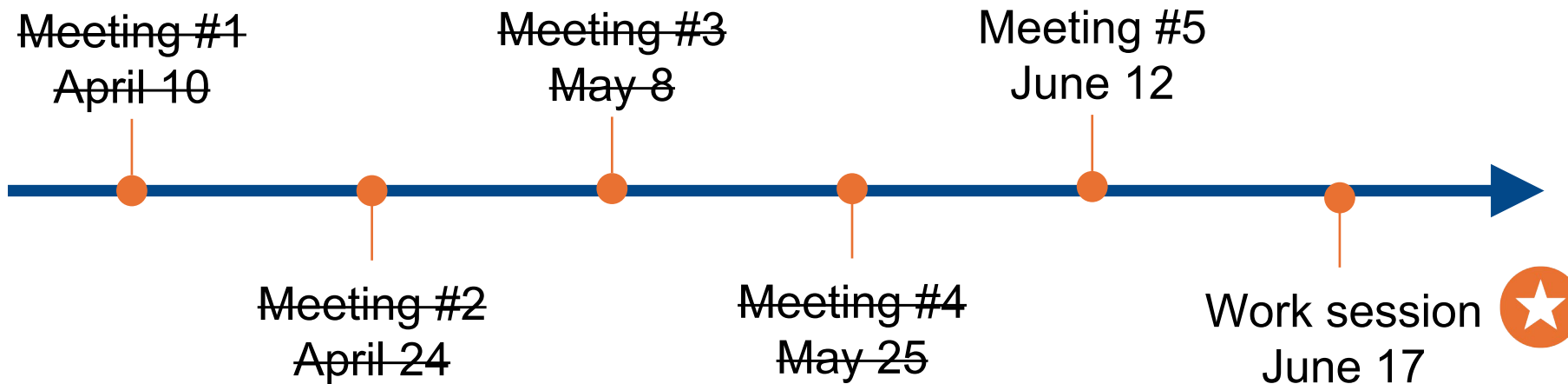


Re-centering Governmental Public Health

- Considerations from Vision Workshops:
 - Re-affirm focus of modernization on governmental public health system given statutory requirements to provide and/or ensure access to public health services and accountability to general fund investments
 - Determine how we want to characterize/describe the role of cross-sector and community partners, including CBOs
 - Build on CBO-LPHA PHAB Workgroup on role clarity, CBO companion document from PHAB, and roles described in Vision + Roadmap
- Question: How, if at all, do we reflect partners in framework or is this more relevant for our future revisit of the modernization manual?

Optional In-Person Work Session

- **Proposal:** Review findings from landscape assessment and continue conversation on framework
- **Question:** How much synthesis of landscape materials would you like in advance of the work session?



