Health, Housing & Human Services
CLACKAMAS COUNTY

Mary Rumbaugh
Director

December 4, 2025 BCC Agenda Date/Item: _____

Board of County Commissioners
Acting as the Board of Health
Clackamas County

Approval of the Public Health Modernization Plan for submission to the Oregon Health Authority. Plan implementation funding is through federal, state and other grants, as well as $2,791,836 of budgeted County General Funds.

Previous Board Action/Review	Policy Session: Public Health Modernization Plan, November 4, 2025		
Performance Clackamas	Public Trust in Government Healthy People		
Counsel Review	NA	**Procurement Review**	NA
Contact Person	Kim La Croix	**Contact Phone**	971-806-0004

EXECUTIVE SUMMARY: At the November 4, 2025, policy session, the Board of County Commissioners—acting as the Board of Health—voted to move the Public Health Modernization Plan forward to a future Business Meeting for final approval and submission to the Oregon Health Authority.

ORS 431.003(3) states that the Local Public Health Authority (LPHA) is the county government, and the "governing body" of an LPHA is the governing body of a county or a Board of Health.

As required by ORS 431.413(1)(c), each LPHA must adopt and implement a public health modernization plan by December 31, 2025. The modernization plan states how Public Health will apply the foundational capabilities established under ORS 431.131, implement the foundational programs established under ORS 431.141, and provide details on any other local public health program or activity that Public Health considers necessary to protect public health and safety.

As required by ORS 431.415(1)(d), the LPHA must review and provide recommendations on the plan prior to submitting it to the Oregon Health Authority (OHA).

For Filing Use Only

RECOMMENDATION: Staff respectfully request that the Board of County Commissioners approve the Public Health Modernization Plan.

Respectfully submitted,

Mary Rumbaugh

Mary Rumbaugh
Director of Health, Housing, and Human Services

Clackamas County Public Health Division Modernization Plan 2025-2030

Introduction

The Clackamas County Public Health Division (CCPHD) developed this Modernization Plan to strengthen the infrastructure, workforce, and systems necessary to deliver core public health services to all residents. This plan fulfills the requirements of ORS 431.413 (1)(c) and aligns with the Oregon Health Authority's Public Health Modernization Framework, delineating the foundational capabilities and programs vital to an effective and equitable local public health system.

Public health is prevention. Every day, CCPHD protects the health and safety of Clackamas County residents, ensuring safe food and water, controlling disease, preparing for and responding to emergencies, and promoting lifelong health. This plan advances those efforts by building the infrastructure, data systems, and workforce necessary to sustain high-quality, equitable services across diverse communities. This plan is also a commitment to keep improving, listening, and adapting. It is a living document that will evolve through continuous evaluation, collaboration with our partners, and engagement with the people of Clackamas County.

Plan Development and Partner Engagement

Plan development was a collaborative effort that engaged CCPHD programs, county agencies, clinical and community partners, and regional systems. A key foundation for the strategies in this plan are from the Healthy Columbia Willamette Collaborative (HCWC) - a regional public-private partnership spanning Clackamas, Multnomah and Washington counties in Oregon and Clark County in Washington. HCWC's community health assessments and regional planning work shaped CCPHD's modernization priorities, grounding them in shared data, community needs, and regional collaboration.

Governance and Adoption

The Board of County Commissioners (BCC) serves as the governing body of the Local Public Health Authority, providing oversight and recommendations to ensure alignment with county priorities and accountability standards.

Funding and Sustainability

Modernization is enabled by a combination of federal, state, local, and Medicaid revenue sources. While many funds are categorical or time-limited, each plays a role in sustaining core public health infrastructure and service delivery:

- Federal Sources: Include CDC funding (e.g., PHEP, immunization), USDA support for WIC, and other federal public health grants.
- State Sources: Include OHA Public Health Modernization funds and funding through the various program elements.
- Local Funds: Include county general funds, Coordinated Care Organizations (CCO) partnerships, licensing/inspection fee revenue, and local contracts. These flexible sources support workforce, infrastructure, and bridging functions.
- Medicaid: Reimbursement for preventive clinical services delivered through Nurse Home Visiting.

Together, these revenue streams sustain the infrastructure, workforce, and data systems that position CCPHD to deliver high-quality, equitable, and resilient public health services for all residents of Clackamas County.

Accountability and Monitoring

CCPHD's modernization efforts are guided by three overarching goals:

1. Sustain funding and workforce capacity to deliver high-quality, equitable public health services.
2. Strengthen partnerships with community members and organizations to advance shared health priorities.
3. Improve systems performance through accountability, evaluation, and continuous quality improvement.

To achieve and monitor these goals, CCPHD uses a structured performance management approach grounded in Oregon's Public Health Accountability Metrics and the findings of the 2016 and 2024 Public Health Modernization Cost and Capacity Assessments. These statewide metrics serve as the foundation for measuring success in key areas, including:

- Reducing congenital syphilis and transmission of syphilis;
- Protecting residents from vaccine-preventable diseases; and
- Reducing health impacts from climate-related hazards such as extreme heat and wildfire smoke.

CCPHD is building a comprehensive performance management system that integrates quantitative data, evaluation, and continuous quality improvement. Each Foundational Capability and Program includes deliverables that are reviewed quarterly, enabling leadership to assess progress, identify gaps, and direct resources accordingly. Data are drawn from state and local systems, including ALERT, EPIC, ORPHEUS, WIC, and Performance Clackamas.

Progress and outcomes are reviewed annually with the Public Health Advisory Council (PHAC) and shared with the BCC to ensure transparency and accountability. The plan itself will be reviewed and updated on an annual basis, or more frequently as policy, funding, or system changes require, to ensure continued alignment with both local priorities and OHA's accountability framework. Together, these processes ensure that modernization is not a one-time effort but an ongoing cycle of improvement that is grounded in data, informed by community voice, and accountable to the residents of Clackamas County.

How to Use this Plan

This plan is organized around the foundational components that define an effective, equitable, and resilient local public health system. It shows how CCPHD is building and sustaining the capabilities and programs needed to protect health, prevent disease, and promote well-being for all Clackamas County residents.

Foundational Capabilities

Core functions that enable every public health program to operate effectively:

1. Leadership and Organizational Competencies
2. Health Equity and Cultural Responsiveness
3. Community Partnership Development
4. Assessment and Epidemiology
5. Policy and Planning
6. Communications
7. Emergency Preparedness and Response

Foundational Programs

Essential services that directly protect and promote the health of residents:

1. Communicable Disease Control
2. Prevention and Health Promotion
3. Environmental Health
4. Access to Clinical and Preventive Services

Each section includes the following components:

Section Element	Description
Cost and Capacity	Resource needs drawn from the 2024 Public Health Modernization Cost and Capacity Assessment.
Deliverables	Tangible outputs and milestones that demonstrate accountability and impact.
Implementation to Date	Major accomplishments, innovations, and partnerships demonstrating progress.
Priorities for Full Implementation	Key actions required to meet statewide modernization standards and sustain capacity, as outlined in the Public Health Modernization Manual (2017).

Barriers and Challenges	Current constraints related to funding, workforce, and systems alignment.

Each section includes an assessment of both Expertise (knowledge, skills, education, and experience) and Capacity (staff and other resources required to implement the role, capability, or program).

Expertise	Description	Capacity	Description
Absent (1)	No or basic awareness of the expertise, but limited ability to apply it.	**Absent (1)**	Staff time and other resources are not present or are largely unavailable.
Basic (2)	Knowledge of the expertise and can apply it at a basic level.	**Minimal (2)**	Some staff time and/or other resources are present to complete basic functions.
Proficient (3)	Expertise is available and can be applied adeptly.	**Moderate (3)**	Most staff time and other resources are present to partially implement most functions.
Expert (4)	Expertise is routinely applied and those with the expertise can build it within others.	**Full (4)**	Sufficient staff time and other resources are present to fully implement all functions.

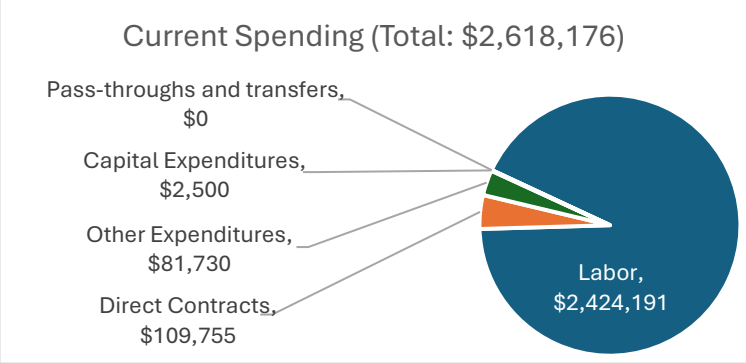
An implementation score is calculated from adding the Expertise and Capacity numerical scores.

Score	Implementation Level
2-3	Minimal
4-5	Limited
6	Partial
7-8	Significant

Leadership & Organizational Competencies

Roles	Deliverables
Leadership and governance	Evidence of engagement in health policy development, discussion, and adoption with PHD to define a strategic direction for public health initiatives
	Evidence of engagement with appropriate governing entities about public health's legal authorities and what new legislative concepts, laws, and policies may be needed.
Performance management, quality improvement, and accountability	Implementation of a performance management system to monitor achievement of and accountability for public health objectives using a nationally recognized framework and quality improvement tools and methods
Human resources	Assessment of staff competencies; provision of training and professional development opportunities
Information technology	Operation and maintenance of interoperable information technology that meets current and future public health practice needs
	Training and technical support plan for users of local public health technology systems and technology resources
Financial management, contracts and procurement services, facility operations	Policies and procedures in place to protect personally identifiable and/or confidential health information

Current Spending	Cost of Full Implementation	Over/Short
$2,618,176	$3,918,825	$1,300,649
Current FTE	**Needed FTE**	**Over/Short**
17.65	20.33	2.68
Expertise	**Capacity**	**Implementation**
Proficient	Minimal	Limited



Overview

- An additional 2.68 FTE and $1,300,649 annually are needed to fully implement this capability
- Significant implementation is currently not possible based on budgets and staffing. Attainable expertise, capacity, and implementation goals for this capability are:
  - Proficient expertise
  - Minimal capacity
  - Limited implementation
- Service Delivery
  - This capability is implemented through LPHA staff
  - No other agencies or partners are responsible for providing this service
  - 100% delivered by CCPHD

Implementation to date

Leadership and governance

- *Evidence of engagement in health policy development, discussion, and adoption with PHD to define a strategic direction for public health initiatives.*
  CCPHD engages OHA through standing meetings, consultation sessions, and active participation in the Conference of Local Health Officials (CLHO) committees such as Systems & Innovation and Communicable Disease. These venues provide a structured forum to share local perspectives on statewide priorities, funding models, and implementation strategies, ensuring that Clackamas County's needs are reflected in state policy development.
- *Evidence of engagement with appropriate governing entities about public health's legal authorities and what new legislative concepts, laws, and policies may be needed.*
  CCPHD works with the Board of County Commissioners and County Counsel to interpret and exercise public health authorities (e.g., orders, enforcement mechanisms, emergency powers, data sharing), ensuring local policies are clear, lawful, and implementable.

  Through CLHO committees, CCPHD collaborates with peer LPHAs and PHD to surface authority gaps, share implementation lessons, and shape joint recommendations on topics such as enforcement tools, funding stability, cross-jurisdictional coordination, and data access.

  CCPHD brings policy and authority topics to the Public Health Advisory Council (PHAC) for community input, using PHAC meetings to review draft policies, discuss ethics (access, privacy, feasibility), and gather recommendations before advancing concepts.

Performance management, quality improvement, and accountability

- *Implementation of a performance management system to monitor achievement of and accountability for public health objectives using a nationally recognized framework and quality improvement tools and methods*
  The CCPHD Performance Management plan specifies the use of domain 9 from PHAB 2022 Standards and Measures as the foundation of our performance management system. CCPHD is currently building a new Power BI dashboard to house its measures on SharePoint. The Quality Improvement Plan identifies the Plan, Do, Check, Act (PDCA) cycle as the Division's defined improvement process along with various other QI tools to use throughout a PDCA cycle.

Human Resources

- *Assessment of staff competencies; provision of training and professional development opportunities*
  CCPHD participated in the 2024 Public Health Workforce Interests and Needs Survey (PHWINS), providing an updated baseline for self-assessed competencies and training needs. This data will prioritize training and professional development needs for staff. CCPHD adopted the 2025-2028 Workforce Development Plan in April 2025. Staff prioritized strategies for the first phase of implementation that include classification and compensation reviews, building career pathways, having supportive workplace policies/practices, succession planning, and technology training needs. Staff have been actively working to address these prioritized goals in FY205-2026.

  CCPHD maintains a role-based competency framework that links each position to the knowledge, skills, and abilities required for reliable service delivery. Supervisors complete an annual performance review with staff. Assessments draw on multiple inputs: performance check-ins, direct observation, optional 360 performance review inputs, case review, and QA/QI findings, which result in targeted development goals. Professional development is delivered through a mixed model: required core trainings (equity and cultural responsiveness, risk communication, ICS/NIMS, HIPAA, and safety), job-specific skills, and elective learning tied to growth plans. CCPHD uses short, modular trainings, protected time for cross-training, mentoring/shadowing to maintain surge coverage, succession planning, and an internship program that develops supervisory skills for staff-level employees. Completion is tracked in the learning system (Brainier), and division leadership reviews participation as part of the annual performance cycle.

Information technology

- *Operation and maintenance of interoperable information technology that meets current and future public health practice needs*
  CCPHD uses SharePoint as its primary platform for documents and lists, organized under hub sites so teams can find, co-author, and retain content consistently. OneDrive allows for cloud-based document sharing and Power BI extend this environment so staff can embed live dashboards in SharePoint pages to track program KPIs and day-

to-day operations. CCPHD Epidemiologists also use Tableau for advanced visualization and for sharing selected public health data internally and with partners.

Program teams maintain and use program-specific databases (e.g., disease surveillance, maternal/child health, environmental health/inspections, outreach tracking) and approved data analysis software (e.g., R/Python or statistical packages) to clean, link, and analyze data; outputs are documented and, when appropriate, promoted to certified datasets that feed Power BI and Tableau. Interoperability and privacy are supported through data-sharing agreements, role-based access, and small-cell suppression for public views.

