Public Health Division

Oregon Public Health Modernization Evaluation Report

2023-2025 Biennium

July 2025

OREGON HEALTH AUTHORITY

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Letter from OHA's public health director

Dear Colleagues and Partners,

This summer marks the ten-year anniversary of the passage of House Bill 3100, landmark legislation that created a new future for health in Oregon through public health modernization. This pivotal bill established a framework for governmental public health centered on the idea that every person should have access to public health services and programs that make health attainable for all. At a time that Oregon was undergoing significant transformation within our health care delivery system, public health modernization recognized that investing in prevention saves lives, avoids costly medical interventions, and prepares our state for emerging health threats, such as those due to emerging communicable diseases and a changing climate. Leaders recognized that sufficient and sustained funding was needed to achieve the new statutory requirements to provide a modern public health system.

Ten years since House Bill 3100 was enacted, we are at a crucial moment to reflect on the progress we've made over the past decade, look critically at gaps that continue to exist and recommit to our path forward for the next ten years.

This report provides a deep dive into changes and improvements that have occurred in our system over the past decade, elevating the voices and perspectives of leaders from local public health authorities, community-based organizations and the Oregon Health Authority's Public Health Division. Findings collected before January 2025 clearly show that, with Legislative investments, public health approaches are effective in serving people throughout Oregon. At the same time, we also know that our workforce is under-resourced, our shared vision from a decade ago has shifted, and that uncertainty about the future inhibits our ability to fully modernize our system.

The recommendations, also developed before January 2025, provide our path forward for the next ten years. At its core, the recommendations in this report provide clear and actionable steps that the Oregon Public Health Advisory Board and Oregon Health Authority Public Health Division can take with local public health authorities and community partners to redefine a shared vision for a modern public health system through partnership, collaboration, and building capacity across our system together. We are committed to taking these steps together in the coming years.

This is the moment for all of us to come together to recommit to our belief that every person deserves a life where health is achievable and that a modern public health system is essential for getting there. Governmental public health, with partners and communities has the power to make the vision a reality for people in Oregon. Momentous system change does not happen in a moment, but takes ongoing dedication, vision and resources. We've come far and the information from this report sets the foundation for how we move forward together.

Naomi Adeline-Biggs
Public Health Director
Oregon Health Authority

Executive summary

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Executive summary

A strong public health system is critical for all 4.2 million people in Oregon to achieve optimal health. Since 2013, Oregon has been rebuilding its public health system to ensure essential public health protections for all people in Oregon through equitable, community-centered and accountable services. The governmental public health system works daily with partners – including community-based organizations (CBOs) – to ensure that communities who experience disproportionate burdens of health inequities receive culturally and linguistically responsive interventions.

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

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

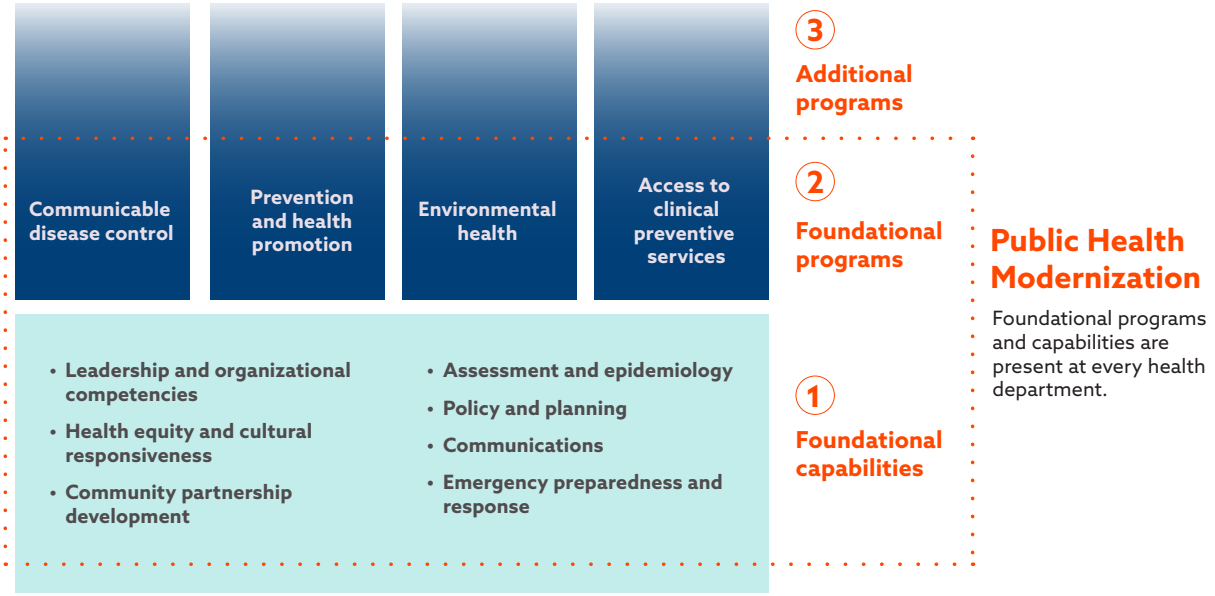
1. *Adopt a set of foundational capabilities and programs to ensure a core set of public health services is available in every area of the state (framework depicted in Figure 1).*
2. *Allocate significant and sustained state funding to support implementation of foundational capabilities and programs.*

These recommendations align with the requirements for national public health accreditation and Centers for Disease Control and Prevention (CDC) funding through the Public Health Infrastructure Grant, released in December 2022.

In 2015, Oregon's Legislature passed House Bill 3100, which codified the Modernized Framework for Governmental Public Health Services into law (Figure 1). Oregon Revised Statutes (ORS) 431.131-431.145 list specific requirements of governmental public health authorities to provide foundational capabilities and programs through Public Health Modernization (PHM).[1] The capabilities are cross-cutting skills and capacities needed to ensure public health protections and to conduct programs and activities.[1-3]

This framework, when fully implemented, ensures that Oregon's public health system is prepared to address new and emerging health threats, such as those related to climate change or emerging infectious diseases. Since 2017, Oregon's Legislature has steadily increased funding to sustain and accelerate changes needed to achieve an equitable, community-centered and accountable public health system.

Figure 1. A modernized framework for governmental public health services[3]



For more information, please see Oregon's Public Health Modernization Manual.[3]

A large-scale system-wide change like PHM takes time, especially in an environment with historical cycles of funding and defunding of public health. Ten years have passed since Oregon codified the modernization framework into law, marking a noteworthy time for partners to collectively reassess the vision, goals and corresponding actions toward this system-wide transformation.

This evaluation report examines specific interest areas for the PHM investments made during the 2023-2025 biennium. These investments occurred after the COVID-19 public health emergency and extensive efforts to advance our health security, which are now at risk as COVID-19 investments end.

The PHM investments – $112.2 million in state General Fund dollars – had four overarching goals:

1 Strengthen and expand communicable disease and environmental health emergency preparedness

2 Protect communities from acute and communicable diseases through prevention initiatives that address health inequities

3 Co-create public health interventions that ensure equitable distribution or redistribution of resources and power and that recognize, reconcile and rectify historical and contemporary injustices

4 Protect communities from environmental health threats through public health interventions that support equitable climate adaptation

Local public health authorities (LPHAs) and the Oregon Health Authority Public Health Division (OHA PHD) can use PHM investments and other funding sources to make progress on Oregon's public health accountability metrics, a set of health outcomes and process measures intended to evaluate the public health system's progress toward achieving statewide health goals.

In 2023, Oregon's Public Health Advisory Board (PHAB) adopted an updated set of accountability metrics that focus on three priority areas: increasing vaccination rates, increasing community resilience for climate impacts on health and reducing the spread of syphilis. For more information on the accountability metrics, please see the "Oregon Public Health Accountability Metrics 2024 Preliminary Report on Health Outcome Indicators."[4]

This evaluation report focuses on public health's organizational structures and accountability metrics, both essential to meeting PHM goals. Progress towards the accountability metrics is part of the Oregon Health Authority's (OHA) Strategic Plan, and PHM is a key agency strategy for achieving OHA's goal of eliminating health inequities in Oregon by 2030.[5]

Oregon has made a long-term commitment to modernize its public health system and eliminate health inequities. State General Fund investments to modernize public health in Oregon are resulting in a system that is more prepared, community-centered and accountable for outcomes. This report reflects two years of those extensive efforts to demonstrate that the system is better serving communities and provides forward-looking recommendations to help Oregon better meet the public health challenges ahead.

Evaluation domains and questions

This report focuses on understanding two evaluation domains:

System-wide organizational structures

The primary evaluation question for this domain was:

- **How do the system-wide structures around PHM facilitate and prevent progress and subsequent impact of the investment?**

Implementation of public health accountability metrics

The primary evaluation questions for this domain were:

- **What facilitates and prevents progress on Oregon's public health accountability metrics process measures and corresponding activities in different parts of the state through LPHAs and OHA PHD?**
- **How is work towards accountability metrics advancing health equity?**

These overarching evaluation domains were chosen to better understand the activities conducted by governmental public health to improve priority health outcomes through the accountability metrics and the organizational structural components necessary for this work.

Methods in brief

Evaluation collaborators

Program Design and Evaluation Services (PDES), an interagency research and evaluation unit within OHA PHD and the Multnomah County Health Department, led this evaluation of 2023-2025 state legislative modernization funding. PDES used the CDC's Program Evaluation Framework to inform the development and implementation of the evaluation.[6] PDES facilitated two separate groups to co-create and guide the evaluation: an Evaluation Working Group and an Evaluation Technical Panel. Their work included:

- **Development of core evaluation domains, questions and methodology**
- **Guidance on data interpretation and analysis**
- **Dissemination review**

The two groups differed in composition and meeting frequency. For more information about committee membership and structure, please see Appendix page 73.

Evaluation domain: System-wide organizational structures

The evaluation team conducted eight virtual focus groups in May and June 2024. These 1.5-hour focus groups were conducted with LPHA administrators grouped by LPHA population size band, key staff from OHA PHD programs, OHA PHD Director's Office staff, PHAB members, and CBO grantees. The evaluation team also conducted three additional key informant interviews with CBOs around the state to expand representation beyond the I-5 corridor. Lastly, the evaluation team utilized LPHA and OHA PHD data from the Public Health Workforce Hiring Survey conducted in June 2024.

Evaluation domain: Implementation of accountability metrics

The evaluation team used a mixed methods approach in this domain. All data collection took place between June and September 2024 and included: 1) survey data of LPHA process measure reporting and similar reporting from OHA PHD, 2) four 1.5-hour focus groups conducted with local and state public health staff in the program areas of immunizations, climate and syphilis and 3) two case studies highlighting work towards the accountability metrics in Lincoln and Multnomah Counties, respectively.

The evaluation team developed recommendations based on the evaluation findings, consultation with the Evaluation Working Group and Technical Panel and other supporting evidence. For more detailed methods, please see Appendix page 73.

Results in brief: Key takeaways and recommendations

Evaluation domain: System-wide organizational structures

Evaluation question: How do the system-wide structures around public health modernization facilitate and prevent progress and subsequent impact of the investment?

Focus group participants provided input on the organizational structure components of their PHM work, including both internal and cross-collaborative structures. These organizational structure components include informational resources (guidance documents, Public Health Modernization Manual, etc.), financial resources (impact of PHM funding, etc.) and human resources (workforce).[7]

Participants were specifically asked about their understanding of the concept of PHM; familiarity with and use of guidance documents, including the Public Health Modernization Manual; and the impact of funding, workplans and workforce. Questions connected to cross-collaborative structures focused on the degree of alignment with system partners, participant perception of their level of influence on decisions and direction for PHM, and power sharing.

Key takeaways

Factors that facilitate progress towards PHM included:

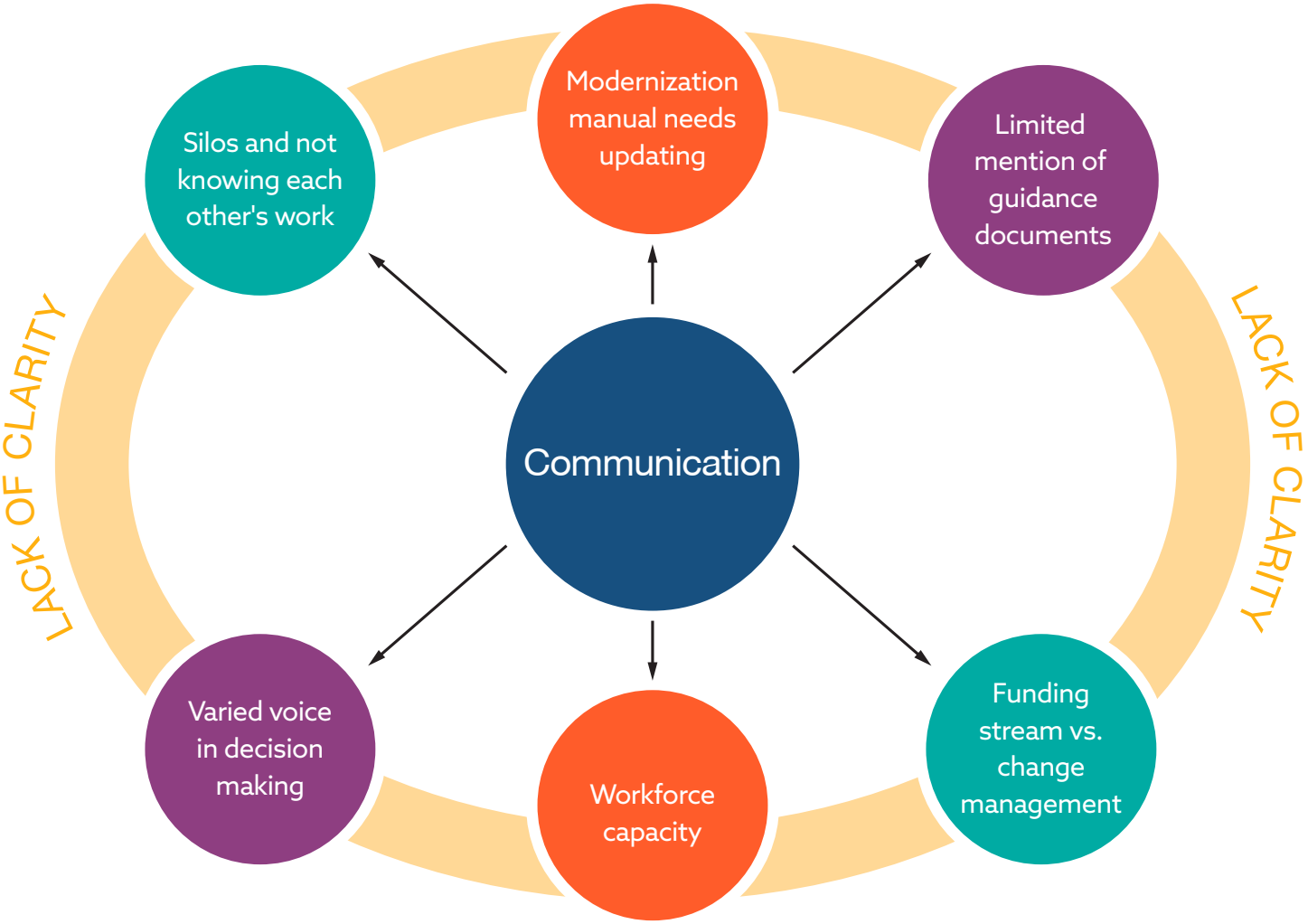
- Increased staff capacity (specifically, more than 850 positions supported at least in part by modernization funds at OHA PHD, LPHAs and CBOs)
- Local decision-making for how modernization funds are spent
- Enhanced collaboration at the local level

Challenges identified by participants included the need for:

- Clarity on PHM's purpose, vision and how it will be sustained over time
- New or updated guidance documents (e.g., Public Health Modernization Manual)
- Improved communication of existing guidance documents
- Greater alignment and communication within and between partners
- Organizational partners voices to be heard equally
- Continued staff capacity, especially at smaller LPHAs and CBOs

The following diagram (Figure 2) connects major themes from focus group participants across all participating organizations (LPHAs, OHA PHD, CBOs and PHAB) regarding the lack of clarity around PHM and identifies communication as an area for continued improvement. The findings and recommendations in this section provide clear opportunities to advance Oregon's public health modernization.

Figure 2. Greater communication needed to address lack of clarity for PHM



"I think there's an opportunity with a new OHA Director—a new Public Health Director—to have [public health modernization] defined, to define a role and define how we can best advise them. I would like to really know exactly what OHA wants, what is the actual question they want us to answer for them, and how is that answer going to be used?"

"I continue to advocate that there needs to be a regular frequency at which that [Public Health Modernization] Manual is revised and reviewed with input from folks in the field doing the work, because I worry that it's a little too academic and not as practice-based as it could be."

Evaluation domain: Implementation of accountability metrics

Evaluation question 1: What facilitates and prevents progress on Oregon's public health accountability metrics process measures and corresponding activities in different parts of the state through LPHAs and OHA PHD?

Focus group participants identified factors that may impact their progress on the accountability metrics process measures and activities, such as access to data, LPHA and other jurisdictional priorities, the extent of established partnerships and a collective approach towards the metrics. Additional questions focused on funding to support accountability metrics work, supports needed to engage in policy-related work and strategies to support accountability metrics work into 2030.

Key takeaways

Facilitators

The focus groups and the LPHA Accountability Metrics Process Measures Survey highlighted facilitators of progress on the accountability metrics process measures and related activities. These included:

LPHAs

- Having modernization funding designated for accountability metrics work
- Identifying priority populations through data (79 percent of LPHAs reported ability to do so)
- Prioritizing accountability metrics program areas
- Connecting the accountability metrics to larger jurisdictional priorities, where possible

OHA PHD

- Aligning metrics with other required strategies, where possible
- Having a skilled workforce

LPHAs & OHA PHD

- Building/maintaining partnerships with local CBOs and other LPHAs

Challenges

While participants identified many facilitators of progress on the accountability metrics, they also noted several challenges. These include:

LPHAs

- Lack of available data in smaller geographic areas
- Limited expertise in assessment/surveillance and outreach at smaller, rural LPHAs
- Insufficient support and resources to engage in policy-related work
- County-wide priorities that may not advance or support public health priorities

OHA PHD

- Competing state priorities

LPHAs & OHA PHD

- Poor data quality (underrepresentation of certain communities, missing data, etc.)
- Need for greater workforce capacity
- Need for coordination and clarity on partner contributions
- Need for funding to support the accountability metrics
- Uncertainty about continued statewide support for accountability metrics work

Evaluation domain: Implementation of accountability metrics

Evaluation question 2: How is work towards accountability metrics advancing health equity?

The evaluation team used survey data of LPHA process measure reporting, process measure reporting from OHA PHD and two case studies highlighting work towards the accountability metrics in two LPHAs to help answer this evaluation question. A sample of actions taken by state and local public health to advance health equity in each of the accountability metrics priority areas are listed below.

PRIORITY AREA: PROTECT PEOPLE FROM PREVENTABLE DISEASES BY INCREASING IMMUNIZATION RATES

Routine immunizations for children, adolescents and adults sharply decreased as a result of the COVID-19 pandemic, leaving communities at higher risk for preventable disease.[4] Local and state public health are taking action to improve immunization rates and protect individuals from communicable diseases.