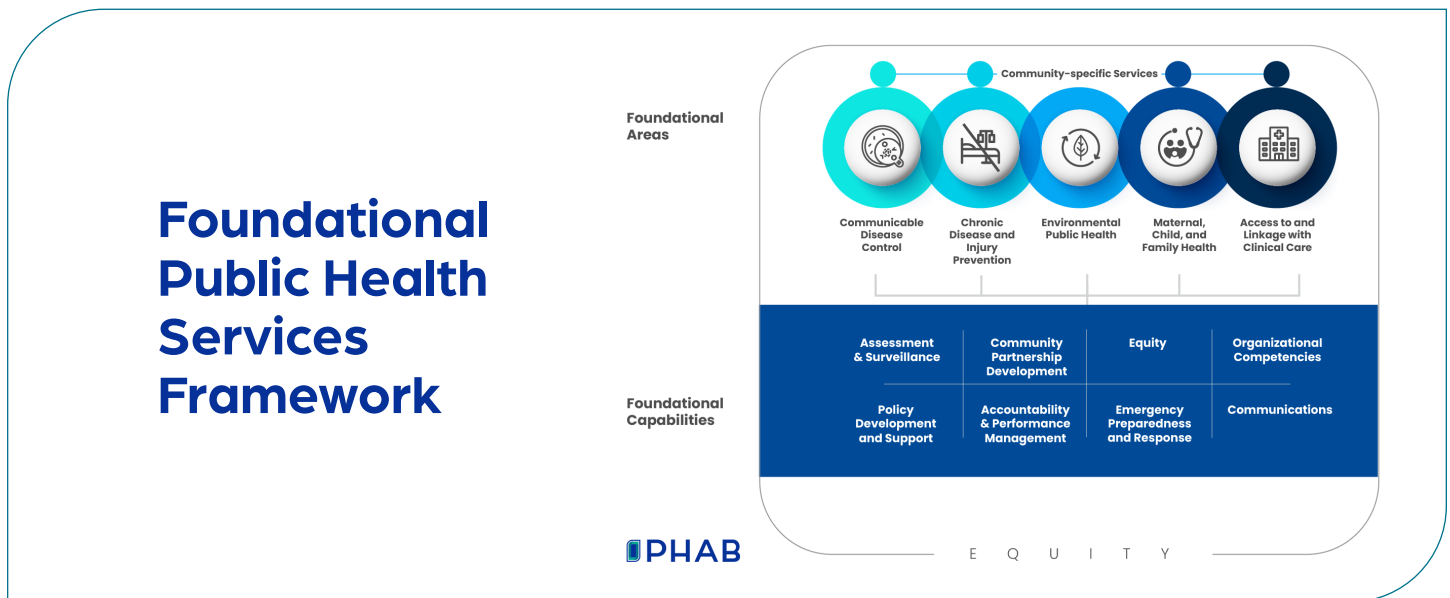
Foundational Public Health Services



Health departments have a fundamental responsibility to provide public health protections and services in a number of areas, including: preventing the spread of communicable disease; ensuring food, air, and water quality are safe; supporting maternal and child health; improving access to clinical care services; and preventing chronic disease and injury. In addition, public health departments provide local protections and services specific to their community's needs.

Health departments serve their communities 24/7 and require access to a wide range of critical data sources, robust laboratory capacity, preparedness and policy planning capacity, partnerships with community, and expert staff to leverage them in support of public health protections.

The Foundational Public Health Services framework outlines the unique responsibilities of governmental public health and defines a minimum set of Foundational Capabilities and Foundational Areas that must be available in every community.



Community-specific Services are local protections and services that are unique to the needs of a community. These services are essential to that community's health and vary by jurisdiction.

Foundational Areas

Public health programs, or Foundational Areas, are basic public health, topic-specific programs and services aimed at improving the health of the community. The Foundational Areas reflect the minimum level of service that should be available in all communities.

Foundational Capabilities

Public health infrastructure consists of Foundational Capabilities that are the cross-cutting skills and capacities needed to support basic public health protections, programs, and activities key to ensuring community health, well-being and achieving equitable outcomes.

Foundational Capabilities

There are eight Foundational Capabilities that are needed in Public Health Infrastructure.

Assessment & Surveillance

- Ability to collect timely and sufficient foundational data to guide public health planning and decision making at the state and local level, including the personnel and technology that enable collection.
- Ability to collect, access, analyze, interpret, and use data from a variety of sources including granular data and data disaggregated by geography (e.g., census tract, zip code), sub-populations, race, ethnicity, and other variables that fully describe the health and well-being of a community and the factors that influence health.
- Ability to assess and analyze disparities and inequities in the distribution of disease and social determinants of health, that contribute to higher health risks and poorer health outcomes.
- Ability to prioritize and respond to data requests and translate data into information and reports that are valid, complete, statistically accurate, and accessible to the intended audiences.
- Ability to conduct a collaborative community or statewide health assessment and identify health priorities arising from that assessment, including analysis of root causes of health disparities and inequities.
- Ability to access 24/7 laboratory resources capable of providing rapid detection.
- Ability to participate in or support surveillance systems to rapidly detect emerging health issues and threats.
- Ability to work with community partners to collect, report and use public health data that is relevant to communities experiencing health inequities or ability to support community-led data processes.

Community Partnership Development

- Ability to create, convene, support, and sustain strategic, non-program specific relationships with key community groups or organizations representing populations experiencing health disparities or inequities; private businesses and health care organizations; relevant

federal, Tribal, state, and local government agencies; elected and non-elected officials.

- Ability to leverage and engage partnerships and community in equity solutions.
- Ability to establish and maintain trust with and authentically engage community members and populations most impacted by inequities in key public health decision-making and use community-driven approaches.
- Ability to convene across governmental agencies, such as departments of transportation, aging, substance abuse/mental health, education, planning and development, or others, to promote health, prevent disease, and protect community members of the health department's jurisdiction.
- Ability to engage members of the community and multi-sector partners in a community health improvement process that draws from community health assessment data and establishes a plan for addressing priorities. The community health improvement plan can serve as the basis for coordination of effort and resources across partners.

Equity

- Ability to strategically address social and structural determinants of health through policy, programs, and services as a necessary pathway to achieve equity.
- Ability to systematically integrate equity into each aspect of the FPHS, strategic priorities, and include equity-related accountability metrics into all programs and services.
- Ability to work collaboratively across the department and the community to build support for and foster a shared understanding of the critical importance of equity to achieve community health and well-being.
- Ability to develop and support staff to address equity.
- Ability to create a shared understanding of what creates health including structural and systemic factors that produce and reproduce inequities.