- *Training and technical support plan for users of local public health technology systems and technology resource*
  Staff receive role-based onboarding for SharePoint/OneDrive, Power BI, Tableau, and County-approved data analysis tools. As a part of the 2025-2028 Workforce Development Plan, staff voted to prioritize the objective: *Increase knowledge and utilization of available technology/systems/work tools for self-organization and project management.* The Workforce Development Coordinator and Performance Management Coordinator have identified training topics and outlined learning objectives for development into training materials. Barriers to completion include competing Division priorities and staff capacity.

Financial management, contracts and procurement services, facility operations

- *Financial management, contracts & procurement, facility operations*
  CCPHD reviews budgets every month and shares notes in SharePoint so program leads know where things stand and what needs attention. CCPHD follows county purchasing rules and County Counsel reviews all contracts. Public Health clinics, offices, and mobile services are kept safe and accessible. Vehicles and outreach equipment are maintained on schedule and deployed as needed to reach both urban and rural communities.

- *Policies and practices to protect personal and confidential health information*
  CCPHD limits access to sensitive information to staff who need it for their work and uses secure systems for storing and sending it (e.g., Epic). Public Health follows set timelines for keeping and disposing of records, and staff complete privacy and security training at hire and annually. When data must be shared, CCPHD uses written agreements that specify what is shared, why it is needed, and how it will be protected. Contractors are held to County security standards.

Priorities in order to achieve full implementation

- Institutionalize workforce development practices initiated in FY2025–2026, ensuring structured coaching and training programs for all staff.
- Strengthen the leadership pipeline by identifying and preparing emerging leaders through mentorship and cross-functional projects.
- Complete implementation of a division-wide QI cycle using a small, stable set of indicators reviewed quarterly.
- Leverage the new Power BI dashboard on SharePoint to track key performance measures and operational metrics in real time.
- Integrate performance management principles from PHAB 2022 standards into daily operations.

Barriers and challenges towards full implementation

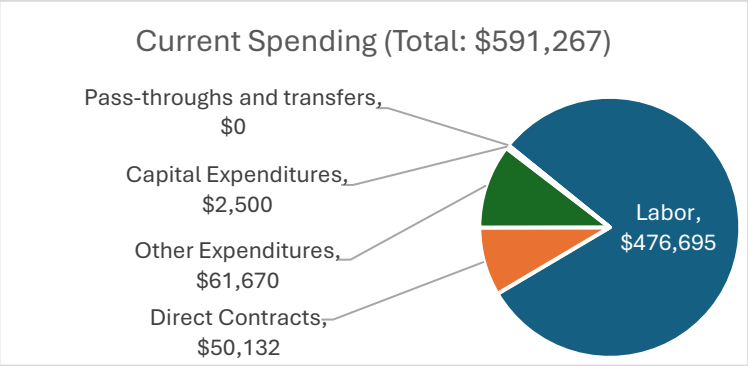
Across all areas, CCPHD's most persistent constraints are funding volatility and categorical restrictions, limited staffing capacity, and the ongoing need to recruit and retain a skilled public health workforce, especially one that reflects the diversity of Clackamas County. Siloed funding and program elements, paired with differing requirements from local, state, and federal funders, create competing directives that complicate long-range planning and consistent service delivery. These pressures stretch existing staff and crowd out time for training, cross-coverage, and quality improvement. Addressing these systemic constraints is essential to fully implement organizational plans and sustain high-quality services. Specific challenges that are relevant to this section include the following:

- Limited leadership capacity and competing operational demands constrain time for strategic planning and program development.
- Performance management and QI systems remain in early implementation stages, with uneven data integration and analytic capacity.
- Workforce recruitment and retention challenges, combined with limited protected training time, hinder progress on the Workforce Development Plan.
- Fragmented data systems and constrained IT support slow modernization efforts, while categorical funding and complex procurement processes limit flexibility to invest in cross-cutting infrastructure.

Assessment & Epidemiology

Roles	Deliverables
Data collection and electronic information systems	No local deliverable.
Data access, analysis, and use	Vital records reports.
Respond to data requests and translate data for intended audience	Summaries of: i. Disease occurrence, outbreaks, and epidemics; ii. The impact of public health policies, programs, and strategies on health outcomes, including economic analyses, when appropriate; iii. Key indicators of community health, which include information about upstream or root causes of health; iv. Leading causes of disease, injury, disability, and death, which include information about health disparities; and v. Analyses of statewide surveys on health attitudes, beliefs, behaviors and practices.
Conduct and use basic community and statewide health assessments	Community health assessment developed within the past five years
	Demonstrated use of data to inform annual updates to community health improvement plan
Infectious disease-related assessment	Documentation of capacity to interact with the State Public Health Lab on a 24/7 basis

Current Spending	Cost of Full Implementation	Over/Short
$591.267	$1,468,735	$877,468
Current FTE	**Needed FTE**	**Over/Short**
3.93	8.10	4.17
Expertise	**Capacity**	**Implementation**
Basic	Minimal	Limited



Overview

- An additional 4.17 FTE and $877,468 annually are needed to fully implement this capability
- Significant implementation is currently not possible based on budgets and staffing. Attainable expertise, capacity, and implementation goals for this capability are:
  - Proficient expertise
  - Minimal capacity
  - Limited implementation
- Service Delivery
  - This capability is implemented through LPHA staff and contracted services
  - Healthy Columbia Willamette Collaborative (HCWC) and Health Management Associates partially deliver this service
  - 86% delivered by CCPHD

Implementation to date

Data access, analysis, and use

- *Vital records reports*
  Vital Records reports and data are accessed through annual reports processed by OHA. These data are analyzed to monitor and detect emerging health trends, including opioid- and suicide-related deaths and infant morbidity and mortality. Analyses also help identify health disparities across race, ethnicity, age, gender, and geographic location. Findings from these reports and analyses inform program delivery methods and support evaluation of how community health initiatives influence mortality trends.

Respond to data requests and translate data for intended audience

- *Disease occurrence, outbreaks, and epidemics*
  - *ESSENCE* – syndromic surveillance to help identify emergency department/urgent care trends and inform emergency response planning, notably during weather-related emergencies, using aggregated data on climate-related health conditions. Data is compiled in an internally shared Tableau dashboard with emergency preparedness staff.

- *The impact of public health policies, programs, and strategies on health outcomes, including economic analyses, when appropriate*
  Data from multiple sources, including emergency medical response (EMS) reports, emergency department (ED) and urgent care visits, vital records and medical examiner reports, electronic laboratory reports, and County-created community surveys, are used to assess the impact of public health policies, programs, and strategies on health outcomes. Data and analyses evaluate influence of opioid and suicide prevention efforts, tobacco prevention and education efforts, and initiatives to expand access to preventive health, particularly through WIC. Data from these sources are analyzed and summarized by County epidemiologists and shared via internal Tableau dashboards and/or written reports. Findings inform adjustments to program service delivery, resource allocation, and community outreach.

- *Key indicators of community health, which include information about upstream or root causes of health*
  County indicators of community health are monitored using data from the U.S. Census Bureau's American Community Survey (ACS), CDC's PLACES dataset, Vital Records reports, Asset Limited, Income Constrained, and Employed (ALICE) reports, and the Healthy Columbia-Willamette Collaborative (HCWC) Community Needs Assessment (CHNA) findings. These large and diverse data sources help to understand broader social, economic, and environmental factors influencing community health. Analyses from these datasets track conditions such as housing stability, income, education, and environmental exposures alongside measures of chronic disease and mortality. Findings are summarized in internally shared dashboards and reports to inform cross-sector strategies that address determinants of health to advance equity across populations.

- *Leading causes of disease, injury, disability, and death, which include information about health disparities*
  Vital Records reports, EMS reports, and ED/urgent care visit data are frequently analyzed to identify and track leading causes of disease, injury, disability, and death in the county. These analyses help detect emerging issues such as trends in opioid-related overdoses, deaths by suicide, and chronic disease mortality. Data are stratified by demographic characteristics such as race, ethnicity, gender, age, and geography, to identify disparities and inform equitable program and policy responses. Analyses are most often shared in internal Tableau dashboards but may vary based on programmatic needs.

- *Analyses of statewide surveys on health attitudes, beliefs, behaviors and practices*
  Survey data from OHA's Student Health Survey is analyzed to understand community health attitudes, beliefs, and behaviors. This robust data source provides insights into youth mental health, substance use, and protective factors. Findings inform school-based interventions and youth-targeted prevention programs.

Priorities in order to achieve full implementation

- Increase access to available data sets (e.g., hospital discharge data) to improve surveillance and comprehensive analysis of disease burden, health disparities, and community health needs
- Support ongoing staff training in epidemiological data analysis, data visualization, GIS, and health equity analysis
- Establish data-sharing agreements with OHA and other local departments and LPHAs, such as the Medical Examiner's Office and tri-county partners, to ensure timely access to data and efficient data-sharing

Barriers and challenges towards full implementation

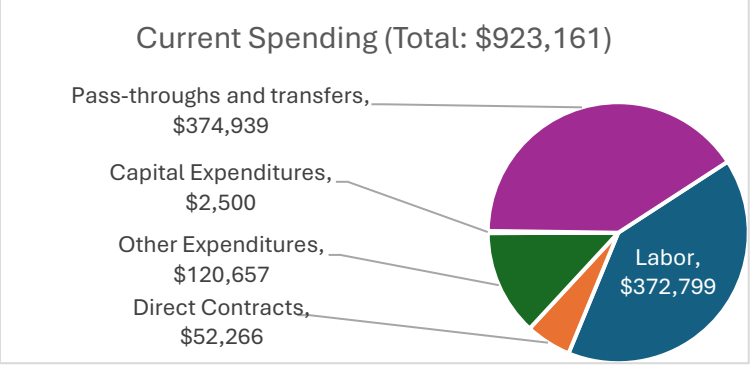
Across all areas, CCPHD's most persistent constraints are funding volatility and categorical restrictions, limited staffing capacity, and the ongoing need to recruit and retain a skilled public health workforce, especially one that reflects the diversity of Clackamas County. Siloed funding and program elements, paired with differing requirements from local, state, and federal funders, create competing directives that complicate long-range planning and consistent service delivery. These pressures stretch existing staff and crowd out time for training, cross-coverage, and quality improvement. Addressing these systemic constraints is essential to fully implement organizational plans and sustain high-quality services. Specific challenges that are relevant to this section include the following:

- Heavy workload prevents staff from dedicating time to expanding surveillance beyond program-specific objectives, such as chronic disease, injury, and disability
- Limited training in advanced analytic methods and tools
- Lack of senior epidemiologist to support, train, and lead team of other epidemiologists
- Limited demographic data and small numbers in subpopulations limit ability to assess disparities

Community Partnership Development

Roles	Deliverables
Identify and develop partnerships	Portfolio of cross-sector partnerships. The portfolio should include a description of partnering organizations, how the partnership supports population health and how the partnership addresses health disparities.
	List of all community partners involved in local and regional health needs, health impact and health hazard vulnerability assessments. The list should include descriptions of partners involved, their roles and contributions to the effort.
	List of all key regional health-related organizations with whom the health department has developed relationships. Documentation of collaborations and corresponding benefits to the public's health in grant progress reports and other summaries of activities.
	List of all local community groups or organizations representing priority populations with whom the local public health authority has developed relationships. Document successes, lessons learned, recognized barriers to collaboration and strategies to overcome these barriers.
	Documentation of training, technical assistance and other forms of support provided to partners.
	Evaluation reports on the effectiveness of community partnerships. Reports should address what is working well, and specific areas where improvement is needed related to communication, identification of shared goals and ability to work together to achieve them.
Engage partners in policy	Documentation of meetings, communications and other efforts to engage communities disproportionately affected by health issues.

Current Spending	Cost of Full Implementation	Over/Short
$923,161	$945,325	$22,164
Current FTE	**Needed FTE**	**Over/Short**
2.94	3.9	.96
Expertise	**Capacity**	**Implementation**
Basic	Minimal	Limited



Overview

- An additional 0.96 FTE and $22,164 annually are needed to fully implement this capability
- Significant implementation is currently not possible based on budgets and staffing. Attainable expertise, capacity, and implementation goals for this capability are:
  - Proficient expertise
  - Moderate capacity
  - Partial implementation
- Service Delivery
  - This capability is implemented through LPHA staff and contracted services
  - Healthy Columbia Willamette Collaborative (HCWC) partially delivers this service
  - 95% delivered by CCPHD

Implementation to date

Identify and develop partnerships

- *Portfolio of cross-sector partnerships. The portfolio should include a description of partnering organizations, how the partnership supports population health and how the partnership addresses health disparities.*
  CCPHD maintains an extensive portfolio of partnerships across public, private, and nonprofit sectors that strengthen population health and address health disparities. A SharePoint-based tracking tool documents more than 160 community partners, including contact information, populations served, and level of engagement. This portfolio - now used by all H3S divisions - facilitates collaboration, improves transparency, and aligns collective efforts to advance health equity countywide.

- *List of all local community groups or organizations representing priority populations with whom the local public health authority has developed relationships. Document successes, lessons learned, recognized barriers to collaboration and strategies to overcome these barriers.*
  CCPHD's partner portfolio includes organizations serving communities of color, LGBTQIA+ residents, older adults, people with disabilities, rural communities, and individuals with low income. The database includes links to partner websites, descriptions of services, and notes on engagement history. The tool will be expanded to document partnership outcomes, lessons learned, and barriers to collaboration, promoting shared accountability and continuous improvement.

- *List of all community partners involved in local and regional health needs, health impact and health hazard vulnerability assessments. The list should include descriptions of partners involved, their roles and contributions to the effort*.

    - **Healthy Columbia Willamette Collaborative (HCWC) Community Health Needs Assessment**
      CCPHD participated in the Community Advisory Group (CAG) for the regional Community Health Needs Assessment (CHNA) with 11 culturally specific and population-focused organizations, including 4D Recovery Center, African Family Holistic Health Organization, Asian Health & Service Center, Black Parent Initiative, IRCO – Greater Middle East Center, Street Roots, Latino Network, Living Islands, NAYA, Oregon Spinal Cord Injury Connection, and Slavic Community Center of NW. The CAG reviewed and refined draft recommendations, completed prioritization surveys, and offered firsthand insights to ensure the CHNA reflects the experiences and priorities of communities most affected by health inequities. CCPHD also led eight rural focus groups in partnership with senior centers in Canby, Estacada, Hoodland, and Molalla, and with Todos Juntos and Clack Co Kids to identify local strengths and barriers in rural areas.