LPHA actions	• Provide mobile immunization campaigns and immunization events to remove barriers to accessing vaccines • Collaborate with partners to develop culturally specific communication materials or provide culturally appropriate education • Provide or coordinate immunizations for people who are homebound
OHA PHD actions	• Develop, maintain and share data for immunization indicators by race, ethnicity and geography through data dashboards • Provide data to coordinated care organizations (CCOs) to meet immunization incentive measures and partner with CCOs on quality improvement implementation • Assure vaccine supply and monitor the state's vaccine finance model to ensure it is sustainable, equitable and adequately funds immunization programs

PRIORITY AREA: REDUCE THE SPREAD OF SYPHILIS AND PREVENT CONGENITAL SYPHILIS

Syphilis diagnoses among people who can become pregnant have continued to rise in Oregon over the past decade, as have congenital syphilis cases.[4] LPHAs and OHA PHD are taking steps to reduce the spread of syphilis and prevent congenital syphilis in Oregon.

LPHA actions	• Increase the percentage of people with syphilis interviewed • Increase the percentage of early syphilis cases treated with an appropriate regimen within 14 days • Increase the percentage of cases with all CDC core variables complete, i.e., race, ethnicity, pregnancy status, human immunodeficiency virus (HIV) status or date of last test and sex of sex partners • Increase the percentage of congenital syphilis cases averted
OHA PHD actions	• Create and publish internal and external data dashboards on syphilis and congenital syphilis indicators by race, ethnicity and geography • Collaborate with partners to raise awareness of and promote syphilis screening during pregnancy

PRIORITY AREA: INCREASE COMMUNITY RESILIENCE FOR CLIMATE IMPACTS ON HEALTH

Oregon has experienced severe climate events in recent years, including extreme heat and wildfires.[4] Oregon's public health system is working to increase community resilience for such events and reduce their impacts on health.

LPHA actions	• Increase access to, and awareness of, cooling centers and cleaner air spaces for people who are more likely to experience negative effects of extreme heat and wildfire smoke • Review communication plan for culturally and linguistically responsive strategies • Develop strategies and systems for supporting groups at higher risk of negative impacts from climate events (provide masks/resources to community members, conduct outreach to medically fragile residents and people experiencing houselessness, etc.)
OHA PHD actions	• Create dashboards of summer hazards data to share data back with community and LPHAs • Document policy changes that are needed to reduce health impacts of climate change, beginning with extreme heat and wildfire smoke, developed with internal and external partners

Investments in PHM and accountability metrics in Oregon show preliminary advancements in the effectiveness of LPHAs and OHA PHD (see Figure 3).[8]

Figure 3. Increasing effectiveness of Oregon's public health system through modernization

MEASURE OF EFFECTIVENESS

Increased reach to target populations

- Administer immunization to homebound individuals and long-term care facilities
- Provide syphilis testing at local jails and juvenile detention centers
- Increase access to cooling centers and cleaner air spaces for priority populations
- Engage communities disproportionally impacted by extreme heat and wildfire smoke in policy planning processes

MEASURE OF EFFECTIVENESS

Quality enhancement of services or programs

- Partner with clinics to provide culturally appropriate services and improve language access
- Translate syphilis education materials to multiple languages
- Provide technical assistance to nontraditional providers, healthcare providers and long-term care facility staff to help increase immunization rates
- Provide subject matter expertise on policy development, implementation or advocacy
- Increase the resilience of schools, day cares and early learning centers to smoke events (trainings, indoor air quality monitors, partner to assess HVAC systems, etc.)

MEASURE OF EFFECTIVENESS

Increased preventive behaviors

- Track percent of congenital syphilis cases averted statewide
- Track percent of prenatal care providers who report screening all pregnant patients in the early third trimester
- Track immunization rates

MEASURE OF EFFECTIVENESS

Dissemination of information, products, or evidence-based practices

- Work with partners to develop culturally specific communication materials or provide culturally appropriate education
- Perform direct outreach to communities to promote immunization
- Provide data to CCOs to meet immunization incentive measures
- Increase awareness of programs that provide air conditioners and air filters
- Collaborate with LPHAs, tribes, CBOs and other OHA sections to share the importance of syphilis screening in pregnancy and raise awareness about congenital syphilis

MEASURE OF EFFECTIVENESS

Quality enhancements of data systems

- Develop and maintain data dashboards by county and race/ethnicity for: 1) two-year old immunizations and 2) influenza (ages 65+) groups
- Update influenza dashboard weekly during flu season
- Develop and maintain OR-ESSENCE Summer Hazards dashboard for LPHAs and OHA that includes data on emergency department and urgent care visits related to non-infectious respiratory illnesses and heat-related illnesses
- Update and maintain public STI data dashboard and internal STI data dashboard for use by LPHAs

MEASURE OF EFFECTIVENESS

Decreased incidence or prevalence of disease

- Track accountability metrics over time – two-year old immunization series, influenza immunization for ages 65+, congenital syphilis and syphilis cases, hospitalizations due to heat and heat deaths

A rise in preventive behaviors will lead to decreased incidence or prevalence of disease for the accountability metrics over time.[8]

Integration of evaluation domains

Organizational structures can either streamline or impede progress on accountability metrics process measures and health outcome indicators. From the examination of these two evaluation domains, partnerships were noted as key facilitators to the work. Similar challenges across evaluation domains were present. These challenges included uncertainty of future direction and funding, need for greater coordination and enhanced communication given siloed work, and limited staffing capacity.

Evaluation team recommendations

To address some of the cross-cutting challenges in each domain, the evaluation team offers the following recommendations. These recommendations were based on the evaluation findings, consultation with the Evaluation Working Group and Technical Panel, and other supporting evidence.

A. Address uncertainty of future direction and funding

1. **Create a visual representation of the alignment between Oregon's public health priorities, including how they connect to each other and their related funding streams** (e.g., State Health Improvement Plan, Community Health Improvement Plans, State and Local Public Health Agency strategic plans, Capacity and Cost Assessment, Public Health Accreditation, Accountability Metrics) so requests for information are clearly understood within this broader context and support clarity in direction.

2. **Support conversations to address which projects or areas of work to delay or eliminate when faced with competing priorities and limited staff capacity.** Support should include identifying risks of delaying or eliminating work. Quality improvement tools can help in the prioritization process.[9]

3. **Develop an inventory of funding streams that support the accountability metrics by each priority health area** which can then help build a funding strategy to support sustained movement towards the metrics.

   A funding inventory by priority area can help assess the extent of revenue diversification across local health departments that support accountability metrics' priority health areas. Compared with less-diversified local health departments, well-diversified departments reported a balanced portfolio with local, state, federal and clinical sources of revenue and higher per capita revenues. Incentives to support revenue diversification can enhance financial resilience and sustainability of local health departments.[10]

   Some questions to consider: What resources are available and utilized to support each accountability metric's priority area? How are those resources being used to support accountability metrics across the state?

   Create opportunities to share funding inventories by priority area across LPHAs by size band, geographic location and other county demographics. Then, use these inventories to further encourage braided funding for each priority health area.

4. **Review current governmental state and local public health operational structures to address both uncertainty in funding and limited workforce capacity.**

   Revisit the Roadmap to Service and Resource Sharing in Public Health.[11]

   Consider expansion of regional positions similar to the regional epidemiologist position and Coalition of Local Health Officials (CLHO) led regional communications position. More frequent shared services arrangements have been found in local public health program areas like emergency preparedness and maternal child health than in departmental operations such as financial management, human resources and communications.[12]

   Explore shared LPHA positions for both departmental operational functions as well as categorical public health program specific areas. Possible positions that may benefit from a regional approach include regional policy analysts, regional climate coordinators/analysts, regional communication coordinators and possibly regional billing positions. Embed state support of regional positions similar to the regional epidemiologist model.

5. **Encourage partners such as CCOs to support and champion public health funding,** recognizing that upstream prevention at a population level reduces the need for downstream costly health care.

6. **Support ongoing shared decision making and transparency** in modernization funding allocations among all funded partners through the Public Health Advisory Board.

7. **Explore analytical tools based on the concept of deep uncertainty** such as Robust Decision Making (RDM) which uses multiple views of the future to identify a plan that performs well in a range of possible futures, avoids situations where it might fail and identifies conditions under which its goals could not be achieved.[13],[14]

8. **Continue to communicate measures of state and local governmental public health accountability.**[15] Documenting successes and their value can help ground and propel public health's mission and support future avenues for direction and funding.

9. **Prioritize hiring people with a learning mindset who are flexible and able to pivot quickly as needs change.**

B. Increase coordination given continued siloed work and strengthen communication and collaboration between silos

1. **Explore Jones et al's (2024) proposed framework to foster organizational collaboration,** which highlights inclusion, shared goals and vision, bi-directional communication, relationship building and developing trust.[16] The authors examine how a culture of collaboration is used to reduce silos at the CDC.

2. **Enhance coordination by strengthening communication pathways that are transparent.** Provide a visual of the feedback loops. Fraser describes two main types of feedback loops: balancing and reinforcing.[17] A reinforcing feedback loop has an amplifying effect in which an action produces more of, or less of, the same action, leading to an increase or decrease in that action over time. A balancing feedback loop can increase or decrease the effects of a change back to the desired state. Examine how these feedback loops create stability or instability.

3. **Communicate orally and visually where intentional efforts to break the organizational silos exist.** Display and share the horizontal avenues and opportunities for collaboration.

4. **Support understanding and recognition of strengths and unique contributions of government and non-government partners,** which will help address the need for role clarity between partners.[18] Specifically strengthen understanding of health system partner contributions (CBOs, CCOs, health care entities, etc.) to each accountability metric priority area as seen in the revised accountability metrics framework for collective responsibility across sectors and partners.[19] Consider using this Public Health Learning Agenda Toolkit to assess the type of change necessary and what's needed to reach the desired outcomes.[20]

5. **Set aside leadership time and budget dedicated to broader systems and strategic thinking.**[17],[21] Promote the development of champions for public health system coordination and assess the extent that cross-collaboration within and between partners exists as part of position descriptions.

6. **Support and widely share the existing communities of practice (CoPs) and learning collaboratives or develop new spaces** (e.g., Lunch & Learns) if needed to advance the three accountability metrics priority areas.

7. **Invest in developing and sharing stories of how funded partners come together to collaborate in service of their shared communities.**[18]

8. **Further understand the evaluation findings and variation at a more granular level within state and local public health departments and programs.** Compare those results within and between LPHA size bands and OHA PHD sections, identify who needs greater guidance and determine how that guidance may be shared.

C. Build staffing capacity

Our national public health system has been chronically underfunded for decades.[22] Efforts to modernize Oregon's public health system have also not been funded for full implementation.[23],[24]

1. **Support focused priorities and consider expansion of regional positions to help address limited staffing capacity.**

2. **Track and align existing workforce assessments with existing workforce gaps within the accountability metrics.** Existing assessments include the Public Health Workforce and Needs Survey, Public Health Infrastructure Grant hiring data and Oregon Public Health Modernization Capacity and Cost Assessment Report.[25-27]

3. **Continue to build the Strategic Skills for the Governmental Public Health Workforce into public health job classifications.**[18],[28]

4. **Preserve institutional knowledge and conduct succession planning.**[18]

D. Prioritize the development of policy capacity within workforce capacity

Top knowledge gaps amongst health department staff include understanding how to: 1) influence law and policy development and 2) contextualize law and policy's effects on public health.[29] In Oregon, policy and planning was identified as the public health foundational capability with the lowest level of implementation among LPHAs.[24]

1. **Review and assess implementation of the policy development and program planning skills domain of the Core Competencies for Public Health Professionals.**[30] This domain includes skills such as the development, implementation, evaluation and improvement of public health policy. The competencies are organized by tiers of responsibility: front line and program support, program management and supervisory roles, and senior management and executive leadership.

2. **Use new resources, such as the Policy Innovation Exchange (PIX)** – currently only focused on HIV, viral hepatitis, sexually transmitted diseases and tuberculosis transmission – to provide law and policy resources to public health leaders.[31]

E. State support and guidance for county contexts to address health inequities

As shared by several LPHA focus group participants, county health priorities may not align with larger public health priorities. Daniel Dawes' presentation of "The Political Determinants of Health" describes some sources of that misalignment and the forces that can lead to the underlying social determinants of health.[32]

1. **Synthesize the forthcoming PHM deliverable – Health Equity Assessments and Plans – across LPHAs to better understand strategies to foster health equity and be more inclusive of rural concerns.**[33] Understanding the language and terminology used by LPHAs across the state when conducting health equity work may be useful for garnering further support for strategies and interventions.[34]

2. **Continue to support and provide guidance to LPHAs that could utilize the Dignity Reframe approach** described in "Talking about Health Equity in Rural Contexts" by Miller et al. (2024).[34]

   In addition, the Association of State and Territorial Health Officials (ASTHO) offers evidence-based technical packages on a variety of topics, such as "Strategies to Prioritize Evidence-Based Public Health Authority," "Effective Public Health Approaches to Reducing Congenital Syphilis," and "Evidence-Based Strategies to Enhance Emergency Preparedness and Response."[35] These resources may be useful to share with LPHAs as needed.

3. **Center rural disadvantage to equip rural leaders with the material and political support needed to drive local policy, public health practice and action while giving them a more meaningful voice in practice and policy decisions that affect rural health.**[36] Additionally, rural leaders can continue expansion of the use of community-based qualitative methods that highlight the heterogeneity of health experiences and outcomes in rural settings.

Conclusion

A large-scale, system-wide change like PHM takes time, especially in an environment with historical cycles of funding and defunding of public health. Despite these sporadic funding cycles, state and local public health authorities – with their partners – are demonstrating measurable health improvements that are saving lives in Oregon.

Delivering the foundational public health capabilities allows the workforce to be responsive to the changing needs and landscape. This core public health work documented throughout the evaluation helps reduce the economic cost of health inequities so every person in Oregon can have a fair chance at optimal health.

Ten years have now passed since the modernization framework was codified into law, marking a noteworthy time for partners to collectively reassess the vision, goals and corresponding actions towards this system-wide transformation. The evaluation findings and recommendations provide a clear path to continue advancing the system change needed to improve health for people in Oregon today and into the future.

Expanded results

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Expanded results

Evaluation domain: Public health system-wide organizational structures

Evaluation question: How do the system-wide structures around PHM facilitate and prevent progress and subsequent impact of the investment?

Focus group participants responded to questions about internal organizational structures and cross-collaborative structures. Questions on internal organizational structures included participant understanding of the concept of PHM; familiarity and use of guidance documents to do their work, including the Public Health Modernization Manual; and the impact of funding, workplans and workforce. Questions on cross-collaborative structures focused on the degree of alignment with system partners, participant views on their voice in informing decisions, direction for PHM and power sharing.

Key themes from focus group participants representing LPHAs, CBOs, OHA PHD and PHAB members, as well as a sample of quotes from participants, appear below.

Local decision making on how modernization funds are spent. Participants appreciate that their organizations can determine how best to use modernization funds to meet funding requirements, compared to funding sources with rigid guidelines on where funds can be allocated. This enables local decision making and the ability for organizations to tailor funds to the needs of their communities.

Need for guidance documents and communication of existing ones. When probed about what documentation or resources guide decisions on how to allocate or use public health modernization funding, very few participants mentioned the use of any guidance documents. Among those who did mention guidance documents, many noted challenges using the Public Health Modernization Manual.

Need for stronger alignment and coordination within and between partners for PHM. Focus group participants noted it is hard to align with partners when they may not be aware of each other's work. Existing silos continue to be a barrier to coordination.

Need for clarity on PHM. Focus group participants described a need for greater clarity on PHM's purpose, vision and how it will be sustained over time.

Concept, purpose and vision. Participants desired greater clarity regarding what PHM means and what success looks like.

Funding stream vs improvement model. Participants shared two broad understandings of PHM, with some viewing it primarily as a funding stream with related requirements while others described it as a larger public health system improvement effort.

Need for clarity regardless of employee tenure. Participants conveyed the need for clarity on the PHM concept, purpose and vision regardless of how long they had been at their respective organizations.

Impact of COVID-19. While not a specific focus group question, participants noted how the COVID-19 pandemic has shaped their views of PHM.

Feelings of public health staff voices not being heard. When asked how they felt about their voice in decision making processes, participants shared that:

- Voice varies by tenure and position in the organization (LPHA)
- More voice locally than state-wide (LPHA)
- CBO participants were more likely to report having a voice in decision-making and feeling of being heard than all other participants
- Power sharing is difficult

Capacity of public health workforce. Workforce is central to the organizational structures of Oregon's public health system. Data reveals that modernization funding plays a key role in sustaining the public health workforce, though focus group participants raised the need for greater capacity.

Growth in capacity. Modernization funding has supported workforce capacity across program areas and job classifications at LPHAs, OHA PHD and CBOs. Based on the Public Health Workforce Hiring Survey, more than 350 positions at LPHAs and OHA PHD have been funded at least in part with modernization dollars. Additionally, modernization funds support nearly 500 positions at 112 CBOs across the state.

As demonstrated in the tables below, most modernization funded positions reported by LPHAs were current positions, meaning these individuals were already employees at their respective LPHA. Modernization funding has helped sustain these positions, and without it, many of them would likely be cut.

The new positions presented in the tables below only represent individuals hired between January 1 and June 30, 2024 who are paid at least in part by modernization funds.

"If we didn't receive the funding, I think our team would have ceased to exist."

Table 1. LPHA positions funded through public health modernization, January 1 – June 30, 2024

Classification category	Current position	New position	Total
Program manager	42	1	43
Agency leadership and management	41	1	42
Public health physician, nurse, and other clinicians or health care providers	29	2	31
Epidemiologists, statisticians, data analysts	25	3	28
Business, improvement and financial operations staff	26	1	27
Community health workers and health educators	24	2	26
Public information, communications and policy staff	19	5	24
Other*	15	2	17
Office and administrative support staff	15	1	16
Preparedness staff	10	1	11
Environmental health workers	6	1	7
Behavioral health and social services staff	1	0	1
Animal control and compliance/inspection staff	0	0	0
Information technology and data system staff	0	0	0
Laboratory workers	0	0	0
TOTALS	**253**	**20**	**273**

Source: 2024 Public Health Workforce Hiring Survey

**Other category includes positions under multiple classification categories at less than 50 percent for each classification.*

Note: Staff are not double counted if they are categorized in multiple job classifications.

Table 2. LPHA regional partnerships positions funded through public health modernization, January 1 - June 30, 2024

Program area	Current position	New position	Total
Communicable disease control	7	0	7
Assessment and surveillance	4	1	5
Organizational competencies	5	0	5
Equity	3	0	3
Other*	3	0	3
Emergency preparedness and response	2	0	2
Environmental public health	2	0	2
Access to and linkage with clinical care	1	0	1
Chronic disease and injury prevention	1	0	1
Communications	0	1	1
Community partnership development	0	1	1
Accountability and performance management	0	0	0
Maternal, child and family health	0	0	0
Policy development and support	0	0	0
TOTALS	**28**	**3**	**31**

Source: 2024 Public Health Workforce Hiring Survey

**Other category includes positions under multiple program areas at less than 50 percent for each classification.*

Note: Staff are not double counted if they are categorized in multiple job classifications.

Note: Fiscal agents for LPHA regional partnerships are Deschutes, Douglas, Jackson, Lincoln, Multnomah, North Central Public Health District and Umatilla.