Organizational Competencies

- **Leadership & Governance:** Ability to lead internal and external stakeholders to consensus, with movement to action, and to serve as the face of governmental public health in the department's jurisdiction. Ability to directly engage in health policy development, discussion, and adoption with local, state, and national policymakers, and to define a strategic direction for public health initiatives, including the advancement of equity. Ability to prioritize and implement diversity, equity, and inclusion within the organization. Ability to engage with appropriate governing entities about the department's public health legal authorities and what new laws and policies might be needed. Ability to ensure diverse representation on public health boards and councils.
- **Information Technology Services, including Privacy & Security:** Ability to maintain and procure the hardware and software needed to access electronic health information to support the department's operations and analysis of health data. Ability to support, use, and maintain communication technologies and systems needed to interact with community members. Ability to have the proper systems and controls in place to keep health and human resources data confidential and maintain security of IT systems.
- **Workforce Development & Human Resources:** Ability to develop and maintain a diverse and inclusive workforce with the cross-cutting skills and competencies needed to implement the FPHS effectively and equitably. Ability to manage human resource functions including recruitment, retention, and succession planning; training; and performance review and accountability.
- **Financial Management, Contract, & Procurement Services, including Facilities and Operations:** Ability to establish a budgeting, auditing, billing, and financial system and chart of expense and revenue accounts in compliance with federal, state, and local standards and policies. Ability to secure grants or other funding (governmental and not) and demonstrate compliance with an audit required for the sources of funding utilized. Ability to procure, maintain, and manage safe facilities and efficient operations. Ability to leverage funding and ensure resources are allocated to address equity and social determinants of health.

- **Legal Services & Analysis:** Ability to access and appropriately use legal services in planning, implementing, and enforcing, public health initiatives, including relevant administrative rules and due process

Policy Development and Support

- Ability to serve as a primary and expert resource for establishing, maintaining, and developing basic public health policy recommendations that are evidence-based and grounded in law. This includes researching, analyzing, costing out, and articulating the impact of such policies and rules where appropriate, as well as the ability to organize support for these policies and rules and place them before an entity with the legal authority to adopt them.
- Ability to effectively inform and influence policies being considered by other governmental and non-governmental agencies that can improve the physical, environmental, social, and economic conditions affecting health but are beyond the immediate scope or authority of the governmental public health department.
- Ability to effectively advocate for policies that address social determinants of health, health disparities and equity.
- Ability to issue, promote compliance with or, as mandated, enforce compliance with public health regulations.

Accountability & Performance Management

- Ability to perform according to accepted business standards in accordance with applicable federal, state, and local laws and policies and assure compliance with national and Public Health Accreditation Board Standards.
- Ability to maintain a performance management system to monitor achievement of organizational objectives.
- Ability to identify and use evidence-based or promising practices when implementing new or revised processes, programs and/or interventions.
- Ability to maintain an organization-wide culture of quality and to use quality improvement tools and methods.
- Ability to create accountability structures and internal and external equity-related metrics to measure the equity impact of a department's efforts and performance.

Emergency Preparedness and Response

- Ability to develop, exercise, and maintain preparedness and response strategies and plans, in accordance with established guidelines, and to address a range of events including natural or other disasters, communicable disease outbreaks, environmental emergencies, or other events, which may be acute or occur over time.
- Ability to integrate social determinants of health, and actions to address inequities, including ensuring the protection of high-risk populations, into all plans, programs, and services.
- Ability to lead the Emergency Support Function 8 — Public Health & Medical for the county, region, jurisdiction, and state.
- Ability to activate the emergency response personnel and communications systems in the event of a public health crisis; coordinate with federal, state, and local emergency managers and other first responders, and private sector and non-profit partners; and operate within, and as necessary lead, the incident management system.
- Ability to maintain and execute a continuity of operations plan that includes a plan to access financial resources to execute an emergency and recovery response.
- Ability to establish and promote basic, ongoing community readiness, resilience, and preparedness by enabling the public to take necessary action before, during, or after a disaster, emergency, or public health event.
- Ability to issue and enforce emergency health orders.
- Ability to be notified of and respond to events on a 24/7 basis.
- Ability to access and utilize a Laboratory Response Network (LRN) Reference laboratory for biological agents and an LRN chemical laboratory at a level designated by CDC.