    - **Clackamas County Resilience Collaborative**
      The Resilience Collaborative is a voluntary network of County agencies, community- and faith-based organizations, and regional partners dedicated to strengthening community resilience. Members share information, align projects, explore funding opportunities, and embed resilience principles into local planning. Participants commit time and expertise to advance climate adaptation, disaster preparedness, and equitable recovery strategies for Clackamas County communities.

- *List of all key regional health-related organizations with whom the health department has developed relationships. Documentation of collaborations and corresponding benefits to the public's health in grant progress reports and other summaries of activities.*
  CCPHD maintains strong partnerships with regional healthcare providers and organizations, including Cascade AIDS Project, Clackamas Free Clinic, Clackamas Health Centers, Neighborhood Health Centers, Orchid Health, Outside In, Quest Center, and Sunrise Family Medical. These partnerships expand access to preventive care, testing, vaccination, and treatment for populations at higher risk for health inequities. Key successes include:
    - Establishing a shared 0.5 FTE Public Health Immunization Nurse between CCPHD and Clackamas Health Centers, enabling walk-in immunization access for community members.
    - Implementing a closed-loop electronic referral system to the Oregon Tobacco Quit Line with Clackamas Health Centers, operationalizing "Ask, Advise, Act" interventions and expanding youth cessation services through school-based clinics.

- *Documentation of training, technical assistance and other forms of support provided to partners.*
    - The Suicide Prevention Coordinator and Latine Liaison partnered with Datahs International to deliver suicide prevention webinars in Spanish, later expanding collaboration with the Infectious Disease team.

- The Immunization Coordinator and Eastern European Liaison convened monthly learning collaboratives with OHA-funded Bridge Grantees, promoting best practices, accurate vaccine messaging, and coordination of multilingual health fairs.
- The Tobacco Prevention and Education Program (TPEP) funded seven CBOs to implement culturally specific prevention initiatives and co-hosted a tri-county conference attended by 80 participants from 38 organizations.
- The Substance Use and Overdose Prevention Program provides naloxone, risk-reduction supplies, and technical assistance to community partners. With Northwest Family Services and Todos Juntos, the program developed a Spanish-language naloxone training using popular education methods.
- CCPHD and NAYA (Native American Youth and Family Center) co-developed culturally specific substance use prevention programming centered on self-determination and Indigenous leadership.
- The program also manages opioid settlement community grants, offering grantees evaluation support, peer connections, and problem-solving assistance.
- CCPHD provided 37 letters of support for community-based organizations applying for OHA Health Equity Grants, aligning proposed projects with CCPHD's modernization and equity goals.

- *Evaluation reports on the effectiveness of community partnerships. Reports should address what is working well, and specific areas where improvement is needed related to communication, identification of shared goals and ability to work together to achieve them.*
  In 2025, CCPHD surveyed 48 partner organizations - including community-based groups, healthcare providers, and advocacy agencies - to assess collaboration quality and inclusivity. Results showed strong trust, responsiveness, and shared purpose, along with opportunities to improve accessibility, communication, and compensation for participation. Key recommendations included:
  - Increase accessibility and participation supports (childcare, timing, stipends).
  - Strengthening cultural and linguistic responsiveness.
  - Close the feedback loop by sharing decisions and rationales after engagement.
  - Clarify and elevate CCPHD's Equity Vision.
  - These findings underscore CCPHD's strong foundation of trust while guiding next steps to deepen inclusion and transparency in community partnerships.

Engage partners in policy

- *Documentation of meetings, communications and other efforts to engage communities disproportionately affected by health issues.*
  CCPHD facilitates and participates in recurring meetings with community partners to share information, coordinate initiatives, and advance equitable policy. These meetings foster shared understanding, identify emerging needs, and align cross-sector strategies to improve population health. Regular convenings include:
  - Clackamas Community Alliance (monthly)
  - Mobile Services Collaborative (monthly)
  - Clackamas CBO Connect (bi-monthly)
  - Resilience Collaborative (quarterly)
  - Sexual and Reproductive Health Coalition (bi-monthly)
  - Suicide Prevention Coalition (quarterly)
  - Participation in Prevention Coalition and Housing Services Community Meetings (monthly)

Priorities in order to achieve full implementation

- Strengthening internal and external partnerships with sectors such as education, transportation, parks and recreation, and organizations serving rural communities, people with disabilities, and communities of color to address health inequities.
- Expand use of the H3S Equity Toolkit to formalize culturally specific partnerships, shared decision-making, and resident-led advisory structures.
- Compensate community partners for their contributions to planning, implementation, and evaluation to ensure equitable participation and sustained collaboration.
- Simplify contracting and grant processes for community-based organizations using quality improvement methods to improve access and reduce administrative barriers.
- Establish a formal communication protocol to close the feedback loop after community engagement—summarizing input received, decisions made, and how feedback influenced outcomes.

Barriers and challenges towards full implementation

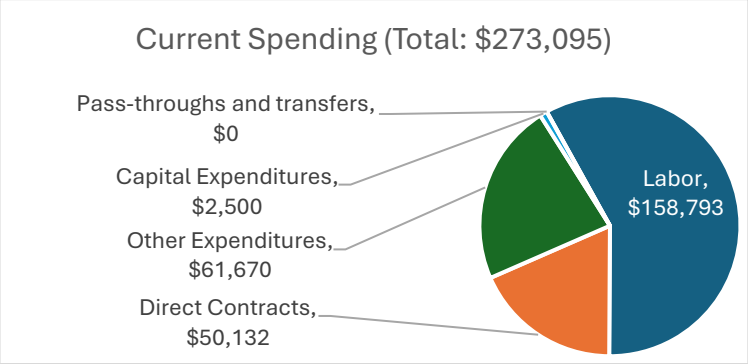
Across all areas, CCPHD's most persistent constraints are funding volatility and categorical restrictions, limited staffing capacity, and the ongoing need to recruit and retain a skilled public health workforce, especially one that reflects the diversity of Clackamas County. Siloed funding and program elements, paired with differing requirements from local, state, and federal funders, create competing directives that complicate long-range planning and consistent service delivery. These pressures stretch existing staff and crowd out time for training, cross-coverage, and quality improvement. Addressing these systemic constraints is essential to fully implement organizational plans and sustain high-quality services. Specific challenges that are relevant to this section include the following:

- Limited staff capacity and funding hinder relationship-building and partner compensation.
- Complex contracting and grant processes create administrative burdens for smaller community-based organizations. Simplifying these systems will require leadership commitment, cross-division coordination, and sustained investment.

Health Equity and Cultural Responsiveness

Roles	Deliverables
Foster health equity	Internal assessment, completed within the previous five years of the local authority's overall capacity to apply a health equity lens to programs and services, provide culturally responsive programming and services, and status of the division's structure and culture as a barrier or facilitator for achieving health equity.
	Action plan that addresses key findings from the internal assessment and includes organizational changes that support a health equity lens and cultural responsiveness. Action plan includes metrics and an accountability structure that identifies responsible work units, tasks, timelines, and performance measures.
	Documentation that demographic data are used to evaluate the impact of public health policies, programs, and strategies on health equity and health outcomes, and to inform public health action moving forward.
	Training plan to increase staff capacity to address the causes of health inequities, promote health equity, and implement culturally responsive programs. Documentation that training is provided to staff annually.
Communicate and engage inclusively	Community health improvement plan, developed within the previous five years, that specifically addresses health equity and cultural responsiveness.

Current Spending	Cost of Full Implementation	Over/Short
$273,095	$594,430	$321,335
Current FTE	**Needed FTE**	**Over/Short**
1.22	3.1	1.88
Expertise	**Capacity**	**Implementation**
Basic	Minimal	Limited



Overview

- An additional 1.88 FTE and $321,335 annually are needed to fully implement this capability
- Significant implementation is currently not possible based on budgets and staffing. Attainable expertise, capacity, and implementation goals for this capability are:
  - Limited implementation
  - Proficient expertise
  - Minimal capacity
- Service Delivery
  - This capability is implemented through LPHA staff and contracted services
  - Conduent, Cascade Aids Project (CAP), CLHO, Healthy Columbia Willamette Collaborative (HCWC), and NW Public Affairs partially deliver this service
  - 95% delivered by CCPHD

Implementation to date

Foster health equity

- *Internal assessment, completed within the previous five years of the local authority's overall capacity to apply a health equity lens to programs and services, provide culturally responsive programming and services, and status of the division's structure and culture as a barrier or facilitator for achieving health equity.*
  ReadySet Solutions Co. (ReadySet) partnered with CCPHD to assess the organization's internal capacity to advance health equity and identify opportunities to strengthen equity-aligned policies, practices, and culture. This engagement was driven by CCPHD's commitment to embed equity more deeply into its operations and to ensure its workforce and systems are positioned to meet the needs of diverse communities.

  To guide this effort, ReadySet used the Bay Area Regional Health Inequities Initiative's Local Health Department Organizational Self-Assessment for Addressing Health Inequities (BARHII Toolkit). The assessment focused specifically on CCPHD's internal documents and centered the voices of both staff and leadership. The goal was to better understand internal strengths, challenges, and gaps in workforce development, organizational culture, health equity infrastructure, and community engagement. Findings summarized in the report are intended to support CCPHD's future planning, development, and resource allocation in service of a more inclusive, equity-centered organization.

- *Action plan that addresses key findings from the internal assessment and includes organizational changes that support a health equity lens and cultural responsiveness. Action plan includes metrics and an accountability structure that identifies responsible work units, tasks, timelines, and performance measures.*
  The Health Equity Action Plan includes SMART objectives that address the findings in the internal assessment. Example: By June 2027, 100% of supervisors and managers will have clarified staff roles and 100% of public health staff will have completed at least one training in community engagement and culturally responsive practice.

- *Documentation that demographic data are used to evaluate the impact of public health policies, programs, and strategies on health equity and health outcomes, and to inform public health action moving forward.*
  The Substance and Overdose Prevention Program uses data to guide rapid response, identify disparities, and target community interventions.
  - Weekly and monthly overdose surveillance reports track spikes, hotspots, shifts in drug supply, and disparities among affected populations. Findings are reviewed in Clackamas Overdose Response (COR) meetings with multidisciplinary partners to coordinate response strategies.
  - Data showing higher overdose rates among Black and American Indian/Alaska Native residents inform CCPHD's partnership strategy, prioritizing funding and collaboration with community-based organizations serving these populations.
  - Using FirstWatch 911 data to locate overdose hotspots, CCPHD developed bilingual door hangers with information on overdose prevention and QR codes linking residents to naloxone and peer support services. In partnership with 4D Recovery, outreach peers distribute materials, deliver supplies, connect residents to services, and collect follow-up feedback.

  The Access to Preventive Health (APH) program uses data to strengthen coordination, streamline referrals, and guide prevention initiatives.
  - APH analyzed referral data to WIC and Nurse Home Visiting (NHV) programs—including provider location, client ZIP code, and pregnancy stage—and shared findings with Federally Qualified Health Centers (FQHCs). The analysis led to a pilot project improving early referrals of pregnant clients through a new EPIC-based referral form. APH staff now enroll new clients and confirm follow-up with providers, resulting in a 16% increase in WIC enrollment of pregnant clients since January 2025.
  - In collaboration with CCPHD Epidemiologists, APH is developing dashboards to align program goals and monitor progress. Dashboards integrate WIC caseload and ZIP code data, immunization rates for NHV clients, and geographic overlays connecting WIC and NHV service areas with Climate & Health initiatives. One shared metric—ensuring pregnant women receive two syphilis tests—advances the division's goal to prevent congenital syphilis.
  - APH launched a Safe Sleep for Infants campaign in October 2025, using data showing alcohol and marijuana are present in most Sudden Unexpected Infant Death (SUID) cases. The campaign and dedicated webpage promote prevention strategies and raise awareness about the connection between substance use and infant sleep safety.

The Tobacco Prevention and Education Program (TPEP) uses data strategically to guide local policy, education, and prevention efforts.

- TPEP reviews Student Health Survey (SHS) data to identify county and district-wide trends in youth use of commercial tobacco and nicotine products. Findings on product types, flavors, and advertising exposure inform policy strategies to reduce youth appeal and access. TPEP uses these data to educate local leaders and support evidence-based policies such as flavored product restrictions, zoning regulations, and retailer density caps.
- TPEP assessed five cities to evaluate readiness for policies that reduce exposure to secondhand smoke and aerosols. The assessment included on-site observations, business and community surveys, and key informant interviews. Results are being used to identify two cities that are most prepared to adopt smokefree or clean air policies and to tailor policy options to each city's context, leadership priorities, and business landscape. Potential strategies include expanding the Indoor Clean Air Act, establishing smokefree downtowns, and restricting indoor public cannabis consumption.
- In partnership with community organizations and the Alcohol and Drug Prevention and Education Program (ADPEP), TPEP completed the Tobacco and Alcohol Retail Assessment (TARA) in June 2025, surveying all 287 Clackamas County retailers. The assessment documents advertising, price promotions, and availability of unregulated substances such as kratom, nitrous oxide, and betel nut, offering critical insight into emerging products and industry tactics. These data are being used to inform policymakers about retail environment trends and to strengthen local protections that reduce youth exposure and access.

- *Training plan to increase staff capacity to address the causes of health inequities, promote health equity, and implement culturally responsive programs. Documentation that training is provided to staff annually.*

CCPHD follows the H3S Strategic Action Plan, which calls for a comprehensive, department-wide equity framework. Goal 2 of the plan - Develop a comprehensive department-wide equity framework - includes six key objectives:

1. Develop and implement an equity lens/toolkit
2. Provide equity training for all employees
3. Establish an H3S Equity Officer position
4. Adopt a department-wide equity policy
5. Conduct an organizational equity assessment
6. Ensure consistent demographic data collection

The H3S Equity Workgroup created an Equity Toolkit and oversees a series of trainings for all staff. A required Foundations course introduces core equity concepts, while optional sessions address topics such as implicit bias, microaggressions, plain language, and trauma-informed practice. By December 2027, 100% of CCPHD employees will have completed at least one of these trainings and demonstrated increased confidence in culturally responsive practice and community partnership.