Table 3. OHA PHD positions funded through public health modernization, July 1, 2023 – June 30, 2024

Program area	Total
Community partnership development	18
Equity	14
Environmental public health	12
Organizational competencies	11
Policy development and support	10
Communicable disease control	8
Assessment and surveillance	4
Accountability and performance management	2
Access to and linkage with clinical care	0
Chronic disease and injury prevention	0
Communications	0
Emergency preparedness and response	0
Maternal, child, and family health	0
Other*	0
TOTAL	**79**

Source: 2024 Public Health Workforce Hiring Survey

**Other category includes positions under multiple program areas at less than 50 percent for each classification.*

Note: Includes both budgeted staff and other staff who charged to modernization funds at any level.

Capacity of public health workforce. (continued)

Benefits of regional positions. LPHA focus group participants highlighted the impacts that regional positions have had on their work, including helping to meet workforce capacity demands.

Ongoing workforce capacity needs. Despite the contributions that modernization dollars have made in funding the state, local and CBO public health workforce, focus group participants shared a continued need for greater capacity to both meet statutory requirements and address current priorities.

Wearing many hats. Participants from smaller LPHAs and CBOs noted how their staff must often wear many hats, filling many roles with a single position.

Communication at the core. There is room for improvement in communication about PHM strategies and activities among all partners.

Table 4. Themes and sample descriptive quotes from the organizational structures domain

Theme	Core sentiments	Sample descriptive quotes
Local decision making in spending funds	Appreciation for local decision making in how funds are spent	"Our priority is absolutely maintaining what we have to the extent possible, so just keeping existing staff…We are doing quite a lot of shifting around depending on other external funding sources that are very specific and that's one thing I have really appreciated about modernization funding is that it is very flexible." "I appreciate that we can use our funds for a variety of [activities], even though there are certain requirements. We can use it for a variety of things based off our county needs." "Compared to other state programs, this funding source has been extremely flexible and let us make changes if new community needs came up and things like that."
Greater need for guidance documents and communication of existing ones	Current guidance documents	"What are the written documents or tools or resources to help us and how we organize amongst ourselves versus how much OHA is supposed to be helping to facilitate and staff? I think a barrier is role clarity."
	Public Health Modernization Manual – challenges to use and needs updating	"The [Modernization] Manual is something I have pointedly avoided because I've heard so much angst expressed over its accuracy and whether it reflects the current vision or direction of modernization." "It's a good guidance manual, but most everyone I've talked to has said that it if you follow it, you will be outside the bounds of modernization funding, rules and guidelines." "I think the challenge to using the Modernization Manual is a couple of things. One, that the funding doesn't cover everything in the Manual. Two, the Manual was created before the pandemic and does lack the cultural input of the impact of that on our work and on our people."

Theme	Core sentiments	Sample descriptive quotes
Need for clarity of public health modernization	Concept, purpose and vision	"[Modernization] is just a word that gets tossed around a lot, and I've not encountered too many people who really have a clear ability to explain it." "It has been exceedingly frustrating because there seems to be a lack of consistency and understanding both at the state and county level what the intent and purpose of modernization is, as well as the direction and future that the program is going." "I felt like we had a really clear pathway forward. We knew what success looked like. I don't really know what success looks like anymore when it comes to public health modernization."
	Funding stream vs. change improvement model	"My understanding is that this is all part of how we advocate for the funds that we need today, whether that be for the state, whether that be for local public health, whether that be for our community-based organizations. It's all coming in this package of modernization." "I don't think that I fully embraced at that time that public health modernization is truly a continuous quality improvement effort and that over time, if we're doing our work right, how we do it is going to fundamentally change, and sometimes that's hard because we don't necessarily like to embrace so much change." "We are actively redistributing resources back out into community, and we're giving community technical assistance to better understand the public health issues so they're better prepared to do the work and we're making sure it's so that they have the money and the science and facts to do the work." "[The foundational capabilities framework] has allowed us to utilize public health modernization as a change process – not a funding mechanism or not dollars from the legislature – to do all kinds of things to improve the public health system in our outcomes."

Theme	Core sentiments	Sample descriptive quotes
Need for clarity of public health modernization (cont.)	Regardless of employee tenure at organization	"Modernization, it's become less clear than when it started. Initially, it was deemed as modernization of governmental public health, and I know that seems to have changed." "I was not familiar with modernization when I came on board a couple of years ago, so my view has gone from not much knowledge around modernization to learning some… I'm still learning little by little." "We spent a lot of time working on developing communication pieces when we first developed modernization. And you know, that was super helpful. We've not done that any longer and don't really have a clear idea of what the end goal is. So, without that, I'm challenged trying to advocate for local public health with my own legislative representatives and commissioners."
	Impact of COVID-19	"I think one of the things that happened for us in [County] during the pandemic is it just became completely obvious to us that we were not going to be able to respond without the active support of community-based organizations as part of our pandemic response team. We didn't have the relationships that they had in the communities that we needed to reach, and that has really clarified for me, that for [County], a modern public health system is really a team sport." "It seems to me things are quite different since COVID and a lot of lessons learned, and so some of what was put into statute or written when we wrote public health modernization or what others did is now different."
Need for stronger alignment and coordination within or between partners	Alignment and coordination	"The not knowing makes it harder to align our work with theirs or align our work with other programs who might be doing things with other LPHAs and CBOs just because it feels like there's like a barrier between us and them, and I feel like when I do find out about things, it's by accident." "I think we really need to look beyond the voluntary sharing of knowledge, information and resources and look into leveraging existing resources in a contractual way and/or legislative way that we're held accountable to work with one another."

Theme	Core sentiments	Sample descriptive quotes
Voice in decision making	Differing feelings across partners if voices are heard	"I don't have a voice. Maybe there's more of an opportunity and I just don't have the capacity." "I think that's a gap, to really feel like programs or sections have sort of an ongoing of voice in how things are unfolding." "I've really been impressed on what a voice that my little CBO in [region] has had with big OHA."
Workforce	Growth in workforce capacity	"I've been at [County] since 2012, and it has been really inspiring to see the shift within our local health department. When I started here, we had one epidemiologist who did all communicable disease epi, all population health, the community health assessment, and now we have five epis. So that's one example of how we built capacity." "We're doing a lot better job with the more capacity of our workforce, we're able to be better about equity in terms of having some bilingual staff, which is helpful."
	Benefits of regional positions	"I do want to just second having [regional position], being able to hire her for communications I think has been instrumental in starting that piece for modernization and having stability with that as well as someone who understands what modernization is." "I think that there are areas in some parts of the state—not every part—where the regional model actually works really well, especially for positions that are hard and difficult to hire and that we don't really need it within each county." "[The regional model] has been successful in [County], and we were one of the first regional, which really helped, especially for positions like epidemiology, which is much more challenging for smaller counties to hire a full-time epidemiologist."

Theme	Core sentiments	Sample descriptive quotes
Workforce (cont.)	Continued staff capacity needs	"We had some LPHAs reach out because they were wanting to align their work plans with CBO work and because they wanted to work together, and we just did not have the capacity to get that information to them in time." "We don't need more staff. We need resources for the staff who are here." "I would also like a lot more staff in addition to resources…Some of the areas that we have not really gotten into and a lot of these are prevention."
	Wearing many hats (especially at small LPHAs and CBOs)	"We've got three people wearing 10 hats…We borrowed one of our environmental health inspectors and turned them into a part-time environmental health modernization person and part time EH inspector." "We try to [have] structure, but everybody has to kind of jump in and wear multiple hats. And so, the structure kind of gets clouded."
Communication at the core	Communication of the vision	"I am reticent to say I fully understand what their [OHA] vision is. I think that's part of what the problem is. I don't feel like that's communicated well." "I just think that there is not a clear communication pathway at this point, or strategy, and that worries me going into the next legislative session."
	Communication between partners	"At the local level with our partners, we don't really bother with talking about this as public health modernization because we know what we're doing and we're just trying to integrate that into our Community Health Improvement Plan work. And we basically document it towards our modernization stuff at the local level." "I also feel like the way that we learn about and understand and talk about modernization on PHAB is in a much more positive and hopeful light than how PHAB has communicated and communicated to and among staff in LPHAs."

Source: LPHA, OHA PHD, CBO and PHAB focus groups for the organizational structures domain.

Public health system structural facilitators and challenges to PHM

There are several clear structural system-level facilitators to PHM, including local decision making in the use of the funds, increased staffing capacity and local level collaborations.

The challenges to PHM across organizations include a lack of clarity of the modernization concept, purpose and vision, minimal use or awareness of guidance documents with the need to update the Public Health Modernization Manual, uncertainty around a sustainable plan, need for greater alignment and coordination within and between partners, differing feelings of voices being heard, as well as ongoing workforce capacity needs, especially at small LPHAs and CBOs.

Some themes emerge as both facilitators and challenges to PHM. Participants mentioned COVID-19 as either facilitating modernization work due to the extent of partnerships established or as a barrier since COVID-19 funds were no longer available. Similarly, among state and local health authority participants, mixed feelings surfaced about trust with community as either a facilitator (i.e., we've gained trust since COVID-19) or a challenge (i.e., we've lost trust since the height of the pandemic).

Participant recommendations by theme

The focus group moderators did not specifically ask participants to provide recommendations, but the following points came up during the sessions and are grouped by theme.

Modernization vision and communications

- Develop new guidance from leadership on shared vision, resetting and providing structure on how aspects of modernization fit together.
  - Provide clearer pathways on how to best advise leadership, including feedback loops.
  - Have clarity on roles and understand who can do what well.
  - Clarify whether modernization should be viewed as a funding stream and/or broader change and quality improvement initiative.
- Communicate the vision internally and externally to partners.
- Further conversation about access to clinical and preventive services as part of the foundational programs.

Guidance documents, including the Public Health Modernization Manual

- Provide new guidance documents and greater communication of existing ones.
- Include the Public Health Modernization Manual in PHAB member training.
- Adopt regular frequency at which the Public Health Modernization Manual is revised and reviewed by staff.
- Increase awareness and create mechanism to review each awardees' funded work and workplans.
- Strengthen mechanisms to hold each other accountable.
- Reduce administrative burden of reporting.
- Consider joint workplans.

Alignment, coordination and communication within and between partners

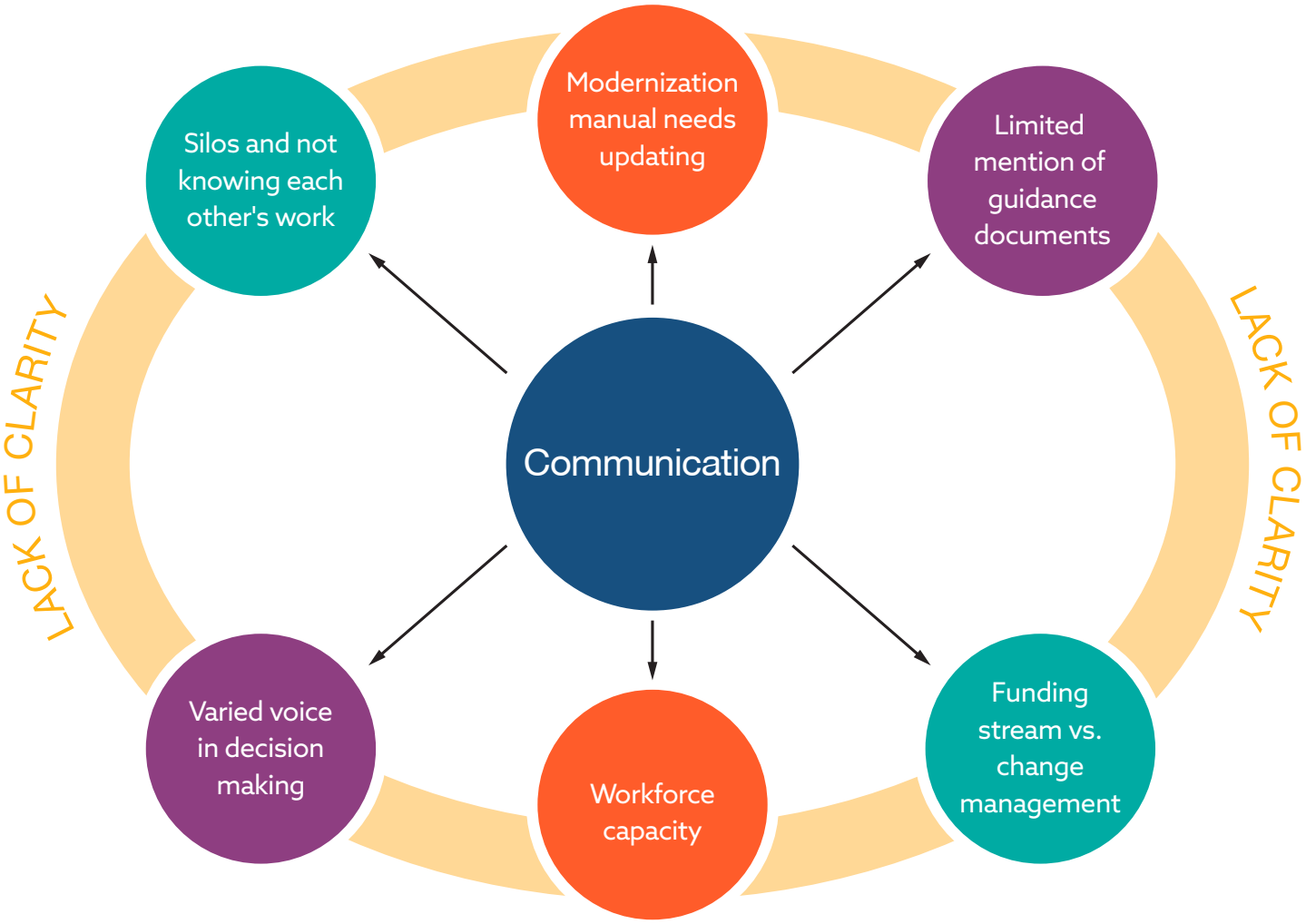
- Explore ways to have LPHAs fund CBOs directly.
- Create more formal accountability structures.
- Strengthen coordination between OHA PHD and LPHA partners.
- Recognize that governmental public health may not always be the best convener of collaborative work.

Budgets and funding

- Allocate more resources and/or intentionally share the load of Emergency Preparedness and Response activities with topical program areas across OHA PHD and LPHAs.
- Improve the pathways and time periods for paying community partners and navigating the contracts and procurement process.
- Provide robust professional development resources for existing workforce programs.

The following diagram connects major themes from all focus group participants (e.g. LPHAs, OHA PHD, CBOs and PHAB) regarding the lack of clarity around PHM and identifies communication as an area for continued improvement. The findings and recommendations in this section provide clear opportunities to advance Oregon's public health modernization.

Figure 4. Greater communication needed to address lack of clarity for PHM



Evaluation domain: Implementation of public health accountability metrics

In 2023, Oregon's Public Health Advisory Board adopted a set of public health accountability metrics for the state's public health system. These metrics, a set of health outcome and process measures, bring attention to three priority areas that the public health system is addressing through state investments in PHM:

- Protecting people from preventable diseases by increasing immunization rates, specifically adult influenza immunization rates for adults ages 65+ and two-year-old immunization rates (4:3:1:3:3:1:4 series)
- Increasing community resilience for climate impacts on health, specifically for extreme heat and wildfire smoke
- Reducing the spread of syphilis and preventing congenital syphilis

Facilitators and challenges to progress on accountability metrics process measures

There were two primary evaluation questions in this domain.

Evaluation question 1: What facilitates and prevents progress on Oregon's public health accountability metrics process measures and corresponding activities in different parts of the state through LPHAs and OHA PHD?

Facilitators

The focus groups and LPHA Accountability Metrics Process Measures Survey identified multiple facilitators of progress on the accountability metrics process measures and activities. These themes are shared below, followed by Table 6 that describes the facilitators identified, the organizations in which those facilitators apply and a sample of descriptive quotes to provide support for each facilitator.

Having modernization funding designated for accountability metrics work. LPHAs need funding to be able to run programs and conduct activities to improve accountability metrics. Designating funds specifically for such activities facilitates progress on the metrics.

Identifying priority populations through the use of data. All LPHAs are required to use data to inform decision-making relative to their respective accountability metrics priority areas. In the prevention of syphilis priority area, LPHAs use data in Orpheus to monitor trends and determine how best to use their resources to reach specific communities. The majority (79 percent) of LPHAs working towards the climate and immunizations accountability metrics priority areas reported use of data from a variety of sources to identify populations that experience disparities in health outcomes. The proportion of LPHAs reporting this use of data, as well as the types of data sources that they utilized, is described in Table 5 and Figure 5.

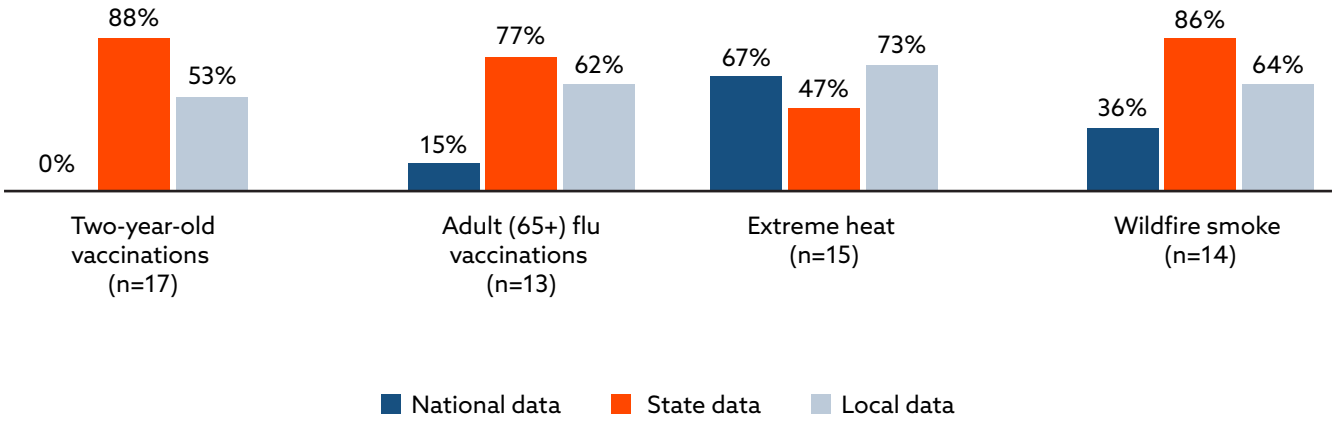
Table 5. Proportion of LPHAs reporting demonstrated use of data to identify priority populations by accountability metrics focus area

Focus area	Demonstrated use of data, n (%)
Protect people from preventable diseases by increasing immunization rates	
• Adult influenza immunization rates, ages 65+ (n=16)	13 (81.2%)
• Two-year-old immunization rates (n=19)	17 (89.5%)
Increase community resilience for climate impacts on health	
• Extreme heat (n=19)	15 (78.9%)
• Wildfire smoke (n=19)	14 (73.7%)

Source: 2024 Oregon LPHA Accountability Metrics Process Measures Survey

Note: The LPHA Accountability Metrics Process Measures Survey may under-represent all activities being conducted by LPHAs in the priority areas. Additionally, the survey did not contain questions about the syphilis accountability metrics priority area.