Communications

- Ability to maintain ongoing relations with local and statewide media including the ability to write a press release, conduct a press conference, and use electronic communication tools to interact with the media.
- Ability to effectively use social media to communicate directly with community members.
- Ability to appropriately tailor communications and communications mechanisms for various audiences.
- Ability to write and implement a routine communications plan and develop routine public health communications including to reach communities not traditionally reached through public health channels.
- Ability to develop and implement a risk communication strategy for communicating with the public during a public health crisis or emergency. This includes the ability to provide accurate and timely information and to address misconceptions and misinformation, and to assure information is accessible to and appropriate for all audiences.
- Ability to transmit and receive routine communications to and from the public in an appropriate, timely, and accurate manner, on a 24/7 basis.
- Ability to develop and implement a proactive health education/health communication strategy (distinct from risk communication) that disseminates timely and accurate information to the public designed to encourage actions to promote health in culturally and linguistically appropriate formats for the various communities served, including using electronic communication tools.

Foundational Areas

There are five Foundational Areas, also known as Public Health Programs. Social determinants of health and actions to address health inequities should be integrated throughout all activities.

Communicable Disease Control

- Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control.
- Identify statewide and local communicable disease control community partners and their capacities, develop, and implement a prioritized communicable disease control plan, and ability to seek and secure funding for high priority initiatives.
- Receive laboratory reports and other relevant data; conduct disease investigations, including contact tracing and notification; and recognize, identify, and respond to communicable disease outbreaks for notifiable conditions in accordance with local, national, and state mandates and guidelines.
- Assure the availability of partner notification services for newly diagnosed cases of communicable diseases according to Centers for Disease Control and Prevention (CDC) guidelines.
- Assure the appropriate treatment of individuals who have reportable communicable diseases, such as TB, STIs, and HIV in accordance with local and state laws and CDC guidelines.
- Support the recognition of outbreaks and other events of public health significance by assuring capacity for the identification and characterization of the causative agents of disease and their origin, including those that are rare and unusual.
- Coordinate and integrate categorically-funded communicable disease programs and services.

Chronic Disease & Injury Prevention

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on chronic disease and injury prevention and control.
- Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop, and implement a prioritized prevention plan, and ability to seek and secure funding for high priority initiatives.

- Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand exposure to harmful substances.
- Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and promising practices aligned with national, state, and local guidelines for healthy eating and active living.
- Coordinate and integrate categorically-funded chronic disease and injury prevention programs and services.

Environmental Public Health

- Provide timely, statewide, and locally relevant, complete, and accurate information to the state, health care system, and community on environmental public health threats and health impacts from common environmental or toxic exposures.
- Identify statewide and local community environmental public health partners and their capacities, develop, and implement a prioritized plan, and ability to seek and secure action funding for high priority initiatives.
- Conduct mandated environmental public health laboratory testing, inspections, and oversight to protect food, recreation sites, and drinking water; manage liquid and solid waste streams safely; and identify other public health hazards related to environmental factors in accordance with federal, state, and local laws and regulations.
- Protect workers and the public from chemical and radiation hazards in accordance with federal, state, and local laws and regulations.
- Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes and resilient communities (e.g., housing and urban development, recreational facilities, transportation systems and climate change).
- Coordinate and integrate categorically-funded environmental public health programs and services.

Maternal, Child and Family Health

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on emerging and on-going maternal child health trends.
- Identify local maternal and child health community partners and their capacities; using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and ability to seek and secure funding for high priority initiatives.
- Identify, disseminate, and promote emerging and evidence-based early interventions in the prenatal and early childhood period that promote lifelong health and positive social-emotional development.
- Assure newborn screening as mandated by a state or local governing body including wraparound services, reporting back, following up, and service engagement activities.
- Coordinate and integrate categorically funded maternal, child, and family health programs and services.

Access to & Linkage with Care

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on access and linkage to clinical care (including behavioral health), healthcare system access, quality, and cost.
- Inspect and license healthcare facilities, and license, monitor, and discipline healthcare providers, where applicable.
- In concert with national and statewide groups and local providers of healthcare, identify healthcare partners and competencies, develop prioritized plans for increasing access to health homes and quality health care, and seek funding for high priority policy initiatives.

Oregon Public Health Modernization Capacity and Cost Assessment

Differentiating Between Foundational and Additional Programs

Oregon’s public health modernization framework includes a set of foundational programs and capabilities (Foundational Public Health Services or FPHS) present at every health department, and additional programs (see figure, below). According to Oregon Statute, state and local public health authorities may have additional programs based on local needs and available resources, but the foundational capabilities and programs establish a common set of essential services that must be available in all areas of the state. Although all programs and services provided by public health authorities are critical and important, not all public health programs and services are FPHS, or under the purview of the Capacity and Cost Assessment (CCA).