Public Health leadership has also updated annual performance summary templates to emphasize engagement with culturally diverse communities and accountability for advancing equity and inclusion. This structure aligns staff performance expectations with the Division's health equity goals and ensures continued workforce development in this area.

Communicate and engage inclusively

- *Community health improvement plan, developed within the previous five years, that specifically addresses health equity and cultural responsiveness.*

The 2020 - 2023 Blueprint for a Healthy Clackamas County, approved by the Clackamas County Board of Commissioners in October 2020, serves as the county's Community Health Improvement Plan (CHIP). The Blueprint aims to improve health and quality of life for all residents by advancing equity and addressing the root causes of health disparities. It builds on priorities identified in the Healthy Columbia Willamette Collaborative's 2019 Community Health Needs Assessment and is guided by four principles: racial and health equity, trauma-informed approaches, health across the lifespan, and climate-conscious strategies.

Priorities in order to achieve full implementation

- Partner with communities to address the root causes of health inequities.
- Provide training for the Public Health Advisory Council, community-based organizations, and residents to effectively engage in the legislative process and advocate on issues affecting health—such as climate, housing, education, transportation, and the economy.

- Establish community resiliency hubs with trusted partners to serve as safe, multilingual resource centers for older adults, LGBTQIA+ individuals, rural residents, and diverse communities, reducing isolation and strengthening climate preparedness.
- Strengthen the Traditional Health Worker (THW) network through regional collaboration to expand culturally and linguistically responsive care and connect underserved populations—including those with disabilities and immigrant or refugee backgrounds—to resources.
- Formalize language access protocols and implement a cultural review process for all public-facing materials to ensure representation and relevance.
- Apply the H3S Equity Toolkit consistently so community voices guide program design, service delivery, and event planning.
- Expand mobile services with community partners to reach underserved areas of the county.

Barriers and challenges towards full implementation

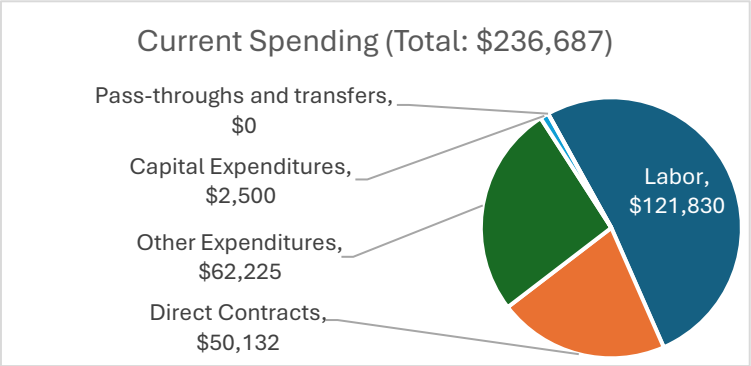
Across all areas, CCPHD's most persistent constraints are funding volatility and categorical restrictions, limited staffing capacity, and the ongoing need to recruit and retain a skilled public health workforce, especially one that reflects the diversity of Clackamas County. Siloed funding and program elements, paired with differing requirements from local, state, and federal funders, create competing directives that complicate long-range planning and consistent service delivery. These pressures stretch existing staff and crowd out time for training, cross-coverage, and quality improvement. Addressing these systemic constraints is essential to fully implement organizational plans and sustain high-quality services. Specific challenges that are relevant to this section include the following:

- Initiatives such resource/resiliency hubs and mobile services are on hold until additional funding becomes available.

Policy and Planning

Roles	Deliverables
Develop and implement policy	Current community health improvement plan.
	Documentation of community health improvement plan updates provided to the governing body to whom the local health authority is accountable
	Local strategic policy plan
	Documentation of developed and amended rules and regulations.
Improve policy with evidence-based practice	No local deliverable
Understand policy results	Documentation of CHIP updates and information made available to the public.

Current Spending	Cost of Full Implementation	Over/Short
$236,687	$589,563	$352,876
Current FTE	**Needed FTE**	**Over/Short**
0.77	3.0	2.23
Expertise	**Capacity**	**Implementation**
Basic	Minimal	Limited



Overview

- An additional 2.23 FTE and $352,876 annually are needed to fully implement this capability
- Significant implementation is currently not possible based on budgets and staffing. Attainable expertise, capacity, and implementation goals for this capability are:
  - Proficient expertise
  - Minimal capacity
  - Limited implementation
- Service Delivery
  - This capability is implemented through LPHA staff
  - No other agencies or partners are responsible for providing this service
  - 100% delivered by CCPHD

Implementation to date

Develop and implement policy

- *Current community health improvement plan*
  Clackamas County's Community Health Improvement Plan (CHIP), or Blueprint for a Healthy Clackamas County, is available at https://www.clackamas.us/publichealth/reports . CCPHD is preparing to update the CHIP based on the 2025 Community Health Needs Assessment report.

- *Documentation of community health improvement plan updates provided to the governing body to whom the local health authority is accountable*
  The *Blueprint for a Healthy Clackamas County* is a living document reviewed and updated as priorities evolve. The 2020–2023 plan was approved by the PHAC, a board-appointed body that advises on health policy and funding decisions. PHAC reviews Blueprint grants, monitors implementation progress, and includes a liaison from the BCC to ensure alignment with county priorities.

- *Local strategic policy plan*
  Clackamas County Public and Government Affairs (PGA) develops an annual legislative agenda with input from CCPHD on public health priorities. CCPHD will present upcoming policy priorities to PGA, including restrictions on flavored tobacco products, regulation of public swimming pools, climate adaptation, workforce development, and modernization of medical examiner systems.

- *Documentation of developed and amended rules and regulations*
  Environmental Health is collaborating with County Counsel to align County Code with state law, allowing enforcement through citations and fines for non-compliance. Staff regularly participate on OHA Rule Advisory Committees (RACs), including the adoption of the Model Aquatic Health Code (public pools and spas) and the Food Rule update (transition from the 2009 to 2022 FDA Food Code). At least one Environmental Health staff member participates in every RAC opportunity.

  The Tobacco Prevention and Education Program (TPEP) worked with the County Administrator and County Counsel to strengthen the Indoor Clean Air Act on county property. The revised ordinance - Smoking Regulations in and around County Facilities - prohibits smoking inside all county facilities and within 25 feet of entrances, exits, and ventilation intakes. Designated outdoor areas are clearly marked with signage. The regulation protects employee and public health, reduces maintenance costs, and lowers fire risk.

Understand policy results

- *Documentation of CHIP updates and information made available to the public*
  Clackamas County's Community Health Improvement Plan (CHIP), or Blueprint for a Healthy Clackamas County, is available at https://www.clackamas.us/publichealth/reports . The update, informed by the 2025 CHNA led by the Healthy Columbia Willamette Collaborative, will identify new policy priorities. Health indicators, mortality data, and social determinants are regularly presented to the BCC, PHAC, and prevention coalitions to inform decision-making and guide public health planning.

Priorities in order to achieve full implementation

- Develop the CHIP, including a strategic policy plan, based on the 2025 CHNA report
- Develop data dashboards and make them available on CCPHD's website
- Work with decision makers and elected leaders to pass and implement local policies as outlined in the Climate Adaptation Plan and Tobacco Prevention & Education workplan to improve health outcomes.

Barriers and challenges towards full implementation

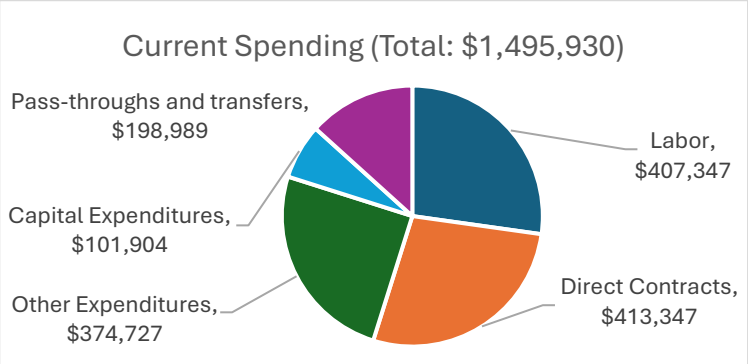
Across all areas, CCPHD's most persistent constraints are funding volatility and categorical restrictions, limited staffing capacity, and the ongoing need to recruit and retain a skilled public health workforce, especially one that reflects the diversity of Clackamas County. Siloed funding and program elements, paired with differing requirements from local, state, and federal funders, create competing directives that complicate long-range planning and consistent service delivery. These pressures stretch existing staff and crowd out time for training, cross-coverage, and quality improvement. Addressing these systemic constraints is essential to fully implement organizational plans and sustain high-quality services. Specific challenges that are relevant to this section include the following:

- Limited Blueprint funding restricts community engagement and data validation efforts.
- Loss of two epidemiologist positions reduces capacity to develop and maintain public dashboards.
- Competing policy agendas and political polarization hinder advancement of key public health initiatives.

Emergency Preparedness and Response

Roles	Deliverables
Prepare for emergencies	Continuity of operations plan for the local public health authority
	Documentation demonstrating planning for emergency preparedness exercises
	Documentation that planned emergency preparedness exercises have been executed
	Public health emergency preparedness plans according to established guidelines
	Plans for the distribution of pharmaceuticals in an emergency
	Approved local ambulance service area plans
Respond to emergencies	Disaster epidemiology reports
	Documented participation in emergency response efforts
	Documentation of enforcement of emergency public health orders.
	Situational assessments and resulting operational plans, including objectives, resources needed and how to resume routine operations
Coordinate and communicate before and during an emergency	Portfolio of community partnerships to support preparedness and recovery efforts
	Documented delivery of health alerts and preparedness communications to partners and the general public

Current Spending	Cost of Full Implementation	Over/Short
$1,495,930	$1,599,892	$103,962
Current FTE	**Needed FTE**	**Over/Short**
2.81	6.3	3.49
Expertise	**Capacity**	**Implementation**
Proficient	Moderate	Partial



Overview

- An additional 3.49 FTE and $103,962 annually are needed to fully implement this capability
- Significant implementation is currently not possible based on budgets and staffing. Attainable expertise, capacity, and implementation goals for this capability are:
  - Proficient expertise
  - Moderate capacity
  - Partial implementation
- Service Delivery
  - This capability is implemented through LPHA staff and contracted services
  - FoneMed partially delivers this service
  - 96% delivered by CCPHD

Implementation to date

Prepare for emergencies

- *Continuity of operations plan for the local public health authority*
  CCPHD collaborates with Clackamas County Disaster Management (CCDM) through the state's COOP platform, *Veoci*, to ensure continuity of essential public health services during emergencies. A Public Health COOP Advisory Group meets quarterly to review and strengthen plans, ensuring alignment with countywide disaster strategies. CCDM provides ongoing support through a dedicated COOP Coordinator who offers monthly trainings, newsletters, and work sessions for COOP coordinators across departments.

- *Documentation demonstrating planning for emergency preparedness exercises*
  CCPHD participates in regional and local preparedness planning with the Public Health Workgroup (PHWG), the Health Preparedness Organization (HPO), and CCDM. Exercises and drills test coordination, communication, and response capacity. Recent examples include planning for the Regional Radiation Community Reception Center, Mass Care Plan, Metro Anthrax Coordination Exercise, and Wildfire Evacuation. Internal drills—such as measles response and Great ShakeOut call-downs through the Everbridge Health Alert Network—build staff readiness. These exercises fulfill CDC-funded PHEP grant requirements (PE-2, PE-12) through OHA, with deliverables tracked via work plans, meeting attendance, and triennial reviews.

- *Documentation that planned emergency preparedness exercises have been executed*
  All completed exercises are documented through After Action Reports (AARs), which summarize objectives, participation, outcomes, and improvement actions. Corrective items are logged into Basecamp by the OHA PHEP Regional Emergency Coordinator (REC) to ensure accountability and follow-up. AARs are available for RADopoly, Radiation CRC, and the Mass Care Plan. Anthrax and Wildfire exercises are currently in development.

- *Public health emergency preparedness plans according to established guidelines*
  Regional Public Health recently aligned its emergency preparedness plans with OHA's modernization framework and CDC's Office of Readiness and Response capabilities (PE-02 and PE-12). The Public Health Base Plan - Support Annex 4 to the County Emergency Operations Plan (EOP) - has been substantially revised and will be publicly available upon completion of the EOP update. Additional plans under development include an Environmental Health Plan and Public Health Preparedness Plan. All core plans (Base, COOP, MCM, and Communications) are reviewed biennially and updated following AAR recommendations.

- *Plans for the distribution of pharmaceuticals in an emergency*
  CCPHD maintains a Medical Countermeasure Dispensing and Distribution (MCMDD) Plan outlining medication distribution for all county residents during a public health emergency. Clackamas County participates in the Cities Readiness Initiative (CRI) and maintains a Medical Reserve Corps for surge staffing. Regional partners, including large employers and long-term care facilities designated as Push Partners, receive training to distribute medications to staff and clients. Clackamas Health Centers serves as a Push Partner to dispense medication to county employees.

- *Approved local ambulance service area plans*
  Under Oregon law, counties must maintain an Ambulance Service Area (ASA) Plan defining emergency medical service delivery, equity standards, and performance metrics. Clackamas County completed its ASA plan update in 2024, outlining ambulance allocation, 911 utilization, and resource coordination to ensure timely, equitable emergency response.

Respond to emergencies

- *Disaster epidemiology reports*
  CCPHD uses Oregon's *ESSENCE* data system to monitor emergency department and urgent care visits related to weather and environmental hazards. Retrospective and real-time data guide targeted alerts and public messaging to populations at greatest risk during extreme weather events. During the August 2025 heatwave, *ESSENCE* data informed coordinated public communications and response planning in the days following the event.