Figure 5. Data sources used by LPHAs to identify populations of focus by accountability metrics priority area (multiple selections allowed)



Source: 2024 Oregon LPHA Accountability Metrics Process Measures Survey

Note: Responses are among LPHAs that reported the use of data. The 2024 Oregon LPHA Accountability Metrics Process Measures Survey did not contain questions about the syphilis accountability metrics priority area.

Prioritizing accountability metrics program areas. Across all three accountability metrics program areas (climate, immunizations and syphilis), LPHA focus group participants collectively agreed their respective LPHAs are making the accountability metrics a priority and conducting work in these areas to make improvements.

Connecting accountability metrics to larger jurisdictional priorities, where possible. Some LPHAs reported being able to connect the accountability metrics to larger jurisdictional priorities (e.g., strategic plans) helps facilitate this work.

Strategically aligning metrics with other required reporting and funding. At the state level, program staff reported aligning the accountability metrics with federal grants and priorities helped enable progress on the measures. This alignment can also reduce the burden of reporting on the workforce.

Having a skilled workforce. OHA PHD program staff noted adequate expertise and skills were clear facilitators of accountability metrics work, despite the need for increased staffing capacity.

Partnering with CBOs, health care providers and other LPHAs. Community partnerships have facilitated progress on the accountability metrics for both local and state public health, filling gaps in resources and services while helping meet the needs of the community. Some LPHAs also highlighted partnerships between LPHAs that increase their capacity to do accountability metrics work.

Table 6. Facilitators to progress on the accountability metrics process measures and sample descriptive quotes

Facilitators	Organization	Sample descriptive quote
Designated modernization funding for accountability metrics	LPHAs	"We use modernization funds. That's really about all we have to be able to use." "I think our lowest hanging fruit was just being able to use modernization funds to incentivize bilingual staff because we were able to, with that extra funding, push through and then compensate 19 staff now that are bilingual, and that wasn't something that there was capacity for previously."
LPHAs prioritizing the accountability metrics	LPHAs	"I would have to say that our local public health agency highly prioritizes the work and the need to track the measures." "For us, our local public health authority, we absolutely are making this a priority. We spend a lot of focus time talking about this, especially this summer." "It's definitely our public health priority."
Connecting the accountability metrics to larger jurisdictional priorities	LPHAs	"We have a unique position because we do provide the majority of the immunizations for our county, so it's definitely a LPHA priority as well as the county level priority." "I would say that it's part of our strategic plan – the syphilis accountability metrics are in there because we identified it as a priority and our previous health administrator was big on making sure we have a strategic plan, and this is what we want to focus on."
Strategically aligning metrics with other required reporting and funding	OHA PHD	"We certainly have metrics in our federal grant that are related to two-year-old immunizations and flu, and I think that's why we're able to use the federal funds to support this work. I think that's really probably where the best synergy is going to come is when we can have state measures that are related to federal funding like ours is." "So the syphilis accountability metrics are based on our CDC STD grant work plan. We would not be able to do any kind of modernization work if that work was completely separate from what our grant requires us to do."

Facilitators	Organization	Sample descriptive quote
Having a skilled workforce	OHA PHD	"We have the skills; we just don't have [enough] staff." "Echoing what others have already expressed, we absolutely have the expertise and skills. However, the primary issue for me is capacity." "I suspect this is most people's critical issue is we do not have an adequate workforce. We have a very skilled workforce."
Partnering with CBOs, health care providers and other LPHAs	LPHAs and OHA PHD	"We were able to have [the hospital system] build in flags into their medical systems, into their charting systems, that just automatically incorporate universal syphilis testing…I think that has been a positive change for us." "Our limited community partnerships are having an impact because I think many of those community-based organizations are able to provide us with more real time information about what's happening." "We are very lucky that we have [the] opportunity to partner with [County] and [County] because they have a much more robust staff capacity and data access, so we benefit from their expertise."

Challenges

The challenges to making progress on the accountability metrics are shared below, followed by Table 7 that describes the challenges identified and a sample of descriptive quotes to support each challenge.

Lack of available data at smaller scales. Across accountability metrics priority areas, LPHA focus group participants identified a need for data to be accessible at smaller geographic scales. Examples include having data available for rural, less densely populated areas and by zip code.

Expertise in assessment/surveillance and outreach at smaller, rural LPHAs. Though identified as a facilitator to making progress on the accountability metrics for OHA PHD program staff, LPHAs primarily in more rural areas of the state reported a need for workforce expertise in certain foundational capabilities, such as "Assessment and Epidemiology" and "Community Partnership Development."

Insufficient supports and resources to engage in policy-related work. Policy development and support is core governmental public health work. Evidence-based policies advance the prevention of disease and promote health, and some of our greatest public health successes would not have been possible without policy change. When asked what supports may be needed to engage in policy-related work, LPHA focus group participants reported a lack of capacity to be able to address policy at the local level.

County-wide priorities that may not advance or support public health priorities. LPHAs are primarily units or departments of local county governments. As such, county priorities may not always align with the priorities of LPHAs. Some LPHA focus group participants reported that their workforce needs do not align with the priorities of their county, limiting their ability to hire employees. Additionally, focus group participants noted attitudes and actions of their county and county leadership can impact their progress on the accountability metrics.

Competing state priorities. OHA PHD focus group participants reported juggling competing priorities at the state level, recognizing the challenges that come along with fulfilling numerous important initiatives.

Poor data quality. Focus group participants from state and local public health identified challenges in collecting high quality data in case investigations and routine surveillance. High quality data is important for identifying needs in the community and making programming decisions.

Need for greater workforce capacity. Additional workforce capacity at both the state and local levels was identified as a critical enabler of progress on the accountability metrics.

Need for coordination and clarity on partner contributions. Participants reported a need for improved coordination between partners involved in accountability metrics work at the state and local level and described a need to better understand the role of each group (e.g., OHA PHD, LPHAs, CBOs) in accountability metrics work.

Need for funding to support the accountability metrics. Accountability metrics work relies on a patchwork of various funding streams, including modernization funding, grants, county general funds (for LPHAs), federal funding, insurance billing and more. Not all state programs currently receive modernization funds, and, in general, there is minimal funding available to support this work at both the state and local levels.

Unclear future direction to support the work. Focus group participants indicated uncertainty regarding future accountability metrics work through 2030.

Table 7. Challenges to progress on the accountability metrics process measures and sample descriptive quotes

Challenges	Organization	Sample descriptive quotes
Lack of available data at smaller scales	LPHAs	"We have some real populated areas in [County] and some very rural outskirts where we know we're having a hard time reaching people and being able to see rates of immunization in those spaces in comparison to our more densely populated, more urban spaces would be really helpful in doing our outreach." "Something that would be helpful for us here in the rural part of [County] specifically is seeing data prepared in more specific ways, like being able to see it broken down by zip code, broken down at the outskirts of our county would be really helpful."
Expertise in assessment, surveillance and outreach at smaller, rural LPHAs	LPHAs	"Our access to data is more on the state side, once we enter it in, how do we find the data? We don't have an epidemiologist in [County]. I'm not trained on data. I'm a nurse. I don't do statistics." "We partner with [County] to get just a small FTE and we don't have a lot of opportunity to slice and dice our data to get a better understanding of really where we need to focus."

Challenges	Organization	Sample descriptive quotes
Expertise in assessment, surveillance and outreach at smaller, rural LPHAs (cont.)	LPHAs	"In regards to the workforce with expertise and skills, I think we struggle in that area of ensuring that we have individuals with expertise for outreach." "When someone's out, there's not really anyone that can do this kind of work."
Insufficient supports and resources to engage in policy-related work	LPHAs	"[Policy is] one area that I've felt that we just don't have any sufficient staff or time." "We don't have capacity with our current staff to be able to take on any policy work or change at [County] currently."
County-wide priorities that may not advance or support public health priorities	LPHAs	"Our county doesn't want us to hire more staff. We're getting funding that says, 'You need to improve this system, you need to hire more people to do this work.' And our county is saying, 'We don't care if you have the money, we don't want to expand. We don't want to hire new people.' So that doesn't help us get this done." "Our County Commissioners feel that good governance is less government." "Our language is 'extreme weather events.' That's how we are able to engage with our county politicians [about climate-related issues]." "I still hear all the time syphilis isn't that common. Why would I test for syphilis?" "I think our county representation for immunization remains pretty steady and positive towards vaccination, but the attitude of our county can swing pretty dramatically now that it's become more of a politicized issue. And so, depending on how the politics of our county commissioners present and reside, that can swing how things in our county go a bit as well." "It's really hard for us to do this without recognizing that we're part of the overall county and the overall county has not had a very trusting relationship or a trustworthy relationship with many of the same partners that we're trying to establish. So we can't call ourselves something else. We are part of the county. We talk about our autonomy, but we're really part of the county and it's hard to not have that baggage on our shoulders when we're communicating with them."

Challenges	Organization	Sample descriptive quotes
Competing state priorities	OHA PHD	"There are a lot of assignments and priorities that come from the Public Health Division, and it's often challenging to figure out which one is the priority of the priorities." "I would argue that it's a lack of priorities and not all the priorities because it's not priority if you're prioritizing everything." "They're throwing a lot of balls and there's not a lot of catchers in terms of the infrastructure that has been developed."
Poor data quality	LPHAs and OHA PHD	"The case investigation piece - sometimes when we are unable to make contact with the case, not being able to follow up with them - that's missing data." "We know that these same communities are underrepresented in our surveillance data... So we've got a long ways to go to make sure that it isn't just about our outreach and education in how we serve communities that way, but also improving our surveillance systems to make it safe and make ourselves trustworthy for those communities to report."
Need for greater workforce capacity	LPHAs and OHA PHD	"Everyone that we have is spread so thin across all the programs." "We do have funded positions. We are very grateful for that, but they're new to the domains of wildfire smoke, climate and health. And so we are building our capacity from a foundational level." "We were using another funding stream to help bolster some of our capacity in our workforce to focus specifically on STIs and that funding has ended. And so that position for us was eliminated. So we're back to just having part time staffing to do all communicable disease investigations which you know, during certain parts of the year, means that person is significantly overextended." "Almost 40 percent of our staff are limited durations [LD] right now and supported by COVID-19 funding but all these LD positions come to an end June 30, 2025. Exactly what the immunization program is going to look like when we lose those LDs, it's not clear, and we certainly won't have capacity to do modernization work or public health accountability metrics work."

Challenges	Organization	Sample descriptive quotes
Need for coordination and clarity on partner contributions	OHA PHD	"There is this disconnect between the vision from leadership and the operational capacity and infrastructure to connect to the vision." "I think that it would be really, really helpful, especially for program managers that are receiving these requests [strategic priorities] that often feel like whack-a-mole, to understand how we can not reinvent the wheel each time we get a request, but how we can relate what's already been done for other initiatives." "I know OHA provides a list of the other entities that are funded from public health modernization, but I would say from what I see on my end, it's very hard to determine really what those organizations are doing and I could not confidently tell you how they are meeting those metrics." "We work with a lot of other agencies and organizations, but I never can tell what's related to this work and what's just part of their core work that is related to other things. So maybe this is something we just need to ask partners, right?"
Need for funding to support the accountability metrics	LPHAs and OHA PHD	"It's hard to feel like things are prioritized when there's no funding behind them whatsoever." "Syphilis is an accountability metric, but we're having to address these issues with the resources that we already have with cases just continuing to rise. We're expected to address syndemic issues even, but we don't even have the core infrastructure to do basic public health work."
Unclear direction of accountability metrics work	LPHAs and OHA PHD	"This is personally the first time that I've been asked this type of question to look forward so far into the future in 2030. I think that's probably telling in terms of how and if there is an overarching strategy from leadership, how that's been communicated to the position that I sit in." "When I read the question, it gave me anxiety. We are not likely to receive any County general funds to support our work in this area and outside of modernization will likely have to get grant funds." "Our strategy is really just to keep doing what we're doing with the small amount of resources we have and try and be as strategic as we can be. So just trying to be very conscientious and thoughtful about the resources we have, where they go and where we're investing our time. And try and keep the morale of the folks on my team up so that they'll keep doing the important work that they do."

Source: LPHA and OHA PHD focus groups for the accountability metrics domain.

Participant recommendations

While not specifically asked to provide recommendations, many participants did so as part of their responses. These recommendations included:

Data

- Provide additional training on data access
- Address gaps in data specifically for rural areas

Workforce

- Within OHA PHD, make additional modernization investments in the state workforce outside of the Director's Office
- Ensure OHA PHD programs are appropriately staffed for accountability metrics work

Policy

- Offer state-supported guidance when county-wide priorities may not align with advancing the metrics
- Increase capacity for policy work, including additional LPHA funding, workforce and state-level capacity to identify funding opportunities

Strategies and coordination

- Stop, regroup and take stock of what has happened to this point for modernization and the accountability metrics
- Invite people to conversations that affect them
- Have a space that connects OHA PHD programs, LPHAs and CBOs engaged in accountability metrics work
- Identify roles, specifically for the OHA PHD Director's Office and OHA PHD programs
- Align metrics to federal funding requirements to reduce burden on workforce
- Design a visualization of how all priorities fit together (state-specific)

Advancing health equity through the accountability metrics

Evaluation question 2: How is work towards the accountability metrics advancing health equity?

In 2019, OHA adopted a strategic goal to eliminate health inequities in Oregon by 2030. OHA's Strategic Plan includes five pillars for reaching this goal by ensuring all people in Oregon[5]:

- Can reach their full health potential and well-being
- Do not face disadvantages due to their race, ethnicity, language, disability, immigration status, age, gender, gender identity, sexual orientation, geography or social class

Guiding documents: Activities that advance health equity

The evaluation team reviewed multiple guidance documents to determine what governmental activities are helping to advance health equity. These documents include:

Public Health Modernization Manual[3]

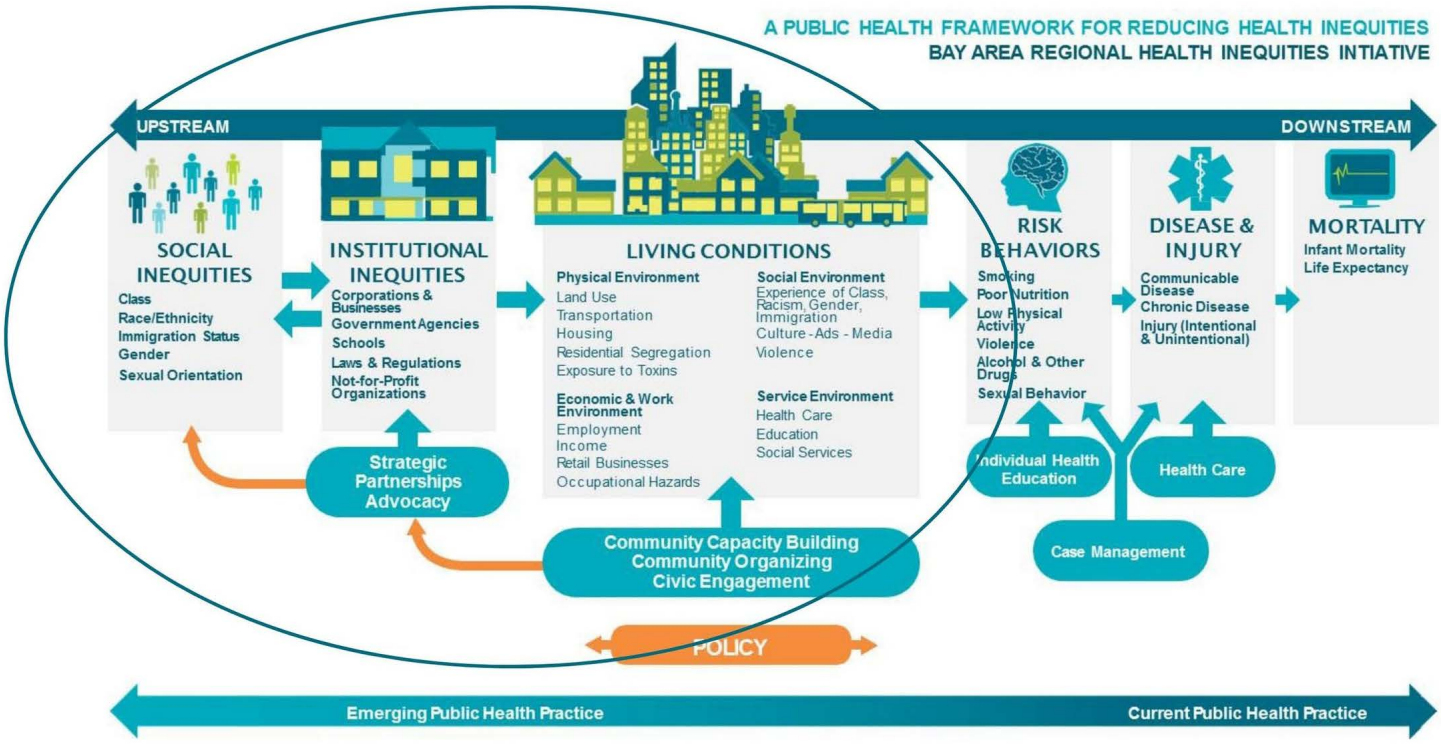
OHA's Strategic Plan[5]

CDC's Equity Framework[37]

Bay Area Regional Health Inequities Initiative (BARHII) framework for reducing health inequities[38]

The BARHII framework (Figure 6) helps make the connection between social determinants and health. Health inequities exist because of upstream social and institutional factors – racism, classism, discriminatory policies and inequitable access to care. These factors have an impact on everything downstream from them – the conditions in which we live, behaviors, morbidity and mortality.

Figure 6. Bay Area Regional Health Inequities Initiative (BARHII) framework for reducing health inequities[38]



Opportunities to address health inequities exist across this continuum. Policy, partnerships and community capacity building are examples of actions that can have an influence upstream. Actions in health education, case management and healthcare make an impact downstream.

This framework, as well as the other guiding documents, helps inform the following actions to advance health equity. All the actions taken by LPHAs and OHA PHD can help advance health equity, though some may do so more explicitly than others. The guiding documents serve as reference points for understanding how the work towards the accountability metrics is helping advance health equity.

Communications and training: Actions to advance health equity

When asked how their respective LPHAs are advancing equity through work towards the accountability metrics, focus group participants centered responses around the communications foundational capability. Participants identified ways in which increased capacity for communications, culturally and linguistically appropriate communications and partnerships with CBOs helped advance health equity in their respective priority areas.

> *"Modernization funds have allowed us to actually have staff focused on communication and messaging... we go through a process to make sure they're translated both from a linguistic and cultural perspective into messages for our emergency preparedness disaster management team."*

> *"Our focus has more been on normalizing syphilis testing and communications around that to try to help our community as a whole understand and break away from this like idea of syphilis testing attached to specific risk factors and that it is just impacting a specific community."*

Participants also reported receiving equity and trauma-informed care trainings, though frequency varied. Most participants noted receiving equity-related training upon hire and having annual trainings to refresh their knowledge and skills. Few participants reported having any trauma-informed training; those that did report it were primarily in the syphilis priority area. Participants demonstrated a desire for additional training opportunities, as in the quotes below.