Modernized framework for governmental public health services



A primary purpose of the CCA is to allocate resources to the foundational programs and capabilities to understand where the strengths and gaps are in the governmental public health system. At times, it may be difficult to differentiate if a specific service or program should be allocated to a foundational program or an additional program. Additional Programs can also be considered direct services, individual services, or community-specific services. These services and programs may be provided in certain jurisdictions depending on community context, but are not expected to be provided by all LPHAs as a component of Public Health Modernization foundational programs.

To add to the complexity of determining how to allocate the work you are doing, some aspects of an Additional Program may be considered foundational. For example, for immunizations, surveillance of vaccine preventable diseases does fall under the foundational program area of Communicable Disease Control, but vaccine administration would fall into Additional Programs. When an Additional Program has foundational activities, include them in the appropriate program area- such as Communicable Disease Control, Prevention and Health Promotion, or Access to Preventive Clinical Services.

Foundation public health services are:

- Population-based health services;
- Services that can be provided by all LPHAs; and
- Services that public health should provide in all communities.

Please note that while all FPHS's are population-based services, the reverse is not necessarily true, some population-based services may not be FPHS. For example, population-based oral health programs are not considered FPHS.

Additional Programs are:

- Any individualized services (e.g., clinical, transactional) or other health care or social services; and
- Services that are not provided uniformly by LPHAs across all counties.

As a starting place for differentiating between foundational and additional programs, review the operational definitions closely. These are included in the CCA tool in the 03. Operational Definitions worksheet, and are pulled directly from [the 2017 Public Health Modernization Manual](#). Worksheet 11. Additional Programs also includes a list of Additional Programs to start from that have been identified by the LPHA OR CCA technical workgroup as common services provided by LPHAs in Oregon.

Some examples of Additional Programs include (but are not limited to):

1. Administering/providing clinical or clinical preventive services; including jail and school health
2. Providing oral health services
3. Enrolling individuals or administering benefits to those enrolled in Women, Infants, and Children (WIC)
4. Providing visits to a family as part of nurse or family home visiting programs; including Prenatal Care Coordination
5. Distributing equipment to individuals; such as Child Passenger Safety for Child Seats
6. Administering/providing vaccines
7. Administering/providing Title X, Family Planning services
8. Administering/providing needle exchange programs
9. Administering/providing Babies First and/or CaCoon programs
10. Emergency Management Services (EMS) and Trauma Services: emergency medical services and their coordination
11. Environmental Protection: Activities related to the protection of the environment

There are two activities that are an exception to the guidance that allocates direct services to Additional Programs: Diagnosis and treatment of TB cases and latent TB infections (Access to Clinical Preventive Services); and Partner

notification services for newly diagnosed cases of syphilis, gonorrhea, and HIV, as recommended by OHA (Communicable Disease Control).

As another resource, [Program Elements](#) (PEs) have tables that indicate which Foundational Programs and Capabilities activities may fit it in, including what is a Direct Service. However, PEs were not designed to differentiate between Foundational and Additional Programs. They can be used as guides, but items that are listed in the PEs that are individual, clinical, or direct services should still be allocated to Additional Programs for purposes of the assessment. For example, although PE 07: HIV Prevention Services lists syringe services as Communicable Disease Control, the purchase and distribution of wound care supplies, sharps containers, and clean supplies used for injection drug use would be included in Additional Programs, not Communicable Disease Control.

Please think judiciously about the work actually being performed to determine whether there is a share of that work that fits within the definitions for Foundational Public Health Services. If you find that you are “making the case” for something to be a FPHS, you may be stretching beyond the Foundational definitions and central goals. It is very important that the FPHS categories are not overestimated by including Additional Programs, because this could inflate existing resources and/or underestimate the gap in resources to provide.