- *Documented participation in emergency response efforts*
  CCPHD documents all Emergency Support Function 8 (ESF-8) activities under the PHEP PE-12 and PE-02 work plans. Recent activations include:
  - July 2024: Extreme heat – Medical Reserve Corps (MRC) on standby for cooling center deployment.
  - August 2024: Wildfires – issued public smoke and air quality communications.

- September 2024: Measles – opened DOC, produced Incident Action Plan and SitStat reports, conducted community outreach.
- October 2024: Marburg monitoring – developed SitStat updates for internal partners.
- October 2024: IV and PD solution shortages – monitored and coordinated with OHA.
- November 2024: Tamiflu workgroup coordination.
- February 2025: Winter weather – activated MRC for medical support at shelters.
- August 2025: Extreme heat – coordinated with Disaster Management on PH response role.

CCPHD collaborates closely with Clackamas County Disaster Management and OHA to maintain readiness and fulfill PE-02 and PE-12 deliverables.

- *Documentation of enforcement of emergency public health orders*
  In October 2024, an H5N1 avian influenza outbreak occurred at a commercial poultry farm in Clackamas County, resulting in Oregon's first confirmed human case. CCPHD worked with OHA to issue a regional quarantine restricting poultry movement and monitored individuals exposed to the infected flock. The Public Health Officer coordinated response activities regionally through the Health Officer Program to meet statutory requirements and protect public health.

- *Situational assessments and resulting operational plans, including objectives, resources needed and how to resume routine operations*
  During emergencies, CCPHD activates its Department Operations Center (DOC) to assess scope, scale, and potential impacts, establishing objectives, identifying resources, and coordinating with County H3S and Disaster Management. The Continuity of Operations Plan (COOP) guides restoration of mission-essential services and transition to normal operations.

  An example occurred during the September 2024 measles response, when CCPHD activated the DOC, produced an Incident Action Plan and Situation Status Report, and conducted staff training on Incident Command System (ICS) protocols. The event doubled as a live exercise to strengthen response coordination and operational readiness.

Coordinate and communicate before and during an emergency

- *Portfolio of community partnerships to support preparedness and recovery efforts*
  CCPHD collaborates with school districts, community-based organizations, and Medical Reserve Corps (MRC) volunteers to deliver emergency preparedness education and multilingual outreach. The Division works regionally with Clackamas County Disaster Management (CCDM) and Clackamas County Voluntary Organizations Active in Disaster (CCVOAD) to coordinate response and recovery efforts, ensuring services are efficient, equitable, and non-duplicative.

- *Documented delivery of health alerts and preparedness communications to partners and the general public*
  CCPHD's Emergency Preparedness Communications Plan aligns with countywide and state systems, including the Crisis and Emergency Risk Communication (CERC) Toolkit. The Public Health Communications Specialist coordinates messaging with PGA. Preparedness communications address all-hazards scenarios and are translated into nine languages—Amharic, Arabic, Korean, Russian, Simplified Chinese, Spanish, Ukrainian, Vietnamese, and English. Multilingual toolkits and social media materials on extreme heat, cold, water safety, and wildfire smoke are shared with community partners for distribution. Emergency preparedness content has also been featured in regional Ukrainian and Russian publications, promoting access to local alert and warning systems.

Priorities in order to achieve full implementation

- Strengthen internal communications through full implementation of the COOP Plan, ensuring managers can coordinate effectively and staff receive timely notifications during emergencies.
- Enhance external communications by delivering timely public alerts and warnings in multiple languages to reach all community members equitably.
- Expand regional training and exercises that promote collaboration, resource sharing, and preparedness across jurisdictions while maximizing limited funding and capacity.

Barriers and challenges towards full implementation

Across all areas, CCPHD's most persistent constraints are funding volatility and categorical restrictions, limited staffing capacity, and the ongoing need to recruit and retain a skilled public health workforce, especially one that reflects the

diversity of Clackamas County. Siloed funding and program elements, paired with differing requirements from local, state, and federal funders, create competing directives that complicate long-range planning and consistent service delivery. These pressures stretch existing staff and crowd out time for training, cross-coverage, and quality improvement. Addressing these systemic constraints is essential to fully implement organizational plans and sustain high-quality services. Specific challenges that are relevant to this section include the following:

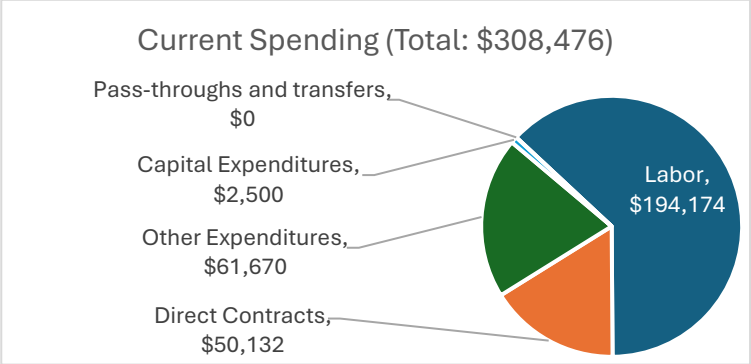
- Limited resources for emergency planning, pharmaceutical distribution, epidemiology, and communications. Insufficient funding for staff training and exercises reduces readiness and operational flexibility.
- Uncertainty in federal guidance from CDC and FEMA, creating ambiguity around evolving preparedness and response expectations.
- Insufficient communication funding, particularly for paid multilingual outreach. This limits the ability to reach underrepresented communities and sustain equitable public trust.
- Information overload and language gaps. The public receives an abundance of English-language preparedness materials from multiple sources but lacks clear, consistent, and translated resources in languages such as Spanish and Ukrainian. Without capacity to adapt and clarify these materials, CCPHD risks duplicating efforts and diminishing impact.

Communications

Roles	Deliverables*
Regular communications	Strategic communications plan that articulates the authority's mission, value, role and responsibilities in its community, and supports department and community leadership to communicate these messages. The strategic communications plan should include high priority issues that require proactive communications with the public.
Emergency communications	Internal communications plan
	Communication products based on the strategic communications plan and risk communication needs that consider the end user and use appropriate format(s) and language(s)
	Communication products that are culturally responsive, incorporate health literacy principles and address varying racial and ethnic backgrounds, geographic locations, and language preferences.
	News releases and public meeting notices
	Policy briefs and other related communications
	Public-facing website with regular updates made to content
	Evidence of two-way communications with the public
	Documentation of annual communications training for any staff beyond the public information officer who communicate with the public about public health issues
	Evidence of two-way communications with PHD
	Evaluation reports on the effectiveness of communications
	Evidence that communications and strategies are adjusted based on evaluation findings
	Communications evaluation plan that is structured around health equity and literacy

*Deliverables for this capability are not associated with a specific role category

Current Spending	Cost of Full Implementation	Over/Short
$308,476	$709,928	$401,452
Current FTE	**Needed FTE**	**Over/Short**
1.43	1.9	0.47
Expertise	**Capacity**	**Implementation**
Proficient	Minimal	Limited



Overview

- An additional 0.47 FTE and $401,452 annually are needed to fully implement this capability
- Significant implementation is currently not possible based on budgets and staffing. Attainable expertise, capacity, and implementation goals for this capability are:
  - Proficient expertise
  - Moderate capacity
  - Partial implementation
- Service Delivery
  - This capability is implemented through LPHA staff and contracted services
  - IZO PR & Marketing partially delivers this service
  - 99% delivered by CCPHD

Implementation to date

- *Strategic communications plan that articulates the authority's mission, value, role and responsibilities in its community, and supports department and community leadership to communicate these messages. The strategic communications plan should include high priority issues that require proactive communications with the public.*
  CCPHD has a strategic communications plan, which is currently being updated based on the CCPHD strategic plan. It articulates the mission, value and role and responsibilities. The updates will include more specific procedures around language access, incorporating community voice into communications and how public health research is utilized for communications.

- *Internal communications plan*
  CCPHD maintains an internal communications plan that outlines risk and crisis communications, internal communications processes and internal communications roles and responsibilities flow chart.

- *Communication products based on the strategic communications plan and risk communication needs that consider the end user and use appropriate format(s) and language(s)*
  CCPHD has created many communications products (social media content, video content, print collateral, communications toolkits, press releases, etc.) based on the priorities in the strategic communications plan in a variety of formats and considering the languages spoken in Clackamas County. This includes risk communications, such as communications about extreme weather.

- *Communication products that are culturally responsive, incorporate health literacy principles and address varying racial and ethnic backgrounds, geographic locations, and language preferences.*
  CCPHD develops culturally responsive communication materials that reflect the diversity of Clackamas County's residents. Products are created with input from community-based organizations and informed by feedback from community liaisons who identify needs at local events. Materials are produced primarily in English, Spanish, Russian, Ukrainian, Vietnamese, and Simplified Chinese - languages most commonly spoken in the county - and occasionally in additional languages as needed. Plain-language principles are applied consistently to ensure accessibility. A key example is the development of targeted, culturally tailored materials for Russian and Ukrainian communities during the 2024 measles outbreak, which improved outreach and trust among affected populations.

- *News releases and public meeting notices*
  CCPHD publishes news releases when needed and has received media coverage of many issues, from rabies exposures to community grants being awarded. Public meetings are published on the website calendar.

- *Policy briefs and other related communications*
  CCPHD has developed policy-related documents, when necessary, such as a public health impact paper on the public consumption of cannabis.

- *Public-facing website with regular updates made to content*
  In 2024, CCPHD completed a comprehensive audit of all public health pages on the Clackamas County website, ensuring accuracy and relevance. Web content is now reviewed and updated regularly, with timely topics featured on the County News page. During public health emergencies, key information is prominently displayed on the county homepage. Current efforts are focused on achieving full ADA compliance to ensure accessibility for all users.

- *Evidence of two-way communications with the public*
  CCPHD has engaged in two-way communications with the public through focus groups, surveys (like a survey of community-based organizations about extreme weather preparedness) and presence at community events.

- *Documentation of annual communications training for any staff beyond the public information officer who communicate with the public about public health issues*
  CCPHD does not currently conduct annual communications training for staff. The communications specialist works with staff on communications training as needed (such as media training, plain language tips, etc.)

- *Evidence of two-way communications with PHD*
  CCPHD worked closely with PHD during the 2024 measles outbreak and has also communicated about other topics, such as avian flu. Staff regularly attend the Disaster Communicators' Community of Practice Meetings.

- *Evaluation reports on the effectiveness of communications*

CCPHD conducts post-campaign evaluations to assess communication effectiveness, using available data such as social media engagement metrics, website traffic, and audience actions taken. These evaluations inform future outreach strategies and help refine messaging for greater impact and reach.

- *Evidence that communications and strategies are adjusted based on evaluation findings*
  Following a survey of community-based organizations on county communications during extreme weather events, CCPHD used the results to strengthen outreach efforts. Findings led to the development and launch of multilingual communications toolkits for both winter weather and extreme heat, improving clarity and accessibility for diverse communities.

- *Communications evaluation plan that is structured around health equity and literacy*
  CCPHD does not currently have a communications evaluation plan.

Priorities in order to achieve full implementation

- Work with Public and Government Affairs and Disaster Management on emergency communications plans with a focus on collaboration with community-based organizations and language access
- Learn about best practices for evaluation and create a communications evaluation plan

Barriers and challenges towards full implementation

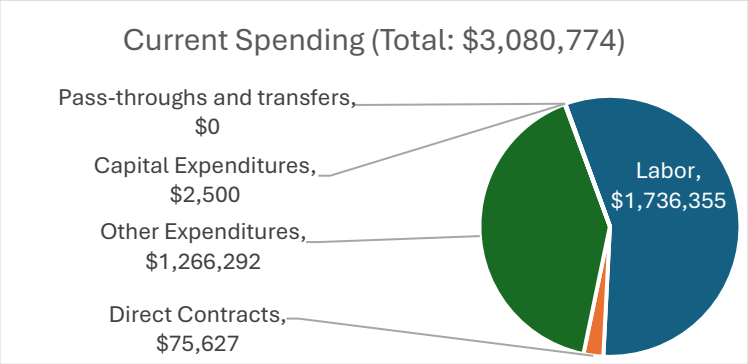
Across all areas, CCPHD's most persistent constraints are funding volatility and categorical restrictions, limited staffing capacity, and the ongoing need to recruit and retain a skilled public health workforce, especially one that reflects the diversity of Clackamas County. Siloed funding and program elements, paired with differing requirements from local, state, and federal funders, create competing directives that complicate long-range planning and consistent service delivery. These pressures stretch existing staff and crowd out time for training, cross-coverage, and quality improvement. Addressing these systemic constraints is essential to fully implement organizational plans and sustain high-quality services. Specific challenges that are relevant to this section include the following:

- Minimal staffing, with only one dedicated communications position to support the entire Division.
- Limited funding for paid media campaigns and for compensating community members who contribute input and feedback.

Communicable Disease Control

Roles	Deliverables
Communicable disease surveillance	Local reports of notifiable diseases
Communicable disease investigation	Portfolio of strategic partnerships with hospitals, health systems, providers, schools, and other partners
	Documented implementation of investigative guidelines
	Documented submission of individual communicable disease case and outbreak data, consistent with Oregon statute, rule and program standards
	Policies in place to ensure maintenance of security of personally identifiable data collected through audits, review, update, and verification
	Protocols for proper preparation, packaging and shipment of disease and outbreak samples of public health importance (e.g., animals and animal products)
	Respond to emerging infectious diseases (e.g., SARS, MERS, Ebola)
	Documented reporting of communicable disease cases and outbreaks to the local public health administrator
	Communications with the public about outbreak investigations
Communicable disease intervention and control	Documentation of policies to ensure appropriate screening and treatment for HIV, STD and TB cases, including pre- and post-exposure prophylaxis for HIV
	Health education resources for the general public, health care providers, long-term care facility staff, infection control specialists and others regarding vaccine-preventable diseases, health care-associated infections, antibiotic resistance, and related issues
	Protocols or process maps for information-sharing between providers to reduce disease transmission
	Plans to allocate scarce resources in an emergency or outbreak
	Reports of gaps in surveillance, investigation, and control of communicable diseases in public health agencies
	Standards and documentation of technical support for enforcement of public health laws (e.g., isolation and quarantine, school exclusion laws)
Communicable disease response evaluation	Assessment reports of outbreak investigation and response efforts, conducted by both state and by local public health
	Evaluation presentations and publications
	Documented results of quality and process improvement initiatives
	Work with PHD to evaluate disease control investigations and interventions. Use findings to improve these efforts

Current Spending	Cost of Full Implementation	Over/Short
$3,080,774	$1,891,001	$1,189,773
Current FTE	**Needed FTE**	**Over/Short**
14.5	8.4	6.1
Expertise	**Capacity**	**Implementation**
Proficient	Minimal	Limited



Overview

- This program has an additional 6.1 FTE and $1,189,773 over what the assessment stated was needed to be fully implemented
- Significant implementation is currently not possible based on budgets and staffing. Attainable expertise, capacity, and implementation goals for this capability are:
  - Proficient expertise
  - Moderate capacity
  - Partial implementation
- Service Delivery
  - This capability is implemented through LPHA staff
  - No other agencies or partners are responsible for providing this service
  - 100% delivered by CCPHD

Implementation to date

Communicable disease surveillance

- *Local reports of notifiable diseases*
  The Infectious Disease Control and Prevention (IDCP) program receives disease notifications through multiple channels, including electronic laboratory reports (ELRs) from major health systems and labs, direct provider and public calls, and online submissions via the county's foodborne illness reporting portal. These systems ensure timely case identification, investigation, and intervention.