> *"[Our training] is very limited and I think it's something we can improve on."*

> *"We don't have a formal system to train staff and leadership or managers in both of those areas...One of the biggest priorities is to identify opportunities for training."*

Advancing health equity in the accountability metrics priority health areas

The following sections of this report demonstrate the actions taken by state and local public health to advance health equity in each accountability metrics focus area. Presented below are LPHA priority populations identified through the use of data, actions that LPHAs are taking to address their respective focus areas and OHA PHD accountability metrics process measures. The Oregon LPHA Accountability Metrics Process Measures Survey is the source of the LPHA data presented. This survey only captures selected LPHA work in a given focus area (i.e., extreme heat, wildfire smoke and immunizations). This may underrepresent all activities being conducted by LPHAs in the priority areas.

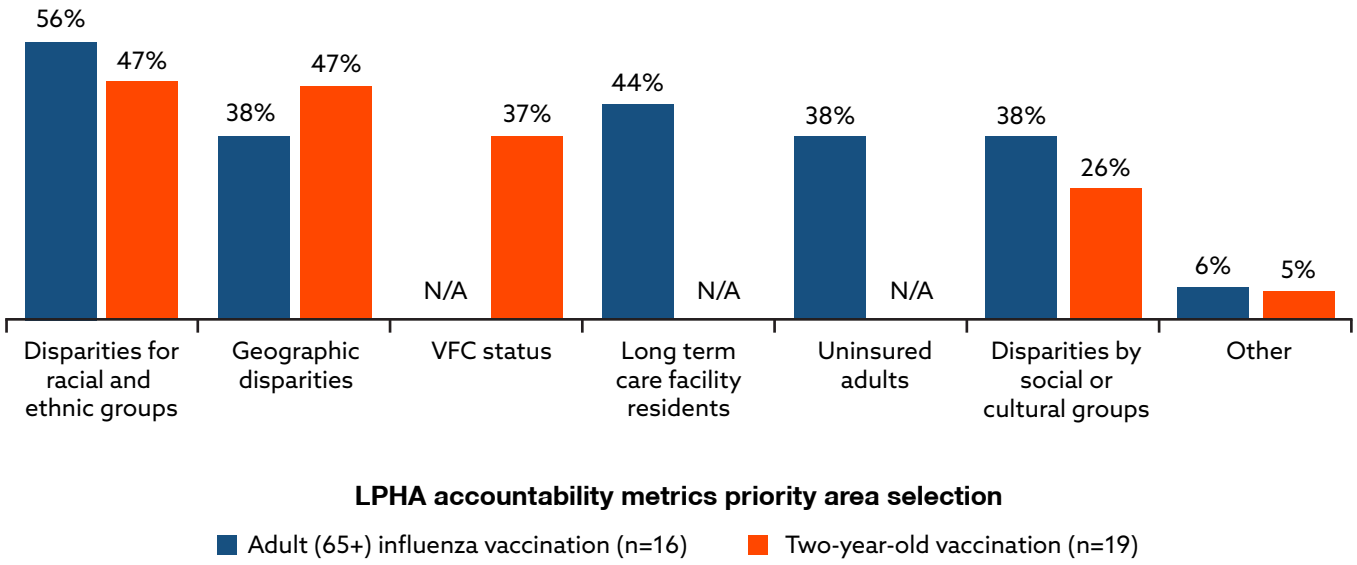
Priority area: Protect people from preventable diseases by increasing immunization rates

LPHAs and OHA PHD are advancing health equity through their efforts to increase immunization rates by using data to identify populations who have experienced disparities in immunization rates, increasing access to immunizations and growing partnerships through LPHAs. At the state level, OHA PHD makes data available to partners and leads multidisciplinary efforts towards state-wide vaccine finance reform.

LPHAs – IDENTIFYING PRIORITY POPULATIONS

LPHAs across the state reported the use of data to identify priority populations – populations that experience disparities in immunization rates – in their respective regions. For both two-year-old immunization rates and influenza immunization rates for adults ages 65+, disparities in immunization rates for racial and ethnic groups and by geography were identified the most by LPHAs.

Figure 7. Priority populations identified by LPHAs through use of data, immunizations priority area (multiple selections allowed)



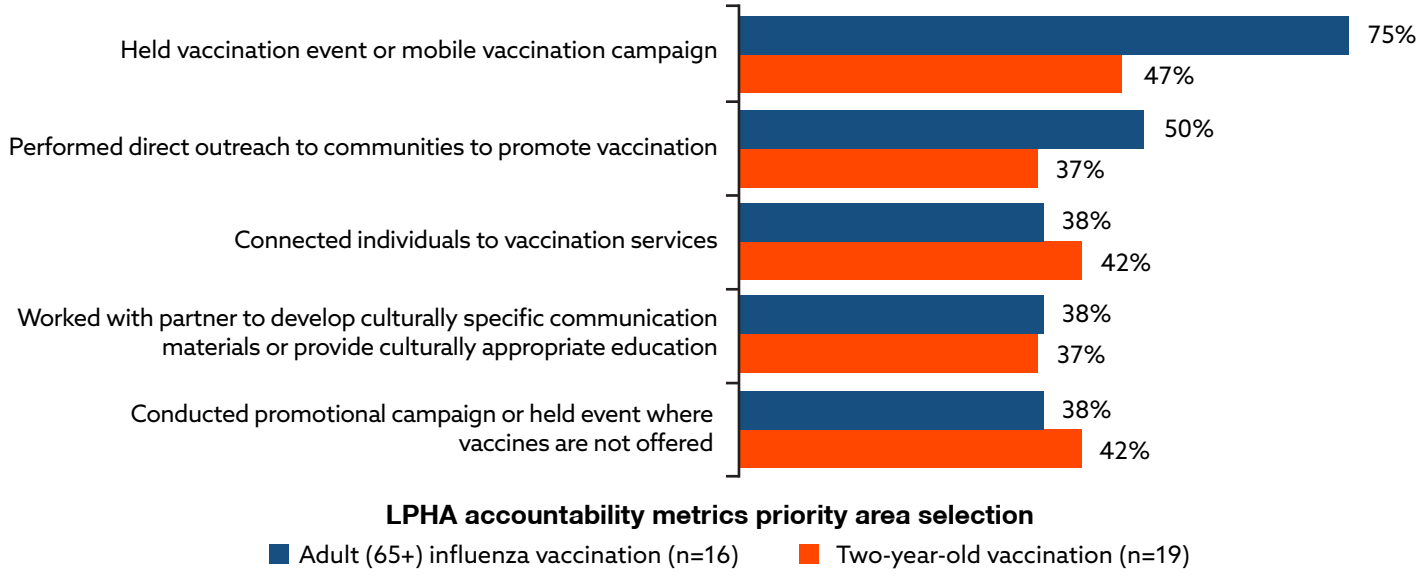
Source: 2024 Oregon LPHA Accountability Metrics Process Measures Survey

VFC = Vaccines for Children

LPHAs – INCREASING ACCESS TO IMMUNIZATIONS

Community engagement activities such as mobile health clinics and immunization events can improve access to immunizations. LPHAs are taking an array of steps to improve access to immunization in their respective communities.

Figure 8. Actions taken by LPHAs to increase access to immunizations, immunizations priority area (multiple selections allowed)



Source: 2024 Oregon LPHA Accountability Metrics Process Measures Survey

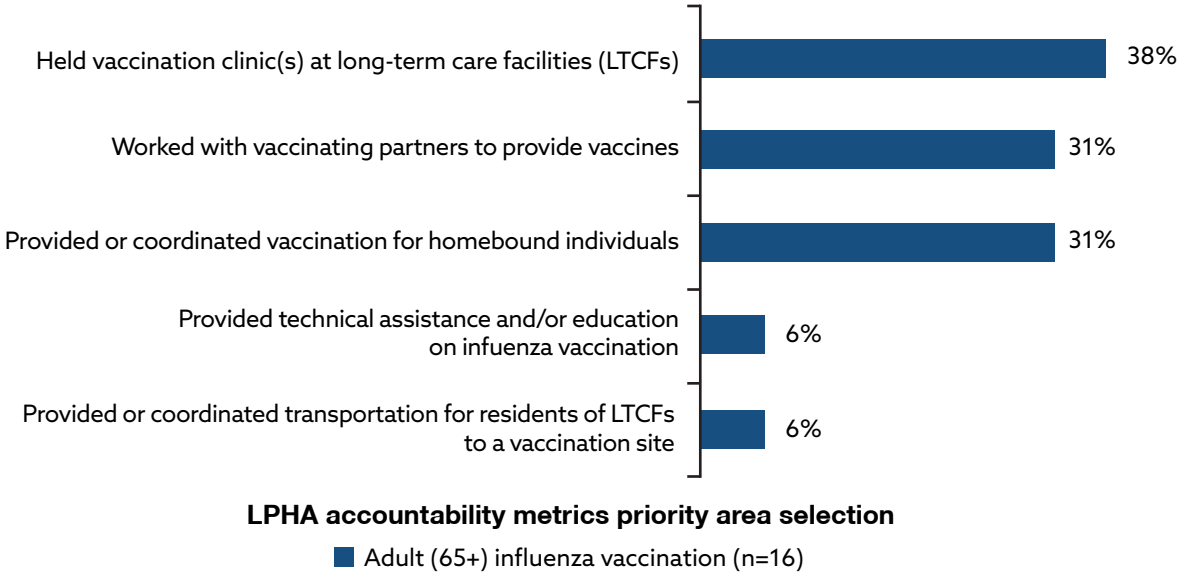
"[We] offered vaccination at family nights at local daycares with Latinx populations, allowing for entire families to get vaccinated at the same time, including multi-generational families of farm workers."

"Partnered with Head Start to present to Spanish-speaking families on the importance of routine vaccinations and well child visits."

"Coordinated and operated vaccine events after typical work hours and on the weekend, at large space venue (the fairgrounds) at local faith-based organization (church), local community centers ([County] Recreational District) and at local school districts to ensure a vaccine event occurred in each area of the county – south, central and north."

Some LPHAs identified adults 65+ in long-term care facilities as a priority population for influenza immunization. The figure and quotes below identify efforts to increase influenza immunization access among this group.

Figure 9. Actions taken by LPHAs to increase access to immunizations, adult (65+) influenza immunization rate focus area (multiple selections allowed)



Source: 2024 Oregon LPHA Accountability Metrics Process Measures Survey

"We held 6 vaccination clinics at LTCFs. 122 high dose flu vaccines, 24 regular flu, 99 COVID vaccines."

"Coordinated with a local FQHC [federally qualified health center] to vaccinate residents at an assisted living facility for COVID and flu in [city], an extremely rural part of [the county]."

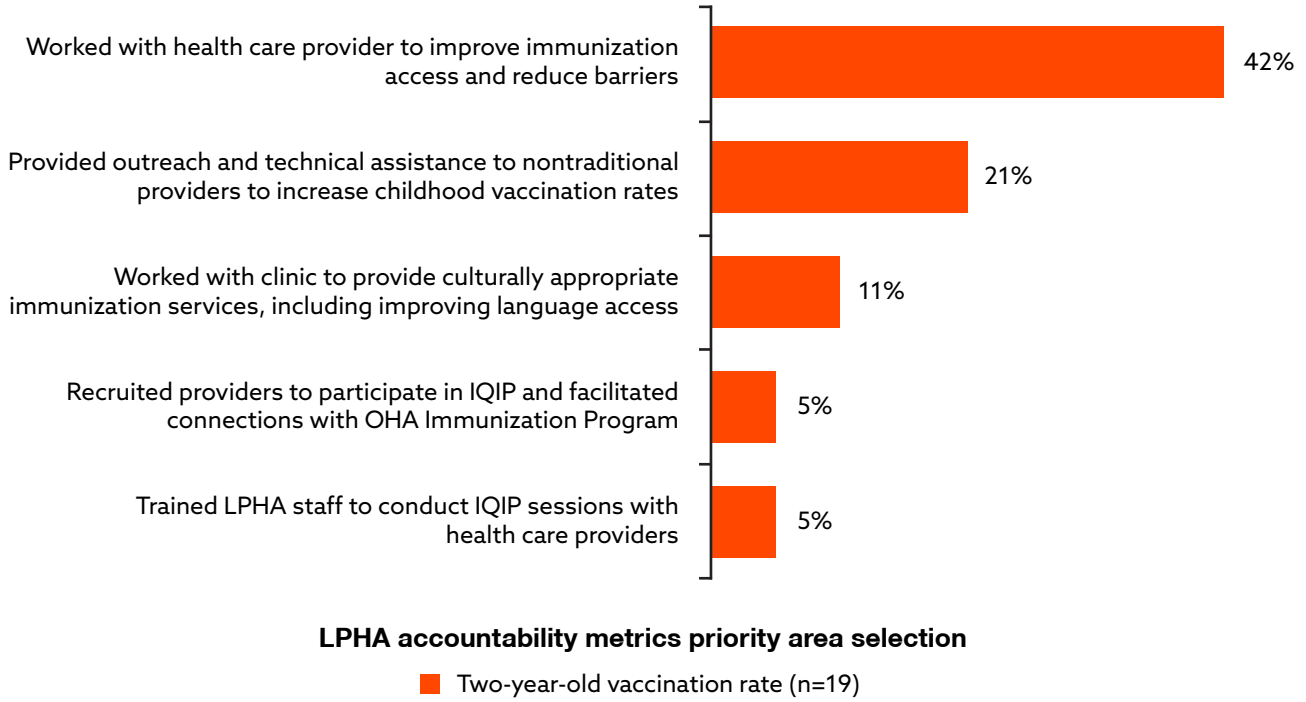
"Coordinated with a pharmacy to do an on-site vaccine clinic at a different assisted living facility in [city] for COVID and flu for residents and staff."

"[County] worked with Albertson's/ Safeway pharmacy and [local pharmacy] to ensure influenza vaccine access to LTCF residents and staff."

LPHAs – WORKING WITH HEALTHCARE PROVIDERS

Partnerships with health care systems and providers are another method to reduce barriers to immunization and improve access. LPHAs prioritizing two-year-old immunizations have reported outreach, technical assistance and efforts to improve language access and cultural appropriate services with providers.

Figure 10. Actions taken by LPHAs to increase access to immunization, two-year-old immunization rate focus area (multiple selections allowed)



Source: 2024 Oregon LPHA Accountability Metrics Process Measures Survey

IQIP = Immunization Quality Improvement for Providers

"We routinely work with nontraditional providers to encourage referrals for childhood vaccines. Recently, we have seen an increase in referrals as a result of these efforts."

"During February 2023, [County] Communicable Disease Section increased our availability for vaccine appointments by extending our hours by 1 hour each day and hiring a part-time RN to increase capacity."

"[LPHA] coordinated with local daycares and provided resources on how and where families could access pediatric vaccines as local providers could not meet the demand. This included reviewing required versus recommended vaccines, identifying clinics providing vaccines outside established patient panels and directly scheduling services with [LPHA]."

OHA PHD ACTIONS

At the state level, OHA PHD is addressing inequities by making data available to LPHAs, CBOs, CCOs and the general public, as well as taking steps to ensure a sustainable vaccine finance model.

Develop and maintain data for immunization indicators.

Data dashboards for 2-year-old immunization rates and influenza immunization rates are available with data by county, race and ethnicity. Data for smaller levels (zip code, clinic, patient, etc.) upon request is a target for the future.

Provide data to CCOs to meet immunization incentive measures and partner with CCOs on quality improvement (QI) program implementation.

In this biennium, OHA PHD provided 100 percent of data files to CCOs in a timely manner.

Assure vaccine supply and monitor the state's vaccine finance model to ensure it is sustainable, equitable and adequately funds immunization programs.

OHA PHD held an in-person summit with healthcare providers from around the state and formed a multidisciplinary vaccine finance reform steering committee.

Priority area: Reduce the spread of syphilis and prevent congenital syphilis

State and local public health authorities are working to implement process measures to improve health equity and health outcomes related to syphilis.

LPHAs – PROCESS MEASURES

Each LPHA in Oregon is required to select two process measures for preventing syphilis. These measures, as well as the proportion of LPHAs that selected each measure, are presented in Table 8.

Table 8. LPHA process measures for the syphilis priority area, 2023-2025 biennium

Process measure	% of LPHAs working towards measures (n=33)
Increase percentage of people with syphilis interviewed	81.8%
Increase percentage of early syphilis cases treated with appropriate regimen within 14 days	72.7%
Increase percentage of cases with all CDC core variables* complete	36.4%
Increase percentage of congenital syphilis cases averted	9.1%

Source: 2024 LPHA syphilis process measure reporting

CDC = Centers for Disease Control and Prevention

Note: Each LPHA reports on two process measures.

**Core variables include race, ethnicity, pregnancy status, human immunodeficiency virus (HIV) status or last HIV test and sex of sex partners.*

LPHAs – IDENTIFYING PRIORITY POPULATIONS

While priority populations for syphilis were not identified from the LPHA Accountability Metrics Process Measures Survey, syphilis focus group participants shared efforts to identify priority populations for their programming.

> *"We look at all sorts of different risk factors and demographic information… we're looking at things like that to see where the major health disparities are and where we need to be doing some additional outreach."*

> *"When we are able to interview cases, the data that comes out of those definitely benefits public health in the long run because it is that data that we can analyze and ask, 'What are we doing well? What aren't we doing? What are the risk factors? The gaps?' and then that allows our prevention side of the team to look at that data and develop strategies to then work with those risk groups and work on what the gaps are."*

Actions to advance health equity in syphilis prevention at the local level included increasing workforce capacity to improve outreach, improving access to sexually transmitted infection (STI) testing and care, and enhancing communication and messaging surrounding syphilis. Quotes for each of these actions are listed below.

LPHAs – INCREASING ACCESS TO TESTING AND CARE

> *"We have achieved a staffing level that allows us to go back into the jail and juvenile detention facilities that offer rapid support testing and a variety of other things."*

> *"[Our nurses] take our outreach testing van out in the community and they go to events for different like LGBTQ organizations – they've worked for years now with [CBO] to attend different events and pride and things – and offer testing. And they usually, depending on what type of event they're going to, will bring Bicillin in the field, and so that's been great."*

> *"Another activity that we have here is through Oregon Health Authority, the Bicillin distribution program. So community providers that are unable to get Bicillin due to cost, things like that, we can get Bicillin from Oregon Health Authority and then dispense that to the medical providers to give to the patients."*

LPHAs – IMPROVING COMMUNICATIONS

"We have multiple bilingual staff, but we also have had a contract in place for a long time with Language Line where we offer video assistant translation services, as well as ASL, and we use all of that quite frequently. I don't know that that always achieves the cultural relevancy need, but at least we can make sure that folks are getting information either verbally or written or through some other means in a language that they understand."

OHA PHD ACTIONS

OHA PHD is sharing data with partners through data dashboards and utilizing community partnerships to promote the importance of syphilis screening and treatment.

OHA PHD created internal and external data dashboards on syphilis and congenital syphilis, making data more accessible to partners and the public.

Partnerships with CCOs, LPHAs, tribes and state departments have provided opportunities to raise awareness of and promote syphilis screening and treatment during pregnancy.