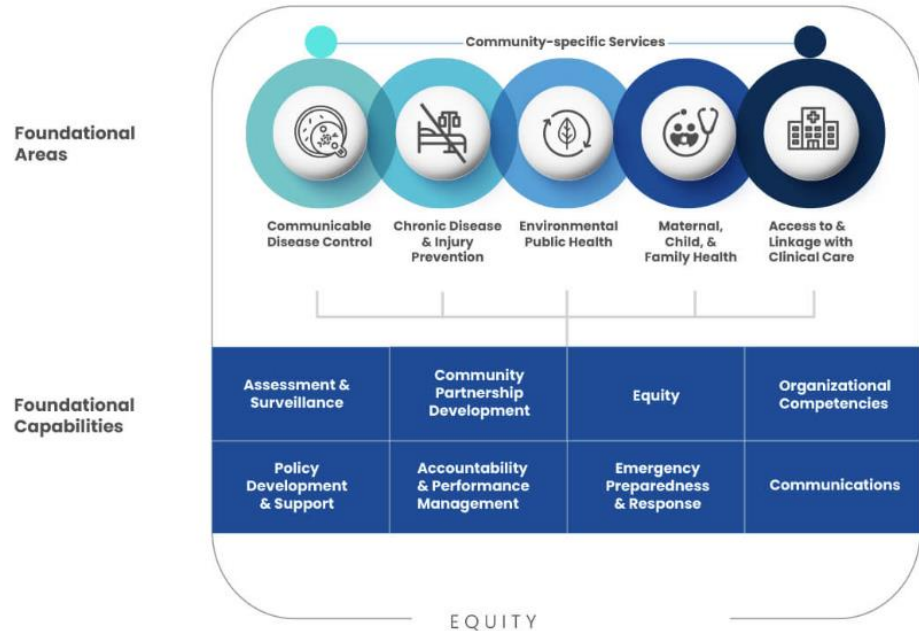
If you have reviewed the definitions and the guidance, and are still unsure if something is foundational or not, please reach out to Audra Baca for a consultation at audra.baca@redegrouP.co.

Foundational vs Community-specific Services: Crosswalk & Guide

[The Foundational Public Health Services \(FPHS\)](#)

framework includes a set of Foundational Capabilities (FC) and Foundational Areas (FA) that are specific to governmental public health. These Capabilities and Areas serve as a “minimum package” of public health services that should be provided by all governmental public health departments in all communities. The framework also acknowledges Community-specific Services (CSS) which are local programs and services that are unique to a specific community and vary by jurisdiction. CSS are not more or less important than FCs and FAs, they are just not considered to be part of the “minimum package”.

Foundational Public Health Services



February 2022

It is sometimes challenging to distinguish between FCs, FAs, and CSS. The distinction is especially important when a health department or health department system is completing the [FPHS Capacity and Cost Assessment Tool](#) to ensure that costs and capacity are not being overestimated, or gaps underestimated relative to foundational activities. This document supports health departments and health department systems as they seek shared understanding and agreement around the distinction between foundational activities and CSS in their jurisdictions. The content is presented in three sections:

- Section 1: General guidance for differentiating between FCs, FAs, and CSS.
- Section 2: List of common CSS by jurisdiction.
- Section 3: Crosswalk template for capturing program activities as FA, FC, and/or CSS.

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Section 1: General Guidance

This section provides general guidance on differentiating between Foundational Capabilities, Areas and Community-specific Services.

Foundational Capabilities are:

- Cross-cutting skills and capacities needed to support basic public health services
- Often referred to as foundational infrastructure

Foundational Areas are:

- Population-based health programs and services
- Required by federal or state law
- Provided by governmental health departments in all communities

Community-specific Services are:

- Individualized services such as those offered through clinical, social, or behavioral health programs
- Services that are not provided uniformly by ALL health departments in ALL communities

To add to the complexity, some CSS may have components or elements that are considered Foundational. Here are some examples:

- Immunization Program
 - Surveillance of vaccine preventable diseases is foundational and would fall under FA: Communicable Disease Control.
 - Vaccine administration is a CSS since it is a clinical, individualized service.
- Car Seat Program
 - Analysis and reporting of related injury and death data would fall under FA: Chronic Disease and Injury Prevention.
 - Distributing car seats and/or holding car seat safety checks is a CSS as it is distribution and/or service to individuals.
- Lead Prevention Program
 - Convening cross-system partners to establish a community or statewide plan for eradicating lead in old homes would fall under FC: Environmental Health.
 - Conducting blood lead testing in children would be a CSS as it is a 1:1 service to individuals.

Here are a few additional tips:

- The [FPHS Operational Definitions](#) and Fact Sheets (see resource section below) are helpful in differentiating between FCs, FAs, and CSS – review these closely and use as a guide.
- It is important to think carefully about the work being performed to determine whether all or part fits within the FPHS operational definitions. These conversations are important as they bring shared awareness, clarity, agreement, and consistency in interpretation.



- For departments or systems completing the FPHS Capacity and Cost Assessment, agreement on what is foundational and what is CSS beforehand will increase consistency and reliability of results.
- The crosswalk template (Section 3) allows health departments and health department systems to document these conversations and decisions for future reference.
- Remember – ALL public health services are critical to our communities. CSS are not more or less important than an FC or FA, they are simply not considered to be part of the “minimum package” of services offered by all governmental health departments in all communities.