- *Portfolio of strategic partnerships with hospitals, health systems, providers, schools, and other partners*
  IDCP maintains strong partnerships across the county and metro region to enhance communicable disease prevention and control. Key collaborators include Cascade AIDS Project, Clackamas Free Clinic, Planned Parenthood, Providence and Legacy Health, Health Share and Trillium CCOs, and the North Clackamas School District. These partnerships expand access to testing and treatment, strengthen community outreach, and support coordinated communication and rapid response across healthcare and public health systems.

Communicable disease investigation

- *Documented implementation of investigative guidelines*
  All documentation of case work is aligned with investigative guidelines with additional recommendations by the health officer as needed.

- *Documented submission of individual communicable disease case and outbreak data, consistent with Oregon statute, rule and program standards*
  IDCP documents all required cases within the Orpheus database system consistent with all Oregon statutes and standards. Outbreaks are tracked and reported via the outbreak database within Orpheus.

- *Policies in place to ensure maintenance of security of personally identifiable data collected through audits, review, update, and verification*
  Policies governing the security of personally identifiable information (PII) are established at the H3S Department level and apply to all CCPHD programs, including IDCP. These policies ensure that data are collected, stored, and reviewed in compliance with privacy standards and state and federal regulations.

- *Protocols for proper preparation, packaging and shipment of disease and outbreak samples of public health importance (e.g., animals and animal products)*
  CCPHD is not directly involved with any animal or animal product preparation/shipment for species of concern in potential rabies cases. For all other human samples (including stool, sputum, serum and certain outbreak related samples), IDCP follows the protocols of the Oregon State Public Health Laboratory for sample processing as well as internal protocols for safe and proper handling.

- *Respond to emerging infectious diseases (e.g., SARS, MERS, Ebola)*
  The IDCP team maintains readiness to respond rapidly and effectively to emerging infectious diseases by reallocating staff, leveraging established partnerships, and utilizing available emergency funds. In FY24, the team successfully managed measles and avian influenza outbreaks in Clackamas County, demonstrating strong cross-agency coordination and surge capacity.

- *Documented reporting of communicable disease cases and outbreaks to the local public health administrator*
  IDCP staff compile and interpret county-level communicable disease surveillance data and case counts, providing regular monthly reports- and additional updates as needed - to the LPHA Administrator. These reports ensure timely situational awareness and informed decision-making during both routine monitoring and outbreak response.

- *Communications with the public about outbreak investigations*
  IDCP works closely with the County Health Officer and PGA to provide timely, accurate, and coordinated public messaging during outbreak investigations. Communications are developed in collaboration with OHA and key partners to ensure clear, culturally responsive, and unified information reaches the public quickly.

Communicable disease intervention and control

- *Documentation of policies to ensure appropriate screening and treatment for HIV, STD and TB cases, including pre- and post-exposure prophylaxis for HIV*

Policies and documentation for tuberculosis (TB) and latent TB infection (LTBI) screening and treatment are maintained by the County Health Officer and public health nurses specializing in TB care. Policies related to HIV and sexually transmitted infection (STI) screening and treatment are in active development as program capacity expands to meet community needs.

- *Health education resources for the general public, health care providers, long-term care facility staff, infection control specialists and others regarding vaccine-preventable diseases, health care-associated infections, antibiotic resistance, and related issues*
  IDCP regularly develops and disseminates educational materials for healthcare professionals, community partners, and the public. Resources include print materials, media campaign content, social media messaging, flyers, and dedicated informational pages on the Clackamas County website.

- *Protocols or process maps for information-sharing between providers to reduce disease transmission*
  Formal protocols or process maps for information sharing between providers are not currently in place. However, existing communication pathways support timely coordination between IDCP, healthcare providers, and other agencies during case investigations and outbreaks.

- *Plans to allocate scarce resources in an emergency or outbreak*
  While written procedures for resource allocation are not yet developed, IDCP maintains the ability to reassign staff and redirect resources as needed during emergencies or outbreaks. Program flexibility and cross-trained personnel ensure continuity of essential disease control functions under constrained conditions.

- *Reports of gaps in surveillance, investigation, and control of communicable diseases in public health agencies*
  IDCP regularly assesses surveillance and investigation capacity, particularly for non-mandated diseases, and adjusts internal priorities based on staffing and resource availability. These reviews help identify operational gaps and guide continuous improvement efforts.

- *Standards and documentation of technical support for enforcement of public health laws (e.g., isolation and quarantine, school exclusion laws)*
  Quarantine and isolation orders, school exclusion notices, and related guidance are routinely reviewed and updated by IDCP staff to ensure alignment with current state and federal public health laws.

Communicable disease response evaluation

- *Assessment reports of outbreak investigation and response efforts, conducted by both state and by local public health*
  Following major or emergent outbreaks, the Infectious Disease Control and Prevention (IDCP) team conducts internal and external debriefs with state and local partners to identify strengths, challenges, and lessons learned. Findings from these evaluations directly inform improvements in future investigation and response efforts.

- *Evaluation presentations and publications*
  IDCP produces an annual report summarizing communicable disease case counts, high-priority conditions, and key response activities. Staff also share program outcomes and lessons learned at professional conferences and through public health networks and have contributed to research publications on communicable disease control and prevention.

- *Documented results of quality and process improvement initiatives*
  Due to limited staffing and competing response priorities, formal documentation of QI initiatives has been limited. However, informal process improvements occur regularly based on post-response reviews and staff feedback.

- *Work with PHD to evaluate disease control investigations and interventions. Use findings to improve these efforts*
  While comprehensive evaluations are not yet routine, IDCP conducts ongoing case reviews with the nursing supervisor and County Health Officer to assess investigation quality, identify data trends, and refine protocols. These reviews serve as a foundation for integrating more structured evaluation practices in the future.

Priorities in order to achieve full implementation

- Strengthen documentation practices, particularly for emergency response procedures and HIV/STI protocols.
- Develop and formalize workflows for communicable disease response evaluation to ensure consistent quality improvement and accountability.

Barriers and challenges towards full implementation

Across all areas, CCPHD's most persistent constraints are funding volatility and categorical restrictions, limited staffing capacity, and the ongoing need to recruit and retain a skilled public health workforce, especially one that reflects the diversity of Clackamas County. Siloed funding and program elements, paired with differing requirements from local, state, and federal funders, create competing directives that complicate long-range planning and consistent service delivery. These pressures stretch existing staff and crowd out time for training, cross-coverage, and quality improvement. Addressing these systemic constraints is essential to fully implement organizational plans and sustain high-quality services. Specific challenges that are relevant to this section include the following:

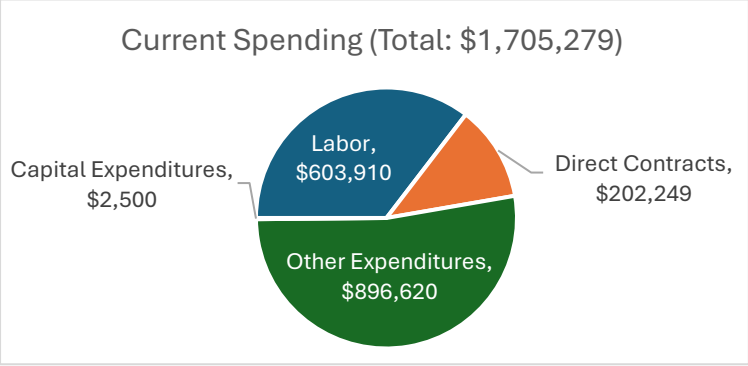
- Reduced internal capacity due to staffing and funding cuts in key program areas.
- Rising workload, as reportable disease investigations and outbreak responses continue to increase in volume and complexity.
- Response-driven operations, where immediate public health demands often supersede planning, workflow development, and documentation—making it difficult to institutionalize evaluation and continuous improvement.

Prevention and Health Promotion

Roles	Deliverables*
Collect, standardize, analyze, coordinate, use and disseminate data	Local summaries, reports and information for: i. Tobacco control; nutrition; oral health; prenatal, natal and postnatal care; childhood and maternal health; physical activity; and unintentional and intentional injuries; ii. Additional health priorities identified in the CHIP or other local prioritization documents; and iii. Behavioral health issues that affect health outcomes for the areas listed in bullet i and ii above. Summaries and reports include information about risk factors and burden of disease among diverse populations.
Provide timely, relevant, and accurate information about social, emotional, and physical health and safety	Documented strategies used to share data, summaries and reports with communities, partners, policy makers and others
Convene stakeholders, engage statewide organizations and partners, and cultivate leadership and vision for prevention and health promotion policies, programs, and strategies	Documented strategies used to educate consumers about the impact of marketing strategies on health
Develop a prioritized plan to address health needs using policy, systems, and environmental change strategies. The prioritized plan aligns the CHIP, the local strategic plan, and other public health planning documents	Portfolio of partners and stakeholders, including local organizations that work with priority populations
Implement local policies, programs, and strategies to improve social, emotional, and physical health and safety at the level supported by existing funding	Documentation of shared priorities and strategies with partners and stakeholders
	Documented participation or leadership in local coalitions
	Documentation of work with the community to build capacity and support community organizing efforts.
	Documented trainings and other learning opportunities made available to partners, stakeholders, and community members
	Local prioritized plan
	Current community health improvement plan. Documentation of annual updates for current CHIP
	Evidence of strategies to reduce health disparities in the CHIP
	Evidence of implementation and coordination of policies, programs and strategies for: i. Tobacco control; nutrition; oral health; prenatal, natal and postnatal care; childhood and maternal health; physical activity; and unintentional and intentional injuries; ii. Additional health priorities identified in the CHIP or other local prioritization plans; and iii. Behavioral health issues that affect health outcomes for the areas listed in bullet i and ii above
	Documented efforts to secure funds for prevention and health promotion programs and interventions
	Evaluation plans; evidence that plans have been shared

*Deliverables for this program are not associated with a specific role category

Current Spending	Cost of Full Implementation	Over/Short
$1,705,279	$3,162,292	$1,457,013
Current FTE	**Needed FTE**	**Over/Short**
4.82	17.6	12.78
Expertise	**Capacity**	**Implementation**
Basic	Minimal	Limited



Overview

- An additional 12.78 FTE and $1,457,013 annually are needed to fully implement this program
- Significant implementation is currently not possible based on budgets and staffing. Attainable expertise, capacity, and implementation goals for this capability are:
    - Proficient expertise
    - Minimal capacity
    - Limited implementation
- Service Delivery
    - This capability is implemented through LPHA staff and contracted services
    - Healthy Columbia Willamette Collaborative (HCWC) partially delivers this service
    - 98% delivered by CCPHD

Implementation to date

Collect, standardize, analyze, coordinate, use and disseminate data

- *Local summaries, reports and information for:*
    - *Tobacco control; nutrition; oral health; prenatal, natal and postnatal care; childhood and maternal health; physical activity; and unintentional and intentional injuries;*
    - *Additional health priorities identified in the CHIP or other local prioritization documents; and*
    - *Behavioral health issues that affect health outcomes for the areas listed in bullet i and ii above.*

  County epidemiologists use local, state, and national data sources - such as the Behavioral Risk Factor Surveillance System (BRFSS), Oregon Student Health Survey, and Nurse Home Visiting program data - to assess trends, identify risk factors, and monitor disease burden across populations. Prevalence and rates are stratified by age, sex, race/ethnicity, and geography to inform resource allocation, outreach, and prevention strategies. Epidemiologists design and maintain reports and data dashboards that translate findings into actionable, equity-focused recommendations for both internal and external partners.

Provide timely, relevant, and accurate information about social, emotional, and physical health and safety

- *Documented strategies used to share data, summaries and reports with communities, partners, policy makers and others*
  Epidemiologists regularly share data through situational awareness meetings, community collaborations, and advisory groups. These include monthly *Clackamas Overdose Response* meetings—where fatal and non-fatal overdose data are presented to community partners, recovery organizations, and law enforcement—and recurring updates to the *Public Health Advisory Council (PHAC)* on emerging public health issues. An internal data dashboard with visualized trend data is maintained to support program planning, communication, and collaboration across Public Health teams and with external partners.

Convene stakeholders, engage statewide organizations and partners, and cultivate leadership and vision for prevention and health promotion policies, programs, and strategies

- *Documented strategies used to educate consumers about the impact of marketing strategies on health*
  CCPHD's Tobacco Prevention and Education Program (TPEP) conducted assessments at all 280 tobacco and alcohol retailers in Clackamas County to document the types of products available and how they are marketed (price promotions, product placement, and advertising). The TPEP Coordinator recruited and trained volunteers to complete the assessments and will present findings to community partners and prevention specialists. These activities build shared understanding of how marketing influences health behaviors and inform community-driven policy strategies.