Priority area: Increase community resilience for climate impacts on health

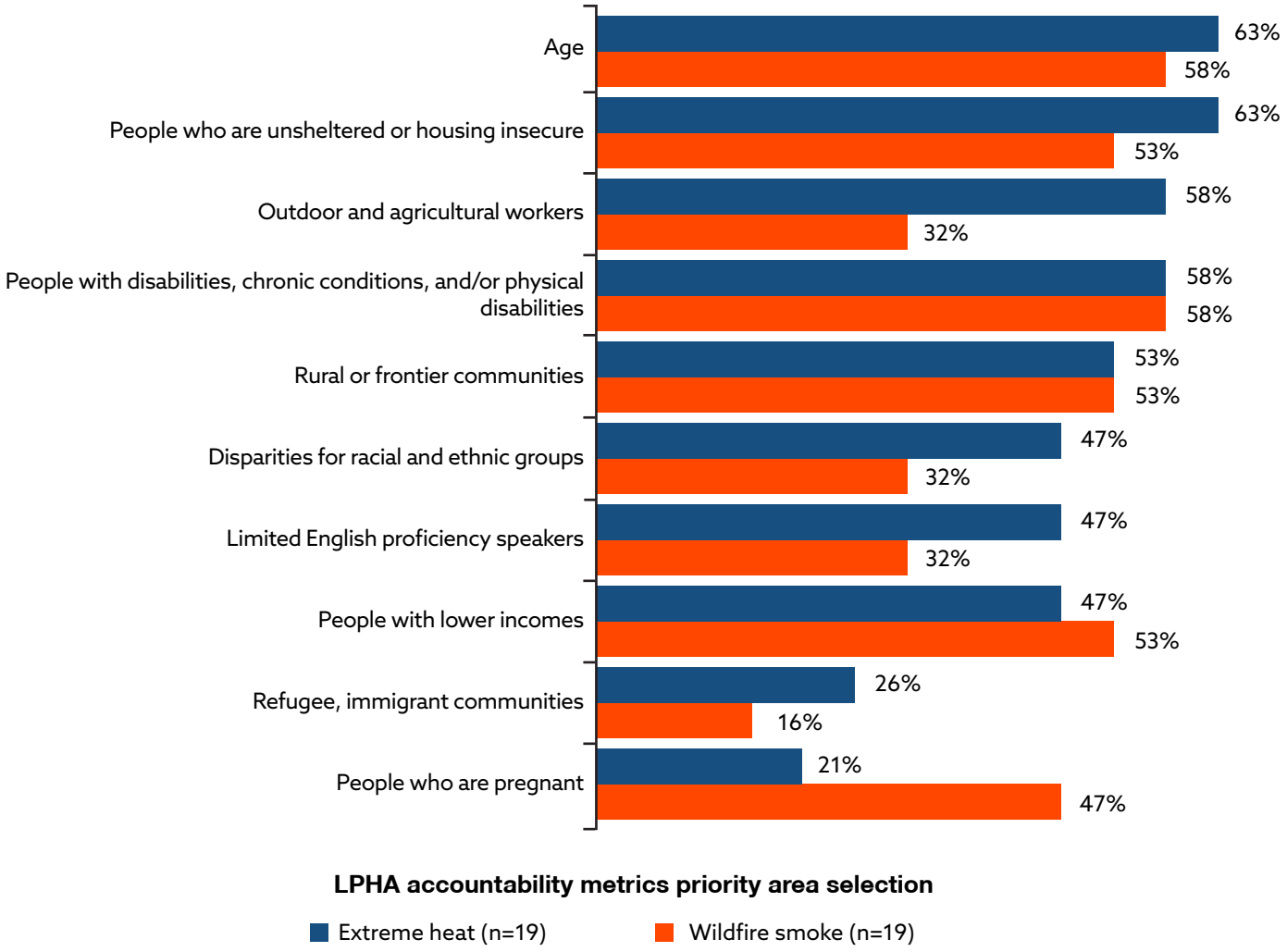
To address the health impacts of extreme heat and wildfire smoke, LPHAs and OHA PHD are advancing health equity by identifying priority populations, advancing policy and planning, improving the environments in which individuals live, expanding communications and making data available to community.

LPHAs – IDENTIFYING PRIORITY POPULATIONS

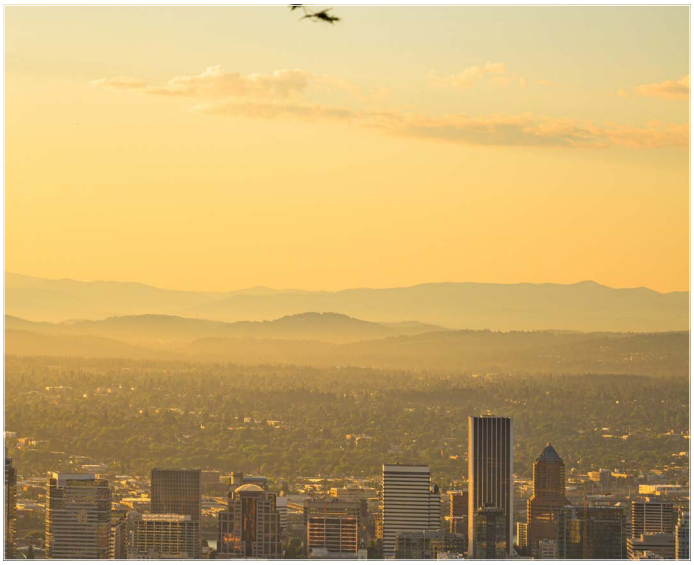
LPHAs identified the following groups as priority populations in addressing health impacts of wildfire smoke and extreme heat.

- Children under 5 years old and adults ages 65 and older
- People with disabilities and/or chronic conditions
- People who are unsheltered, experiencing housing insecurity or living in conditions that make them more vulnerable to environmental hazards

Figure 11. Priority populations identified by LPHAs through use of data, climate priority area (multiple selections allowed)



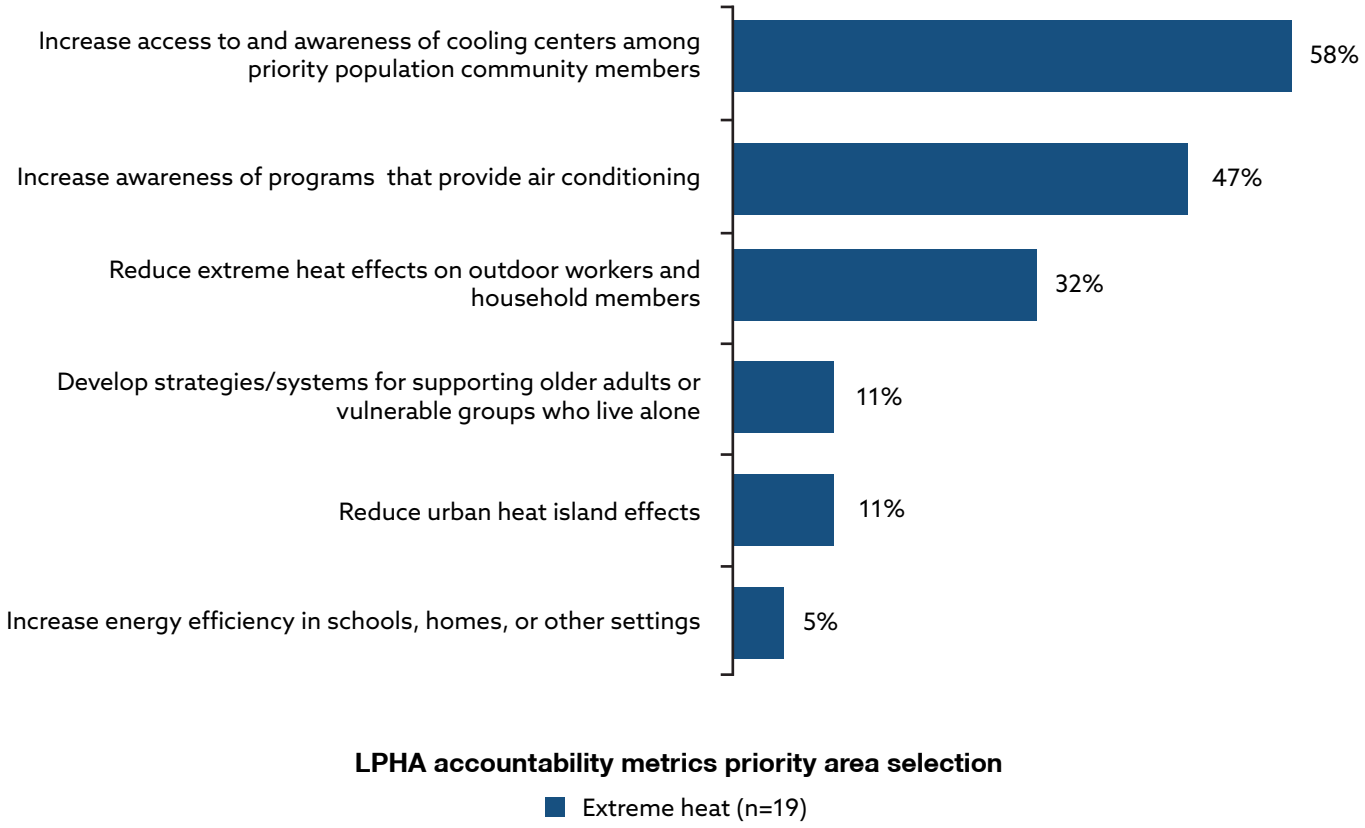
Source: 2024 Oregon LPHA Accountability Metrics Process Measures Survey



LPHAs – ACTIONS TO ADDRESS EXTREME HEAT AND WILDFIRE SMOKE

The actions of local public health and community partners can help reduce the impacts of extreme heat and wildfire smoke while simultaneously advancing health equity. Improving access to resources, building awareness of programs and improving infrastructure are some actions that LPHAs reported. The following figures and quotes provide specific examples for extreme heat and wildfire smoke, respectively.

Figure 12. Actions taken by LPHAs to address extreme heat (multiple selections allowed)



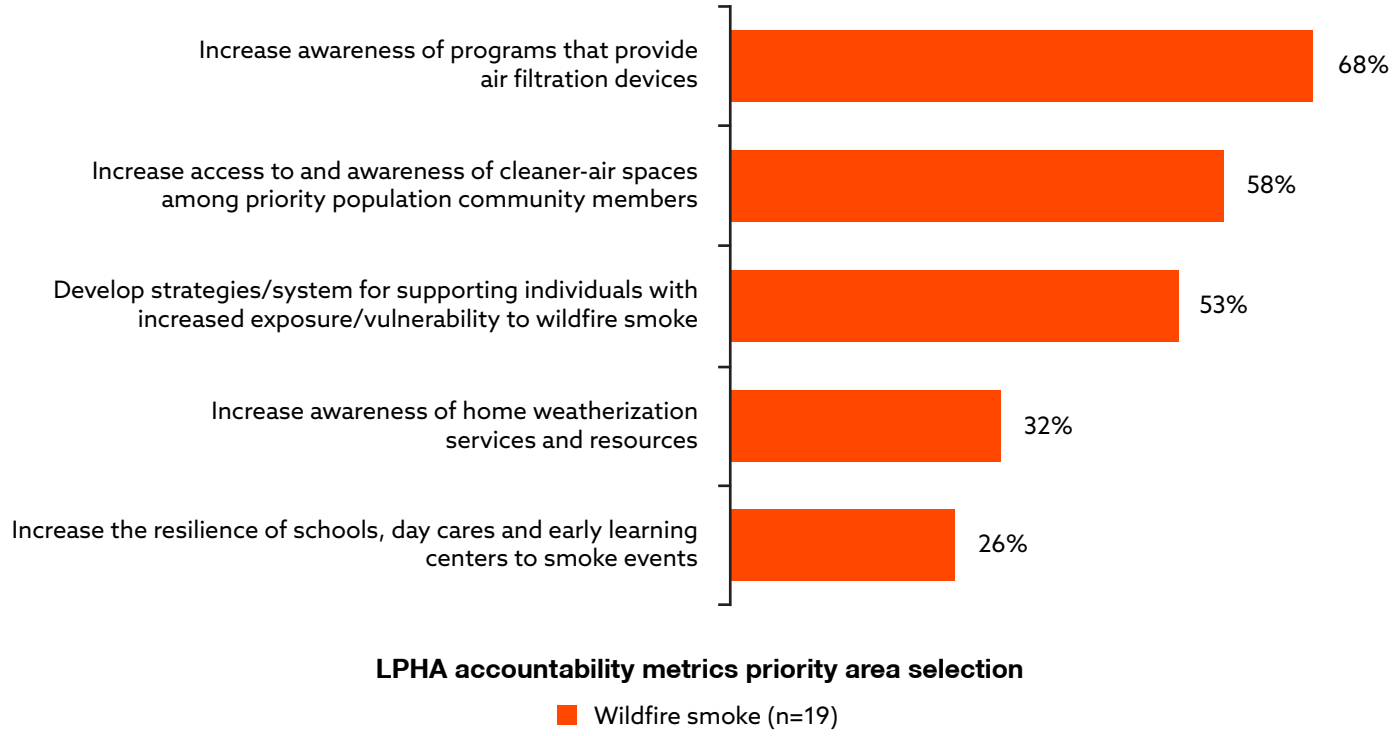
Source: 2024 Oregon LPHA Accountability Metrics Process Measures Survey

"Collected and provided hats, cooling rags, bandanas and sunscreen to farmworkers to help decrease the effects of extreme heat. Education provided about importance of staying hydrated and cool while working outside."

"Worked with day shelters to offer our services on site to help vulnerable populations become aware of cooling sites. Staff that works with unhoused population shared site information for cooling centers and provided transportation to shelters as needed."

"[CCO partner] provided air conditioners to their clients in need, we ensured that the community knew about this benefit through social media, CBO communication and word of mouth during events."

Figure 13. Actions taken by LPHAs to address wildfire smoke (multiple selections allowed)



Source: 2024 Oregon LPHA Accountability Metrics Process Measures Survey

"Air filtration machines were purchased with PE 12 and PE 51 funding to disperse throughout the community."

"Public Health staff worked directly with [the] Latino Community Center and faith-based network to designate clean air options within [County]."

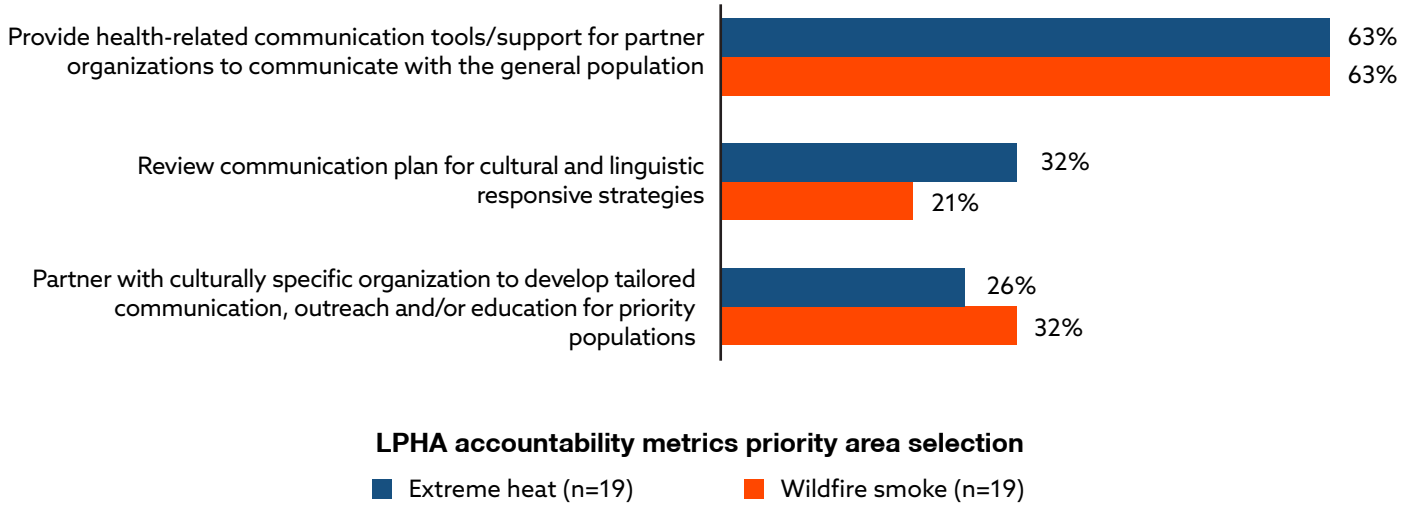
"We have begun partnering with [CBO] to provide education on air filtration devices and resources available. [CBO] gave [LPHA] air purifiers to distribute to community members who may not qualify to receive one through their insurance."

"We partnered with [school district], EPA and [City] to assess readiness of school HVAC systems, resulting in a toolkit for other jurisdictional use/consideration."

LPHAs – EXPANDING COMMUNICATIONS

To improve equitable access to information, LPHAs have taken actions to make climate-related communications culturally and linguistically relevant for all populations they serve.

Figure 14. Actions taken by LPHAs to expand communications, climate priority area (multiple selections allowed)



Source: 2024 Oregon LPHA Accountability Metrics Process Measures Survey

"Utilized YouTube channel and Facebook to create, post and promote how to create homemade indoor air filter for high AQI days, shared multiple infographics on how to prepare, mitigate and manage health consequences of wildfire smoke."

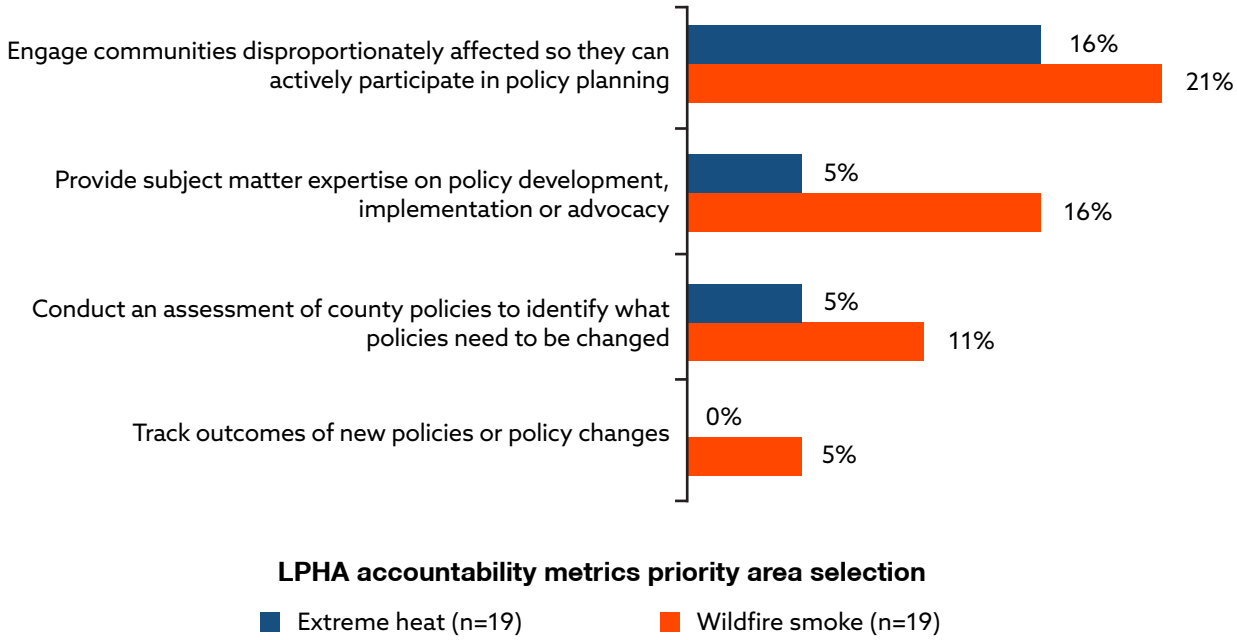
"Working with Latino Community Association on developing and translating local smoke information and resources that is culturally specific to [County] and available in Spanish."