Links to Helpful Resources:

- [FPHS Framework](#)
- [FPHS Operational Definitions](#)
- [Communicable Disease Control Fact Sheet](#)
- [Chronic Disease and Injury Prevention Fact Sheet](#)
- [Environmental Public Health Fact Sheet](#)
- [Maternal, Child, & Family Health Fact Sheet](#)
- [Access to & Linkage with Clinical Care Fact Sheet](#)
- [Assessment and Surveillance Fact Sheet](#)
- [Community Partnership Development Fact Sheet](#)
- [Organizational Competencies Fact Sheet](#)
- [Policy Development & Support Fact Sheet](#)
- [Accountability & Performance Management Fact Sheet](#)
- [Emergency Preparedness & Response Fact Sheet](#)
- [Communications Fact Sheet](#)

For additional questions about this document, PHAB’s products and services, or to talk to a PHAB staff member about your specific needs, email phabta@phaboard.org.

Section 2: Common Community - specific Services by Foundational Area

Below is a list of common CSS organized by Foundational Area. This list was adapted, with permission, from the [Public Health Foundation](#). It is not all inclusive but rather provides examples of common local public health programs and services that are considered community specific vs foundational. However, as noted in the section above, there may be elements of a CSS listed below that are supported by crosscutting FCs and/or there may be CSS that are outlined in statute or code making it foundational for that health department or health department system.

Communicable Disease Control

- Vaccination Services: administering vaccinations to individuals, including those for international travel
- STI Services: testing and treatment of sexually transmitted infections
- TB Services: testing for TB infection, direct observation therapy unless state mandated
- Harm Reduction Programs: needle exchange programs
- HIV/AIDS Services: testing, PrEP, and treatment of HIV/AIDS

Chronic Disease and Injury Prevention

- Diabetes Services: screening individuals for diabetes, providing nutrition/health coaching
- Weight Management: monitoring weight, providing medications or coaching for weight loss
- Child Passenger Safety: car seat distribution, car seat safety checks
- Firearm Safety: gun lock box distribution
- Safe Routes to Schools Program: establishing safe walking routes, increasing the number of children walking or biking to school
- Traffic Safety Programs: enhanced enforcement, drunk driving simulators, mock crashes
- Workplace Wellness: employee wellness education, programs, and incentives
- Drowning Prevention: education on pool safety, distribution of flotation safety devices
- Alcohol and Drug Services and Project DAWN: monitoring and treatment of alcohol and drug misuse, harm reduction activities (ex. distribution of fentanyl test strips and Narcan)
- Breast and Cervical Cancer Project (BCCP): screening for breast and cervical cancer, patient navigation services
- Creating Healthy Communities: funding to select local communities to address issues such as physical inactivity, tobacco use, food deserts, etc.
- Suicide Prevention: staffing of hotlines, general education regarding suicide prevention

Environmental Public Health

- Agricultural Camps: inspecting camps that house farm workers
- Outdoor Air: air quality monitoring/notification systems
- Recreational Water: monitoring and testing beaches and marinas
- Exotic Animals: monitoring private exotic animal ownership, enforcement of exotic animal bans
- Building Code: development and enforcement of building safety codes
- Solid Waste Programs: landfill inspections, recycling programs, scrap tire collection, river clean ups
- Indoor air: testing homes or businesses for radon, lead, mold
- Plumbing/Sewage Programs: inspecting plumbing systems on new builds/remodels, inspecting septic systems

Environmental Public Health, continued

- Storm Water Programs: regulation of storm water discharge from construction sites, industry, and municipalities
- National Pollutant Discharge Elimination System: permitting and regulating point sources of pollutant discharge
- Tobacco Enforcement: enforcement of Tobacco 21 or other tobacco related laws.
- Mosquito Control: setting and monitoring mosquito traps, fogging/spraying

Maternal Child and Family Health

- Care Coordination: linking mothers and infants to clinical/well-being services
- WIC: nutrition education, enrollment in SNAP benefits, pediatric referrals
- Breastfeeding Programs: peer support/coaching for breastfeeding mothers, distribution of breastfeeding supplies
- Newborn Home Visiting/Help Me Grow: mom and baby wellness checks by a nurse or CHW; early intervention programming for infants
- Safe Sleep: crib or sleep box distribution; distribution of education packets to new parents/caregivers
- Child Abuse/Neglect: investigation of possible child abuse or neglect cases
- Prenatal Care: clinical monitoring and care of expectant mothers
- Family Planning: education and administration of birth control (prescription birth control, condom distribution, IUD implants)