Develop a prioritized plan to address health needs using policy, systems, and environmental change strategies. The prioritized plan aligns the CHIP, the local strategic plan, and other public health planning documents

- *Portfolio of partners and stakeholders, including local organizations that work with priority populations*
  The prioritized plan aligns the Community Health Improvement Plan (CHIP), the local strategic plan, and other public health planning documents. CCPHD maintains a shared partner and stakeholder spreadsheet in SharePoint for all Program Planners and Coordinators. The directory includes organization names, populations served, and points of contact to strengthen coordination and communication across programs.

Implement local policies, programs, and strategies to improve social, emotional, and physical health and safety at the level supported by existing funding

- *Documentation of shared priorities and strategies with partners and stakeholders*
  CCPHD demonstrates shared priorities and strategies with community partners through collaborative events and funding initiatives.
    - Community-based partnerships: Public Health staff co-created events with Bridging Cultures and Medical Teams International to provide mobile dental services for farmworkers and organized an Overdose Awareness Day to honor survivors and those lost.
    - Grantmaking and alignment: CCPHD distributes grant funding to partners to advance CHIP strategies. Competitive RFPs addressing tobacco and opioid use have drawn broad participation, reflecting strong alignment across community partners.

- *Documented participation or leadership in local coalitions*
  CCPHD leads the Clackamas Community Alliance (focused on substance use and overdose prevention), the Suicide Prevention Coalition, and the Sexual & Reproductive Health Coalition. Staff also actively participate in the

Clackamas County Prevention Coalition and the Hispanic Interagency Networking Team (HINT) to coordinate prevention efforts and share resources.

- *Documentation of work with the community to build capacity and support community organizing efforts.*
  In partnership with Multnomah and Washington Counties, CCPHD received a grant from Health Share to build Traditional Health Worker (THW) capacity to help communities adapt to climate change. THWs, trained in popular education, engage communities in preparing for climate-related emergencies and advocate for sustainable workforce and policy strategies. The initiative includes training THWs and supervisors in community organizing and legislative advocacy to strengthen resilience and self-determination.

- *Documented trainings and other learning opportunities made available to partners, stakeholders, and community members*
  - Naloxone Training: The Substance Use and Overdose Prevention team offers regular trainings to partners and community members, combining data, myth-busting, and destigmatization content. The curriculum has been adapted for Spanish speakers, and sessions are held at accessible community venues.
  - Suicide Prevention: The Suicide Prevention Coordinator and Latine Liaison co-created a virtual suicide prevention training with Datahs International for Spanish-speaking audiences. The presentation integrates cultural values and trauma-informed practices.
  - STI Testing Training: The IDCP program convened organizations offering STI testing and treatment to train them on rapid syphilis and STI testing in community settings, supporting early detection and response.
  - Tobacco Prevention Learning Collaborative: TPEP facilitated learning collaboratives for two cohorts of grantees and hosted the first regional conference focused on strategies to reduce commercial tobacco and vaping use. The conference drew over 80 attendees from culturally and linguistically diverse communities across the Portland metro area.

- *Current community health improvement plan. Documentation of annual updates for current CHIP*
  The 2020–2023 Community Health Improvement Plan (CHIP) - Blueprint for a Healthy Clackamas County - is a living document, reviewed and revised as priorities and conditions evolve. In 2020, a steering committee of PHAC members and community experts updated the 2017–2020 Blueprint, revising goals and adding two new focus areas: COVID-19 Recovery and Resilience and Systemic Racism and Health Equity. The next update is planned for 2026, following the Healthy Columbia Willamette Collaborative's 2025 Community Health Needs Assessment.

- *Evidence of strategies to reduce health disparities in the CHIP*
  The Blueprint is grounded in guiding principles that emphasize health equity, trauma-informed approaches, lifespan health, and climate-conscious strategies. It is organized into five sections:
  - Access to Health Care & Human Services
  - Culture of Health
  - Healthy Behaviors
  - COVID-19 Recovery & Resilience
  - Systemic Racism & Racial Health Equity

  The plan aims to make local health systems more responsive by elevating the voices and priorities of Black, Indigenous, and People of Color (BIPOC) and addressing social determinants of health to improve outcomes for all.
- *Evidence of implementation and coordination of policies, programs and strategies for:*
  - *Tobacco control; nutrition; oral health; prenatal, natal and postnatal care; childhood and maternal health; physical activity; and unintentional and intentional injuries;*
  - *Additional health priorities identified in the CHIP or other local prioritization plans; and*
  - *Behavioral health issues that affect health outcomes for the areas listed in bullet i and ii above*

  Ten organizations received funding through a competitive RFP process to implement Blueprint priorities:
  - Project Access NOW – Hired a Community Health Worker to support chronic disease management (especially diabetes) among immigrant and non-English-speaking communities through culturally specific health education and resource referrals.
  - Clackamas Service Center – Expanded culturally preferred food access through a new 8,000 sq. ft. warehouse, serving Latino, Eastern European, Middle Eastern, and Afghan refugee communities.

- Providence Willamette Falls (BOB Program) – Supported patients with behavioral health and housing needs through peer and outreach specialists assisting post-discharge recovery and stabilization.
- Familias en Acción – Distributed produce boxes and offered Spanish-language nutrition, cooking, and disease prevention education.
- Clackamas Women's Services – Partnered with Clackamas Health Centers to co-locate a Latinx Advocate for improved behavioral health and suicide prevention support for survivors of violence.
- Clackamas Fire District / Project Hope – Expanded addiction resource access and coordinated data-driven responses for individuals with behavioral health and substance use challenges.
- Our House of Portland / Esther's Pantry – Provided affirming, culturally relevant food access for LGBTQ+ and immigrant clients, including multilingual signage and outreach.
- LoveOne – Operated a rural food pantry at Redland Grange to meet nutritional, mental health, and housing stability needs.
- Immigrant Mutual Aid Coalition – Distributed culturally specific food and health education in partnership with Bridging Cultures and local volunteers.
- Oregon Firearm Safety Coalition – Engaged firearm owners in suicide prevention through trauma-informed, community-led initiatives promoting safe storage and behavior change.

- *Documented efforts to secure funds for prevention and health promotion programs and interventions*
  Public Health programs submit robust work plans to OHA to secure funding through the Program Elements (PE). Funding is becoming increasingly more competitive and is not guaranteed. In addition, Public Health staff have requested funding from Health Share, Care Oregon, and the federal government for Sargeant Fox Suicide Prevention among veterans. In addition, Public Health staff have supported community partner organizations in applying for funding. For example, the Natural and Built Environment Analyst secured funding for a community group in the Sunrise Corridor to plant trees in effort to cool their heat island. Program Planners across CCPHD met over 40 organizations applying for Health Equity Grants from OHA to explore collaborative opportunities and align prevention and health promotion strategies in Clackamas County. The conversations with partners resulted in the Director providing letters of support for nearly all organizations. If funded, CCPHD will diversify the populations reached through partners.

- *Evaluation plans; evidence that plans have been shared*
  Every CCPHD program includes an element of evaluation in the work plans submitted to OHA. The Public Health Strategic Plan includes Accountability and Performance Management to monitor program effectiveness. CCPHD submits metrics for every program to the BCC as required by Performance Clackamas.

Priorities in order to achieve full implementation

- Partner with community-based organizations to improve the representativeness and interpretation of data
- Establish peer review system and quality control processes of all data products and reports
- Develop a public-facing data dashboard to increase transparency and data sharing between the County and other public health departments, community partners, and the general public
- Invite community feedback to improve future reporting

Barriers and challenges towards full implementation

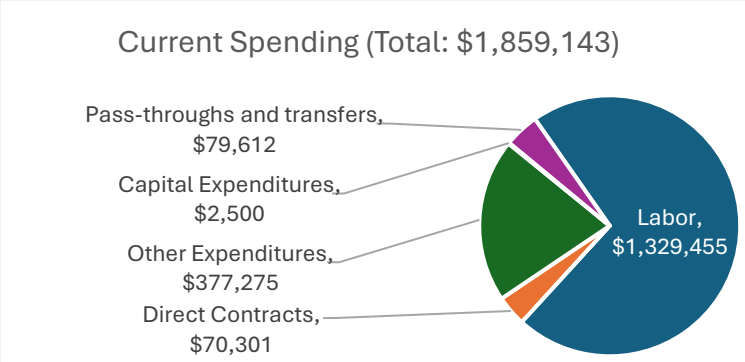
Across all areas, CCPHD's most persistent constraints are funding volatility and categorical restrictions, limited staffing capacity, and the ongoing need to recruit and retain a skilled public health workforce, especially one that reflects the diversity of Clackamas County. Siloed funding and program elements, paired with differing requirements from local, state, and federal funders, create competing directives that complicate long-range planning and consistent service delivery. These pressures stretch existing staff and crowd out time for training, cross-coverage, and quality improvement. Addressing these systemic constraints is essential to fully implement organizational plans and sustain high-quality services. Specific challenges that are relevant to this section include the following:

- Insufficient local-level data for key health indicators, limiting the ability to detect and respond to emerging trends.
- Fragmented data systems, particularly between behavioral health and chronic or maternal and child health datasets, which hinder integrated analysis and coordinated intervention planning.

Environmental Health

Roles	Deliverables
Identify and prevent environmental hazards	Current community health assessment that includes environmental health
	Written best practices for vector control
	Policy briefs and other communications on environmental health impacts
	Documented communications on environmental health hazards and protection recommendations to regulated facilities, the public and stakeholder organizations
Conduct mandated inspections	Documented provision of licensing and certification of recreational facilities, food service facilities and tourist accommodations
	Review and inspection reports of regulated entities and facilities
	Documented investigation of complaints and assessment of fines/penalties, including those related to: i. Waterborne disease; ii. Regular drinking water testing and reporting of results; and iii. Failure to meet water quality standards and requirements
	Documented compliance with standards and processes
	Documented enforcement of regulations
	Information systems that provide current and accurate information to support environmental health functions at the state and local level
	Documented consultations on the assessment and mitigation of environmental health hazards for the food service industry and the general public
Promote land use planning	Documentation of health analyses prepared for other organizations with recommended approaches to ensure healthy and sustainable built and natural environments
	Communications on environmental justice concerns and disparities

Current Spending	Cost of Full Implementation	Over/Short
$1,859,143	$6,370,388	$4,511,245
Current FTE	**Needed FTE**	**Over/Short**
10.06	32.2	22.14
Expertise	**Capacity**	**Implementation**
Basic	Minimal	Limited



Overview

- An additional 22.14 FTE and $4,511,245 annually are needed to fully implement this capability
- Significant implementation is currently not possible based on budgets and staffing. Attainable expertise, capacity, and implementation goals for this capability are:
  - Basic expertise
  - Minimal capacity
  - Limited implementation
- Service Delivery
  - This capability is implemented through LPHA staff and cross-jurisdictional sharing
  - Multnomah County, Washington County collaboratively delivers this service
  - 98% delivered by CCPHD

Implementation to date

Identify and prevent environmental hazards

- *Current state or community health assessment that includes environmental health*
  The 2020–2023 Blueprint for a Healthy Clackamas County serves as the county's Community Health Improvement Plan (CHIP) and was approved by the Board of County Commissioners in October 2020. It seeks to improve health and quality of life through an equity-driven framework built on four guiding principles: racial and health equity, trauma-informed approaches, health across the lifespan, and climate-conscious strategies. The Blueprint builds upon priorities identified in the Healthy Columbia Willamette Collaborative's 2019 Community Health Needs Assessment.

  In April 2025, CCPHD completed the Climate and Health Adaptation Plan, which outlines actions to reduce climate-related health risks and strengthen community resilience - particularly for populations disproportionately affected by climate change. Implementation of this plan will continue through 2027.

- *Written best practices for vector control*
  The Clackamas County Vector Control District, an independent entity, manages the control of flies and mosquitoes within the county. CCPHD Environmental Health staff reference best practices from the Centers for Disease Control and Prevention (CDC) and OHA's Environmental Public Health program. These standards guide Environmental Health Specialists (EHS) during inspections of licensed facilities, reviews of school Integrated Pest Management plans, and consultative responses to public complaints related to pests in non-regulated environments (e.g., neighborhood rodent concerns).

- *Policy briefs and other communications on environmental health impacts*
  CCPHD communicates environmental health risks during severe weather and wildfire events. In periods of extreme heat, cold, or smoke, the Division partners with PGA to issue guidance on air quality, water safety, and exposure prevention. Messaging is targeted to at-risk populations and shared through press releases, social media, and multilingual alerts. These coordinated efforts inform policy, support preparedness, and strengthen community resilience to climate-related health impacts.

- *Documented communications on environmental health hazards and protection recommendations to regulated facilities, the public and stakeholder organizations*
  Environmental Health staff communicate regularly with regulated facilities, community partners, and the public about environmental health hazards and protective actions. Messages are shared through inspection reports, advisories, press releases, and direct outreach to ensure timely, accurate information.

  Examples include email alerts to food establishments during ice storms or utility disruptions; notifications to drinking water systems when power loss or pressure drops occur due to wildfires or safety shutoffs; coordinated messages with PGA during norovirus outbreaks detailing control measures; and advisories for public water system boil-water notices. CCPHD also partners with the Oregon Department of Agriculture (ODA) and the Department of Early Learning and Care (DELC) to align messaging and ensure rapid, coordinated response.

Conduct mandated inspections

- *Documented provision of licensing and certification of recreational facilities, food service facilities and tourist accommodations*
  CCPHD uses OHA's HealthSpace licensing and inspection software to issue and manage facility licenses. All licenses and inspection reports are stored within the database in accordance with Oregon's records retention schedule [OAR 166-150-0070 (8)]. Completed license applications and plan reviews are uploaded into *HealthSpace*, while plan documents and blueprints are maintained in paper files for reference during facility reviews.

- *Review and inspection reports of regulated entities and facilities*
  Environmental Health Specialists (EHS) inspect all CCPHD-licensed facilities at OHA-set frequencies: two routine compliance inspections per calendar year (once annually for seasonal recreational facilities and tourist accommodations; once per licensing period for temporary restaurants). Performance is measured against the OHA Intergovernmental Agreement (IGA) requirement to complete ≥90% of routine inspections each calendar year; the program goal is 100%. Inspection reports are drafted in HealthSpace and emailed to facilities at the time of inspection. When technical issues occur, paper reports are used and later entered into HealthSpace.