"Provided OHA education on extreme heat in English and Spanish at cooling stations throughout the county. Also provided heat education to local newspaper that included the location of the cooling stations."

LPHAs – POLICY AND PLANNING

Few LPHAs reported activities to address environmental health policies. This aligns with LPHA focus group participants reporting limited capacity for policy-related work at the local level. Those who did engage in policy work made efforts to involve community in the planning process.

Figure 15. Actions taken by LPHAs in policy and planning, climate priority area (multiple selections allowed)



Source: 2024 Oregon LPHA Accountability Metrics Process Measures Survey

"With our Office of Sustainability, we concluded a framework planning process and launched a steering committee to develop a climate justice plan for the County. All community members contributing were/are representatives from culturally specific organizations."

"We are engaging all communities in our planning and development of our climate adaptation plan."

OHA PHD ACTIONS

OHA PHD has created new data dashboards to share information with community. Additionally, the Environmental Public Health (EPH) section is identifying potential policy changes for the state.

OHA PHD EPH created dashboards to share data with communities and LPHAs.

OHA PHD EPH created: 1) a dashboard of summer hazards, including air quality-related respiratory hospital visits and heat-related illness hospital visits, and 2) a dashboard on air quality around the state. Both dashboards are public facing.

OHA PHD EPH is working towards Health in All Policies, a collaborative approach that integrates health considerations into policymaking across sectors and at all levels, documenting policy changes needed to reduce the health impacts of climate change, beginning with extreme heat and wildfire smoke.

Case studies

This evaluation included two case studies to gain a deeper understanding of progress towards the accountability metrics at the local level. The actions of Lincoln County Public Health to prevent communicable disease and actions of Multnomah County Health Department to address extreme heat are highlighted below.

Preventing the preventable: Lincoln County Public Health Division increases immunization rates and reduces the spread of syphilis

Lincoln County is making progress on the accountability metrics related to communicable disease control, specifically through immunizations for persons 65 years and older and STI testing. This case study highlights how Lincoln County's communicable disease control activities help advance health equity and tie into the public health foundational capabilities. Data from the 2023-2025 biennium is presented. The full case study can be found here.

Projects highlighted in this case study include:

- Expansion of mobile immunization clinics to reach the 65+ population, including outreach to individuals who are homebound to provide immunizations
- A partnership with the Lincoln County Jail to offer weekly STI testing and provide STI education and resources
- Harm reduction activities with people who are houseless and substance-using populations, where STI testing and treatment are offered in addition to other harm reduction services

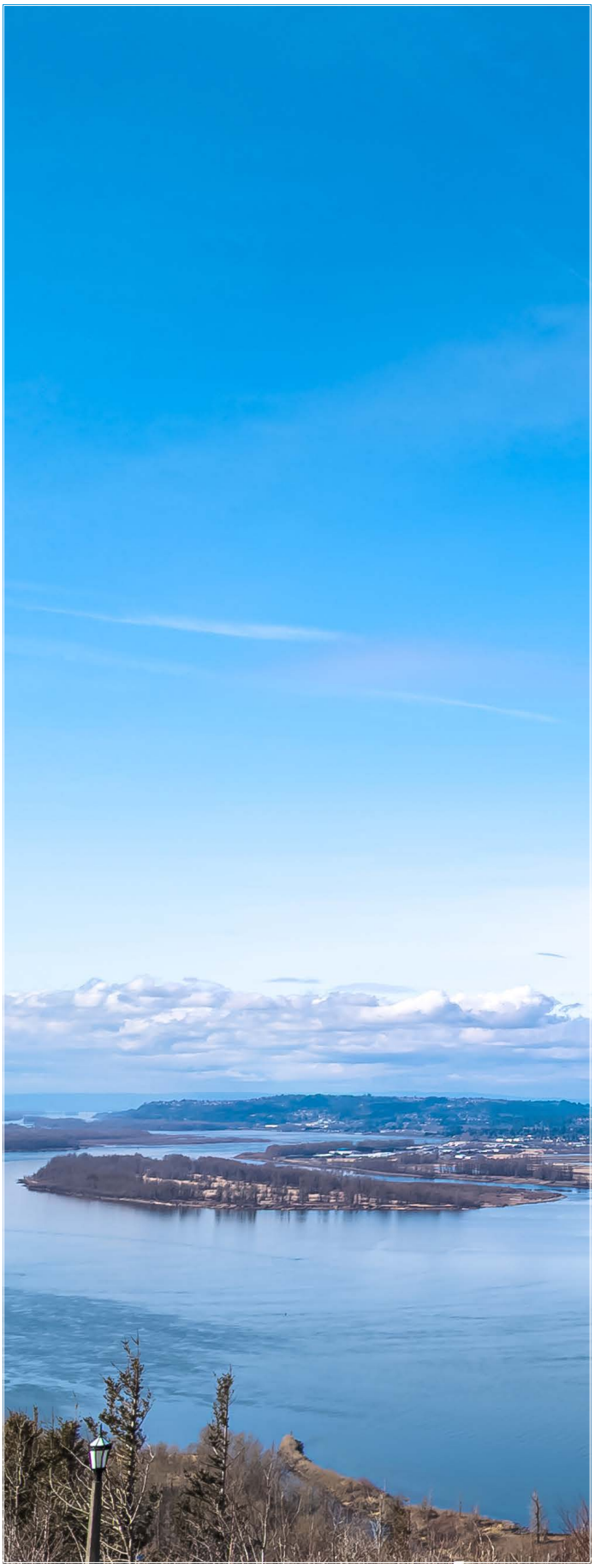
Rising temperatures, rising solutions: Multnomah County Health Department builds resilience against extreme heat

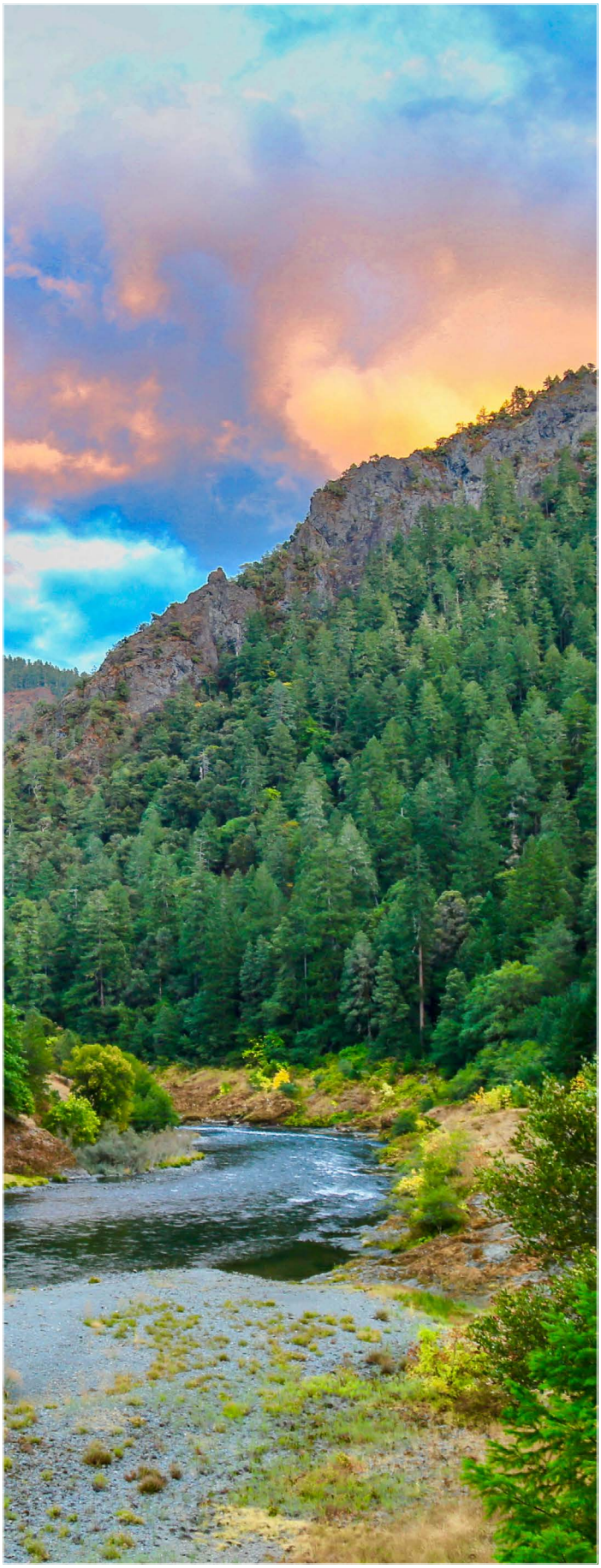
Multnomah County is building community resilience against the impacts of extreme heat. This case study highlights how Multnomah County's climate and health projects help advance health equity and address the public health foundational capabilities. Data from the 2023-2025 biennium is presented. The full case study can be found here.

The Wood Village Green pilot project is one example of many impactful activities to address extreme heat in Multnomah County this biennium. In the short period between June and July 2023, a multi-agency partnership between the county, the City of Wood Village and the Líderes Naturales CBO resulted in 36 homes in the Wood Village Green Mobile Home Park being retrofitted with ductless mini-split heat pumps to provide energy efficient cooling in the summer and heating in winter.

This successful project made it safer for residents to be at home during extreme heat events in one of the hottest areas of the county.

This project, along with many others, is explained in detail in the full case study.





Advancing measures of public health department effectiveness

Investments in PHM and accountability metrics in Oregon show preliminary advancement in the following measures of health department effectiveness:

- **Increased reach to target populations**
- **Quality enhancement of services or programs**
- **Dissemination of information, products or evidence-based practices**
- **Quality enhancement of public health data systems**[8]

Increased preventive behaviors are seen through tracking of immunization rates, congenital syphilis cases averted, and the percentage of prenatal care providers who report screening all pregnant patients in the third trimester.

A rise in these preventive behaviors will lead to decreased incidence or prevalence of disease for the accountability metrics over time. This includes the two-year old immunization series, influenza immunization rates for ages 65+, congenital syphilis and syphilis cases, respiratory (non-infectious) emergency department and urgent care visits, heat-related emergency department and urgent care visits, and heat deaths.

Table 11. Oregon's public health system quality improvement through the accountability metrics and PHM

Measure of effectiveness	Examples
Increased reach to target populations	• Administer immunization to homebound individuals and long-term care facilities • Coordinate immunization events and mobile immunization clinics • Provide syphilis testing at local jails and juvenile detention centers • Increase access to cooling centers and cleaner air spaces for priority populations • Engage communities disproportionally impacted by extreme heat and wildfire smoke in policy planning processes
Dissemination of information, products or evidence-based practices	• Work with partners to develop culturally specific communication materials or provide culturally appropriate education • Conduct promotional campaigns for immunization • Perform direct outreach to communities to promote immunization • Share statewide immunization, syphilis and health impacts of climate data through publicly available data dashboards • Provide data to CCOs to meet immunization incentive measures • Increase awareness of programs that provide air conditioners and air filters • Collaborate with LPHAs, tribes, CBOs and other OHA sections to share the importance of syphilis screening in pregnancy and raise awareness about congenital syphilis
Quality enhancement of services or programs	• Partner with clinics to provide culturally appropriate services and improve language access • Translate syphilis education materials to multiple languages • Provide technical assistance to nontraditional providers, healthcare providers and long-term care facility staff to help increase immunization rates • Provide subject matter expertise on policy development, implementation or advocacy

Measure of effectiveness	Examples
Quality enhancement of services or programs (cont.)	• Implement the Immunization Quality Improvement for Providers (IQIP) Program, performing IQIP visits with Vaccines for Children (VFC) enrolled providers • Develop strategies/systems for supporting individuals with increased exposure/ vulnerability to wildfire smoke (provide masks/other resources to community members, outreach to medically fragile residents and houseless populations, etc.) • Increase the resilience of schools, day cares and early learning centers to smoke events (trainings, indoor air quality monitors, partner to assess HVAC systems, etc.)
Quality enhancements of data systems	• Develop and maintain data dashboards by county and race/ethnicity for two-year old immunizations and influenza immunizations for the 65+ age group. • Update influenza dashboard weekly during flu season • Develop and maintain OR-ESSENCE Summer Hazards dashboard for LPHAs and OHA that includes data on emergency department and urgent care visits related to non-infectious respiratory illnesses and heat-related illnesses • Update and maintain public STI data dashboard and internal STI data dashboard for use by LPHAs
Increased preventive behaviors	• Track percent of congenital syphilis cases averted statewide • Track percent of prenatal care providers who report screening all pregnant patients in the early third trimester • Track immunization rates
Decreased incidence or prevalence of disease	• Track accountability metrics over time – two-year old immunization series, influenza immunization for ages 65+, congenital syphilis and syphilis cases, hospitalizations due to heat and heat deaths

Discussion

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Discussion

Integration of evaluation domains: Key takeaways

Organizational structures can either streamline or impede progress on accountability metrics process measures and health outcome indicators. From the examination of these two evaluation domains, partnerships were noted as key facilitators to the work. Similar challenges across evaluation domains were present. These challenges included uncertainty of future direction and funding, need for greater coordination and enhanced communication given siloed work, and limited staffing capacity.

Among all focus groups across evaluation domains, partners appreciated the forum to hear from others. In several cases, they shared contact information to learn more from each other's work.

Evaluation team recommendations

To address some of the cross-cutting challenges in each domain, the evaluation team offers the following recommendations. These recommendations were based on the evaluation findings, consultation with the Evaluation Working Group and Technical Panel and other supporting evidence.

A. Address uncertainty of future direction and funding

1. **Create a visual representation of the alignment between Oregon's public health priorities, including how they connect to each other and their related funding streams** (e.g., State Health Improvement Plan, Community Health Improvement Plans, State and Local Public Health Agency strategic plans, Capacity and Cost Assessment, Public Health Accreditation, Accountability Metrics), so requests for information are clearly understood within this broader context and support clarity in direction.

2. **Support conversations to address which projects or areas of work to delay or eliminate when faced with competing priorities and limited staff capacity.** Support should include identifying risks of delaying or eliminating work. Quality improvement tools can help in the prioritization process.[9]

3. **Develop an inventory of funding streams that support the accountability metrics by each priority health area,** which can then help build a funding strategy to support sustained movement towards the metrics.

   A funding inventory by priority area can help assess the extent of revenue diversification across local health departments that support accountability metrics priority health areas.

   Compared with less-diversified local health departments, well-diversified departments reported a balanced portfolio with local, state, federal and clinical sources of revenue and higher per capita revenues. Incentives to support revenue diversification can enhance financial resilience and sustainability of local health departments.[10]

   Some questions to consider: What resources are available and utilized to support each accountability metrics priority area? How are those resources being used to support accountability metrics across the state?

   Create opportunities to share funding inventories by priority area across LPHAs by size band, geographic location and other county demographics. Then, use these inventories to further encourage braided funding for each priority health area.

4. **Review current governmental state and local public health operational structures to address uncertainty in funding and limited workforce capacity.**

   Revisit the Roadmap to Develop Shared Services Arrangements Between Local Health Departments and Health Centers.[11]

   Consider expansion of regional positions similar to the regional epidemiologist position and Coalition of Local Health Officials (CLHO) led regional communications position. More frequent shared services arrangements have been found in local public health program areas like emergency preparedness and maternal child health than in departmental operations such as financial management, human resources and communications.[12]

   Explore shared LPHA positions for both departmental operational functions as well as categorical public health program specific areas. Possible positions that may benefit from a regional approach include regional policy analysts, regional climate coordinators/analysts, regional communication coordinators and possibly regional billing positions. Embed state support of regional positions similar to the regional epidemiologist model.

5. **Encourage partners such as CCOs to support and champion public health funding,** recognizing that upstream prevention at a population level reduces the need for downstream costly health care.

6. **Support ongoing shared decision making and transparency** in modernization funding allocations among all funded partners through the Public Health Advisory Board.

7. **Explore analytical tools based on the concept of deep uncertainty** such as Robust Decision Making (RDM), which uses multiple views of the future to identify a plan that performs well in a range of possible futures, avoids situations where it might fail and identifies conditions under which its goals could not be achieved.[13],[14]

8. **Continue to communicate measures of state and local governmental public health accountability.**[15] Documenting successes and their value can help ground and propel public health's mission and support future avenues for direction and funding.

9. **Prioritize hiring people with a learning mindset who are flexible and able to pivot quickly as needs change.**

B. Increase coordination given continued siloed work and strengthen communication and collaboration between silos

1. **Explore Jones et al's (2024) proposed framework to foster organizational collaboration,** which highlights inclusion, shared goals and vision, bi-directional communication, relationship building and developing trust.[16] The authors examine how a culture of collaboration is used to reduce silos at the CDC.

   Actions that perpetuate silos noted by their study participants were organizational structure and culture, lack of information sharing, red tape/bureaucracy and remote work. Producing quality work products and building an internal culture of collaboration motivated participants to work together.

   Collaboration was encouraged by having forums for open communication where people may seek feedback or engagement on a product, topic, proposal or other work-related activity. Integrating a culture of collaboration into the organizational structure itself was a key strategy.

2. **Enhance coordination by strengthening communication pathways that are transparent.** Provide a visual of the feedback loops. Fraser describes two main types of feedback loops: balancing and reinforcing.[17] A reinforcing feedback loop has an amplifying effect in which an action produces more of, or less of, the same action, leading to an increase or decrease in that action over time. A balancing feedback loop can increase or decrease the effects of a change back to the desired state. Examine how these feedback loops create stability or instability.

3. **Communicate orally and visually where intentional efforts to break the organizational silos exist.** Display and share the horizontal avenues and opportunities for collaboration.

4. **Support understanding and recognition of strengths and unique contributions of government and non-government partners, which will help address the need for role clarity between partners.**[18]

   Strengthen understanding of health system partner contributions (CBOs, CCOs, health care entities, etc.) to each accountability metric priority area as seen in the revised accountability metrics framework for collective responsibility across sectors and partners.[19] Consider using this Public Health Learning Agenda Toolkit to assess the type of change necessary and what's needed to reach the desired outcomes.[20]

5. **Set aside leadership time and budget dedicated to broader systems and strategic thinking.**[17],[21] Promote the development of champions for public health system coordination and assess the extent that cross-collaboration within and between partners exists as part of position descriptions.

6. **Support and widely share the existing communities of practice (CoPs) and learning collaboratives or develop new spaces** (e.g., Lunch & Learns) if needed to advance the three accountability metrics priority areas.

7. **Invest in developing and sharing stories of how funded partners come together to collaborate in service of their shared communities.**[18]

8. **Further understand the evaluation findings and variation at a more granular level within state and local public health departments and programs.** Compare those results within and between LPHA size bands and OHA PHD sections, identify who needs greater guidance and determine how that guidance may be shared.