Access to and Linkage to Clinical Care

- Behavioral Health: psychiatry or counseling services
- Dental Care: screenings, cleanings, sealant programs for adults and school aged children
- Home Health/Home Visiting: nurse, social worker or CHW home visits for elder care, newborn home visits, etc.
- Medicaid/Insurance: outreach and enrollment services for individuals seeking health insurance
- Therapy: 1:1 therapy services including but not limited to: occupational, physical, speech
- Pharmacy: distribution of prescribed medications
- Rural Health: clinical healthcare services in rural areas
- Primary Care: general clinical/healthcare services for children and adults, including physicals for sports or foster care
- School Nursing: providing nursing services in primary and secondary schools
- Drug Testing: screening or collecting samples to test for presence of legal or illegal drugs
- Mobile Health Units: provision of clinical services via a mobile unit
- Clinical Licensing: clinical facility licensing such as FQHCs, hospitals, nursing homes

Section #3: Crosswalk Template

This template, adapted with permission from the Oregon Health Authority, assists health departments and/or health department systems with conducting a crosswalk between the Foundational Public Health Services (FPHS) framework and public health program responsibilities to differentiate between Foundational Capabilities (FC), Foundational Areas (FA), and Community - specific Services (CSS). This exercise is helpful to foster shared awareness, understanding, and consistency in FPHS interpretation and can be especially useful when a health department or health department system is conducting the [FPHS Capacity and Cost Assessment](#). This section includes instructions for conducting the crosswalk, a blank crosswalk template, and a sample completed crosswalk.

INSTRUCTIONS:

1. Save a copy of the template as a working file.
2. For each program area, assemble a small group of individuals (4-8) to complete the crosswalk.
 - a. If completing as a single health department, this may include the facilitator/lead, a leader from the program area, and 1-2 staff who can speak directly to program activities.
 - b. If completing as a state system, participation may include a facilitator/lead, 1-2 state health department staff, and 3-5 local representatives from health departments of various sizes and geographic locations.
3. Review the [FPHS framework](#), [FPHS Operational Definitions](#), and the FC/FA Fact Sheets (see Section 1 – Links to Helpful Resources) before getting started. Keep these resources close by for reference while completing the crosswalk.
4. Review the list of common public health programs and services that are considered CSS in Section 2.
5. Enter the program's name and short description on the template provided. Include any definitions that may be helpful for context, particularly to those not familiar with the program.
6. List the key program activities in the left-hand column of the table. Add or delete rows as needed.
7. For each program activity, indicate on the template if it addresses one (or more) of the five FAs using an X or other indicator. If a program activity does not address an FA, leave blank.
8. For each program activity, indicated if elements of the work are supported by FCs. If the program activity does not align with a FC, leave blank.
9. Remember, that a program area could generally be considered a CSS but have elements that are considered Foundational.
10. Capture any additional context, justification, outstanding questions, etc. in the notes section.
11. Upon completion, delete all but the completed crosswalk and save using your preferred naming convention.
12. For questions regarding this template, contact phabta@phaboard.org.



Program Name:

Program Description:

Program Definitions:

FPHS Cross Walk:

PROGRAM ACTIVITIES	COMMUNITY-SPECIFIC SERVICE	FOUNDATIONAL AREAS					FOUNDATIONAL CAPABILITIES							
	Individualized services or those specific and unique to a community	Communicable Disease Control	Chronic Disease and Injury Prevention	Environmental Public Health	Maternal, Child, and Family Health	Access to & Linkage with Clinical Care	Assessment and Surveillance	Community Partnership Development	Equity	Organizational Competencies	Policy Development & Support	Accountability & Performance Mgt.	Emergency Preparedness & Response	Communications
Notes:														

Sample Program Name: Tobacco Control Program

Sample Program Description: The goal of the tobacco control program are to 1) reduce tobacco and nicotine use through prevention, education, and cessation.

Sample Program Definitions: Tobacco 21: Federal law that prohibits retailers from selling nicotine or tobacco products to anyone <21yo

Sample FPHS Cross Walk:

PROGRAM ACTIVITIES	COMMUNITY-SPECIFIC SERVICE	FOUNDATIONAL AREAS					FOUNDATIONAL CAPABILITIES							
	Individualized services or those specific and unique to a community.	Communicable Disease Control	Chronic Disease and Injury Prevention	Environmental Public Health	Maternal, Child, and Family Health	Access to & Linkage with Clinical Care	Assessment and Surveillance	Community Partnership Development	Equity	Organizational Competencies	Policy Development & Support	Accountability & Performance Mgt.	Emergency Preparedness & Response	Communications
Tobacco cessation services	X													
Mass education campaigns (ex. billboards)			X											X
Smoke free housing program	X									X				
Tobacco 21 enforcement	X									X				
County-wide tobacco control plan			X											
Annual tobacco data report			X				X							