- *Documented investigation of complaints and assessment of fines/penalties, including those related to:*

- *Waterborne disease*
  When laboratory-confirmed, presumptive, or complaint-based reports of waterborne illness are received by the Infectious Disease Control and Prevention (IDCP) program, IDCP staff notify Environmental Health (EH) for investigation. Environmental Health Specialists (EHS) coordinate with the Health Officer, nurses, epidemiologist, and supervisors to collect and review information and plan the response. Investigation documentation is stored in a designated shared drive folder and, depending on the location, may also be filed in *HealthSpace* (for licensed facilities), drinking water files (for public water systems regulated by CCPHD), and/or *ORPHEUS* (for confirmed outbreaks assigned a state outbreak number).

- *Regular drinking water testing and reporting of results*
  OHA notifies CCPHD when public water systems under local jurisdiction fail to submit required test results or when reported results exceed detection or maximum contaminant levels. OHA maintains this information and alert data in the state's online database *Your Water, Oregon*. All communications between EHS and the affected water systems are documented there as contact reports.

- *Failure to meet water quality standards and requirements*
  EHS conduct sanitary surveys of public water systems assigned to CCPHD at OHA-defined intervals. CCPHD provides survey reports to OHA, which are available online through *Your Water, Oregon* portal, and retains copies in local facility files. When water quality issues are identified- either during surveys or from test results - EHS work directly with systems to resolve deficiencies and meet correction timelines following OHA Drinking Water Services (DWS) procedures.

  When total coliform or E. coli is detected, a Level 1 investigation (conducted by the water system operator) or a Level 2 investigation (conducted by EHS) is required to identify and correct sanitary defects. CCPHD prioritizes informal enforcement to bring systems into compliance, reserving formal enforcement actions for persistent or high-risk violations. Formal enforcement is led by OHA DWS, and all compliance documentation is maintained in the state's online database.

- *Documented compliance with standards and processes*
  The EH Manager or Supervisor monitors inspection progress monthly and adjusts workloads as needed. All inspections meet OAR 333-012 requirements, with training provided by both OHA and CCPHD. CCPHD participates in the FDA's Voluntary National Retail Food Regulatory Program Standards and aims to fully meet Standard 4 (Uniform Inspection Program) by 2028. EH management shadow EHS every one to three years to review inspection techniques and code interpretation. EHS complete FDA Standardization every three years and conduct annual peer maintenance inspections. QA reviews ensure accuracy, consistency, and compliance with documentation maintained in the shared drive. OHA conducts triennial reviews of EHS performance and inspection files under OAR 333-012 and IGA standards.

- *Documented enforcement of regulations*
  Enforcement of violations for licensed food, recreational, and tourist facilities follows OHA procedures and is documented in *HealthSpace*. Enforcement activities for non-licensed facilities are tracked by Administrative Services and retained electronically for ten years, including referrals to other enforcement agencies.

- *Information systems that provide current and accurate information to support environmental health functions at the state and local level*
  CCPHD issues newsletters and email notifications to licensed facilities about rule changes, fee updates, recalls, and other public health concerns. During boil-water advisories, EHS send guidance and consult directly with affected food facilities to ensure safe operations. OHA's HealthSpace system captures CCPHD data on facility licenses and completed inspections.

- *Documented consultations on the assessment and mitigation of environmental health hazards for the food service industry and the general public*
  Food service consultations are documented in HealthSpace as part of inspection, re-check, or stand-alone consultation reports. Public complaints and related correspondence are retained electronically for ten years by Administrative Services.

Promote land use planning

- *Documentation of health analyses prepared for other organizations (and agencies) with recommended approaches to ensure healthy and sustainable built and natural environments.*

CCPHD integrates health and equity into land use and transportation planning through the work of its Built and Natural Environment Analyst and Epidemiologist. Using a Health in All Policies approach, staff have partnered with the Department of Transportation and Development (DTD) and Community Development to incorporate health analysis, data, and recommendations into key projects such as the Sunrise Community Visioning Plan, Transportation System Plan Equity Analysis, and Transportation Safety Action Plan.

Health Impact Assessments (HIAs) have been conducted for projects including the Transitional Shelter Community for Veterans, Hillside Master Plan, and Courtney Avenue Complete Streets - evaluating potential health impacts and identifying mitigation strategies. When full participation isn't possible, CCPHD provides health data and recommendations for specific plan components, such as the Walk Bike Clackamas Plan and the Transportation Equity Index for Oregon's proposed tolling project.

The Climate and Health Adaptation Plan (2023–2025) further embeds health and resiliency into County planning. This cross-departmental collaboration informs policy and funding decisions to reduce climate-related health risks, especially from extreme heat and poor air quality, and supports communities most impacted by climate change.

- *Communications on environmental justice concerns and disparities*
  CCPHD communicates environmental justice and health equity concerns through active participation in local and regional planning efforts. The Built and Natural Environment Analyst serves on committees such as Metro's Technical Advisory Committee, the Safety System Approach Technical Advisory Committee, and the Resiliency Collaborative, which convenes quarterly to align resilience-building strategies across agencies and community organizations.

  Staff present findings from the Regional Climate and Health Monitoring Report and Regional Heat Mapping Project to audiences across housing, transportation, disaster management, and environmental health sectors. CCPHD also collaborates with Multnomah and Washington Counties to align strategies and produce joint analyses, including the Tri-County Jurisdictional Scan and Regional Public Health and Climate Hazards Coordination Assessment.

  Through partnerships with the Office of Public Health Emergency Services, Disaster Management, and Health Services, CCPHD incorporates environmental justice principles into County emergency communications and public messaging, ensuring that information reaches and resonates with communities most at risk.

Priorities in order to achieve full implementation

- Strengthen internal and external partnerships. Effective land use and transportation policy work depends on trusted relationships between community advocates and agencies with decision-making authority.
- Co-create solutions with community partners to address health inequities and build local capacity for policy engagement in Clackamas County.
- Provide training for the Public Health Advisory Council, community-based organizations, and residents to understand and participate in legislative and policy processes that influence health—such as climate, housing, transportation, education, and the economy.
- Build staff capacity across departments to integrate health and equity considerations into land use and transportation planning.

Barriers and challenges towards full implementation

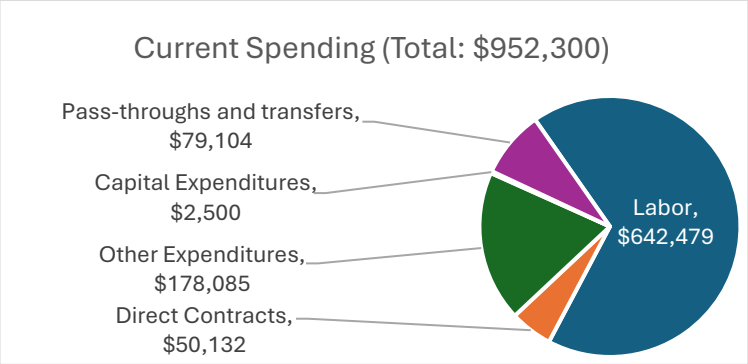
Across all areas, CCPHD's most persistent constraints are funding volatility and categorical restrictions, limited staffing capacity, and the ongoing need to recruit and retain a skilled public health workforce, especially one that reflects the diversity of Clackamas County. Siloed funding and program elements, paired with differing requirements from local, state, and federal funders, create competing directives that complicate long-range planning and consistent service delivery. These pressures stretch existing staff and crowd out time for training, cross-coverage, and quality improvement. Addressing these systemic constraints is essential to fully implement organizational plans and sustain high-quality services. Specific challenges that are relevant to this section include the following:

- Variable capacity and priorities across departments and jurisdictions limit policy change. Smaller jurisdictions often struggle to meet state mandates, leaving little capacity for voluntary or innovative policy work.
- Partnership gaps persist, particularly with community organizations engaged in advocacy and built-environment work, reducing opportunities for collaboration and shared action.

Access to Clinical Preventive Services

Roles	Deliverables
Ensure access to cost-effective clinical care	Jurisdictional reports on access to clinical preventive services
	Documentation of resources provided to clinical and community partners on evidence-based guidelines for the delivery of clinical preventive services
	Documentation of work with partners to recommend strategies for improving access to clinical preventive services
	Documentation for the development and implementation of a plan for improved access to clinical preventive services, particularly for priority populations. Document implementation of this plan
	Evaluation reports of policies implemented to improve access to clinical preventive services
	Documentation of compliance with state and federal laws

Current Spending	Cost of Full Implementation	Over/Short
$952,300	$863,394	$88,906
Current FTE	**Needed FTE**	**Over/Short**
4.82	4.47	0.35
Expertise	**Capacity**	**Implementation**
Proficient	Minimal	Limited



Overview

- This program has an additional 0.35 FTE and $88,906 over what the assessment stated was needed to be fully implemented
- Significant implementation is currently not possible based on budgets and staffing. Attainable expertise, capacity, and implementation goals for this capability are:
  - Proficient expertise
  - Moderate capacity
  - Partial implementation
- Service Delivery
  - This capability is implemented through LPHA staff and contracted services
  - University of Washington, Cascade Aids Project (CAP), Planned Parenthood partially delivers this service
  - 89% delivered by CCPHD

Implementation to date

Ensure access to cost-effective clinical care

- *Jurisdictional reports on access to clinical preventive services*
  CCPHD ensures access to preventive clinical services through an integrated network of School-Based Health Centers (SBHCs), Federally Qualified Health Centers (FQHCs), the Women, Infants, and Children (WIC) Program, and Nurse Home Visiting (NHV) services. These programs collectively expand access to immunizations, reproductive health, family planning, nutrition support, and maternal-child health services, particularly for uninsured, underinsured, and Medicaid-eligible residents.
  Routine data reports track utilization, visit types, and demographic trends across these programs. Metrics include vaccination coverage, reproductive health access, WIC participation, and home visiting caseloads. These data are used internally to guide program improvement and outreach activities.

- *Documentation of resources provided to clinical and community partners on evidence-based guidelines for the delivery of clinical preventive services*
  CCPHD ensures that clinical and community partners have access to current, evidence-based guidelines for the delivery of preventive services. Staff regularly share and implement recommendations from the CDC, the U.S. Preventive Services Task Force (USPSTF), and OHA through joint trainings, resource materials, and standing collaborative meetings.

- *Documentation of work with partners to recommend strategies for improving access to clinical preventive services*

CCPHD collaborates with FQHCs and community partners to reduce barriers and improve access to preventive services for families. Working with FQHC providers, Public Health developed a streamlined electronic referral process in EPIC that allows medical providers to directly refer newly pregnant individuals to WIC and Nurse Home Visiting (NHV) programs early in pregnancy. Public Health staff close the loop by enrolling clients and confirming referrals with providers, resulting in earlier access to nutrition education and prenatal support.

Additionally, CCPHD partners with Head Start programs across Clackamas County to connect enrolled families with WIC services. WIC staff participate in Head Start family events, provide on-site outreach and eligibility screening, and coordinate referrals with family advocates. This collaboration helps ensure that young children receive nutritional support, growth monitoring, and early access to preventive services that promote lifelong health.

- *Documentation for the development and implementation of a plan for improved access to clinical preventive services, particularly for priority populations. Document implementation of this plan.*
  CCPHD does not currently have a plan for improved access to clinical preventive services, particularly for priority populations.

- *Evaluation reports of policies implemented to improve access to clinical preventive services*
  CCPHD demonstrates this standard through consistent sharing of evidence-based resources and training with clinical and community partners. Examples include:
  - Resource dissemination: Routine distribution of CDC, OHA, and U.S. Preventive Services Task Force (USPSTF) updates to FQHCs, School-Based Health Centers (SBHCs), WIC, and NHV staff. Topics include immunizations, reproductive health, chronic disease prevention, safe sleep, and nutrition.
  - Training and technical assistance: Public Health Nurses, WIC nutrition counselors, and program coordinators provide in-service trainings, webinars, and partner meetings to align local practices with current evidence-based guidelines.
  - Standardized materials: Client education materials, clinical standing orders, and referral protocols are reviewed regularly to ensure they reflect national best practices and state guidance. WIC and NHV outreach materials and nutrition education handouts are translated and adapted for cultural and linguistic appropriateness.
  - Documentation: Meeting notes, email communications, and training records are maintained in program files as evidence of information sharing and implementation support.

- *Documentation of compliance with state and federal laws*
  All CCPHD programs comply with federal and state laws governing the provision of clinical services, including confidentiality (HIPAA), informed consent, minor access to reproductive health care, and nondiscrimination. SBHCs and FQHCs operate under OHA and HRSA guidelines and are subject to periodic audits and clinical compliance reviews. WIC and NHV programs meet all USDA and OHA reporting, documentation, and confidentiality standards.

Priorities in order to achieve full implementation

- Strengthen partnerships with FQHCs, School-Based Health Centers (SBHCs), WIC, and Nurse Home Visiting (NHV) programs to improve early access to preventive services for pregnant individuals, children, and families.
- Expand closed-loop referral systems between healthcare providers and WIC/NHV to ensure timely enrollment and follow-up for eligible clients.
- Increase data integration between CCPHD programs and partner clinics to identify service gaps and track outcomes.
- Support consistent training across programs and partners on evidence-based preventive care guidelines and culturally responsive practices.
- Continue to align public health communication and outreach efforts to ensure equitable access to immunizations, reproductive health, and nutrition services across diverse communities.

Barriers and challenges towards full implementation

Across all areas, CCPHD's most persistent constraints are funding volatility and categorical restrictions, limited staffing capacity, and the ongoing need to recruit and retain a skilled public health workforce, especially one that reflects the diversity of Clackamas County. Siloed funding and program elements, paired with differing requirements from local, state, and federal funders, create competing directives that complicate long-range planning and consistent service delivery. These pressures stretch existing staff and crowd out time for training, cross-coverage, and quality

improvement. Addressing these systemic constraints is essential to fully implement organizational plans and sustain high-quality services. Specific challenges that are relevant to this section include the following:

- Limited funding for staff and data infrastructure to sustain partnership development and system integration.
- Capacity constraints at FQHCs and SBHCs that delay referrals and follow-up for preventive services.
- Inconsistent data-sharing agreements between partners, which hinder coordinated care and evaluation.
- Ongoing barriers to care for rural and limited-English-proficiency populations, including transportation and language access.