C. Build staffing capacity

Our national public health system has been chronically underfunded for decades.[22] Efforts to modernize Oregon's public health system have also not been funded for full implementation.[23],[24]

1. **Support focused priorities and consider expansion of regional positions to help address limited staffing capacity.**

2. **Track and align existing workforce assessments with existing workforce gaps within the accountability metrics.** Existing assessments include the Public Health Workforce and Needs Survey, Public Health Infrastructure Grant hiring data and Oregon Public Health Modernization Capacity and Cost Assessment Report.[25-27]

3. **Continue to build the Strategic Skills for the Governmental Public Health Workforce into the public health job classifications.**[18],[28]

4. **Preserve institutional knowledge and conduct succession planning.**[18]

D. Prioritize the development of policy capacity within workforce capacity

Top knowledge gaps amongst health department staff include understanding how to: 1) influence law and policy development and 2) contextualize law and policy's effects on public health.[29] In Oregon, policy and planning was identified as the public health foundational capability with the lowest level of implementation among LPHAs.[24]

1. **Review and assess implementation of the policy development and program planning skills domain of the Core Competencies for Public Health Professionals.**[30] This domain includes skills such as the development, implementation, evaluation and improvement of public health policy. The competencies are organized by tiers of responsibility: front line and program support, program management and supervisory roles and senior management and executive leadership.

2. **Use new resources, such as the Policy Innovation Exchange (PIX)** – currently only focused on HIV, viral hepatitis, sexually transmitted diseases and tuberculosis transmission – to provide law and policy resources to public health leaders.[31] The PIX Portal's goal is to assist public health decision-makers in navigating complex law and policy landscapes including issues unique to their state or local jurisdictionPreserve institutional knowledge and conduct succession planning.

E. State support and guidance for county contexts to address health inequities

As shared by several LPHA focus group participants, county health priorities may not align with larger public health priorities. Daniel Dawes' presentation of "The Political Determinants of Health" describes some sources of that misalignment and the forces that can lead to the underlying social determinants of health.[32]

1. **Synthesize the forthcoming PHM deliverable – Health Equity Assessments and Plans – across LPHAs to better understand strategies to foster health equity and be more inclusive of rural concerns.**[33] Understanding the language and terminology used by LPHAs across the state when conducting health equity work may be useful for garnering further support for strategies and interventions.[34]

2. **Continue to support and provide guidance to LPHAs that could utilize the Dignity Reframe approach** described in "Talking about Health Equity in Rural Contexts" by Miller et al. (2024).[34]

   In addition, the Association of State and Territorial Health Officials (ASTHO) offers evidence-based technical packages on a variety of topics, such as "Strategies to Prioritize Evidence-Based Public Health Authority," "Effective Public Health Approaches to Reducing Congenital Syphilis," and "Evidence-Based Strategies to Enhance Emergency Preparedness and Response."[35] These resources may be useful to share with LPHAs as needed.

3. **Center rural disadvantage to equip rural leaders with the material and political support needed to drive local policy, public health practice and action while giving them a more meaningful voice in practice and policy decisions that affect rural health.**[36] Additionally, rural leaders can continue expansion of the use of community-based qualitative methods that highlight the heterogeneity of health experiences and outcomes in rural settings.

Conclusion

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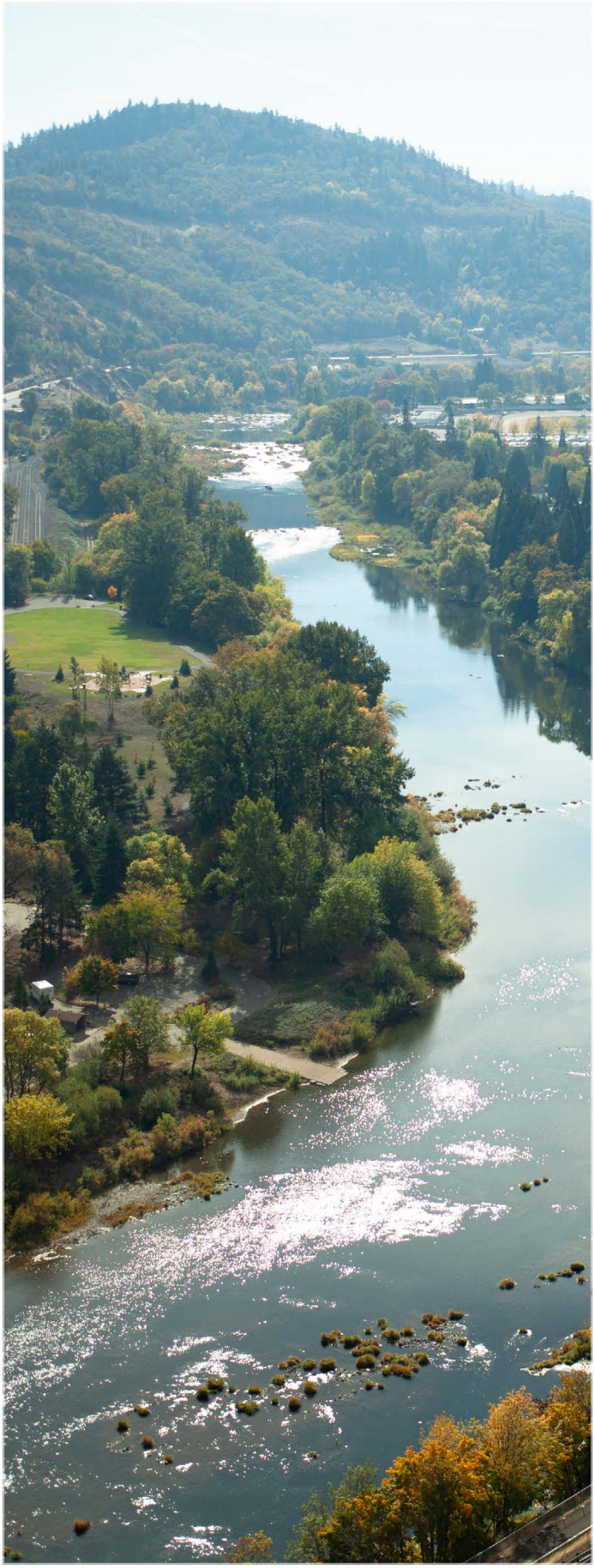

Conclusion

A large-scale, system-wide change like PHM takes time, especially in an environment with historical cycles of funding and defunding of public health. Despite these sporadic funding cycles, state and local public health authorities – with their partners – are demonstrating measurable health improvements that are saving lives in Oregon.

Delivering the foundational public health capabilities allows the workforce to be responsive to the changing needs and landscape. This core public health work documented throughout the evaluation helps reduce the economic cost of health inequities so every person in Oregon can have a fair chance at optimal health.

Ten years have now passed since the modernization framework was codified into law, marking a noteworthy time for partners to collectively reassess the vision, goals and corresponding actions towards this system-wide transformation. The evaluation findings and recommendations provide a clear path to continue advancing the system change needed to improve health for people in Oregon today and into the future.

Appendix

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Appendix

Acknowledgements

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Program Design and Evaluation Services

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Detailed methods

The charters for both the Evaluation Working Group and Technical Panel share a similar purpose: "To assist Oregon Health Authority (OHA) Program Design and Evaluation Services in co-creating an evaluation of the 2023-2025 state legislative modernization funding." This work included:

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

Evaluation teams co-created and guided the evaluation

1. Evaluation Working Group

The Evaluation Working Group consisted of 12 representatives of the public health system from LPHAs, Oregon CLHO and OHA PHD. Members had diverse, on-the-ground experiences with day-to-day LPHA, CBO and OHA PHD activities that support modernization funding and other investments in the areas of communicable disease prevention, planning and response, environmental health and impacts of climate related emergencies, community engagement, public health workforce and measurement of governmental public health agency performance. This Evaluation Working Group met every other week or less frequently during periods of data collection and analysis.

2. Evaluation Technical Panel

The Evaluation Technical Panel consisted of 11 representatives of the public health system from local, state and tribal governmental public health; one member from PHAB; two PHM funded CBOs; and a national public health partner. Members had experiences in the legislative aspects and guiding direction for the investments in public health in the areas of communicable disease prevention, planning and response, environmental health and impacts of climate related emergencies, community engagement and measurement of governmental public health agency performance. This Evaluation Technical Panel met bimonthly or more frequently as needed.

Evaluation domains, questions and methods

The discussion and guidance from the Evaluation Working Group and Technical Panel led to finalizing two evaluation domains in Spring 2024 that reflected key program priorities for the 2023-2025 biennium. The evaluation domains focused on understanding two areas: 1) system-wide organizational structures for PHM and 2) implementation of Oregon's public health accountability metrics.

Evaluation domain: System-wide organizational structures

The evaluation question for public health system-wide organizational structures domain was:

- How do the system-wide structures around public health modernization facilitate and prevent progress and subsequent impact of the investment?

FOCUS GROUPS WITH LPHAS, OHA PHD, PHAB AND CBOS

A total of eight virtual focus groups were conducted via Microsoft Teams between May and June 2024. Four virtual focus groups were held with LPHAs conducted by size band. One focus group was conducted with each of the following groups: CBOs, OHA PHD staff, OHA PHD Director's office and PHAB. Three additional key informant interviews lasting one hour each were conducted with CBOs to expand CBO representation beyond the I-5 corridor.

Question development for five separate focus group guides occurred from December 2023 through April 2024. Focus group questions were developed with the Evaluation Working Group, while the Evaluation Technical Panel reviewed and provided guidance. Recruitment for focus group participants occurred through an invitation sent to all LPHA administrators by size band, key OHA PHD program staff and OHA PHD Director's Office staff, PHAB members and to CBO grantees.

All focus groups were 90 minutes in length and consisted of three to five participants each. Participants received the focus group questions one week in advance. All virtual focus groups were recorded with participant verbal consent. Participants were encouraged (but not required) to turn on their video cameras.

Participants were asked to respect the privacy of other focus group members by not disclosing any content discussed. Finally, participants were informed that their responses would remain confidential and no names would be included in any reporting.

Microsoft Teams recordings were automatically transcribed and data were manually cleaned for analysis. Three evaluation team members independently reviewed all transcripts using thematic analysis that identified initial codes. Key themes and sub-themes were then analyzed.

These themes were organized and interpreted within the context of the evaluation question for this domain:

- Views of public health modernization and implementation over time
- Staffing, workload and workplans are organized around PHM
- Understanding of expectations for modernization funding
- How PHM funding has grown capacity in the foundational capabilities and programs
- Understanding participant voice in PHM decision making
- Aligning PHM requirements and activities across partners that support this work
- Existing opportunities to advance collaboration and intentional alignment of efforts as a result of the modernization funded workforce
- Ways in which resources are shared with partners to benefit community in modernization work

Evaluation domain: Implementation of accountability metrics

There were two primary evaluation questions in this domain:

- What facilitates and prevents progress on Oregon's Public Health Accountability Metrics process measures and corresponding activities in different parts of the state through LPHAs and OHA PHD?
- How is your work towards accountability metrics advancing health equity?

The evaluation team used a mixed methods approach to answer the evaluation questions in this domain. Data sources included: 1) 2024 Oregon LPHA Accountability Metrics Process Measures Survey, 2) OHA PHD process measures reporting, 3) focus groups with local public health and state public health staff with content expertise in environmental health, immunizations and syphilis and 4) case studies highlighting the activities of two LPHAs.

2024 OREGON LPHA ACCOUNTABILITY METRICS PROCESS MEASURES SURVEY

LPHAs reported on public health accountability metrics priority areas, process measures and corresponding activities for the biennium through a survey on the climate impacts on health and immunizations priority areas, respectively. The LPHA accountability metrics workgroup and OHA PHD program staff developed the survey with subject matter expertise in environmental health and immunizations. OHA PHD Director's Office administered the survey via Smartsheet from June 3 to July 8, 2024. Data were transferred to R for further analysis.

2024 OHA PHD ACCOUNTABILITY METRICS PROCESS MEASURES REPORTING

OHA PHD sections reported on state public health accountability metrics process measures for the biennium. Data were reported to the OHA PHD Director's Office between July and September 2024.

FOCUS GROUPS WITH OHA PHD AND LPHA STAFF

A total of four virtual focus groups were conducted via Microsoft Teams between August and September 2024, each having four to five participants and lasting a total of 1.5 hours. There were three LPHA focus groups, with one for each accountability metrics priority: 1) immunizations, 2) climate impacts on health and 3) syphilis. The fourth focus group consisted of OHA PHD staff across all three accountability metrics priority areas.

Question development for two focus group guides occurred from March 2024 to August 2024. Focus group questions were developed with the Evaluation Working Group, while the Evaluation Technical Panel reviewed and provided guidance.

Recruitment for focus group participants occurred through an invitation sent to all LPHA administrators and select OHA PHD program staff who work on the accountability metrics. Focus groups were organized to help ensure each group represented various LPHA size bands, geographic regions and accounted for LPHA participation in the organizational structures focus groups. All participants received focus group questions approximately one week in advance.

All virtual focus groups were recorded with participant verbal consent. Participants were encouraged (but not required) to turn on their video cameras. Participants were asked to respect the privacy of other focus group members by not disclosing any content discussed. Finally, participants were informed that their responses would remain confidential and no names would be included in any reporting.

Microsoft Teams recordings were automatically transcribed and data were manually cleaned for analysis. Two evaluation team members independently reviewed all transcripts using thematic analysis that identified initial codes. Key themes and sub-themes were then analyzed. These themes were organized and interpreted within the context of the following evaluation questions areas:

- Factors that impact progress on the accountability metrics process measures and activities
- Supports needed to engage in policy-related work
- Combinations of funding that support programs or projects aligned with the accountability metrics
- Strategy to support this work until 2030 and how do it will change over time
- How the PHM funding received advances health equity practices relative to the accountability metrics and process measures
- How modernization work connected to the accountability metrics is completed while focusing specifically on cultural and linguistic relevancy
- Activities done to increase trust with new partners/demographics/communities
- Types of equity and/or trauma informed training that staff receive

Case studies with Lincoln and Multnomah Counties

"PREVENTING THE PREVENTABLE: LINCOLN COUNTY PUBLIC HEALTH DIVISION INCREASES IMMUNIZATION RATES AND REDUCES THE SPREAD OF SYPHILIS"

Mixed methods include: 1) document review, 2) four one-hour key informant interviews and 3) use of data from Oregon's 2024 LPHA Accountability Metrics Process Measures Survey. Data collection and document review took place from April to November 2024. Activities that demonstrated actions towards advancing health equity and spanned multiple of the seven public health foundational capabilities were highlighted. A draft of the case study content was provided to Lincoln County Public Health, the Evaluation Working Group and the Evaluation Technical Panel. Feedback from these groups was incorporated into the final case study.

Document review

Documents that demonstrated work towards the accountability metrics were gathered from Lincoln County and OHA PHD, then reviewed by the evaluation team. These documents listed below included workplans, dashboard data, presentations, brochures, meeting notes and survey results.

- LPHA Accountability Metrics Process Measures Survey responses for Lincoln County
- Syphilis accountability metrics process measure reporting
- Public Health Modernization Workplan 2023-25 for Lincoln County
- Scans from the performance management system "AchieveIt" of real time vaccination status or tracking of vaccinations, including long-term care facilities, senior centers and other Lincoln County partners
- AchieveIt Simplified Workplan
- Rapid Community Assessment PowerPoint presentation
- Immunization Outreach After Action Report 2023-2024
- STI pamphlets, available in English and Spanish
- Quarterly Provider Newsletter (January edition)
- Harm Reduction PowerPoint presentation
- Harm Reduction Kit ingredients (one pagers for four different kits)
- Opioids Overdose Outreach PowerPoint presentation
- Position descriptions for public health modernization-funded positions

Key informant interviews

Four key informant interviews were conducted with partners in Lincoln County. Interviews were held with: 1) the Lincoln County Public Health (LCPH) director, 2) the LCPH disease prevention project manager, 3) the sergeant at the Lincoln County Jail and 4) an LCPH public health nurse who provides syphilis testing and harm reduction outreach. Interviews were between a half hour to one hour in length.

Activity selection and review

The evaluation team selected activities to highlight in this case study based on relevance to the public health accountability metrics and how the actions made advancements in health equity. The selected activities each involve intentional outreach to historically underserved communities after incorporating lessons learned from the COVID-19 pandemic. Selected activities were organized by the foundational capabilities.

"RISING TEMPERATURES, RISING SOLUTIONS: MULTNOMAH COUNTY HEALTH DEPARTMENT BUILDS RESILIENCE AGAINST EXTREME HEAT"

Mixed methods included: 1) key informant interview with Wood Village leadership, 2) ongoing discussions with staff from the Multnomah County Health Department and Multnomah County Department of County Human Services, 3) document review and 4) review of Oregon's 2024 LPHA Accountability Metrics Process Measures Survey.

Data collection and document review took place from April to November 2024. Activities that demonstrated actions towards advancing health equity and spanned multiple of the seven public health foundational capabilities were highlighted. A draft of the case study content was provided to Multnomah County Health Department, the Evaluation Working Group and the Evaluation Technical Panel. Feedback from these groups was incorporated into the final case study.

Document review

The evaluation team gathered and reviewed documents that demonstrated work towards the accountability metrics from Multnomah County Health Department and OHA PHD. These documents (listed below) include reports, communication products, presentations and survey results.

- LPHA Accountability Metrics Process Measures Survey responses for Multnomah County
- Heat Vulnerability Index
- Climate Justice Framework
- Tri-County Heat Mapping Campaign
- Heat Watch Report Summary
- CAPA Jurisdictional Scan
- Regional Climate and Health Monitoring Report
- Climate Litigation Against Big Oil documents
- Community health worker (CHW) Climate Resilience Training
- Summer 2023 Health Impact Report
- Schools as Community: Cleaner Air and Cooling Center Report
- Environmental Justice Zine
- Help for When It's Hot website
- Cooling Center Interactive Map
- Cooling Kit Pilot Program
- Cooling Resource Library information

Key informant interviews

Key informant interviews were conducted with partners in Multnomah County. Interviews were held with; 1) City of Wood Village representatives Greg Dirks, Jairo Rios-Campos and Caroline Hinders, 2) Multnomah County Department of County Human Services program specialist Eron Riddle and 3) Multnomah County Health Department research evaluation analyst Abe Moland.

Interviews were between a half hour to one hour in length. Ongoing discussions with staff from Multnomah County Health Department and Multnomah County Department of County Human Services also occurred.

Activity selection and review

The evaluation team selected activities to highlight in this case study based on relevance to the public health accountability metrics and how the actions made advancements in health equity. The selected activities each involve intentional outreach to historically underserved communities after incorporating lessons learned from the COVID-19 pandemic. Selected activities were organized by the foundational capabilities.

Limitations

Please consider the following limitations when reviewing this work.

LPHAs self-reported process measures and associated activities for their respective priority areas. LPHAs were only required to report on a single activity per selected process measure, though many decided to report on more than one. As such, this data may under-represent all activities being conducted by LPHAs in the accountability metrics priority areas. Data represent local and state health department activities as perceived by those entities and do not represent the views of the recipients of those activities.

Focus groups results conducted across both evaluation domains represent only the individuals who participated and do not represent opinions of the wider OHA PHD, the OHA PHD Director's Office, LPHAs, CBOs or PHAB. Space constraints restricted focus group participation to a single representative from each LPHA and CBO.

A few participants had last-minute conflicts and were unable to join their scheduled focus group. Several focus group participants from the Public Health Division work in programs that do not directly receive PHM funds, yet were engaged in broader modernization related work. Greater representation of non-participant (i.e., not receiving modernization funds) voice should be considered another limitation.

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